OPTUM®

Optum Idaho

Idaho Behavioral Health Plan
Quality Management and Utilization Management
Annual Evaluation

2020

The Quality Management and Utilization Management (QMUM) 2020 Annual Evaluation summarizes Optum Idaho's performance in accordance with the contract between the Idaho Department of Health and Welfare (IDHW), Division of Medicaid and Optum. This report highlights the outpatient behavioral health services covered by the State of Idaho and provided on behalf of Medicaid members, also known as the Idaho Behavioral Health Plan (IBHP). This QMUM report provides a year over year annual view of performance and outcomes data.

Doc ID 246-2020

Table of Contents

Table of Contents (continued)

Introduction and Overview

The Quality Management Utilization Management (QMUM) Annual Evaluation provides an analysis of the Medicaid outpatient mental health and substance use disorder services managed by the Idaho Behavioral Health Plan (IBHP) in the State of Idaho. The time frame of this evaluation includes activities beginning January 1, 2020 through December 31, 2020 and provides comparative performance from 2014 – 2020.

Our Mission

The following mission statement was written and distributed by the Idaho Department of Health and Welfare (IDHW) and serves as a guiding declaration for the IBHP QMUM Program:

Our mission is to promote and protect the health and safety of Idahoans.

- Improve the quality of care provided to all behavioral health Members;
- Improve behavioral health Member satisfaction with services received; and
- Improve health outcomes for all behavioral health Members.

This mission is actualized in the strategic goals developed by the Optum Idaho Leadership Team and monitored through 3 required Core Documents: *Quality Assurance Performance Improvement (QAPI) Program Description*, the *Outcomes Management and Quality Improvement Work Plan*, and the *Quality Management Utilization Management Annual Evaluation* (this document). These documents are reviewed, updated, and submitted to the Quality Assurance Performance Improvement Committee (QAPI) each year for review and approval.

This *QAPI Program Description* represents Optum Idaho's blueprint for ensuring continuous quality improvement (CQI) is implemented throughout the entire organization, as well as the provider network and in all our interactions with the community. The *QAPI Program Description* establishes the groundwork that drives improvement for key measures identified in our *Outcomes Management and Quality Improvement Work Plan*.

The *Work Plan* outlines the key service and utilization metrics related to clinical and administrative effectiveness that are monitored on a monthly, quarterly, and annual basis. The purpose of the work plan is to drive continuous improvement in care and service by addressing system-wide quality improvement opportunities. The CQI philosophy enables use of the work plan to facilitate:

- Ensuring performance targets continue to be met.
- Identifying opportunities for improvement.
- Developing action plans based on root cause analysis for targets not met.
- Ensuring implementation of appropriate actions in a timely fashion.
- Monitoring effectiveness of interventions implemented.
- Developing additional targets and or activities when indicated.

Optum Idaho's comprehensive QMUM program encompasses outcomes, quality assessment, quality management, quality assurance, and performance improvement. The QMUM Program is governed by the QAPI Committee and includes data driven, focused performance improvement activities designed to meet IDHW and federal requirements. Optum Idaho's QMUM Program utilizes key measures and outcomes to evaluate and improve the services we provide to IBHP members. The QAPI Committee routinely monitors performance of key measures and outcomes.

This *Annual Evaluation* provides an assessment of the overall effectiveness of the IBHP's programs and services provided. The purpose of this *Annual Evaluatio*n is to share with internal and external stakeholders, Optum Idaho's performance, outcomes and improvement activities related to services we provide to IBHP members and contracted providers.

Executive Summary

In 2020 Optum continued to promote and be a positive influence to achieve the right care at the right time for members. Each quarter, Optum Idaho monitored performance measures to ensure the needs of IBHP members and providers were being met. Performance targets are based on contractual, regulatory, or operational standards. Included in this report is an analysis of Optum Idaho operational functions—these include outcomes analysis, member satisfaction surveys, provider satisfaction surveys, performance improvement projects, access and availability, member protections and safety, provider monitoring and safety, utilization management and care coordination, population analysis, and claims.

Based on the overall 2020 annual data, Optum Idaho met or exceeded performance for 30 (94%) of the 32 total key measures. Two (2) measures fell slightly below the performance goal but were still within 5% of meeting the goal: 1) Adverse Benefit Determination (ABD) written notification turnaround time and 2) response to written notification turnaround time. Optum Idaho continually monitored the performance metrics and implemented strategies to address measures that fell below the goal. Optum Idaho remained committed to IBHP members and families in transforming the behavioral health care system in the State of Idaho.

