

7A.2.1 Executive Summary

This is a time of dramatic change in Iowa's human services delivery system. In the face of budget shortfalls, declining state revenues, and increasing demand for services, the Department of Human Services and the Department of Public Health (Departments) are facing incredible new challenges. From providing better services to children and families to expanding crisis services statewide, the Departments are focusing their efforts on re-designing programs and re-aligning services to assure the most effective use of all their resources.

This landscape of change clearly demonstrates the importance of re-designing and re-aligning the way in which services are provided through the Iowa Plan for Behavioral Health (the Iowa Plan), a major resource for both Departments. With the right Contractor, the Iowa Plan can support system re-design while improving the delivery of mental health and substance abuse services. We appreciate the opportunity to demonstrate that ValueOptions of Iowa, LLC (VOI) is the right Contractor.

THE CHALLENGES—RECOGNIZING THE NEEDS OF IOWANS

The Iowa Plan was established, first and foremost, to ensure that Iowa's citizens have access to high-quality behavioral health services. With the Iowa Plan, the State has laid the groundwork for a system that is based on state-of-the-art recovery and resiliency approaches to caring for Eligible persons in need of mental health and substance abuse care, as well as their families. The Iowa Plan is designed to provide services to Eligibles of all ages, from young to old. Its mandate is to provide these services in the most effective, high-quality manner possible, through an infrastructure that is based in the communities and counties in which Eligible persons live. The structure of the Iowa Plan requires extensive collaboration between all stakeholders to ensure an integrated and comprehensive behavioral health system that is responsive to the needs of all Eligible persons accessing this system.

Understanding this background, the Request for Proposals (RFP) reflects the desire of the Departments to continue to improve the Iowa Plan for Behavioral Health. The challenges facing the state are large; however, in choosing VOI as the contracted Single Statewide Contractor (SSC), the Departments will ensure the systems enhancements and innovative strategies that address the following areas of concern are put into place:

Fragmented System and lack of unified approach: *“There is little coordination between DHS and Magellan, which handle Medicaid-funded services, and the CPC, which oversees non-Medicaid-funded services to the county. ... A recent national study of state mental health systems described Iowa's system as being “among the most convoluted ... in the country” An Analysis of Iowa's Mental Health Care System, University of Iowa, 2007.*

Complete Lack of a Coordinated Children's System of Care: *“Children's Mental Health Services ... are non-existent in many counties.” Mental Health Systems Improvement in Iowa: A Report to the Legislature and Governor January 31, 2008. “Families are also bewildered by a system that really offers no single point of entry for them and this increases the inability of communities to be appropriately responsive.” State of Iowa SAMHSA System of Care Grant Application for Children's Mental Health, 2007.*

Emergency Department (ED) Overspending/Lack of Mobile Crisis Services: *“There are no state-wide standards for the establishment, accreditation and operation of emergency mental health crisis services in the state.” DHS Proposed Legislative Package, 2008 Legislative Session “dollars spent for persons in need of emergency mental health services is inconsistent ... a significant trend towards the transportation of persons in crisis to emergency departments rather than developing, implementing, and maintaining in-home or other alternative community-based mobile crisis services ... In the most recent year Magellan reported that only \$35,000 was spent statewide on mobile crisis services” Mental Health Systems Improvement in Iowa: A Report to the Legislature and Governor January 31, 2008.*

Lack of physicians (particularly child psychiatry): *“Iowa ranks 47th in the nation in the number of psychiatrists per resident. Given that Iowa's psychiatrists are concentrated in only 30 of the 99 counties, it is often difficult to meet the needs of the state's mental health population.” An Analysis of Iowa's Mental Health Care System, University of Iowa, 2007.*

No single statewide data source: *“Iowa does not have a mechanism in place for system-wide data sharing, and the criteria used to collect this information often produce misleading and disconnected information.”* *An Analysis of Iowa’s Mental Health Care System*, University of Iowa, 2007. *“We do not have adequate IT capacity (to) identify where consumers are entering into and served in the system, and that if the system continues to have more than one point of entry this could contribute to confusion on access, fragmentation of service, and possibly cost inefficiency through duplication of efforts.”* *Mental Health Systems Improvement in Iowa: A Report to the Legislature and Governor* January 31, 2008.

In addition to the above, many more areas of concern were identified by individuals who receive Iowa Plan services throughout the state. To illustrate instances when identified concerns can lead to improvement, we have incorporated the actual words of individuals and stakeholders with whom we met throughout the RFP process. We believe that all of the challenges they describe, and those that we identify in this proposal, can be overcome when the state chooses VOI to implement innovative and proven strategies aimed at ensuring 1) *all* Eligible persons of the Iowa Plan receive high-quality and appropriate treatment, and 2) the overall cost effectiveness of the Iowa Plan. When VOI is selected as the Iowa Plan’s SSC, it will be our privilege to be responsive and accountable to the Departments while achieving both objectives.

A New Approach — ValueOptions® is the nation’s largest **privately held** behavioral health care company and is a recognized leader in public sector managed behavioral health care. As a result, stock market fluctuations and shareholder issues that worry our publicly-held competitors and their staff do not distract us from delivering efficient and effective services for the Eligible persons or our State customers.

In developing our proposal in response to the Iowa Plan RFP, we have taken the best of the “lessons learned” from our public/private partnerships and combined them into a program that will enable the Departments to leverage ValueOptions’ national experience while building upon the local expertise of the counties, providers, and other stakeholders. VOI believes the Iowa Plan is a Partnership and we have the experience and expertise to customize our program to meet the needs of the Departments. This experience will ensure that the Departments not only receives the same level of service currently expected, but also observes significant enhancements leading to better coordination of care, improved consumer outcomes, and enhanced partnering and collaboration among stakeholders and service providers.

The current Contractor for the Iowa Plan can no longer assure effective services and system development using a traditional managed care model—one in which staff and services are based in a centrally located Service Center. Instead, the VOI will work with Eligible persons, families, and providers in their own communities, focusing resources on those most in need and on those whose access to the system is most limited. VOI staff will participate personally in individual treatment planning and in community planning meetings. VOI will make Iowa Plan data available to support local planning efforts. VOI will make opportunities to participate in quality management initiatives and consumer-centered programs available across the state.

Furthermore, using evidence-based and best clinical practices, VOI will work with the Departments to build community partnerships and strengthen local delivery systems.

Many of our recommendations came from suggestions of Iowans who are most familiar with the Iowa Plan and how it is working today.

In our response to this RFP, VOI offers a variety of strategies that will support and enhance the Departments’ new initiatives while at the same time improving the effectiveness of current mental health and substance abuse services. Some of our recommendations were adapted from successful public sector programs that ValueOptions operates in partnership with other states. Others programs were selected based on our analysis of current Iowa Plan utilization data. Many new offerings were developed from the suggestions of Iowans who are most familiar with the Iowa Plan today—Eligible persons, family members, providers, advocates, county staff and state legislators.

The result of the consolidation and analysis of this information is this proposal—VOI’s recommendations to establish a completely new paradigm for serving Iowa’s behavioral health care community and for supporting the Departments.

RECOGNIZING THE OPPORTUNITIES—PRIORITIES FOR THE 2010 IOWA PLAN

When selecting VOI as its behavioral health vendor, the Departments must be convinced that VOI will be responsive to the state's and to providers' needs, is fully accountable for the services rendered, and offers the strategies most likely to ensure the appropriateness of treatment and the cost effectiveness of the delivery system. It is noteworthy that the challenges identified above and the state's priority areas addressed below are not new. In the five years since this contract was last bid, it is apparent that progress towards addressing these priority areas has been lacking. Highlights of our proposal, which we believe will allow us to address the challenges discussed above, in addition to the other state priorities described below, include:

Provision of Services to Eligibles Age 65 and Older in the Iowa Plan — VOI's basic goal in providing services for elder Iowans is that they will experience improved quality of life and gain/regain more independent functioning and enjoyment. ValueOptions has a wealth of experience in serving this population through our other public sector and private contracts and success in the smooth transition of services within state systems for this age group. Because VOI would be assuming the responsibility for services to this population in addition to the other Eligibles who will be new to VOI, our transition plan and communications plan will address comprehensively the unique needs of these Eligible persons and their providers in the context of a seamless transition. Because of this, **we are committed to serving this population on day one of the contract start date.**

Expansion of Recovery and Rehabilitation Services — In support of the Departments' emphasis on expanding the integration of rehabilitation and recovery principles across the delivery system, VOI has adapted some of our most successful peer programs for the Iowa Plan. Our proposal includes the following initiatives:

- VOI will offer a **warm line** at the Service Center to be staffed by consumers and family members who are trained by advocacy organizations. We will implement the innovative model developed by Ed Knight, Ph.D., ValueOptions' Vice President for Rehabilitation, Recovery and Mutual Support. In this model, warm lines are "active" as opposed to "passive"—that is, **Peer Specialists** routinely call selected Eligible persons and families to see how things are going from their perspective. Clinical Care Managers and providers are notified whenever concerns are identified.
- VOI will increase the number of **Certified Peer Specialists** and expand this offering to include Family Peer Specialists and Substance Abuse Peer Specialists/Recovery Coaches.

Improvement in Services for Children and Families — VOI agrees with the Departments' analysis that there is a significant opportunity to improve services for eligible children with emotional and behavioral issues. VOI believes that a children's system of care that utilizes the following strategies will significantly reduce the extended lengths of stay currently common in Psychiatric Mental Institutions for Children (PMICs).

- **Family Peer Specialists** are individuals who are family members of children or adults who have received behavioral health care and/or substance abuse treatment. These Family Peer Specialists work along with the clinical providers to ensure the communication of a recovery and resiliency orientation in the behavioral health care system and work directly with eligible children and youth, and families to strengthen families' capacity to understand and cope with their behavioral health diagnoses.
- VOI will promote and provide the infrastructure for the adoption of **System of Care (SOC)** principles and **expansion of wraparound** for all youth and families.
- The expansion of **early childhood mental health consultation**, early childhood mental health specialist credentialing and **school-based mental health care** will be one of VOI's priorities.
- Developing a process for granting **flexible funding** through the community reinvestment fund (CRF) will ensure that non-traditional services and supports are available to support eligible children and families in remaining in their homes and communities.

Reduction in Readmission Rates — Based on our analysis of Iowa Plan data, our first priority will be the development of local crisis systems to offer mental health and substance abuse services to children and adults; the success of these systems is critical to reducing rates of inpatient readmissions. We will provide training in a variety of crisis response models and work with the Departments to encourage participation by providers, decategorization boards, community partnership programs, and county staff. With the Departments, we will establish minimum standards for the local systems and procedures to prioritize implementations across the state. VOI believes this crisis

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response system, in addition to the following new resources, will reduce readmission rates significantly, particularly for eligibles who are children.

- We propose to develop the capacity for mental health sub-acute care across the state through the development of 24-hour crisis stabilization services—for example, the use of **peer-run crisis hostels** and **hospital diversion homes**.
- VOI will work with the Departments, local providers, emergency responders, and other stakeholders to develop and implement **mobile crisis response teams** throughout the State.
- VOI will develop and contract for **Professional Resource Family Care** (out-of-home crisis stabilization), which will provide direct 24-hour-a-day care and supervision for a child or youth with a serious emotional disturbance (SED) who might otherwise be placed in a more restrictive setting, without requiring the relinquishment of custody to access supportive services.

Statewide Service Availability — We will set goals to develop capacity for “required services” to Iowa Plan Eligible persons on a statewide basis over the term of the contract. VOI will work with the Departments and stakeholders to determine the priority in which to engage in service capacity building across the State. In response to the overwhelming concerns regarding access to psychiatric and medical support, VOI will focus on expanding access through innovative approaches that have proven successful in other ValueOptions programs, including the recruitment of mid-level practitioners to allow for the establishment of a psychiatric medical home in local communities, expansion of the **use of telehealth** and the implementation of our proven model of **psychiatric consultation to primary care physicians**.

Expanded Measurement of Outcomes — VOI is proposing that the State of Iowa utilize CONNECTIONS as the single statewide data management system for the collection of Substance Abuse and Mental Health Services Administration (SAMHSA) National Outcomes Measures (NOMs) and other data requirements for all Eligibles. CONNECTIONS is ValueOptions’ information system that provides Web-based applications. This would include Eligibles in the Iowa Plan and **all other members of target populations identified by the state**. Through a simple-to-use Web-based consumer registration process (ProviderConnect), VOI will collect all demographic, clinical, and functional criteria required to meet SAMHSA and DHS/DPH reporting requirements.

Continuous Quality Improvement — Because the providers in Iowa are well acquainted with managed behavioral health care, VOI will focus our clinical resources on serving Eligible persons identified as “high need” or “high risk.” We will also use provider profiling strategies to identify providers whose practice patterns indicate the need for additional training and clinical consultation. Through this strong program of outlier management—which includes the use of our advanced analytics such as **PharmaConnect®**—we will minimize the amount of time both our Clinical Care Managers and provider agencies must spend in the prior authorization and concurrent review of treatment processes.

In addition to the priority areas identified above, VOI has addressed the State’s other state-defined priority areas throughout our proposal. The strategies and methods for integrating and coordinating care across diagnoses and throughout systems, including with other state and local agencies, are detailed in *Section 7A.2.3, Coordination and Integration of Services*.

ADDRESSING THE CHALLENGE—INNOVATIONS IN CARE MAKE THE DIFFERENCE

At first glance, a transition process can seem overwhelming. However, some of our largest and most successful public sector programs began with a transition from an incumbent vendor. From our experiences in Massachusetts, Tennessee, and Texas, we have learned the most effective ways to work with an incumbent, the state agency, and the program’s stakeholders to make the implementation period an opportunity for introducing a new, revitalized program.

Recognizing that the transition to a new SSC is daunting not only for the state but also for those Eligible persons who access behavioral health care services, VOI will utilize the time between award and January 1, 2010, to establish a comprehensive Service Center in the Des Moines and satellite service centers in other parts of the state, while working with the Departments to fully inform, involve, and prepare Eligible persons, their family members, providers, and others who depend on the Iowa Plan. Although transition periods can be stressful, VOI’s significant experience

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implementing new programs and our ability to leverage our national resources and local consultants will ensure that this transition will be smooth and seamless to consumers.

To dispel concerns about a change in SCCs—and to emphasize our own confidence in our ability to provide a smooth transition process—VOI is willing to negotiate timelines and performance guarantees related to the implementation process.

VALUEOPTIONS ... THE RIGHT CHOICE ... THE RIGHT CHANGE IN 2010

Iowa's human services delivery system is under stress and in the midst of major change. The Iowa Plan for Behavioral Health can play an important role in supporting the Departments' efforts to re-design the ways in which they offer services to Iowa's citizens. VOI offers a new approach to improving mental health and substance abuse services while supporting the Departments' increasing focus on communities, counties, and local delivery systems.

Iowa deserves a new contractor with the vision and experience to create the innovations in care required to successfully manage the Iowa Plan in accordance with the Departments' new strategies. As one provider told us during our pre-bid environmental scan, *"the broken system managed by someone you know can be preferable to the fear that comes along with changing to a new contractor."* With the significant changes facing the State of Iowa, now is not the time to fear change. With the right change can come innovations in care that lead to better outcomes for Eligible persons and better management for the State. Continuing the status quo has not addressed the significant deficits that have impeded Iowans' access to the high-quality behavioral health care they desire and deserve. We believe ValueOptions of Iowa is the right choice for Iowa in 2010 and look forward to partnering with the Departments as an integral component of Iowa's behavioral health system.

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Describe the Bidder’s experience in treating individuals aged 65 and older. Please provide information on:

- other states in which the Bidder provides or has provided such coverage;
- particular challenges the Bidder has encountered in serving this population;
- any recommended additions to the provider network to better serve those aged 65 and older, and
- a proposed transition plan to ensure continuity of care while enrolling the population into the Iowa Plan, including a communication plan.

In the United States, there is an “invisible” and generally insidious problem of neglect in some of the elderly population. Often these elder adults have mental health problems that are overlooked. ValueOptions’ basic goal in providing services for elder Iowans is that they will experience improved quality of life, and gain/regain more independent functioning and enjoyment. This will be facilitated through providing opportunities for self-determination, full participation in decision-making regarding their unique service needs, and when they can receive them in the natural setting in the communities with which they are most familiar and where they have spent the majority of their lives.

ValueOptions has extensive experience with serving this population through our other public sector and private contracts. Other states where ValueOptions has contractual responsibility for providing and coordinating Medicaid-funded behavioral health services for the elderly include: California, Colorado, Florida, Illinois, Kansas, Massachusetts, New York, North Carolina, New Mexico, Tennessee, and Texas. This extensive experience has provided ValueOptions the necessary skills and a clear vision for integrating mental health services and supports into the already existing service systems which provide elder care. Additionally, they have provided the opportunity to develop and coordinate creative solutions to the complex challenges associated with meeting the needs of this population.

CHALLENGES IN SERVING THE AGING POPULATION

The Challenge	The ValueOptions of Iowa (VOI) Solution
<p>Stigma of Mental Illness Many over-65 Eligibles struggle with the issues and philosophy of recovery in a world in which they feel they have been forgotten or are ignored. Often, conflicts exist between long-held cultural and personal belief systems and the messages they receive through and approaches to recommended treatment.</p>	<p>Coordination of training and education for seniors, their families, practitioners and concerned individuals about the full spectrum of mental health and substance abuse disorders experienced by this population, and the solutions for overcoming the barriers that prevent access to needed supports and services.</p>
<p>Recognition of Depression Older adults may fail to report depressive symptoms when seeking medical assistance from their primary care physician (PCP). They may assume that depression is a normal part of aging or that providing negative information to the PCP will cause them to become engaged in the healthcare system in an unpleasant way.</p>	<p>Early screening, assessment, and referral will be a priority. VOI will provide training to PCPs as well as mental health and substance abuse providers on topics such as depression and the standardized screening tools that can be used to identify depression in this population. This will assist PCPs in identifying elderly Iowans at risk for depression who may present with somatic complaints or behavioral manifestations of mood disorders <i>rather than a specific depressed mood</i>.</p>
<p>Prescription Drug Interaction or Misuse Older adults are frequently on multiple medications, both for physical and behavioral health issues. They may have sensitivity to medications, adverse reactions and complications of other medical regimes requiring close monitoring, coordination and communication with all treatment providers.</p>	<p>ValueOptions’ PharmaConnectSM, described later in this proposal, will be utilized to identify potential care gaps and to develop protocols that include co-management strategies, prescription “lock” decisions, and communication/education plans for the Eligible.</p>
<p>Delays in Access The lag between a screening and assessment and the actual first contact with a mental health provider frequently interferes with the engagement in treatment of the elderly adult.</p>	<p>ValueOptions has strict access standards that are routinely monitored for referrals as well as a detailed follow-up protocol to ensure that older persons discharged from acute inpatient hospitals and residential settings receive community services in an expedient manner.</p>
<p>Hospitalizations Seniors face unique challenges that when in need of psychiatric hospitalization. These clients are often dealing with concurrent health issues, so psychiatric hospital care must be capable of addressing both mental health and physical health needs.</p>	<p>During the admission process, VOI’s clinical staff will work with medical providers to identify co-occurring medical issues that need to be addressed during hospitalization and after discharge. VOI’s clinical staff will coordinate care with network providers, PCPs, and other senior-serving agencies to ensure comprehensive integrated care for each Eligible—</p>

The Challenge	The ValueOptions of Iowa (VOI) Solution
	whether transition is to home, to an Adult Care Facility or Long Term Care Facility—so that appropriate transitional services are in place at the time of discharge.
<p>Caregiver Support Across Iowa, there are many adult children who are not only taking care of their children but also their aging and aged parents. This demand can place the family under an extreme amount of stress.</p>	VOI will work with community agencies and physical health centers to improve access for all Eligibles of the family. This may include providing mental health services and supports to the caregivers, such as respite services.
<p>Conflict With Traditional Beliefs Elderly individuals with multicultural and diverse ethnic backgrounds often encounter challenges with accessing culturally sensitive treatment options. For example, natural and traditional healings that frequently are not covered as mental health benefits are practiced by many elderly Eligibles of Native American heritage.</p>	For the elderly with traditional cultural beliefs and experience, ValueOptions recognizes the evidence-base that supports recovery and resiliency using traditional healing practices. In other public sector programs, ValueOptions has been successful in working with state partners to include these services as covered benefits for special populations.

RECOMMENDATIONS TO BETTER SERVE THOSE 65 AND OLDER:

VOI proposes to implement and utilize the following practices to better serve the senior population in Iowa:

- **Active Outreach, Education and Training** – An example of this is outreaching to the Office of Aging and Senior Community Centers to identify natural supports for the elderly.
- **Mental Health Consultation** – VOI will offer free psychiatric consultation to PCPs regarding evidence-based treatment issues for the elderly, such as medication management, treatment of schizophrenia, bipolar disorder, or dementia spectrum disorders, as well as co-occurring medical problems. Our goal is to increase the confidence and competence of long-term care staff by providing immediate access to psychiatric consultation, so that they can better manage behaviors effectively and safely. Our staffing will include a registered nurse to provide clinical expertise and consultation to the team of Intensive Care Managers (ICMs) working with this population.
- **Local Care Coordination and Collaboration** – Older Iowans in rural areas may have limited access to transportation and or services close to home. Our Clinical Care Managers (CCMs) and ICMs are skilled and trained to support and assist in this coordination of services at the community level through the planning of long-term services that are respectful of the process of recovery, and include the elder Iowan in the decision-making process. We will also expand the use of telemedicine to rural communities to improve access to services.
- **Promotion of Evidence Based Practices (EBPs)** – The promotion, implementation, and monitoring of EBPs for the elderly population in Iowa seeking treatment include family psycho-education, Assertive Community Treatment (ACT), dual diagnosis assessment and treatment, illness management and recovery, medical management, and coordination with multiple community support services. Peer support, that is specifically focused on adults as they age, is an EBP that is most likely to result in engagement in treatment and positive outcomes of treatment. VOI will develop and implement an evidence-based culture throughout the State of Iowa. That culture will include promising practices as well as EBPs.

TRANSITION

During a transition of services, self-directed care and Eligible participation in decision-making from the onset of service provision is essential to promoting recovery and resiliency. ValueOptions has experienced success in smooth transition of services within State systems. Since VOI would be assuming this population in addition to the other enrollees who are new to VOI, our transition plan and communications plan will comprehensively address the needs of these enrollees and their providers in the context of the transition that all individuals will be making. We are committed to serving Iowans who are 65 and older on day one of the contract start date. In order to facilitate this transition, we recommend the following:

- We will hold a series of public forums across the State that will include providers, Eligibles, and families. These forums will provide us with an opportunity to explain the transition of services and then to obtain feedback from the multiple stakeholders about concerns and perceived difficulties.
- We will provide education about barriers through public forums, Webcasts, educational material distribution, Eligible handbooks, an Eligible warm line and, most importantly by developing partnerships with natural supports

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such as the senior community centers, public libraries, social centers, housing authorities, primary care providers, and substance abuse treatment programs.

- We will also reach out to the University of Iowa Center on Aging to ensure that current best practices and EBP continue to be supported across the State.

Part of any transition plan is capitalizing on the efficiency of our data management system to register all individuals currently in services so that there is a central repository of information that can be accessed as a person moves along the continuum of care. This will create effective mechanisms for determining eligibility for services, as well as providing the capacity for authorizations to be attributed to the right service, for the right individual, at the right time. Our data management system, CONNECTIONS, has the capacity for reporting utilization, tracking trends, and monitoring services across Iowa.

In our other public sector contracts, as part of the transition, ValueOptions has developed agreements and workflows with medical carriers and other service providers to ensure a continuity of care during system and individual transition. This has been accomplished in developing communication workflows, hosting and participating in co-managed case conference/clinical rounds, and developing partnerships with community support services, schools, nursing homes, the justice system and waiver programs targeted toward special populations. In the following table we provide a sample transition and communication plan.

STRATEGY	FREQUENCY	START DATE
Eligibles		
Eligible orientation meetings and aging forums	Six regional forums during implementation; with three additional during year one	07-2009
Eligible Handbook	Prior to go-live; monthly to new Eligibles	12-2009
VOI Web site/ Achieve Solutions educational Web site	Continuous	09-2009
Toll-free Eligible Line	24/7	12-2009
Regional Representatives meet Eligibles individually; provide information to community meetings of Eligibles/advocates	Continuous	06-2009
Mental Health and Substance Abuse Summits	Annually	08-2010
Participation in QM Committees	Generally quarterly	01-2010
Provider Satisfaction Surveys	Annually	07-2010
Providers		
Provider orientation meetings	Six during implementation; three additional during year one	08-2009
Provider forums/training	Semi-annually	02-2010
Provider orientation and Training Webinars	Monthly during implementation; as needed after	08-2009
Regional Representatives meet Eligibles individually; provide information to community meetings of Eligibles/advocates	Continuous	06-2009
Pre-Registration of future Enrollees and Registration for all new enrollees	Upon approval of the department and Continuous throughout contract cycle	10-2009
VOI Web site; ValueOptions' national Web site including on-line support for network providers	Continuous	09-2009
Achieve Solutions educational Web site	Continuous	09-2009
Provider Handbook: posted on Web site and available upon request	Upon request	10-2009
Toll-free Provider Line	24/7	10-2009
Participation in QM Committees	Generally quarterly	01-2010
Provider Satisfaction Surveys	Annually	07-2010
Provider Profiling	Semi-annually	01-2011
Dashboard of reports on administrative data	Continuous	01-2009
Mental Health and Substance Abuse Summits	Annually	08-2010
The Departments		
Contract management meetings	Weekly during implementation; at least monthly after go-live	05-2009

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STRATEGY	FREQUENCY	START DATE
Contract Orientation and training on CONNECTIONS	Continuous	10-2009
Required reports/data analyses	As contractually required	11-2009
Access to CareConnect	Continuous	12-2009
Dashboard of reports on administrative data	Continuous	01-2009
Contractually required plans (e.g. QM)	Prior to go live – Annual thereafter	10-2009
VOI Web site/Achieve Solutions	Continuous	09-2009
QM Committees including Steering Committee	Monthly and quarterly	01-2010
Conference rooms in VOI offices available for The Departments and other state meetings	Continuous	09-2009
VOI participation in established committees/meetings	As requested	08-2009
Medical Community and Other Service Systems		
Invitations to provider orientation	Six during implementation; three additional during year one	08-2009
Regional Representatives meet Eligibles individually; provide information to community meetings of Eligibles/advocates	Continuous	06-2009
Written program information and frequently asked questions including 1-800 number for referrals	Distributed to those suggested by The Departments; updated as requested	10-2009
Telephone clinical consultation via toll-free number	Continuous	01-2010
VOI Web site/Achieve Solutions	Continuous	09-2009
Training/presentations	As requested	09-2009
Letters of agreement setting forth referral protocols and related information	Updated annually or as required	10-2009
Participation in committees as mutually agreed upon or requested by The Departments	Generally quarterly	01-2010
Screening tools and other material for use in provider offices and professionals in other fields	As requested	10-2009
Clinical Director designated as key contact to medical community; also Medical Director for physicians	As contacted	08-2009
VOI staff designated as key liaisons with major system	Available when requested	08-2009
VOI participation in existing regional/community planning meetings	As requested	01-2010
Shared Quality Improvement Plan (QIP) initiatives or other studies	As directed by The Departments	04-2010

- a) Describe what strategies the Bidder would employ to ensure the coordination and integration of service delivery for Eligible Persons who receive services through the Iowa Plan. In particular, please describe how the Bidder will improve integration of services for:
- Eligible Persons with concurrent mental health and substance abuse conditions
 - Eligible Persons with concurrent medical and mental health and/or substance abuse conditions;
 - Eligible Persons with mental health and/or substance abuse conditions who are involved with the adult correctional system;
 - Enrollees with concurrent mental health needs and mental retardation, and
 - Eligible Persons with mental health and/or substance abuse conditions who are involved with the child welfare/juvenile justice.
- Include background information, research data, and your experience in other states on how best to structure coordination and integration. Describe lessons learned and how they will be applied in Iowa.

ENSURING COORDINATION AND INTEGRATION OF SERVICE DELIVERY

The Departments have provided a framework for the coordination and integration of the delivery of behavioral health care. In response, ValueOptions has created a design to support the Departments' new direction. Although the strategies will vary somewhat in application between services provided through Medicaid funding, DPH state and substance abuse Block Grant treatment funds, Regions and the State Payment Program (SPP), ValueOptions will establish a system that includes the following "Lessons Learned" from our Environmental Scan of Iowa and other ValueOptions' public sector programs:

Development of Regional Clinical Teams and Local Offices — A significant step toward integration and improved coordination of services would be achieved by having regional clinical teams assigned to serve each of the Iowa Plan regions (Northwest - Sioux City, Southwest Council - Bluffs, South Central - Des Moines, North Central - Des Moines, Northeast - Cedar Rapids, Southeast - Cedar Rapids). Each team will include VOI clinicians and provider representatives who live and work in communities across the State; these representatives will possess significant knowledge of specific and varied Systems of Care (e.g., substance abuse treatment system; correctional system; juvenile justice; mental retardation/developmental disabilities; child welfare) in their assigned regions.

These clinical teams can then serve a major coordination function by facilitating joint treatment planning and coordinated treatment delivery for Eligibles with co-occurring/co-morbid disorders or involvement with multiple service systems. These teams would also facilitate the development of written agreements and referral protocols between providers in all three Iowa Plan funding streams as well as with providers and agencies in other human services agencies, such as the schools, the courts, and county governments. Additionally, they would ensure participation in regional quality management committees and would provide county/region-specific data to support local planning efforts to expand the array of community-based services.

Although all the strategies are important, ValueOptions has learned that identifying and focusing on high-need Eligibles has far greater impact than individuals needing routine care. The coordination of services for this group is the single most important step in assuring the coordination and integration of services.

Eligibles Identified as High-Need Consumers — Typically, ValueOptions works with the State, as well as stakeholders involved in the local behavioral health care community, to establish criteria that will identify Eligibles who qualify as "high-need." Within the regional areas in Iowa, priorities will vary. ValueOptions will work with the Departments to establish criteria to identify people who are "high-need" and "at-risk."

The development of these criteria will establish the benchmarks upon which we will measure clinical outcomes. ValueOptions will seek out Eligible input into the criteria development by invitation into specified work groups and/or input from Eligible and family forums. In addition, reports from the CONNECTIONS system will initially identify high-need Eligibles based on utilization data for those served through Medicaid and the state payment program. The system utilizes advanced analytics to review authorization, utilization, and other data sources to identify "high-need" and "high-risk" Eligibles.

7A.2.3 Coordination and Integration of Services

Provide Intensive Care Coordination and assure leadership or participation by our clinicians in joint treatment planning. Care coordination includes assisting the person and his or her support system to navigate the service delivery system, coordinate available resources, and be creative in locating resources and natural supports, facilitating access to the service array and tailoring care management interventions to the individual's specific needs. In addition, VOI has an extensive history with "co-managed" rounds that may include, among other components, the medical health plan, involved family, support staff, courts/probation officials, and other service providers.

Monitor High-Need Eligibles to assure optimum clinical outcomes as well as excellence within the provider network. The CONNECTIONS system allows for the "flagging" of high-need Eligibles and provides an identification mechanism for targeted case review and reporting. ValueOptions' clinical and provider relations teams conduct periodic monitoring of provider practices to ensure that coordination and levels of integration are evident. Evaluation of the outcomes of services is achieved through monitoring specific indicators that may include, among others, satisfaction surveys (Eligible and provider), absence of adverse outcomes, improved functional status, decreased readmissions, and increased engagement in community-based services, and other as defined by the State, providers, and Eligibles of services.

Develop Consumer-Run Programs that help high-need Eligibles connect with a natural support network and the support recovery, rehabilitation, and resilience. ValueOptions will invest in the expansion of peer support and family support services to assist Eligibles and families to negotiate the behavioral health service system and to understand and participate in joint treatment planning. This will include the utilization of family driven "wrap-around" services facilitated by the Family Peer Specialists for youth receiving services. Additionally, ValueOptions has the experience of operating a "warm line" (described later in this proposal). This warm line is staffed by trained individuals in recovery who have an ability to connect with and support others through the Bridging/Bridger Project.

THE VALUEOPTIONS OF IOWA CARE COORDINATION APPROACH

ValueOptions' approach to care coordination is designed to ensure that Eligibles transition effectively between levels of care as well as across Systems of Care. Achievement of successful treatment outcomes is based upon a number of integrated factors, such as access to timely and appropriate services, delivery of services within the continuum of care, and coordination of care.

In collaboration with the Iowa Plan, VOI will provide a service delivery system that effectively incorporates these three components. Effective coordination of care involves clinically appropriate utilization review, continuity of care along the spectrum of services, meaningful service planning, and the development of treatment alternatives. ValueOptions has developed comprehensive coordination of care policies and procedures that are aimed at ensuring appropriate care that is focused on the holistic needs of the Eligible.

Care coordination is no longer limited to the referral of Eligibles for basic services. Care coordination is an important concept that has become more prominent with the maturing of managed care initiatives nationwide. It touches upon every aspect of the Eligible's psychological, biological, and socioeconomic existence. For Eligibles, it signifies the delivery of services provided within a continuum of care that reflects individualized social and mental health needs. For providers and CCMs, it means the identification and delivery of services that provide Eligibles the opportunity to meet both life and treatment goals, within specified timeframes, and in accordance with defined social and medical necessity criteria. ValueOptions is committed to providing care coordination at two levels: at an individual Eligible-level; and at a systems-level.

Care Coordination at the Individual Eligible Level. Individuals with mental health issues, especially those with Serious and Persistent Mental Illness (SPMI), a Chronic Mental Illness (CMI), and those with complex needs such as children and adolescents, elderly Eligibles over the age of 65, pregnant substance abusing women and person's transitioning to community support services from longer term institutions such as jail or a nursing home or state operated facility, often are involved with multiple providers and Systems of Care. Each of these services and providers play an important role in meeting the overall needs of the Eligible and in offering a comprehensive approach to care. However, without adequate assistance, many Eligible persons are unable to access required services, remain involved in treatment, or actualize their life and treatment goals.

7A.2.3 Coordination and Integration of Services

Eligible persons and the Eligible's family can negotiate a Systems of Care, managing the various aspects of the service delivery process, and meeting multiple needs when VOI provides the resources necessary to assist with training, education, and the development of skills necessary to fully engage in the treatment planning process. CCMs and Peer Specialists assist Eligibles in obtaining and coordinating required services to achieve quality-of-life goals.

Peer-Supported Services and our Care Coordination activities will be based upon the unique and individualized needs of Eligibles, taking into consideration the Eligible's holistic needs. To be effective, these VOI clinical staff and Peer Support providers will maintain close contact with the Eligible family, involved community programs and services, providers, human service agencies, and advocates to identify, obtain, and maintain services. The overall objective of these services is to enhance the Eligible's ability to participate in and meet their self-determined recovery goals. Communication with other care providers, collaboration on the delivery of services, identification of new and innovative programs and resources, and Eligible empowerment are all important aspects of the care coordination process. The Eligible will be the ultimate leader of this process.

VOI's care coordination process will be facilitated by CCMs or ICCs who will assist in completing or providing the following activities with Eligibles:

- a comprehensive review of the Eligible's clinical history, including treatment, life goals and objectives, and the impact of any cultural issues on the treatment and recovery process;
- an Individualized Treatment Plan (ITP);
- treatment whenever possible of Axis IV diagnoses which often interact as triggers with Axis I diagnoses with a skills-based approach;
- an individual crisis plan as clinically indicated;
- active involvement of the Eligible's family and significant others;
- coordination of mental health, physical health, and informal community supports;
- necessary releases for information sharing;
- information and education on recovery and reintegration concepts and services;
- appropriate crisis and discharge plans as part of the treatment process;
- continuity of care upon disenrollment from the Plan; and
- identification of gaps in the service delivery process that affect the Eligible's ability to participate effectively in treatment services.

Care Coordination Across Systems of Care. Individual coordination of care for Eligibles is unlikely to be achieved without a corresponding coordination across the Systems of Care with which the Eligible is involved. Such coordination can be attained only when there is a consistent mutual understanding of goals and working relationship for all ages across the Systems of Care. ValueOptions believes that coordination of services is best achieved through ongoing communication across the Systems of Care with defined roles and responsibilities for each provider involved with the Eligible and direct participation of the individual in the treatment planning process. The guiding force for this coordination is the system's collective desire to assist Eligibles in their journey towards recovery and resiliency and the recognition that the Eligible is at the center of the services.

The integration of mental health services with other human service, community, and provider agencies into a seamless system is part of our overall program design. This system is focused on maximizing resources and individual Eligible potential to recovery and fully participate in their community. Below are examples of how ValueOptions will focus on serving specific groups of high-need, high-risk Eligibles based on specified populations identified in Iowa. These individuals are at particular risk due to the high incidence of a co-occurring disorder in addition to a mental health condition.

An example and outcomes for programs targeted to these individuals is outlined below.

Eligible Persons With Concurrent Mental Health And Substance Abuse Disorders COORDINATION AND INTEGRATION FOR MEMBERS WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS (COMHSA)

There are a number of fundamental components needed to provide integrated treatment to individuals with COMHSA. For any such programs to be successful, the following elements must be present:

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- the ability to simultaneously treat both the chemical dependency issues and the symptoms of the mental illness, including an integrated treatment plan;
- the ability of the system to be Eligible-focused and friendly;
- the ability of the system to follow the Eligible through the continuum of care;
- Eligible and family involvement;
- treating the Eligible and their social Systems of Care as a whole; and
- identification of and adherence to specific attitudes and values about COMHSA.

ValueOptions has integrated all of the above principles into its program of care for individuals with COMHSA, as well as for Eligibles who have other diagnoses. We have actively integrated and built upon these premises in identifying, treating and ensuring continuity of care for Eligibles with COMHSA.

Identifying Eligibles with COMHSA. Identification of Eligibles with COMHSA is often a challenging and complicated process. To ensure the appropriate and timely identification of Eligibles with COMHSA, we will use the following:

- **Education and Training.** We will provide extensive training and education to providers, community services, Eligibles, and CCMs on COMHSA identification, assessment and treatment. On an ongoing basis, we will provide information on EBPs and ways of identifying the presence of such illnesses in Eligibles. We will educate Eligibles and family members on the various mechanisms through which the Iowa Plan Treatment Programs can be accessed. We will also continue to actively support efforts to build a community of providers with COMHSA competencies in the treatment of both mental health illnesses and chemical dependency issues. ValueOptions' clinical staff will receive in-depth and ongoing training on the processes of identifying and engaging individuals with COMHSA. Our training will include issues such as: myths about COMHSA, empathy for and understanding the needs of individuals with COMHSA, engaging the Eligible with COMHSA in the initial and ongoing treatment processes, and identifying the appropriate provider to provide treatment services.
- **Inpatient Assessments.** Inpatient hospitalizations are often prime opportunities for a thorough and complete assessment of any Eligible for the presence of COMHSA. As part of the assessment process completed during Eligible inpatient stays, facilities are expected to evaluate the Eligible for the potential existence of COMHSA.

Treating Eligibles with COMHSA. The clinical treatment process begins with a thorough and complete assessment of the Eligible. Assessments examine the Eligible's ability to function, the presenting problem, and the availability of treatment modalities to address identified needs. The provider assesses each of these components in more detail with the Eligible and family member, if appropriate, during the assessment and treatment planning process. ValueOptions' treatment process for individuals with COMHSA includes an array of components, such as:

- **Dual Treatment.** Providers are expected to identify mechanisms through which services can be provided in an integrated and holistic manner. Use of medications, referral to community support groups, involvement of the family in the treatment process, collaborative working relationships between mental health and chemical dependency providers, and the use of basic theories of treatment must all incorporate the interchange and integration of both the recovery and rehabilitation frameworks for treatment. The provider must ensure a culture of treatment that cultivates adherence to the essential aspects of both mental health and chemical dependency treatment processes.
- **Relapse and Recovery Prevention Approach.** ValueOptions uses the relapse and recovery prevention approach, designed for individuals with diagnoses of SMI, SED or co-existing mental health and substance abuse issues, as one of its primary approaches to treatment for persons with COMHSA. The traditional approaches to such illnesses focused on the inability of the Eligible to recover, but the Relapse and Recovery Approach focuses primarily on providing the Eligible with the tools needed to maintain a healthy and functional existence. This model focuses on quality of life, the possibility of relapse, and the ability of the Eligible to regain stability, regroup, and find a sense of purpose in the treatment and in life, in general.
- **Prevention Focus.** One of the most important components of any health care program is the active education of Eligibles about ways through which the onset of mental health and substance abuse illnesses can either be decreased or avoided. It is imperative that prevention programs offer Eligibles and families a clear and concise definition of COMHSA, its symptoms and complications, and treatment modalities. It is also essential for any educational program to offer Eligibles hope and a sense of empowerment in identifying and coping with such a complex behavioral health issue.

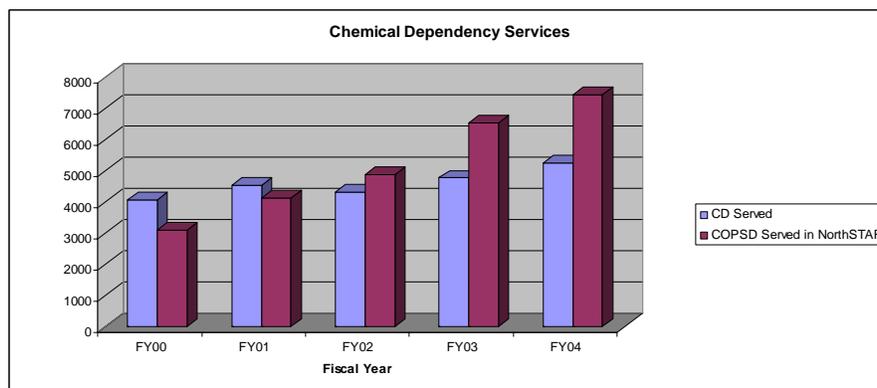
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- **Continuum of Care Follow-Through.** Providers and CCMs are expected to ensure that services required for continued support and treatment are in place prior to discharge or to transition from one level of care to another. It is imperative that services be identified and established that meet the Eligible’s mental health and chemical dependency service needs prior to the transition.
- **Eligible and Family Involvement.** One of the most important factors in understanding and developing a successful treatment program is ensuring the active participation of the Eligible and his or her family, if appropriate, in the treatment planning process. Involvement in assessment, treatment, establishment of goals, and discharge planning are all aspects through which families and Eligibles can actively participate in treatment. Most Eligibles are also more likely to maintain active participation and to follow through on assigned tasks when they, and appropriate families or support systems have had the opportunity to determine parts of the treatment process.
- **Management of the Eligible and the Social Situation.** ValueOptions providers are held to a standard of addressing the Eligible’s social needs as part of the treatment process. This includes the identification and/or development of community programs that enhance the Eligible’s ability to manage daily life issues. Child care, transportation, mother and child residential programs for detoxification and chemical dependency management, parenting classes, collaboration with WIC and other social service agencies, in addition to the delivery of clinical treatment services, are examples of a holistic approach to the management of COMHSA.

Ensuring Continuity of Care. One of the most important factors for continued remission in COMHSA is the identification and procurement of community programs of care that meet the Eligible’s mental health and chemical dependency needs. An example of such collaboration is the expansion of the Alcoholics Anonymous support group concept to include groups that address COMHSA issues. The expanded groups that encompass issues for persons with co-occurring disorders are called Dual Recovery Anonymous. Other support groups for this group of Eligibles are Double Trouble and APAA (Association of Persons Affected by Addictions).

By using a holistic approach to recovery and rehabilitation, providers and CCMs also work closely with the Eligible and family to identify any wrap-around services or social supports required to assist the Eligible in maintaining an active and productive level of participation in the treatment program. They actively work with community programs and agencies to ensure that supportive services are available to accommodate the Eligible’s social needs.

An Example of the Benefit of Co-Occurring Treatment. Untreated and under-treated mental health and substance abuse affect all ages and culture within the Medicaid population and are disproportionate contributors to medical costs under Medicaid, to the costs of crime and corrections, the costs of social services and child welfare, the costs of homelessness, and the costs of long-term care in nursing homes. Investment in COMHSA treatment shows significant return to the State. The following graph shows the increase in COMHSA services under ValueOptions’ management of the NorthSTAR Program in Texas:



A Significant Increase in Utilization of COMHSA Services

The Return on Investment: A preliminary analysis conducted by Texas Legislative Budget Board staff in 2008 found that overall Texas Medicaid spending was lower for Medicaid adults who received integrated treatment through NorthSTAR during fiscal year 2006. As shown in below, Texas Medicaid spending in fiscal year 2006 was \$5,869 less

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per client among SSI and SSI related Medicaid adults who received coordinated mental health and substance abuse treatment services through NorthSTAR and \$4,439 less per client among TANF and TANF-related Medicaid adults.

	SSI/SSI RELATED	TANF/TANF RELATED
Untreated Group	\$14,239.00	\$8,366.00
NorthSTAR Treatment Group	\$8,371.00	\$3,928.00
Spending Reduction	\$5,869.00	\$4,439.00
NorthSTAR Treatment	\$2,364.00	\$1,443.00
Net Spending Reduction	\$3,505.00	\$2,996.00

Eligible Persons With Concurrent Medical And Mental Health And/Or Substance Abuse Conditions

Throughout the country, ValueOptions has undertaken many initiatives to encourage and improve coordination between mental and physical health providers to support delivery of care to both Medicaid and non-Medicaid members.

MASSACHUSETTS

In partnership with MassHealth, the Massachusetts Medicaid Agency, ValueOptions' Massachusetts Behavioral Health Partnership (MBHP) program established the Essential Care (EC) Program in 2003 to help provide and coordinate benefits for individuals with a high risk for adverse medical events. The program was designed to increase access to all care services, integrate physical and mental health care, and improve members' health status. MBHP worked with MassHealth to develop an extensive mixed services protocol that outlined responsibility for services between the mental health and medical entities. An independent evaluation of the program revealed improvements in both mental and physical functioning scores for participants.

INTEGRATION WITH AND IMPROVEMENT OF PHYSICAL HEALTH CARE

Situation: Some members in the Massachusetts program are too ill to seek needed care

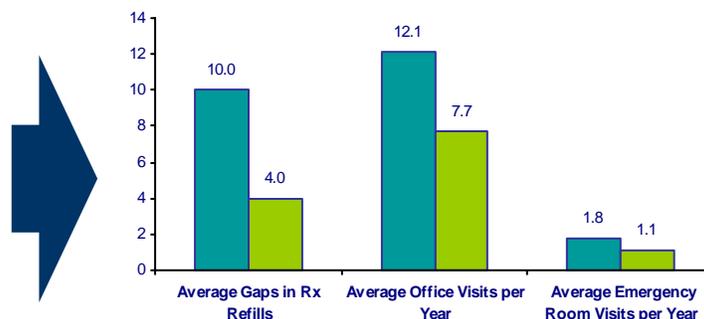
Impact: Participant PMPM medical costs reduced from \$798 to \$648

A 2005 academic study found that enrolled members:

- received more targeted, integrated medical and behavioral health care, with increased access to primary care;
- improved on both the mental- and physical-related physical functioning scores on a standardized tool;
- increased compliance with behavioral and physical care; and
- required less acute and emergency care services.

Essential Care Medical Care Management Program

- Assigns each member a Care Manager who coordinates the services of the primary care clinician, behavioral health providers, state agencies, and community services, and any others required.
- Program has grown to serve over 740 members from July 2005 to present



Source: Study conducted by the Center for Health Policy Research (CHPR) at the University of Massachusetts Medical School

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Situation: Statewide in Massachusetts, many PCPs did not know how to treat, screen, and refer patients with behavioral health issues

Massachusetts Child Psychiatry Access Project (MCPAP)

- Teams of child psychiatrists, social workers, and care coordinators provide psychiatric telephone consultation to PCPs within 30 minutes
- Consultation guides PCP to the appropriate level of care based on the member's needs



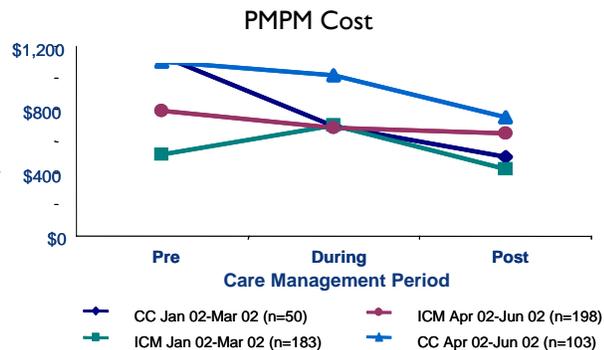
Impact on Children

- Surveys show that PCPs participating in MCPAP report that they are now able to meet the mental health needs of children and adolescents in their practices
- Program was implemented in FY05; 34% of pediatric practices were enrolled by September 2005. Full statewide PCP participation is expected by end of FY06

Care Management Decreases Physical Health Costs

Other MBHP Initiatives

- Regional staff visit PCC Plan offices bi-annually to ensure that primary care staff know how to access behavioral health services and have a good relationship with a behavioral health provider
- MBHP places care managers in primary care offices to serve members with depression



Eligible Persons With Mental Health And/Or Substance Abuse Conditions Who Are Involved With The Adult Correctional System; STRATEGIES FOR THE JUSTICE SYSTEM:

In collaboration with the court and juvenile justice system, we have implemented prevention and outreach programs such as jail diversion, identification and coordination, and aftercare and to decrease the likelihood of future court system involvement for Eligibles. The mission of the ValueOptions Mental Health Jail Diversion Programs is to provide a comprehensive, coordinated system of mental health care for offenders with serious mental illness. The goals of the Programs are to:

- provide early screening, assessment and court intervention to eligible offenders through expedited jail diversion;
- provide an integrated program of mental health services to eligible offenders, including crisis housing, intensive case management and rehabilitation services;
- promote collaboration between law enforcement, prosecution, judicial, community providers, and other stakeholders;
- promote public safety by reducing recidivism to crime; and
- promote self sufficiency and empower mentally-ill offenders to become productive and responsible Eligibles of the community.

The ValueOptions Mental Health Jail Program (MHJP) has been specifically designed to provide expedited diversion or integration of eligible offenders out of the traditional criminal justice system and into community-based treatment that provides temporary crisis housing, intensive case management, medication management, rehabilitation, and judicial monitoring. Effective referrals are particularly important for individuals referred by the criminal justice system for substance abuse services, because of the often-involuntary nature of their participation. If the individual is engaged in the process of selecting the treatment alternative, he or she is more likely to commit to recovery and remain in treatment. Aggressive engagement is just one of the strategies that ValueOptions recognizes as a best practice for those involved in the criminal justice system

Jail/Provider Communications. ValueOptions **JailConnect** system, which is one element of our overall CONNECTIONS capabilities, provides information of individuals incarcerated and ready for release. This population is at a particularly high risk of recidivism because of the potential of these individuals to exit the criminal justice system with mental health and substance abuse issues that may be under-treated or not treated at all during incarceration. JailConnect works to increase coordination and referral through the collection of booking information from the local county jail (when data sharing agreements are reached). At the time of booking, detainee information will be compared to the VOI registration and eligibility files to determine which detainees are enrolled in the Iowa Plan. Once identified as an Iowa Plan Eligible, the information will be further sorted through our IT system to attach to the most recent provider of record. Our CCMs will act as liaisons in this process and notify the provider of record and case management entity of Eligible's status at the jail. This is often critical information in quickly re-establishing contact with Eligibles who may have dropped out of care or experienced decompensation. It further provides a conduit for opening communication for important information exchange with jail health care providers, e.g., prescribed medications, diagnosis, history, and date last seen. The JailConnect capability assists ValueOptions to coordinate services for these individuals by working with local providers and case management entities to ensure that linkages and re-integration into the community include the individual's choices, ensures living environments that support recovery, and are of a quality that motivates the individual to return to community living in a positive way. An example of how ValueOptions has worked with other jail diversion programs can be seen in our NorthSTAR public sector account.

NorthSTAR - Dallas County Adult Jail Diversion Program. DANSA, ValueOptions, Dallas County, The Dallas Public Defenders office, six Dallas adult network providers and the Dallas District Attorney's office, have partnered to develop a comprehensive jail diversion program for Dallas County. The clinical team works closely with the court system on diversion programs for nonviolent offenders (adolescent and adult). In addition, there is an Outpatient Competency Restoration (OCR) program that is focused on the reduction in reliance on inpatient beds in state hospitals, reduction of wait time in jail settings, and continuity and integration of services to support more long-term stabilization. More than 140 adults were diverted in the first year of the project. These NorthSTAR members have received intensive case management services through the mental health court as well as receiving the full array of intensive mental health services through the NorthSTAR providers. After successful completion of six to twelve months in the program, these members will have all legal charges dismissed and will have the opportunity to continue in NorthSTAR services. With several members having graduated from the program, the Jail Diversion Advisory board has now implemented a peer provider services from members still receiving intensive case management services.

Eligibles With Concurrent Mental Health Needs And Mental Retardation

Eligibles with mental illness and mental retardation or developmental disabilities (DD) are estimated to be three to four times more likely than those in the general population to experience an emotional, behavioral, or psychiatric disorder. Recent advances in a number of fields and disciplines, including the neurosciences, genetics, psychopharmacology, developmental neuropsychiatry, psychology, and education show promise for improving the treatment and lives of those with mental retardation and developmental disabilities. However, diagnosis of mental illness in people with MR/DD can be complicated by a lack of understanding of the Eligible's environment and physical health. Often the behavioral symptoms that are presented and misinterpreted as mental illness are underlying medical issues that have not been diagnosed or treated. VOI will provide specialized training and support to those few providers who are qualified to work with this special needs population.

Persons with DD, as well as mental health illness, require special attention and must be evaluated and treated in the context of their environment and how the behavior that is exhibited relates or does not relate to their current physical condition. Prompt assessment, diagnosis and syndrome-related treatment are essential. Coordination of resources and services plans will be particularly acute for children who may also be receiving services through Waiver programs and/or early intervention and treatment programs. Services will be coordinated to avoid unnecessary duplication or worse, services that are contraindicated or that run afoul of other goals and objectives.

VOI will build constructive working relationships with the local MR/DD providers in each region to address the extremely complex service needs and requirements for special models of service coordination. In other states, ValueOptions has been an active contributor to the development of the statewide treatment guidelines for the dually diagnosed population. VOI will work with the Departments to modify and adopt those guidelines for use in Iowa. To establish common understanding of the services provided by each and to coordinate services and roles, we will jointly

7A.2.3 Coordination and Integration of Services

work with DHS and local MR/DD providers to describes eligibility and procedures for accessing services in routine and emergency situations. In support of Eligibles with dual diagnoses, VOI will recruit and train providers who specialize in the needs of this dual diagnosed population even though such providers are in short supply. We will offer specialized training and support to providers who require this specialization, as needed. We will provide all medically necessary mental health services to this population regardless of whether the mental health diagnosis is primary or secondary. Because of our commitment to integrated services at every level, we will encourage our network to develop onsite services at MR/DD provider site and in Eligibles' homes.

Highlights from some of ValueOptions' programs include the following:

- Many children who were diagnosed with MR/DD, and who were involved with agencies that provided both mental health and MR/DD services, were served through the Massachusetts Commonworks program. Commonworks was a child welfare project that provided services for adolescents aged 12 through 18 who were in the care or custody of the Massachusetts Department of Social Services. The program provided **an integrated array of services** through six individual networks of private providers, each under the management of a lead agency.
- Charged with meeting requirements of the federally-mandated Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), ValueOptions' Pennsylvania Service Center implemented an **independent assessment program that ensures a thorough assessment of every child's needs**, including services required to address any developmental disabilities. The evaluators use a standardized assessment tool developed by ValueOptions that incorporates the principles of the Child and Adolescent Service Program (CAASP) and focuses on the strengths of the child and family across multiple life domains.
- In collaboration with the Arizona Department of Economic Security, Division of Developmental Disabilities and a provider agency, ValueOptions created a **specialized mobile community support team for adults and children with MR/DD**. Other services to individuals with MR/DD included pre-crisis services upon discharge from an acute care facility and expanded vocational-related services. The provider network was also expanded to include contracts with rehabilitation specialists and agencies whose primary mission was to serve the MR/DD population.
- In Colorado, ValueOptions and its provider partners have developed **joint programs to effectively meet the needs of persons with co-occurring mental illness and developmental disabilities**. These programs include combined efforts to work with the police, sheriff's department and judicial system to ensure appropriate referral of Eligibles with MR/DD/MI who become involved with law enforcement officers and/or the judicial system.
- In central Florida, ValueOptions and its provider partners worked with Eligibles and their families to develop **specific clinical criteria and best practices** to ensure appropriate services to people who have MR/DD.

Eligible Persons With Mental Health And/Or Substance Abuse Conditions Who Are Involved With The Child Welfare/Juvenile Justice.

We will work with DHS to develop ways to identify high need youth based on services provided through non-Iowa Plan Medicaid funds as well as through the Child Welfare/Juvenile Justice (CW/JJ) delivery system, such as providing for expedited assessments of youth in CW/JJ and development of a JailConnect system (described above) for the Juvenile Justice populations. ValueOptions has experience in other states with developing partnerships with the parole officers and the court system to develop diversion programs for youth at risk for incarceration.

MASSACHUSETTS COURT OBSERVATION PROGRAM

ValueOptions will work with DPH and substance abuse programs to define the best ways to offer assessment and evaluation services for Iowa Plan Eligibles, including evaluating the feasibility of implementing the Massachusetts Court Observation program model. In Massachusetts, ValueOptions convened a Juvenile Justice Working Group (JJWG) to determine effective ways to streamline services for persons referred by the Criminal Justice System. The JJWG (whose membership is similar to that recommended for the ValueOptions Quality Management (QM) Substance Abuse sub-committee) defined the needed service, and ValueOptions created the Behavioral Health Court Observation Model.

The Behavioral Health Court Observation Program model provides a 24-hour assessment and observation service with moderate levels of supervision, structure, and intensity of service. Behavioral Health Court Observation Programs offer a protected and structured environment in which a child or adolescent, upon referral by a court clinic, is assessed and evaluated for further treatment and/or placement. Behavioral Health Court Observation Programs offer a comprehensive clinical assessment and evaluation service to identify the youth's individual needs and the appropriateness of various treatment options that address their substance abuse, psychiatric, and medical needs, as well

7A.2.3 Coordination and Integration of Services

as other issues. This service is designed for a length of stay of up to 10 days. In the Massachusetts program, extended stays are not available unless the safety of the individual is compromised. Based on issues identified in the Child and Family Services Report (CFSR), if a similar model were implemented in Iowa, referral sources probably should be limited, and services offered only to those youth for whom the specific optimal service disposition is unclear.

ValueOptions also will draw from its experience in providing services through coordinated payment structures to individuals referred by the criminal justice system. In Massachusetts, ValueOptions has partnered with other payers to provide the acute phase of court-mandated treatment, with agreements that other payers will reimburse for the remaining portion of the required treatment episode. This collaboration has allowed valuable treatment alternatives to remain financially viable, and continue to provide important and cost-efficient services.

NEW JERSEY

ValueOptions of New Jersey (VO-NJ) is the statewide contracted system administrator for the Division of Child Behavior Health Services (DCBHS). DCBHS was created in 2001 and pooled \$167 million from Child Welfare, Juvenile Justice, Mental Health and Medicaid programs into a single statewide children's Systems of Care. It is a complex plan with a simple mission: to create happier endings for the state's most troubled children. VO-NJ makes services accessible, regardless of the child's entry point in the local service delivery system. They maximize family involvement and ensure that residential facilities keep children on the path to recovery, with a focus on integrating the children into the community. Some examples of activities to enhance coordination include:

- **Single, Common Electronic Clinical Record:** ValueOptions has developed a clinical information system that allows for more than 5,000 users across the state to access an integrated record of all child and family information. This clinical records system drives communication and coordination across multiple funding sources, state and county agencies, and local providers.
- **Residential Bed Tracking:** ValueOptions is the single clearinghouse for residential treatment services provided in the state. This allows for "real time" tracking of current openings through an electronic online reporting system used by more than 200 providers.

The impact of these efforts has been clear:

- More than 90 percent of children receiving mobile response and follow-up support services have been diverted from residential care and able to stay in their current living situation, exceeding the nationwide success rate by five percent.
- ValueOptions has introduced data mining and advanced analytics that help produce an additional 64 million in incremental Medicaid reimbursement which has been reinvested back into care.
- Inpatient readmission rates have been reduced to 10.5 percent, well below the national benchmark of 15 percent.
- Family involvement with family members being actively engaged in the treatment planning for their children and in the review and sign-off of program materials and service standards has increased. 93 percent of families surveyed reported that they were more involved in their children's treatment planning.
- Due to these efforts, children remain with their families and are supported with services tailored to their needs.

- a) Describe the Bidder’s experience in providing behavioral health services through a recovery-oriented approach and detail the model that the Bidder would implement under the Iowa Plan to promote this approach to care, recognizing the priority that the Departments are placing on effecting change in this area during the Contract period. The description should specifically address what approach it will take with respect to:
 - Contractor interactions with Eligible Persons;
 - service system planning and design, and
 - provider adoption of a rehabilitation, recovery and strength-based approach to services.

EMBRACING RECOVERY AND RESILIENCE: VALUEOPTIONS’ EXPERIENCE

A commitment to Eligible involvement is the foundation of every ValueOptions public sector program. Below are two examples of nationally recognized programs that incorporate innovative options for Eligible recovery.

Colorado. Colorado Health Network (CHN), an equal partnership between ValueOptions and eight community health centers across 43 of the state’s 64 counties, was among the first Managed Care Organization to fully embrace member involvement and employ members and family members as part of the executive management team. The Colorado Service Center serves primarily rural areas and has used peer specialists and member and family-directed services as a way to provide increased access to rural residents. They have used the following strategies:

- **Development of an extensive network of Empowerment Centers.** Empowerment Centers are staffed by trained peer specialists. Some are financially supported by the local community mental health center, while others are free-standing, independent 501(c)(3) organizations. Peer specialists hold support groups, conduct outreach to homeless shelters and to shut-ins, conduct Wellness Recovery Action Plan (WRAP) groups, and provide drop-in center services. Several also provide vocational services, working with local employers to help members enter or re-enter the workforce.
- **Establishment of a Crisis Hostel.** In one rural, farming community (covering approximately 10,000 square miles), ValueOptions and the community mental health center created a crisis hostel designed to provide support services for people with serious mental illness. The program has won national awards (the 2000 Eli Lilly Reintegration award and the 2003 American Psychiatric Association Silver Award) for expanding access to rural members who might otherwise not receive services. Two of the major strategies that have enabled the program to be successful have been to create a system in which treatment is driven by Eligible persons’ choice, and to employ trained peer specialists. The hostel also contracts with an Eligible persons’-run business to provide transportation for Eligible persons who live in outlying areas. This strategy has resulted in dramatic improvement in member outcomes (see below).
- **The use of peer specialists as WRAP trainers.** Approximately 30 members in the Colorado service area are certified WRAP trainers. Trained peer specialists conduct WRAP groups and the Eligible person’s WRAP plan is incorporated into the Eligible’s treatment plan.
- **Warm Line services.** Trained peer specialists in several rural areas operate Warm Lines. These warm lines are “active” warm lines as opposed to “passive” warm lines—that is, the peer specialist routinely initiates calls to high-risk Eligible persons, to check in, to ask if the Eligible person is taking his or her medication and if his or her basic needs are being met, and to provide emotional support. Eligibles also initiate calls to the peer specialist, but the most effective strategy is to be proactive, by calling the member first.
- **Leadership training and development of a formal peer-specialist network.** Beginning in 1995, CHN was instrumental in the development of the Colorado Leadership Academy, an Eligible persons’-designed and led empowerment program that continues to be a successful force in the Eligible persons’ movement through its annual training academies. The CHN partnership:
 - provides leadership for peer advocate staff at the ten community mental health centers in the region;
 - facilitates initiation of multiple self-directed groups throughout the network;

“We need more crisis lines - you actually often get put on hold with the crisis line we have in this area, and there is no such thing as a warm line right now. The people who handled the crisis line are not well trained. There just don't seem to be enough dollars for necessary services.” *Iowa Focus Group Participant - 2009*

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- educates and organizes Eligible persons and family members, and
- fosters development of Eligible persons'-run services.

The Colorado philosophy is that peer specialists are an integral element of the care continuum. Therefore, Colorado has implemented ongoing leadership and management training for their peer specialists and Eligible leaders including a focus on client confidentiality, professional ethics and boundaries, listening and empathy skills, volunteer recruitment, strategic program planning, data collection and management, fundraising and grant-writing. These skills have enabled some of the empowerment centers to become independent non-profit organizations or Eligible persons'-run service. Colorado also has developed a "trade association" of empowerment center managers. This association meets quarterly, and not only provides networking opportunities, but also enables the peer specialists throughout the state to consult and collaborate with each other.

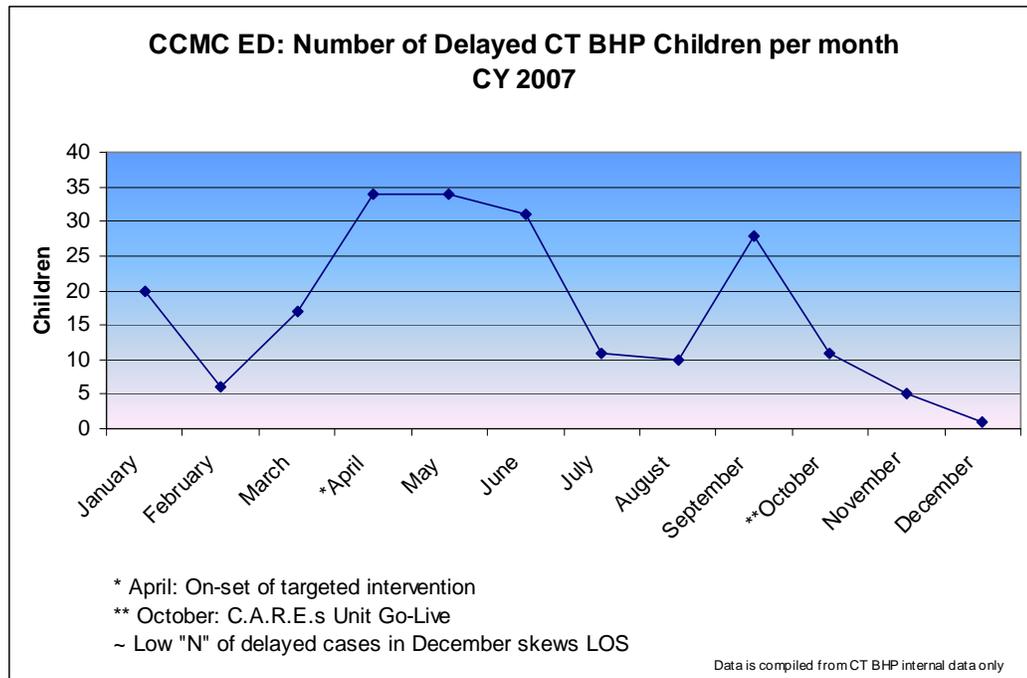
By implementing recovery and peer support, CHN has cut costs for individual Eligible persons by 40 percent as Eligible participants moved out of restrictive programs to community-based treatment, such as clustered housing with home health aide support and supported employment. These outcomes were validated in another study demonstrating that overall costs for direct treatment were reduced by more than \$3,000,000 from pre- to post-recovery periods. These savings were then used to re-invest in the development of additional recovery and safety net services.

Connecticut. Connecticut Behavioral Health Partnership (CT BHP) fully integrates peer support and family support specialists within clinical operations, a practice unique within managed care organizations. Since 2005, ValueOptions has provided administrative services for the integrated public behavioral health services system for children and families enrolled in the state's Medicaid and State Child Health Insurance Programs (S-CHIPs), and for other children with complex behavioral health needs. The program uses both peer support specialists and family support specialists, who are fully integrated members of the care management team, to link Eligible persons and their families to services, community resources, and advocacy assistance. The peer/family peer specialists are full members of ValueOptions' CT management team to ensure that all decisions and planning are consistent with Eligible persons' and family needs and issues. The peer/family peer specialists work one-to-one with parents who are recovering from their own behavioral health diagnoses and addictions and who may require additional supports to maintain their behavioral health and wellness goals. In Connecticut's most recent Eligible persons satisfaction survey, Eligibles reported 100 percent satisfaction with the peer support services.

Addressing Gridlock in Hospital Emergency Departments. ValueOptions has worked closely with its Connecticut state partners to successfully respond to the problem of increased numbers of children with behavioral health crises entering the Emergency Department (ED). As a result of ValueOptions' intervention, the time spent by children presenting at EDs has declined. In this model, a **Family Peer Specialist** responds to every emergency situation regarding an Eligible person who presents at an emergency department. The Family Peer Specialist plays a crucial role in this effort, providing support to individuals and their families within EDs, coaching and consulting with Eligible persons regarding treatment and discharge, bringing hope to those who live with mental illness, and navigating and negotiating both traditional and non-traditional service delivery systems.

Data was collected to track CT BHP enrolled children (Medicaid enrolled and/or DCF involved) who experienced discharge delay in the ED. Discharge delay was defined as any CT BHP member who remained in the ED longer than eight hours. The reasons for discharge delay were numerous and included lack of psychiatric inpatient bed availability, reluctance on the part of caregivers (including foster parents, group home and residential treatment center providers) to have the child returned to their care, and lack of specialized resource for complex children with co-occurring disorders that involved substance abuse, involvement in the juvenile justice system, or developmental delays. Collectively, the interventions demonstrated significant impact on ED gridlock.

While the volume of children presenting with behavioral health issues increased dramatically between the months of March through June, as the following graph illustrates, the average length of stay in the ED decreased significantly when the support of the Family Peer Specialist was fully implemented and utilized.



The impact of the **Family Peer Specialist** is believed to have exerted a significant impact on the clinical thinking of all professionals involved in the process. Rather than making an immediate referral to an inpatient unit (at a time when bed availability was particularly tight), ED and psychiatric staff were supported in their efforts to think creatively about alternative services that would provide the level of crisis intervention and support required, but that would allow for a discharge back to a community setting when appropriate.

Our 2007 experience in Connecticut served to solidify what is intuitively embraced within the System of Care model and philosophy; collaboration, child-centered, family focused treatment and clinically informed focus on community based treatment can result in positive outcomes for children. As the CT BHP continues to focus on reducing ED discharge delay, the basic tools used to assist in this effort will be replicated elsewhere.

PROMOTION OF RECOVERY AND RESILIENCY – A MODEL FOR IOWA

The adoption of the principles of recovery and resilience begins with a coordinated effort of Eligible person and family empowerment and provider recognition and adoption, all of which is facilitated by VOI’s embrace of this concept throughout our business functions.

Creating a culture of Aspiration — The entire design of this Iowa Plan proposal is developed around the “creation of a culture of aspiration.” VOI will work toward the development of a system that encourages and fosters the aspirations of the persons it serves.

A culture of aspiration empowers a person experiencing a mental illness or addiction to clarify their own values and interests, set their own goals, explore environments of interest, and create or find support. This includes empowering a person to manage the symptoms of his or her mental illness or addiction, advocate successfully to overcome barriers interfering with their daily functioning, and use problem solving techniques to deal with the many challenges and fears they faces in a world which stigmatizes mental illness and addiction. A culture of aspiration prepares a person to overcome limitations in his or her beliefs that have been internalized from stigmatizing environments and teaches that person how to manage other people’s fears of their diagnosis. The key is motivation created by hope and a culture of aspiration. Within this culture of aspiration, our goal is to assist a person who wishes to develop, maintain, or recover their independence to fully embrace their strengths and talents and to develop the skills necessary to achieve their goals and desires. The following is a graphical illustration of how we view recovery and resiliency:

Building a Culture of Aspiration: Recovery & Resiliency



For children and families, VOI will fully adopt the Core Values of a Children’s Mental Health System of Care. We will develop and emphasize services to support families and help children remain at or close to home and do well in their own community. Through this effort ,VOI intends to develop and shape an organized system of care for children and youth experiencing mental, emotional and behavioral disorders.

Our core values will be:

- **Child-centered, family focused, and family driven** – Families will be involved as full participants in all aspects of the planning, delivery and evaluation of VOI services and supports for children and youth.
- **Strength-based** – VOI will individualize services in accordance with the unique strengths and needs of children and youth experiencing mental, emotional or behavioral problems and their families.
- **Community-based** – VOI will provide services for children and youth that support their participation in the least restrictive, most normal environment appropriate for their health and safety, preferably within their homes and communities.
- **Culturally competent and responsive** – VOI will be sensitive and responsive to racial, ethnic, linguistic and cultural differences and will ensure nondiscrimination in access to services
- **Integrated care with coordinated planning across all service systems** – VOI will integrate services and supports for children and families by using (or creating) linkages among the agencies with responsibility for children and youth. We will employ Intensive Care Coordinators to ensure that multiple services are delivered in a coordinated and effective manner in accordance with each child’s and family’s changing needs. VOI recognizes that children are not little adults and that there must be separate planning for children and youth that addresses their physical, emotional, social and educational needs in a comprehensive and coordinated fashion, in the context of their family, school and community.
- **Prevention, early identification and intervention focused** – VOI will promote early identification of problems, ensure early intervention and encourage activities that identify and improve or remedy environmental factors that put children at risk for developing mental, emotional or behavioral problems.
- **Designed to smooth transitions among agencies, providers, and to the adult service system** – VOI will ensure that children and youth experience smooth transitions, such as when returning from residential placements to their community or from youth services into the adult system, if that is necessary.

VOI will utilize proven strategies such as Family Peer Support, Wrap-Around, and Flexible Funding (described in detail in *Section 7A.2.6, Covered Services, Required Services, Optional Services*) to assist providers and families to fully embrace these System of Care principles and to ingrate their use into the every day operations of all programs and engagement with all children and youth enrollees. Where coordination and integration does not exist, VOI community-based Intensive Care Coordinators and Provider Representatives will actively work to develop the protocols, processes, and relationships required. When there are no services or supports for children and families, we will target resources for their

development. We will push the system to improve and lead by example by demonstrating a commitment to recovery, resilience, and the proven core values of a system of care throughout our business functions and operations.

Contractor Interactions With Eligible Persons

INTEGRATING A CULTURE OF ASPIRATION INTO EVERY INTERACTION WITH AN IOWA PLAN MEMBER

In order to ensure that recovery and resilience are the fundamental fabric of our approach to business and services, VOI has developed a thoughtful and comprehensive structure to integrate Eligible persons' and family voice into all of our business functions.

The following are strategies VOI will employ to promote Eligible persons involvement. Through their involvement, Eligible persons and families will become active participants in the oversight of the program and along with the state will hold VOI accountable for the high level of service to which Iowa Plan enrollees are entitled. Among these are:

- VOI will make a commitment to affirmatively employ and contract with individuals and/or family members of individuals who have experienced a mental illness. Our proposal has been designed to ensure that every aspect from outreach to outcomes is conducted in a manner that supports and encourages recovery and resiliency. Our internal staffing is designed in such a way that Eligible's voice is emphasized throughout the organization. The Member Services Department will be staffed by a Member Services Director (1 full-time equivalent [FTE]) and two Prevention Education & Outreach (PE&O) Peer Specialists (two FTEs), comprising a total of three FTEs. This Department will focus on the capacity of the "system" and is resourced to foster and support Eligible and family participation, maintain relationships with Eligible persons and family communities, provide contract oversight to ValueOptions Eligible and family programs, and contribute to the Eligible person and family education and training agenda. In addition, the Department will be responsible for contracting with Eligible persons and family advocacy and support organizations regionally to provide support for the following ValueOptions initiatives:
 - **Eligible Advocacy Warm Line.** ValueOptions will contract with one or more Eligible/family member advocacy organizations, to provide trained Eligibles and family members to operate a Warm Line (described later in this proposal) within the Service Center that follows the pro-active model that has been highly effective in Colorado.
 - **ValueOptions Statewide Member and Family Peer Support and Assistance Programs.** Our regional family support and consumer peer programs will be major opportunities for family members and Eligible persons to participate in the Iowa Plan by providing support to others. VOI will assist in developing the relationships required for these programs to be successful through partnerships between local providers and existing advocacy groups, such as the Alliance for the Mentally Ill of Iowa, NAMI of Iowa, the Iowa Advocates for Mental Health Recovery, the Depression and Bipolar Support Alliance chapters in Iowa, the Iowa Dual Recovery Anonymous groups, Iowa Mental Health Recovery and Advocacy, The Mental Health Recovery Center, and the Iowa Federation of Families.
- ValueOptions is committed to ensuring that all staff are trained to support a culture of aspiration and in the core values of a children and family system of care. Dr. Ed Knight, ValueOptions' Vice President of Rehabilitation and Mutual Support, has trained professionals and lay providers in these concepts for 21 years and in many states. The basics of a culture of aspiration are building agency and practical reason. Agency is the facilitation of choice in individual Eligible persons and families and the culture of family and Eligible movements. Practical reason is the spelling out of one's own values and training *in vivo* to gain the practice wisdom to realize these values. Dr. Knight's training emphasizes and supports our staff's belief in the ability of Eligibles and family members to exercise agency and practical reason through the adoption of a comprehensive understanding of recovery research.

Service System Planning And Design

First and foremost, ValueOptions understands that Eligible persons' involvement is fundamental to any successful system of care. Eligibles, families and clinicians are vital partners in the development of a culture of aspiration. To ensure that their voice is the primary driver of VOI design, we began this process while developing our bid response. **ValueOptions, in partnership with the Iowa Federation of Families and DBSA, conducted six focus groups across the State of Iowa to solicit feedback and suggestions regarding the design of the future Iowa Plan.** A summarized description of the outcomes of these focus groups is found in Section 7A.2.6, with a full written description available at the VOI Web site, <http://www.valueoptions.com/demos/iowa/>. Eligibles and families were

instrumental in defining the scope of services that are needed and identified how we can improve upon the existing services.

In addition to our pre-bid work to integrate Eligible and family feedback into the VOI Iowa Plan design, we will adopt the following strategies to ensure that the principles of Recovery and Resilience are continually stressed in our ongoing system design, future planning, and evaluation. These strategies include:

- **ValueOptions’ commitment to ensuring that Eligibles and/or their family members who have experienced a mental illness are represented on every QM committee, and will chair the Member and Family Member Committees.** The chart that follows briefly describes some of ValueOptions’ internal committees where Eligible and family input and experiences will enhance ValueOptions’ focus on and commitment to Recovery and Resilience:

Committee and Scope of Work	Relationship
Executive Leadership Team Responsible for strategic planning, contract management, and oversight of operations; consults with advisory councils; manages emergent and critical issues; makes policy and programming decisions.	The Member Services Director is an integral part of the Executive Leadership Team.
Member Advisory Council Advises the Executive Leadership Team on all aspects of the operations; quality of care, Eligible communications, recovery and resiliency and system performance; focuses on issues relevant to adult Eligibles.	Eligibles, member advocates, community stakeholders, and the Eligible Peer PE&O specialist. This committee will be chaired by a self-identified Eligible.
Family Advisory Council Advises the Executive Leadership Team on all aspects of the operations; quality of care, Eligible communications, recovery and resiliency and system performance; focuses on families, caregivers and supports systems who are caring for an individual with mental health issues.	Eligible family members, youth experiencing SED, child and family advocates, community stakeholders, and the Family Peer PE&O specialist. This committee will be chaired by a Parent or Family Member of a youth experiencing SED.
Quality Assurance/Performance Improvement Committee Responsible for accountability to the state agency and to Eligibles, family members, advocates, providers, stakeholders and the general public; focuses on both internal operations and the functioning of the entire behavioral health care delivery system; primary format for seeking and incorporating the ideas and perspectives of all those impacted by services; coordinate with quality review teams.	The Member Services Director and representatives from the Member Advisory Council and the Family Advisory Council will ensure that the Eligible and family voice is woven throughout all quality initiatives.

- **ValueOptions is committed to ensuring that that Eligibles and/or their family members who have experienced a mental illness will be heard using their own VOICE – “ValueOptions Member Empowerment Program.” To achieve this goal:**
 - ValueOptions will commit to a minimum of two focus groups/town hall meetings biannually in every region. Eligibles and families will be asked to facilitate or conduct these activities, creating an atmosphere in which individuals feel free to criticize or disclose problems.
 - Our PE&O program will be designed with the guidance of Eligibles and family members, and they also will have responsibility for carrying out some of the activities. For example, we will use Eligibles and family members in orientation and training sessions for Eligibles and providers on topics such as recovery and rehabilitation, promoting wrap-around and family-centered care plans and addressing operational issues identified by Eligibles and families, as well as other topics.
 - The Member and Provider Services Department will use feedback from Eligibles and family members to guide our effort to produce educational materials. Their ideas will be used to identify topics, content, and readability of educational materials. All educational materials will be reviewed by the Family and Member Advisory Councils prior to dissemination.

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- We intend to work with DHS and DPH to explore administrative contracts (independent of the Iowa Plan) with State Universities to guide our efforts to measure and improve Eligible and family member satisfaction. This specifically will include development with input from Eligibles, family members, and advocates and approval of the Quality Assurance/Performance Improvement Committee. In addition, we will work with the Departments to develop mechanism for our University partners to ensure that Eligible persons, family members, and advocates conduct the surveys and review the results of the surveys, and that the Member/Family Advisory Councils provide feedback and recommendations to further strengthen the Iowa Plan.

VOI will remain a champion of Eligible person and family member voice in all aspects of the mental health services delivery system. Eligibles and their families are the reason for our existence and their input throughout planning, development, and implementation is fundamental.

STRATEGIES FOR INVOLVING ELIGIBLE PERSONS IN THE DEVELOPMENT OF RECOVERY-BASED SERVICES

ValueOptions will take a unified approach to developing models, exploring funding opportunities, and planning consumer-operated services (COS) or consumer-operated businesses through the following five strategies:

- **Outreach and Envisioning** – ValueOptions will reach out and involve all of Iowa. We will conduct Town Meetings for Empowerment throughout the state and in each provider organization and the advocacy organizations identified above. The first round of Town Meetings will be educational, with a presentation of the broad research base for COS and their contributions to recovery. This presentation will include the various kinds of COS from recovery centers to case management and supported housing member agencies. The next round of Town Meetings for Empowerment will be visioning sessions in which Eligibles will create a vision of an Iowa mental health system that includes COS¹. We will use Peer Specialists, working in concert with National experts, to lead these efforts.
- **Developmental Infrastructure, Capacity Building, and Training** – We will develop the infrastructure necessary to foster consumer-run programs. This infrastructure-building process will begin with the vision resulting from the Town Meetings. In the implementation of this vision, we will first locate mental health agencies with Eligibles interested in starting or expanding COS. We will then use the Fidelity Assessment Common Ingredients Tool (FACIT)—a research-based protocol for fidelity from the Member Operated Services Multisite Research Initiative to measure the level of current level of COS. The results of the fidelity assessment will serve as a baseline that when combined with the vision, will give us a blueprint for affirmative movement to develop COS. The developmental process will begin within agencies with training in areas of Eligible vision and interest. Broadly speaking, we need to develop two kinds of experience among interested Eligibles: 1) program experience; and 2) experience in running an organization. Our staff will assist with setting up Member Advisory Boards to begin the organizational experience. We also will conduct training in offering peer to peer services with an initial phase of gathering volunteers to gain program experience.
- **Research Eligible, Quality and Innovation Initiatives** - Through the Quality Management Department, VOI will develop research initiatives and quality improvement initiatives in this arena. The various member program advisory boards and consumer-operated services (COS) agency boards will choose representatives to a statewide Consumer-operated Services Community Advisory Board (COS CAB). The COS CAB will work with the Quality Management Department to develop such initiatives.
- **Develop Family, Eligible, and Provider Partnerships** – ValueOptions will develop family member and provider partnerships. We will train on EBPs, recovery, and mutual support to further provider and Eligible understanding of the importance of family and Eligible networks and enterprises. The initial phase of training will be Staff Support Skills for Self-Help, a member-led training program that research shows has a positive impact on provider attitudes

¹ Powell, I.G., & Knight E. L. (1994) Empowering the Disempowered. Chapter in Government Works, Troxel, J.P., Miles River Press. Alexandria, VA.

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and skills on recovery². The staff and member trainers will emphasize heavily shared decision-making as a practice modality.

- **Fostering the Visibility of Eligible/ Family Recovery & Resiliency** – VOI will give visibility and voice to the recovery and resiliency stories of families and Eligibles. Research demonstrates that self-narrative changes as mutual support, recovery, and resilience grow from an illness story to a recovery and resiliency story. We will support Eligible and family conferences and speaking engagements to engage in this important story telling function.

VOI will build a culture of aspiration in Iowa through many venues. The central venue will be helping Eligibles negotiate the tasks of building COS. Our strategies to initiate and sustain viable COS led to the development and expansion of COS in public mental health systems³. In addition to the above, VOI also will follow the strategies listed below for incorporating wellness and recovery-based services into the program:

- **Saturation Training** - In addition to conducting Town Meetings for Empowerment as described above, VOI will reach out to involve all of Iowa in its training efforts. This will involve Eligible person and family teams in the training of all provider agencies on recovery and resiliency and the Eligible and family point of view and experience.
- **Development of Recovery and Resiliency Learning Labs** – VOI will develop an infrastructure of Eligible and family-staffed recovery and resiliency learning labs in each provider agency. These learning labs will have computer access for families and Eligibles who cannot afford such access themselves. This will help solve a documented problem in computer access among people of poverty or near poverty. We will also make available a library of the most important recovery and resiliency materials from the University of Kansas, such as Pathways to Recovery; Boston University Center for Psychiatric Rehabilitation; and UCLA’s PsychRehabProgram: PsychRehab Consultant, as well as others, as appropriate.
- **Probe into New Areas of Recovery and Resiliency** - VOI will train Eligible persons and family leaders to conduct quarterly strategic planning sessions with Eligibles and family employees, Eligibles and the COSAB to probe new possibilities for recovery and resiliency and Eligibles and family involvement. The planning meetings will review current challenges, the assisting and resisting forces, initiating actions to be conducted immediately, and the catalytic actions that will further the progress of recovery and resiliency initiatives

Provider Adoption of a Rehabilitation, Recovery and Strength-Based Approach to Services.

Transformation of mental health services to embrace Eligible person involvement and to promote recovery and resiliency is driven by a fundamental change in values and expectations for individuals, providers, and the service delivery system. A recovery-oriented system requires embracing the principles and research on recovery, and instilling these principles in all facets of the service delivery system. To be effective, they must co-exist, but for purposes of highlighting our provider training efforts, we will engage in and outline the following specific activities:

- In conjunction with advisory councils, we will develop a provider education agenda that promotes increased skill and awareness of recovery and resiliency and fluency in current research on recovery and resiliency. When feasible, we will outsource this agenda to Eligible persons and family organizations.
- We will help providers ensure that recovery and resiliency is reflected in chart documentation, where Eligibles’ voice will be present at intake, in the treatment plan, in a crisis plan, and in progress notes, medical notes, and review summaries. Chart audits at each agency will include measurements of these indicators.

Core Training Topics for Recovery Model of Treatment	
Eligible Belief	Professional’s Response
What a person believes about him or herself because the diagnosis of mental illness can often be more disabling than the illness itself.	The professional needs to work with people to help them change what they believe.

² Young, A.S, Chinman, M, Forquer,S, Knight,E, Vogel,H, Miller,A, Rowe, M, Mintz, J. Use of a Member-Led Intervention To Improve Provider Competencies, Psychiatric Services, August, 2005, Vol. 56, No. 8

³ Knight, E.L. (1997). A Model of the Dissemination of Self-Help in Public Mental Health Systems. Chapter in the Successful Diffusion of Innovative Program Approaches. Hollingsworth, E.J., Number 74, Jossey-Bass Publishers.

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Core Training Topics for Recovery Model of Treatment	
Eligible Belief	Professional's Response
Recovery is not the absence of symptoms, but the development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness.	The professional needs to work with people to help them find significant ways to become engaged and develop their strengths.
Each person is responsible for his or her own life and should voice their concerns and choices.	Professionals must help people create the life and make the decisions the person wants, not the life the agency or staff wants them to have.
Everyone has the ability to grow and change.	If professionals relate to a person's potential, there is the possibility of achieving impressive goals.
Eligibles have learned to focus on symptoms and pathology.	Professionals need to help people look for the strengths and abilities in themselves and in others, and collaboratively identify goals that use and build upon Eligible strengths and abilities.
People give power to whatever they focus their energies on.	Professionals need to help people focus on what they want to create not on what they want to 'get rid of.' Person centered and strengths based planning and goal development is essential.
For life's most difficult problems, the only real answers come from within.	The most important thing that a professional can do for someone having difficulties is to ask questions that put him or her in touch with his or her inner wisdom.
The major impact of the diagnosis of mental illness is a sense of loss and disconnectedness	Professionals need to help Eligibles reconnect with themselves, others and their higher power.
The longer the focus remains on the illness the more likely a person is going to begin to question their own abilities and potential for growth.	Professionals need to shift the focus to wellness as soon as possible so they can begin to think about their future in a different way.
People are motivated to change the way they think and act (to accept responsibility for their recovery and their negative behavior) when they see how their thinking and acting prevent them from creating the kind of life they want	The major task of professionals is to help people see possibilities and help them set their own goals.
Eligibles are typically asked the question: "What is wrong?"	By changing the question to: "Who you want to become" changes the entire process of how services are provided.
Stigma inhibits Eligibles from participating in "normal" activities as they believe they are incapable due to their illness	By allowing for alternative avenues of services in the community, the stigma is reduced because Eligibles have the opportunity to enter the system through various, non-traditional channels and be accepted for who they are.
Eligibles believe that the professional is the expert on their treatment and services	The Eligible is the expert of his or her reality and therefore the professional will facilitate learning and growth in coordination with the Eligible's goals. The focus of treatment is shared decision-making, which enhances the Eligible's ability to progress in their recovery.
Behavioral health services are provided first over an extended period of time before other services can be deemed appropriate.	Prevention and intervention services, including vocational and educational services, are encouraged and parallel services to enhance behavioral health treatment.

The training sessions for providers will address the structural and programmatic issues that arise in hiring, training, supervising, supporting, and integrating peer workers. Trainings also will focus on the recovery process and motivating recovery, promoting a culture of respect, implementing recovery-oriented practices in workplaces, merging clinical and recovery oriented cultures, and integrating peers into the mental health workforce. Finally we will hold an annual Partnering for Recovery Conference as a venue for provider education in recovery and resiliency and a Children's Mental Health Conference to train service providers and others on the fundamentals of a system of care evidenced based services for children and families. With this foundational training, we expect to expand the recovery and resiliency services that empower and help individuals reach recovery.

- a) Describe the Bidder’s philosophy of how best to involve Eligible Persons in the planning of their care. The description should include:
 - how the Bidder intends to ensure Eligible Person and, as appropriate, family members, participation in treatment planning, and
 - a description of any instances in which it employed such strategies with each of these populations under other contracts, with documentation of any related measurements of effectiveness.

DEVELOPING ELIGIBLE-LED SERVICES PLANS REFLECTING RECOVERY AND RESILIENCY PRINCIPLES

VOI will focus on person-centered planning that puts the Eligible person at the center of the service plan and gives Eligible persons and families the power they should have (barring issues of danger to self or others)—to choose their services and providers. Our approach to service planning is based on the work of Neal Adams and Diane M. Grieder and includes the following components:

- “an opportunity for creative thinking;
- a successful strategy for managing complexity;
- an opportunity to build an alliance with the individual receiving services;
- a mechanism for acknowledging the hopes and dreams as well as the strengths and resources of each individual and family;
- a means for assuring the provision of person-centered effective (and, whenever possible, evidence-based) services; and
- a process for creating a guide for the journey to recovery of each individual and family.”⁴

For children and families, VOI will train Family Peer Support specialists and providers to implement the wraparound process. This process is a team of individuals who are identified by and important to the well-being of the family and child or youth experiencing a serious emotional disturbance (e.g., family members, other natural supports, service providers, and Intensive Care Coordinators [ICCs]). This team will collaboratively develop an individualized plan of care, implement this plan, and evaluate its success over time. The wraparound plan typically includes formal services and interventions, together with community services and natural supports and assistance provided by friends, family, and other people drawn from the family’s social networks. The team convenes frequently (not less than every six months) to measure the plan’s components and outcomes. Plan components and strategies are revised when outcomes are not being achieved. The process of engaging the family, convening the team, developing the plan, implementing the plan, and transitioning the youth out of formal wraparound will be facilitated by a trained family peer specialists or other approved “wraparound facilitators.” The wraparound process, and the plan itself, is designed to be culturally competent, strengths-based, and organized around family members’ own perceptions of needs, goals, and likelihood of success of specific strategies.

Adopting these approaches will ensure that planning becomes a meaningful task for consumers and families, and a method of measuring achievement towards the Eligible person, family, or youth-identified goals. Hence, plan goals are written in the words of the Eligible person, family or youth, are reflective of informed choice, and are individualized and adaptable to assist the Eligible, family, or youth in navigating their path to wellness, recovery, and resiliency.

Self-Directed Care — In addition to a practices described above, ValueOptions has begun work in public sector accounts utilizing Self Directed Care (SDC). This is a grass roots efforts recognized by consumers, NAMI and other interested stakeholders. VOI is very interested in working with DHS and DPH to incorporate SDC into currently existing and new Iowa behavioral health waivers and programs, and would be very supportive of expansion of the self-directed care pilots that are currently operating in Iowa. SDC is an innovative service delivery paradigm placing individuals with mental illnesses squarely at the center of decision-making. SDC hinges on the belief that individuals are capable of choosing services and making purchases that will help them begin or remain on the road to recovery and to

⁴ Adams, Neal and Grieder, Diane M. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*. Elsevier Academic Press: Burlington, MA.

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develop or regain a life of meaningful, productive activity. Individuals select the providers, services, and activities that they deem necessary for recovery and the achievement of the highest level of desired personal wellness and quality of life. Through a careful self-assessment of previous purchases, experiences, and outcomes, individuals are given the flexibility to make adjustments to fit their needs in order to engage in meaningful activities and to attain a higher quality of life, this can include budgetary authority. VOI is looking forward to working closely with the Departments to expand these practices and to ensure providers have a readiness to work with consumers in the SDC model.

EVALUATING AND IMPROVING CONFORMANCE TO RECOVERY AND RESILIENCY PRINCIPLES

Once the service plan is developed, the Eligible person and/or family will be asked to review and modify it, and when she/he is satisfied that the service plan accurately reflects his or her needs, aspirations, strengths, and desires, the Eligible person will be asked to sign the plan. The signature is not nearly as valuable as the individual’s voice in the development of the treatment plan, so ValueOptions will require documentation of active participation in the treatment plan in addition to the signature. In those rare cases in which the Eligible person elects not to sign the service plan, the clinician is asked to note this fact in the chart with a clear statement that summarizes the stated rationale for the refusal to sign.

“This is the first time anyone has ever asked me what I needed or what I wanted for services or supports”
Iowa Focus Group Participant, 2009

If an individual is receiving treatment involuntarily, service plans will be formally reviewed by the Eligible person and the team monthly. The treatment team for Eligible persons certified for involuntary treatment will include a licensed psychologist or licensed physician who also signs off on the service plan and each monthly review. The involuntary treatments or services required under mental health certification will be incorporated into the overall service plan and goals, and the requirements for terminating the involuntary treatment are written in the same manner as required above, including Eligible person and family participation. The service plans will be recovery-based and will honor the Eligible person’s and family’s choices to the degree possible under the court order.

VOI will require, as a matter of policy, that every individualized service plan demonstrate the major treatment and case management goals for the Eligible person, and that these goals and their degree of attainment be periodically reviewed by the Eligible person and modified as appropriate. Any change in the Eligible person’s circumstances, level of functioning, or care needs is to be noted in the service plan and, if indicated, the plan is to be modified accordingly. The plan will be updated on a regular schedule, but at a minimum it must be reviewed annually.

AUDITING PROVIDERS ADHERENCE TO PERSON-CENTERED PLANNING

ValueOptions will ensure that staff are trained in consumer- and family-centered service planning. Utilizing a research-based evaluation tool, Dr. Ed Knight will train the VOI Clinic Chart Audit Reviewers, Intensive Care Coordinators, Provider Relations Representatives, and Peer and Family Peer Specialist to conduct reviews of service plans. Evaluation of service plans will be reviewed with the provider. If necessary, corrective actions will be initiated based on these reviews. In these circumstances, there will be additional follow-up to ensure appropriate corrective action was taken.

- b) Provide the names, telephone numbers and email addresses of two references who can be contacted to confirm the effectiveness of the Bidder’s performance.

The following references are for person-centered care, including consumer in treatment plans:

- Suzanne Fields, Director of Behavioral Health, Office of MassHealth, telephone (617) 348-5101, email suzanne.fields@state.ma.us.
- Debora Delman, Executive Director, Transformation Center; telephone (617) 442-4111; email drdelman@comcast.net; and/or Jonathan Delman, Executive Director, Consumer Quality Initiatives; telephone (617) 427-0505; email jdeman@cqi-mass.org
- Karen Andersson, Ph.D., Director of Mental Health, Connecticut DCF, telephone (860) 550-6683, email Karen.andersson@ct.gov; and/or Mark Schaefer, Ph.D., Director, Medical Policy and Behavioral Health, telephone (860) 424-5067, email Mark.schaefer@ct.gov.

a) Describe the Bidder's strategy to ensure statewide capacity for required services

As we move ahead, our process for constructing and refining our network development plan will be an incremental one that minimizes disruption of care and maximizes participation by the current providers in the system. Stability and viability of the current provider network is our initial goal. In subsequent months and years, as the system matures, we will propose redesign and other network development initiatives to enhance a unified system of care that embraces the concepts of resiliency, recovery, and empowerment and addresses the network priorities of the Iowa plan contract.

IMMEDIATE NETWORK DEVELOPMENT PLAN ACTIVITIES

1. Ensure that all current providers can participate in the ValueOptions system on January 1, 2010.
 - a) **Accept Current Provider Network** — Initiating network recruitment will be one of the first priorities of the implementation team. ValueOptions will accept into its network all providers in good standing who are delivering services as of December 31, 2009. This initial approach to network development will minimize disruption in services for Eligibles already in care and allow for a more seamless delivery. To facilitate a rapid and smooth transition into the ValueOptions network, our Provider Relations Representatives will work with providers in completing or providing information required by our application process.
 - b) **Establish Contract Rates and Payment Mechanisms** — Upon award of a contract, we will work closely with the Departments to identify current rates and payment mechanisms for each fund type. Using this information, we will work with the Departments and providers to review existing rates, contract amounts, and payment methodologies for each provider's contract. As part of the rate-setting process, we will undertake a comprehensive analysis of all utilization and membership data. This will allow us to finalize the array of services we expect to make available during the first contract year to Medicaid customers who are in managed care. To the greatest extent possible, we will establish uniform reimbursement for like services across all agencies. All reimbursement schedules will be reviewed with the Departments prior to implementation.
 - c) **Develop Contracts** — During the implementation period, we will review current provider terms and will identify the specific language that must be included in provider contracts for the first contract year. We will draft contracts for review by the Departments and will present final contracts to providers for execution.
2. Ensure that all current providers can successfully interface with ValueOptions' operations on the go-live date:
 - a) Ensure the entry of provider and contract data into the ValueOptions CONNECTION System.
 - b) Ensure that providers can access electronic technologies for the enrollment of customers, registration of care, submission of customer- and provider-specific data, and submission of claims/encounter data. Ensure that "drop-to-paper" safety nets are in place for all critical functions.
 - c) Ensure that all providers have fully-executed contracts.
 - d) Ensure that all providers have been trained in new service definitions and billing codes.
3. Provide orientation, training, and technical assistance to providers during the transition period to ensure their ability to participate successfully in ValueOptions' network operations, including both administrative and clinical functions.
4. Implement re-credentialing functions for all providers that were in the Iowa provider network prior to go-live as they approach their re-credentialing dates:
 - a) ValueOptions will accept providers in good standing who are delivering services as of December 31, 2009. During the pre-implementation period, the ValueOptions implementation team and staff will train providers in re-credentialing requirements, timelines, and protocols and will ensure that recredentialing and privileging applications are distributed to all providers.
5. Identify service gaps in the current network that are so substantial that they would compromise the ability to provide comprehensive mandated covered services on January 1, 2010. This analysis will be conducted during pre- and post-implementation and on an ongoing basis to ensure that gaps in service are minimized.
 - a) Upon award of a contract, we will analyze updated utilization data and prioritize critical service gaps that must be addressed prior to January 1, 2010. Based on local and regional input, we will make every effort to recruit potential providers to fill the gap.
6. To prioritize a stable transition and the viability of current providers, ValueOptions will not undertake substantial expansion or changes to the existing provider network.

Subsequent Network Development Activities

7. Ongoing network development functions will emphasize strengthening fragile providers, filling of identified gaps in service type and capacity, developing customer/peer operated services, and using diagnosis-related treatment guidelines for all customers.
8. During the initial months, we will continue to monitor provider capacity against demand and will do the following:
 - a) Analyze the adequacy of the current provider network, including GeoAccess and density reports and all of the data gathered and analyzed.
 - b) Monitor waiting lists, access-to-care data, and other information from providers and referral sources to identify service capacity issues in each region.
 - c) Review identified gaps and service needs with interagency teams, to “fine tune” preliminary service plans for each region. Service plans will identify and prioritize service development needs and will identify resource allocation issues to be addressed in ValueOptions contracting. The plans will also identify specific strategies for strengthening and expanding services within the existing provider network, as well as the recruitment of new providers when necessary.
 - d) Identify which providers are appropriately trained to be able to serve other funding streams and begin to expand their contracts.
 - e) Augment the presence of local crisis response systems where necessary.
9. ValueOptions will incorporate regional service plans into a comprehensive annual network development plan to enhance the delivery of behavioral health services throughout the state. The plan will identify specific network development objectives for each year, including opportunities for providers to participate in pilot projects or other regional initiatives.

Moving the System Forward. In the sections that follow we discuss what we project the priorities may be for post-implementation. This listing is not meant to cover all network development activities, since most activities initiated during the implementation period will be continued throughout the contract term. VOI will continue to work with the Departments and their Work Groups to expand access, services, and quality of care. New areas of emphasis, however, will be added each year.

Post-Implementation. During post-implementation, or Phase Two, our priorities will include:

- expanding Eligible’s access to medication management by developing effective contracting and consultation arrangements with primary care clinics and Federally Qualified Health Centers (FQHCs) across the state;
- working with providers and the Departments to explore the effective use of technology including telemedicine and primary care consultations;
- working with the Member Services Department to implement a pilot Self Determination project;
- contracting with additional local agencies to support implementation of community-wide crisis response systems;
- working with the Departments, the UM and QM Departments to support the expansion of evidence-based and promising practices through training;
- identifying at least one opportunity to work with a local agency to design and implement a model transition process for adolescents moving toward adulthood, coordinating delivery systems, and using Family Support Specialists; the protocol “Transitioning to Adult Services” is one design that will be presented for the review of the DHS and DPH
- implementing new provider reimbursement methodologies and incentive pools; and
- focusing on clinical and quality data to ensure accuracy, completeness, timeliness, and adequacy to move forward into the quality and performance improvement initiatives envisioned for Year Three.

Refining the System. As we now envision it, the final phase, Phase Three, will be the period in which VOI will have accumulated enough data to analyze utilization trends and clinical outcomes across all programs. While refining the system, we believe the Departments will be able to begin to refine their delivery system in accordance with the expectation of a “good behavioral health system.”

The VOI Provider Relations Department will have a major responsibility in assisting the Departments to provide training and technical assistance to those provider agencies and practitioners who may need assistance in adapting their clinical services and programs. To assure the viability of Iowa’s behavioral health delivery system, it will be important to

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work through the Departments and their committees to monitor the progress of every provider in implementing any changes necessary.

We also believe that during Year Three, providers may be in the process of—or ready to—create new strategic alliances to form local systems of care. ValueOptions will provide the potential models for consideration, standards that might be required for recognition as a local system of care, and reimbursement strategies that would incent/reward effectiveness within those systems.

THEMES TO GUIDE NETWORK DEVELOPMENT

Key issues and themes will guide our network development as we work to ensure adequate capacity and access throughout the state, including the following:

- **Ensuring stability and expansion of high-quality services through existing providers.** Our Network Development Plan will capitalize on the strengths and potential of current providers and will find creative ways for providers and customer-operated and owned organizations to collaborate with each other to expand and enhance a comprehensive, coordinated delivery system. If current providers—given the opportunity and necessary technical assistance—cannot deliver needed services, we will recruit providers from other areas of Iowa to fill key gaps in services.
- **Ensuring Customer and Family Choice.** To ensure customers and families have a choice of providers, VOI will expand the provider network through an open network policy. We also will provide technical assistance to prepare providers to serve customers from multiple funding streams, further broadening the options available to customers and families. Providers who are not currently in the provider network, but are requested by Eligible persons or family members, will be invited to apply for network participation and/or offered a Single Case Agreement. Single Case Agreements are used to make payment arrangements with a provider whose specialized expertise is needed for or requested by a particular customer, and to arrange immediate treatment while the credentialing and contracting process for full network participation is completed.
- **Equitable resource distribution.** We are familiar with issues and perceptions of inequitable resource distribution that exist in states with both urban and rural/frontier sub-regions. We continually assess and adjust funding so that customers in all regions of the state have equitable access to a comparable range of quality services.
- **Recruitment Strategies to Better Serve Rural Areas.** VOI will draw upon ValueOptions' public sector success in other rural areas, such as Colorado and Pennsylvania, to develop strategies to ensure that customers who live outside of the metropolitan area have responsive services. Some of these strategies include:
 - encouraging quality providers to expand services in rural areas through contract addenda, including incentives;
 - providing technical assistance to providers who are willing and qualified and to serve customers from all or multiple funding streams, especially those recommended by Collaborative customers and agency staff as excellent providers;
 - enhancing and/or arranging transportation services to allow rural customers to access care quickly and easily in adjacent areas;
 - arranging for qualified clinicians to render in-home services (when clinically appropriate);
 - implementing comprehensive outreach and customer education efforts;
 - establishing rates that reflect the real costs of delivering services in small communities necessitating significant staff travel time;
 - expanding the current limited use of telemedicine;
 - working with other medical professionals, IHS, and FQHCs to develop and/or open access for mental health and substance abuse services; and
 - using family, peer, and natural supports to expand traditional treatment resources.

VOI plans not just to maintain a sufficient network and provide a full continuum of skilled behavioral health providers, but also to work to expand both access and the available array of services. We also will work with the Departments to shift the philosophy of the network to one that encourages and supports self-direction and recovery for adults and the development of resiliency for children and their families.

We fully recognize that this will be an incremental process and that the development process will vary by funding stream. However, we are committed to developing an integrated behavioral health care delivery system and will work

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flexibly with the provider community to move toward that goal. The diversity of cultures and, the differences in communities and regions requires a creative approach to service delivery.

Summary of Key Strategies. Important strategies we will employ to assure our network is sufficient include the following key components:

- We will work with the Iowa Plan to identify, develop, monitor, and continually assess our network sufficiency and ways to address unmet needs.
- We will recruit and contract with all current providers serving the Plan.
- We will maintain an open panel and actively recruit all willing and qualified providers and practitioners to contract to serve the Plan's Eligibles.
- We will seek ways to expand utilization of peer and family supports and to foster the development of Eligible-operated and Eligible-owned businesses.
- We will accommodate existing provider networks who want to participate in the network as a single organization.
- We will provide technical assistance to current providers to enable them to become contracted to serve customers in multiple funding streams.
- We will implement reimbursement strategies that assure an adequate cash flow for all providers.
- To assure statewide consistency and equity, as well as a single point of accountability, VOI will retain all responsibility for network development and oversight.

DEFINING, ESTABLISHING AND MONITORING NETWORK SUFFICIENCY

As soon as we receive updated information about current utilization and customers, we will analyze the distribution of customers for each funding stream by ZIP codes and regions, as well as statewide. Next, we will overlay the providers that have traditionally rendered care to the customers by program to determine the existing levels of care to which customer have had access. In the next step, we will review the aggregate data and estimate both geographic and level-of-care needs. This data will be compared to utilization data from the other programs we run in other public sector programs. We also will make comparisons to national norms. All these factors are included in the process of estimating the sufficiency of the provider network required and the availability of service providers. All of the data will be used to develop a network development model for the whole system of care.

What is most important to VOI is to expand the array of providers to ensure more choice for Eligibles where possible and to allow for the most appropriate use of available resources. For example, one reason we will recruit medical clinics and FQHCs, as well as private practitioners, into the network during Phase Two is to allow them to assume responsibility for the "traditional" users of mental health and substance abuse services, who require only incidental outpatient services. This will free staff of specialty behavioral health care providers to focus on serving those with more serious and complex issues.

Assistance in Network Planning. During implementation, ValueOptions will ask the Departments to name a Work Group to assist in finalizing the network development plan. Representatives of local peer organizations will be part of that Work Group, and will be crucial in providing input to the plan for their region. We anticipate that the Work Group will continue to advise the ValueOptions Network Operations Department on an ongoing basis, especially in evaluating proposed changes in network strategies or expanding the array of covered services.

Network Assessment and Design. Regularly during the contract period, Network Development staff will perform GeoAccess studies and density reports to highlight gaps in the array of services to maintain and preserve optimum delivery of behavioral healthcare services. Results of these studies will be shared and discussed with the Departments as well as with those committees and work groups designated to support operations. As part of our ongoing network assessment process, we will identify additional providers and evaluate the need for specialty services, review rates of service utilization where data are available, and determine capacity requirements to serve Iowa Eligibles.

FOCUSING ON REGIONS AND LOCAL COLLABORATIVES

An important part of our monitoring will focus on the six regions, because that is where much of the network development work will actually occur. We will design a standard set of reports cooperatively with the representatives of local groups. These reports will reflect data from each group as well as each region and statewide.

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Our analysis—local, regional, and statewide—will look at demand and utilization broken down by demographic characteristics, ethnic and cultural populations, and by provider. In addition, we will incorporate:

- recommendations from work groups or task forces formed to assist our network development activities;
- trended historical data;
- findings of quality and credentialing site visits;
- interviews with providers;
- surveys of Eligibles, family members, and community support organizations;
- automated GeoAccess mapping processes to match population and utilization needs with existing capacity and density reports; and
- consultation with county and state agencies and other community services.

In later years of the contract period, we expect the local groups to begin to produce their own plans and we will incorporate them into our own annual Network Development Plan. Data from ValueOptions' prior experience in other public sector programs will be valuable in evaluating the needs of special and priority populations as well as estimating the number of customers who are under-served or un-served. In addition, the historical statewide utilization patterns of Iowa will be compared with the prior patterns for yet another opportunity to address possible gaps in service array or geographical accessibility.

Monitoring the Delivery System. In addition, our Network Development staff will work with the Quality Management (QM) Department and Committees. The work group established initially to assist ValueOptions with network development strategies during the implementation period may become a permanent component of the QM Committee structure to assure a focus on network development as well as an opportunity for stakeholders to work directly with the Network Development staff. With these stakeholders, VOI will look at the delivery system from a statewide perspective. Among access measures we will review will be geographic distance, travel time, appointment timelines, the number of professionals per customer, penetration rates, demographic information, cultural needs of the community, practice and utilization patterns, and customer-reported satisfaction to ensure network access is monitored.

Additionally, our basis for determining sufficiency of the provider network will include monitoring access standards using all of the following tools:

- tracking and responding to all customer complaints;
- maintenance and analysis of data contained in our provider database, including:
 - services offered;
 - capacity to accept new customers;
 - access for people with physical disabilities; and
 - languages spoken and knowledge of American Sign Language;
- population growth and provider distribution, which are reviewed annually and when a provider leaves the network;
- access-to-care line monitoring of issues related to provider access;
- calls and site visits to independently measure and monitor actual versus reported accessibility (e.g., riding with transportation providers to monitor transportation response times);
- analysis of data on percentages of customers accessing treatment by provider, diagnosis, and utilization by diagnosis and level of care, timeliness of service delivery, and comprehensiveness of the provider network as indicators of access;
- customer satisfaction surveys, which include questions concerning geographic, appointment, and provider accessibility;
- analysis of utilization and complaint/grievance data to see if patterns of service use point to any barriers to access;
- inclusion of accessibility and appointment standards in provider contracts;
- requests from customers or family members for access to a particular service or provider;
- the need for a provider or service in a particular geographic areas based on the number of covered lives in that area;
- the number of out-of-network authorizations; and
- feedback from network providers and Service Center clinical staff.

The Perspective of Customers and Families — Although all the computerized and data-based analyses of access and capacity are important, some of the most important information will be feedback from Eligible persons and family members. Our Recovery and Resiliency Department will be responsible for our programs of prevention,

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education, and outreach. In that role, they will be responsible for getting feedback, both formally and informally, from the Plan’s Eligibles.

Although anecdotal feedback is not scientifically based, we have learned—especially through our public sector programs—that anecdotes are often grounded in truth. We will follow up on all customer information that indicates either access to, or quality of, services is inadequate.