Monitoring member satisfaction with behavioral health services remained vital to establishing the voice of the member. Overall member satisfaction met the goal of ≥85% throughout 2020. The goal was also met for member satisfaction with Counseling and Treatment; Optum Support for Obtaining Referrals or Authorization; and Accessibility, Availability, and Acceptability of the Clinician Network. Members also indicated that they were consistently satisfied with the time it took to get an appointment and with the ability to find care that was respectful of their language, culture, and ethnic needs.

Monitoring provider satisfaction with Optum Idaho is vital to establishing the voice of the provider. Several action plans were implemented during 2020 to impact provider satisfaction and, for the first time since the provider satisfaction survey was implemented, the goal of ≥85% overall provider satisfaction was met at 88%.

Throughout 2019, challenges were experienced in meeting the performance measure of answering member calls within 30 seconds. During 2020, Optum Idaho continued to monitor this measure and while performance did not meet the goal during 2 quarters (Q3 and Q4), overall performance for this measure met the goal for the year.

Other areas in which Optum Idaho continued to meet and/or exceed performance standards are: provider customer service calls, access standards to urgent, critical and non-urgent appointment wait times; provider dispute resolutions; member appeal resolutions; critical incident reviews; and claims paid within 30 and 90 days.

Medicaid Expansion

In November 2018 Idaho voters passed Medicaid Expansion. In March 2019 IDHW submitted a waiver to CMS for Medicaid Expansion. In April 2019 the Legislature allocated funding for Medicaid Expansion. An estimated 91,000 Idahoans gained eligibility through expansion, with an estimated 70,000 eligible on the go live date of 1/1/2020.

Optum Idaho collaborated with IDHW to serve new members as they became eligible for Medicaid through the Medicaid Expansion population. Optum implemented changes to the 834 eligibility file, added new eligibility codes, ensured that eligibility and information in Linx was correct, worked to ensure that network met adequacy standards, implemented new services, ensured claims system worked, and updated reports to ensure the authorization/services/claims correctly conveyed information.

During Medicaid Expansion, additional services were added to the IBHP continuum of care (implementation of each service included routine implementation tasks, such as revisions to the provider manual, level of care guidelines, fee schedule, and trainings):

- Recovery Coaching
- Partial Hospitalization (MH/SUD)
- Reimbursement for Medicaid members seen at Regional Crisis Centers.

Telemental Health

During the COVID-19 pandemic, Optum Idaho and IDHW worked quickly and collaboratively to provide telemental health as an option for providers to ensure providers had the ability to continue to offer services to members. Telemental health has been shown to successfully impact issues of access, quality, engagement, coordination of care, and cost effectiveness. And it's a great alternative when clients are unable to visit a provider's office in-person. Along with other aspects of telemedicine, telemental health has grown rapidly with more customers and health care consumers requesting the technology. To ensure best practices, major clinical associations such as the American Psychological Association (APA) and American Telemedicine Association (ATA) have developed and released best practices and guidelines.

During 2020, members and providers were made aware of the availability of this service to ensure members had the ability to receive continued care during the pandemic.

Hello Idaho!

Hello Idaho! was developed in 2020 to help reduce isolation and encourage everyone to reach out and connect with those around them. This year-round campaign provides tools for students, businesses and community members to talk about mental health and help reduce both emotional and physical isolation.

Youth Empowerment Services

YES services continued to provide a way for families to find the mental health help they need for their children and youth. YES is strengths-based and family-centered, and it incorporates a team approach that focuses on providing individualized care for children.

The YES System of Care refers to the entirety of the mental health supports and resources for children and adolescents in Idaho who have been determined to have a serious emotional disturbance (SED). The YES System of Care requires provider adherence to the YES Practice Model and the YES Principles of Care for all child and adolescent Members they serve. All mental health services are part of the YES System of Care.

The YES Program refers to a specific population within the YES System of Care. These are individuals who are eligible for Medicaid under the 1915(i) State Plan Option. To be eligible for Medicaid under the 1915(i) State Plan Option, individuals must undergo an independent assessment that will be used to determine if the child or adolescent has a SED. If it is determined that the child or adolescent has a SED, those who did not previously qualify for Medicaid will then re-apply for Medicaid with higher income limits. If established, these now eligible Members may receive Medicaid-funded services.

The services that were added to the IBHP as part of the YES System of care:

- Behavior Modification and Consultation
- Child and Adolescent Needs and Strengths (CANS)
- Child and Family Team (CFT) Interdisciplinary Team Meeting
- Crisis Intervention
- Crisis Response
- Day Treatment
- Family Psychoeducation
- Respite
- Intensive Home and Community Based Services
- Skills Building Treatment Planning – Teaming
- Targeted Care Coordination
- Youth Support

Throughout 2020, Optum Idaho remained dedicated to raising awareness about mental health and wellness and the resources that are available to help people reach recovery. Through community engagement activities, informational media coverage or organized events, Optum Idaho continued its focus on an outcomes driven, recovery-centered system of care for Idaho members.

Quality Performance Measures and Outcomes

Below is a grid used to track the Quality Performance Measures and Outcomes. It identifies the performance goal for each measure along with yearly outcomes from 2014 - 2020. Those highlighted in green met or exceeded overall performance goals. Those highlighted in yellow fell within 5% of the performance goal. Those highlighted in red fell below the performance goal.

Met the goal. **Within 5 percentage points of the goal.** **Did not meet the goal.**

Measure	Goal	2014	2015	2016	2017	2018	2019	2020
2014 – 2016 Member Satisfaction Survey Results*								
Experience with Optum Idaho Staff and Referral Process	**≥85%**	*84%*	*85%*	*92%*	*NA*	*NA*	*NA*	*NA*
Experience with the Behavioral Health Provider Network	**≥85%**	*91%*	*91%*	*94%*	*NA*	*NA*	*NA*	*NA*
Experience with Counseling or Treatment	**≥85%**	93%	94%	95%	NA	NA	NA	NA
Overall Experience	**≥85%**	90%	92%	94%	NA	NA	NA	NA
**New Survey Implemented, results below*								
2017 – 2020 *New Survey*: Member Satisfaction Survey Results								
Optum Support for Obtaining Referrals or Authorizations	**≥85%**	NA	NA	NA	80%	92%	94%	91%
Counseling and Treatment	**≥85%**	NA	NA	NA	95%	95%	95%	94%
Accessibility, Availability, and Acceptability of the Clinician Network	**≥85%**	NA	NA	NA	89%	93%	93%	93%
Overall Satisfaction	**≥85%**	NA	NA	NA	80%	92%	94%	90%
Provider Satisfaction Survey Results								
Overall Provider Satisfaction	**≥85%**	69%	65%	75%	77%	79%	76%	88%

Measure	Goal	2014	2015	2016	2017	2018	2019	2020
Accessibility & Availability – Idaho Behavioral Health Plan Membership								
Membership Numbers	**NA**	*314,538*	*330,474*	*336,394*	*342,357*	*336,997*	*318,331*	*383,601*
Accessibility & Availability – Member Service Call Standards								
Total Number of Calls	**NA**	6,483	4,838	5,153	5,292	4,658	4,641	6,999
Percent Answered Within 30 Seconds	**≥80%**	91%	91%	88%	84%	71%	76%	84%*
**Overall, this measure met performance. However, there were 2 quarters where the measure fell slightly below the goal. Optum Idaho will continue to monitor.*								
Average Daily Hold Time	**≤120 Seconds**	13	13	15	19	33	25	20
Abandonment Rate	**≤3.5% internal, ≤7% contractual**	1.5%	1.9%	2.2%	2.3%	3.1%	3.0%	1.5%
Accessibility & Availability – Customer Service (Provider) Call Standards								
Total Number of Calls	**NA**	*16,323*	*14,205*	*12,220*	*13,016*	*12,036*	*12,332*	*13,597*
Percent Answered within 30 seconds	**≥80%**	84%	97%	97%	98%	98%	98%	98%
Average Daily Hold Time	**≤120 seconds**	35	6	4	4	3	3	4
Abandonment Rate	**≤3.5% internal, ≤7% contractual**	2.9%	0.6%	0.3%	0.4%	0.2%	0.3%	0.4%
Accessibility & Availability – Appointment Access Standards								
Urgent Appointment Wait Time	**48 hours**	18.5	22.8	24.2	23.1	22.4	19.0	15.0
Non-Urgent Appointment Wait Time	**10 days**	3.8	4.7	6.0	6.0	4.8	4.0	3.5
Critical Appointment Wait Time*	**6 hours**	NA	NA	NA	5	3	3	3
**Began tracking in 2017.*								