- b) Describe any additional existing service gaps, by region, which the Bidder has identified in preparing this proposal, and the basis on which the Bidder has made this determination. Describe how the Bidder would address those gaps and provide an implementation timeline showing the dates for the introduction of any new services that the Bidder would provide, by region. The Bidder shall minimally address:
- Level I Sub-acute Facility services delivery
 - 24 hour mental health stabilization services, noting that past attempts to do so for the Iowa Plan have not proven successful, and
 - Substance abuse peer support/recovery coaching.

In the *Iowa SAMHSA Part I: Systems Assessment and Gap Analysis for Money Follows the Person*, a most telling statement is made. “Momentum for systems transformation,” write the authors, “is steadily increasing.” This statement speaks directly to the statewide, region-wide, and county-wide gaps that prevent the present behavioral health care system from being as effective as it could be. They further note “significant barriers in community integration,” a gap that indicates a global failure to access services at all levels. Although others may look at these two realities as a good news/bad news conundrum, VOI sees them as a challenge with great potential for success.

ANALYZING GAPS IN SERVICES

In conducting this gap analysis, ValueOptions of Iowa relied upon a multi-tiered approach. This included:

10. Reviewing all available state conducted gap analysis including the following:
 - a) An Analysis of Iowa’s Mental Health Care System. Iowa Civic Analysis Network (I-CAN), University of Iowa. December, 2006. Accessed 1/21/2009 at: <http://www.uiowa.edu/~ipro/Papers%202006/mentalhealth010207.pdf>
 - b) State Gap Analysis for both “Money Follows the Person” and “Children’s SOC”:
MFP: <http://www.ime.state.ia.us/docs/Part1SystemsAssessment.doc>
SOC: <http://www.ime.state.ia.us/docs/Part1SystemAssessment.doc>
 - c) 2008 report to the legislature on MH system improvements:
http://www.dhs.iowa.gov/mhdd/reports_publications/Reports_Publications.html
 - d) Olmstead report on meeting the needs of older adults:
http://www.dhs.iowa.gov/mhdd/reports_publications/Reports_Publications.html
 - e) Iowa MH Block Grant Application 2008. Accessed 1/22/2009 from <http://www.dhs.iowa.gov/mhdd/docs/BLOCKGRANTAPPLICATIONcmhs2008.pdf>
 - f) County MH Strategic Plans (for Block Grant) and Needs Analysis:
<http://www.dhs.state.ia.us/mhdd/docs/SP01.pdf> through <http://www.dhs.state.ia.us/mhdd/docs/SP99.pdf>
11. Conducting an analysis of medical budget expenditures by category and rate cell to determine where utilization patterns showed disproportionate expenditures based on our experience in other public sector programs.
12. Conducting Focus Groups with Children and Families and Adult Eligibles of Behavioral Health Services.

Highlights of the gap analysis by region are described in the table below. Only those needs that were relevant in a high proportion of the counties within each region are included. Many other needs and gaps were identified throughout the information reviewed by VOI.

REGION	GAPS
Region I Buena Vista through Wright Counties	<ul style="list-style-type: none"> • Lack of youth transitioning; • Lack of person-centered service focus; • Lack of emergency services;

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REGION	GAPS
	<ul style="list-style-type: none"> • Lack of services specifically designed for children and older adults; • Lack of programming for respite care; • No self-advocacy training or support; • Lack of technical support for providers; • Need for transitional/crisis beds; • Failure to establish linkages between community and provider organizations; and • Inadequate Targeted Case Management (TCM).
<p>Region II Boone through Worth Counties</p>	<ul style="list-style-type: none"> • Lack of person-centered care; • Lack of jail diversion programming; • Lack of provider access to emergent data, client resource and application capability, online provider billing); • Lack of community, home-based supports for those who are chronically ill; • Lack of emergency and crisis programming, need for alternatives to inpatient care; • Need for Eligible empowerment programming; • Need for increased 24-hour supervised residential programming; • Need for public education efforts to reduce stigma; • Need to assist in transitioning youth with disabilities to adult service providers; • Need to decrease the number of committals.
<p>Region III Allamakee through Winniesheik Counties</p>	<ul style="list-style-type: none"> • Lack of children and family services, need for smoother transitions from youth to adult care; • Lack of 24-hour structured care for crisis conditions and difficult patients; • Shortage of psychiatrists; • Lack of clubhouse programming and small group activities; • Need for the development of alternatives to incarceration for person with SPMI, lack of linkages with justice system; • Lack of transition services; • Need for a drop-in center and peer support programming; • Need for SCL services to address waiting lists; • Lack of respite programming; and • Lack of adequate system outcomes data.
<p>Region IV Adair through Union Counties</p>	<ul style="list-style-type: none"> • Lack of a “method to better track the changes that occur on a frequent basis in the services, number of hours of services, and cost of services for each Eligible, need for “more detailed evaluation of delivery system, satisfaction data, education and training opportunities, and community meetings”; • Lack of coordination between the MBHO and hospitals, need to monitor the hospitalization commitment process and the hospital discharge planning services; • Lack of psychiatrists, lack of telemedicine program; • Need for natural community and peer supports, need for WRAP services; • Lack of programming for children; • Need for more coordinated response to emergencies, lack of after hours and mobile crisis services; • Inadequate availability of targeted case management services; and • Need to improve transition services for those just entering the system, for those making the transition from youth to adulthood and those making transition from the justice system.
<p>Region V Jasper through Warren Counties</p>	<ul style="list-style-type: none"> • Lack of transition planning for youth entering the adult system; • Lack of quality service options and providers; • Need for TCM; • Need for non-Title 19 case management; • Need for mobile crisis services; • Need to improve management information systems;
<p>Region VI Appanoose through Wayne Counties</p>	<ul style="list-style-type: none"> • Need to establish better county and provider relationships; • Lack of person-centered planning; • Lack of supported community living; • Need for Eligible-driven peer support, drop-in centers, Eligible-directed attendant care;

REGION	GAPS
	<ul style="list-style-type: none"> • Lack of planning to improve transitions for adolescents to adult care; • Lack of stakeholder engagement and input, Need for quality assurance mechanisms, lack of accountability; • Lack of psychiatrists; and • Lack of mobile crisis services.

STATEWIDE GAPS AND TRENDS:

Among our key findings were the following trends:

- A significantly higher-than-expected proportion of the medical budget is used for inpatient acute and residential services. For example, based on the two years of utilization data provided, inpatient services averaged more than 40 percent of medical budget expenditures in some rate cells. Despite the wide array of community-based services and supports available, the percentage of dollars required for 24-hour levels of care was also higher than our experience in other Medicaid Behavioral Health carve-outs. Mobile crisis and in-home services accounted for a substantially lower proportion of expenditures than ValueOptions has experienced in other mature public sector programs.
 - To address this, VOI is proposing the development and expansion the State of Iowa’s Emergency Mental Health Crisis Services.
- All State and County Needs Assessment in addition to the Child and Family Focus groups expressed dissatisfaction of the lack of a coordinated children’s system of care. Services from early childhood to transition to adult are lacking. In addition, there is lack of information provided to families include limited assistance with referrals, no single identified entity responsible for the coordination of care (no required case management), no formalized support to families to negotiate the service system, and no emphasis or training on family directed care (i.e. wrap-around).
 - To address this, VOI is proposing the development statewide Children’s System of Care.
- Peer support and person-centered service planning and treatment are still underdeveloped. Peer run and peer-directed services are not consistently available across the State. Drop-In Centers, Living Rooms, and other non traditional mental health and social supports are not available in many areas. Families of children experiencing SED have no formal peer supports.
 - To address this, VOI is proposing the expansion of Peer Run/Peer Supported services throughout the State of Iowa include the addition of Family Peer Support and Substance Abuse Peer Support/Recovery Coaching.
- Lack of physicians (particularly child psychiatry). Efforts to address this include the use of Telepsychiatry is still limited in scope. Additionally there is little coordination with primary care and mid-level practitioners.
 - To address this, VOI is proposing the statewide expansion of telepsychiatry and the development of PCP behavioral health consultation.
- All data sources including the focus groups and interviews with providers and other stakeholder pointed to the lack of a single statewide data source as a significant problem. State Officials cannot pinpoint an accurate number of individuals receiving services, providers have no “real time” access to data for decision support and management of services, and Eligibles and families have expressed frustration with the lack of ready access to their information including not receiving an explanation of the services received (EOBs).
 - To address this, VOI is proposing the utilization of a suite of interconnected IT’ tools that will capture the required data for the National Outcomes measures for all individuals (including those targeted population individuals not currently enrolled in the Iowa Plan), will allow for “real time” data support and access to business intelligence for providers, and will allow members to access pertinent information and assistance with negotiation of the Iowa Plan and traditional and non tradition services.

ADDRESSING THESE NEEDS - THE VALUEOPTIONS OF IOWA PROPOSAL:

I. Expansion of the Emergency Mental Health Crisis Services System:

As defined by the State of Iowa Emergency Mental Health Crisis Services System, VOI will adopt all workgroup recommendations from the 2008 report to the legislature on MH system improvements. This will include expanding upon the following recommendations to ensure:

- service accessibility 24 hours a day, 365 day a year;
- use of best practices in the delivery of emergency mental health services;

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- the new standard of care focuses on local availability, personal contact, and local coordination of services; that the shift to community-based service provision is supported through all related processes across agencies; and
- the standard of care for mental health supports an integrated health model.

In order to facilitate this, VOI is proposing the following additional services be implemented according to the timeframes below:

a. Mobile Crisis Response

The mobile crisis service are time-limited crisis intervention services available to reduce escalation of crisis situations, relieve the immediate distress of individuals experiencing a crisis situation, reduce the risk of individuals in a crisis situation doing harm to themselves or others, and promote timely access to appropriate services for those whom require ongoing mental health or co-occurring mental health and substance abuse services.

VOI will work with DHS and DPH, local providers, emergency responders, and other stakeholder to develop and implement mobile crisis response teams throughout the State of Iowa. A mobile crisis team is an interdisciplinary team of mental health professionals (e.g., nurses, social workers, psychiatrists, psychologists, mental health technicians, addiction specialists, peer counselors) in addition to designated first responders. Teams operate under the auspices of designated providers agencies, municipals hospitals, or city or county first responders. They respond to persons in the community, usually visiting them at home or at other designated locations to ensure safety of all parties. VOI will work with the Departments to prioritize areas where Mobile Crisis Response is most needed and can be used to support the ongoing State initiatives.

b. Professional Resource Family Care (out of home crisis stabilization)

VOI will develop and contract for Professional Resource Family Care which provides direct 24 hour care and supervision for a child or youth with a serious emotional disturbance who would otherwise be placed in a more restrictive setting without the relinquishment of custody. Using a co-parenting approach, the professional resource family will assist the family and Eligible with support and education in order to reduce overall family stress and provide the family with the skills necessary manage the symptoms of the Eligible's mental illness and are designed to achieve the Eligible's return home at the earliest possible time. It is expected that both the family and the professional resource family are integral members of the Eligible's individual treatment team. For the purposes of this service, "family" is defined as the persons who live with or provide care to the child or your, and may include a parent, spouse, children, relatives, grandparents, or foster parents. Services must be recommended by a treatment team, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child or youth's individualized treatment plan. Services must be provided in a family home setting that is licensed by the State of Iowa.

c. Level I sub acute services

Persons who require short-term intensive intervention are often hospitalized or incarcerated since no suitable alternative exists in Iowa. A sub-acute facility provides brief, inpatient treatment as a more desirable alternative. The purpose of this service is to intervene when an individual's mental health symptoms escalate beyond those manageable in an outpatient setting. Since the person remains linked to the community, length-of-stay is minimized and the individual is less likely to lose critical recovery supports including Medicaid eligibility and housing.

These programming will be developed by VOI in local communities utilizing existing local resources. These may include establishing contract with small (under 16) group congregate homes, nursing facilities, psychiatric residential treatment facilities, or local and regional hospitals. When existing beds are unavailable, VOI will work with providers within the network as described earlier in this proposal to expand capacity for this service. Rates will be developed in conjunction with DHS and DPH.

d. 24 hour crisis stabilization services – Hospital Diversion Homes

Hospital Diversion Homes will provide peer-operated services based on the philosophy that recovery is not only possible, but is the expectation. The project shall promote full recovery, active engagement, hope, stabilization and development of an extensive personal support system, and the pursuit of productive meaningful lives. Program values center on human resiliency, hope and respect. This compassion-based approach has been proven to be successful in helping those at risk to accept and respond to engagement that they find open and productive.

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The Hospital Diversion Model will provide innovative and unique crisis diversion services where individuals seeking temporary residential care/respite care can stay for one to five nights. Each Hospital Diversion House will be designed to help “at risk” individuals break the cycle of learned helplessness and recidivism through twenty-four hour peer support, self-advocacy education and self-help training. The program will use an integrated services team approach that includes crisis diversion as an integral part of treatment and recovery.

VOI’s strategic relationship with PEOPLE, Inc. will bring the necessary training to the State of Iowa on how to open and operate a Hospital Diversion House in each of the six regions of the state.

THE ROSE HOUSE MODEL

The Rose House is an innovative and unique “hospital diversion” facility where individuals seeking temporary residential care/ respite care can stay for one to five nights. Services at The Rose House are designed to help “at risk” individuals break the cycle of learned helplessness and recidivism through twenty-four hour peer support, self-advocacy education and self-help training. Guests are taught to use new recovery and relapse prevention skills and to move away from what are often long histories of cycling year after year from home to crisis to hospital. The home-like environment is warm, friendly, safe and supportive. Interventions at The Rose House are conducted by PEOPLE, Inc. peers who are trained to listen and validate issues or concerns in an empathic and loving manner. All of the peers in The Rose House have experienced similar crises in the past, and their experience brings authentic strength and healing to the environment.

The Rose House is equipped with professional musical instruments, art equipment, self-help tapes, videos and DVD’s. It has an exercise room and video games; each room is equipped with a television and small stereo. These amenities are designed to distract guests from perseverating on their impending crisis and to remind each guest that he/ she is a person first, who is in crisis, second.

The original Rose House Hospital Diversion Model has been in operation since 2001. It has served over 400 individuals since opening and has reduced hospital admissions for many people. A study is currently under way at The College of St. Rose in Albany, New York. The outcome data will be available in June of 2009. The Rose House is designed to serve individuals with symptoms of mental illness and to provide a non-coercive, home-like environment for recovery. This peer-staffed facility uses the development of personal relationships and the expectation of recovery as its primary intervention.

The average cost of a hospitalization in the Hudson River region is \$1,200/day per person. The cost of an overnight stay at the Rose house in 2008 is \$182/day per person. With over 1,500 overnight guest stays at the Rose House since opening, the cost of hospitalization would have equaled \$1,800,000. Over this time period, the State accrued a total savings of over \$1,535,000.

The Hospital Diversion House focuses primarily on wellness and moves away from illness. It is designed to be a safe and comfortable environment that offers support from the perspective of people who have experienced distress and have successfully found a way to learn new or different self-determined and purposeful techniques or practices to divert personal crises. The model offers flexibility in serving a diverse group of people who live in the community. Admission criteria, length of stay and treatment structure are not dependent on insurance restrictions or DSM IV TR criteria. This flexibility fosters a more person-centered approach to quality care and has been a catalyst to building trusting relationships between the peer staff and guests served.

The Hospital Diversion Homes model will serve Iowa a unique way by filling the gaps that exist in community mental health services. It serves those people who often do not need acute care in a psychiatric emergency room and those who do not meet criteria to be admitted. The Hospital Diversion model serves those who are discharged by an acute care setting who are not “ready” for full community re-integration. It serves those who are going into crisis who do not desire a hospital setting. The Hospital Diversion model also assists those who cannot be served by the traditional mental health service system due to overutilization and/or “burned bridges”.

As these services are developed for Mental Health Crisis response, VOI believes that they would be valuable for substance abuse and co-occurring Eligibles who would benefit from a peer support social detoxification program.

2. Development of a Statewide Iowa Children’s System of Care:

As discussed in *Section 7A.2.4*, VOI will fully adopt the Core Values of a Children’s Mental Health Systems of Care (SOC). We will develop and emphasize services to support families and help children remain at or close to home and do well in their own community. Through this effort, ValueOptions of Iowa intends to develop and shape an organized system of care for children and youth experiencing mental, emotional and behavioral disorders. We will begin this process by incorporating these principles into every training opportunity with VOI staff, providers, other stakeholders, and Eligibles and family’s who access Iowa Plan services. In order to fully realize the potential for SOC, ValueOptions intends to develop the following services and supports:

a. Family Peer Support Services

A Family Peer Specialist is an individual who is a family member of a child or an adult who has received behavioral health care and/ or substance abuse treatment. Family Peer Specialists work along with the clinical providers to ensure the communication of a recovery and resiliency orientation into the behavioral health care delivery system and work directly with Families and members to strengthen the family’s capacity to understand and deal with their behavioral health diagnosis. The Peer/Family Peer Specialist encourages members to focus on their strengths and abilities in their recovery process while utilizing friends, family, and other natural supports.

Family Peer Specialists work in conjunction with VOI Intensive Care Coordinators and local providers to coordinate care and community resources to assist the members in coping with a behavioral health care diagnosis and treatment. The Peer and the Family Peer Specialist also work directly with members in the following ways:

1. Provide support, to the member/family either by phone or in person, during times in their life when their symptoms are interfering with their day to day activity.
2. Ease the stress of members/ families when there is a change in their care or treatment plan.
3. Help members/families to be fully involved in the treatment plan process.
4. Encourage members/ families to speak freely about their concerns with their behavioral health care providers.
5. Assist members in accessing and filling out paperwork for community based resources and programs
6. Facilitating the Wrap-Around process for treatment plan development.

Goals of the Family Peer Support Program:

Iowa Family Peer Specialists work in conjunction with ValueOptions of Iowa UM and ICC to ensure effective system management, easy access to appropriate services, and the development and maintenance of high quality services. In order to achieve improvements in care, ValueOptions’ will utilize the support of the Family Peer Specialists in the following ways;

- **Coordination and Continuity of Care:** Care must be provided in a fashion that is well coordinated and easy for Eligibles to utilize with better access to information and services through a one-stop source for assistance. This includes facilitation of the wrap-around process.
- **Emphasis on Early Intervention:** Early detection and intervention is essential for children with complex behavioral and social histories who require immediate access to care at the first sign of behavioral difficulty.
- **Value-added Services:** Services need to be both traditional and non-traditional and should emphasize Eligible choice and need. Creative individual-centered planning approaches will be promoted and supported. The Peer/ Family Peer Specialist works closely with Families and providers to ensure a person centered approach in all aspects of treatment planning.
- **Greater Accountability:** The service system must keep families and Eligibles engaged to seek the input necessary to improve its performance as measured by Eligible satisfaction, quality of life, and positive health outcomes
- **Cultural Competency:** The unique cultural needs of the client and family need to be recognized and respected as individual services are identified and coordinated. The unique cultural diversity within the *state* must be recognized and respected as the system increases its service and system scope.

As this service becomes formalized, the VOI Member Services Department will coordinate with these service providers and will seek to arrange a professional network of family peer specialists for the purpose of mutual support and ongoing training and education.

b. School Based Services

The Surgeon General’s Report estimated that up to 20 percent of youth experience mental health problems in any given year, and approximately 75-80 percent of youth in need of treatment and support services do not receive adequate care. Less than 30 percent of youth with a diagnosed mental disorder receive *any* service, and of those who do, less than half receive adequate treatment. Emotional and behavioral health problems represent significant barriers to academic success and school decorum. Mental health is not only the absence of mental illness, but includes having the skills needed to deal with life’s challenges. Children do not learn at their optimum when experiencing mental illness or when overwhelmed by life’s stressors. Children and adolescents with emotional disturbances (5-9 percent of school-aged youth) have the highest failure rates, with 50 percent of these students dropping out of high school.

”We need a lot more Certified Peer Specialist paid for, like they do in a lot of states. Peer specialists help keep people out of the hospital, and they help people find out how to get things done. They also show that recovery is possible.” Iowa Focus Group Participant - 2009

The President’s New Freedom Commission suggests that schools offer unparalleled access to students to address both academic and mental health needs, and these needs are intricately related to each other. Further, students are more likely to seek counseling when services are available in schools (Slade, 2002).

Key Components of School based Mental Health and Substance Abuse Services:

- Mental health promotion, education, and the continuum of mental health services - prevention, consultation, assessment, treatment, and follow-up provided in a school through the collaboration of the school district’s student support services and the mental health system, in partnership with families.
- To promote students’ emotional and social well being, to ensure early identification of mental health needs, and to offer timely access to mental health services to address social, emotional, or behavioral issues.
- School-based SA activities to prevent the use of harmful substances such as tobacco, alcohol, and drugs. Services may include informational materials, staff/student workshops, in class lessons, student and family consultation, referrals for therapeutic counseling.
- Resulting in increased life success, improved health, behavior, and school success through improved social and emotional maturity.

VOI will utilize the key component of a school based mental health system for children to build the local relationships required to comprehensively support children and families. As a component of any system of care, the supporting relationship between the family, school, and mental health treatment providers is integral.

c. Early Childhood Prevention and Intervention Services

The Development of an Early Childhood Mental Health Service System is an integral component of a children’s system of care. The addition of specific strategies and services will be described in detail in *Section 7A.10*.

3. Support and Expansion of Recovery Focused Peer Support Services:

As discussed in *Section 7A.2.4*, Rehabilitation, Recovery, and Strength-Based Approach to Service Delivery, Support and Expansion of Recovery Focused Peer Driven/Run services is a core components of ValueOptions of Iowa program design.

a. Mental Health Peer Support

Mental Health Peer Driven/Run services will be expanded utilizing the approaches for empowering a Eligible movement as previously described. In addition, ValueOptions will specifically develop two new peer run services as described above, Family Peer Specialists and Peer Run Hospital Diversion Homes.

b. Substance Abuse Peer Support / Recovery Coaching

One of the greatest challenges facing behavioral health professionals is the increase in clients who present at substance abuse treatment programs with co-occurring psychiatric disorders or vice versa. Nationally-recognized researchers, such as Kenneth Minkoff, Robert Drake, and others, have confirmed through numerous studies that more than one-third of clients in substance abuse treatment services have some form of co-occurring psychiatric disorder. Data from most

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states show that among Medicaid clients receiving mental health services, from 20 percent to 40 percent have a history of substance abuse.

The key to meeting this challenge will be the application of evidence-based models such as Mentally Ill with Co-occurring Chemical Addiction (MICCA) and the work of Kenneth Minkoff's Community Consensus-Building Collaborative, as well as treatment based on the Stages of Change Model by Prochaska and DiClemente. **In three national studies, these approaches to dual diagnosis treatment have not only been proven to be clinically effective, they also have been proven to reduce acute and sub-acute substance abuse treatment costs from 35 percent to 69 percent over a six-month period.**

We would recommend that key stakeholders be included in the decision making to advance a system of care that is fully integrated for individuals with co-occurring disorders (COD). This would include inter county collaboration for services, work groups that can create transportation options, development of programs for skills development to promote re-integration back into the community and working with the school system to provide screening for early identification of children/adolescents at risk with early and prompt referrals.

4. Enhancement and Expansion of Psychiatric and Medical Support:

In order to enhance and expand access to psychiatric and medical support, VOI will utilize the approaches described in *Section 7A.2.13*. This includes the recruitment of mid level practitioners to allow for the establishment of a psychiatric medical home in local communities, the expansion of Telepsychiatry and the implementation of our proven model psychiatric consultation to primary care physicians. The combination of these approaches will allow expanded and timely access to medical professionals for the purposes of prescription and medication management.

5. Implementation of a comprehensive Management Information System:

ValueOptions of Iowa is proposing the use of our CONNECTIONS system to address the data and decision support needs of the DHS, DPH, providers, and members of the Iowa Plan. While the capabilities of CONNECTIONS are described in detail later in this proposal, functionality of the system that directly addresses the identified gaps above include:

- VOI proposes the State of Iowa utilize CONNECTIONS as the single statewide data management system for collection of NOMS and other required data elements for **all individuals**. This would include individuals in the Iowa Plan **and all other Target Population individuals identified by the State**. Through a simple to use web based Eligible registration process (ProviderConnect), VOI will collect all demographic, clinical, and function criteria required to meet SAMHSA and DHS/DPH reporting requirements. The specific data elements and tools for registration will be customized to meet the identified needs of DHS and DPH. Other benefits of this approach include: 1) Assignment of a single identifier that crosses funding sources (Medicaid, IDPH, waivers, non-funded) and allows for tracking of Eligible outcomes and service utilization across funding streams and across providers, 2) Proactive identification of non- Iowa Plan Eligibles who may be retroactively eligible for Iowa Plan Services, 3) Reduced burden on providers and Counties to correctly report to multiple funding sources and reduces IT maintenance costs by consolidating any IT change request into one statewide management system as opposed to 99 (or more) independent MIS, and 4) Allows for the development of a data support system of tracking the entire spectrum of Mental Health and Substance Abuse funding.
- In order to support providers and DHS/DPH with business intelligence and decision support necessary, ValueOptions is proposing the use of our IntelligenceConnect system. While ValueOptions will provide all required reporting as specified in the RFP, this tool allows the State and providers “real time” access to data, allowing this data to be immediately available through dashboards, canned reporting functions, and the ability to manipulate information for your specific needs.
- Finally, Eligibles will have Web access through: 1) MemberConnect - their own utilization information, 2) ReferralConnect – an easily accessible and searchable database of providers and resources, and 3) Achieve Solutions – our award winning behavioral health information library.

Implementation Timeline

The chart that follows identifies the services VOI will introduce and the timeframes for their development and implementation. All will be reported based on existing Iowa Plan procedure codes; multi-function services (e.g.,

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community-based crisis response and supplemental case rates) may be reported in multiple procedure codes, depending on the services provided. All proposed services are subject to modification by the Departments.

Service	Planned Introduction	Action Steps
Community-based Mobile crisis response	January 1, 2010 with full implementation statewide by June 30, 2012.	Establish funding formula during contract negotiations; provide technical assistance during pre-implementation; evaluate results and support local development efforts throughout contract period.
Professional Resource Family Care (out-of-home crisis stabilization).	Will begin first quarter of the contract period, prioritize next regional expansion based on utilization data	Establish funding formula during contract negotiations; evaluate utilization data not available during procurement process to isolate geographical areas/cities where children utilize most ER/inpatient services; contract with the Iowa Federation of Foster and Adoptive Parents or other agency to recruit/train families.
Level 1 Sub Acute	Phased implementation will begin first quarter of the contract period, prioritize next regional expansion based on utilization data	Establish funding formula during contract negotiations; evaluate utilization data not available during procurement process to isolate geographical areas/cities with highest utilization of ER/ inpatient services. Establish contracts with providers (hospitals /nursing homes).
Hospital Diversion Homes (24-Hour Crisis Stabilization)	Phased implementation beginning second quarter of the contract period, prioritize next regional expansion based on utilization data. Target two additional homes each quarter of 2010.	Establish funding formula during contract negotiations; evaluate utilization data not available during procurement process to isolate geographical areas/cities with highest utilization of ER/inpatient services. Establish contract with PEOPLE, Inc. and begin contracting/training in regions with two highest utilizers.
EATS / CBAT-CO	Implementation will begin in 2010	Representatives of local substance abuse programs and DPH will review both models included in this proposal; all will be presented to DPH and DHS for consideration with implementation of the Departments' selected model(s).
Family Peer Support	Will begin first quarter of the contract period, expansion will continue throughout contract period with regular training scheduled to increase available providers.	Establish funding formula during contract negotiations; begin planning in pre-implementation with training to start in quarter one. Provide technical assistance ongoing; evaluate results and support local development efforts throughout contract period.
Early Childhood Screening and Assessment	Will begin first quarter of the contract period, expansion will continue throughout contract period with regular training scheduled to increase available providers.	Establish funding formula during contract negotiations; begin planning in pre-implementation with training to start in quarter one. Provide technical assistance ongoing; evaluate results and support local development efforts throughout contract period.
Early Childhood Mental Health Consultation	Will begin first quarter of year two, will begin training in quarter two of the contract period with regular training scheduled to increase available providers.	Establish funding formula during contract negotiations; begin planning in quarter one with training to start in quarter two. Provide technical assistance ongoing; evaluate results and support local development efforts throughout contract period.
Substance Abuse Peer Support	Will begin first quarter of the contract period, expansion will continue throughout contract period with regular training scheduled to increase available providers.	Establish funding formula during contract negotiations; begin planning in pre-implementation with training to start in quarter one. Provide technical assistance ongoing; evaluate results and support local development efforts throughout contract period.
Telepsychiatry	Will begin first quarter of the contract period, expansion will	Establish funding formula during contract negotiations; begin planning in pre-implementation

Service	Planned Introduction	Action Steps
	continue throughout contract period.	with additional contracting to new telepsychiatry providers to start in quarter one. Provide technical assistance ongoing; evaluate results and support local development efforts throughout contract period.
PCP Psychiatric Consultation	Will begin second quarter of the contract period, expansion will continue throughout contract period.	Establish funding formula during contract negotiations; begin planning in pre-implementation and through quarter one. Contract with psychiatry providers to start in quarter two. Provide technical assistance ongoing; evaluate results and support local development efforts throughout contract period.

In the last 15 years, ValueOptions has implemented literally dozens of statewide and regional behavioral healthcare programs in partnership with mental health and substance abuse agencies across the nation. Through our experience in working with this dedicated group of professionals, ValueOptions has learned the importance of helping assure their economic stability during the system transition and therefore their continuing availability to Eligibles in priority populations. ValueOptions as an arm of the state agency responsible for the programs we have been selected to administer, has adopted a number of strategies that have been very effective in assuring that we are able to expand services and fill gaps where needed. For the service noted above and any other potentially identified gaps in service, we will enlist multiple proactive strategies to ensure that each level of care or gap in service is addressed to explore any and all opportunities.

c) Describe the process by which integrated mental health services and supports will be authorized for Enrollees and who will be allowed to authorize them. Include any parameters that would be implemented to guide the authorization of integrated services and supports. The Bidder should provide examples of any past experience with the provision of such services.

As the system of care approach to delivering services continues to evolve and mature in Iowa, VOI will partner with Eligibles, families, and local community-based service providers to maximize the appropriate use of integrated mental health services and supports and will join other stakeholders in the development of plans to close service gaps. The authorization process for integrated services and support is described below.

AUTHORIZING SERVICES

VOI will provide three ways by which providers can request authorization for services: by discussing a Eligible’s needs with a Clinical Care Managers (CCMs) or Intensive Care Coordinators (ICCs) via the toll-free Access to Services telephone lines; by registering the Eligible and requesting authorization through the ProviderConnect system assessable through the VOI Web site, or as part of a treatment planning process in which an ICC has participated in the team’s discussions and approves the recommended services. When services are routine in nature and standard components of the Iowa Plan, the first two mechanisms will likely be utilized.

Authorizing Integrated Services and Supports. When services are being coordinated across agencies or include non-traditional supports needed to assist in achieving recovery or resilience, the ICC, in addition to the peer specialists, providers, and other stakeholders will utilize a wrap plan for adults or a wrap-around process for children to coordinate all available traditional or non-traditional resources. In addition, VOI is proposing the use of flexible spending funds granted to mental health providers through the community reinvestment fund as a mechanism to ensure the availability of non-traditional supports. VOI will work with the Departments to develop the protocols and procedures for accessing these funds and will work to ensure their coordination available funding through the Decategorization and Empowerment Boards.

Authorizations on the Access to Care Lines. Clinical Care Managers (CCMs) and Intensive Care Coordinators (ICCs) will staff the toll-free Access to Care Lines in the VOI Service Center 24 hours a day, 365 days a year. Our telephonic authorization process is designed to be both thorough and efficient with a focus on licensed clinicians handling the most clinically complex calls and routine request for information and assistance with identifying resources

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and/or services handled by highly trained clinical support. Our CCMs are trained to work with providers to determine the most appropriate treatment service for a Eligible while also identifying issues that are important to the Eligible's overall improvement. Therefore, our CCMs will follow a standard format in assessing a Eligible's clinical condition, and the format will be included in all provider materials so providers can assemble all necessary clinical information before initiating a call for authorization. The CONNECTIONS system is designed in a similar way that eases the burden of providers submitting needed information for authorization purposes.

After the CCM has gathered all information required to assess the Eligible's condition, if the CCM is able to determine that the requested service is medically necessary based on the Iowa Plan clinical criteria, the CCM will inform the provider and enter an authorization into the ValueOptions management information system. Based on his/her clinical judgment, if the CCM cannot justify the requested services, the CCM will talk with the provider about services that do meet the clinical criteria and try reaching a compromise with the provider by offering alternative. If the provider and CCM cannot agree, the CCM will refer the request to a Peer Advisor for a Peer Review. CCMs can only approve authorization requests. Only the Medical Director, Associate Medical Director or Peer Advisors are authorized to deny requests for authorization.

The CCM will document all discussion and decisions in the ValueOptions Management Information system. If treatment is approved, a notification letter will be generated within one business day to the Eligible, the treating provider, and the Primary Care Practitioner if that information has been supplied to ValueOptions by the Eligible person's MCO. If treatment is denied, the notification letter will include a notice to the Eligible of the procedures to appeal the denial.

Authorizations by Registering Care. To improve efficiency of authorizing outpatient services and the effectiveness of managing that level of care, VOI is proposing the use of a registration system based on the SAMHSA national outcome measures which will be available either through our Web-enabled registration form. This Web-based registration is an integral part of the wide array of Web-enabled services available to providers through ProviderConnect. By completing the registration, providers will be able to:

- register Eligibles and enroll them for Iowa Plan services,
- receive a Recipient Identification Number for the Eligible if one has not already been assigned, and
- request authorization for services.

Providers will access the registration system through the Web-enabled process. The automated registration system will use branching logic that moves the provider through the same utilization management process that would have been conducted by the Outpatient Review staff. It requires the provider to verify that requested services fall within Iowa Plan clinical criteria based on the provider's face-to-face assessment of the Eligible. Throughout the process, providers who require further assistance or whose service registration falls outside the defined parameters will be connected to a Service Center CCM for further assistance. ProviderConnect will be modified for the State of Iowa, as necessary.

The use of the automated authorizations provides much better clinical oversight than the pass through approach often used by managed care organizations. With automated authorizations, VOI will have immediate information on services being provided to an Eligible rather than awaiting a provider's submission of claims. Authorization data can be reviewed and monitored continuously to identify Eligibles who may require additional support by an ICC or providers who may benefit from consultation.

Authorizations by CCMs and ICCs. CCMs will focus on the utilization and review process as a primary function. The ICC carries a caseload that is usually longer in duration and requires coordination and collaboration with providers, the Eligible and other stakeholders in the community. Both of these clinicians will have the authority and technological capability to authorize any required services. VOI anticipates that many integrated services and supports, as well as wraparound services, will be authorized by our community-based ICCs as they participate in family conferencing, wraparound planning, and joint treatment planning. This approach allows for the immediate generation of the authorization for services and reduces the need to re-review clinical, family, and social history during a separate authorization process. In addition, services outside of the behavioral health arena can be agreed upon, coordinated, and pursued.

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All CCMs and ICCs will have laptops and the software necessary to access the CONNECTIONS system remotely via a telephone line and our Web-enabled care management module. Providers will be able to coordinate with VOI to have an ICC on site that can approve services during these face to face meetings. We will work with these providers to determine the most appropriate way for these staff members to have the necessary equipment onsite to document decisions. This technology will enable ICCs to authorize services and obtain authorization numbers for providers in real time.

The Web-enabled care management module also will allow CCMs and ICCs access to all the information in the ValueOptions' CONNECTIONS System about an individual Eligible so the care coordinating entities or service providers, in conjunctions with ValueOptions' staff, can use that information in making medical necessity determinations while onsite. The same written notifications will be generated by the management information system when authorizations are entered via the Web-enabled care management module.

PARAMETERS

Authorization of integrated mental health services and supports will be based on the evaluation of the consistency and focus on the identified treatment goals, the Eligible's choice and preferences related to his or her recovery and resiliency, and evidence-based and best practices preferred. Service requests will be evaluated for Eligible self-direction, person-centeredness, and goals of Eligible responsibility for eventual self care. Additional parameters and protocols for service authorization are found in Section 7A.8.

PAST EXPERIENCE

The concept of providing flexible, individualized services and supports is a key component of every public sector program operated by ValueOptions. For example, for the New Jersey Children's System of Care, ValueOptions authorizes individualized services and supports that are funded with 100 percent state dollars. These state dollars, although limited, have been critical in the New Jersey Department of Human Services' success in braiding services from across the Department's funding streams into family-focused treatment. In the New Jersey system, both the care management organizations (lead agencies) and the contracted systems administrator (ValueOptions) have access to state dollars to pay for individualized services and supports.

Another ValueOptions example of providing integrated services is the Family-Focused Care Program, which MBHP manages in collaboration with the Massachusetts Division of Medical Assistance, the Department of Mental Health, the Department of Social Services, the Department of Youth Services, and the Department of Education. The Family-Focused Care Program is a Systems of Care initiative that provides individualized, family-focused, coordinated care to children and adolescents with serious emotional disturbance. The program will serve a total of 250 children each year across five communities. The program was launched in June 2003 after three years of planning and building infrastructure.

The following two references are for UM to maximize coordination with local service delivery systems:

- Suzanne Fields, Director of Behavioral Health, Office of MassHealth, telephone (617) 348-5101, email suzanne.fields@state.ma.us.
- Matthew Ferrara, Office of NorthSTAR and Special Initiatives, telephone (512) 206-5444, email matthew.ferrara@hshs.state.tx.us.
- Linda Zelch, Area Director, Western Service Area, Office of Mental Health & Substance Abuse Services, DPW, telephone (412) 565-5226, email lzelch@state.pa.us.

d) Describe how the Bidder will incorporate evidence-based practice into its management of the Iowa Plan and how that will impact the services offered through the Iowa Plan during the term of the Contract.

IMPROVING NETWORK EFFECTIVENESS THROUGH EVIDENCE-BASED PRACTICES

Our analysis of the Iowa Plan utilization data supports the Departments’ initiatives to implement evidence-based best practices. As described above, data indicate that even within the Iowa Plan, services are not effectively integrated. In addition, Iowa Plan expenditures are only one component of the overall system which includes HCBS services, Rehabilitative Treatment Services and the Adult Rehabilitation Option.

Implementation of evidence-based practices is one strategy for integrating community-based services and supports. An excellent example of this approach has already been provided by DPH, which has focused on identifying best practices for serving people who have both substance use and mental health treatment issues.

The most effective way to implement evidence-based clinical practices is to do so in collaboration with funders, providers, Eligibles, families, and stakeholders. In Iowa, collaboration is particularly important, so the evidence-based practices implemented through the Iowa Plan are the same—or at least support—the treatment models selected by DHS and DPH. VOI will provide technical assistance in developing and implementing evidence-based practices approved by the Departments. VOI also will work with the Departments in monitoring outcomes.

Implementing evidence-based practices across funding streams is a key to developing effective local delivery systems in Iowa.

The MHDS Recommendations on Mental Health System Improvements with respect to evidence-based practices lists a number of practices that ValueOptions has successfully implemented in other public sector arenas. For example, in the Texas NorthSTAR program, we were able to increase the number of ACT teams five fold, virtually eliminating waiting lists for these programs, dramatically reducing recidivism and improving the quality of services offered through the use of a Fidelity Tool developed in concert with the State of Texas.

The MHDS Task Force recommends an ambitious implementation of evidence-based practices in Iowa, at the same time cautioning against possibly overwhelming available resources. VOI proposes the following implementation plan for Evidence Based Practices, recognizing that whether the implementation is Statewide adoption or limited/demonstration project-adoption, the following critical steps and processes apply to either: 1) promotion of the practices; 2) training of providers; 3) selection and use of a Fidelity Tool to assure appropriate implementation and usage of the practice; 4) evaluation of outcomes. This proposed implementation schedule is designed to introduce evidence-based practices in such a way as to have the greatest impact on service needs with a logical progression from Limited Demonstration Projects in one year to full Statewide implementation in the following year.

Proposed implementation of evidence-based practices include the following:

Contract Year	Adult EBP	Child/Adolescent EBP
Year One	Integrated Treatment for Co-Occurring Disorders – Limited Demonstration Projects	Integrated Treatment for Co-Occurring Disorders – Limited Demonstration Projects
Year Two	a) Integrated Treatment for Co-Occurring Disorders – Full Statewide b) Assertive Community Treatment – Limited Demonstration Projects	a) Integrated Treatment for Co-Occurring Disorders – Full Statewide b) School-Based Mental Health Services – Limited Demonstration Projects
Year Three	a) Assertive Community Treatment – Full Statewide b) Peer Support – Limited Demonstration Projects	a) School-Based Mental Health Services – Full Statewide b) Intensive Case Management with Wrap Around – Limited Demonstration Projects

7A.2.6 Covered Services, Required Services, Optional Services

- e) Should the Bidder anticipate that it will elect not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, describe services that it will not provide.

VOI does not anticipate that we will elect not to provide, reimburse for, or provide coverage of any counseling or referral service because of an objection on moral or religious grounds.

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7A.2.7 Organization of Utilization Management Staff

- a) Describe the Bidder's proposed organization of Utilization Management Staff. The description should include:
- the number of Utilization Management staff which the Bidder proposes, their credentials and expertise, and the rationale behind the number and the mix of expertise the Bidder has determined would be necessary;
 - a discussion of what the precise roles of each of the different types of Utilization Management staff would be;
 - the way in which the Bidder proposes to ensure maximum coordination between Utilization Management staff and local service delivery systems, and
 - the method by which the Bidder would ensure continuity of Utilization Management for Eligible Persons who make frequent use of the delivery system.

RATIONALE, NUMBER OF UM STAFF, CREDENTIALS AND EXPERTISE

VOI's Utilization Management (UM) Program recognizes that Iowa Plan providers are already accustomed to the use of clinical guidelines and other managed care strategies. Therefore, we propose strategies that are designed to:

- minimize the requirements for prior authorization and concurrent review as well as the number of staff dedicated to telephone-based utilization management;
- reward excellent providers by reducing/eliminating prior authorization and concurrent review of those intensive services, such as inpatient, which will require review by a VOI Care Manager;
- support effective coordination with Iowa's providers and local delivery systems by organizing clinical services into geographic teams; and
- include Community-based Intensive Care Coordinators who will participate in joint treatment planning sessions and offer consultation to providers, CW/JJ workers, CPCs, Targeted Case Managers, schools and other human service agencies to provide educational information via Web application, provider bulletins, letters, and email to all stakeholders regarding the function and contact number for the utilization management team for the Iowa Plan.

Position/FTEs	Credentials/Expertise
Medical Director 1 FTE	<p>Education: Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school.</p> <p>Licensures: Board-certified in psychiatry, as defined by the American Board of Psychiatry and Neurology. Independently licensed to practice medicine in the State of Iowa. American Society of Addiction Medicine Certification required. Board certification in Quality Assurance and Utilization Review preferred.</p> <p>Relevant Work Experience: Minimum five years post-graduate experience in the treatment of psychiatric and chemical dependency disorders and/or child and adolescent expertise or certification. Experience in Iowa public sector delivery system preferred.</p> <p>Roles and Responsibilities: The Medical Director will have overall responsibility for all clinical functions of the VOI Service Center, for recruiting and supervising peer advisors, and for providing clinical consultation and training to VOI clinicians, provider staff and other professionals, including non-psychiatric physicians. The Medical Director will play a leadership role in Quality Management activities as well as in the VOI Service Center. The Associate Medical Director will support the Medical Director and perform functions delegated by the Medical Director.</p>
Associate Medical Director 0.5 FTE	<p>Education: Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school.</p> <p>Licensures: Board-certified in psychiatry, as defined by the American Board of Psychiatry and Neurology. Independently licensed to practice medicine in the State of Iowa.</p> <p>Relevant Work Experience: Minimum five years post-graduate experience in the treatment of psychiatric and chemical dependency disorders and child and adolescent expertise or certification. Experience in Iowa public sector delivery system preferred.</p> <p>Roles and Responsibilities: The Associate Medical Director will have overall responsibility for all clinical functions of the VOI Service Center, for recruiting and supervising peer advisors, and for providing clinical consultation and training to VOI clinicians, provider staff and other professionals, including non-psychiatric physicians. The Medical Director will play a leadership role in Quality Management activities as well as in the VOI Service Center. The Associate Medical Director will support the Medical Director and perform functions delegated by the Medical Director.</p>
Peer Advisors PRN	<p>Same qualifications as Medical Director.</p> <p>Roles and Responsibilities: VOI will contract with psychiatrists and psychologists to provide peer review of requested services that do not, in the opinion of a Clinical Care Manager, meet criteria for the requested level of care. Clinical Care Managers are not permitted to deny request for services. Peer</p>

7A.2.7 Organization of Utilization Management Staff

Position/FTEs	Credentials/Expertise
	advisors may provide clinical consultation to Clinical Care Managers, DHS/JCS workers and other professionals, including non-psychiatric physicians, as well as primary care physicians
Director of Clinical Operations 1 FTE	Education: Master's degree in a mental health or related discipline required. Licensure: A valid Iowa license for independent practice in counseling, family therapy, nursing, social work, or psychology. Relevant Work Experience: Five to eight years of management experience in a health care or managed care environment. Must have at least three year's experience in direct provision of mental health and chemical dependency counseling services; at least one year as a clinician (Care Manager, Peer Advisor, Quality Manager, Auditor) in the managed care industry. Experience in Iowa public sector delivery system and experience with children/adolescents preferred. Roles and Responsibilities: The Director of Clinical Operations will have responsibility for all utilization management activities and staff of the VOI Service Center.
Utilization Management Manager 1 FTE	Education: Master's degree in a mental health or related discipline required. Licensures: A valid Iowa license in counseling, family therapy, nursing, social work, or psychology. Relevant Work Experience: Three to five years of management experience in a health care or managed care environment. Must have at least three years' experience in direct provision of mental health and chemical dependency counseling services; at least one year as a clinician in the managed care industry; and at least one year of experience in managing clinical MH/CD professionals; experience in Iowa public sector delivery system and experience with co-occurring disorders is preferred. Roles and Responsibilities: The UM Manager will supervise Care Management staff and have responsibility for utilization management functions.
Intensive Care Coordination Manager 1 FTE	Same requirements as the UM Director. Roles and Responsibilities: The Afterhours UM Supervisor will supervise Care Management staff and have responsibility for utilization management functions.
UM Afterhours Supervisor (Evenings) 1 FTE	Same requirements as the UM Director Roles and Responsibilities: The Afterhours UM Supervisor will supervise Care Management staff and have responsibility for utilization management functions.
Community-based Intensive Care Coordinators (Adult) 7 FTEs	Education: Master's degree in a mental health or related discipline preferred Licensures: A valid Iowa license in counseling, family therapy, nursing, social work, or psychology. Relevant Work Experience: Must have at least three years' experience in direct provision of mental health services to adults. At least one year as a clinician in the managed care industry is preferable; experience in Iowa public sector delivery system is required. Bilingual capabilities preferred but not required Roles and Responsibilities: VOI Intensive Care Coordinators (ICCs) for Adults will live and work in Iowa communities to support joint treatment planning and provide consultation to providers, TCMs, DHS/JCS workers and others in their assigned geographic area. They will be assigned responsibility for assisting high-need/high-risk Eligible persons with specific emphasis place on those at risk for or discharge from inpatient/institutional care. Eligibles assigned to ICCs also may have medical conditions that require coordination with the Eligible's HMOs, MediPASS physicians or other medical caregivers.
Community-based Intensive Care Coordinators (Youth) 7 FTEs	Same qualifications as the Community-based Care Coordinators for Adults except that the experience must be in working with children and adolescents. Roles and Responsibilities: VOI Intensive Care Coordinators (ICCs) for Youth will live and work in Iowa communities to support joint treatment planning and provide consultation to providers, TCMs, DHS/JCS workers and others in their assigned geographic area. They will be assigned responsibility for assisting high-need/high-risk Eligible persons with specific emphasis place on those at risk for or discharge from inpatient/institutional care. Eligibles assigned to ICCs also may have medical conditions that require coordination with the Eligible's HMOs, MediPASS physicians or other medical caregivers.
Clinical Care MH Managers (Call Center) 12 FTEs	Same qualifications as Community-based Care Coordinators; experience in Iowa is preferred, but not required. Roles and Responsibilities: Clinical Care Managers (CCMs) will review requests for service received from providers or consumers in their assigned geographical area. CCMs also will provide crisis counseling, and participate in joint treatment planning meetings via telephone. They will be responsible for documenting the outcome of all requests for services and the rationale for the decision. They also will participate in quality management activities and in provider training. CCMs will work in the VOI Service Centers/regional offices. CCM support will be available 24 hours a day, seven days a week.

7A.2.7 Organization of Utilization Management Staff

Position/FTEs	Credentials/Expertise
Clinical Care Managers DPH (Call Center) 5 FTEs	<p>Education: Master's degree preferred; bachelor's degree required</p> <p>Licensures: Certified Alcohol and Drug Counselor (CADC) according to the Iowa Board of Substance Abuse Certification.</p> <p>Relevant Work Experience: Five years of experience in a health care or managed care environment. Must have at least three years' experience in direct provision of chemical dependency counseling services to adults. At least one year as a clinician in the managed care industry is preferable; experience in Iowa public sector delivery system is required.</p> <p>Roles and Responsibilities: Clinical Care Managers (CCMs) will review requests for service received from providers or consumers in their assigned geographical area. CCMs also will provide crisis counseling, and participate in joint treatment planning meetings via telephone. They will be responsible for documenting the outcome of all requests for services and the rationale for the decision. They also will participate in quality management activities and in provider training. CCMs will work in the VOI Service Centers/regional offices. CCM support will be available 24 hours a day, seven days a week.</p>
RN Clinical Care Coordinator 1 FTE	<p>Education: Registered Nurse, Master's degree preferred;</p> <p>Licensures: Licensed by the Iowa State Board of Nursing</p> <p>Relevant Work Experience: Must have at least three years experience in direct provision of nursing services to adults or children with a mental health or substance abuse disorder. At least one year in the managed care industry is preferable; experience in Iowa public sector delivery system is required.</p> <p>Roles and Responsibilities: The Registered Nurse Care Coordinator will have primary responsibility for liaison with HMOs and MediPASS physicians and providing consultation to other CCMs, psychiatrists, and clinicians regarding the treatment of individuals with co-occurring medical and mental health/substance abuse disorders.</p>
Member Services Manager 1 FTE	<p>Education: Master's degree preferred Bachelor's Degree in Social Services or related field desired.</p> <p>Licensures: None.</p> <p>Relevant Work Experience: Direct experience with the Iowa behavioral health delivery system is required, either as a consumer or as a family member of a consumer.</p> <p>Roles and Responsibilities: The Member Services Manager will be responsible for coordinating with advocacy and consumer run organizations or providers that contract with VOI to provide the Warm Line services to specialty programs (see below).</p>
Customer Service Representatives 4 FTEs	<p>Education: Bachelor's Degree in Social Services or related field desired. Some college with two years of experience or High School degree with four years of experience required.</p> <p>Licensures: None.</p> <p>Relevant Work Experience: Call Center and customer service experience desired. Knowledge of the mental health delivery system within Iowa is beneficial. Computer and phone skills are imperative.</p> <p>Roles and Responsibilities: Customer Service Representatives (CSRs) will not make utilization management decisions, but will serve as the "front door" to the Call Center UM process as they respond to calls from Eligibles, family members and providers on the VOI toll-free access to care lines. They will be trained to identify emergency situations and immediately "warm transfer" such calls to VOI Care Managers, never leaving the caller on hold. They also will gather and document demographic and referral information.</p>

Within the Clinical Care Management unit, liaisons will be designated as primary points of contact for the following:

- Youth Services Liaison will serve as a primary point of contact for DHS/JCS workers and administrators as well as the juvenile court. The position will be responsible for providing consultation to other Clinical Care Managers, for coordinating the work of CCCs for Youth.
- Substance Abuse Services Liaison will serve as the point of contact for substance abuse treatment programs that serve Iowa Plan Eligibles. The position will provide consultation to other CCMs, psychiatrists, and clinicians regarding ASAM criteria, evidence-based substance abuse treatment, and related clinical issues as well as working with treatment programs to support the implementation of dual diagnoses programs and other priorities of DPH.
- Adult/County Services Liaison will be the primary point of contact for CPCs, TCMs, and DHS staff.

VOI will contract with psychiatrists and psychologists to provide peer review of requested services that do not, in the opinion of a CCM, meet criteria for the requested level of care. CCMs are not permitted to deny request for services. Peer advisors may provide clinical consultation to CCMs, DHS/JCS workers and other professionals, including non-psychiatric physicians, as well as primary care physicians

7A.2.7 Organization of Utilization Management Staff

As an adjunct to the clinical staff who provide UM services, VOI will contract with an advocacy agency or coalition identified in section 7A.2.4, to train Eligible persons and family members to staff a Warm Line at the Service Center. VOI will provide the toll-free line and the equipment as well as financial support to select, train and employ the Warm Line staff. The Warm Line will be based on the successful example pioneered in ValueOptions' Colorado Service Center (See Section 7A.4). These individuals will also support the VOI clinicians in maintaining contact with families new to the system, with high need and at risk consumers, and with consumers identified as SPMI as well as consumers with dual diagnoses.

ENSURING COORDINATION WITH LOCAL SERVICE DELIVERY SYSTEMS

While care coordination is a responsibility of all VOI staff, ensuring coordination of care across service systems will be the primary responsibility of the ICCs. Outside of Intensive Care Coordination, other key strategies include:

- geographically-organized clinical teams to support strong working relationships with providers, agencies, counties, and community resources;
- community-based clinical and provider relations staff assigned to each of the six Iowa Plan regions;
- designated points of contact for specialty services such as CW/JJ and the courts, substance abuse providers, and health plans;
- UM staff participation in QM Committees, such as the Clinical Advisory Committee and Adult, Youth and Substance Abuse Sub-committees to foster ongoing communication and problem-solving.
- Participation of providers and consumers on focused workgroups and committees working on strategies for delivery system enhancements secondary to gap analyses and reviewing EBPs, clinical practice guidelines (CPGs), and access data.

ENSURING CONTINUITY OF UTILIZATION MANAGEMENT

Services will be coordinated for people who frequently use the system as described in section 7A.2.3 *Coordination and Integration of Services* and in h) below. The VOI QM and clinical departments will identify these individuals through our outlier management program or through referral from providers or other stakeholders. Eligibles who utilize multiple services concurrently, or who require or are at risk of requiring intensive 24-hour care will be assigned to CCMs or to ICCs for additional supervision and support. In addition, all clinical staff of the VOI Service Center will be available to support substance abuse program staff who request clinical consultation for participants served through DPH state and block grant funds. Substance abuse program staff can call the toll-free number 24 hours a day and describe the clinical condition of their client without providing personally identifying information. VOI staff will provide consultation and referral information.

All staff serving adults who have mental health needs also will be made available to provide consultation to CPCs, TCMS, primary care physicians, and DHS/JCS. Center staff, Medical Director and other clinicians will consult with stakeholder via the toll-free Access Line. This service will be provided free of charge.

- b) Provide the names, telephone numbers, and e-mail addresses of three of the Bidder's clients for which it has organized its Utilization Management staff to maximize coordination with local service delivery systems and who can be contacted to confirm the effectiveness of the Bidder's performance.

The following three references are from clients for whom VOI has organized our UM staff to maximize coordination with local service delivery systems:

- For additional information on the MassHealth program, contact Suzanne Fields, Director of Behavioral Health, Office of MassHealth; telephone (617) 348-5101; email suzanne.fields@state.ma.us.
- for additional information on the NorthSTAR program, contact Matthew Ferrara, Office of NorthSTAR and Special Initiatives; telephone (512) 206-5444; email matthew.ferrara@hshs.state.tx.us.

- a) Attach to the proposal a complete copy of any Utilization Management Guidelines that the Bidder would use in authorizing mental health services. Also, attach any guidelines the Bidder would use in applying ASAM criteria for the authorization or retrospective monitoring of substance abuse services. The attachment(s) must be clearly numbered and labeled. The pages in the attachments(s) will not be counted in the page limit established for this section of the proposal.

Utilization Management (UM) Guidelines from the Massachusetts Behavioral Health Partnership (MBHP) were selected for inclusion with this RFP because the carve-out programs in Iowa and Massachusetts were implemented at approximately the same time, and both are statewide in scope. In addition, there is inclusion of social necessity guidelines that will support those individuals seeking services. The MBHP guidelines are submitted as **Attachment 1**. ValueOptions’ UM criteria are supplemented by the ASAM Patient Placement Criteria, Second Edition-Revised (ASAM PPC-2R) for substance abuse. In deference to copyright restrictions, those criteria are not reprinted in the attachment. However, we have included an example of MBPH’S work in applying the ASAM PPC2-R guidelines to support the creation of appropriate performance specifications for designated levels of care within their continuum. The sample in the attachment demonstrates how ValueOptions uses nationally accepted ASAM criteria as the basis in which local programming can be developed, monitored, and evaluated.

- b) Describe how the Utilization Management Guidelines would generally be applied to authorize or retrospectively review services. Specifically address how the Bidder would both manage the appropriateness of treatment duration and the potentially high volumes of service requests.

REGISTERING MEDICAID-FUNDED SERVICES

Few Medicaid-funded services will require prior authorization by a Clinical Care Manager (CCM). An Iowa Plan Eligible person will be able to make an appointment for almost any outpatient service with a network provider. The provider will assess the Eligible person’s clinical condition and initiate the appropriate treatment. The provider will then register the treatment with ValueOptions via our Web-enabled ProviderConnect component of our CONNECTIONS system.

Service registrations that providers complete are immediately reflected in the CONNECTIONS system, just as service authorizations are entered by CCMs. Therefore, VOI knows which services are being provided to each eligible person, even if prior authorization is not required. For high-need Eligible persons, registration of services is particularly important because it allows CCMs and other clinicians an accurate, timely overview of all services being provided to that Eligible person. Service utilization that is necessary but more routine in nature is analyzed via the authorization and claims payment system. Trend analysis is conducted to identify overall utilization, spikes in services and individuals and/or providers that would benefit from outreach and coordination efforts. These CCM activities are usually reserved for Eligible persons needing more intensive coordination and authorization of higher levels of care.

Registering services will allow VOI to minimize prior authorizations and focus clinical attention on those eligible persons and providers who can most benefit from more focused support.

The ProviderConnect system supports monitoring of the quality and appropriateness of treatment. VOI monitors both registered and authorized services continuously to identify Eligible persons identified with high needs / high risk and providers whose treatment significantly exceeds established thresholds. This outlier management approach will allow our clinicians to provide intensive support to those Eligible persons and providers who can benefit most from this resource. Services to IPDH participants also will be reviewed to identify high-need Eligible persons, based solely on IPDH-funded services and also based on a combination of IPDH and Medicaid-funded services if the Eligible person is transitioning between funding streams. Our technology allows for authorization of services for the same Eligible person under more than one funding source—that is the foundation of the “braided funding” model. By building this capability into the MIS, VOI can provide detailed and summary reports of utilization so that overall systems transformation is based on data rather than on speculation and/or the assumption of gaps in services.

PRIOR AUTHORIZATION OF MEDICAID-FUNDED SERVICES

Prior authorization and concurrent review will be required for a limited number of higher-intensity services. When an Enrollee requires these services, the provider will contact VOI by calling the toll-free Access Line, which will be staffed 24 hours a day by VOI CCMs. CCMs will follow a standard format in assessing an Enrollee's presenting clinical condition and discussing the treatment recommended by the provider. Providers will have prior training on the standard format so there is full knowledge of what information will be needed to complete a review. That format will be included in the VOI Provider Manual so the clinical determination process can be completed efficiently and effectively. The CCM will make an authorization decision after evaluating the eligible person's clinical condition as well as the clinical history, services, and medication currently being provided, and other issues important to the eligible person's health and safety. Psychosocial necessity considerations when authorizing services is clearly established in the UM Guidelines, which are submitted as **Attachment 1**. If the CCM cannot justify the requested services, or reach consensus with the provider on alternate services, the CCM will refer the request to the Medical Director/Peer Advisor. The Medical Director/Peer Advisor will review the request and communicate the decision with the provider. CCMs are not permitted to deny a request. All clinicians will use the VOI UM Guidelines as the foundation for assessing appropriate services and supports, but will use and document their independent clinical judgment in making their final determination.

Appropriateness of Treatment Duration — For services that require authorization, the appropriateness of treatment duration will be addressed through the concurrent review process, which is similar to the prior authorization process. Criteria to guide continuing stays are included in the UM Guidelines. For registered services, the treating provider simply will complete another request for authorization via ProviderConnect. Appropriateness of treatment duration is a key focus of the outlier management program described above.

High Volume of Service Requests — The CCM staffing was designed to handle the expected call volume from all those served through the Iowa Plan and their providers. Because of the limited number of services that require prior authorization, we do not anticipate a high call volume. However, the VOI Call Center will be linked to the ValueOptions Central Night Service (CNS), so should the Service Center experience a surge in call volume, CNS will provide back-up telephone support. The CNS Care Managers use the same management information system, and will be trained in the Iowa UM guidelines and other program requirements, which will assure continuity and consistency. There will be a licensed Utilization Care Manager on duty at all times to assist the CNS as needed to remain compliant with Iowa Plan requirements.

- c) Discuss any special issues in applying the UM Guidelines for:
 - i. substance abuse services for pregnant and parenting women;
 - ii. substance abuse services provided to Enrollees in PMICs;
 - iii. mental health inpatient services provided to Enrollee children in state mental health institutes;
 - iv. Eligible Persons with concurrent need for both mental health and substance abuse treatment, and
 - v. Assertive Community Treatment (ACT).

i. Substance Abuse Services for Pregnant and Parenting Women

The review of services for women who are pregnant is complicated by other factors that are related specifically to injection of drugs, higher incidence of overdose, needle-sharing issues, transmission of AIDS, Hepatitis C, infectious diseases, birth defects, and compromise to the baby during delivery. Given that there are two lives at stake, our responsibility is twofold: to assist the pregnant woman in obtaining required services to abstain from using drugs and to increase the chances for the unborn child to have a normal birth and healthy life. The application of ASAM guidelines for pregnant and parenting women and the Medical Necessity criteria for this population exemplified by the MBHP criteria will provide the flexibility needed to consider special circumstances and needs among these clients. In addition, the concepts of social necessity are a special consideration when making a utilization management decision for this population. The CONNECTIONS system has a “flagging” and tracking feature that will allow for these high risk individuals to be followed over time to ensure linkage to a full array of services. We also will collaborate with substance abuse providers to assure they coordinate with the woman's obstetrician. We will review case information to ensure that prenatal care is provided in a timely manner and that all follow-up services are in place for the mother and baby as well

as other children in the home. We will support the substance abuse program as necessary to coordinate and identify a pediatrician who can assist the newborn child, should the child be born with side-effects of the mother's drug abuse, such as withdrawal symptoms, developmental and respiratory issues. Simultaneously, we will also work with the mother and her support network to implement a safe environment for her and her child's care, for ongoing medical care for both, and for continued support in assisting the mother to remain drug free. VOI will work with DPH and the Iowa substance abuse providers to adapt these general guidelines to incorporate Iowa requirements for helping pregnant and parenting women:

- standardized assessment and evaluation, including assuring prenatal care services;
- development and provision of gender-specific treatment;
- specialized staff training;
- collaboration with community agencies and health providers;
- provision of wraparound services, such as child care and transportation;
- case management services;
- education;
- outreach to and inclusion of spouses, children, and other family members; and
- support of vocational, parenting, and budgeting education.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed an approach to treatment for pregnant substance abusers that we will review with DPH to determine its applicability in Iowa. It is designed to provide treatment support and continuity to all pregnant women seeking substance abuse treatment. This national "Point of Entry" model could be used in refining these services throughout the state of Iowa, to follow a woman from assessment through medical withdrawal, prenatal care, delivery and continuing substance abuse treatment.

ii. Substance Abuse Services Provided in Psychiatric Medical Institutions for Children

Two of Iowa's Psychiatric Medical Institutions for Children (PMICs) are substance abuse-licensed treatment programs and are approved to provide services to adolescents under the age of 21. VOI will work with representatives of Alegent Behavioral Health Service and the Gordon Recovery Center to assure our compliance with the Departments' requirements for authorizing substance abuse services in a PMIC. PMIC admission and continued-stay criteria as well as discharge criteria and social support needs will be used as a basic guideline for the authorization of substance abuse services provided in PMICs.

In addition, the VOI and IPDH CCMs will work with the substance abuse PMICs to assure that youth admitted to their programs continue to be authorized for treatment so long as the treatment remains appropriate, even if the youth's primary diagnosis changes. The IPDH CCMs also will review all requests for admission to a substance abuse PMIC even if the youth is not eligible at the time of admission, as described in *Section 7A.10 Children in Transition*.

iii. Mental Health Inpatient Services Provided to Children in State Mental Health Institutions

VOI will review all requests for treatment to be provided at the Cherokee or Independence Mental Health Institute (MHI) to children under the age of 21. VOI plans to contract with the two MHIs to provide three levels of care for children and adolescents: inpatient, sub-acute, and residential. Even if the child is not an Iowa Plan Eligible person at the time of admission, requested services will be reviewed, and VOI will retain the authorization until eligibility and enrollment are finalized as described in *Section 7A.10 Children in Transition*. In addition to considering the impact of the child's or adolescent's clinical history, family/living environment, and other factors of psychosocial necessity such as traditional healing. VOI also will assure at least five days reimbursement for children ordered for an inpatient evaluation in a state mental health institute.

iv. Eligible Persons with Concurrent Need for Both Mental Health and Substance Abuse Treatment

The criteria established by ASAM will guide appropriate admission, continued stay and discharge practices, utilizing the six dimensions (primarily three to six) to integrate the complex needs presented by individuals who are dually diagnosed. Our approach also will incorporate the Principles for the Care and Treatment of Individuals with Co-Occurring Psychiatric and Substance Disorders as they apply to Persons with SPMI, which were created by a national panel of experts through a SAMHSA grant in Massachusetts for ValueOptions and its collaborators.

v. Assertive Community Treatment (ACT)

ACT is an intensive integrated rehabilitative crisis, treatment and rehabilitative support service for adults (18 years of age and older) provided by an interdisciplinary team to Persons with SPMI or co-occurring mental health and alcohol/substance abuse disorders. The service is intended to promote symptom stability and appropriate use of psychotropic medications, as well as restore personal care, community living, and social skills. ACT services will be available 24 hours per day, seven (7) days per week, with emergency response coverage, including psychiatric coverage. Crisis services will be available 24 hours per day, seven (7) days per week. A minimum of 75 percent of all team contacts are expected to occur out of the office. ACT programs provide an intensive level of services and supports, and participation in the program requires that Enrollees understand the program and concur with its philosophy. ACT is an evidence-based practice that has demonstrated positive results in supporting individuals to live, enjoy, and prosper in the community. With the increasing emphasis on incorporating recovery principles into ACT programs, we must engage Enrollees and support them to accept the responsibilities inherent in recovery, rehabilitation, and resilience. VOI will work with the ACT programs and similar integrated community support programs to identify Enrollees that would benefit from this approach as well as providing monitoring to ensure that there is fidelity to the model in provision of services.

Enrollees accepted into an ACT team must understand the program and be committed to working as part of the team.

- d) List each Medicaid mental health or substance abuse service or level of care for which the Bidder would not require prior authorization.
 - i. Describe a quality improvement related circumstance that would lead the Bidder to request Departments approval to require prior authorization for a service that does not usually require authorization.

VOI will require prior authorization for all 24-hour levels of care, including inpatient, sub-acute, and residential services, unless the provider has met the requirements for exclusion status through pur ValueSelect Provider Program, detailed later in our response. No Medicaid funded outpatient levels of care or ambulatory services will require prior authorization except the following:

- 23-hour observation in an inpatient setting,
- intensive outpatient services,
- partial hospitalization programs,
- non-traditional integrated services and supports,
- ACT and Intensive Community Treatment,
- services for Eligible persons identified through the outlier management program, and
- services requested by providers identified through the outlier management program.

PRIOR AUTHORIZATION IN SPECIAL CIRCUMSTANCES

To assure appropriate coordination of treatment and optimum clinical outcomes, VOI may require prior authorization of all services being provided to a high-need Eligible person identified through the outlier management program, even for services that regularly require only registration. When this occurs, a CCM or Community-based Intensive Care Coordinator will be assigned to work with the Eligible person, the Eligible’s family, and providers to implement and monitor a comprehensive treatment plan. The treatment planning process will be focused on ensuring that the Eligible person has been intimately involved in the development of the plan. This process is more than a signature of the Eligible person that can be identified in a provider monitoring audit. An example of a recovery-focused treatment plan is the inclusion of a “crisis plan” that would describe the individual’s specific needs should they not be able to make their own decisions. This plan could include notifying friends at a club house, having someone take care of a pet during a hospitalization, payment of bills, or inclusion of supports in the discharge planning process. When a provider is identified through the outlier management program as having aberrant utilization trends, VOI will contact the provider to discuss the reasons for this variance. If no programmatic or member-based reasons are identified, the provider will be offered additional training and consultation. In some instances, the provider’s right to register services may be temporarily suspended and all requested services will be prior authorized telephonically with a CCM. If improvement is not evident, that provider may be barred from accepting additional Iowa Plan referrals and could, as a last resort, be removed from the provider panel.

- e) Discuss how the Bidder would self-evaluate both the clinical effectiveness and administrative efficiency of these authorization processes. Describe in what circumstances, if any, the Bidder would consider waiving prospective utilization review for certain providers based on a provider’s past performance.

The clinical effectiveness of the prior authorization and registration processes will be reviewed through the Quality Management (QM) Department’s monitoring of utilization trends by service; provider profiles; compliance with the Departments’ performance standards; number of outlier providers and high-need eligible persons assigned to mandatory prior authorization; findings of QM studies; reports of external evaluators; feedback from the Departments; and results of consumer Enrollee and provider satisfaction surveys and focus groups. Administrative efficiency within VOI will be evaluated by trending telephone response times and reviewing CCM and Intensive Care Coordinator workload and accuracy as reflected in supervisory audits. Administrative efficiency also will be evaluated based on comments and recommendations of clinicians who review requests for service authorizations. For those providers that have demonstrated excellence in their past performance, VOI will offer the ValueSelect Program. A full description of the ValueSelect Program (VSP) can be found in *Section 7A.2.14 Network Management*.

- f) Describe how the Bidder would operationalize the state’s concept of “psychosocial necessity” in the authorization process for mental health services and “service need” in the authorization process for substance abuse services. Contrast this to the Bidder’s use of a stricter “medical necessity” approach with clients under other contracts, or, if not applicable, describe how, in the Bidder’s understanding, the authorization process approaches differ.

OPERATIONALIZING PSYCHOSOCIAL NECESSITY

VOI uses criteria in all our public sector programs that incorporate elements of psychosocial necessity as described in the Iowa Plan RFP. The UM Guidelines included as **Attachment 1** incorporate consideration of psychosocial factors that, if present, may change the assessment of risk or present a barrier to effective treatment. In addition, if a VOI CCM questions the appropriateness of a requested treatment, the CCM is trained to communicate with the provider and find a mutually acceptable treatment intervention. That process guarantees consideration of all the elements included in Iowa’s psychosocial necessity. Our perspective on the difference between the two authorization processes follows.

Differentiating Medical Necessity from Psychosocial Necessity — When a CCM considers a request to authorize treatment, the CCM evaluates many factors in addition to those that constitute medical necessity. A diagnosis is not sufficient to determine clinical appropriateness, because individuals with the same diagnosis—or even one individual over time—may exhibit a wide range of severity of symptoms. The UM Guidelines provide the framework for the authorization decision, but the CCM also uses independent clinical judgment to consider the impact of other factors, including co-occurring disorders, clinical history, availability of safe and appropriate living arrangements, legal status, co-morbid medical conditions, and many other factors listed on pages three through six of the attached UM Guidelines. A stricter approach to authorization considers only acute symptomology and immediate treatment needs. The more traditional evaluation of medical necessity does not allow authorization of individualized services and supports that may be critically important, especially to an Eligible person identified as high-need/high-risk. In a recovery model, it is important to recognize the natural setting and supports are part of the individual’s unique environment. These factors speak to meaning and purpose in an individual’s life and are an essential part of the recovery and resilience.

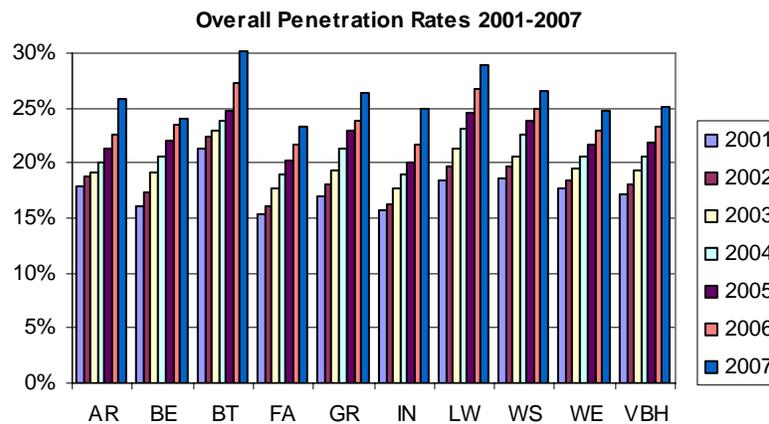
Documented Results of Successful Authorization Process — The concept of psychosocial necessity fits well with the goal of “braiding” public sector funding streams and providing comprehensive services through joint treatment planning. ValueOptions also has noted administrative savings from the use of a more flexible approach to determining the necessity of services. An authorization process based on narrowly defined medical necessity criteria results in a multitude of appeals. This is not the case when psychosocial necessity also is considered in authorizing services.

In our Pennsylvania program, we have shown that peer review and denial rate has not affected the penetration or access to services, which was one of the stated goals at the Commonwealth’s initiation of managed care. The chart below shows the comparison of requests for authorizations for 2006 through 2008 and the percentage that were sent to Peer

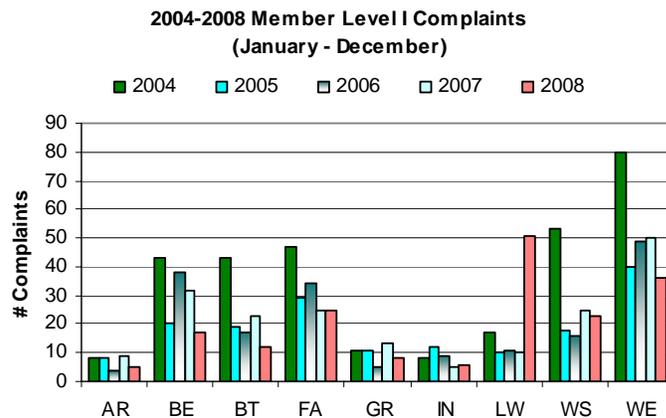
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Review for rehabilitation services, Inpatient Psychiatric Treatment (IP Psych), Residential Treatment Facilities (RTF), and Family Based Mental Health Services (FBMHS). Authorizations include each initial request for service and any additional reviews. **Consistent with 2006 and 2007, only one percent (1%) of the total authorizations requested went to Peer Review in 2008, and only one percent of all authorizations were non-certified or denied which has also been statistically consistent over the past three years. In most cases if a denial occurs, it is recommended the member receive a more appropriate level of care or a change in the number of hours prescribed.**

	2006			2007			2008		
	Authorizations	Peer Review	Rate to PR	Authorizations	Peer Review	Rate to PR	Authorizations	Peer Review	Rate to PR
BHRS	23528	440	2%	100415	1090	1%	137386	2246	2%
IP Psych	13453	187	1%	17311	248	1%	22828	378	2%
RTF	2310	110	5%	3137	198	6%	5911	267	5%
FBMHS	2815	111	4%	3107	112	4%	4308	173	4%
All Auths	119158	1170	1%	212017	2126	1%	275407	3780	1%



The number of complaints have decreased across the years in the VBH-PA program, as reflected in the following chart.



Providers who received more than three complaints in a quarter were reviewed by the Quality of Care Committee (QOCC). During the fourth quarter 2007 through third quarter 2008 there were a total of 14 providers reviewed. Some action plans that resulted were:

- Two providers had a provider field coordinator assigned to conduct a follow-up conversation with them about reporting capacity issues.

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- Three providers were independent prescribers and the network department concurred that they were aware of the issues and special attention was being paid to all independent prescribers evolving around education.
- QOCC did not believe that further action was warranted with most of these providers.

As part of the internal training process, VBH-PA staff completed the complaint training via email. A PowerPoint presentation gave an overview of the complaint process and how to file a complaint. A template on how to file a complaint was also provided. Provider staff were required to submit validation that they completed the training module.

- g) Describe the process the Bidder would implement for the administrative authorization of services. Include the way in which the Bidder would allow for authorization for services provided during all the months of enrollment even if Medicaid eligibility is determined after the initiation of services.

ADMINISTRATIVE AUTHORIZATION PROCESS

To complete the authorization process, a VOI CCM enters a code indicating the rationale for authorizing the service. In most public sector contracts, the contract requires the provision of designated services, even in the absence of clinical justification. The CCM conducts reviews regularly to monitor the Eligible person's clinical condition and treatment appropriateness and progress. However, the authorization code entered is one that indicates the service is being provided in response to a particular contractual requirement. A different authorization code is established for each contractually required authorization type, which permits tracking and reporting of each category of service including those that require administrative authorization.

AUTHORIZATION PRIOR TO MEDICAID ELIGIBILITY DETERMINATION

If acceptable to DHS and DPH, VOI will require providers to register (and authorize depending on the level of care to be provided) all consumers of mental health or substance abuse services, including those who are not currently Medicaid eligible but who are, or will be, in the application process. CONNECTIONS allows registrations and authorizations for persons who are not included on an eligibility file. CONNECTIONS generates a "hold" number, and the registration or authorization can be retained for any period of time specified by DHS. Generally, VOI holds pending registrations and authorizations for 60 days awaiting eligibility determination. Claims will not be paid until eligibility is established and the Eligible person is included on the Iowa Plan enrollment file. Our response to *Section 7A.2.16 (b)* provides more technical detail on this process.

RETROSPECTIVE REVIEWS

The retrospective review of substance abuse treatment provider records will be conducted to assess compliance with both clinical and administrative requirements. Retrospective reviews are one of the major responsibilities delegated to the Iowa Plan contractor by DPH. This is critical to ensure the quality and appropriateness of treatment services provided to all those who receive substance abuse treatment through the Iowa Plan. To assure that appropriately trained staff are available to conduct retrospective reviews, VOI will include one Certified Alcohol and Drug Counselor, who holds an Iowa Board of Substance Abuse Certification as a member of its QM staff. In addition, the five CADCs acting as CCMs in the clinical Call Center, as well as those ICCs who are CDAC will be available to support the QM CADC in the retrospective review of substance abuse services.

The clinical focus of these reviews will be to assure that ASAM criteria have been met and, for Medicaid-funded treatment, services provided are consistent with the service authorized. In addition, the clinical review will assess the providers' consistency in using EBPs and other best practices endorsed by DPH. The administrative component of the retrospective review will verify that I-Smart/SARS data and Medicaid claims submitted by the program are supported by the clinical record and, when DPH funds were used, to verify that the client was eligible for no other funding stream. The provider's overall record-keeping system also will be evaluated, as well as compliance with standards for documentation of services provided.

Tool Used — The Iowa instrument and process will be developed in consultation with the Departments, because it is critical to incorporate all elements required by DPH and DHS as well as by the VOI QM program. However, as a starting point, VOI will provide protocols for retrospective review of substance abuse services that are used by

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ValueOptions programs in Massachusetts and Kansas for the Departments' consideration. In addition, as EBPs and Iowa best practices are implemented system-wide, the clinical review tool will be expanded to include the fidelity measures incorporated in the original design. As in other QM initiatives, ValueOptions believes it is important to allow providers input into the process of developing both the tool and the review process. With provider involvement, the review process also can incorporate information that will support their internal quality assurance efforts. Therefore, we recommend that DPH and VOI work with the Substance Abuse Services sub-committee to update the present process.

The retrospective review process should be designed to support the internal quality management efforts of substance abuse programs as well as assessing compliance with DPH requirements.

Actions to be Taken — The findings of retrospective reviews will be shared with individual programs and, as necessary, corrective action plans will be developed, implemented and monitored by the VOI QM staff, under the direction of DPH. All retrospective reviews will become part of the program's credentialing file to be used in provider profiling and in re-credentialing activities. At the request of DPH, both retrospective reviews and corrective action plans will be shared with the Department. Findings of retrospective reviews will be aggregated and shared with the providers, the Departments, as well as the Clinical Advisory Committee and the Substance Abuse Services sub-committee. These findings will help to identify local best practice among Iowa providers, the need for additional EBPs, and trends for which training and technical assistance will be required and provided.

h) Describe how the Bidder would provide Intensive Clinical Management to certain Iowa Plan Eligible person, and the relationship of those activities to Targeted Case Management.

The VOI Intensive Clinical Coordination (ICC) program is designed for Iowa Plan Eligible persons who are not responsive to the "standard" programmatic system of care (which includes Targeted Case Management). These individuals, whether they be considered "high need" or "at risk", represent individuals with complex treatment needs whose treatment plans have encountered specific barriers to care resulting in sporadic high intensity/high cost services and poor adjustment to community placement. Not all eligible persons in Targeted Case Management need Intensive Clinical Management. Targeted Case Management is provided to persons with chronic mental illness who may require intensive support for specified periods of time (for example, during the transition from inpatient hospitalization discharge to community placement). This level and intensity of service may be sufficient to serve the individual's needs and Intensive Care Management might not be necessary. However, if the individual also has a history of repeat admissions, has other co-occurring disorders (for example substance abuse in addition to a Chronic Mental Illness), or has living conditions that represent a high risk for treatment failure or noncompliance (for example, homelessness), then a consideration of Intensive Care Management in addition to Targeted Case Management would be indicated. As previously stated, not all eligible persons in Targeted Case Management would also be in the Intensive Care Management program; not all eligible persons in the Intensive Care Management program would also be in the Targeted Case Management program. But when there is an overlap between these two programs, Targeted Case Management becomes a critical component of the individual's Intensive Care Management individualized Care Plan.

The admission criteria for the ICC program are as follows:

1. readmission to Inpatient, Detox or Residential levels of care within 30 days of discharge;
2. three admissions to Inpatient, Detox, or Residential levels of care within the past year;
3. three or more Emergency Room visits within the past six months;
4. evidence of high risk behaviors, including, but not limited to, wandering, non-compliance with medication, engaging in repeated self-injurious behaviors;
5. multiple failed treatment attempts for substance abuse or mental health services as evidenced by not following up with referrals or leaving Against Medical Advice (AMA);
6. involvement with two or more community/legal agencies;
7. individuals identified through statistical outlier management or PharmaConnect (described in *Section 7A.2.15.e*); and
8. SPMI and co-morbid condition (substance abuse; medical condition) that contribute to barriers in receiving appropriate behavioral treatment.

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This is not necessarily an exhaustive list of all possible referral or admission criteria. In general, the concepts of “high need” and “at risk” (see response to *Section 7A2.9b*) capture the possible need for Intensive Care Coordination. If either of these two general conditions apply, a referral to or consideration for ICC would be initiated. Our response to *Section 7A2.9b* above describes how these eligible persons are identified through flags in the CONNECTIONS. Referrals to the ICC program can come from a number of different sources. The majority of referrals are made internally by our Clinical Management/Medical Management staff and identified through the management information system flags described previously, or PharmaConnect, described in *Section 7A.2.15.e*. However, there are also a substantial number of cases referred to the program by community treatment providers, community agencies, and primary care physicians.

Upon referral, the Eligible person is assigned to an Intensive Clinical Coordinator (ICC) who proceeds with an assessment of the Eligible person for appropriateness of admission into the program. First, the eligible person is contacted to inform him/her of the referral to the ICC program, the program is explained to the Eligible person, to include the purpose and operations of the program. In addition, the ICC explains the need for releases by the Eligible person so that communication and coordination with treatment providers and community agencies can occur. Once this initial contact is made and appropriate releases obtained, the Intensive Clinical Manager begins a comprehensive evaluation/assessment process. This includes:

1. review of treatment history contained within the CONNECTIONS system;
2. contact with referral source and all other treatment providers or community agencies involved to obtain and confirm other additional historic treatment and psychosocial information; and
3. re-contact with the Eligible person to conduct a telephonic assessment and begin developing an appropriate alliance with the Eligible person.

This assessment process, which can take as much as seven (7) to 14 days, has two (2) major goals. First, the ICC has to identify and prioritize the specific barriers that exist for the Eligible person’s successful treatment and maintenance in the community. In general, the barriers to treatment are encountered in any of the following spheres: medications; safety; living conditions; support system; occupation/finance; medical/physical; transportation; language; communication; culture; social functioning; legal; other co-morbid conditions. For example, in the area of medications, it may be that the Eligible person is non-compliant with a medication regimen, and when he/she does not take his/her medication, he/she relapses, begins re-experiencing psychotic symptoms and needs to be readmitted and stabilized on medications again. And this may be the area representing the primary barrier to successful treatment. Second, the ICC tries to understand the contributing factors to the barriers and shape a Care Plan with the individual. Again, using the medication non-compliance example, it may be that the Eligible person stops taking his/her medication because he/she does not have means of transportation to get his/her prescription filled and his/her family, with whom he/she resides, deny his/her need for medication, poke fun at him/her for taking the medication, or refuse to drive him/her to the pharmacy. With a more complete understanding of the barriers themselves and the contributing factors, the ICC begins to collaborate with the eligible person to develop an Individualized Care Plan that is directed at reducing the identified barriers to treatment. In the working example, it may be to assist the eligible person to get Medicaid transportation, coordinate with his/her prescribing physician to give him/her actual medication rather than a script, or secure home nursing assistance to administer his/her medication. The Individualized Care Plan may also call for family education around the eligible person’s illness, the continuing need for medication, and how best to support the eligible person in treatment.

It is important to emphasize that there are no set formulas for what the ICC does in the context of following the Individualized Care Plan. There are coordination activities, education, resource finding, skill-building, relationship-building and other strategies that lead to the success of the Intensive Clinical Coordination. Guiding principles, though, are that the Eligible person is collaboratively involved in the development of the Care Plan and contributes significantly to its success and evaluation of outcomes.

- i) Describe how the Bidder would provide 24 hour crisis management, and provide examples of how that service has been provided in other states.

VOI will have independently licensed clinicians working in the Service Center to answer the toll-free Access Lines. Licensed Iowa Clinicians will be on duty 24 hours a day, seven (7) days a week to ensure that the Iowa contract is

appropriately enforced. All clinicians assigned to the Call Center will be trained in crisis counseling as well as in reviewing and authorizing services. Because the CCMs will be assigned to geographically-organized teams, they will become well acquainted with the providers, high need consumers, community and county agencies, and local resources in their assigned regions. VOI will hire clinicians with varied backgrounds and areas of expertise that will include work with children/adolescents, 65 and older population, substance abusing Eligible persons and those with a dual diagnosis that can include but not be limited to medical issues and developmental disabilities

CRISIS CALLS

Callers to the Des Moines Service Center will have a menu of options available to assist them in directing their call to the most appropriate VOI staff. The first option on the automated menu will be “If this is an emergency, please press “one.” The question will be immediately repeated in Spanish. When the caller presses one, the call is immediately routed to the top of the queue that is answered by the CCM. All emergency calls will be immediately responded to and managed by licensed CCMs who have been trained in emergency and crisis response and de-escalation techniques. Customer Service Representatives (CSRs) and CCMs are trained to identify emergency situations, even if the caller does not select the emergency prompt. When the caller reaches a CSR and they identify the situation as an emergency, they will immediately complete a warm transfer to a CCM who will proceed to determine the nature of the emergency and facilitate an immediate local response to the Eligible person’s mental health need. Our telephone technology allows for the clinician to maintain open contact with the caller at all times. Through an internal messaging system and/or three-way conference calling, the clinician is able to access identified crisis response systems, the State’s suicide hotline, and 911 emergency services if needed. This system assures that the Eligible person has telephonic contact with a staff member at all times. **The caller is never put on hold during an identified crisis or emergency situation**

Caller-defined Emergencies — When a caller identifies the situation as an emergency, it will always be treated as such. If the caller and the CCM define the situation differently, the more urgent definition will always be used. ValueOptions manages crisis services 24 hours a day, seven (7) days a week for all of our public sector contracts. We provide an example of an innovative crisis program created for one of our programs in Texas.

24 Hour Crisis Example – NorthSTAR — Psychiatric emergencies have a significant impact on individuals and families and place demands on local and regional resources including law enforcement, criminal justice systems, local emergency rooms, and the State Hospital system. In response to the systemic pressures from psychiatric emergencies, the NorthSTAR public program in Texas developed a comprehensive continuum of psychiatric emergency care that includes a Psychiatric Emergency Service Center (PESC). The existing psychiatric emergency services continuum of care in this service area include access to the PESC, and is available as a safety net for residents in psychiatric crises regardless of diagnosis or precipitating events, such as substance abuse, psychosocial, or psychiatric needs. The target population for the enhanced PESC are persons identified as in need of psychiatric emergency.

This program has evidenced a dynamic and successful interface between police departments, criminal justice systems, the homeless population and crisis services. Currently, 25-30 percent of all individuals taken to PESC by law enforcement are seeking these services for the first time. Prior to the development of this comprehensive continuum of care and the open access policy for the NorthSTAR region, there was an excessive use of state hospitals for admissions. At its peak, NorthSTAR had a daily census of over 425 individuals in the state hospital. As a result of the psychiatric emergency services continuum of care, including the PESC, the average daily census for the NorthSTAR region has decreased by 150 -175 patients per day. In addition, NorthSTAR area police departments now have immediate access to psychiatric crisis services for individuals who previously would have been booked into the jail, and are better able to address the individual’s primary needs for psychiatric care and stabilization in the community.

- a) Describe the 24-hour crisis and referral service that the Bidder would make available to Iowa Plan Eligible Persons. The description should include a discussion of:
- how the Bidder would ensure the availability of clinicians with expertise in providing mental health and substance abuse services to children, and
 - how the 24-hour crisis and referral service would interface with the emergency crisis service system.

IMPROVING LOCAL CRISIS RESPONSE SYSTEMS

Based on numerous analyses, the most critical service gap in the Iowa Plan is the absence of an effective crisis response system across the 99 Iowa counties. Developing an effective crisis response system requires extensive collaboration amongst providers and relevant public service first responders such as community police. The ultimate goal of a crisis response system is the de-escalation of an abrupt onset of a crisis as perceived by the Eligible person or family, the provision of stabilization for short-term safety, and the avoidance of out of community placement.

To proactively prevent crises, easy and immediate access to routine services for Eligible persons and families must be ensured. For this reason, VOI will establish and maintain an online directory of providers and services for Eligible persons, families and providers. In addition, there will be a toll-free clinical Access to Care Line, which will be provided as part of the crisis response system. Calls to the Access to Care Line that are identified as an emergency, as described above, will be answered by a licensed clinician within 30 seconds, if not sooner. Our experienced staff is trained to identify the treatment/resource needs of an enrollee calling in a crisis situation, engage them in a comforting manner, and refer him or her to the appropriate resource (i.e., crisis services, emergency department, network practitioner, community resource, medical plan, and/or other community resources and programs). The telephone technology allows for the clinician to maintain open contact with the caller at all times while making a “warm transfer” to a community-base service. Through an internal messaging system and/or three-way conference calling, the clinician is able to access identified emergency crisis response systems, the State’s suicide hotline, and 911 emergency services if needed. **The caller is never put on hold during an identified crisis or emergency situation**

When mobile crisis intervention is needed, the community-based crisis team(s) will be engaged. The mobile crisis teams are trained to provide in-home stabilization; referral to short-term crisis stabilization units; authorization for appropriate flexible funding for additional staff to respond to crisis situations within residential facilities; walk-in center access; face-to-face evaluation access; and consultations with emergency room staff. Every crisis response system will have unique services based on the priorities and resources of that community. VOI will facilitate the dialogue regarding needed crisis team approaches to reach consensus by the various stakeholders at the community level. Crises involving children typically occur either in the school setting or at home. Therefore, VOI will provide both home-based and school-based crisis programs. Examples of additional components include hospital diversion and referral to safe homes, drop-in centers, and peer support specialists. An effective crisis response system must include clinicians and peer specialist who have training in handling adult mental health crises, substance abuse crises as well as crises involving children and families. VOI will provide adult expertise, substance abuse expertise, and child and adolescent expertise. VOI first will work with the Departments to finalize the elements required of a local crisis response system for the Iowa Plan. All Iowa Plan providers will be offered training on the agreed upon crisis response model(s). We will work with Community Partnership Programs (CPCs, and de-categorization boards as well as the Departments) to encourage providers to create the strategic alliances required to create and implement local crisis response systems.

- b) Describe the Bidder’s process for identifying those Eligible Persons who have demonstrated the need for a high level of services or who are at risk of high utilization of services. Describe how the Bidder would initiate ongoing treatment planning and coordination with the Iowa Plan Eligible Persons and all others appropriate for planning the Eligible Person’s treatment.

IDENTIFYING “HIGH NEED” AND “AT RISK” ELIGIBLE PERSONS

For Eligible persons who are using multiple services or who are at risk for high service utilization, VOI initiates Intensive Care Coordination resources. VOI will follow the parameters contained in the service definitions and

7A.2.9 Required Elements of Individual Service Coordination and Treatment Planning

Performance Monitoring sections of the RFP and work with the Departments to make recommendations for modifications if necessary.

Using the CONNECTIONS system, reports will identify all Eligible persons who meet the “high need” and “at risk” criteria as described above and flags will be entered into these files to alert staff who authorize or review services for these Eligible persons with a special status. VOI recognizes that individuals may require intensive support for specified periods of time. Intensive Care Coordination resources are dedicated to the individuals with high care coordination needs to avoid an inpatient hospitalization or to provide additional resources for children/adolescents in jeopardy of out of home placements. While “high need” and “at risk” Eligible persons can be identified based on Medicaid-funded services, VOI can individually identify “high need” and “at risk” Iowa Plan members being served by substance abuse programs with the permission of DPH, either through providers who participate in the online registration of all individuals in their care, or through matching redacted Social Security Numbers or with DPH client numbers that identify Eligible persons being served in both systems, either concurrently or consecutively. If requested, VOI will work with programs whose I-Smart/SARS data indicates that they serve many clients who fall into high need categories, such as those who are dually diagnosed pregnant women who are abusing substances, child/adolescents at risk for out of home placements and the elderly over age 65 in need of services.

JOINT TREATMENT PLANNING

Joint treatment planning and service coordination is of paramount importance in an effective service delivery system. ValueOptions will initiate joint treatment planning meetings and participate in joint treatment planning arranged by targeted case managers, DHS/JCS workers, network provider staff, school counselors, and other professionals. At the core of treatment planning are the principles of recovery and resiliency that foster involvement of the enrollee in all aspects of the treatment planning process. Treatment planning requires a recognition and response to the complex behavioral health, social, medical and developmental needs of Eligible persons and their families. To achieve effective treatment planning, continuity of care and coordination of care among multiple providers (including mental health, substance abuse, primary care physicians, and non-plan providers) it is necessary to communicate effectively and efficiently to facilitate enrollee person choice.

VOI will identify high need and at risk eligible persons by running reports based on the “high need” and “at risk” criteria. Each Clinical Care Management Team will be given a weekly list of members in their geographic area who meet the criteria. The teams will be responsible for reviewing the enrollee’s information, speaking with the enrollee family members, DHS/JCS workers (if assigned) and providers as appropriate to make a determination if enrollee would be best served by a Community-based Intensive Care Coordinator (ICC). The assigned VOI ICC will initiate a joint treatment planning meeting(s) with the enrollee and the enrollee’s supports, or our clinician will arrange to participate in treatment planning meetings that are already being held. The assigned ICC will monitor each high need and at risk enrollee to assure that a joint treatment plan is developed and implemented. The treatment plan will include a crisis prevention/response plan. Key elements of the treatment and crisis prevention plans will be compiled by VOI clinicians into a clinical profile which can be shared with other clinicians when appropriate. VOI will track service utilization of those eligible persons who are assigned to ICCs and will make those reports available to the Departments upon request. In addition, VOI will design outcome tracking in collaboration with the Departments to monitor clinical outcomes of at risk and high need eligible persons.

- c) Describe the program the Bidder would implement in conjunction with officers of the courts to assure that court-ordered treatment complies with substance abuse criteria and therefore is reimbursable through the Iowa Plan.

VOI will work with officers of the court to help assure that treatment ordered by the courts complies with substance abuse criteria and therefore, for Medicaid Eligible persons, who are eligible for the Iowa Plan. VOI will use the American Society for Addiction Medicine PPC-2R (ASAM) criteria to determine medical necessity for substance abuse services. VOI will provide training on the ASAM criteria to court and parole officers to ensure that all parties understand the medical necessity components of this patient placement criteria. These trainings will be conducted in

regional forums, web based conference calls and face to face trainings. In addition, the clinical care managers that review requests will provide education and guidance in ASAM criteria application.

An example of this type of coordination occurs in our Massachusetts Service Center. ValueOptions has developed Court Observation programs that accept direct referrals from court clinicians. These programs provide a comprehensive evaluation and facilitate treatment recommendations for the court officers, that is Medicaid reimbursable. While the court structure is different in Iowa, successful components of this process can be adopted, including a Juvenile Justice Working Group model which brings together probation officers, court clinicians and providers of youth services every month for policy development and case consultation. In the VOI design, this working group is similar to the QM Substance Abuse Services sub-committee. Effective referral processes provide the foundation for treatment retention. In addition, liaisons will be available to officers of the court to assist Clinical Care Managers and providers in meeting the Court's needs for clinical information, treatment recommendations and placement availability. The close communication between ValueOptions and the court system, inclusive of parole officers will ensure that appropriate diversion strategies are in place to avoid unnecessary incarceration and promote reintegration into the community in the most expedient manner.

- d) Describe how the Bidder would actively promote and ensure coordination by Iowa Plan network providers with Enrollee's primary care physicians
 - describe how the Bidder will assess network provider compliance with such care coordination requirements, and
 - provide results of monitoring efforts conducted for other clients of the Bidder to verify that coordination had been occurring effectively. Information provided should include the names of the programs and the names and telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

ValueOptions has found the coordination between providers of behavioral health care and medical care to be an important, but often neglected component of assuring good treatment outcomes for Eligible persons. VOI will establish policies and procedures to encourage sharing information about individual Eligible persons between behavioral health clinicians and PCPs, co-management opportunities with MCOs, and also to facilitate referrals, quality improvement efforts, collaborative care management and clinical problem-solving. VOI expects that individuals who are experiencing complex behavioral health, social, medical and developmental disorders have their needs assessed to achieve effective treatment planning, continuity of care, and coordination of care among multiple providers, including mental health, substance abuse, primary care physicians, and non-plan providers. This type of communication and coordination supports recovery and resiliency. It also enhances the quality of care delivered by contracted providers by creating a timely and appropriate flow of information throughout the delivery system. Auditing tools have been developed that identify the name of the program, the telephone number, email address, chart documentation, and additional references that are necessary to ensure that coordination of Iowa Plan network providers is occurring.

COORDINATING WITH MEDI PASS PHYSICIANS AND HMOS

With the approval of DHS, VOI will implement the following strategies to support the coordination of information about Eligible persons with MediPASS physicians and to monitor providers' compliance:

- During implementation and at intervals across the contract period, VOI will meet with the Iowa Medical Society and other professional organizations to determine the information most useful to MediPASS physicians and the format in which it can most easily be used.
- VOI will offer training and educational information to non-psychiatric physicians through their professional organizations and also will provide basic behavioral health screens, as approved by DHS, to assist in the identification of potential mental health and substance abuse treatment needs.
- Contracts with all Iowa Plan network providers will include requirements for the identification of the enrollee's physician; regular record audits will assess compliance with the requirement, and provider compliance will be reflected in profiling reports.

7A.2.9 Required Elements of Individual Service Coordination and Treatment Planning

- Iowa Plan network providers will be required by contract to request a release of information to share information with an enrollee’s physician, especially when medication is prescribed or changed; record audits will be conducted and results reflected in provider profiling.
- PharmaConnect (described later) will be utilized to notify all physicians and pharmacies prescribing and dispensing medication of identified care gaps.
- Provider handbooks, newsletters, Web site material, training and other educational resources will provide information about the requirements for releases and sharing of information; all providers will be supplied with information on how to identify their Eligible persons’ health plan and/or MediPASS physician via the Medicaid Recipient Eligibility Verification System (REVS).
Network providers also can request the information by calling VOI’s toll-free clinical Access Line.
- Member handbooks, Web sites, forums, peer support staff and others who work with the Eligible persons and their families will explain the importance of informing both medical and behavioral health care providers about services being provided to the member.
- ICCs will work with Families and Eligible persons to coordinating treatment options with their identified medical home.

Sharing analyses of psychotropic medication prescriptions will support coordination with MediPASS physicians and HMOs as well as helping identify joint quality management initiatives.

Coordinating with Health Plans — In addition to the contract requirements, training and educational strategies described above, VOI will implement the following policies related to coordination of services with the Health Maintenance Organizations (HMOs) serving Medicaid beneficiaries, such as Humana of Iowa, Total Health Network, Wellmark BlueCross and BlueShield and Cigna/Great West:

- VOI will partner with the HMOs to design policies relating to referral for services, joint identification of high need/high risk Eligible persons, coordinated care management for high needs/high risk Eligible persons, co-managed rounds, monitoring the information exchange between network providers, and problem resolution.
- Using the MBHP universal release form described in the examples that follow, ValueOptions proposes to work with the Departments, the Medicaid HMOs and representatives of MediPASS physicians to tailor the form for Iowa.
- With DHS’ support, VOI will host meetings quarterly to enhance communication and problem resolution between health plans. Toll-free call-in numbers will be provided for those plans who cannot participate in person.

RESULTS OF MONITORING EFFORTS

As examples of the impact of monitoring, results from our program in Massachusetts (MBHP) are summarized below.

Massachusetts —MBHP staff has found that the biggest challenges faced in any efforts to collaborate physical health and behavioral health relate to issues of confidentiality. Behavioral health programs and physical health programs involve numerous organizations, individual practitioners, separate funding streams, separate contract managers, and complex regulations governing issues of confidentiality. MBHP has addressed this challenge by developing a universal release form in partnership with governmental divisions and the physical health HMOs. As a result, recipients now sign the universal release at either the mental health provider or physical health provider, allowing communication to occur.

A second challenge is that of meeting the needs of PCPs and medical specialists to rapidly access information and care for their patients. Physicians often consider mental health systems to be frustratingly complex mazes characterized by non-responsive information and referral procedures. Adding to their frustration, physicians perceive the flow of information between them and mental health providers to be one way—from the physician to mental health—and they often do not receive follow-up information from mental health providers that they would expect from other treating professionals. Among the strategies MBHP has used to improve collaboration with PCPs are the following:

- Incorporate the PCP’s and the recipient’s medical needs into all care management activities. Care Managers have access to data on a recipient’s compliance with medical care, particularly elements of the PCP profile such as the need for a Pap smear or mammogram. Community Support Providers (CSPs) are available to help recipients achieve integration of care through increasing compliance.

7A.2.9 Required Elements of Individual Service Coordination and Treatment Planning

- Profile PCPs and behavioral health providers on integration measures. Network management, through the Profile Improvement Cycle program, supports performance improvement on those measures. A Reminder Report for the integration measures improves integration for specific recipients needing such coordination.
- Conduct targeted outreach.
- Sponsor medical/psychiatric grand rounds.
- Provide education materials in the form of newsletters and diagnostic-related informational materials.
- Use the PCC Clinical Advisory Committee to advise MBHP and the Massachusetts Behavioral Division on barriers to better integration.
- Arrange for PCCs to hold clinical sessions at DMH facilities for Eligible persons who regularly attend day programs.
- Encourage recipients with serious mental illness to use PCCs who cooperate with the tenets of the joint DMA/DMH/MBHP “SMI” project, including close collaboration with DMH case managers and office practices which are conducive to care of recipients who have a serious mental illness.

PharmaConnect - Psychotropic Medication Gap Analysis — In addition to the example above, VOI proposes using the analysis of psychotropic medications and prescriber behavior as one of the greatest opportunities to coordinate with health plans. The results of the PharmaConnect program, which support increased coordination, are described in our response to *Section 7A.2.15 (e)*. Sharing information on outlier providers and members with potential drug over utilization and drug interactions has been highly effective in promoting good clinical outcomes and also cost effective utilization of psychotropic medications. With the sharing of the results of the PharmaConnect analytics program, the HMOs and VOI can implement, under the direction of DHS, joint quality improvement initiatives to address identified training opportunities. Information on practice patterns of MediPASS physicians will be shared with DHS and/or with DUR for monitoring and follow-up.

REFERENCES

The following three references are from clients for whom ValueOptions provides Individual Service Coordination and Treatment Planning:

- for additional information on the NorthSTAR program, contact Matthew Ferrara, Office of NorthSTAR and Special Initiatives; telephone (512) 206-5444; email matthew.ferrara@hshs.state.tx.us.
- for additional information on the MassHealth program, contact Suzanne Fields, Director of Behavioral Health, Office of MassHealth; telephone (617) 348-5101; email suzanne.fields@state.ma.us.
- for additional information on the Florida Prepaid Mental Health Program, contact Jorja Daniels, Florida PMHP Area 6 Contract Manager; telephone (813) 871-7600 Ext. 132; email Danielsj@ahca.myflorida.com.

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Describe the Bidder's experience in transitioning children from inpatient settings (including inpatient hospital and PMIC-like entities) and provide successful strategies for putting in place appropriate discharge placement from such settings.

The development of an Iowa Children's Mental Health Systems of Care as described in section 7A.2.6 Covered Services, Required Services, Optional Services b) is fundamental to the development of successful strategies for supporting children with Serious Emotional Disturbance (SED) by diverting from institutional placement, when possible, and with the appropriate discharge planning from inpatient and residential settings.

The following are examples of the many strategies that ValueOptions utilizes to transition or divert children from inpatient settings, and that may also be of interest to Iowa's delivery system:

- Key components of the Massachusetts Commonworks program were the Lead Agencies which receive a case rate from the Massachusetts Department of Social Services to serve high-need children and families. Administrative support provided by ValueOptions allowed the Department and the Lead Agencies to assure consistent policy implementation across providers, monitor performance indicators and service outcomes, and offer case consultation. One example is the Coordinated Family-Focused Care (CFFC) program which is a Systems of Care initiative designed to support children and their families, with the goals of maintaining children in the community and reducing or eliminating the need for acute or residential treatment.
- A common management information system provides the infrastructure to allow ValueOptions to support the New Jersey Department of Human Services' Partnership for Children. The system-wide MIS allows Care Management Organizations (which are similar to lead agencies) to submit comprehensive treatment plans electronically for the review of ValueOptions' CCMs. Thus, services are approved in the context of a comprehensive approach rather than approving individual services by various providers separately.
- As the Maricopa County RHBA, ValueOptions was responsible for services needed by more than 45,000 members in the Phoenix area. The most important benefits to the children's delivery system came through implementation of the Arizona Principles and Vision for Children and Families, a massive effort to implement their Child and Family Team model. The Arizona 12 Principles were the basis of all contracts, all training modules, all orientations to the system, all service delivery, and all monitoring tools. Seven Comprehensive Service Providers were trained to deliver services in accordance with the Arizona model, and nearly 1100 children and their families were involved in Child and Family Teams.

THE VALUEOPTIONS OF IOWA DESIGN:

Accepting the responsibilities set forth in the RFP, VOI also will maintain the services and supports currently reimbursed through the Iowa Plan. In addition, VOI will provide the following resources to assist in serving children being discharged from 24-hour services funded through the Iowa Plan:

Expansion of the Emergency Mental Health Crisis Services System — The clinical expertise to provide crisis intervention and support to youth and families will be a critical requirement of the local Crisis Response Systems which VOI will develop in collaboration DHS, DPH, and Iowa communities and counties. Crisis stabilization will be the first step at minimizing admissions and re-admissions to inpatient settings. In areas where Crisis Response Systems have not yet been fully developed, VOI will work with home health agencies and child specialty agencies. By training their staff to provide intensive in-home services, more effective crisis stabilization services will be implemented. By using trained crisis workers to go into homes, and remain for as long as three days, ValueOptions has been extremely successful in stabilizing crisis situations in our other public sector programs, such as Colorado.

Family Peer Support Services — Family Peer Support Specialists will work directly with families and children who are experiencing a serious emotional disturbance to strengthen the families' capacity to understand and provide support for their child in their own home. In Kansas, a border state to Iowa, Parent Support and Training has consistently been found to be the most effective service at keeping a child in their home and community as reported by parents in the Kansas Family Satisfaction Survey. Additionally, ValueOptions has successfully utilized this model to reduce emergency room contacts in the Connecticut program as described previously.

Professional Resource Family Care (out of home crisis stabilization) — The voluntary use of Professional Resource Families (therapeutic foster care) for respite, both brief and unplanned, has been an important component in

7A.2.10 Children In Transition

keeping Colorado children in their homes and with their families in ValueOptions' Colorado program. Professional Resource Families care also can be an effective alternative to hospitalization and provides an important transition for a child leaving a 24-hour treatment environment. During the implementation period, VOI will work with DHS to initiate recruitment and training for Professional Resource Families in Iowa. VOI will work with DHS to determine an equitable sharing of the non Medicaid reimbursable costs such as room and board.

Flexible Funding — As described earlier, VOI is proposing the creation of Flexible Funding Grants to be awarded out of the CRF to mental health providers in order to fund non-traditional services and support needed to maintain a child in their home with their families.

Roster of Bed Availability and Children Awaiting Placement — With the support of DHS and CW/JJ providers, VOI will work to maintain an electronic roster of beds available across the state. VOI's Clinical Care Managers will have access to the roster and also will be better able to support CW/JJ workers and the courts in discharge planning and transition. In addition, VOI will regularly prepare a roster of children who are in inpatient settings and whose stay is being administratively authorized. The report will be organized based on the DHS Service Area responsible for each child and will be shared with DHS administrators as well as Service Area Administrators. VOI also will prepare profiles of the each Service Area to track length of stay and other parameters related to administrative authorizations. A similar initiative has been implemented by ValueOptions in the New Jersey Partnership for Children. The electronic tracking system has already significantly enhanced the coordination between children who need residential treatment and available beds.

“Families can learn to advocate for themselves and seek out services for their child but at the beginning when child first diagnosed families need a parent partner to help them”
2009 Iowa Focus Group Participant

Effective Communication and Coordination with CW/JJ — The Youth Services Liaison will be a key liaison with DHS/JCS workers and also for juvenile court judges. In addition to assisting in obtaining necessary services for children and adolescents involved with the juvenile court system, the Youth Services Liaison will work with DHS and JCS to implement effective strategies for communication and problem resolution between systems. In addition, the Youth Services QM Sub-committee will provide a regular venue for discussing opportunities for improving working relationships. The ICCs also will be an important part of VOI's coordination with the CW/JJ system. These staff will be assigned to work directly with case worker and providers in implementing treatment plans and communicating with juvenile court judges. VOI will work with the courts and DHS/JCS administrators to design reports that will allow mutual tracking of children involved in both systems, those awaiting placement, utilization by region and related data. These reports also can be provided to local planning groups and statewide re-design committees to identify unmet needs and opportunity for system development.

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- a) Describe the process the Bidder would put in place for the review of Enrollee appeals, including which staff would be involved. Provide a flowchart that depicts the process and time frames the Bidder would employ, from the receipt of a request through each phase of the review to notification of disposition.

STREAMLINING THE APPEALS PROCESS

In the Iowa Plan, an action is related to the Contractor’s decisions regarding authorization of services, reimbursement for services, timely provision of services, or compliance with timeframes for grievances or appeals. The appeal process is established to address requests of Enrollees or providers for review of the Contractor’s actions.

The Iowa Plan appeal process is open to Medicaid beneficiaries who have received or requested services through the Iowa Plan. Providers who provide or request Iowa Plan services on behalf of Medicaid beneficiaries or SPP members in the Iowa Plan also may file an appeal.

VOI understands the importance of providing an appeal process that allows Enrollees and their representatives the right to request a review of services that were not authorized. Appeals not only protect the rights of Enrollees, they also help VOI re-evaluate their UM Guidelines and clinical review processes. Therefore we are proposing an appeal process that will ensure Iowa Plan Enrollees are aware of their right to appeal as well as how to file an appeal, and information about examining a case file.

With the approval of DHS and CMS, VOI will invite a provider representative and an Enrollee representative to participate in the Appeals Committee to assure the fairness of the process.

Key features of our appeal process are:

- providing accurate, timely quarterly reporting to the Departments on all grievances and appeals, in the requested format;
- convening an Appeal Review team at least weekly to assure prompt consideration and rapid turnaround;
- actively promoting awareness of Enrollees’ rights to an appeal, including distribution of appeal information through our Web site, through printed materials, and contractually requiring providers to abide by the state’s guidelines;
- training our Member and Provider Relations Staff and Clinical Care Managers to help Enrollees file an appeal;
- training our Family Partners and Recovery Ambassadors to assist Enrollees move through the appeal process; and
- hiring a full-time Grievance and Appeals Coordinator to ensure rapid processing of all grievances and appeals as well as timely information and support to the Departments.

VOI’s proposed appeal process is designed to assure that at least 95 percent of all standard appeals are resolved and notice is provided as expeditiously as the Enrollee health requires at a minimum within 14 days of receipt of the appeal and that all are resolved within 45 calendar days of the receipt of the appeal. Additionally, all expedited appeals are resolved and notice is provided as expeditiously as the Enrollee health requires at a minimum within 14 days of receipt of the appeal

Appeals Reporting — Through our management information system, CONNECTIONS, we will maintain records of grievances and appeals and report them to the Departments quarterly. Each quarter, VOI will submit to the Departments a Grievance and Appeal Report in the required format, which will summarize each grievance and appeal handled during the quarter as well as a summary of all grievances and appeals. In all cases where the Departments need additional information, all pertinent documents, including Enrollee records, will be rapidly provided to the Departments.

Standard Appeals Process — Through communications materials (described later in this section), VOI will ensure that providers, facilities, Enrollees or designated representatives, may appeal an action, either verbally, in writing, or by fax up to 30 days after receipt of notice of action. Enrollees and providers can request and receive copies of all documents relevant to an appeal. If VOI receives an oral request to appeal, or inquiry as to the process of appealing, our Clinical Care Manager, Member/Provider Service Representatives and/or Grievance and Appeals Coordinator will file an appeal on behalf of the Enrollee and inform the caller that the appeal must be signed to be valid. The VOI employee will work with the caller to determine whether to mail or fax the appeal for signature.

7A.2.11 Appeal Process

Upon the receipt of an appeal from an Enrollee or provider acting on behalf of the Enrollee, VOI will send a written acknowledgement of the receipt of the appeal within one working day. The letter will contain notification of the date on which the Appeal Committee will review that appeal. The letter will invite the Enrollee or provider to present evidence in person, via telephone or in writing and will inform the Enrollee and provider of their right to examine the Enrollee's case file. The letter also will inform the Enrollee of the right to request an extension of up to 14 days, and the process by which to request that extension. The VOI Grievance and Appeals Coordinator will open an appeal record to allow tracking of the appeal process, the issues in question, and the determination. A case file also will be developed to contain any information provided by the Enrollee or provider. The VOI Grievance and Appeals Coordinator will pull documentation from the CONNECTIONS system related to the decision under appeal and will forward the case file to members of the VOI Appeals Committee.

VOI's Appeals Committee — The VOI Medical Director, Associate Medical Director, and/or a VOI Peer Advisor will chair the VOI Appeals Committee which will meet at least once a week. Other members of the VOI Appeals Committee will include the Director of Clinical Operations and Utilization and Intensive Care Coordination Managers. With the approval of the Departments and CMS, VOI also will invite a provider representative and an Enrollee representative to participate in the Appeals Committee to assure the fairness of the process. If any Appeals Committee member has been involved in a decision under appeal, she or he will recuse herself or himself from the review of that particular case, and another VOI clinician will participate in the review process on that member's place. The VOI Appeals, Complaints, and Grievance Manager will staff the Appeals Committee.

If the Enrollee or the provider filing the appeal chooses to participate in the VOI Appeals Committee's deliberation on their appeal, they may join in person or via a toll-free conference line that will be provided by VOI. If VOI determines it is in the Enrollee's interest to extend the initial review period by up to 14 calendar days, the Grievance and Appeals Coordinator will request the approval of DHS for the delay and notify the Enrollee and the provider of the reason for the extension. Should extensions be requested by the Enrollee, the provider or VOI, they will be fully documented in the appeal record and reported in the aggregate to DHS.

Expedited Appeals — An expedited appeal process will be available to Enrollees and providers:

- when the Enrollee files an expedited appeal, either orally or in writing, or
- when the provider indicates, or VOI determines, that the time required for the standard appeal process could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain or regain maximum function.

When an expedited appeal is requested, VOI will inform the Enrollee and the provider of the limited time available for presentation of evidence. VOI will ensure that each expedited appeal will be resolved and notice will be provided, as expeditiously as the Enrollee's health condition requires, and within three working days after VOI receives the appeal.

The Enrollee or provider may request an expedited appeal verbally or in writing. Upon receipt of an expedited appeal, the Grievance and Appeals Coordinator will open an appeal record and a case file, following the same processes required for a standard appeal.

For an expedited appeal, the Grievance and Appeals Coordinator will consult with the Medical Director, who will select a Peer Advisor who has not been previously involved with the case, to conduct a review. Information contained in CONNECTIONS and files about the case will be forwarded by secure e-mail or by fax within one business day. The Peer Advisor will review the material and call the treating provider to discuss the clinical aspects of the case in more detail. The telephone conference will be requested by the Peer Advisor within one business day. A provider involved in an Expedited Appeal will be expected to be readily available to discuss the case with the assigned Peer Advisor. If the conference cannot be scheduled because the provider is not available for the call within three (3) business days after receipt of the appeal and the Enrollee does not request an extension, VOI will consult with the Departments to determine whether an extension would be in the Enrollee's interest. VOI will resolve the expedited appeal and provide notice within the timeframe approved by the Departments. If the Departments approves an extension of the three-day timeframe, VOI will notify the Enrollee and the provider of the reason for the extension.

Notification to Enrollee and Provider — When the appeal review (either expedited or standard) is completed, the VOI Medical Director or the Medical Director’s designee will verbally inform the provider within one business day of the decision, including the length of authorization and the level of care authorized, and/or any alternatives or recommendations that are clinically appropriate. VOI will also make every reasonable effort to verbally inform the Enrollee of the decision on the same business day. The Enrollee’s clinical record and appeal file will be updated to reflect the actions taken.

VOI will also provide written notice of disposition of the appeal to the Enrollee and provider within one business day, which will include:

- the results and date of the appeal resolution;
- for decisions not wholly in the Enrollee’s favor:
 - the right to request a state fair hearing;
 - how to request a state fair hearing;
 - the right to continue to receive benefits (pursuant to 42 CFR 438.420) pending a hearing;
 - how to request the continuation of benefits;
 - notice that if the Contractor’s action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits;
 - the relevant citation from the Iowa Administrative code, which supports the decision; and
 - that in the state fair hearing, the Enrollee may represent himself or herself or use legal counsel, a relative, a friend, or a spokesperson; the specific regulations that support, or the change in federal or state law that requires the action, and an explanation of the individual’s right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.

State Fair Hearing — While the Enrollee should exhaust the VOI appeal process, VOI will not implement policies or procedures that would preclude the Enrollee from seeking a fair hearing at any time during the above process. VOI’s Medical Director or designee will be available to represent DHS and present appropriate information at the State Fair Hearing at the Department’s request. VOI will prepare and provide appropriate copies of documentations to support the decision under appeal.

Promoting Awareness of the Right to Appeal — VOI will ensure that Enrollees are aware of their right to file an appeal (as well as a grievance) by:

- outlining the process during meetings across the state which include Enrollees, especially during implementation;
- training Family Partners and Recovery Ambassadors to assist Enrollees in filing appeals and participating in the appeal process;
- training VOI staff to assist Enrollees in filing appeals;
- sharing information with advocacy groups, provider agencies and others who work with Enrollees and their families;
- including detailed information in the Iowa Plan Enrollee Handbook; and
- highlighting the right to appeal and the process for filing an appeal on the VOI Web site.

VOI also will assure that providers are aware of the appeal (and grievance) process and how to access it by:

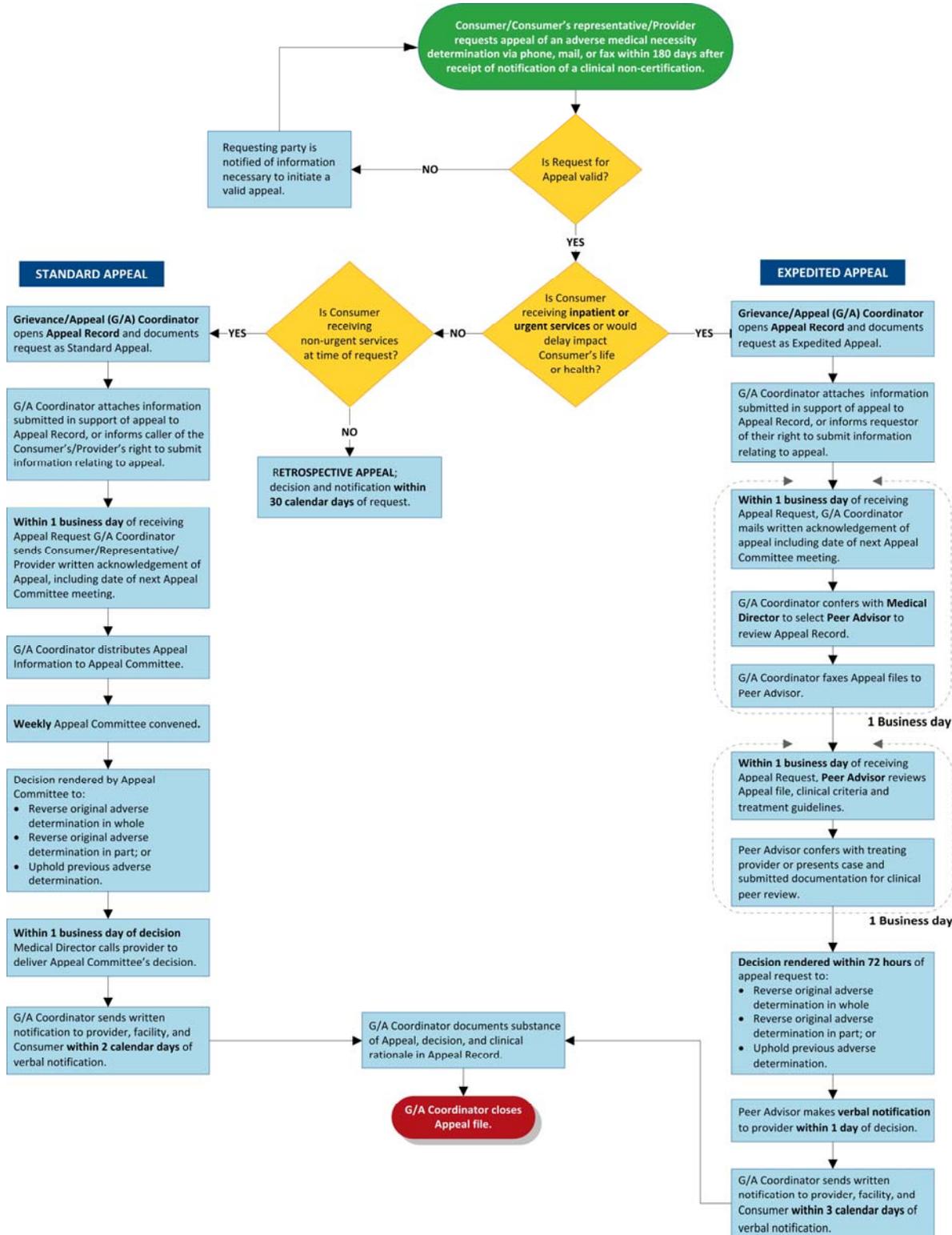
- outlining the appeal process in the Provider Handbook;
- discussing the appeal process as well as reviewing data on appeals through the Clinical Advisory Committee;
- directing providers to the VOI Web site; and
- providing training on filing appeals and grievances, especially as part of orientation.

Compliance with DHS and CMS Requirements — The appeal process described in this section are proposed for the review of DHS and will be modified in response to the Department’s request. In administering the program, VOI will comply with all requirements of DHS and CMS related to appeals and grievances as set forth in the RFP or as subsequently modified by DHS or CMS. **During the appeals and state fair hearings process described above, all benefits will be provided consisted with 5B.2.12 through 5B.2.17 of the RFP.**

7A.2.11 Appeal Process

Provide A Flowchart That Depicts The Process And Time Frames The Bidder Would Employ, From The Receipt Of A Request Through Each Phase Of The Review To Notification Of Disposition.

We have provided a flow chart of our appeal process and timeframe on the following page. As indicated in the previous response, extensions of up to 14 days may be requested by the Enrollee, the Enrollee’s provider or VOI.



- a) Describe the processes the Bidder would put in place for the review of Enrollee grievances and Eligible Persons complaints.

GRIEVANCE PROCESS

In the context of the Iowa Plan, a grievance is defined as “an expression of dissatisfaction about any matter other than an action.” As noted in the response to the previous Section 7A.2.11, Appeal Process, actions relate mainly to the authorization, provision, and reimbursement of treatment. Therefore, the VOI grievance process will focus on concerns other than those directly related to actions. ValueOptions’ proposed grievance process will provide a formal review of all concerns raised by Enrollees, their designees, and others who are not enrollees or designees. The process is designed to assure that at least 95 percent of all grievances are resolved within 14 days of receipt of all required documentation and that all are resolved within 90 days of the receipt of all required documentation. To assure the effective and efficient resolution of grievances, the ValueOptions grievance process will begin with Customer Services Representatives (or any other ValueOptions employee), who will accept all grievances verbally, documenting them immediately in the ValueOptions tracking system. The staff will also document what the caller is requesting as an acceptable resolution to the grievance. If possible, the staff will take action that will resolve the grievance during the initial telephone call. Grievances will not require a signature to be logged into the tracking system, but the caller will be requested to provide information regarding his or her relationship to the Plan (such as provider, consumer, family member, and advocate) and contact information to allow follow-up by telephone or mail. If a grievance is received by mail, or if the staff cannot immediately resolve a caller’s concern, the grievance will become the responsibility of the Complaints and Grievances Coordinator. As necessary, the Complaints and Grievances Coordinator will complete the process of logging the grievance into the ValueOptions tracking system. Upon award of the contract, VOI will work with IDPH to develop a system to provide IDPH participants the opportunity to file a complaint. This complaint system will be fully operational by the contract start date.

Grievances will be reviewed by a member of the ValueOptions Executive Management Team within five business days following the receipt of the grievance, and appropriate responses initiated within the next five business days.

Review of Grievances — The Grievance and Appeals Coordinator will review each grievance filed to determine if additional documentation or clarification is required. If additional information is required, the Coordinator will notify the individual in writing and also may call the grievant to discuss the issue. These actions are entered into the grievance tracking system. **Within five business days**, the Coordinator will prepare a written summary of findings related to the grievance and recommendations regarding its disposition, including the recommendations of the person who filed the grievance. The written summary and recommendations will be presented to the Service Center Vice President and his or her direct reports, or the team member’s designee, who has administrative responsibility for the functional area addressed in the grievance. If more than one functional area is involved, the Coordinator will meet with all appropriate Executive Team members or their designees. **Within five business days**, the Executive Team member(s) will initiate appropriate action in response to the grievance.

Notification of Resolution — The Coordinator will document all decisions and actions to be implemented in response to the grievance in the grievance tracking system. Within two business days of the Executive Team member(s) determination, the Coordinator will generate a written notification to the person who filed the grievance.

Tracking Grievances — ValueOptions will generate regular reports to DHS documenting grievances received, grievances resolved, grievances pending, and other information requested by the Department.

Compliance with DHS and CMS Requirements — The grievance process described in this section is proposed for DHS’ review and will be modified in response to the Department’s recommendations. In administering the program, ValueOptions will comply with all requirements of DHS and CMS related to appeals and grievances as set forth in the RFP or as subsequently modified by DHS or CMS.

- a) Describe how the Bidder would ensure that the provider network is adequate and that access is maintained or increased to meet the needs of Iowa Plan Eligible Persons. Where there are potential issues of lack of capacity within the Bidder’s network, please describe the steps the Bidder would take to increase capacity. Provide examples from current contracts of how the Bidder has ensured network adequacy in states with a shortage of psychiatrists or other specific behavioral health professionals.

ENSURING AN ADEQUATE PROVIDER NETWORK;

ValueOptions will conduct GeoAccess surveys at least quarterly to determine the overall compliance of our provider network with the access standards established by the Departments in Sections 5C as well as 441 IAC 88.67(4). If one or more of the access standards are not met, ValueOptions will work with the Departments to create a corrective action plan and will implement agreed-upon actions immediately. Monitoring the impact of the corrective actions would be done at least monthly.

However, GeoAccess surveys will not identify potential access issues for sub-populations of people entitled to services through the Iowa Plan. ValueOptions will implement focused tracking to monitor the access available to the Departments’ priority consumers including homeless eligible persons, IV drug users, and children who are in need of residential substance abuse services. Data will be collected by the QM Department and shared with appropriate QM sub-committees as well as with the Departments. Strategies to improve effectiveness of existing services and to expand the service availability if necessary will be developed as part of the assessment process.

ADDRESSING POTENTIAL LACKS OF CAPACITY

VOI will assure providers are accessible and available to Eligible persons and that the provider network contains the specialties necessary to accommodate the specialized needs of Eligible persons. ValueOptions has developed a comprehensive system for monitoring patient load and overall network capacity. This system consists of the following monitoring protocols, which will be evaluated on a quarterly basis. Information resulting from these monitoring efforts will be analyzed by the Local Credentialing Committee, which will be responsible for ensuring the adequacy of the network. When adequacy issues are identified, the Local Credentialing Committee will initiate corrective actions to address them.

Special strategies will be implemented to focus on identifying potential access issues for selected groups of people eligible for Iowa Plan services.

GeoAccess Reports — VOI will use GeoAccess reports from ValueOptions’ system to review and monitor geographic accessibility. These reports will provide the geographic distance in miles from Eligibles to the nearest providers, indicate whether any Eligible persons are greater than 40 miles from a provider, the number of Eligible persons impacted, and where the affected Eligible person(s) reside. The report will contain additional information on geographic accessibility by provider type.

Network Adequacy Reports — The network adequacy report will contain the following information:

- number of Eligible persons in each county in the Service Area,
- number and type of facility and organizational provider by county,
- number and type of individual practitioner, by county,
- number of providers not accepting new Medicaid Members,
- number of single case agreements initiated, by county and provider type, and
- number of Members who are greater than 40 miles from a provider.

Timeliness of Service Appointment Reports — This report will present data on appointment timeframes that meet and do not meet the standard, by provider. In addition to corrective actions taken with individual providers, trends indicating problems in meeting appointment standards may indicate the need for recruitment of additional providers.

Caseload Ratio Report — Although normal variation may occur in caseload ratios, significant trends or deviations indicating a decrease in the number of practitioners/prescribers will be evaluated for the need to add additional providers to the network. Caseload ratios will be based on the number of Eligible persons accessing treatment and the number of providers, both prescribers and non-prescribers, available. Through an evaluation process, the Local

7A.2.13 Requirements For The Provider Network

Credentialing Committee will determine that capacity is adequate to meet the needs of Eligible persons and family members is assured. Following this determination, caseload ratios will be monitored closely for trends other than normal variation.

Provider Disenrollment Reports — This report specifies the number, licensure, location, and specialties of any providers who disenroll, either voluntarily or involuntarily, from the network and the reason for the disenrollment.

Action Plans — Evaluation of network adequacy through the aforementioned reports is the responsibility of the Local Credentialing Committee. Following each evaluation, the Local Credentialing Committee will identify any concerns regarding the adequacy of the network and specify the resulting actions to be taken to address the inadequacies identified. Actions may include, but not be limited to, recruiting providers who have specific licensures, certifications, specialties, languages or locations; evaluating fee schedules for specific services, provider types or specialties; and initiating the corrective action plan process for compliance issues, such as not meeting access standards.

Based on results of network adequacy reviews, VOI will recruit practitioners and facilities to help us meet capacity and Eligible persons’ choice requirements. Particular emphasis will be put on recruiting those professionals with specialized expertise (e.g., serving children and families, adoption competency, older adults, those with substance use disorder, dual diagnosis, and/or specific linguistic capabilities). Providers who have an expressed interest in contracting with VOI represent an array of specialties including co-occurring disorders, chronic pain, PTSD, ADHD, domestic violence, and eating disorders.

PROVIDER RECRUITMENT

While we already have a strong core of providers already under contract in the state, we will engage in network recruitment and development for any underserved areas or specialties. Currently, although we have providers across the state who serve children and families, we are focusing on expanding our network to increase the number of providers who specialize in serving children and adolescents.

To ensure we have an adequate number of providers in underserved areas/specialties, ValueOptions will run regular GeoAccess reports specific to the Iowa Plan membership. The Iowa Service Center will receive quarterly GeoAccess reports indicating the distribution of our provider network. Data from these reports, as well as anecdotal data from Call Center Operations, will be reviewed by the Utilization Management/Quality Management Committee as well as the Quality Management Steering Committee to determine any potential network gaps or recruitment needs. Once a network gap or need is identified, this information is relayed to ValueOptions’ Network Development and Management Department to begin the recruitment process. The Iowa Service Center will have a liaison with the Corporate National Network Development and Management Department to prioritize these providers and expedite the credentialing process.

Resources Used to Recruit Providers — We outline the resources used to recruit and contract providers in the following table.

NETWORK DEVELOPMENT PLAN	
Nomination of Potential Providers	<ul style="list-style-type: none"> • Share ValueOptions’ Credentialing Criteria with DHS and IDPH representatives. • Establish list of providers to be recruited with DHS and IDPH representatives. • Mail applications to selected providers.
Recruitment Follow-up	<ul style="list-style-type: none"> • At 15-day and 30-day intervals from the date the application is mailed, ValueOptions engages written correspondence to nominated providers reminding them of the importance of completing the application process. • In coordination with the Iowa Plan’s Provider Relations’ staff and DHS and IDPH, ValueOptions will establish a telephonic outreach plan for those providers identified as key or high volume, reminding them of the importance of completing the application process. • If a provider is not interested/non-responsive, ValueOptions will determine whether additional providers are needed and initiate necessary recruitment efforts. • Provide DHS and IDPH with a recruitment status report (weekly, or monthly, depending upon your indicated needs).

NETWORK DEVELOPMENT PLAN	
Credentialing Process	<ul style="list-style-type: none"> Review to determine receipt of complete application and related materials. Review for criteria and completeness and conduct Primary Source Verification (PSV) activities. Generate Letter of Acceptance to Network that includes an executed Practitioner Agreement and informs the provider of ValueOptions' Web site in order to obtain the Provider Manual. If an application is incomplete, National Network Operations will place one (1) call and send written request for missing materials via fax or letter. If a provider does not meet criteria, National Network Operations will generate Letter of Denial (specify criteria not met) and update credentialing system appropriately.
Conduct Provider Education	<ul style="list-style-type: none"> Coordinate with DHS and IDPH the types of provider educational strategies that are necessary. Examples include provider forums or telephonic educational meetings to provide educational materials and provider overview of ValueOptions policies and procedures.
Network Development Status	<ul style="list-style-type: none"> Meet with DHS and IDPH to review Network Development strategies.
Credentialing Timeline	<ul style="list-style-type: none"> Credentialing a provider into our network takes approximately 60 days once the completed application and related material are received.

Provide Examples From Current Contracts Of How The Bidder Has Ensured Network Adequacy In States With A Shortage Of Psychiatrists Or Other Specific Behavioral Health Professionals.

Currently, ValueOptions has a sizeable network across the state of Iowa; however, as ValueOptions establishes the provider network in Iowa, special attention will be paid to the number of psychiatrists and child psychiatrists available to meet Eligibles' needs. Nationally, there is a shortage of these valuable physicians. ValueOptions has successfully utilized telemedicine as a means of expanding access to psychiatrists. To assure accessibility for Eligible persons, VOI will also supplement psychiatric time through the use of other prescribers, such as nurses with prescribing authority.

New Mexico Physician Extenders — A core strategy to improve rural access in New Mexico is the recruitment and credentialing of “physician/psychiatrist extenders” including nurses and psychologists with prescriptive authority. New Mexico is one of two states that have developed licensing requirements that allow specially trained APNs and psychologists to prescribe medication. VONM developed criteria to support the recruitment of appropriately qualified prescribing psychologists and has credentialed nearly a dozen psychologists with prescriptive authority. Nurses with the prescriptive authority specification, along with education and experience in behavioral health treatment also have been used to address areas with limited access to psychiatrists. These physician extenders have strongly augmented the physician network and increased the access to services in rural areas.

Telehealth — ValueOptions was one of the first behavioral health care companies to adopt and disseminate guidelines for telehealth. With numerous of locations in five states (Pennsylvania, Texas, Colorado, Tennessee, and New Mexico) and currently establishing locations in Louisiana and Mississippi to address the needs of communities affected by Hurricane Katrina and other natural disasters, ValueOptions has been on the cutting edge of this technology. In New Mexico specifically, we established more than 30 sites.

- b) Describe proposed strategies to bring services to underserved communities, including but not limited to:
 - the use of telehealth and distance treatment options, and
 - provision of child psychiatric consultation services to primary care clinicians.

Key findings of the 2007 report of the Task Force on the Iowa Physician Workforce indicate that only 32 of Iowa's 99 counties have at least one psychiatrist, limiting accessibility to mental health treatment statewide. Additionally, Iowa has a large number of federally defined Health Professional Shortage Areas (HPSAs). For Mental Health Services, 84 of Iowa's 99 counties are Mental HPSAs, meaning that there is at least a 20,000:1 population to psychiatrist ratio within a designated catchment area. These statistics point to the need to develop alternative mechanisms for ensuring medical supervision of mental health services. The examples below demonstrate ValueOptions' experience with providing TeleHealth and psychiatric consultation as a mechanism to address these significant shortages.

TELEHEALTH

Upon contract award, VOI will dramatically expand the offering of Telepsychiatry with the intent of making it available statewide by the end of contract year two. This innovative program is designed to ensure that enrollees have a local medical home and provide the medical professional in this medical home with access to a Board-certified child psychiatrist for the purposes of diagnosing and treating mild to moderate mental health conditions. VOI will begin this process by working with the Iowa Psychiatric Society and the University of Iowa Department of Psychiatry to develop an infrastructure to support expansion statewide. If there are not enough in-state psychiatric providers, VOI will seek contractual relationships with out-of-state providers. We will begin by seeking mental health provider organizations that wish to participate as host organizations. Additionally, we will expand our network to include other medical homes such as FQHCs, Community and Public Health Clinics, Indian Health Services, Rural Health Clinics, and School-Based Clinics. Contracting with these providers will open access to an array of medical providers including mid-level practitioners. To encourage the expansion of the network, VOI will provide training on mental health care and will facilitate the coordination of services provided by these entities with services provided by traditional mental health providers.

VOI will work to make telehealth services available for diagnostic and medication therapies through a HIPAA-compliant telehealth service system. At full capacity, the telehealth program will operate Monday through Friday during established hours with a goal of significantly reducing wait times for appointments to see a medical professional. In addition to consultations, the Telehealth child psychiatrist and staff will provide referrals to VOI mental health services when necessary. The psychiatrists participating in the telehealth program also will work with VOI Clinical Advisory/Utilization Management and Quality Improvement Committees to define and improve our integrated healthcare guidelines, policies, and procedures. ValueOptions has instituted similar programs in other States, examples of which are below:

Greene County, Pennsylvania —One of our sister companies, VBH-PA has taken the lead in building a program through which Pennsylvania-licensed child psychiatrists provide medication management to children and adolescents in schools. VBH-PA was the first BH-MCO in the state of Pennsylvania to launch a telepsychiatry initiative.

Medication management services using telepsychiatry were implemented in October 2005 for targeted children and adolescents. The pilot program was accomplished through the collaborative efforts of Centerville Clinics Inc., Central Greene School District, Greene County Human Services, the Office of Mental Health and Substance Abuse Services, and Value Behavioral Health of PA, Inc. In the telepsychiatry program implemented in Greene County, medication management is performed by Pennsylvania-licensed child psychiatrists contracted with VBH-PA. The child/adolescent participates from a confidential setting in their school. Telepsychiatry has eliminated the “no show” rate for appointments and has decreased the number of school days missed by children/adolescents receiving treatment.

“Telepsychiatry has been hailed as the future of psychiatric care, especially in rural and underserved communities. This type of care has the power to bridge distances between the doctor and his patients. Centerville Clinic’s relationship with ValueOptions has made it possible to provide Telepsychiatry in Greene County. Overall, Telepsychiatry has provided increased access to mental health services and has helped to enhance the provision of these services to families with children who live in Greene County. Our patients have responded well to this technology. One student has remarked, “It’s just like sitting across from the doctor.” Our professionals feel Telepsychiatry has given them an opportunity to work more efficiently as a Team. Throughout this new endeavor, ValueOptions has been supportive of our efforts to expand this service into additional school districts. They have provided excellent, ongoing technical support. In addition they have developed the ongoing studies and tools used to monitor Telepsychiatry. This program would not have been possible without their relationship.”

Ann D. Gaydos
Mental Health Director
Centerville Clinics Inc.

Results Analysis — To measure the effectiveness of this program, VBH-PA analyzes quality assurance surveys to measure overall quality of service and satisfaction with telepsychiatry services; and compares data on attendance

behavior to pre- and post-implementation activities to ascertain compliance with scheduled appointments and access provided by telepsychiatry services.

Findings —The most significant findings of this QIA were that technology has provided uncompromised audio/visual performance 97 percent of the time during sessions, has increased compliance with psychiatric appointments by 25 percent, and has improved the “No Show” rate for psychiatric appointments by 15 percent.

New Mexico — ValueOptions of New Mexico (VONM) regards telehealth as an enabling technology capable of extending needed behavioral health services into rural and frontier areas of the state. Geography, along with well-chronicled shortages of behavioral health professionals of all disciplines combine to limit service capacity within large sections of New Mexico. The focus is on live, interactive two-way audio-video communication. Taking advantage of an expanding telecommunication infrastructure, VONM has successfully undertaken efforts to increase both the availability and the accessibility of behavioral health care, particularly psychiatric services in 36 locations throughout the state. Although telehealth has the potential to support provision of a variety of services, the current focus is on psychiatry and medication management. VONM is continuing the successful efforts currently underway to extend broad-based utilization of telehealth technology as a means of increasing both the availability and accessibility of behavioral health care throughout New Mexico. VONM has supported development of HIPAA-compliant telehealth service systems within its Network by enabling providers to access TTY, 711, and other telecommunication relay services.

ValueOptions’ Massachusetts Behavioral Health Partnership (MBHP) Program has instituted a program similar to the CPCS. As of the end of their Fiscal Year 2008 (June 30, 2008), MBHP has received over 14,000 encounters, and over 75 percent of all practices called each quarter.

CHILD PSYCHIATRY CONSULTATION SERVICES

Upon contract award, VOI will implement the Child Psychiatry Consultation Service (CPCS). This innovative program is designed to provide pediatricians and primary care physicians in the state an avenue to seek consultations and quality information, provided by a Board-certified child psychiatrist, about how to diagnose and treat mild-to-moderate children’s mental health conditions.

VOI will make CPCS available for diagnostic and medication consultations through a toll-free number that will operate Monday through Friday from 8:00 am to 5:00 pm CST. All physician callers will receive a consultation in 30 minutes or less. In addition to consultations, the CPCS child psychiatrist and staff will provide referrals to VOI mental health services when necessary. The CPCS psychiatrist will also work with VOI Clinical Advisory/Utilization Management and Quality Improvement Committees to define and improve our integrated healthcare guidelines, policies, and procedures.

ValueOptions has instituted a similar program in its Massachusetts Behavioral Health Partnership (MBHP) program. Approximately 96 percent of the PCP practices serving children participate in this program and feel that they are better able to meet the mental health needs of children and adolescents. As of the end of their FY08 (June 30, 2008), MBHP has received more than 14,000 encounters and more than 75 percent of all practices called each quarter.

We are confident that this new and innovative program will improve the quality of care Iowa Members receive while also bolstering the effectiveness of integration between physical and mental health care. Immediately upon contract award, VOI will initiate engagement of other BHO contractors with the goal of collaboratively offering this service statewide. Initially, we will make the CPCS available for only Medicaid Members; however, we have elicited interest from multiple sources in providing grant assistance to make CPCS available to ANY Iowa child or adolescent.

This service can improve outcomes for the most complex cases. The following are some examples of consultation topics that have been experienced in other areas that have led to positive outcomes for members:

- admission to and discharge planning from an acute inpatient level of care,
- initiation of treatment with psychotropic medications,
- change in psychotropic medications,
- lab values or test results pertinent to physical health provider care,
- Enrollee’s receipt of psychotropic medications from more than one provider,
- adverse medication side affects experienced by Enrollees,

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- Enrollee has experienced clinically significant changes in physical or mental health status, and
- Enrollee has complicated medical or drug interactions.

- c) Describe the Bidder's experience under other contracts to ensure delivery of services to these populations when provider network capacity was initially found to be inadequate. Include the names of the programs and provide the names, telephone numbers and e-mail addresses of three references who can be contacted to verify the description submitted by the Bidder.

As a potential key stakeholder in the delivery of service for eligible Iowa Plan consumers, ValueOptions is committed to maintaining a statewide provider network that meets the behavioral health needs of all eligible consumers and priority populations throughout Iowa. Two examples are provided in the paragraphs that follow.

We have learned from our experience that a person's culture is relevant to his or her recovery and the services they receive. Therefore, we are committed to establishing a plan of care for consumers that is individualized and reflect appropriate integration and utilization of the existing systems within their community. ValueOptions has experience working with Indian Health Services in New Mexico to expand services to the Native American population and to offer EBPs to this population. Native American Region 6 in New Mexico has been able to prioritize support of traditional healing services through both the existing reimbursement structure and through the use of Community Reinvestment funding. Total Behavioral Health Funding to Tribal/Pueblo programs currently is nearly \$13 million. Contracts with Community Reinvestment, Community-Based Service Expansion, Robert Wood Johnson, Telehealth Expansion, Data Infrastructure Grant, Methamphetamine Initiative, General Funds for the Homeless and Prevention and Education were awarded in New Mexico. Where initial experience might have identified a lack of services or an inadequate network, ValueOptions has found opportunities to successfully respond and provide a solution. For example in New Mexico, with invaluable input, non-traditional programs that promote Recovery and Resiliency were developed throughout the state, including establishing three drop-in-centers and helping to sustain four at the brink of closure. To increase access for consumers in rural and frontier areas, ValueOptions established numerous telemedicine sites across the state. Examples of this experience are provided in our response above.

REFERENCES

We provide the following references of clients for with whom we have experience ensuring the delivery of services when the provider network was initially found to be inadequate:

- Katherine Scheib, Texas Department of State Health Services, Office of NorthSTAR and Special Initiatives; telephone (512) 206-4536; email Katherine.scheib@dshs.state.tx.us.
- Suzanne Fields, Director of Behavioral Health, Office of MassHealth; telephone (617) 348-5101; email suzanne.fields@state.ma.us.
- Vic Degravio, Executive Director, Mental Health and Substance Abuse Corporations of Massachusetts; telephone (508) 647-8385; email vdigravio@mhsacm.org.
- David Dickinson, Director of Addiction and Prevention Services, Kansas Department of Social and Rehabilitation Services; telephone (785) 368-6392; email ddickinson@srs.ks.gov.

d) Describe the Bidder's experience in implementing Medicaid managed behavioral health programs in which the Bidder successfully promoted the development of:

- psychiatric rehabilitation services;
- mental health self-help and peer support groups, and
- peer education services.

Provide the names of the programs and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

The President's New Freedom Commission stated that recovery must be **the goal** of a transformed mental health system, and ValueOptions has committed ever since to transforming its service delivery systems to meet this goal. This includes integrating rehabilitation and recovery values into managed care and developing peer education and support services to foster self-help and recovery. In this spirit, ValueOptions has made significant strides over the last few years in introducing new recovery and rehabilitation-oriented services, including psychiatric rehabilitation, self-help and peer support groups, and peer education services. To continue this expansion, ValueOptions has hosted nationwide Recovery Summits. Leading consumer advocates from every ValueOptions' public sector Service Center have helped us define strategies to further transform our service systems; finalize ValueOptions' recovery definition, mission, and vision statements; and kick off recovery-oriented best practices initiatives. Below are examples of four of our Medicaid managed behavioral health programs with their accomplishments in promoting recovery and rehabilitation.

MASSACHUSETTS

ValueOptions in Massachusetts has taken a leadership role in envisioning, planning, and guiding the implementation of a variety of peer-run recovery initiatives and the integration of peers in multi-agency service delivery statewide. This type of initial planning has resulted in a number of groundbreaking efforts to integrate peers and recovery into service systems, including:

Recovery Learning Communities — The Massachusetts Consumer Family Workgroup was convened by the ValueOptions Rehabilitation and Recovery Department in Massachusetts, which hosted Dr. Ed Knight presenting ValueOptions' Colorado partnership experience. ValueOptions in Massachusetts then facilitated the development of the initial Recovery Learning Communities proposal to develop six regional peer-run and peer-operated resource centers. The proposal attracted both state and federal funding, and the six centers have now been implemented throughout the state. In this new conceptual peer-run model, the centers are hubs in which Eligible persons learn about wellness and community resources and take part in mutual support and self help.

Quality Initiatives for Eligible Persons— ValueOptions in Massachusetts collaborated with two Massachusetts consumer organizations to launch a contract for a consumer satisfaction team to evaluate service delivery by interviewing Eligible persons about their service systems experience of care delivery. ValueOptions ongoing collaboration and support has led to the development of an independent, nationally known, consumer research organization, Consumer Quality Initiatives (CQI). ValueOptions continues its collaboration and partnership with CQI and its executive director, Jonathan Delman, MPH, JD, who was recently awarded a prestigious Community Health Leaders Award for 2008 from the Robert Wood Johnson Foundation.

Boston University Center for Psychiatric Rehabilitation — MBHP engaged the Boston University Center for Psychiatric Rehabilitation to develop parameters on how to operationalize recovery and rehabilitation-oriented services at the program level. The parameters cover the domains of treatment setting, policies and procedures, staff selection, training and supervision, quality improvement procedures, and utilization management procedures. In addition, this partnership continued when they were hired by MBHP to work with day treatment providers to re-engineer their day treatment services to make them recovery and rehabilitation oriented. The providers analyzed what aspects of the services already were recovery oriented, and eliminated or redesigned other aspects of their services to embrace principles of recovery.

Peer Educators Project — This statewide peer support project was launched 11 years ago in collaboration between ValueOptions and nationally known local peer leaders Moe Armstrong and Naomi Pinson. It continues to be a vibrant

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network offering more than 20 Spanish and English weekly peer groups. The Peer Educators Project has served a vital function in creating the first rung of a peer specialist career ladder for many public system clients in Massachusetts, which has in turn consolidated the recovery gains of public clients in employment and community living.

Massachusetts Clubhouse Coalition Dual Recovery Anonymous — This network of 39 weekly meetings throughout the state has offered peers the opportunity to develop leadership skills through launching, supporting, and maintaining self-help meetings and to provide mutual support and cross-training through monthly leadership meetings and an annual leadership development conference. This model, pioneered through partnership between the Massachusetts Clubhouse Coalition and ValueOptions, has become a national and even internationally recognized model for dual recovery throughout the International Center for Clubhouse Development network.

Peer Support in Aftercare — ValueOptions launched this project in 2002 to link Eligible persons being discharged from inpatient care with Eligibles and resources in their home communities. Through hospital visits and ongoing support, peers enhance discharge planning and aftercare support for 90 days following discharge. A major finding of this project is a statistically significant positive correlation between the number of peer support sessions and community tenure, which suggests that the more peer support that members receive after discharge from inpatient hospitalization, the longer they are likely to stay out of the hospital and in the community. In addition, statistical analysis demonstrated a statistically significant decrease in the total cost of services and in the average costs of inpatient, emergency, and outpatient services.

Other Examples of the ongoing peer-run recovery initiatives and the integration of peers in multi-agency service delivery include Peer-run Provider Training, Emerging Recovery Programming, Massachusetts Leadership Academy, and Statewide Recovery Conference.

COLORADO

Southeast Mental Health Services is a community mental health center located in La Junta, and one of the provider partners with ValueOptions in Colorado Health Partnership. The American Psychiatric Association has awarded Southeast Mental Health Services its 2003 Silver Achievement Award. The November 2003 issue of *Psychiatric Services* includes a two-page article that highlights the achievements of Southeast Mental Health Services. Some of the strategies that the Center used to move from a “one size fits all approach” to embrace a recovery model of care and service include:

- changing the Center’s mission statement to eliminate references to symptoms of mental illness and instead focus on fostering the “success of individuals;”
- developing self-help and peer support meetings;
- working with local employers to increase the pool of jobs available to Eligible persons;
- developing a service menu, from which Eligible persons could chose from social skills and work training, daily living skills training, education about mental illness and medications, symptom management, and therapy;
- developing clustered housing in community settings, which allowed Eligible persons to move into apartment complexes in the community;
- developing an 11-bed crisis hostel that Eligibles can use voluntarily for additional support—no predetermined level of distress or dangerousness is required for consumers to use the crisis hostel services; and
- hiring home health aides to help Eligible persons manage their homes, finances, and their lives.

Outcomes from their emphasis on recovery have included the following:

- A pre/post evaluation for 50 Eligible persons showed a dramatic increase in the level of functioning of more than one point on a 5-point scale. This increase moved the group from a below-average rating to an average rating.
- Under the new model, Eligible persons received fewer restrictive services, such as residential and day treatment services, and more integrative services, such as vocational rehabilitation and case management.

Peer Education — To spearhead its public sector efforts across the country, ValueOptions employs a nationally recognized leader who provides consultation about recovery and resiliency approaches. Edward L. Knight, PhD, CPRP is the Vice President of Recovery, Rehabilitation, and Mutual Support for the ValueOptions-Colorado Health Networks (ValueOptions-CHN) Medicaid contract with the Colorado Department of Healthcare Policy and Financing. Dr. Knight has been instrumental in training ValueOptions-CHN staff in the implementation of the Boston University

model of recovery for consumers and in developing clubhouses and drop-in centers in Colorado. Before coming to ValueOptions, Dr. Knight founded and ran the successful Mental Health Empowerment Project in New York State, which started dozens of consumer-operated services (COS) and hundreds of mutual support groups. The COS are consumer-sponsored 501(c)(3) organizations responsible for a range of services from clubhouses and empowerment centers to supported housing and case management. Dr. Knight will be available to provide training sessions in Iowa.

PENNSYLVANIA

Pilot Project to Provide Medicaid Mental Illness Peer Support Services Via Secure TeleHealth® —

Value Behavioral Health of Pennsylvania (VBH-PA) is engaged in a pilot project with Secure TeleHealth® to test the viability of providing peer support for individuals with mental illness via two-way video conferencing. The pilot, approved by the Pennsylvania Department of Welfare (DPW), Office of Mental Health and Substance Abuse Services, will help peer mentors and peer specialists connect with selected individuals with mental illness in a variety of settings. The hope is that the use of this equipment can enhance the number of contacts individuals have with their peer specialist/mentor or psychiatric rehabilitation worker. Participating consumers live in private apartments, two different long-term structured residences, a personal care home, and a nursing home.

Secure TeleHealth provides a secure, PC-based video conferencing service for the delivery of behavioral and physical health care in the community. The Secure TeleHealth service includes an option to record video conference sessions for electronic medical record-keeping. It also provides the capability for the provider of the service to remote-control the client-side appliance so the client never has to touch the appliance.

The pilot program began in 2008 and will be evaluated in June of 2009. Desired outcomes include increasing the number of contacts between peer mentors and individuals with mental illness, increased access to additional services when needed, assessing the convenience of the equipment, the adequacy of the training, the effectiveness of video-conferencing compared to an onsite visit, and consumer and professionals’ satisfaction.

REFERENCES

The following clients will provide references regarding ValueOptions’ experience in implementing Medicaid managed behavioral health programs which successfully promoted the development of psychiatric rehabilitation services, mental health self-help and peer support groups, and peer education services:

- Suzanne Fields, Director of Behavioral Health, Office of MassHealth; telephone (617) 348-5101; email suzanne.fields@state.ma.us.
- Debora Delman, Executive Director, Transformation Center; telephone (617) 442-4111; email drdelman@comcast.net.
- Jonathan Delman, Executive Director, Consumer Quality Initiatives; telephone (617) 427-0505; email jdeman@cqi-mass.org
- Cindy McLaughlin, Chief Executive Officer, Behavioral Health of Cambria County, Pennsylvania; telephone (814) 534-4436; email Cmclaughlin15@verizon.net.
- Karen Andersson, Ph.D., Director of Mental Health, Connecticut Behavioral Health Partnership, Connecticut DCF; telephone (860) 550-6683; email Karen.andersson@ct.gov; and Mark Schaefer, Ph.D., Director, Medical Policy and Behavioral Health; telephone (860) 424-5067; email Mark.schaefer@ct.gov.

e) Describe the Bidder’s experience with contracts that include SAPT Block Grant funding. Provide the names, telephone numbers and email addresses of two references that can be contacted to verify the description submitted by the Bidder.

ValueOptions has experience managing SAPT Block grant funding for our Kansas and New Mexico contracts. We also have experience managing SAT grant funds in Texas for our NorthSTAR program.

KANSAS

ValueOptions of Kansas (VO-KS) assures access to Kansans who have Medicaid- and SAPT-funded substance abuse treatment. We also have used a variety of strategies to improve access to services, especially for SAPT-funded treatment, such as:

- VO-KS works collaboratively with the Regional Alcohol and Drug Assessment Centers (RADACs) to consistently screen all applicants for services and assures that other sources of payment—including private insurance—are fully utilized.
- We support the process already underway in Kansas to expand community-based treatment services, reserving 24-hour treatment beds for those clients whose conditions require 24-hour care.
- We work with providers and SRS to identify and implement EBP's consistent with Kansas' approach to treatment that improve the effectiveness of treatment provided with SAPT and Medicaid dollars, reducing recidivism and treatment duration as appropriate.
- We implemented a Provider Excellence Program, which recognizes providers whose programs show the best treatment outcomes by minimizing the requirements for authorization of services they provide.
- We provide forums—both through our QM program and through an annual Kansas Substance Abuse Summit—in which excellent providers and programs present their treatment approach so others can adapt those strategies as appropriate.
- Through our contacts with the Substance Abuse and Mental Health Services Administration as well as Congressmen and -women, we complement Kansas' efforts to assure continuation of substance abuse block grant funds, with increases as possible.

ValueOptions of New Mexico began a statewide contract on July 1, 2005, and currently supports the New Mexico Behavioral Health Interagency Collaborative to provide management of substance abuse and mental health services funded through the Collaborative's state agencies, including the New Mexico Department of Health (MH and SAPT block grant funds and state only dollars), the Children, Youth and Families Department, the Corrections Department, and the Human Services Department (Medicaid Managed Care and Medicaid Fee for Service, TANF, and federal grants).

SAPT dollars in Texas are split between treatment and prevention. The prevention dollars go to another agency in the NorthSTAR area, but ValueOptions manages all the treatment dollars.

REFERENCES

The following clients will provide references regarding ValueOptions' experience with contracts that include SAPT Block grant funding:

- David Dickinson, Director of Addiction and Prevention Services, Kansas Department of Social and Rehabilitation Services Substance Abuse Treatment Program Prepaid Inpatient Health Plan; telephone (785) 368-6392; email ddickinson@srs.ks.gov.
- Matthew Ferrara, Office of NorthSTAR and Special Initiatives; telephone (512) 206-5444; email matthew.ferrara@hshs.state.tx.us.

- f) Describe the Bidder's experience contracting with networks of comparable or greater size than those of the Iowa Plan within the timeframe afforded by this procurement. Provide the names of the programs and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

LEARNING FROM OTHER PROGRAMS

Our vision to use network development strategies to support the principles and best practice models is guided by our experience in other states. We believe that the following successes have taught us valuable lessons that we can apply as we work with the Iowa Plan.

ValueOptions' Experience — ValueOptions has the most experience—and the most documented successes—in partnering with state behavioral health and Medicaid agencies, including contracting with networks of great size. This

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experience is highlighted in the following paragraphs with examples of other contracts including Texas NorthSTAR Program, Massachusetts Behavioral Health Partnership (MBHP), Connecticut Behavioral Health Partnership, Illinois Department of Health, Kansas Department of Social and Rehabilitation Services, New Jersey Contracted Systems Administrator to name a few.

In **Texas**, we improved access to care by **expanding the provider network**. An independent evaluation by the LBJ School of Public Affairs said the increased penetration rates were due largely to the expansion of the provider network, noting that, “Consumers within NorthSTAR can seek services not only at non-traditional providers, but also anywhere within the seven-county NorthSTAR service delivery area. By contracting directly with a network of facility-based and individual providers, ValueOptions has made it possible for Medicaid and non-Medicaid consumers to be successful in finding an appropriate provider.” A second and equally important element of this geographic economy of scale results from the introduction of mobility and flexibility of providers.”⁵

In **Massachusetts**, we increased the availability of **treatment for co-occurring disorders** in its provider network. In 1999, the Massachusetts provider network was significantly lacking in services and programs to serve individuals with co-occurring disorders. Through joint collaboration with the Massachusetts Department of Public Health and the Massachusetts Department of Mental Health, ValueOptions implemented a broad initiative to train providers on the provision of screening and treatment for individuals with co-occurring disorders mental health and substance abuse disorders, and worked with providers to develop new integrated treatment programs. Because of this effort, Massachusetts now has 25 programs for the treatment of co-occurring disorders, which span each of the six regions of the Commonwealth. The programs emphasize the use of evidence-based best practices and have been responsible for helping develop a number of promising practices that ValueOptions has helped evaluate through the Quality Management Program.

Other programs of comparable or greater size include:

- ValueOptions began administering the Substance Abuse Prepaid Inpatient Health Plan (SA-PIHP) for the **Kansas Department of Social and Rehabilitation Services** in July of 2007. On behalf of the Department, ValueOptions of Kansas (ValueOptions-KS) manages substance abuse services provided through Medicaid as well as through Substance Abuse Prevention and Treatment block grant funds. The Division of Addiction and Prevention Services supervises the contract, which covers some 280,000 Medicaid beneficiaries as well as persons eligible for block grant services. ValueOptions coordinates with the existing provider community and Regional Alcohol and Drug Assessment Centers in order to provide high-quality, culturally sensitive care to participants in the state.
- **Connecticut Department of Social Services and Department of Children and Families** – The Connecticut Behavioral Health Partnership, (CT BHP) operates with a combination of Medicaid and non-Medicaid funding from the Department of Social Services and the Department of Children and Families (DCF) to provide services to more than 300,000 Medicaid beneficiaries.
- **Illinois Department of Human Services** – ValueOptions began serving as the Administrative Services Organization (ASO) for the Illinois Department of Human Services’ Division of Mental Health (DMH) in December 2007 and covers the 166,000 Illinois residents who use DMH-funded services.
- **New Jersey Division of Child Behavioral Health Services** – ValueOptions serves as the contracted systems administrator for the New Jersey Division of Child Behavioral Health Services.

REFERENCES

The following clients will provide references regarding ValueOptions’ experience contracting with networks of comparable or greater size than those of the Iowa plan within the timeframe afforded by this procurement.

- Katherine Scheib, Texas Department of State Health Services, Office of NorthSTAR and Special Initiatives; telephone (512) 206-4536; email Katherine.scheib@dshs.state.tx.us.

⁵ Lyndon Baines Johnson School of Public Affairs, the University of Texas. NorthSTAR: A Successful Blended-Funding, Integrated Behavioral Health Carve-Out Model: Final Report in the Independent Assessment of NorthSTAR. Prepared for Texas Department of Mental Health and Mental Retardation and Texas Commission of Alcohol and Drug Abuse. September 2003.

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- Suzanne Fields, Director of Behavioral Health, Office of MassHealth; telephone (617) 348-5101; email suzanne.fields@state.ma.us.
- Vic Degravio, Executive Director, Mental Health and Substance Abuse Corporations of Massachusetts; telephone (508) 647-8385; email vdigravio@mhsacm.org.
- David Dickinson, Director of Addiction and Prevention Services, Kansas Department of Social and Rehabilitation Services Substance Abuse Treatment Program Prepaid Inpatient Health Plan; telephone (785) 368-6392; email ddickinson@srs.ks.gov.

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- a) Describe how the Bidder would actively manage quality of care provided by network providers of all covered services. The description should include:
- the Bidder’s proposed methodology for conducting provider profiling, including as examples, the content of the report for providers of inpatient mental health services to children; providers of outpatient mental health services to adults, and providers of substance abuse services. The Bidder shall specify the frequency of report distribution, and a timeline for developing and implementing provider profiles for all provider and service types;
 - the explicit steps the Bidder would take with each profiled provider following the production of each profile report, including a description of how the Bidder would generate and facilitate improvement in the performance of each profiled provider;
 - the process and timeline the Bidder proposes for periodically assessing provider progress on its implementation of strategies to attain improvement goals;
 - examples of how the Bidder has used provider profiling to improve services delivered by a provider, or provider type in a managed care program;
 - a description of how the Bidder would reward providers who demonstrate continued excellence and/or significant performance improvement over time, and how the Bidder would share “best practice” methods or programs with providers of similar programs in its network, and
 - a description of how the Bidder would penalize providers who demonstrate continued unacceptable performance or performance that does not improve over time.

Actively managing the quality of care provided through the Iowa Plan is one of the most important responsibilities the Departments delegate to the Contractor. For example, the utilization management process (including the retrospective record reviews required by DPH) is designed to assist providers in matching the intensity of treatment with the clinical and psychosocial needs of the Enrollee. The Quality Management Department is responsible for monitoring utilization data, critical incidents, grievances and appeals, Enrollee and provider satisfaction, emerging best practices, and stakeholder input to identify opportunities for improvement. Provider record audits are another important way in which QM staff members actively manage the quality of care being delivered. In addition to these tools, VOI will develop a comprehensive provider profiling report building off of our lessons learned in other public sector programs.

METHODOLOGY FOR PROVIDER PROFILING

Through its many public sector contracts, ValueOptions has learned that a “one size fits all” approach is sure to fail. This is true in provider profiling, because the content of provider profiles must be responsive to each program in which they are used. In fact, in our experience, the process of designing a provider profiling program and selecting provider profiling elements is almost as valuable as the findings. By working together to determine the most important elements to include, the behavioral health community— Enrollees, advocates, providers, the state agencies and VOI—comes to consensus on what represents excellent performance.

One of the most frequent comments about today’s Iowa Plan is that it does not support a true partnership with providers. Focusing on data that will support network providers’ internal quality management programs will be a key step in re-invigorating provider profiling and also creating effective working relationships with the provider network.

Potential Content for Mental Health Services Provider Profiles

Some of the data elements most frequently selected in ValueOptions’ public sector programs for provider profiling are listed below. To the extent they are most appropriate for a particular provider or level of care, a notation follows:

- Enrollee volume by age, gender, and diagnosis;
- average number of visits per Enrollee by age, gender and diagnosis including dual diagnoses (outpatient services);
- average length of stay (24 hour care settings);
- readmissions care within 7/30/60/90 days (24 hour settings);
- average cost per Enrollee;
- number of peer advisor referrals (services requiring authorization only);
- number and percentage of non-certifications (services requiring authorization only);
- wait time to accept new referrals;
- grievance and/or appeal rates;
- validated incident reports;
- critical findings of record reviews;

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- status of corrective action plans;
- percent of claims submitted which meet “clean claims” standards; and
- percent of claims submitted electronically.

If a provider’s performance is significantly below other providers who offer the same services, VOI clinicians and a Community-based Provider Relations Coordinator will meet with the provider to analyze the reasons and implement training or other corrective actions as appropriate.

VOI proposes the above list as the starting point for determining provider profiles for children’s inpatient mental health providers, adult outpatient mental health providers, and selected other mental health provider categories. We will modify the list based on input from the Departments and from representatives of Iowa’s behavioral health community, including enrollees, as noted above.

Minimum Profiling Elements for Substance Abuse Programs — Provider profiles will be generated for substance abuse programs and will include, at a minimum:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Enrollee admissions, • Enrollees receiving services, • services delivered to Enrollees, • Enrollee discharges, • placement screening wait times, • overall Enrollee satisfaction at discharge, • discharge reasons, • co-occurring treatment | <ul style="list-style-type: none"> • Enrollee length of stay, • Enrollees’ hospitalization, • Enrollees’ arrest, • Enrollees’ work/school days missed, • Enrollees’ income status, • substance use frequency, and • breakdown of enrollees by funding source. |
|---|--|

Frequency of Reports and an Implementation Timeline — Iowa Plan provider profiles will be generated quarterly. VOI staff will begin working with the behavioral health community to select the first provider profiling elements during the pre-implementation period. However, to assure sufficient data to make the profiles meaningful, we do not anticipate issuing the first provider profiles of Medicaid-funded services until 2010. In addition, to assure validity of reports, VOI recommends profiling only those Medicaid providers with a relatively high volume of Enrollee and paid claims. We will work with DHS to quantify those measures. Because I-Smart data has been collected regularly for some time in its current format, profiles of substance abuse programs can be generated using data from July-September 2010 and quarterly thereafter.

Other Methods for Reporting — In addition to the quarterly provider profile reports, VOI will make available “real time” reporting capabilities through our IntelligenceConnect system described later in this proposal. The information captured for the purposes of provider profiling will be available for providers to utilize for business intelligence and decision support. This will be available to them without the lag common on quarterly reports. As providers become better able to manipulate the data in IntelligenceConnect, VOI will work with the Departments to make this the standard for reporting.

STEPS IN THE PROVIDER PROFILING PROCESS

Provider profiles will be reviewed by the Departments and designated QM committees to ensure a broad range of input, including that of consumers, and will be distributed quarterly to network providers. At the time the profiles are distributed, providers will also receive notice of opportunities to discuss the profiling results. In general, these discussions will be part of the quarterly provider forums that will be held across the state. Discussions will focus on opportunities for improvement in the system and potential training needs.

If an individual provider profile shows significantly poorer performance than other similar providers, VOI staff will schedule a face-to-face meeting with that provider. The VOI Medical Director, Clinical Director, Quality Management Director, Substance Abuse Program Liaison, ICCs, Provider Relations Representatives, and/or other VOI staff will participate in the meeting. If necessary, a plan of corrective action will be developed and implemented. Follow-up action will be taken as necessary by the Provider Relations Representatives and QM staff.

The Process And Timeline The Bidder Proposes For Periodically Assessing Provider Progress On Its Implementation Of Strategies To Attain Improvement Goals

The positions for Provider Relations Representatives were included regionally to ensure that onsite consultation will be available to providers, as onsite consultation is a particularly important component of performance improvement for network providers. Progress will be assessed in a variety of ways. When each quarterly report is generated, the provider's performance will be reviewed by the Provider Relations Department in comparison to previous performance levels. A significant deterioration in performance will trigger the individual provider conference described above. The provider's performance also will be reviewed as part of the re-credentialing process conducted every three years.

In addition, the overall performance of all providers will be assessed at least annually by the Quality Management Department and by the Provider Relations Department to identify potential quality improvement initiatives, needs for training, and examples of excellence. Examples of excellence will be compiled so as to identify and disseminate best practices. At least annually, the QM Clinical Advisory Committee will review the provider profiling tool and aggregate results, and recommend changes for the Departments' consideration.

CONFIDENTIALITY OF PROVIDER PROFILES

Providers are often sensitive to having their individual performance information shared with others. Obviously, the Departments will determine what level of information will be made available to whom. Individual performance data are probably most important to the individual providers and VOI quality and network management staff. By monitoring the average performance of all like providers, most quality management committees and state agencies are easily able to identify trends that may suggest needs for policy changes.

Examples Of How The Bidder Has Used Provider Profiling To Improve Services Delivered By A Provider, Or Provider Type In A Managed Care Program;

As discussed in previous questions, provider profiling varies widely based on the priorities of different state and county agencies as well as the design of the program. Clinical Advisory Committees and other quality management sub-committees also have a significant influence on what is measured, the format in which it is presented, and the way in which the information is used. To demonstrate the variety of ValueOptions' profiling strategies, we will discuss three programs: the PCC program in Massachusetts, and the county-focused system in Pennsylvania.

MASSACHUSETTS

The Massachusetts Behavioral Health Partnership (MBHP) is under contract to the Division of Medical Assistance (DMA) to administer the Primary Care Clinician (PCC) Plan's Network Management Services (NMS) program. DMA requires HMOs to provide behavioral health care for their enrollees, so all Medicaid beneficiaries served through MBHP receive medical care from a PCC. Therefore, the strong quality improvement focus of the PCC NMS program complements the overall quality management focus of MBHP. MBHP has collaborated with the Division to develop, implement, and continuously improve provider profiles for PCCs. Such collaboration has focused on developing the structures and processes necessary to administer and manage the NMS program.

At present, MBHP is responsible for working with the Division to develop and publish provider profiling reports twice each year. The profiling process incorporates many activities designed to help PCCs improve the quality and effectiveness of their services, including: individually reviewing Provider Profile reports with PCCs that have 200 or more MassHealth recipients; developing "Action Plans" with individual providers that target opportunities to improve quality of care; monitoring ongoing improvements and progress toward completion of Action Plans; assisting PCCs on an ongoing basis with quality improvement initiatives; evaluating Profile Reports on an ongoing basis (at least annually); and collaborating with Division staff to continually improve the content, development, distribution, and overall quality of Profile Reports. The current Profile Report includes general information about the PCC's practice, designed to give PCCs an overview of their patients.

PENNSYLVANIA

The Value Behavioral Health of Pennsylvania (VBH-PA) Service Center serves 14 counties, and their approach to provider profiling was designed to provide the information requested by those counties and their providers. As a result, VBH-PA:

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- profiles providers of Behavioral Health Rehabilitative Services (BHRS) separately from other services (BHRS were developed for children and adolescents under the Medicaid rehabilitation option and operate under different regulations than other services in the Pennsylvania HealthChoices program);
- profiles service utilization and provider performance by county as part of the individual contractual requirements of each of the Service Center's nine county partners; and
- profiles service utilization and provider performance of high volume providers across the nine-county area.

County-by-County Utilization Profiling — The county-specific profiling has been designed to track each county's behavioral health care delivery and to examine utilization patterns and trends in care. The QM Department also does a county-specific statistical analysis of the following indicators for inpatient mental health providers who discharge more than ten Southwest Pennsylvania HealthChoices members in a calendar year:

- readmission rates,
- length of stay,
- discharges,
- demographic data (age, gender, diagnosis), and
- voluntary/involuntary rates.

The results of this profiling, both by hospital and in aggregate, are part of the data shared with counties in their annual report. Differences between counties are analyzed and used as the basis for each county's individual quality management and network development plans.

Profiling Individual Providers — Individual network inpatient providers also are profiled based on services delivered to VBH-PA Enrollees in all 14 Pennsylvania counties. Data are divided into three groups for the purposes of analysis: providers with greater than 200 discharges, providers with 50 to 200 discharges, and providers with 10 to 50 discharges. Data for Enrollees who have Medicare primary were reviewed separately. Data for each individual provider are compared with the overall Service Center averages. The QM Department completes the initial data analysis annually, and results are sent to each provider. Aggregate findings are shared with the Clinical Advisory Committee to help identify training needs, potential areas for implementation of EBPs, and examples of provider excellence. Based on the most recent analysis:

- the average length of stay decreased slightly to 7.24 days;
- the involuntary rate was at 27.7 percent, an increase of four percent; and
- the readmission rate was 14 percent for zero to 30 days, 5.5 percent for zero to seven days, and 8.6 percent for eight to 30 days.

REWARDING PROVIDER EXCELLENCE AND/OR SIGNIFICANT IMPROVEMENT

VOI suggests two strategies for rewarding provider excellence:

Strategy 1. Incentivize The Adoption Of Evidence Based Practices That Meet Fidelity Guidelines —

The first proposed strategy would rely on enhanced rates for adoption of and fidelity to identified EBPs. VOI would work with the Departments to identify and prioritize the EBPs to be eligible for enhanced rates. VOI would then work with providers to develop code modifiers for billing and protocols for determining fidelity to the models. Strategic relationships with researchers and the University's will assist with them process.

Strategy 2. Reduced administrative burden through the adoption of the ValueSelectSM Provider Program —

In addition to the protocols listed above, VOI will use additional tools to facilitate authorization of services and utilization management in an efficient and cost effective manner. One of these tools, ValueSelectSM, is our recently implemented provider reward program, and is designed to identify and reward providers who are high performers. Providers under the ValueSelect designation use proven treatment techniques, comply with our credentialing and quality standards at 100 percent, have consistently positive results on key outcome measures and commit to supporting data collection that further advance the field. These distinguished providers have technological resources and administer a majority of their transactions online using ValueOptions' secure technology.

Evidence-Based Practices — ValueSelect endorses and supports EBPs, and looks for providers who have received verifiable, advanced training in treatment techniques that have been shown to be clinically effective.

ValueSelect Member Questionnaire Data Collection — To support quality improvement efforts and to give our providers valuable feedback regarding their practice, ValueSelect providers are expected to encourage their patients to complete ongoing satisfaction surveys regarding their experience with treatment. These satisfaction surveys are in addition to those completed bi-annually as part of the QM evaluations. By obtaining feedback on their treatment experience, ValueOptions helps to ensure high-quality behavioral health services. Members can complete the survey by calling a new toll-free number and answering the brief survey, or by accessing the survey on MemberConnect. Members are being educated about the survey through an informative message that will soon be found on the Explanation of Benefits (EOB) document, or from a card the ValueSelect providers will be offering to their patients at their appointments.

ValueSelect Benefits — There are several benefits for providers who join the ValueSelect program:

- **Opportunity for increased referral volume** – ValueSelect providers are identified in our provider search engine, ReferralConnect, which is used by ValueOptions’ clinical staff, clients and Enrollees to identify providers for potential Member referrals;
- **Educational opportunities** – ValueSelect providers are invited to participate in Continuing Medical Education (CME), CEU, or Professional Development Hour (PDH) offerings at no charge.
- **Training Discounts** – ValueOptions has partnered with Behavioral Tech, LLC a nationally renowned EBP training organization, and offers a 10-percent discount on training for ValueSelect providers.
- **Regular Feedback on Performance** – ValueSelect providers will have access to feedback regarding their performance.

The ValueSelect designation reflects our commitment to identify providers for their excellence in practice and outcomes, and to help Enrollees make the best choices for themselves and their families.

VALUESELECT FACILITY PROGRAM

ValueOptions’ Facility ValueSelect Program supports the identification of high-quality inpatient programs and referrals of Enrollees. The Facility ValueSelect Program identifies inpatient facilities that have exhibited track records of consistency with regard to specific metrics. Included in these metrics are patient length of stay, length of certification, step-downs to alternate levels of care, appropriate and timely discharge plans, and key quality indicators such as applicable HEDIS measures (i.e., seven-day and 30-day ambulatory follow-up rates) and readmission rates.

Facilities that have partnered with us in this program generally receive an initial block certification for the inpatient level of care if the patient meets medical necessity at time of pre-certification. The numbers of days for the block certification are based on historical data that indicates how the facility has been able to manage the stays within certain lengths of stay. Concurrent reviews are not necessary during the “block certification” timeframes.

We then have monthly telephonic meetings with the facility to monitor and discuss the data and/or any other issues that may impact the indicators. We work toward assisting the facility to succeed, and offer whatever resources we might bring to bear in order to optimize the continued success of the partnership. If facilities have difficulties maintaining the standards, we make every attempt to work with the facility to return to baseline so that the partnership can continue. Our experience with this type of program has been quite successful, and has proven to be a true “win-win” situation for ValueOptions and our key inpatient facilities/partners. The following criteria are monitored for inclusion in the ValueOptions’ Facility ValueSelect Program:

- demonstrated history of collaboration with ValueOptions on treatment planning and coordination of care,
- facility compares favorably to the average community length of certification for care,
- facility meets HEDIS standards for discharges and has acceptable ambulatory follow-up rates,
- facility maintains readmission rates lower than the community standard,
- complaints from Enrollees meet acceptable standards,
- adverse incidents meet acceptable standards,

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- claims are correctly submitted with all appropriate information, and
- compliance with Quality Improvement audits.

ValueOptions will also conduct periodic onsite reviews for quality. Onsite reviews of quality are done when a pattern of quality of care or quality of service is identified. ValueOptions is in compliance with the URAC standards for onsite reviews.

VALUESELECT OUTPATIENT CLINIC PROGRAM

Similar to the Facility ValueSelect program, ValueOptions has a ValueSelect Outpatient Program for select outpatient mental health/substance abuse providers who demonstrate excellent service. This program has been in place for 12 years. Performance metrics include the average number of sessions, average number of sessions by diagnostic category (i.e., mood disorders or substance abuse disorders), average number of sessions by age category (i.e., child 0 – 12 or geriatric 65+), and other categories, such as cases referred to Integrated Care Coordination Programs, PCP integration, and quality indicators such as complaints/grievances. The Outpatient ValueSelect Program incorporates the same principles and is designed to identify and reward providers who are high performers and who meet more stringent requirements, including advanced training. Through this program ValueOptions works to establish relationships with our providers and facilities to ensure excellent quality of care for all Enrollees. ValueOptions selects providers based on the following criteria:

- providers who use ProviderConnect for key transactions;
- providers who comply with ValueOptions’ credentialing and quality standards at 100 percent; and
- providers with verifiable advanced training in identified EBPs.

SHARING BEST PRACTICES

In addition to implementing selected EBPs, VOI also will support the identification of best practices within the Iowa Plan provider network. Some of the ways in which best local practices will be identified and highlighted include the following:

- Sharing information on clinical outcomes of new treatment programs will be a standing agenda item for QM committees.
- Providers who regularly qualify for ValueSelect or have the best scores on provider profiles will be asked to give presentations at QM committees, provider training, or VOI in-service sessions.
- Providers with the best documented clinical outcomes will be featured in VOI provider communications and in articles posted on the Web site.
- **Weekly Newsletter** – In order to maintain continuous communication with providers, we have established a weekly online newsletter for Iowa providers. Key topics will be customized to the Departments’ needs and may include:
 - a clinical feature (i.e., the availability of provider resources and tools such as our award-winning member content site at Achieve Solutions);
 - a claims payment tip;
 - a “provider spotlight” or feature provider, recognizing a key contribution to the consumer community or award; and
 - training opportunities (i.e., both ValueOptions’ sponsored Webinars and/or training discounts coordinated by ValueOptions).

Feedback regarding the weekly newsletter has been tremendously positive, with providers under other state contracts telling us that they anticipate reading it each week. This vehicle not only gives providers additional technical support, but heightens provider interest and involvement in system expansion initiatives.

- **Provider Alerts** – In order to assure key policy changes are quickly and appropriately communicated, ValueOptions disseminates Provider Alerts through an email notification and posting of these provider alerts online. For ease of review, Provider Alerts are continuously available to the provider through ProviderConnect, and can be easily sorted by content or date through the ProviderConnect search functionality. Additionally, provider alerts will be sent when identified through PharmaConnect, as described later in this proposal.
- **Face-to-Face Provider Trainings and Monthly Webinars** – VOI will offer trainings in a variety of ways including face-to-face programs and Webinars for Iowa providers. Topics covered in recent months for ValueOptions’ providers in other states have included:
 - Obtaining and Maintaining Network Status,

- Specialized Care Coordinated Service,
- ValueOptions’ Commitment to Program Integrity,
- Quality Of Care and Critical Incident Reporting, and
- Enrollment and Billing Manual/EFT.

In order to minimize provider burden traveling to and from provider trainings, losing clinical appointment time, and the expense and hassle of traveling, Webinars have become the preferred method of reaching providers.

- **Provider Web Site** – VOI’s provider Web site at www.valueoptions.com/demos/iowa, will provide easy access to contract specific requirements for VOI providers.
 - **Message Center** – A component of the Web site, the message center, is designed to “push” personalized, individualized communications to our providers via a secure message center. For example, provider performance reports and other confidential information may be delivered through this application. The message center allows the provider to send and receive responses to inquiries, operating much like a personal e-mail box.
- **Auto-Dialer** – The auto-dialer is a computer-based program that generates phone calls, delivering a personalized message to a human or an answering machine, with the ability to connect the provider with a ValueOptions’ representative. The auto-dialer is a convenient means of submitting a brief message regarding upcoming functions (i.e., provider forums or Webinars) or to highlight more detailed information available on the Web site or provider handbook.
- **Medical Grand Rounds** – To support clinical consultations and peer review, weekly medical grand rounds will be conducted with applicable providers and VOI medical staff to identify strategies to address difficult cases. Although frequently managed telephonically, in other states, ValueOptions has installed video-conferencing equipment in our Service Centers and Regional Offices to support these clinical consultations as well as training forums.

“The web trainings have been such a boost to me both from a professional and administrative standpoint. I was struggling with claims payment issues and since the training on electronic funds transfer, I’m finding significant improvements in my cash flow. The clinical trainings have been helpful as well; I know of no other managed care organization offering such a wide array of educational opportunities. Thank you.”

SPECIALTY PROVIDER FORUMS

As part of our commitment to the ongoing education and training of providers, ValueOptions organizes and presents specialty forums on a wide variety of topics that are identified by provider relations staff, providers, Enrollees, family members, and advocates. Forum topics may include cultural competency and diversity, psychotropic medication updates, strategies for interfacing with PCPs and others who serve our Enrollees, and discussions of promising practices presented by those providers who have demonstrated excellence in a particular treatment approach.

How The Bidder Would Penalize Providers Who Demonstrate Continued Unacceptable Performance Or Performance That Does Not Improve Over Time

As described earlier in this response, VOI will make every effort to support providers’ continuous improvement. Provider profiling, provider credentialing and recredentialing, provider participation in QM Committees, discussions with CCMs, consultations by the Medical Director and Peer Advisors, and a number of other strategies will be in place to support network providers. CCCs and CPRCs will be located across Iowa to support Iowa Plan providers. When a provider’s performance does require improvement, a corrective action plan will be developed, implemented and monitored. In some instances, referrals will be stopped until the provider’s performance reaches an acceptable level. In the most extreme instances, network status will be terminated. Our provider contracts allow for due process for the provider. VOI will involve the Departments in the review and termination process at their request.

PROVIDER MONITORING

Monitoring Through Recredentialing — ValueOptions has taken disciplinary action against providers as a result of audits or the recredentialing process. To ensure the continued safety of our membership and our staff, ValueOptions diligently monitors individual providers and facilities on their compliance with our quality of care protocols and procedures. Extensive qualities of care and/or service indicators monitored by ValueOptions include but are not limited to provider inappropriate and/or unprofessional behavior, clinical practice-related issues, access to care-related issues,

and attitude and service-related issues. Additional monitoring items are added based on the unique needs of our public sector customers. A full description of the quality of care/service indicators that ValueOptions monitors is provided on the VOI Website at: www.valueoptions.com/demos/iowa.

CORRECTIVE ACTION PROCESS

Our National Network Operations Department regularly reviews disciplinary action/sanctions reports, via the Web site or hardcopy publication, to identify any practitioners that have been sanctioned by Medicare/Medicaid, the appropriate state agency, licensure or certification board. If issues are discovered, ValueOptions requests information about the sanction/disciplinary action from the NPDB and OIG provider sanctions database. With the permission of DHS, ValueOptions of Iowa will include a review of the CMS Medicare Eligibility Data file (MED) provided to all Medicaid Agencies. All information is forwarded to the ValueOptions National Credentialing Committee (NCC) to review and to take any appropriate action. The NCC must approve any monitoring or suspension of network participation for all practitioners/facility providers. Any ValueOptions’ staff member may notify our Provider Relations Department regarding a potential quality-of-care issue, incident, or improper action by a practitioner/facility. Provider Relations reviews the notification and forwards the information to National Networks (if necessary). National Networks then determines if any prior history of compliance actions or sanctions exist for the identified practitioner/facility, and reports the results back to Provider Relations staff. Existing historical information assists in determining what level of corrective action or sanction may be necessary. Provider Relations reviews the prior history (if any) and reports the results to the VOI Provider Relations Director and the Iowa Service Center Vice President.

The Provider Relations and/or the Iowa Service Center Vice President determines what type of corrective action is appropriate for the identified compliance issue. The following corrective actions are used by ValueOptions to address provider quality of care issues, incidents, or improper actions.

Consultation — Incidents requiring consultation include the first occurrence of:

- balance billing,
- failing to notify ValueOptions of an address change,
- rudeness,
- inappropriate care,
- providing clinical care without pre-authorization,
- not meeting routine access standards,
- referring patients to out of network practitioners, and
- non-participation with the quality improvement program.

When a consultation is indicated, the Medical/Clinical Director or designee contacts the practitioner or facility to discuss the alleged action or improper incident. The practitioner will be provided with an explanation of possible sanctions if corrective actions are not taken. A Consultation Form is completed and forwarded to the National Networks office and the practitioner/facility (via certified mail). National Networks places a copy of the Consultation Form in the practitioner or facility file. The call will be documented to include the date and subject for consultation. Appropriate educational materials will be sent via certified mail.

Written Warning — Incidents requiring a written warning include the first occurrence for not meeting urgent and emergent access to care standards, and the second occurrence of issue(s) previously given a consultation.

When a written warning is indicated, the Medical/Clinical Director or designee provides written notification and any educational materials regarding the improper action to the practitioner/facility via certified mail and forwards a copy to National Networks, which files a copy in the provider’s file. Possible sanctions, if corrective actions are not taken, will be explained. Corrective action will be monitored as necessary.

Monitoring — Monitoring is conducted by ValueOptions’ staff (NCC, Regional Medical Director, Provider Relations, Chief Medical Officer, Quality Management) when data from one or more of the following indicate that ValueOptions’ standards are not met:

- credentialing criteria – malpractice/litigation issues,
- administrative issues,
- site visit results,
- utilization patterns,
- quality concerns, and
- treatment Record Audit results.

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The monitoring may last for a period of 30 days, during which time an investigation may take place; however, the NCC may extend this time period as necessary to gather additional information. Monitoring is only used for serious infractions that are probable cause for termination.

Routine Involuntary Disenrollment — Routine involuntary disenrollments terminate the provider/facility’s contract for breach of contractual obligations, such as, but not limited to:

- non-responsiveness to the recredentialing process,
- the practitioner can not be located,
- non-renewal of the agreement (without cause), or
- the practitioner is deceased.

Upon NCC or Medical Director approval, the disenrollment team sends the provider a notice via certified mail regarding the termination of his or her participation in the network(s) within five business days of the decision date. The written notification of involuntary disenrollment outlines the appeal process available to the provider. Copies of all documentation related to the disenrollment are appropriately filed in the provider’s electronic record within NetworkConnect.

Immediate Involuntary Disenrollment — Immediate involuntary disenrollment is the process for terminating a provider for non-compliance with ValueOptions’ established network participation requirements as outlined in the agreement, including but not limited to:

- loss of license,
- loss of malpractice insurance coverage,
- Enrollees endangerment.
- loss of primary admitting privileges, and/or
- felony conviction.

When ValueOptions is notified via internal or external sources that a provider may be recommended for immediate, involuntary disenrollment, the Credentialing Administrator (CA) gathers additional information and completes an Advisory Form that includes all facts leading to the immediate involuntary disenrollment recommendation. The CA notifies the VOI Director of Provider Relations and the appropriate Medical Director or designee of the pending action and seeks a written recommendation regarding the disenrollment. The written recommendation must be dated and signed by the staff submitting the recommendation.

Upon approval of the National Credentialing Committee and the General Counsel, the NCC Liaison sends the written notification, via certified mail, to the practitioner within 10 business days of the date of the NCC decision. Practitioners who have been immediately involuntarily disenrolled from the network are not eligible to re-apply.

b) Describe any comparable network management activities performed by the Bidder for other state clients.

ValueOptions provides network management activities for Massachusetts, Kansas, and Texas NorthSTAR, to name a few. We have more than 20 years of experience recruiting, contracting, credentialing, and monitoring behavioral health network providers and facilities for public sector clients.

c) Provide copies of provider profiles that the Bidder has employed for two clients, and describe measurable performance improvement achieved as a result of such efforts.

We have provided copies of provider profiles ValueOptions has used for two Public Sector clients as **Attachment 2**.

MEASURABLE PERFORMANCE IMPROVEMENT ACHIEVED

We provide details about the performance improvement achieved based on provider profiles prepared by our Pennsylvania Service Center.

Pennsylvania

Inpatient Provider Profiles — Three areas of improvement were targeted as a result of the inpatient provider profile reports: follow-up after discharge rate, reporting critical incidents, and readmission rates. The improvements for each of the three areas identified above are provided below:

- **Follow-Up after Discharge Rate** - The VBH-PA Provider Profiling Advisory Committee targeted the follow-up after discharge rate as an area of improvement in 2006 based on the results from the inpatient provider profiles. An action plan was developed, which involved individual phone conferences between VBH-PA's QM Department and county representatives. Based on these discussions, the follow-up after discharge rate increased slightly from 44 to 45 percent.
- **Reporting Critical Incidents** - In 2006, 10 of the 27 providers included in the inpatient provider profile did not report critical incidents. As a result, VBH-PA sent letters to the remaining 17 providers reminding them of their contractual requirement to report critical incidents to VBH-PA. As a result, in 2007, approximately 23 of the 27 providers reported critical incidents.
- **Readmission Rate and Involuntary Rate** - In 2006, one of the profiled provider's readmission rates of 24.3 percent were targeted for an action plan. Part of this action plan included ongoing meetings with this provider and VBH-PA's Medical Director and Clinical Department to address the high rate of readmissions. As a result, the 2007 readmission rate for this provider decreased to 18.8 percent. Additionally, another provider's high involuntary rate decreased from 24.2 percent in 2006 to 23 percent in 2007 as a result of an action plan examining the timeline between the commitment process and the request for authorization by the hospital.

Outpatient Provider Profiles — As a result of the outpatient provider profiles conducted from July, 2007 to June, 2008, the following improvements were achieved:

- 56 percent of providers met the standard of offering the first appointment after discharge within seven days (an increase from 50 percent in the previous year); and
- 29 percent of providers met the 85-percent performance goal for adherence to best practice guidelines for ADHD, bipolar disorder, major depression, and schizophrenia (an increase from 21 percent in the previous year).

Behavioral Health Rehabilitation Services Provider Profiles — VBH-PA conducted provider profiles for 22 providers who deliver behavioral health rehabilitation services. This profile focused on the average cost per member to the VBH-PA average for each diagnosis, an outlier analysis by diagnosis, and provider-specific complaint and peer review information. As a result of the profiles conducted from April, 2007 to March, 2008, the following improvements were achieved:

- the average cost increased from \$12,110 in the previous year to \$12,164 for an increase of approximately 0.05 percent;
- the overall distinct member count increased from 2,710 the previous year to 2,939 for an increase of eight percent; and
- treating Enrollees with a primary diagnosis of Autism Spectrum Disorder (ASD) comprised 59.4 percent of the total behavioral health rehabilitation services dollars paid, while ADHD accounted for about 16 percent of the total paid amount. There was an 11.7 percent decrease in the average units per member for ASD and nine percent decrease in the average units per Enrollee for ADHD from the previous year.

d) Describe the Bidder's plan to assure the accuracy of I-SMART data submitted by the providers of substance abuse services (Section 4B.5 (pgs. 60-61)).

VOI will ensure the integrity of the data collected through the I-Smart system by conducting follow-up validation through retrospective onsite reviews and focused studies. Annually, VOI will utilize the data collected to refine the QM Plan, making recommendations for further refinement, review, or study of the I-Smart data to improve care and delivery of services and better utilize public funds.

The VOI QM Department will hold the central responsibility for monitoring the accuracy of information included in I-SMART, and will be assisted in this activity by the Provider Services Representatives and our National Provider Relations Team.

- a) Describe the Bidder's experience in using data-driven evaluation of organization-wide initiatives to improve the health status of covered populations. Provide quantified, statistically significant evidence of:
- improved mental health quality – process measures;
 - improved substance abuse quality – process measures;
 - improved mental health quality – functional or clinical outcome measures;
 - improved substance abuse quality – functional or clinical outcome measures;
 - improved mental health quality – consumer-reported outcome measures, and
 - improved substance abuse quality – consumer-reported outcome measures.
- Include the names of the programs and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

Within VOI, responsibility for organization-wide initiatives to improve the treatment outcomes and health status of those served through the Iowa Plan will be coordinated by the Quality Management (QM) Department. However, because every functional area will have an impact on VOI's organization-wide initiatives and overall effectiveness, every Service Center Department will be responsible for defining, monitoring, and reporting on performance indicators.

To provide a framework for organization-wide accountability to the Departments, VOI will develop a QM Plan that will be reviewed by the Iowa Plan Advisory Committee and its Sub-committees. It will include a description of each committee and its responsibilities, data that will be reported for committee review, and the program's annual goals. Prior to its implementation, the QM Plan will be submitted to the Departments for approval. The Plan will be revised and reviewed annually.

OVERVIEW OF QUALITY MANAGEMENT COMMITTEES

As described in more detail in *Section 7A.2.14 (d)* below, the entire QM Program is designed to assure involvement of all stakeholders in monitoring the effectiveness of the Iowa Plan for Behavioral Health. The committee structure is the vehicle for that involvement. Eligibles and family members will be represented on all committees and sub-committees.

The VOI QM Program will include the following components:

- The Departments' **Iowa Plan Advisory Committee** will serve as the Steering Committee and include members from all Sub-committees and others appointed by the Departments. It will be co-chaired by representatives of DHS and DPH.
- The **Consumer Advisor Council** will advise the Executive Leadership Team on all aspects of the operation, quality of care, consumer communications, recovery, and system performance. It focuses on issues relevant to adult consumers. The Council will be chaired by a consumer; VOI staff will provide administrative support.
- The **Family Advisory Council** will advise the Executive Leadership Team on all aspects of the operation, quality of care, communications, resiliency, and system performance. It focuses on issues relevant to families, caregivers, and support system who are caring for an individual experiencing a serious emotional disturbance. The Council will be chaired by a family member; VOI staff will provide administrative support.
- The **Iowa Plan Clinical Advisory Committee** will be chaired by the Medical Director, and oversee development and implementation of all clinical policies and procedures, including utilization management guidelines.
- The **Adult Services Sub-committee** will review coordination and integration of mental health services for adults, especially those with serious and persistent mental illness (SPMI). Members will include CPCs, advocates, consumers and VOI. Data from the SPP also will be reviewed by this group. A subcommittee of this group will also specifically focus on the service needs of older adults.
- The **Youth Services Sub-committee** will include representatives of DHS and JCS as well as others from Iowa's child-serving agencies, will provide a forum to address and resolve issues in policy, procedure, training needs, and related concerns.
- The **Substance Abuse Services Sub-committee** will include representatives of substance abuse programs and the Department of Public Health (DPH) as well as others requested by the Departments, will focus on the development of services to people with dual diagnoses as well as other issues related to coordination and service delivery.

Participation in committees is always a challenge in statewide programs. Therefore, VOI's Intensive Care Coordinators (ICCs) and Provider Relations Representatives will host quarterly, regional QM forums to encourage input from across the State. The statewide committees will define discussion topics for the regional meetings, and input from the regional participants will be funneled back to the appropriate QM Committee. The regional QM Forums will also be an important component in the process of defining and disseminating best practices in substance abuse and mental health treatment.

Reimbursement for Eligible Persons and Family Members — All VOI QM Committees will include Eligible persons and family member representatives. To encourage their participation, Eligible persons will be reimbursed for their travel expenses. In addition, with the approval of the Departments, Eligible persons and family members will be paid for their participation in QM activities.

Examples of Improvement — ValueOptions has implemented clinical quality improvement initiatives using findings from data-based evaluations in all of its public sector Service Centers. The following examples were selected to demonstrate the scope of quality improvement programs currently underway.

IMPROVED MENTAL HEALTH QUALITY – PROCESS MEASURES

Massachusetts — The Massachusetts Behavioral Health Partnership (MBHP) analyzes authorization and claims data to assure clinical effectiveness and consistency of service to enrollees by the 43 acute psychiatric hospitals in its network. The study was initiated in response to concerns of MBHP clinicians, advocacy organizations and the Department of Medical Assistance about the difference in utilization patterns between various hospitals and the hospitals' compliance with expected levels of performance. When the quality of care initiative was begun, the MBHP QM staff used authorization and discharge data to calculate average length-of-stay (LOS) by hospital. The average LOS was then risk-adjusted according to the Massachusetts Medicaid aid categories (disabled, families, and other case-mix variables). The risk-adjusted LOS for each hospital was then compared to the average risk-adjusted LOS for all 43 hospitals in the MBHP network. Based on statewide averages, compared to a given hospital's actual average LOS, MBHP established a risk-adjusted, expected LOS.

Once a hospital's expected LOS was established, MBHP staff met with the hospital to explain the rationale for the expected LOS and to adjust the risk formula, as needed (e.g., if the hospital has unforeseen case-mix issues). After the hospital profile was explained to each hospital, MBHP staff reported that few hospitals questioned the established target. In the first year of the initiative, MBHP worked individually with the hospitals with the longest LOS to improve their clinical systems and implement best practices, such as establishing immediate linkages with community resources and conducting joint discharge planning. Incentives, such as automatic five-day authorizations for new admissions, also were established for hospitals that achieved their expected LOS target. For hospitals with risk-adjusted lengths of stay that fell below the statewide average, MBHP provided consultation to improve their clinical systems, but these hospitals were not expected to achieve further reductions in their LOS. In fact, if a hospital's LOS was significantly below the mean, MBHP performed record audits to assure that MBHP enrollees in those hospitals had received sufficient care within the relatively short period of hospitalization.

Pennsylvania: Second Generation Atypical Antipsychotic Prescribing Practices — Antipsychotic medications are an important component in the medical management of many psychotic conditions. With the introduction of Second Generation antipsychotics, the use of these medications has greatly increased. Although there are many notable benefits, their use has been associated with reports of dramatic weight gain, diabetes, and an atherogenic lipid profile (metabolic syndrome). As a result of these health concerns, a consensus statement was published identifying best practices for prescribers in monitoring for metabolic syndrome.

In 2006, the Value Behavioral Health of Pennsylvania (VBH-PA) Service Center began auditing high volume prescribing practices for 16 indicators of monitoring for metabolic syndrome, and the follow up action taken by prescribers when it was indicated. The quality improvement initiative has continued with annual audits, and in the past year, corrective action planning from prescribers. Prescribers have shown steady improvement over the past three years.

IMPROVED SUBSTANCE ABUSE QUALITY – PROCESS MEASURES;

Prior to the implementation of managed care in 2007, the state of Kansas did not have a consistent and accurate way to measure access to services. The state of Kansas drew on ValueOptions’ national experience to measure performance standards for access to care. At the State’s request, ValueOptions implemented and uses a State-designed authorization system to measure access standards. The State also worked with ValueOptions to include access to care standards as part of provider contracts. Upon the recommendation of providers, the following were implemented across the state:

- partnering with the Regional Alcohol and Drug Assessment Centers to create 24 hours a day, seven days a week mobile assessment and placement teams;
- opening up the Block Grant and Medicaid network in order to meet geographic access standards;
- raising provider reimbursement rates to help offset costs associated with increasing access;
- developing a provider directory to include hours of operation and emergency contact information to help with the referral process;
- working to create codes for telemedicine to provide a cost effective way to provide treatment for rural Kansans; and
- adopting access to care as the outcome measure for FY09 which allowed providers to share results of barrier analyses and best practices for interventions.

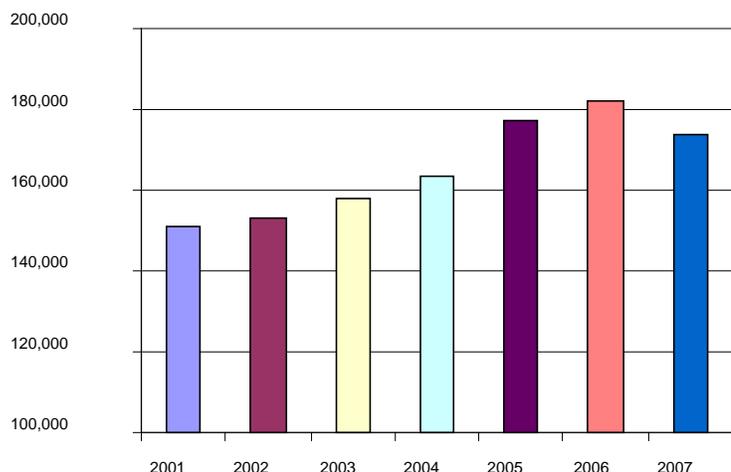
ValueOptions also made internal changes to ensure successful access to care. Two best practices that were created because of access to care requirements were the development of an intensive case management team and utilizing regional provider relations representatives. Intensive Case Coordinators (ICCs) are assigned to high-risk populations to ensure that these members receive timely access to needed services. ICCs contact the members and the providers in order to facilitate timely placement into the treatment location that will best suit the member’s unique treatment needs. Provider relations staff conduct onsite provider visits on a quarterly basis to review data and help answer questions. In order to help improve access to care, the staff’s role was expanded to include helping providers review and eliminate member wait lists. Provider relations staff educate providers about their specific wait times and help them eliminate barriers to timely access.

Measuring success — One of the key indicators for access is how long a member had to wait from the time of assessment to treatment. The State had an existing wait list system in place however; very few providers knew about or accessed their list on a regular basis. ValueOptions developed reports to show providers how long their members were waiting and the level of care recommended. Quarterly analysis of statistical data including weighted averages showed that because of the efforts of ValueOptions staff, the number of members on the wait list decreased by over 86 percent. When comparing utilization data from Q1 2008 to Q1 2009, ValueOptions has also served over 400 more Medicaid members and 1,000 more Block Grant members. This is another indicator that access to care has increased dramatically within the State as a result of stakeholders coming together to improve care.

IMPROVED SUBSTANCE ABUSE AND MENTAL HEALTH QUALITY – PROCESS MEASURES;

In Pennsylvania, one of the State’s targeted areas for improvement in implementing a managed care program for behavioral health was demonstrating improved access to mental health and substance abuse services. Through improving the continuum of care as well as consumer educational initiatives and embracing a recovery-based paradigm, Pennsylvania has been successful in this regard. Penetration rates are utilized as an additional measure of overall utilization of services and an evaluation of the saturation into the eligible population. Penetration rates are defined as the percentage of distinct members for which claims have been paid

**Enrollment 2001-2007
Nine County**



based on the total enrollment. A lag of five months is implemented to ensure that claims have been received and paid. Overall penetration for all levels of care in all nine counties increased from 17.16 percent in 2001 to 25.2 percent in 2007. The impact of targeted activities to improve the continuum of care in Pennsylvania is demonstrated by the clear improvement in access.

IMPROVED MENTAL HEALTH QUALITY – FUNCTIONAL OR CLINICAL OUTCOME MEASURES

Improving Compliance with Pennsylvania Clinical Best Practice in Suicide Risk Assessment — In 2007, a VBH-PA baseline study was conducted regarding barriers to suicide risk assessment and treatment. A chart audit of serious suicide attempt cases over a six-month period indicated that the majority of individuals who attempted suicide had been in treatment less than seven days before the attempt, most often the therapeutic contact was void of any individualized crisis prevention planning or comprehensive risk assessment. In addition, a content analysis of responses from consumer focus groups revealed that more than half of consumers indicated that they would not tell their therapist if they had suicidal feelings. These findings were shared with providers, along with feedback from Quality Management Committees (QMCs), and tools for intervention. A chart audit re-measure demonstrated improvement in crisis prevention planning. Further interventions with providers are being designed in 2009.

Follow-Up After Inpatient Hospitalization

Research has demonstrated that patients who do not have an outpatient appointment after discharge were two times more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment. An outpatient visit within at least 30 days (ideally seven days) of discharge is necessary to ensure that the patient’s transition to home and/or work is supported and that gains made during hospitalizations are maintained. Re-hospitalization rates are often used as an indicator of the effectiveness of inpatient treatment. Ambulatory follow-ups help ensure that treatment regimens, including psychiatric medication and therapy, are being followed, which in turn reduces the chances of recurrence and readmission.⁶ VBH-PA members with multiple discharges on or before December 1, 2007, more than 30 days apart, and with a principal diagnosis indicating one of the mental health disorders specified, were counted more than once in the eligible population. If a discharge for one of the selected mental health disorders was followed by readmission or direct transfer to an acute mental health facility within 30 days after discharge, only the discharge from the readmission or direct transfer was counted if that readmission discharge date occurred on or before December 1, 2007. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS 2002 methodology for Follow-Up After Hospitalization for Mental Illness measure.

After the 2007 re-measurement, results have been analyzed and the interventions reviewed. From re-measurement year 2006 to re-measurement year 2007, VBH-PA’s program increased on all four follow-up after hospitalization indicators:

- Indicator #1 (HEDIS 7-day): Increased from 38.1 percent in 2006 to 42.9 percent in 2007
- Indicator #2 (HEDIS 30-day): Increased from 61.3 percent in 2006 to 66.1 percent in 2007
- Indicator #3 (PA-Specific 7-day): Increased from 43.4 percent in 2006 to 55.3 percent in 2007
- Indicator #4 (PA-Specific 30-day): Increased from 68.7 percent in 2006 to 73.8 percent in 2007

Summary of Quality Improvements — From the 2004 baseline year to the 2005 re-measurement year, the Pennsylvania Service Center improved on follow up after discharge rates for Quality Indicators #1, #2 and #4 and remained statistically unchanged for Indicator #3. From re-measurement year 2006 to re-measurement year 2007, the follow-up rates increased overall, and either increased or remained stable for all counties except one, which had an increase in Indicator #3 only. The following table shows the baseline and re-measurement rates.

	2004 Baseline	2005 Re-measurement	2006 Re-measurement	2007 Re-measurement
Indicator 1	35.3%	40.7%	38.1%	42.9%

⁶ Reference: Commonwealth of Pennsylvania Follow-up After Hospitalization for Mental Illness External Quality Review Project, June 29, 2004, page 8

	2004 Baseline	2005 Re-measurement	2006 Re-measurement	2007 Re-measurement
Indicator 2	59.3%	63.3%	61.3%	66.1%
Indicator 3	44.9%	44.8%	43.4%	55.3%
Indicator 4	66.2%	69.2%	68.7%	73.8%

IMPROVED SUBSTANCE ABUSE QUALITY – FUNCTIONAL OR CLINICAL OUTCOME MEASURES;

Clinical Outcomes of Chemical Dependency Treatment – Texas NorthSTAR — The purpose of this focus study was to provide evaluative feedback on the length of program stay and clinical outcomes of NorthSTAR’s step-down outpatient treatment program for individuals with chemical dependency. The following represent three goals of the study: 1) Examine profiles of overall length of treatment: Explore how various demographic profiles including substance abuse history and client characteristics impact the length of stay; 2) Examine length of stay post-transfer to the next level of care: Effective program completion requires successful transitions to the next step-down level of care; and 3) Use this information to evaluate clinical outcomes for clients completing chemical dependency treatment through NorthSTAR: Following treatment, assess quality of life as measured by indicators such as employment status and abstinence. NorthSTAR uses a model of the least restrictive setting possible. In the NorthSTAR model, there are two (2) basic settings: inpatient and outpatient. The step-down levels provided by NorthSTAR are as follows:

- Level I: Includes detoxification treatment services and includes 24 hour treatment supervision that emphasizes medical management of detoxification or other medical crisis, usually for a short period of time. Detoxification may be conducted in inpatient or outpatient residential facilities.
- Level II: Includes residential treatment that occurs in a live-in facility with 24 hour supervision.
- Level III: Includes intensive outpatient services. It is often recommended for patients transitioning from residential or hospital settings.
- Level IV: Includes outpatient treatment, one tract Level IV- nonpharmacotherapy refers to support outpatient services that do not include medications. Level IV- pharmacotherapy is a methadone maintenance or opioid substitution program.

Changes from Admission to Follow –Up — The first analysis examined the relationship between length of treatment and abstinence at follow-up. This analysis contrasted those individuals who had been abstinent during the 30 days preceding the follow-up contact to those who had not. The results indicate that those who were abstinent had been in treatment longer (mean = 31.57, standard deviation = 33.48) than those who were not abstinent (mean = 21.56, standard deviation = 23.28), a difference that is statistically significant ($p < 0.001$).

The second set of analyses examined differences between admission and follow-up on a number of outcome indicators. Although such an analysis does not offer causal evidence about program success, these descriptions can offer preliminary insight into program-related change and point to directions for future study. In these analyses, differences between admission and follow-up were examined for employment status, involvement in the legal system, abstinence, hospital and ER visits, and reported problems on a number of dimensions. With respect to employment status, chi-square analysis was used to compare the number of clients employed and unemployed at admission to the number of unemployed and employed clients at follow-up. This analysis showed that, for the 784 who had follow-up data, 709 (90.4%) had been unemployed at admission and 490 (62.5%) were unemployed at follow-up. In addition, whereas only 75 were employed at admission, 294 were employed at follow-up. This difference is statistically significant ($p < 0.001$), and shows that the ratio between employment and unemployment shifted from admission to follow-up, such that a greater percentage of clients were employed at follow-up than at admission.

With respect to legal status, chi-square analysis revealed a positive shift from admission to follow-up. For the 724 clients who had follow-up data, 321 (44.3%) were involved in the legal system at admission, whereas 183 (25.3%) were involved at follow-up. A total of 403 had no involvement in the legal system at admission, while at follow-up 541 had no involvement. The difference is statistically significant ($p < 0.001$), and shows that the ratio between legal involvement and no legal involvement shifted from admission to follow-up, such that a smaller percentage of clients were legally involved at follow-up than at admission. The table below contains average admission and follow-up scores on additional indicators. Most of the comparisons were statistically significant and indicate positive change at follow-up.

For example, clients were abstinent for a greater number of days at follow-up than at admission. Clients reported fewer days with problems at follow-up than at admission. The number of monthly ER/hospital visits did not change from admission to follow-up, and the number of visits at admission and follow-up was not significantly correlated ($r = 0.060$, $p = 0.080$).

Differences between Admission and Follow-Up on Outcome Indicators

Outcome Indicator	Mean (Std. dev) at Admission	Mean (Std. dev) at Follow-up	Significance
Number of days abstinent in prior 30 days	6.64 (9.63)	24.03 (11.66)	$p < 0.001$
Number of hospital/ER visits ^a	0.70 (0.14)	0.70 (0.27)	Non-significant
Number of days in prior 30 days with problems regarding:			
Sickness	15.24 (14.61)	2.31 (7.71)	$p < 0.001$
Employment	22.20 (13.01)	5.10 (11.15)	$p < 0.001$
Family	21.99 (13.04)	4.37 (10.48)	$p < 0.001$
Peer and social contacts	21.61 (13.32)	4.12 (10.21)	$p < 0.001$
Emotional/psychological issues	19.26 (14.15)	4.47 (10.39)	$p < 0.001$
Drugs/alcohol	23.25 (12.30)	4.83 (10.79)	$p < 0.001$

Notes. a) Because the scale for hospital/ER visits is different at admission (visits within prior 12 months) and follow-up (visits since discharge), these values have been converted to monthly rates.

While the above study was limited due to its one group design, the initial findings demonstrate positive outcomes for clients based on pre- and post-treatment comparisons.

IMPROVED MENTAL HEALTH QUALITY – CONSUMER-REPORTED OUTCOME MEASURES; Change Towards a Recovery Oriented System of Care - Pennsylvania

— Change toward a recovery-oriented system of care is taking place concurrently on both the consumer and provider levels of the service system. Part of the process of change requires persons with SMI to change their self-concept and expectations about what is possible. Likewise, practitioners and other mental health workers must alter fundamental beliefs and help create environments that teach and support personal recovery. Exploratory recovery oriented surveys were conducted with consumers in four Partial Hospitalization Programs (PHP) to identify strengths and weaknesses in supporting recovery.

Two surveys were utilized: ROSI (Recovery Oriented System Indicators), a 42-item survey that measures consumers’ perceptions of the treatment environment, and the RAS (Recovery Assessment Scale), a 41-item measure of personal recovery. In addition, the Marlowe-Crowne Social Desirability Short Scale (MC-2) was embedded within the ROSI. The scale has 10 items designed to assess and control for response bias in self-report research. Social desirability (SD) is a common response tendency with self-report measures. It is the inclination to present oneself in a manner that will be viewed favorably and to be accepted by others. Since consumers were asked to rate their current Partial Hospital Provider, during attendance at the program it was reasonable to assume that some scoring may have social desirability effects present, even though surveys were anonymous. Both surveys were administered by the VBH-PA Prevention Specialist on site at four PHP programs. Questions were read aloud, and provision was made for one-on-one help for individuals requiring assistance. Consumers were free to decline participation. The order of the survey administration was reversed at two of four sites to eliminate possible order effects in the data collection. There were 73 consumers surveyed, all 73 completed the RAS and 66 completed the ROSI.

Analyses and Results

ROSI – Recovery Oriented System Indicators — The ROSI is made up of two scales. The first scale asks how much a consumer agrees on a scale of one through four (1- 4) with various items. Agreement indicates the presence of a recovery-oriented indicator. The second scale is frequency data. It asks the consumer on a scale of 1 to 4 how often something occurs or is present in the environment. **On both scales anything less than a score of 3 indicates the consumer feels the recovery-oriented indicator is not available or occurs infrequently.** The overall mean across all items and all PHPs was 3.1, indicating some degree of recovery orientation in the treatment environments. The individual program aggregate means were as follows:

PHP A	PHP B	PHP C	PHP D	All Programs
3.1	3.3	3.0	3.0	3.1

Average responses to individual items were examined to identify possible areas for Quality Improvement. (Reverse scored items are identified by R).

ROSI Indicators with Means Below 3.0

Q#	Question	Total Mean
23	Mental health services helped me get or keep employment	2.1
15	I have enough income to live on.	2.2
27	There are consumers working as paid employees in the mental health agency where I receive services	2.4
13 R	Mental health services led me to be more dependent not independent	2.7
41	My family gets the education or supports they need to be helpful to me.	2.7
26	There was a consumer peer advocate to turn to when I needed one.	2.8
5 R	I do not have enough good service options to choose from.	2.8
14 R	I lack the info or resources I need to uphold my client rights and basic human rights	2.8
4	I do not have the support I need to function in the roles I want in my community.	2.8
6 R	Mental health services helped me get housing in a place I feel safe.	2.9
7 R	Staff do not understand my experience as a person with mental health problems	2.9
17	I have a say in what happens to me when I am in crisis.	2.9
24	I have a chance to advance my education if I want to.	2.9
36	My right to refuse txt is respected	2.9

RAS - Recovery Assessment Scale (a measure of personal recovery)

The overall aggregate mean score of the RAS indicates the general extent to which consumers in PHP understand and engage in the recovery model, and to some extent, the impact the provider has on helping consumers move forward in recovery. Survey responses are an agreement scale from 1.0 to 5.0. **Anything less than a rating of 4.0 indicates a lack of recovery processes i.e. empowerment, quality of life, hope, and symptom management.** The total aggregate mean score across programs was 3.9. Fifty one percent of the individual items had mean responses below 4.0 indicating a relatively poor perception of personal recovery. The table below drills down to those item means that had modal responses below 4.0, indicating that the majority of individual responses were less than the cut off.

Q#	RAS INDICATORS WITH MODE BELOW 4.0	Total Mean
8	I can handle it if I get sick again.	3.5
18	Although my symptoms may get worse, I know I can handle it.	3.5
28	My symptoms interfere less and less with my life.	3.3
36	I can handle stress.	3.4

The common factor that presents itself among the concerns listed above is the inability to control stress and the resulting effects on exacerbating symptoms of illness.

Summary

Consumers indicated that one third of the ROSI were not consistently present in their Partial Hospital Treatment Program, 14 items. (It should be noted that because the ROSI attempts to be broad based enough to capture most of the recovery domain, not every indicator can be affected by every treatment environment. An example would be, “I have enough income to live on.” There is limited assistance a PHP can offer. However, the majority of indicators do apply to almost any treatment environment). More than one-half of the items measuring personal recovery did not meet the cut score. Three items on the ROSI (13, 17, 41) that did not meet the cut off score, and all four items with modal responses below the cut off on the RAS (8,18,28,36) can be directly addressed through Crisis Prevention Planning.

SCALE	RESPONSE
ROSI	Mental health services led me to be more dependent not independent

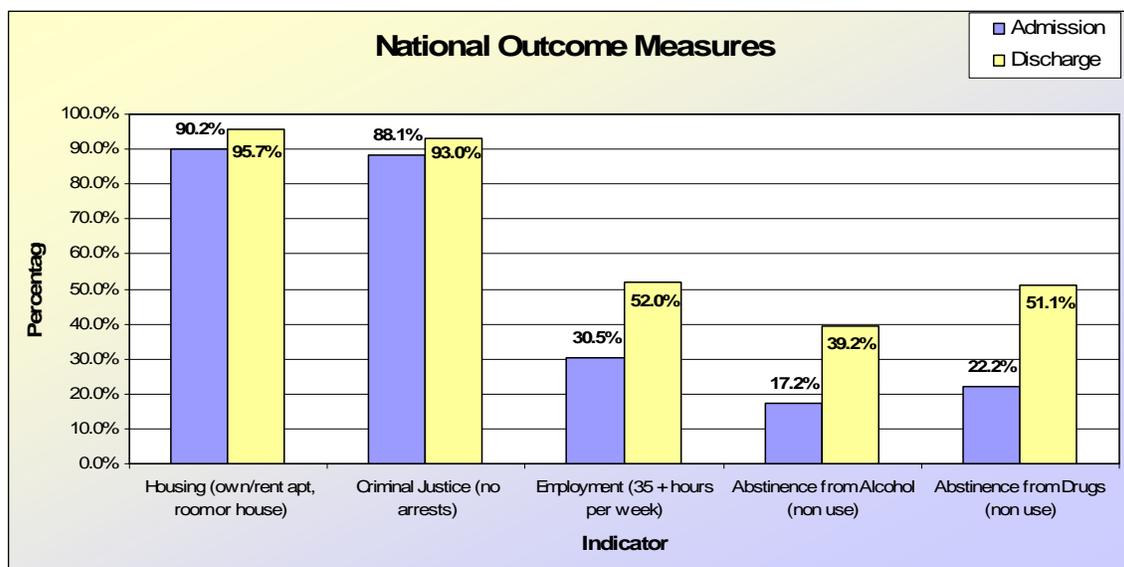
SCALE	RESPONSE
ROSI	I have a say in what happens to me when I am in crisis.
ROSI	My family gets the education or supports they need to be helpful to me.
RAS	I can handle it if I get sick again.
RAS	Although my symptoms may get worse, I know I can handle it.
RAS	My symptoms interfere less and less with my life.
RAS	I can handle stress.

Recommendations Implemented By VBH-PA To Assure Quality Improvement

- Widely disseminated the template for creating individualized Crisis Prevention Plans to Partial Hospitalization Programs;
- Facilitated the use of Peer Specialists in helping to create a CPP or WRAP plan; and
- Piloted the use of Peer Specialists and WRAP planning in one Partial Hospitalization Site.

IMPROVED SUBSTANCE ABUSE QUALITY – CONSUMER-REPORTED OUTCOME MEASURES.

Kansas Substance Abuse QIAs — During implementation of the Kansas contract, one of the largest barriers facing the vulnerable citizens of Kansas was access to substance abuse services. These results were confirmed in an annual member satisfaction survey (95% confidence level +/- 5%). When asked, “For this urgent problem, were you seen as soon as you wanted?” only 60 percent of members gave a positive response. When asked, “Were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours?” 61 percent of members responded that the wait was over 48 hour for an urgent appointment. Over the first two years of the contract, ValueOptions of Kansas (VO-KS) stressed access to care. Since national outcome measures (NOMs) data shows that treatment positively affects member recovery, improving access was the top priority for VO-KS. During the first contract year, VO-KS stressed access to care. This emphasis on access to care was reviewed utilizing the outcomes of treatment based upon NOMS data for Medicaid and Block Grant members. As seen below, the data showed that treatment improved the lives of members in the five key functional areas measured. Since NOMs data show that treatment positively affects member recovery, this emphasis on increased access and the subsequent increase in NOMs measures as reported by VO-KS members validates this approach and led to additional efforts to make substance abuse services widely available and accessible across the state.



Data compares member self-report 30 days prior to admission and discharge.

REFERENCES

The following clients will provide references regarding ValueOptions' experience in using data-driven evaluation of organization-wide initiatives to improve the health status of covered populations:

- Linda Zelch, Area Director, Western Service Area, Office of Mental Health & Substance Abuse Services, DPW; telephone (412) 565-5226; email lzelch@state.pa.us.
- Matthew Ferrara, Office of NorthSTAR and Special Initiatives; telephone (512) 206-5444; email matthew.ferrara@hshs.state.tx.us.
- Karen Andersson, Ph.D., Director of Mental Health, Connecticut Behavioral Health Partnership, Connecticut DCF; telephone (860) 550-6683; email Karen.andersson@ct.gov; and Mark Schaefer, Ph.D., Director, Medical Policy and Behavioral Health; telephone (860) 424-5067; email Mark.schaefer@ct.gov.

- c) Describe the Bidder's experience with implementing instruments in publicly funded managed care programs that assess changes in functional status and/or recovery. Specify the tools, the populations and subpopulations of consumers with whom the tools were applied, the size of the sampled groups, the nature of the findings, and what was done with the captured information.

Assessing changes in functional status, clinical outcomes and/or recovery are part of ValueOptions' Quality Management Programs. Examples have been provided in response to various questions throughout this proposal, and also in response to previous sections of this question. Examples from the Massachusetts Behavioral Health Partnership, which have not been previously offered, are summarized below.

MASSACHUSETTS

MBHP has a strong commitment to promoting the principles of recovery and rehabilitation within its provider network. MBHP has a director of recovery and rehabilitation who oversees a variety of programs and activities. MBHP has sponsored a variety of peer support services that have been offered through network providers and mental health club houses. A particularly successful model has been two "peer support in aftercare" programs.

Clinical Outcomes Management Program — In May 2004, MBHP implemented a Clinical Outcomes Management Program that had been two years in the planning and preparation. This quality initiative requires that all providers for all levels of care use valid and standardized assessment instruments to measure the effects of their treatment interventions. Providers are given a choice of MBHP-approved instruments from which they can choose. In addition, MBHP identified the Treatment Outcome Package (TOP), published by Behavioral Health Laboratories (BHL), as its "preferred" instrument. In order to encourage the use of the TOP, MBHP has subsidized the cost of this proprietary instrument. To further ensure compliance with its outcomes program, MBHP has made all provider rate increases, when available, contingent upon providers' documented participation in the outcomes program.

Over the several years of this initiative, more than half of MBHP provider network has chosen to use the TOP for their clinical evaluations. The TOP forms are self-completed by the members, and then the completed forms are faxed by the provider to BHL, where they are scanned and entered into an electronic and secure database. TOP data for MBHP members are then transferred to MBHP, where the TOP clinical assessments are matched to MBHP's member utilization data. This data set, which combines standardized clinical information and outcomes with utilization history, becomes the foundation for analysis and reports by MBHP. During nearly five years in operation, the MBHP outcomes program has generated over 180,000 TOP evaluations for over 70,000 unduplicated members.

The MBHP outcomes program has had three goals: to improve quality of care at three levels - member, agency, and statewide system. With regard to improving quality of care at the member level, MBHP has offered many training opportunities for providers about using clinical assessments and re-assessment for case formulation, treatment planning, and documentation of treatment progress. MBHP's quality department also offers a technical assistance center for providers with questions about using outcomes data. For quality improvement at the agency level, MBHP has held regional provider forums where providers come together in small groups to share their efforts in aggregating data, analyzing the data, and then using the analysis to inform agency-wide quality improvement projects.

7A.2.15 Quality Assessment And Performance Improvement Program

For quality improvement at the statewide systems level, MBHP has published several reports through the Performance Improvement Report Series. The focus of these reports has been on population-based clinical characteristics and utilization patterns of members with substance abuse disorders, homelessness, violence, depression, and other clinical domains. Through additional research, MBHP has identified TOP responders whose scores are predictive of higher service utilization over six months. These findings will be helpful in building assessment-based predictive models for high risk members who may profit from intensive care management.

VOI's Proposal to Use Standardized Functional Assessment Tools — As has been seen throughout our proposal, the implementation of a data-driven system of care is a core value of any ValueOptions program. For this reason, VOI is proposing the adoption of the State-approved functional assessment tools: The Child and Adolescent Functional Assessment Scale (CAFAS) for children experiencing a serious emotional disturbance and the Multnomah Community Ability Scale (MCAS) for adults experiencing a chronic mental illness. In addition, we would propose the utilization of the P-CAFAS for very young children and will work with the departments to identify an appropriate assessment for the aging population. VOI proposes including these assessments (or selected aggregate scores) in the Registration Process described later in this proposal. This process will ensure that all members have a completed functional assessment at a minimum every six months.

d) Describe how the Bidder would involve Eligible Persons and family members in the quality assessment and performance improvement program

VOI is committed to ensuring that Eligible persons and/or family members who have experienced a mental illness are represented on every QM committee, and will chair the Consumer and Family Member Committees. A comprehensive description of the involvement of Eligible persons and family members in the quality assessment and performance improvement program is detail in section *7A.2.4 Rehabilitation, Recovery, and Strength-based Approach to Services*.

e) Describe the way in which the Bidder would utilize state pharmacy data to:

- identify utilization that deviates from clinical practice guidelines for schizophrenia and major depression, and
- identify those Enrollees whose utilization of controlled substances warrants intervention either because of multiple prescribers, excessive quantities or prescribing that is inconsistent with the clinical profile of the Enrollee.

ValueOptions proposes utilizing our PharmaConnectSM System and state pharmacy data to identify utilization that deviates from clinical practice guidelines for schizophrenia and major depression, and to identify those Enrollees whose utilization of controlled substances warrants intervention either because of multiple prescribers, excessive quantities or prescribing that is inconsistent with the clinical profile of the Enrollee.

PHARMACONNECTSM

PharmaConnect uses evidence-based clinical practice guidelines to screen the entire population for patient-specific care gaps. We then notify the physicians of the care gaps and associated guidelines to assist them with improving the quality of care for their patients. The PharmaConnect service promotes improved practice patterns through the educational benefits of ongoing identification and notification of patient-specific care gaps. The PharmaConnect service uses nationally-accepted clinical guidelines to create the rules used within the alert engine. Our team of pharmacist and physician behavioral health care experts review and approve both the rules and output (e.g., notifications) of this service. The PharmaConnect service screens all patients for potential controlled substance abuse with configurable rules that include multiple prescribers, multiple pharmacies, excessive quantities and the unique ability to calculated total daily controlled substance doses grouped by drug category.

Our PharmaConnect team will ensure coordination with the Departments including 1) describing the service, 2) reviewing the alert rules, 3) reporting on interventions and outcomes and 4) offering to include Commission members on our National Pharmacy and Therapeutics Advisory Group. The PharmaConnect service screens prescriptions from both psychiatrists and non-psychiatrists. In addition, the patient-specific alerts will include the contact information for all involved prescribers and pharmacies to simplify collaboration on therapy changes.

Care Gaps Lead to Poor Outcomes and Unnecessary Costs — A variety of care gaps contribute to poor outcomes and unnecessary costs. For example, studies suggest that under-use drives up to 20 percent of medical and 50 percent of behavioral health admissions. While care management helps high-risk Enrollees who are experiencing a mental health or substance abuse disorder, a significant number of care gaps occur in consumers who are high-risk, but non-participating, difficult to reach, and lower acuity, but with care gaps leading toward high-risk situations.

ValueOptions offers PharmaConnect as the solution to these challenges. This enhances provider collaboration and increases our ability to help more consumers by notifying all providers related to the specific issue in writing of any identified care gaps, so they can work together to coordinate care for the consumer. Key attributes include:

4. Screening the entire population and intervening earlier to reduce the chances of Eligible persons becoming high-risk and high-cost;
5. Reducing hospitalizations, often exceeding 10 percent, primarily due to improved medication compliance and persistency for all maintenance drugs;
6. Positive reactions from physicians, with a change rate that often exceeds 60 percent;
7. Enabling CCMs and other identified individuals to receive the alerts for inclusion in the treatment plan; and
8. Availability as a behavioral health-only program or as entire medical and pharmacy program.

Key benefits include:

9. the use of thousands of alert rules;
10. typical identification of >20 care gaps per 100 lives;
11. reduced hospitalizations, often exceeding 10 percent, primarily due to improved medication compliance and persistency for all maintenance drugs;
12. flexibility that enables clients to configure cover letter content and alert selection.

Sample Alert Rates

	Rate Per 1000 lives	Example
Sub-optimal Therapy	> 50	No follow-up or Rxs following admissions
Underuse	> 50	Inadequate dose, plus inconsistent refill history
Early Discontinuation	> 50	Patient stopping ALL chronic medications
Missing Procedures	> 50	Missing procedures (e.g., colonoscopy, flu vaccine)
Admits; No Follow-Up	> 25	Inpatient or ER visit; but no follow-up visits or medications
Drug Interactions	12	Interacting drugs from multiple prescribers and pharmacies
Polypharmacy	11	Complex chronic medication regimens
Age Limits	11	Drugs that increase risk of falls in the elderly
Monitoring	4	Missing lab tests or no action based on lab values
Overuse	5	Overuse of controlled substances from multiple providers
Other Medication Gaps	> 5	Duplications and related due to Rxs from multiple providers

Sample Alert

Review Date: 10/30/08
Consumer Name: Lyon, Ron

Consumer ID#: 987654321

Birth Date: 7/19/57

Please review for possible early discontinuation of antipsychotics.

349743

Date	Rx#	Drug	Qty	Prescriber	Pharmacy	Cost
7/11/08	12345	Zyprexa 10mg	30	Crick, Francis	Discount Drugs	\$397
8/10/08	12345	Zyprexa 10mg	30	Watson, James	Discount Drugs	\$397
9/12/08	12345	Zyprexa 10mg	30	Watson, James	Discount Drugs	\$397

This list includes only those prescriptions directly related to the issue. It does not include medications not obtained through the prescription benefit (e.g., samples).

Diagnosis	First Date	Recent Date
Schizophrenia	1/3/08	10/4/08

We notified the following providers:

Provider	Contact Info
Crick, Francis	(555) 555-1212
Watson, James	(555) 555-3131
Discount Drugs	(555) 555-1414

NO RESPONSE IS NECESSARY; please feel free to fax any comments to 757-555-1212 and reference the ID# listed in **bold** next to the specific recommendation above.

Alert Examples

ALERT TYPE	EXAMPLE
Poor Compliance	Monitors all chronic physical and behavioral health drugs for under-use or inconsistent refill patterns; along with Early Discontinuation, this alert type has the greatest impact on reducing preventable hospitalizations.
Early Discontinuation	Monitors all chronic physical and behavioral health drugs for discontinuation of therapy for all drugs within that category.
Duplicate Therapy	Concurrent therapy with more than one drug within all chronic medication categories (i.e., lipid-lowering, diabetes, antipsychotics, antidepressants) prescribed by more than one physician and dispensed by more than one pharmacy.
Polypharmacy	Concurrent therapy with more than a set number of chronic drugs (e.g., > 5) and prescribed by more than one physician and dispensed by more than one pharmacy, indicating a need to confirm care coordination.
Drug-Drug Interactions	Identifies moderate-to-severe alerts for all maintenance drugs when prescribed and dispensed by multiple physicians and pharmacies.
Duplicate Therapy	Identifies unnecessary drug duplication for all maintenance drugs when prescribed and dispensed by multiple prescribers and pharmacies.
Overuse/Substance Abuse	Primarily used to identify overuse of controlled substances when received from multiple prescribers and pharmacies. Combines percentage of daily usage for related drugs (e.g., a consumer receiving 50 percent of the maximum recommended daily amount of four narcotics generates a total daily narcotic use of 200 percent).
Age-Inappropriate Therapy	Drugs to be avoided in the elderly or pediatric patients.
Monitoring	Missing labs (e.g., HbA1c, therapeutic drug levels).
Missing Procedures	Missed screenings (e.g., colonoscopy, mammography), flu vaccines.
Sub-Optimal Therapy	No beta-blockers after heart attacks, No ACEI/ARBs in CHF.
BEHAVIORAL HEALTH-RELATED ALERTS	
Depression Without Antidepressants	Diagnosed with depression but is not filling prescriptions for an antidepressant.
Follow-Up After Hospitalization for Mental Illness	Consumers hospitalized for treatment of selected mental health disorders but not seen on an ambulatory basis or in intermediate treatment with a mental health provider.
Acute and Continuation Phase Depression Treatment	Consumers diagnosed with a new episode of depression, were treated with antidepressant medication, but discontinued therapy prior to six months.
Optimal Practitioner Contacts for Medication	Consumers diagnosed with a new episode of depression and treated with antidepressant medication, but have not had at least three follow-up contacts with a practitioner during the

ALERT TYPE	EXAMPLE
Management of Depression	84-day (12-week) Acute Treatment Phase.
Medications that Aggravate Depression	Multiple drugs have been reported to cause depression in some consumers. Elderly people are particularly at risk.
Schizophrenia Without Antipsychotics	Consumer appears to have schizophrenia but is not filling prescriptions for an antipsychotic.
Antipsychotic Medications and Metabolic Screening	Consumers treated with an atypical antipsychotic agent that have not had a diabetes screening.
Bupropion and Eating Disorders	Combination bupropion and eating disorder increasing risk of seizures.
Bipolar Disorder Without Mood Stabilizers	Consumer appears to have a bipolar disorder, but is not filling prescriptions for a mood stabilizer.
ADHD Medication Management	Attention deficit hyperactivity disorder (ADHD) consumers on first-line medication that have less than one (1) follow-up visit per year.

PharmaConnect will identify utilization that deviated from clinical practice guidelines for all diagnosis categories, including schizophrenia and major depression, and will identify those Enrollees whose utilization of controlled substances warrants intervention either because of multiple prescribers, excessive quantities, or prescribing that is inconsistent with the clinical profile of the Enrollee.

f) Identify what the Bidder believes to be the greatest opportunities for quality improvement in public managed behavioral health programs like the Iowa Plan. Discuss the approaches the Bidder would pursue to realize two such opportunities in Iowa.

The Iowa Plan for Behavioral Health is a mature managed behavioral health care program, and under the Departments’ guidance, has achieved many of the benefits that can be realized when a single contractor is delegated responsibility for services from multiple funding streams. ValueOptions recognizes the leadership of the Iowa Department of Public Health and the Iowa Department of Human Services, which has resulted in a program that has made many contributions to the Iowa behavioral health care delivery system and also served as a template for other programs across the nation. VOI hopes to partner with the Departments to implement the new opportunities for improvement described here and throughout our proposal.

GREATEST OPPORTUNITIES FOR QUALITY IMPROVEMENT

The opportunities for quality improvement in public managed behavioral health programs like the Iowa Plan are broad. Many examples have been described in response to previous questions.

Among those from other ValueOptions’ programs that have not yet been discussed and may be of particular interest are the following:

- The utilization of advanced analytics and data management system that are more readily available in the private sector to provide business intelligence and decision support at all levels of the service system from the consumer of services to the State program managers.
- Establish self help and peer support groups, including Spanish-speaking groups, to increase the cultural competency of programs; using the same consumers to train VOI staff and network providers and increase their cultural sensitivity. An emerging priority in Iowa may be developing more culturally competent services for Black and Native Americans.
- Adapting the principles of rehabilitation and recovery to specific cultural groups, such as Latinos.
- Offering limited network credentialing to general practitioners and other non-psychiatrists to expand access to medical management and monitor medication for consumers who live in remote rural areas.
- Creating consumer satisfaction survey teams to conduct focus groups to replace or augment traditional consumer satisfaction questionnaires and partner with States and Universities to maximize federal administrative participation in the evaluation of managed care programs..

7A.2.15 Quality Assessment And Performance Improvement Program

- Providing dual diagnosis recovery education, including Dual Recovery Anonymous (DRA), which may lead to the establishment of consumer-facilitated DRA 12-step recovery groups and elements of the principles of Community Consensus-building Collaboratives.
- Developing and implementing an educational and support model curriculum for families with children who are receiving or have received mental health services and who may be at risk for a decrease in their level of functioning.

Opportunities in Iowa...The Departments' priorities listed in Section 1.2 of the RFP are a ready-made agenda for system-wide quality improvement initiatives for the next contract period. ValueOptions' staff has spent a significant amount of time over the last few months talking with Iowa consumers and family members, providers and provider organizations, advocacy organizations and other stakeholders about how the behavioral health care delivery system could be improved. We have reviewed recommendations made by the mental health/developmental disabilities (MH/DD) in 2008, needs and gap assessment completed as required for federal funding, and external independent reviews by Universities and the EQRO. We have compared Iowa Plan data with that generated in ValueOptions' public sector carve-out programs. In synthesizing all the advice and data, we found that Iowa's current system re-designs have already set the pace for the Iowa Plan and its Contractor. The Children's System of Care (SOC) and Emergency Crisis Response initiatives of DHS and the priorities of the DPH for substance abuse programs and services—all point to the most important opportunities for the Iowa Plan Contractor:

...To Assist in the Development of a Statewide Network of Local Systems of Care — The Iowa Plan has an adequate array of services to meet the needs of children served through the Iowa Plan. However, few if any, providers offer a comprehensive array of services to children and even fewer provider coalitions have been developed to offer a seamless continuum of services and supports. Despite efforts to implement joint treatment planning, the behavioral health care delivery system remains fragmented. When considered in relationship to services funded in other related delivery systems such as Child Welfare/Juvenile Justice, counties and schools, the fragmentation is even more problematic. To address this, VOI has proposed beginning the development of a comprehensive and coordinated children's system of care. This is described in detail in section 7A.2.6 *Covered Services, Required Services, Optional Services* as a component part of the needs and gaps analysis in subsection b).

...To Reduce Inappropriate Utilization of Inpatient and Residential care

In a mature behavioral health delivery system, the Contractor should direct its efforts toward assuring that appropriate services are provided to those most at risk for institutional care. The outline for an Emergency Crisis Response system has been developed and proposed by the Departments. VOI intends to support this initiative and work towards expanding access to emergency crisis supports and services that divert from institutionalization. This is described in detail in our response to *Section 7A.2.6 Covered Services, Required Services, Optional Services* as a component of the needs and gaps analysis in subsection b).

- h) Describe the Bidder's experience in adapting policies or procedures based on input from publicly funded consumers and from advocacy groups. Describe the measured impact of the changes based on quality assessment studies, feedback from affected groups, or other data. Include the names of the programs and provide the names, telephone numbers and e-mail addresses of consumer advocacy groups that can be contacted to verify the description submitted by the Bidder.

We value input from consumers and advocacy groups and take their feedback seriously to help us develop new programs, shape our policies and procedures, inform our quality improvement strategies, and improve our educational materials. The President's New Freedom Report states that consumers and families must be the driving forces behind transforming our mental health and substance abuse systems. Consumers and advocates are the driving forces behind many levels of our service planning, evaluation, and improvement efforts. The following are examples in which changes in our programs or policies were implemented based on input from consumers and advocacy groups.

MASSACHUSETTS

In 1999, MBHP developed the Massachusetts Consumer Satisfaction Team Initiative. In this initiative, consumer and family members conduct in-person interviews with individuals receiving mental health and/or substance abuse treatment services, analyze the information findings, and present their findings and recommendations.

In 2001, the consumer satisfaction teams surveyed more than 20 day treatment programs. They identified three programs needing quality improvement strategies in several areas, including consumer involvement in treatment planning and access to crisis services. The teams shared these findings and recommendations with the day treatment program directors and with MBHP provider network representatives. Many of the teams' recommendations were implemented.

In 2002, to monitor the impact of those consumer-recommended changes, ValueOptions asked the consumer satisfaction teams to re-measure satisfaction at the same three day treatment programs. The consumer satisfaction teams discovered that all three day treatment providers had implemented a substantial number of their recommendations. One day treatment provider had implemented a new psychiatric rehabilitation philosophy and another day treatment provider had replaced some of its key staff with new staff who had a background in a rehabilitation philosophy.

Rather than formally re-measuring program satisfaction, the consumer satisfaction teams conduct in-depth focus groups with consumers as part of their monitoring. In those groups, consumers reported a much greater level of satisfaction with the programs, and they were pleased to have been included in the process.

PENNSYLVANIA

The VBH-PA Service Center is committed to moving recovery focused services and supports forward, both in formal treatment settings, as well as grass roots support groups. In one contracted rural county, VBH-PA funds the first and only mental health Drop in Center (DIC). The Open Arms DIC is fully operated by consumers, with oversight from Steps In Side, a consumer run 501 (c)3 for Substance Abuse support. Steps In Side acts as fiduciary for the Pennsylvania Service Center funding for Open Arms. In 2008, VBH-PA organized a steering committee, including peer specialists, consumer co-directors and supervisors, with representation from the County Mental Health Department, and the VBH-PA Recovery and Resiliency Specialists. The group began monthly meetings to develop strategic planning to bring the DIC into the forefront as the focal agency to promote consumer based recovery initiatives in the County. The steering committee, facilitated by a Recovery Specialist acting as consultant, is modifying the PATH (Planning Alternative Tomorrows with Hope) model to target both short and long term outcomes. The first goals were reached at the end of 2008 when all consumer staff became certified in CPR, and formal relations were established with the Behavioral Health Unit of the local hospital.

REFERENCES

- NAMI Massachusetts, Laurie Martinelli, Executive Director, (781) 938-4048, Lamartinellinami@aol.com
- NAMI Southwestern Pennsylvania, Christine Michaels, Executive Director, (412) 366-3788, cmichaels@namiswpa.org

- i) Describe the process by which the Bidder would conduct retrospective monitoring of all substance abuse service providers in accordance with Section 5.D.1.2. The description should include:
 - the source of the evaluation tool with which the Bidder would assess the appropriateness of clinical services delivered, and
 - what actions the Bidder would propose to take with a provider who it has determined does not deliver services or follow contract guidelines appropriately, both in the event of an initial finding and of a repeated finding.

RETROSPECTIVE MONITORING

VOI will use the processes in the following paragraphs to conduct retrospective monitoring of all substance abuse service providers, in accordance with *Section 5.D.12*.

7A.2.15 Quality Assessment And Performance Improvement Program

To enhance practices that promote recovery, resiliency and self-determination, and to ensure that Iowans receives the best value for the services purchased from contracted providers, a formal, comprehensive, and fully integrated monitoring program to evaluate providers' performance is necessary. Provider monitoring is an inherent responsibility in network management and is performed in coordination with other responsible entities such as the licensing boards and other regulatory agencies that provide oversight. Reviews will be completed by VOI Certified Alcohol and Drug Counselor (CADC) or Advanced Certified Alcohol and Drug Counselor (ACADC) reviewers and Provider Relations Staff in collaboration with DPH. During each contract year, VOI will provide retrospective monitoring for substance abuse services. The process will include a retrospective review of a statistically valid sampling methodology of treatment providers, their corresponding records, and may be supported by onsite auditing, interviews with individuals receiving treatment with their consent, interviews with staff providing the specified substance abuse treatment interventions, a post payment review of submitted claims to ensure that the services billed were provided in accordance with the established policies and procedures of the agency/provider.

Data will be collected by developing and administering a standardized tool focused on evidence-based practices (EBPs) and promising practices described by SAMHSA. VOI will work with the Departments on the development of this tool and will provide the tools utilized in other ValueOptions' public sector programs as a starting point. The tool will include an administrative and programmatic fidelity review, post payment reviews and clinical record review. The administrative and programmatic fidelity reviews include:

- documenting evidence of staff training on specific EBPs;
- reviewing policy and procedures;
- reviewing critical/adverse incidents;
- reporting (when available) on trends in treatment such as frequency of detox episodes, admissions to residential/medical facilities related to substance abuse;
- reviewing complaints and grievances as defined in the policies;
- ensuring that I-SMART data are accurately reported;
- ensuring that providers maintain structured record keeping systems, including documentation of delivery of all appropriate components of treatment services; and
- ensuring compliance with other contractual requirements as defined by the Departments.

Post payment review includes:

- reviewing claims data reports,
- ensuring that IDPH funds are used as payment of last resort for IDPH Participants;
- matching the service billed to the documentation in the clinical record to show that the Eligible person received the service on the date and time noted, and that there is a signature identifying the licensure of the staff providing the service; and
- identifying service variance when compared to like providers in the same geographic area with commensurate access to community supports.

The clinical record review includes:

- ensuring a substance abuse and mental health assessment based on America Society of Addiction Medicine Patient Placement Criteria -2R. (ASAM PPC-2R);
- ensuring a diagnosis has been entered;
- ensuring services provided are consistent with the level of care authorized;
- ensuring treatment and service planning that include SAMHSA-defined EBPs and best practices;
- reviewing for service delivery and the relationship among these clinical processes and treatment record indicators, including but not limited to those related to general chart reviews, such as a medication review, physical examination, and vital signs, when indicated;
- checking that there is documentation when members are not progressing in treatment;
- reviewing subsequent changes in the treatment plan;
- identifying outlier providers whose performance differs significantly from practice patterns;
- identifying Member/family involvement; and
- ensuring substance abuse coordination with PCPs.

7A.2.15 Quality Assessment And Performance Improvement Program

In addition, the clinical record review audit tool will include the identification and implementation of consensus-based guidelines developed by clinical, research, and administrative experts in the field. The Center for Substance Abuse Treatment (CSAT) has identified current effective treatment practices for use by treatment professionals in treating individuals with substance abuse disorders. The audit tool will include applicable services that the provider is licensed or certified to deliver.

Review Results Reporting Process

13. At the conclusion of the provider review onsite visit preliminary results of the findings will be verbally reviewed with the provider and other stake holders present.
14. Review tools and findings are provided to the VOI QM Analyst for scoring.
15. The QM Analyst scores tools and sends results to the Director of Provider Relations.
16. Director of Provider Relations reviews and forwards results to State designee.
17. Director of Provider Relations provides a written report of the review results. The written report of review results includes a detailed analysis of the review tools, and an overall evaluation of provider performance of reviewed elements, and recommendations
18. Review results may also be coordinated with other provider monitoring entities and State authorities as appropriate.

What Actions The Bidder Would Propose To Take With A Provider Who it Has Determined Does Not Deliver Services Or Follow Contract Guidelines Appropriately, Both In The Event Of An Initial Finding And Of A Repeated Finding.

The VOI process for engaging providers in our network who do not deliver services or follow contract guidelines appropriately is outline in the final response to *Section 7A.2.14 Network Management*. For IDPH providers, VOI will work with the Department to modify these processes to ensure integrity of the IDPH program. In other public sector programs, ValueOptions has a predetermined process for actions that would be required when a provider does not deliver services or follow contract guidelines appropriately, both in the event of an initial finding and of a repeated finding. Providers are required to submit a plan of correction within 30 calendar days of receipt of the review report. Technical assistance is available from ValueOptions to assist the provider in preparing the plan. In advance of any communication to a provider about potential sanctions resulting from the review results, the sanction and the plan of correction and process are reviewed with the designee of the State. There is typically target follow up based on the degree and area of deficiencies. It is typical to allow a time frame of 3-6 months to implement the plan and gather results prior to a targeted review. Annually the Quality Management Committee (QMC) of ValueOptions performs an analysis of aggregate review findings and recommendations for training, technical assistance, topics for the next year.

- g) Provide a copy of a 2008 QA Plan that the Bidder developed for a publicly funded client.

We have included as **Attachment 3** the VBH-PA, Greene County, QM Plan and work grid, as well as the VBH-PA Annual Summary as examples of QA plans developed for a publicly funded client.

- a) Describe the strategy that the Bidder will invoke in order to increase access to and utilization of prevention and early intervention services. Describe the Bidder’s experience in implementing such strategies under other contracts. Describe the measured impact of such programs in terms of changes in the process and outcomes of care. Include the names of the programs and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

Early Intervention and Prevention is defined as “in its simplest terms is about relationships—promoting and supporting nurturing relationships for all infants and toddlers” (Ellen, 1993). ValueOptions will join with the State to unify and create a comprehensive statewide infrastructure that will be specifically dedicated to helping infants and young children (0-5) with social emotional and mental health needs. We will identify, support children and families that are in need because of a lack of opportunities for prevention, early identification, fragmented treatment services, and low priority for resource allocation. We will ensure the emotional health of infants, young children, and their families by providing a continuum of comprehensive, culturally competent services which incorporates the promotion of social and emotional growth and development, as well as prevention, early intervention, and treatment services.

Why develop an early intervention and prevention system?

- Social and emotional concerns are present in a significant number of children ages birth to three.
- Infants and toddlers are often excluded from preschool, daycare, and other services because of social and emotional problems, and family life is severely affected by behavior problems of children under the age of three.
- Family psychosocial issues are the most difficult challenges that face many early childhood care and educational staff.
- Mental health services in most communities do not have staff trained to work with infants, toddlers, and their families.
- Early childhood care and education staff neither feel prepared to meet the needs of these children nor are they properly trained to do so.
- Programs are more prepared to meet the social and emotional needs of young children and their families if they have specially trained staff or access to trained mental health consultants.

VOI is proposing the adoption of the following three recommendations to enhance prevention and early intervention services:

Recommendation I — Develop a coordinated system to screen and assess the social and emotional mental health needs of children birth to age five and develop a consistent referral procedure.

- **Strategy A:** Pediatricians are the professionals with the most contact with infants, toddlers and preschoolers. We will work collaboratively with the pediatricians in Iowa to set standards for incorporating developmental and behavioral health screening into their well-baby checks. We will offer training to the pediatricians and their nursing staff on developmental guidelines and signs/symptoms of behavioral disorders that have early onset (e.g., Attention Deficit Hyperactivity Disorder; Autism Spectrum Disorders; Oppositional Defiance Disorder). Additionally, we will ensure that the pediatric practices have information about referral sources in their communities for more comprehensive early assessment and treatment.
- **Strategy B:** We will recommend screening and assessment instruments and protocols designed to identify emotional, behavioral and social developmental issues in children birth to age five (i.e., post the tool on the web site and publish widely in the community of service providers). VOI will work with the Departments and providers to identify and widely disseminate the use of evidenced-based screenings and assessments. This may include the use of tools such as the Infant and Toddler Social Emotional Assessment Scale (ITSEA /BITSEA), Parents’ Evaluation of Developmental Status (PEDS), or the Ages and Stages Questionnaire (ASQ) specifically along the behavioral health domains.
- **Strategy C:** We will encourage service providers working with young children to administer the recommended healthy social and emotional development screenings and assessments (e.g., pediatricians, PCP, schools).
- **Strategy D:** We will encourage communities and service providers within those communities working with young children to develop a simple and consistent referral mechanism for mental health services for children birth to age five (e.g., outreach to Head Start programs, day care centers, pre school programs).

7A.2.16 Prevention And Early Intervention

Recommendation 2 — Increase and support mental health treatment options and interventions for children from birth to age five and their families.

- **Strategy A:** We will make Early Childhood Mental Health treatment options available in each community for children and families in need of services: Specifically adopt the CMHS Early Childhood Mental Health Consultation Model as defined by SAMHSA. VOI will work with the Departments to develop Iowa Plan fundable services which may include reimbursement of the Assessment components and work with children, families, and care providers.
- **Strategy B:** We will encourage all programs, professionals, and agencies who diagnosis mental health conditions to adopt the National Center For Clinical Infant Program’s Diagnostic Classification Of Mental Health And Developmental Disorders Of Infancy And Childhood For Children Birth To Age Three (DC-03), And The DSM-IV-PC for 4 and 5 year olds as their basis for defining medical necessity for early childhood mental health services.
- **Strategy C:** VOI will offer access to Achieve Solutions for families and providers for current educational materials and articles on a multitude of behavioral health and related topics.

Recommendation 3 — Develop a training infrastructure for early childhood and mental health professionals based on the Minnesota Model for Early Childhood Mental Health Specialists developed through CEED or other state approved curriculum. Outcomes associated with the implementation of the above recommendations to create a comprehensive prevention and early intervention system are well documented and include:

- decreased frequency of problem behaviors (externalizing and internalizing);
- decreased intensity of problem behaviors;
- improved socialization skills;
- improved peer relations;
- improved communication skills;
- improved emotional competence;
- improved adaptive skills;
- increased social interaction;
- increased referrals to early intervention services; and
- increased access to, and availability of, community resources for children with challenging behaviors.

In addition to the above, VOI will provide access to Achieve Solutions for families and providers. This robust, online library has current educational materials and articles on a multitude of behavioral health related topics. We invite the Departments to explore Achieve Solutions at www.achievesolutions.net/iowa.

Other ValueOptions’ Public Sector Programs that Support Young Children — All ValueOptions public sector programs have Prevention, Education and Outreach (PE&O) programs, which are designed to complement the priorities of the sponsoring state agency. Our work in Connecticut, Pennsylvania, New Mexico, Texas, Massachusetts, and New Jersey includes responsibility for PE&O that is focused on working with very young consumers and their families, promoting their involvement as one way to prevent further regression and to promote recovery and rehabilitation.

For our New Mexico contract, ValueOptions of New Mexico (VONM) has implemented evidence-based prevention programs and supports, and promotes the development and implementation of evidence-based prevention initiatives in New Mexico. The Strengthening Families Program (SFP) is a 14-session family skills training program designed to increase resilience and reduce risk factors for substance abuse, depression, violence and aggression, delinquency, and school failure in high-risk, 6-12 year old children and their parents. This behavioral and cognitive skills training program was developed by Dr. Karol L. Kumpfer and associates at the University of Utah in 1982 with National Institute on Drug Abuse (NIDA) research funds. SFP is recognized by many federal agencies (e.g., Office of Juvenile Justice and Delinquency Programs, Center for Substance Abuse Prevention, the Center for Mental Health Service, the Department of Education, the Office of National Drug Control Policy, and National Institute on Alcohol Abuse and Alcoholism) as an exemplary, research-based family model. Additionally, VONM added the following priority areas to its existing strategies:

- developing and expanding the current “Linkages” Housing initiative approved by the BHPC, with the goal of building through consumers’ grass roots efforts, 5,000 supportive housing units over a ten year period. Data from similar supportive housing programs demonstrate their effectiveness in reducing homelessness and promoting consumer’s engagement in treatment;
- developing a community-based system of care for children/youth affected by developmental disabilities, including autism spectrum disorders;

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- supporting the expansion of viable, in-home treatment options for children and adolescents;
- promoting the expansion of Assertive Community Treatment for adults with SPMI residing outside Albuquerque;
- expansion of culturally appropriate practices for the treatment of substance abuse disorders;
- supporting the development of services for individuals with a dual diagnosis of mental illness and developmental disabilities, or ASD to support in-state treatment of the developmentally disabled population; and
- maintaining and expanding the peer and family specialist programs central to a consumer-centered approach.

REFERENCES

- Linda Zelch, Area Director, Western Service Area, Office of Mental Health & Substance Abuse Services, DPW; telephone (412) 565-5226; email lzelch@state.pa.us.
- Matthew Ferrara, Office of NorthSTAR and Special Initiatives; telephone (512) 206-5444; email matthew.ferrara@hshs.state.tx.us.
- Suzanne Fields, Director of Behavioral Health, Office of MassHealth; telephone (617) 348-5101; email suzanne.fields@state.ma.us.

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- a) Describe in detail the management information system the Bidder would implement for the Iowa Plan. The description should emphasize the way in which the MIS system would function to gather required data and produce required reports as well as providing detail on hardware capabilities.

ValueOptions recognizes that the Departments have unique behavioral health care priorities, delivery system challenges, and program goals. Our extensive experience, technological innovations and flexible program design capability will enable us to work well with the Departments. We look forward to developing and implementing an adaptive operating system and network infrastructure that is readily responsive to the state of Iowa's mental health and substance abuse care needs.

CONNECTIONS

ValueOptions' comprehensive management information system, the CONNECTIONS platform, is capable of supporting complete managed behavioral health programs from the initial Enrollee contact through the claims adjudication and payment processes, in conjunction with the full range of management and utilization reporting requirements. Unveiled in 2005, CONNECTIONS is a suite of fully-integrated and customizable applications designed to support our innovative behavioral healthcare programs. In particular, the CONNECTIONS platform represents over 20 years of behavioral health experience and associated best practices in supporting public sector behavioral healthcare programs. Working off of a shared database, the platform consists of highly sophisticated, scalable Web-based components designed for:

- Enrollee enrollment,
- care coordination,
- authorizations,
- research,
- inquiry tracking,
- customer service,
- electronic data exchanges,
- Braided FundingSM,
- financial operations
- provider network management,
- care management,
- clinical notes,
- provider communication,
- appeals, complaints and grievances,
- claims processing and payment, and
- reporting functions.

This integrated computing environment has significantly enhanced our ability to improve the coordination of care and service delivery for the nearly 23 million behavioral health recipients we serve throughout the country. It also has allowed us to customize our system to support the varying requirements of our public/private partnerships across the nation. Since 2005, ValueOptions has continued to enhance the CONNECTIONS platform to specifically meet the current and future needs of the public sector behavioral health programs that we manage. Together, these enhancements created the framework of **ValueOptions Braided FundingSM System**. Unlike any other system in the industry, the ValueOptions Braided FundingSM System automatically identifies Medicaid eligibility and applies the State's funding-source hierarchy and managed care principles. This allows appropriate maximization of federal matching funds, while reducing administrative burden for providers during the Enrollee registration and claims submission processes. In addition, advanced capabilities have been designed throughout the system to further improve coordination of care services, and can be customized specifically for the state of Iowa contract. Furthermore, this system is ready and fully compliant with the requirements outlined in the system requirements of the Statement of Work.

ValueOptions' approach to the application of new and emerging information systems leverages the efficiency and reliability of proven, existing technologies to implement new types of service delivery options. We have assembled technologies that allow us to approach data collection, analysis, and management in new and more efficient ways. Our approach provides the information technology designed to focus on behavioral healthcare management that is highly functional and reliable. By developing a collaborative working relationship with the state of Iowa, CONNECTIONS in conjunction with the systems utilized by the providers and other State Agencies will provide an IT solution to support the requirements of the state of Iowa. The following descriptions of the CONNECTIONS Web-based software systems and technologies provides specific information about the processes and tools used to gather the required data to perform the functions for the Iowa Plan.

ServiceConnect — ServiceConnect will help Customer Service Representatives (CSRs) deliver faster, more accurate, and more efficient customer service to Iowa Enrollees and providers. ServiceConnect allows CSRs to provide “first call resolution” for many of the customer service calls we receive. ServiceConnect’s powerful tracking and analytics capabilities allow quality management (QM) staff to continuously monitor CSRs’ performance, and identify opportunities to improve processes and service delivery. ServiceConnect functionality includes:

- creating and responding to inquiries
- validating provider and Enrollee information
- adding and viewing inquiry notes
- accessing open inquiries quickly and easily
- researching claims and authorizations,
- providing access to a recipient’s detailed benefit package information.
- image archival and retrieval of key documents including but not limited to:
 - explanation of benefits,
 - checks and authorization letters, and
 - provider or Enrollee correspondence,
- collecting member and provider complaints, and
- managing individual and group work queues.

CareConnect — CareConnect allows Clinical Care Managers (CCMs) to quickly focus on the most pertinent clinical data for each Enrollee and easily locate and view historical data summaries to efficiently formulate cases. CareConnect provides advanced tools that enable CCMs to monitor, follow up, and report on the clinical conditions, treatment and treatment needs of the Enrollees they serve. CareConnect functionality includes:

- creating referrals (routine, urgent, emergent);
- completing and tracking requests for service authorizations;
- completing reviews for medication management, inpatient/higher levels of care, and other services where clinical decision-making is needed for authorization requests;
- completing second level reviews;
- entering discharge information, completing discharge reviews, and managing after-care follow-up;
- processing and tracking grievances and appeals; and
- processing and tracking clinical information associated with child and adolescent services and home treatment services.

Whether information is provided in a telephone discussion, via fax, the Web, or data from the I-SMART application, ValueOptions’ CCMs will review requests for authorizations for those services specified in the Utilization Management section of this proposal. Any clinical data provided, as well as the rationale for decisions rendered, will be recorded in CareConnect and become an integral part of the Enrollee’s record. If the CCM is unable to authorize the requested service, the case will be referred to a Peer Advisor, and the determination of the Peer Advisor, as well as any interactions with the provider, will also be documented in CareConnect. Client and program-specific codes can be developed to augment the information required by VOI’s clinical policies as justification for each authorization/non-authorization decision.

CareConnect assigns a unique number to each authorization with information included in each authorization header file and within the authorization detail file. The authorization number is the key to both of these files as all authorizations are associated with a specific member, a specific provider and are linked to a case. The system also assigns a unique number to each case. A case consists of one member, one or more providers, and one or more treatment settings. In cases involving multiple providers or settings, all providers of record can be linked to the CareConnect system in order to ensure integrated treatment planning and to provide a full composite of the enrollee’s service needs. The case may also be associated with a specific set of clinical notes.

The system supports functionality to search for all authorizations and/or all cases for a specific member or for a specific provider. Authorizations for a specified time period can be amended or revised in CareConnect.

Enrollee and Provider Portals — ValueOptions’ MemberConnect and ProviderConnect portals offer a wide range of flexibility for Enrollees and providers when submitting inquiries related to claims status and reconciliation; performing eligibility verification and benefits verification; checking prior authorization status including services authorized and services used; or seeking identification of network providers and their locations, as well as other types of inquires. Users are presented with comprehensive and easy to read information within seconds.

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Our Enrollee and provider portals were designed with the following features:

- ability to properly identify and authenticate users;
- creation of audit records whenever users inquire or update records.;
- provide for access controls that are transaction-based, role-based, or user-based;
- controls to ensure that transmitted information has not been corrupted;
- message authentication to validate that a message is received unchanged; and
- encryption or access controls, including audit trails, entity authentication, and mechanisms for detecting and reporting unauthorized activity in the network.

In addition to MemberConnect and ProviderConnect, Enrollee and provider portals can be accessed through the VOI Web site, <http://www.valueoptions.com/demos/iowa>.

MemberConnect accelerates an Enrollee’s ability to access secure, Web-based information and perform many routine customer service transactions 24 hours a day, seven days a week. MemberConnect enables Enrollees to:

- verify their eligibility,
- check authorizations of services requested on their behalf,
- view authorization letters, explanation of benefits and other correspondence,
- access Achieve Solutions,
- submit an inquiry to customer service;
- obtain educational materials;
- search claims and view details of claim (i.e. claim status, paid date, check number); and
- check their benefits.

ProviderConnect accelerates providers’ workflows by delivering a Web-based system for collaborative business processes, and enables providers to perform many routine customer service transactions via a secure Web site. ProviderConnect functionality includes:

- Enrollee registration submission, update and search;
- claims submission with any HIPAA-compliant 837P or 837I formatted file (free 837P software is available to providers);
- correspondence search with print capability (includes authorizations);
- reports of submitted registrations, claims, rejected and paid claims; authorization request and search (both outpatient and inpatient);
- receipt of messages via ValueOptions’ online Messaging Center;
- eligibility/benefit search;
- claims search for specific Enrollee(s) and view of claim details (i.e. claim status, paid date, check number);
- claim submission directly into our system for immediate feedback with validation of Enrollee ID and claim number;
- provider’s practice profile validation and change requests of demographic information; and
- email customer service requests via HIPAA secure technology.

The ProviderConnect Enrollee registration module will be customized for The Departments to allow the specific data elements to be captured for the registration and eligibility requests for the state of Iowa, as well as to support Enrollee’s enrollment into the appropriate benefit package based on their clinical condition and treatment history.

EligibilityConnect — EligibilityConnect is an automated front-end load eligibility module that can either process enrollment and disenrollment information in the HIPAA 834 format via the DHS Medicaid Management Information System (MMIS), a specific format required by a client such as the Family and Child Services (FACS) file or develop a customized load. ValueOptions has the ability to store client-specific data, such as linking a member to a family unit, and which can be made available for ad hoc and client-specific reporting. EligibilityConnect can be configured to use a unique, client-defined ID, including the Enrollee’s Social Security Number (SSN), to merge or link the population within the multiple databases and information systems with which we will be required to interface. Any client-specific data can easily be made available online to clinical, customer service and claims staff if this information is needed for them to perform their job functions. The eligibility and enrollment modules in EligibilityConnect interact with references, benefits, contracts, groups, claims, providers, authorizations, and utilization during the adjudication process to ensure eligibility of an Enrollee entering treatment.

NetworkConnect — NetworkConnect is our provider credentialing program which includes imaging, automated forms processing, online faxing, and ad hoc query capabilities. NetworkConnect serves as the single source of all data entry related to providers. Because CONNECTIONS is fully-integrated, information entered into NetworkConnect automatically feeds into the CONNECTIONS suite to help manage claims payments, referrals to specific providers, provider service inquiries, provider demographic changes, as well as application submission and/or recredentialing submission/review activities. NetworkConnect has the following features and benefits:

- automated tracking of expired documents (i.e., malpractice and licensure) and key timeframes (i.e., recredentialing cycles) to ensure accurate, up-to-date provider information for referral and claims payment;
- secure multi-user, multi-location access to provider data to ensure accurate and timely information is available to all ValueOptions locations;
- workload management capabilities that support electronic shifting of work among staff as necessary to meet deadlines and expedite provider credentialing;
- in-bound and out-bound communication technology via multiple methods (e.g., e-mail and fax) helping to maintain provider data accuracy without disrupting the provider’s practice; and
- audit module which allows remote access to identified provider files and key elements allowing network audits to occur efficiently (i.e., without travel or movement of hard-copy files) and effectively (focused on elements of interest).

NetworkConnect assigns each provider a unique identification number, and also has the ability to store multiple alternative provider identification numbers, such as the I-SMART number, Medicaid ID or any other Iowa-assigned provider identification number. Each practice location or vendor is also assigned a unique NetworkConnect number for each different location. The combination of provider and vendor numbers identifies a specific provider at a specific location, and a separate file lists all the valid combinations of provider and vendor numbers. This automated provider numbering system eliminates duplicate provider records, thus ensuring accurate referrals and claims payment. It also helps ValueOptions address our clients’ concerns about managed care companies offering “phantom networks” comprised of repeated or duplicate provider names.

NetworkConnect supports other critical processes involving provider network management. Fee arrangements, service pricing and controls, provider reports, and more can be managed to support the requirements our organization is expected to meet to maintain our accreditations and quality standards. In addition, the system includes built-in and customizable tools that allow:

- primary source verification, including automated access to key verification sources such as licensure boards and the National Practitioner Data Bank (NPDB);
- system-generated letters, guided by provider’s method of choice (i.e., fax or email);
- automated medical director “approval” process based on system triggers and embedded credentialing criteria;
- auto-population of critical claims payment data, resulting in quick and error-free loading of client-specific fee codes;
- field-level security and ongoing tracking of every system transaction (i.e., date, time, user,) to support quality control monitoring; and
- easy access to pre-populated provider performance reports.

We anticipate developing an electronic link to this provider monitoring repository and other interactive databases used to conduct post-payment reviews and record keeping practices.

TeleConnect — The TeleConnect Interactive Voice Response (IVR) system enables rapid, 24 hour a day, seven day a week self-service resolution of many member and provider requests. While callers will always have the option of connecting to a CCM or CSR at any time, TeleConnect allows providers and members to quickly and easily resolve basic customer service issues with the use of speech recognition technology, and ensures that for simple requests, members and providers have a faster, self-service alternative to live contact. At the same time, providers and behavioral health recipients will still get the personal service they need. TeleConnect functionality allows behavioral health recipients and providers to verify eligibility, check the status of a claim, and request any needed forms.

ClaimsConnect — ValueOptions' ClaimsConnect is one of the most robust claims systems in the managed behavioral healthcare industry. ClaimsConnect accepts claims electronically or via paper and is capable of collecting and maintaining data for the CMS-1500 and 1450. The claims processing capabilities in ClaimsConnect are augmented by the integrated eligibility/enrollment, provider, electronic claims submission, inquiry tracking, data warehouse, and interactive voice response subsystems. ClaimConnect verifies that the Enrollee for which the claim was submitted was eligible for services for that funding stream at the time the service was provided. Unless all the system requirements are met, the claim will not adjudicate, and payment will not be rendered.

QualityConnect — QualityConnect is used by our quality staff to manage and track adverse incidents (an occurrence that either represents actual or potential serious harm to the well being of an Enrollee; actual or potential serious harm to another person by a ValueOptions member). QualityConnect facilitates the investigation of adverse incidents by assigning a Severity Index (SI) (Sentinel, Major, Moderate, Minimal) to each incident that occurs, and sends out e-mails to notify select users that an event has occurred. The CONNECTIONS platform integrates the adverse incidents collected in QualityConnect with the complaints and grievances data housed in ServiceConnect to provide aggregate data for reporting and management purposes.

FinanceConnect — FinanceConnect is the financial system component of CONNECTIONS, and consists of Oracle Financials, software for Accounts Payable (AP), Accounts Receivable (AR), and General Ledger (GL) modules functions, and Hyperion software for budgeting and forecasting functions. The Oracle General Ledger, coupled with the other application modules enable ValueOptions to manage contracts like the State of Iowa in an efficient and effective manner.

The Oracle General Ledger module is a comprehensive financial management solution that provides advanced financial controls and data collection for the entire ValueOptions' enterprise. Oracle's General Ledger solutions provides a robust account structure that supports full cost accounting including appropriate capture and reporting of direct, indirect and G&A costs. FinanceConnect supports cost-plus, firm fixed price and time and material type contracts, and provides for the detail accumulation of contract-level detail, as well as the overall aggregation financial data. The Oracle Accounts Receivable Subsystem module provides the necessary functions to support the related processes involving invoicing, adjustments, and payments for supplied services and/or products. The Oracle Accounts Payable Subsystem supports the related processes involving invoices, adjustments, and payments for supplied services and products. The Accounts Payable vendor setup supports small, disadvantaged business reporting.

Within FinanceConnect, ValueOptions has the ability to track utilization and report financial results by funding stream through the use of the general ledger system and the finance reporting engines that are contained within FinanceConnect. ValueOptions has extensive experience providing this type of reporting for other clients. For instance, in our contract with the Commonwealth of Pennsylvania, we report revenues and medical utilization by seven different funding streams and over 15 defined levels of care, and for our contract with the State of Texas, we report revenues and the medical split between Title XIX Medicaid and state indigent appropriations. In order to complete this reporting, FinanceConnect sets up separate general ledger coding and accounts representing each funding stream. We then leverage our data warehouse to segregate authorization/utilization information by funding stream.

Additionally, ValueOptions maintains a robust internal control system to ensure that reporting by funding stream is accurate. Our National Revenue Reconciliation teams analyze the payment received from our client and split the payment into key data sets, such as distinct funding streams. Once completed, the payment and funding stream information accompanying the payment is compared and reconciled with the eligibility data for which the payment is to be based, which in this case, would be provided to ValueOptions by the State's MMIS via a HIPAA compliant 820 file format. If any discrepancies are discovered, ValueOptions' Revenue Reconciliation team will work directly with the appropriate state and local staff to make the necessary corrections. In addition, on an annual basis, ValueOptions can work with its external auditors to complete additional analysis of the data or audits that our clients would request to verify reporting at the funding stream level.

FileConnect — FileConnect is a communication system designed for the interchange of electronic data files between subcontracted providers, clients, business partners or associates, and supports secure file transfer protocol (FTP) file

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transfers via direct dial connections, secure Internet connections, and site-to-site virtual private networks (VPNs). FileConnect will transfer files to and from the State’s MMIS and the Mental Health Institution MHI systems.

With several unique features and capabilities, FileConnect is programmed to receive and process electronic records automatically and seamlessly with our CONNECTIONS applications, and also includes provisions for file and format verification, the prompt addition of new file types, and provides notification of file validation results (whether the file was successfully processed or not) by Wildcat BBS e-mail or via the Internet. FileConnect allows for desktop retrieval of processing results via an Intranet server using any Web browser and Internet Service Provider (ISP). This interface allows us to provide a reliable, efficient, and uniform process for transferring data.

FileConnect complies with HIPAA standards for all EDI transactions. The solution is highly scalable, and receives, routes, stores and sends transactions consistent with ANSI X12 standards. It supports all HIPAA-regulated EDI transactions as well as client-specific custom files that ValueOptions exchanges with providers and state agencies. In addition, we also maintain a backup system for the EDI, so that even if one line goes down we can handle the same job multiple ways. The specific advantages and features of FileConnect include:

- accepting inbound transactions from multiple sources;
- supporting customer-specific file formats;
- supporting multiple file transfer protocols including FTP, FTPS, SFTP, Web interface, Web services;
- compliance-checking all inbound/outbound HIPAA-regulated EDI transactions;
- allowing submitters to track all file submissions; and
- supporting industry standard security protocols.

Below is a table of transactions that ValueOptions currently exchanges with other clients/vendors:

Interfaces/Transaction Types	Compatible Solution(s)
837 Professional 837 Professional Health Care Claim - ASC X12N 837	FileConnect
837 Institutional Health Care Claim - ASC X12N 837	FileConnect
835 Health Care Claim Payment Advice - ASC X12N 835	FileConnect
276 Health Care Claim Status Request – ASC X12N 276	FileConnect
277 Health Care Claim Status Response – ASC X12N 277	FileConnect
278 Healthcare services review – ACS X12N 278	FileConnect
834 Benefit Enrollment and Maintenance – ACS X12N 834	FileConnect

ValueOptions’ system is fully compliant with submitting and receiving the 834 enrollment/disenrollment transaction sets. For example, ValueOptions accepts 834 transaction sets in most of our public sector programs, specifically New Mexico, Pennsylvania and Connecticut. Additionally, ValueOptions has extensive experience coordinating large membership databases for a variety of contract partners, from state and National employees with diverse benefit arrangements, to large populations of public assistance recipients. ValueOptions maintains and systematically updates a master file of all enrollment information using EligibilityConnect.

The table below is presented as further evidence of our success and experience with our public sector accounts regarding eligibility loads. All accounts presented below successfully converted from each client’s custom eligibility format to the HIPAA-compliant 834 format. The data indicates the number of eligibility loads our National Eligibility department has completed successfully with our public sector accounts.

Public Sector Contract Partners	Frequency of Update	File loads completed	Average Update TAT	Transport Media or Method
Massachusetts	Daily	3,120	1 day	ETS, our secure Web site
Texas NorthSTAR	Daily	2,469	1 day	ETS, our secure Web site
Pennsylvania (12 separate county contracts)	Daily	24,234	1 day	ETS, our secure Web site
Florida (5 separate area contracts)	Bi-weekly	270	1 day	Retrieve from vendor secure Web site, route through ETS

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Public Sector Contract Partners	Frequency of Update	File loads completed	Average Update TAT	Transport Media or Method
Connecticut	Daily	691	1 day	Retrieve from vendor secure Web site, route thru ETS
Kansas	Daily	246	1 day	ETS our secure Web site

ValueOptions interfaces with a majority of our clients via batch data exchanges, and we exchange data with our clients’ systems to cover all our lines of business. Our data exchange experience not only includes the data exchanges typical to our industry (i.e., eligibility, membership, authorization, claims, and financial data) but also includes client-specific or customized data exchanges based on our CONNECTIONS data collection capabilities and our clients’ requirements. When required, we also establish the required connectivity to accommodate online access to a client’s system for our staff. ValueOptions will work with the State to ensure that all VOI users required to accept I-SMART data will have computers that are configured appropriately, with sufficient memory and the correct applications installed (SQL and Microsoft Access), which are required to open, store and process the I-SMART data.

Transfer media, magnetic media or data transmission will be determined during the implementation period depending on the volume and frequency of data exchange. ValueOptions prefers to exchange data via computer-to-computer communications: we support secure FTP file transfers via direct dial connections, secure Internet connections, site-to-site VPN, and when volume is a consideration, via a dedicated fractional T-1 frame relay or MPLS connection between the ValueOptions and our clients’ information systems.

The following table details our ability to meet the requirements within our information systems environment as outlined in **6.4, Management Information Systems** section of this RFP.

6.4 MANAGEMENT INFORMATION SYSTEM		
Requirement	ValueOptions’ Method of Ensuring Data Collection and Reporting Capabilities	Status
Maintain an Enrollee database, using Medicaid state ID numbers, on a county-by-county basis which contains eligibility begin and end dates; enrollment history; utilization and expenditure information (Enrollees only);	EligibilityConnect	Meets
County of legal settlement for Enrollees shall be included in the Contractor’s management information system subsequent to a written agreement with a county or a county’s representative to provide and update such information as well as to provide required Enrollee releases (Enrollees only)	EligibilityConnect	Meets
Maintain a database which will incorporate required clinical information (from Section 6.3) on those Enrollees who access mental health and substance abuse treatment;	CareConnect	Meets
Maintain information and generate reports required by the performance indicators established to assess the Contractor’s performance	KnowledgeConnect/ IntelligenceConnect	Meets
Conduct claims processing and payment (Enrollees only);	ClaimsConnect	Meets
Maintain data to support medication management activities (Enrollees only);	CareConnect/ PharmaConnect	Meets
Maintain data documenting distribution of the capitation payment according to the proposal submitted by the Contractor (Enrollees);	FinanceConnect	Meets
Maintain data on incurred but not yet reimbursed claims (Enrollees only);	ClaimsConnect	Meets
Maintain data on third party liability payments and receipts (Enrollees only);	ClaimsConnect	Meets
Maintain data on the time required to process and mail claims payment (Enrollees only);	ClaimsConnect	Meets
Maintain critical incident data;	QualityConnect	Meets
Maintain clinical and functional outcomes data and data to support other QA activities such as provider profiling and Iowa Plan Eligible Persons and provider satisfaction surveys;	CareConnect/ ProviderConnect	Meets
Maintain data on clinical reviews, appeals, grievances and complaints and their outcomes;	CareConnect/ ServiceConnect	Meets

6.4 MANAGEMENT INFORMATION SYSTEM		
Requirement	ValueOptions' Method of Ensuring Data Collection and Reporting Capabilities	Status
Maintain data on services requested, authorized, provided and denied (Enrollees only);	CareConnect/ ProviderConnect	Meets
Maintain the capacity to perform ad hoc reporting on an "as needed" basis, with a turnaround time to average no more than five working days;	IntelligenceConnect	Meets
Maintain data on all service referrals for mental health and substance abuse treatment outside the Iowa Plan;	CareConnect	Meets
Maintain a data base, using I-SMART, state ID number, on a county-by-county basis which contains information;	CareConnect EligibilityConnect/ NetworkConnect	Meets
Maintain all data in such a manner as to be able to generate information specific to mental health and substance abuse services; and for substance abuse services, between services to Enrollees and IDPH Participants;	CareConnect/ KnowledgeConnect	Meets
Maintain all data in such a manner as to be able to generate information on Enrollees by age of Enrollees and to identify Enrollees who are referred to CW/JJ services;	EligibilityConnect/ CareConnect	Meets
Provide encounter data to DHS in a format specified by DHS;	FileConnect	Meets
Ensure that data received from providers is accurate and complete by <ul style="list-style-type: none"> • verifying the accuracy and timeliness of reported data; • screening the data for completeness, logic, and consistency, and • collecting service information in standardized formats to the extent feasible and appropriate. 	ProviderConnect/ FileConnect/ KnowledgeConnect	Meets
Make all collected data available to the Departments and to the CMS, upon request.	IntelligenceConnect	Meets

All VOI systems defined above currently meet the requirements of the RFP, which will ensure a seamless implementation with less disruption to enrollees, providers, and the Departments.

Access to Iowa Plan Data for DHS and IDPH:

ClientConnect —Many of our customers request access to online reporting capabilities, administrative processes, and information. We will work with the Departments to identify and assign authorized staff access to our ClientConnect application. This will allow third party payers with authorized 'real-time' access to obtain behavioral health program information, membership data, authorizations data, and reporting online. ClientConnect is fully encrypted and is completely compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Within ClientConnect, authorized DHS/DPH staff may view Iowa Plan data and client reporting, via our online reporting tool, IntelligenceConnect. If a report has been designed to include drill-down capabilities, the user can double-click one of the categories in the report to display the underlying records that made up that piece of the report, and then customize reports based on specific needs. Users can store and print client reporting directly from this resource.

InfoView is the IntelligenceConnect user interface that simplifies information access and helps users to be more productive by providing a single Web interface to access and interact with any type of business intelligence (BI) application – including reports, queries, analytics, and dashboards. InfoView also includes the ability to automatically generate and distribute Web Intelligence® and Crystal Reports®. Its integrated scheduling function can generate and distribute BI documents on virtually any timetable, including daily or weekly schedules, as well as on month-end or quarter-end business calendars. Users can share documents via email or send them to a system inbox, printer, or file – in several different formats – allowing for further interaction. InfoView also leverages the Business Objects security configuration allowing content and features to be customized based on Login. This functionality facilitates ValueOptions' ability to restrict or grant individual users rights to specific folders, report objects, dashboards, or limit functionality within WebI.

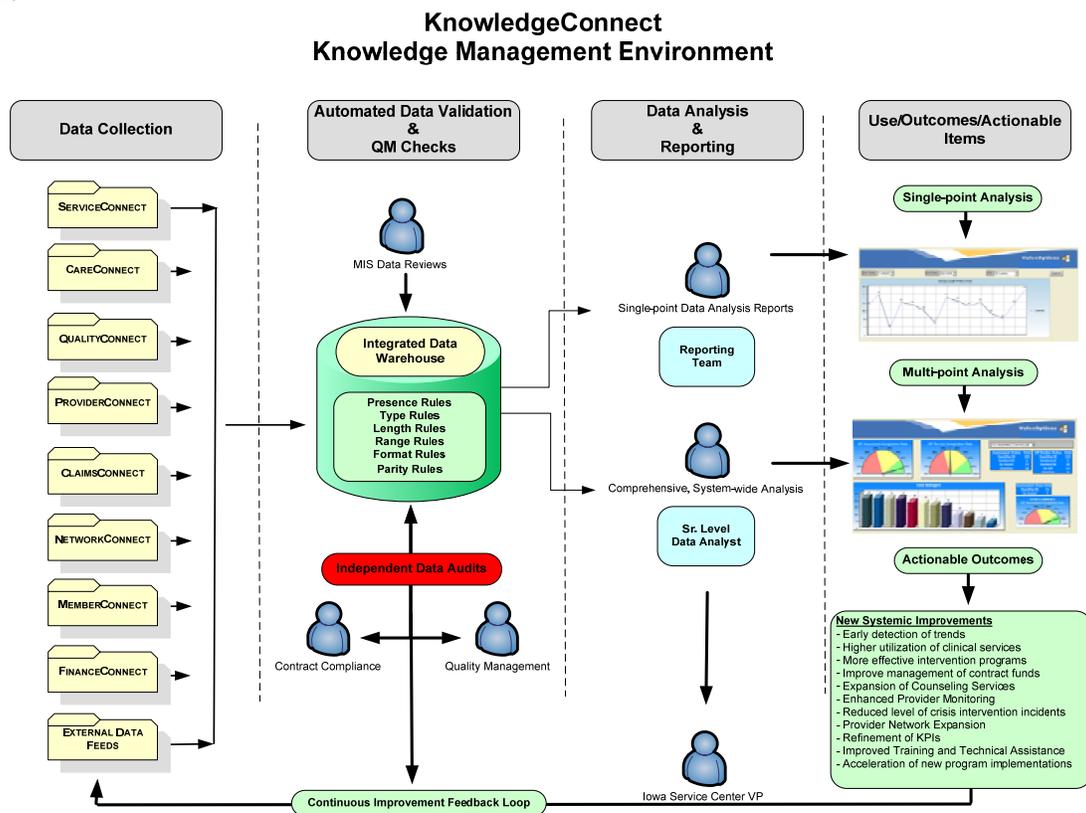
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The IntelligenceConnect hardware infrastructure is composed of three Gateway servers, each with 16 GB RAM and two 2.8 GHz Intel Core 2 Duo processors. To provide maximum performance, we have also chosen to leverage a Storage Area Network (SAN) with more than a terabyte of file storage capacity, thus further optimizing input and output operations. The combination of these powerful servers and the SAN provides users of IntelligenceConnect with incredible performance and the reliability of a system that is always available. Previous requirements for site-to-site VPN access have been replaced by a simple Web-based interface that provides encrypted VeriSign certified access directly to IntelligenceConnect from a basic Web browser.

The IntelligenceConnect platform (Business Objects Enterprise XI) is a service-oriented architecture supporting all users in accessing BI content, and has been designed for scalability, reliability, fault tolerance, extensibility, and high availability. It has earned the highest levels of certification for scalability and reliability from VeriTest, the Microsoft Certified for Windows designation, and the Microsoft DataCenter certification for reliability. The security module within IntelligenceConnect provides for control over which documents a user can see, interact with, and even print or export. The interface lets security administrators access third party security entitlement databases, such as LDAP or Windows NT/Active Directory, and use the information to control user access rights. In addition, the security module provides folder, object, and even data-level security for users and groups.

ValueOptions' integrated Data Warehouse, KnowledgeConnect, receives imports from the CONNECTIONS platform and other systems for reporting purposes. The hub of KnowledgeConnect's powerful data mining and ease of use capability is an advanced data warehouse based on state-of-the-art high performance Oracle 10g technology. Through sophisticated correlation mechanisms, KnowledgeConnect turns raw, disparate data (i.e., the correlated data from the CONNECTIONS applications) into valuable operational and business information focusing on Eligibles, State of Iowa customer, and service delivery dimensions.

This data is formatted and stored as standard data in our Oracle relational database, and is specifically configured for each client's unique reporting needs. An advantage of this data warehousing technique is the easy insertion of data from external sources, which can be integrated into the data models to enhance reporting capabilities. These standard data models are used as the foundation for report generation, statistical analysis, decision support, and outcomes management.



7A.2.17 Management Information System

ValueOptions has adopted and employs throughout its operations a fully-integrated approach to Business Intelligence (BI), made possible by the strategic application of various products and services supplied by Business Objects™, a recognized leader in the BI realm. IntelligenceConnect allows us to deliver best of breed, enterprise-wide solutions designed to meet and exceed the Departments’ reporting requirements outlined in the Statement of Work. IntelligenceConnect’s features include powerful report development tools, an intuitive and feature rich user interface, a reliable and efficient hardware infrastructure, and a scalable operating platform.

Our data structures are very flexible and can accommodate the Departments’ reporting requirements. Our system can also be modified to accommodate the future needs of our clients because we own the source code to the CONNECTIONS platform, and our National IT staff maintains and supports the application. We have built our Decision Support and Reporting System, KnowledgeConnect to support our full line of business. Any data captured by the CONNECTIONS production database is also loaded into our robust decision support and reporting system. All the data structures contained within the CONNECTIONS DB2 database and our reporting database were designed and are maintained by our IT staff. The Reporting Analysts are highly trained and skilled in producing ad hoc reports based on our customers’ needs. Ad hoc reports requested by our Client’s, that are based on our current data structures are usually developed and delivered to our client within five days from the date that the specifications have been outlined.

6.5 CONTRACT MONITORING AND GENERAL REPORTING REQUIREMENTS

Requirement	ValueOptions Method/Capabilities	Status
The Departments will monitor the Contractor’s performance pursuant to the terms of the Contract and RFP by confirming timely receipt of deliverables referenced within and by monitoring appeals, fair hearings, and grievances, critical incidents, progress on projects established in the Contract, required financial accounts, and review of the Contractor’s QA plan and goals.	The VOI Executive team will provide oversight and management of the Iowa Plan. This team will meet regularly with the State to review all reports, identify deficiencies and develop a plan of action. During Implementation the VOI team will work closely with the state to define all reporting requirements, including but not limited to the required data elements, the specific format and delivery schedule. VOI has the ability to provide reports in electronic and hard copy format and is capable of providing ad-hoc reports as defined by the Departments. Our Reporting Analysts are highly trained and skilled in producing ad hoc reports based on our customers needs. Ad hoc reports requested by our clients, which are based on our current data structures are usually developed and delivered to our client within 10 days from the date that the specifications have been outlined.	Meets
6.5.1 Reports Required Monthly		
General statistical reports in hard copy and in an electronic format compatible with systems used by the Departments; information to be included, and format required will be negotiated by the Departments and the Contractor.	ValueOptions recognizes that the timely and accurate delivery of production reports is key to meeting the State of Iowa’s needs for relevant information concerning program operations and results. ValueOptions has more than 20 years of experience supporting the diverse reporting and data needs of publicly funded contracts. Recognizing the need for accurate and timely reporting, we will employ local staff in Iowa to support the reporting requirements with additional support of the National Data Management and Analysis Department to aid in development efforts when necessary. ValueOptions will meet the standards as set forth by this measure.	Meets
Encounter data must be submitted electronically in a format that complies with requirements of the Centers for Medicare and Medicaid Services.	ValueOptions has demonstrated experience in the development of outbound 837 encounter and pre-priced claims extracts as well as corresponding response files (997, 277 and client-specific formats). We currently provide HIPAA compliant 837 claims files on behalf of 10 clients, and have two additional implementations underway. In support of these clients we submit files on a daily, weekly, and monthly basis. In most cases, we receive 997 and 277 response files, however we also receive custom detail response files. We interface with one or more state agencies for each of the ten clients referenced above. Data is transmitted to and received from our agency partners, and the data exchanged varies from state to state and agency to agency within each state. ValueOptions’ data exchange experience not only includes the typical data exchanges in our industry (i.e., eligibility, membership, authorization, claims, and financial data) but also includes proprietary (client-specific) or customized data exchanges based on our CONNECTIONS platform data collection capabilities and can be customized to meet any local requirement.	Exceed

6.5 CONTRACT MONITORING AND GENERAL REPORTING REQUIREMENTS

Requirement	ValueOptions Method/Capabilities	Status
	<p>We have developed a core set of standard programs to select and format the outbound data and to import response files. Data is tracked throughout the transmission process, including submission and response status. ValueOptions has the ability to check compliance of file formatting and data content using nationally accredited compliance checking tools.</p> <p>In addition, controls are in place to suspend the submission of a claim or encounter that does not pass “pre-scrubbing” edits. These edits are intended to mimic the MMIS adjudication edits, and result in our submission of files that meet all MMIS processing and edit requirements. These pre-scrubbing edits are specific to the type of claim, and include but are not limited to the validation of the service code, the modifiers, the date of service, the place of service, and the providers’ NPI number on file with the MMIS. We also ensure that claims already successfully accepted by the MMIS are not sent a second time. Our system automatically generates reports after each extract with the claim identifier and the rejection reason for all claims not successfully extracted.</p> <p>Recognizing that a quality provider file extract process is vital to a successful acceptance of claims data by the MMIS vendor, ValueOptions includes a pre-extract provider file validation of required data. The claim and encounter extract process will suspend the submission of a claim or encounter if the related provider record has not been successfully extracted for submission to the MMIS. The MMIS provider extract response file is evaluated for rejected provider records, and each denied record is analyzed for correction within one week.</p>	
Monthly I-SMART reports shall be provided to all network providers who provide substance abuse treatment services and to DPH, electronically.	ValueOptions has reviewed the I-SMART program as well as the reports published and distributed to the providers. We will be able to at least meet this requirement. We have direct experience in providing report cards to providers via the web and would utilize our experience to bolster the current process.	Meet
Monthly report to DPH for the first six months, quarterly thereafter.	ValueOptions will meet the standards as set forth by this measure.	Meet
Contractor must report a description of certain transactions with parties of interest.	ValueOptions will meet the standards as set forth by this measure.	Meet
6.5.2 Reports Required Quarterly		
Financial statistical report covering the total number of Enrollees served in the Iowa Plan on a monthly basis, revenues – including capitation payment and investment income, medical expenses, administrative expenses, and net income to the Contractor. Expense data shall be reported in the format of the Budget Worksheet, unless otherwise approved in writing by DHS.	ValueOptions has significant experience in reporting requested detail financial statistical information including enrollees, capitation payment and investment income, medical expenses, administrative expenses and net income. This information will be made available from the Oracle/Hyperion General Ledger and financial reporting system.	
Quality assessment and performance improvement report covering all areas established in Section 5D in format to be negotiated between the Departments and the Contractor; the first QA report shall be due 30 days after the close of the first quarter.	ValueOptions will meet the standards as set forth by this measure. In conjunction with designated client representatives, we will identify performance improvement projects and associated indicators and measures.	Meet
Staff and Provider Network Reports: showing changes in all key staff positions and changes in the	ValueOptions will as required run Quarterly Access reports using Geo mapping software to assess changes to the network including access and availability.	Meet

7A.2.17 Management Information System

6.5 CONTRACT MONITORING AND GENERAL REPORTING REQUIREMENTS		
Requirement	ValueOptions Method/Capabilities	Status
provider network, including GeoAccess reports on the provider network for access and availability.		
Report on the number and percent of contracted providers who are credentialed by the Contractor.	ValueOptions will meet the standards as set forth by this measure. Geo mapping software as indicated above will be utilized to indicate the total number of contracted and credentialed providers to serve the Iowa community. ValueOptions can also supply separately if as desired and/or required the number and percentage of contracted and credentialed providers.	Meet
Summary of findings of provider profiling by provider category .	ValueOptions will meet the standards as set forth by this measure.	Meet
Quarterly summary report on performance indicators.	ValueOptions will work with DHS to establish an agreed upon list of performance indicators and then will provide quarterly monitoring reports on them.	Meet
A financial statement verifying the Contractor’s continuous compliance with the requirements to maintain a restricted insolvency protection account, a surplus fund, working capital and any other applicable requirements related to the Contractor’s compliance with requirements for a Limited Service Organization.	ValueOptions will provide a financial statement verifying the Contractor’s continuous compliance with the indicated requirements. Information to support this statement will be available from the Oracle/Hyperion General Ledger and financial reporting system. ValueOptions has significant experience in providing this type of compliance to a wide variety of clients and governmental agencies.	Meet
A summary of the distribution of service expenditures for Enrollees for mental health and substance abuse services; the summary information shall be provided separately for each of the populations corresponding to the four Medicaid rate cells.	ValueOptions will report service expenditures for Enrollees for mental health and substance abuse services by the four Medicaid rate cells. This reporting will be accomplished by utilizing the Oracle financial reporting system and our Data Management system which has the ability to segregate utilization by eligibility type and service code. Currently, ValueOptions utilizes this reporting for several contracts including Pennsylvania and New Mexico. In the case of Pennsylvania, the General ledger system has been structured so that the monthly revenues are presented at a rate cohort/cell level and medical expenses are presented by 12 defined levels of care by rate cohort/cell.	Meet
6.5.3 Reports Required Annually		
An annual audited financial report that specifies the Contractor’s financial activities under the contract must be submitted within 6 months following the end of each calendar year.	ValueOptions will be prepared to submit audited financial requirements with additional financial content as required under the RFP. ValueOptions has significant experience with this process and provides annual audited statements with additional specific content/agreed upon procedures for no less than five of its Public Sector contracts.	Meet
The Contractor may be required to comply with other prescribed compliance and review procedures.	ValueOptions will be prepared to comply with other prescribed compliance and review procedures as they arise.	Meet
Upon completion of the audit, a press release shall be published to announce the availability of the audit report for review by the public at the Contractor’s office.	ValueOptions shall issue a press release indicating the availability of the audit report for review as required by the RFP. Copies shall be maintained at the ValueOptions’ office in accordance with the RFP. ValueOptions currently manages a similar process with its Kansas Public Sector contract.	Meet
In addition to the annual audit, the Contractor shall be required to submit to the Departments copies of the quarterly National Association of Insurance Commissioners (NAIC) financial reports.	ValueOptions shall maintain and submit required quarterly and annual NAIC reports. ValueOptions has significant experience in working with NAIC examiners and submitting NAIC compliant financial reports on a routine basis.	Meet
A final reconciliation shall be completed by the independent auditing firm that conducted the annual audit.	ValueOptions will retain an independent auditing firm to reconcile the community reinvestment accounts within the period indicated in the RFP. The company has reinvestment provisions in most of its existing Public Sector risk contracts and is capable of insuring that the claims run-out is isolated to the correct period so that	Meet

6.5 CONTRACT MONITORING AND GENERAL REPORTING REQUIREMENTS		
Requirement	ValueOptions Method/Capabilities	Status
	reinvestment can be accurately calculated in order for reinvestment plans to be developed and executed.	
6.5.3.2 Annual Quality Assessment and Performance Improvement Report		
An annual Quality Assessment and Performance Improvement Report shall be submitted within 60 days following the close of each contract year.	It is standard practice for VO to conduct an annual evaluation of both operational processes and formal quality improvement activities This evaluation provides comprehensive status assessment and drives improvement activities for the following year. (Work plan with goals and related activities are attached to the evaluation document). Key business performance indicators are included in the measure monitored. The summary report will include findings on clinical and administrative processes, satisfaction, regulatory and contractual compliance. although the report is produced annually, quarterly updates are provided a the Quality Management Committee meetings.	

All VOI reporting defined above currently meets or exceeds the requirements of the RFP, which will ensure a seamless implementation with less disruption to enrollees, providers and the Departments.

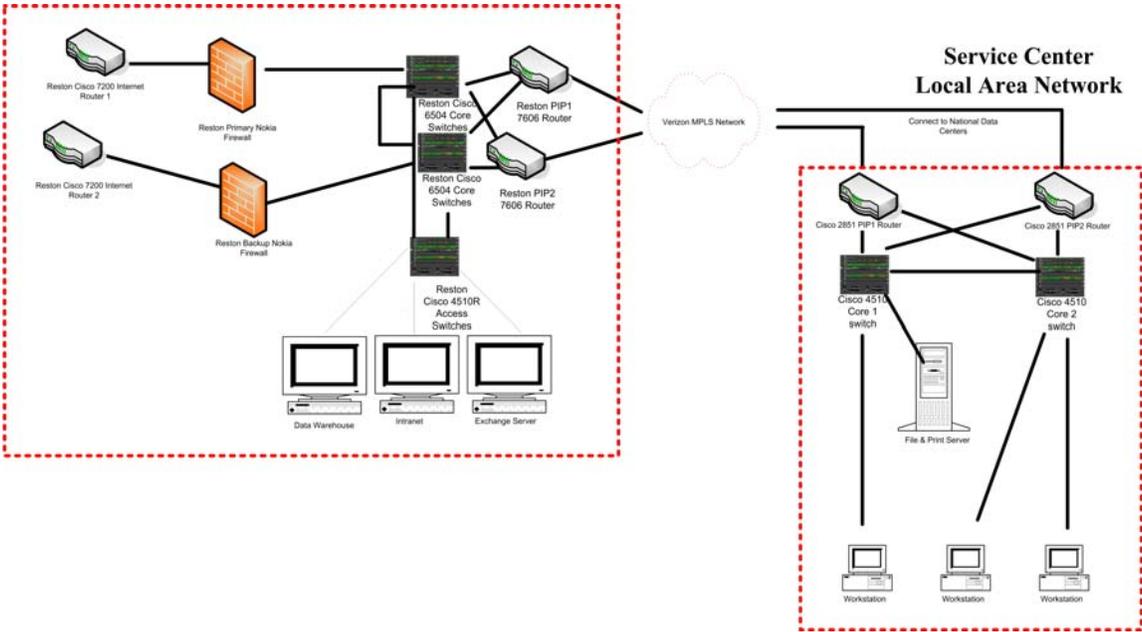
VALUEOPTIONS’ NATIONAL DATA PROCESSING CENTER

The ValueOptions National Data Center resides in Reston, Virginia, and operates on a 24 hour a day, seven day a week schedule. The data center provides the platform and support for CONNECTIONS platform, providing managed care processing for our clients. Our National Data Processing Center provides support for all major software platforms that provide managed care services for the Departments. Our application resides on an IBM iSeries (AS/400) i5 570 application server running IBM’s V5R4 OS/400 operating system. The ValueOptions i5 570 consists of multiple logical partitions including production and development environments. It is configured with a 16-way POWER5 64bit CPU with 198GB of memory, 58500 CPW Enterprise Edition and over 38 Terabytes of mirrored disk storage. An IBM 3494 Automated Tape Library (ATL) containing 23 3590-E1A and six 3592-J1A high-speed tape drives are attached for fully automated backups. Additional tape device support includes IBM 3490E cartridge and 9348 reel for client file compatibility. Host network communications includes four 1Gbps and seven 100Mbps Ethernet adapters.

For improved application availability, database transactions are replicated in real-time to a local iSeries model i5 570 840. The data replication process is executed through the use of DB2 database journaling and Visions Solutions’® MIMIX High Availability data replication software. Additionally, ValueOptions has a Business Continuity and Recovery Services contract with IBM which allows for a 48 hour hot-site recovery.

Service Center Local Area Network (LAN)— The majority of the managed care functions for the State of Iowa will be performed by our Iowa-based staff in Des Moines, as well as the three satellite offices located in Iowa. Service center and satellite office personnel will have access to the CONNECTIONS platform supported by the ValueOptions National Data Processing Centers and other system resources through the service center LAN. The service center and satellite office LAN will include network hardware, software, and communications components that support service center operations. In addition, office automation software for word processing, electronic mail, spreadsheet, and database applications run under Windows on each workstation on the service center and satellite office’s LAN. The capacities and numbers of required LAN components are determined by the expected number of personnel needed to support the forecasted number of members to be served. Reporting analysts have access to KnowledgeConnect via the LAN, which supports the required report generation and data analysis. The service center IT functions are supported by onsite IT staff and ValueOptions’ National IT staff. We have provided a physical network and infrastructure diagram on the following page as a sample of the VOI Des Moines Service Center’s configuration.

7A.2.17 Management Information System



Requirement and ValueOptions' Method of Ensuring General System Requirements	Status
<p>6.4.1 General Systems Requirements</p>	
<p>The CONNECTIONS application suite is a feature-rich suite of Web-enabled applications that was specifically designed to reduce the administrative burden imposed on providers and clinical care managers, allowing them to concentrate on behavioral health recipients rather than on paperwork. The system emphasizes paperless transactions and ensures instantaneous access to real-time comprehensive program information. In addition, our technology solutions enable and support improved communications and increased collaboration among providers, staff, and Enrollees. Our software provides real-time intelligence and greater flexibility through the use of leading software development technologies such as JAVA and partnerships with leading technology vendors, including IBM and Oracle. CONNECTIONS is composed of multiple, fully-integrated components that cover all of the functions normally required in the administration of a managed health care operation. The CONNECTIONS platform uses a shared database that integrates membership, provider data, inquiry tracking, clinical notes, authorization, and claims processing.</p>	<p>Meets</p>
<p>6.4.1.1 Edits, Audits, And Error Tracking</p>	
<p>ValueOptions receives response files from the majority of our accounts with MMIS vendors. In addition to the tight controls in place to assure compliance, and the accuracy of data submission to the MMIS vendors, we also have a robust reconciliation and management process for oversight of the response file application and process:</p> <ul style="list-style-type: none"> • Reconciliation Database – a relational database populated with ValueOptions paid claims and/or encounters submitted to the MMIS coupled with the matching MMIS disposition. This allows us to determine the outcome for each claim at the service line level (i.e., processed successfully or rejected). • Integrity/quality control process – a process utilizing multiple metrics sourced from the reconciliation database to compare submitted claims and encounters at the line and header level against the MMIS disposition status. A claim or encounter can error out at the header or line level, and fail at either the MMIS upload and validation process, or during the MMIS adjudication process. We therefore, evaluate the results at each potential failure point, and generate weekly reports from the reconciliation database to determine the current MMIS status of 100 percent of all header and line level records. These multiple metrics include paid, adjusted, and rejected claims, and reflect the MMIS disposition of newly submitted claims and encounters, the updated status of corrected claims and encounters, and summary level data used to measure the overall success of submissions. <p>The knowledge that ValueOptions has in this area is immense. In-depth knowledge and understanding of all aspects of this process to achieve and maintain submission of complete and accurate data is critical.</p>	<p>Exceeds</p>
<p>6.4.1.2 System Controls and Balancing</p>	
<p>ValueOptions implemented a comprehensive Data Verification, Validation and Accuracy program to ensure the integrity and reliability of our information. We utilize cutting-edge technology and procedures that enforce data integrity rules through a series of field edits, data validation rules and run-to-run balancing routines. Measures range from parity algorithms that verify the referential integrity of the files as well as verification checks against header/trailer information. We also reduce the threats to data integrity by having regular data backups, controlling the access of data</p>	<p>Exceeds</p>

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Requirement and ValueOptions' Method of Ensuring General System Requirements	Status
<p>by defining roles and privileges and installing security tools, designing user interfaces that can prevent invalid input, and use error detection and correction tools during data transmission. Through these methods, we ensure data integrity, validity, and completeness of all information</p> <p>The knowledge that ValueOptions has in this area is immense. In-depth knowledge and understanding of all aspects of this process to achieve and maintain submission of complete and accurate data is critical. Below we have provided brief descriptions of some controls within the CONNECTIONS platform.</p> <ul style="list-style-type: none"> • Encounter Data Receipt – Encounter data is usually submitted to ValueOptions by way of our FileConnect System, which can be accessed via a dial-up Bulletin Board System or the World Wide Web. When an encounter file is submitted through FileConnect, a number of validation routines are performed. First, the file is compared to validate it meets the expected format, then integrity checks are executed for data inside the file (header/trailer) and from data supplied from the submitter (number of records), lastly required critical data elements are checked. If the file fails any one of these validation routines, an automated message will be sent to the submitter. • KnowledgeConnect (Data Warehouse) – Encounter data is imported into KnowledgeConnect weekly. During these processing runs a number of checks are performed to validate that the data loaded into the Data Warehouse accurately matches what was transmitted. First, record counts are checked to validate that the same number of records were loaded into KnowledgeConnect as were sent to it; second, parity checks are done. Parity checks sum up dollar amounts, member numbers, procedure codes, and a few other fields to ensure that not only the same number of records exists, but the exact records are the same. • Encounter Submission – Often ValueOptions is responsible for submitting encounter data to clients and/or other third parties. In these cases we perform a number of the same validation routines that were listed in the KnowledgeConnect scenario, but in addition to that, we complete field level validation to ensure the data integrity of each data unit. Unlike the KnowledgeConnect model, if a record fails due to field level validation, rather than rejecting the entire batch, the individual record is rejected and the rest of the file is allowed to process. All rejected records are then written to a report where quality analysts correct the data in the source system and the updated records are extracted in the subsequent load. • Data Controls for All Data Exchanges – Controls are customized to the needs of the client. Many controls are in the CONNECTIONS application platform ensuring quality data. Controls such as file naming conventions include client name and file creation date, header and trailer records or record counters within each transmission, as well as IP address validations during transmissions. Additional data validations are built into our extract process. • Error Resolution – We generally create the extract as a test file, correct any issues in the CONNECTIONS application, and then generate the extract that is sent to the client. We also have custom error reports for each extract that identify any record that fails any specific client edit. The error report is then worked, and corrected data is included in the next data file. 	
6.4.1.3 Back-Up of Processing and Transaction Files	
<p>Comprehensive Daily, Weekly, Monthly and Annual Data Backup and Recovery Services – ValueOptions' technical staff within our Reston hosting facility perform full daily back-ups of all ValueOptions' production systems including our CONNECTIONS application data and our host and LAN systems. The technical staff utilizes leading automated backup and recovery utilities for daily, weekly, monthly, and annual backups. The primary tools include the following: Tivoli® Storage Manager (TSM) and Business Rules Management System (BRMS) verification and audit programs. Backups are stored offsite in a secure facility. Scheduled and random tests are executed to confirm the successful retrieval and restoration of data.</p>	Exceeds
6.4.2 Data Management	
<p>KnowledgeConnect receives imports from the CONNECTIONS platform and other systems for reporting purposes. This data is formatted and stored as standard data into our Oracle relational database system. An advantage of this data warehousing technique is the easy insertion of data from external sources. Data from outside sources can be integrated into the data models to enhance reporting capabilities. These standard data models are used as the foundation for report generation, statistical analysis, decision support, and outcomes management.</p>	Meets
6.4.3 Pharmacy Information Transmission	
<p>The PharmaConnect service screens all patients for potential controlled substance abuse with configurable rules that include multiple prescribers, multiple pharmacies, excessive quantities and the unique ability to calculated total daily controlled substance doses grouped by drug category.</p>	Meets

All VOI systems defined above currently meet the requirements of the RFP, which will ensure a seamless implementation with less disruption to enrollees, providers and the Departments.

- b) Describe adaptations to the Bidder's MIS which would be made to allow reimbursement for covered, required and optional services provided even if the Enrollee's Medicaid eligibility and Iowa Plan enrollment effective date were determined subsequent to the Eligible Person's month of application.

To address retroactive eligibility and ongoing service request needs, VOI proposes the use of our Enrollee registration process available to providers through ProviderConnect. VOI will work with the Departments to require providers to complete the registration process for all Iowa Plan Enrollees in addition to those targeted Enrollees of mental health or substance abuse benefits who are not currently funded through the Iowa Plan, but may be eligible for services in the future. The registration will be requested prior to rendering care, or requesting an authorization for those services that require prior authorization.

If the Enrollee is being seen on an urgent basis, the provider will contact our Clinical Customer Service unit, which will create a "temporary" Enrollee record, and services will be authorized. Once the Enrollee's condition is stabilized, the provider will then be required to complete the registration process. The Enrollee registration module is customizable to meet the needs of the Iowa Plan; the process can be as simple as submission of the minimum data needed to establish an eligibility record, or can be customized to collect the data necessary to validate eligibility for different funding sources or the national outcome measures (NOMs). For Medicaid-covered services, the registration serves only to notify VOI of a new Enrollee. Medicaid eligibility would not become effective until the Enrollee's enrollment data is submitted via the 834 eligibility file or FACS files from the MMIS.

VOI will seamlessly integrate registration data submitted by providers with MMIS eligibility and FACS data. We maintain and systematically update a master file of all enrollment information using EligibilityConnect. For the Iowa Plan, VOI will ensure that the MMIS eligibility and FACS data is loaded promptly based on the agreed-upon frequency (e.g. daily/weekly) to minimize the risk of denying a claim inappropriately. To ensure that duplicate registrations are not entered into the system, as the provider creates the registration, our system will validate that no other record for that person already exists within our CONNECTIONS platform.

- If there is no match, CONNECTIONS will create a unique Enrollee ID and record using the demographic information the provider entered during the Enrollee registration process. This information can be associated with multiple funding sources and benefit structures or only those select funds, depending upon the customizations requested.
- If there is an exact match to a previously registered Enrollee, or to a record that was provided by the MMIS, the state may prefer that we simply notify the provider of the existing Enrollee ID, or may require that a second registration be completed. Registrations can be fund-specific, and if the provider wishes to provide services under a fund for which the Enrollee is not registered, the provider is advised of the funds for which registrations are on file, and will be prompted to continue with the registration for the new fund requested. The registration data from multiple submissions or providers is linked to the Enrollee and is available for reporting as well as processing of authorizations and claims.
- If the record is a potential duplicate, the system will alert the provider that the registration must be suspended. Our Eligibility Specialists will review the potential duplicates within the system and determine if the provider is attempting to register a new Enrollee. We will notify the provider of the outcome via telephone, or via ProviderConnect, which includes secure email transaction capability. If the registration is indeed a duplicate, the Enrollee's ID will be provided; if it is not a duplicate, the provider will be asked to complete the registration.

Providers may submit Medicaid-covered services for registered Enrollees. If the Enrollee's Medicaid application has not yet been approved (eligibility has not been transmitted by the MMIS), we can either:

- deny the claim, notifying the provider that the Medicaid enrollment has not been received, but if approval is received within 90 days, VOI will reprocess the claim automatically; the provider will not need to resubmit the claim, or
- hold the claim open for up to 60 days to allow for eligibility to be transmitted from the MMIS or FACS, and process the claim once eligibility has been received; if eligibility data is received after 60 days and after we have denied the claim, the provider will need to resubmit the claim, or call our claims customer service department.

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For non-Medicaid benefits, “assumed” eligibility records are created for the Iowa Plan benefits and services authorized accordingly. The Enrollee record will be flagged to denote that the Enrollee record was created via the Enrollee registration process and does not exist in the MMIS eligibility file. Claims payment would occur and the encounter information would be passed to the state’s MMIS for eligibility validation purposes. If during the MMIS eligibility validation process, it is determined that the Enrollee is not eligible for benefits, this information would be passed back in the reconciliation file. Based on the error code received, the claim will be reviewed and handled in accordance with the established recoupment policy and procedure.

EligibilityConnect has an automated front-end eligibility load module to process enrollment and disenrollment information in VOI’s standard format, or a customized load. Client preferences control identification codes that control processing requirements, such as allowing the capability to link a family unit to an individually enrolled member.

ValueOptions’ fully-integrated membership eligibility and enrollment module interacts with references, benefits, contracts, groups, claims, providers, authorizations, and utilization during the adjudication process to ensure eligibility of a member entering treatment. The National Eligibility Specialists coordinate eligibility data transfer, to ensure that all information is loaded properly and interpreted quickly so that the system remains up-to-date. Managing the membership area of a program such as the Iowa Plan requires that specific functions be performed at regular intervals. These functions typically involve the entry and maintenance of membership information, billing, reports, and member cards, and inquiries necessitating specific information for phone conversations. Some of the basic membership features include the following:

- online and batch Enrollee-entry processing,
- multiple option/benefit packaging per Enrollee group (population/cohort) with provider network,
- integrated correspondence generation capabilities,
- free-form message tracking for inquiry and reporting,
- free form Enrollee numbers up to 15 characters,
- automatic retroactive capitation/billing based on eligibility changes,
- integrated general ledger by company/Enrollee group/benefit parameters,
- user-defined eligibility edits and reporting,
- user-defined service edits by Enrollee/Enrollee group to control adjudication, and
- online changes with history archival.

c) Describe the process the Bidder would put into place to ensure appropriate allocation of reimbursement in the following situations:

- services were being provided to a person who was an Enrollee and whose Medicaid eligibility terminated and the person then, during the same treatment episode, became a IDPH Participant,
- services were being provided to a person who was an IDPH Participant receiving services and, during the same treatment episode, became an Enrollee.

Provide as references the name, telephone number and e-mail addresses of three publicly funded clients that can be contacted to discuss the Bidder’s MIS performance under similar contracts.

Based on policies established by DPH and DHS, DPH will be considered the “payor of last resort.” Therefore, VOI will ensure that all substance abuse programs comply with the following guidelines:

- During months in which an Enrollee of a substance abuse program is included on the Iowa Plan enrollment tape generated by DHS, the substance abuse program must authorize or register that Enrollee’s services with VOI as Iowa Plan Medicaid services. The substance abuse program will submit a claim, which will be reimbursed by VOI from funds in the medical budget allocation of the Medicaid capitation payment.
- Services provided by a substance abuse program during a month in which an Enrollee is not included on the Iowa Plan enrollment tape should be included in DPH minimum number and Enrollee counts based on DPH eligibility criteria.

Therefore, in the situations cited above, in (i), the provider would bill the Iowa Plan for services provided during months in which the Enrollee was enrolled in the Iowa Plan and would report the Enrollee as a DPH client during

7A.2.17 Management Information System

other months in which services were provided. The same logic would be followed in the scenario reflected in (ii). Treatment episodes do not impact financial responsibility for those served through substance abuse programs. The only instance in which an Enrollee would appropriately access services through both DPH and Medicaid during the same month is a woman who is an Iowa Plan Enrollee and is being served in one of the women and children's programs which receive joint funding through DPH and DHS.

To assure compliance with this requirement, VOI will work with DPH to do a comparison of Enrollees included in the DPH client count with the Medicaid enrollment file of the same month. As long as the I-SMART number is retained in the file provided by DPH to VOI, the VOI reporting analysts will be able to identify potential errors in allocation by matching part of the I-Smart number and segments of Medicaid Enrollees' social security numbers.

REFERENCES

The following clients will provide references regarding the process ValueOptions has put in place to ensure appropriate allocation of reimbursements:

- Jackie Manker, Associate Director for Community Services, Illinois Department of Human Services, Division of Mental Health Statewide; telephone (217) 782-5700; email Jackie.manker@illinois.gov.
- Linda Zelch, Area Director, Western Service Area, Office of Mental Health & Substance Abuse Services, DPW; telephone (412) 565-5226; email lzelch@state.pa.us.
- David Dickinson, Director of Addiction and Prevention Services, Kansas Department of Social and Rehabilitation Services Substance Abuse Treatment Program Prepaid Inpatient Health Plan; telephone (785) 368-6392; email ddickinson@srs.ks.gov.

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- a) Disclose the financial instruments the Bidder would use to meet the requirements of all fund and accounts required in Section 6.6. Disclose the source of the capital required.

As required by Section 6.6 of the RFP, VOI will maintain the following:

INSOLVENCY

To comply with the insolvency requirements, VOI will provide at all times an account containing an amount equal to two months of the total annual Medicaid capitation amount. The insolvency protection account will be a restricted account that may be drawn upon with the authorized signatures for the two designees of VOI and the DHS designees. DHS shall have the right to draw upon this account to pay incurred claims, should a determination of insolvency be made. The required funds will be provided by ValueOptions, Inc., and will be deposited into an escrow account. The funds will be invested in a combination of certificates of deposit, money market funds, short term commercial paper, and cash.

SURPLUS FUND

VOI will maintain surplus at all times, in the form of cash, short-term investments allowable as admitted assets, or restricted funds or deposits controlled by the DHS, an amount equal to 150 percent of the Contractor's average monthly Medicaid claims fund (83.5 percent of the capitation payment) for the most recent quarter. Funds in the Insolvency Protection Account may be included in the surplus amount. The required funds will be provided by ValueOptions, Inc., and will be deposited into an escrow account. The funds will be invested in a combination of certificates of deposit, money market funds, short term commercial paper, and cash.

WORKING CAPITAL

VOI will maintain working capital in the form of cash or equivalent liquid assets controlled by the DHS at least equal to the total amount of the designated Medicaid administrative fund from the most recent three-month period of the capitation payments. The required funds will be provided by ValueOptions, Inc., and will be deposited into an escrow account. The funds will be invested in a combination of short term commercial, paper, certificates of deposit, money market funds and cash.

In accordance with Section 6.6 of the RFP, VOI will establish these accounts prior to the payment of the first capitation payment.

COMMUNITY REINVESTMENT ACCOUNT

From the monthly capitation payment, ValueOptions will transfer the community reinvestment required amounts into a separate bank account from which disbursements for community reinvestment activities shall be made. The separate bank account shall be for the purposes of reinvestment activities only and will not commingled with any other operating funds.

INTEREST EARNED

ValueOptions' Treasury department manages a sophisticated investment program whereby on a daily basis any funds not required for immediate payment/release are invested. Using guidelines approved by the company investment committee, investments are made primarily in money market funds with a 2a-7 status under the Securities Act of 1940, and are classified as a domestic money market fund. Additionally the funds that we use are generally collateralized with US treasury obligations. The investment funds are also rated as Class 1 under NAIC and are approved the Department of Insurance. Interest earned is separated by Iowa funding source (e.g., interest on claims, interest on community reinvestment, interest on insolvency/surplus). Interest due to the state shall be remitted to the appropriate Iowa treasury department as required by the RFP.

- b) Demonstrate that the Bidder's organization is in sound financial condition and/or that appropriate corrective measures are being taken to address and resolve any identified financial problems. The Bidder must attach the most recent two (2) years of independently certified audited financial statements of the Bidder's organization as well as the most recent two years of financial statements for the Bidder's parent company, if applicable. These financial statements are not included in the page limit established for this section.

To document VOI's sound financial strength and resources, we provide ValueOptions' two most recent independent audited financial statements and associated enrollment figures as **Attachment 4**.

In accordance with Code of Iowa Section 22.7.18 and Section 2.20 of this RFP, **ValueOptions requests that the financial reports included in response to this question be considered confidential.**

- c) Discuss what impact the recent declines in the stock market have had on the Bidder's financial stability, how the Bidder has responded, and any implications for the Bidder's ability to meet the requirements of this RFP.

Stock market issues will not hinder ValueOptions' ability to meet the requirements of this RFP. ValueOptions, the nation's largest independent behavioral health care company, is a privately held company, meaning ValueOptions does not trade on a stock exchange. Rather, we are owned by private shareholders. Their focus is that we operate our business consistent with the long-term needs of our clients. As a result, the market fluctuations and shareholder issues that worry our public-company competitors do not distract us from delivering efficient and effective services for our State customers.

If the stock market goes down, there is no direct impact on ValueOptions. That means we can continue to place all of our focus on helping our clients and the people we serve every day. Our competitors worry about how far their stock prices have dropped and what cutbacks they will have to make in order to prop up their sagging dividends. As a private company, ValueOptions is not distracted by such issues and can focus full attention on those who need our services.

In fact, we have found that in these difficult economic times our public sector clients need ValueOptions to help them find new and innovative ways to manage their already tight behavioral health care budgets. As you can see, issues on Wall Street have no direct impact on ValueOptions' ability to fulfill all of its contractual requirements.

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7A.2.19 Claims Payment By The Contractor

- a) Describe the process the Bidder would implement to ensure compliance with the required time frames for claims processing. The Bidder may suggest more restrictive time frames than those required in Section 6.7 of this RFP for the processing of claims that the Bidder wishes to implement.

ValueOptions' CONNECTIONS platform is uniquely qualified to meet the claim processing requirements for the State of Iowa. Not only is CONNECTIONS' claims module, ClaimsConnect, capable of managing standard claims requirements, such as timely filing, and compliance with state and federal laws, rules and regulations, but it is unique within the industry as it is capable of managing Iowa's claims processing requirements across and within multiple funding streams. Specifically, it can maintain benefit structures, provider reimbursement methodologies, and adjudication rules for each program. It is fully-integrated with EligibilityConnect (including data collected regarding other coverage a consumer may have), NetworkConnect for provider contracting and fee schedules, as well as payment hierarchy, benefits, timely filing, duplicate validation, authorization requirements and many more. All functions allow custom edits configured to meet the processing requirement of DHS and DPH.

Paper claims are scanned, allowing ValueOptions to create digital versions which are processed as electronic data interchange (EDI) claims. An online image, which is made available to claims and customer service, is also created from this process. ValueOptions receives and processes encounter-based services utilizing the same procedures and controls for services covered under Block Grants applying appropriate funding stream, adjudication rules, provider accumulations (e.g., one/twelfth drawdown, application of encounter value maximums, and payment maximums either at the service level or for a specific time period), and payment methodologies. Paper "EDI" claims/encounters, batch claims/encounters submitted via HIPAA 837P and 837I files, as well as claims/encounters submitted directly through our Web application are auto-adjudicated against the same rules. ValueOptions is capable of achieving an auto-adjudication rate between 80 and 85 percent for its public sector accounts.

When clients request that checks are generated only once per week, timeframes for claims processing are calculated from the day the claim is received by VOI until the date the claim is ready for payment. When multiple check runs occur per week, time frames are calculated using the date of the postmark (or electronic record for electronic remittance) which returns either the payment or denial to the provider. In order to accommodate the Iowa Plan claims processing timelines outlined in Section 6.7, we may need to have multiple check runs within a given week to accommodate the turnaround time as defined in the RFP:

- for at least 85 percent of claims submitted, payment shall be mailed or claims shall be denied within 14 days of the date the claim is received by the Contractor;
- for at least 90 percent of claims submitted, payment shall be mailed or claims shall be denied within 30 days of the date the claim is received by the Contractor, and
- for 100 percent of claims submitted, payment shall be mailed or claims shall be denied within 90 days of the date the claim is received by the Contractor.

CLAIMSCONNECT

ClaimConnect is one of the most robust systems in the industry. Our claims processing capabilities in ClaimsConnect are augmented by the integrated eligibility/enrollment, provider, electronic claims submission, inquiry tracking, data warehouse, and interactive voice response subsystems. In virtually all of our large accounts, we coordinate closely with the client's medical/surgical carrier or HMO to ensure coordinated claims payment and benefits administration. Not only does this require orchestrating a number of claims-related processes with providers, our clients and their intermediaries, it also necessitates having technical flexibility. ValueOptions will use this technical flexibility to design a claims processing program that meets the unique claims processing and reporting requirements of the Iowa Plan.

The ValueOptions Braided FundingSM logic within ClaimsConnect uses client-defined hierarchy rules to determine the funding source applicable for authorization and claims processing. Therefore, the highest priority funding stream, as defined by the client, is used to process the claim where the service is covered, the consumer is eligible or registered, and the provider of service is contracted. To facilitate robust reporting of claims data, the correct funding source is associated to all claim lines and is available for all reporting, customer support, and processing functions within the system.

7A.2.19 Claims Payment By The Contractor

- b) Describe the Bidder's experience in implementing contracts in which the claims payment process supported the accurate and timely payment of claims as of the first day of operations. Include the names of the programs, the number of covered lives in each, and provide the names, telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

ValueOptions has experience in implementing contracts in which the claims payment process supported the accurate and timely payment of claims as of the first day of operations in our Massachusetts, Pennsylvania, and Texas programs.

MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP

The Massachusetts Behavioral Health Partnership was selected by the Commonwealth to manage one of the largest existing Medicaid managed behavioral health carve-out contracts in the nation. Since its selection, the Partnership has been responsible for managing mental health and substance abuse benefits for more than 400,000 Medicaid beneficiaries and 30,000 uninsured persons. The program has been in operation since July 1, 1996, when the contract was assumed from another vendor

Claims were accepted from the first day of the contract period and have always been paid within contract specifications. The claims payment issue was especially sensitive in the implementation since this was a contract previously held by another vendor. Based on ValueOptions performance during this contract, the contract was re-awarded in July 2000 with an effective start date of October 1, 2000 for a contract period of 5 years with 5 one-year extensions.

Internal Reference: for additional information on this program, contact Suzanne Fields, Director of Behavioral Health, Office of MassHealth, telephone (617) 348-5101, email suzanne.fields@state.ma.us.

PENNSYLVANIA

ValueOptions has been managing the HealthChoices program in nine Southwest Pennsylvania counties since 1999. Under the contracts, ValueOptions manages mental and substance abuse services for approximately 150,000 Medicaid recipients.

On April 1, 2002, the Pennsylvania Service Center completed an IT migration and went "live" while concurrently opening its own claims payment operation. Twenty-four hours later, the Service Center produced its first check run. Since that date, the Service Center has been processing 8,000 to 11,000 claims per week. Currently, 75 percent of electronic clean claims adjudicate and generate payment in no more than four business days. All claims, clean and unclean, are processed with a maximum 21 day turn-around-time. In addition, they maintained timely and accurate submissions of all state mandated reporting, prior to, during and following the systems migration.

The 14 counties have just extended their contracts with ValueOptions, and the customer and provider satisfaction with claims payment greatly contributed to the successful determination. ValueOptions has also recently added Erie and Cambria counties, as well as the six-county Northwest Behavioral Health Partnership.

Internal Reference: for additional information on this program, contact Dave McAdoo, Executive Director Southwest Behavioral Health Management, Inc. (can discuss our contract for the Southwest six (6) counties), telephone (724) 657-3470, email cmcadoo@swsix.com.

TEXAS

On July 1, 1999, ValueOptions became the managed behavioral health care program for NorthSTAR, a Medicaid carve out program in Dallas, Ellis, Hunt, Kauffman, Navarro, and Rockwall Counties in Texas. On July 27, 2000 the Texas Department of Mental Health and Mental Retardation announced the transition of 130,000 new consumers to ValueOptions' care from the network of another managed behavioral health care company. ValueOptions grandfathered all consumers into our program and expanded the provider network to encompass all NorthSTAR providers who were not previously ValueOptions providers.

Prompt and accurate claims payment was one of many successful components of the implementation. Consumers, providers, and other community stakeholders responded favorably. Karen F. Hale, Commissioner of the Texas

7A.2.19 Claims Payment By The Contractor

Department of Mental Health and Mental Retardation (TDMHMR) said, “We have had a positive first year working with ValueOptions. We appreciate their responsive attitude and we look forward to our next year with them. ValueOptions has consistently proven to be collaborative and professional in their dealings with this agency, the Dallas Area NorthSTAR Authority, and the seven counties [served by the program].”

We provide the following references of clients for with whom we have experience implementing a claims payment process:

- for additional information on the NorthSTAR program, contact Matthew Ferrara, Office of NorthSTAR and Special Initiatives, telephone (512) 206-5444, email matthew.ferrara@hshs.state.tx.us.
- for information on the Florida program, contact Jorja Daniels, Florida PMHP Area 6 Contract Manager, telephone (813) 871-7600 Ext. 132, email Danielsj@ahca.myflorida.com.

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- a) Describe how the Bidder will comply with the Departments' Fraud and Abuse requirements and provide examples of how your internal controls successfully work to prevent such Fraud and Abuse.

ValueOptions' comprehensive Compliance Program is designed with the overarching goal of ensuring contractual, regulatory, legal, and ethical behavior is maintained in all aspects of the Department's work entrusted to ValueOptions. This not only includes ValueOptions' business operations but those of our providers and subcontractors as well. The ValueOptions Compliance Plan addresses overall program integrity, including anti-fraud activities. ValueOptions has dedicated company resources and has aligned our Compliance Plan to be consistent with the priorities and emphases established by state and federal anti-fraud authorities.

COMPONENTS OF VALUE OPTIONS' COMPLIANCE PLAN

ValueOptions' Compliance Plan specifically encompasses the seven components of a Compliance Plan consistent with the federal sentencing guidelines.

1. Policies and Procedures

Code of Conduct

ValueOptions' Code of Conduct establishes and provides instruction on the Company's expectations for all staff to act in an ethical manner and comply with federal and state laws. All staff are required to review and attest to their understanding of the Code of Conduct within 90-days of hire and on an annual basis thereafter. ValueOptions also has an Agent and Vendor Compliance Program Notification published on ProviderConnect, informing agents, subcontractors, vendors, and consultants of the expectation that they adhere to the ValueOptions Compliance Program.

Policies and Procedures

ValueOptions' written Policies and Procedures include, but are not limited to reporting and investigation of unethical conduct, including fraud, abuse and special investigations, conflicts of interests, privacy, debarment and sanction screening, document retention and policy review. ValueOptions of Iowa, will develop additional procedures to address specific requirements for the State of Iowa, including procedures for reporting to the Departments within appropriate timelines and utilizing state approved forms.

2. Training

All ValueOptions' staff are required to complete training within 90-days of hire and annually thereafter in Fraud and Abuse, Whistleblower Regulations, Privacy and Confidentiality and the Code of Conduct. The Annual Training complies with the Deficit Reduction Act. ValueOptions will inform consumers on how to identify and report suspicious activity or potentially fraudulent provider practices, consumer responsibility, consequences of wasteful, abusive, or fraudulent use of the health care services, and the existence and role of the Medicaid Fraud Control Unit (MFCU). Such information is distributed through the Enrollee Handbook.

3. Accountability

ValueOptions of Iowa will have a designated Compliance Officer who will report to the Executive Director and be responsible for the Fraud and Abuse Program and activities related to the Iowa Plan for Behavioral Health. VOI will also have a Compliance Committee that includes the Executive Director, Chief Operation Officer, Chief Financial Officer who may require attendance by other individuals as necessary. The VOI Compliance Officer will also be supported by the ValueOptions National Compliance Department. The National Compliance Officer reports to General Counsel and has authority to report directly to the Chief Executive Officer and the Board of Directors. ValueOptions has established a two-tier Compliance Committee Structure. The Executive Compliance Committee consists of executive level management. The National Compliance Work Group consists of service center compliance leads/officers and the National Directors of Compliance. The National Directors of Compliance coordinate communications between the two Compliance Committees. Compliance leads/officers are responsible for coordinating communications from the Committees to appropriate staff within their Service Center.

4. Open Lines of Communication

ValueOptions' Code of Conduct requires staff to report potential fraud and abuse and ethical violations. Staff may report such concerns to either management, Human Resources, Service Center Compliance Leads or the National

Compliance Department, through the ValueOptions Ethics Hotline. Employees will not be subject to retaliation or retribution for reporting, in good faith, actions that they feel may violate the law or established policies.

5. Disciplinary Guidelines

ValueOptions enforces the Company's ethics and compliance standards through consistent application of disciplinary action, up to and including termination. ValueOptions prohibits hiring of employees or contracting with providers, vendors, or other third parties who are excluded, debarred, or ineligible to participate in federal and state health care programs. ValueOptions' background investigation and credentialing processes include review of the Excluded Parties List System, List of Excluded Individuals and Entities, and Specially Designated Nationals List. Employees, providers, and vendors are also checked on an ongoing basis.

6. Auditing and Monitoring

ValueOptions conducts ongoing monitoring and auditing activities to prevent and detect waste, abuse, fraud, and other unethical/non-compliant conduct. ValueOptions' Audit and Recovery Unit conducts retrospective reviews of monthly reports created to capture all claims that are paid with system edits/identifiers (e.g., possible duplicate, eligibility, and no authorizations).

In conjunction with the authorization search and message indicators, if there are multiple services billed on the same service date, or range of service dates, the CONNECTIONS Administrative System will administer either a possible duplicate or duplicate claim edit. The possible duplicate or duplicate claim edit is received when the same member identification number, date of service, provider of service, or service code is consistent on more than one date or claim. Claims processors research duplicate claim edits to deny duplicate claims once the duplication is verified.

The SIU examines and identifies billing trends through a set of reporting tools. These "data mining" tools include biweekly, monthly, and yearly reports examining:

- high volume of sessions, dollars paid and/or unduplicated enrollees reports,
- family groupings of sessions,
- duplicate claim submission, and
- matching surnames (providers and members with matching surnames).

7. Investigation, Response, and Corrective Actions

The Compliance Department and/or SIU conduct preliminary investigations of all reports or reasonable indications of possible violations of the Code of Conduct, Fraud, Abuse or other unethical conduct. All credible cases are fully investigated by either the Compliance Department or SIU, in accordance with compliance investigation policies and procedures and applicable federal and state laws and regulations.

Additionally, ValueOptions is a Corporate Member of the National Health Care Anti-Fraud Association (NHCCA). Membership with this organization includes: access to the SIRIS Database of Member Companies' Active Investigations, case-specific Requests for Investigations Assistance from Law Enforcement, and national news clips regarding health care fraud.

Corrective action to address identified non-compliance and/or unethical conduct or activity will be initiated within an appropriate timeline to mitigate and/or prevent future harm. Corrective actions may include, but are not limited to, amending or developing policies and procedures, training, recoupment of overpayments, on-going monitoring and disciplinary action, up to and including termination of employment or contracts.

RERPORTING AND COOPERATION

The VOI Compliance Officer will be responsible for coordinating and reporting information to the Department and oversight agencies as required by the contract and applicable federal and state laws and regulations. ValueOptions, through its policies and contracts, requires employees and subcontractors to cooperate fully with oversight agencies responsible for fraud and abuse detection and prosecution activities, including providing access to all necessary case information, computer files and appropriate staff.