Measure	Goal	2014	2015	2016	2017	2018	2019	2020
Geographic Availability of Providers								
Area 1 – Requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties	**100%**	*99.9%**	*99.8%**	*99.8%**	*99.9%**	*100.0%*	*99.8%**	*99.9%**
Area 2 – Requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	**100%**	*99.8%**	*99.9%**	*99.8%**	*99.8%**	*100.0%*	*99.8%**	*99.7%**
**Performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number).*								
Member Protections and Safety – Notification of Adverse Benefit Determinations (ABDs)								
Number of ABDs	**NA**	2,266	2,038	2,139	2,164	1,325	475	78
Clinical ABDs*	**NA**	NA	NA	NA	930	773	381	22
Administrative ABDs*	**NA**	NA	NA	NA	318	552	94	56
**Began tracking in 2017.*								
Written Notification	**100% w/in 14 calendar days from request for services**	NA	NA	NA	99.9%	99.6%	98.7%*	98.5%*
**This is due to 1 ABD being routed to the wrong LINX worklist and therefore, written notification timeframe was missed.*								
Written Notification Sent within 1 Business Day	**100.0%**	77.3%	98.4%	97.0%	NA*	NA*	NA*	NA*
**New 14-day requirement tracked above.*								

Met the goal. **Within 5 percentage points of the goal.** **Did not meet the goal.**

Measure	Goal	2014	2015	2016	2017	2018	2019	2020
Member Protections and Safety – Member Appeals								
Number of Appeals	**NA**	*278*	*92*	*73*	*113*	*53*	*14*	*3*
Member Appeals Turnaround Time*	**≤30 days**	10	12	16	NA	NA	NA	NA
**Now reporting Non-Urgent/Urgent separately. See below.*								
Non-Urgent Appeal Resolution Turnaround Time	**≤30 days**	NA	NA	NA	9	8	3	4
Urgent Appeal Resolution Turnaround Time	**72 hours**	NA	NA	NA	25	53	19	18
Member Protections and Safety – Complaint Resolution and Tracking								
Total Number of Complaints	**NA**	*569*	*133*	*61*	*63*	*67*	*67*	*45*
Percent of Complaints Acknowledged within Turnaround time	**100% w/in 5 business days**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Quality of Service Complaints	**NA**	560	122	55	56	54	55	34
Percent Quality of Service Resolved within Turnaround Time	**100% w/in ≤10 business days**	100.0%	99.3%	100.0%	96.4%	100.0%	96.0%	100.0%
Number of Quality of Care Complaints	**NA**	9	11	6	7	13	12	11
Percent Quality of Care Resolved within Turnaround Time	**100% w/in ≤30 calendar days**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Member Protections and Safety – Critical Incidents								
Number of Critical Incidents Received	**NA**	60	66	67	61	49	42	60
Percent Ad Hoc Reviews Completed within 5 Business Days from Notification of Incident	**100.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Measure	Goal	2014	2015	2016	2017	2018	2019	2020
Member Protections and Safety – Response to Written Inquiries								
Percent Acknowledged ≤2 Business Days*	**100.0%**	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*98.0%*	*99.0%*
**One response was out of compliance due to customer services staff having to wait for information from another team prior to responding to provider.*								
Provider Monitoring and Relations – Provider Quality Monitoring								
Number of Audits	**NA**	210	287	368	519	717	439	458
Percent of Audits that Received Passing Score of ≥85%	**≥85%**	81%	82%	90%	89%	74%	80%	84%
Percent of Audits that Required a Corrective Action Plan	**NA**	19%	18%	10%	11%	26%	20%	16%
Provider Monitoring and Relations – Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)								
Percent PCP is Documented in Member Record	**NA**	91%	93%	95%	96%	96%	97%	98%
Percent Documentation in Member Record that Communication/Collaboration Occurred Between Behavioral Health Provider and PCP	**NA**	83%	80%	85%	78%	74%	78%	76%
Provider Monitoring and Relations – Provider Disputes								
Number of Provider Disputes	**NA**	156	57	52	88	111	138	579
Average Number of Days to Resolve Provider Disputes	**≤30 days**	11.2	8.3	13.4	7.8	8.3	8.0	9.0
Utilization Management and Care Coordination – Service Authorization Requests								
Percentage Determination Completed within 14 Days	**100%**	No data available	98.8%	99.1%	99.2%	99.1%	100.0%	100.0%

Measure	Goal	2014	2015	2016	2017	2018	2019	2020
Utilization Management and Care Coordination – Person-Centered Service Plan (PCSP)								
Number of PCSPs Received	**NA**						*925*	*863*
Average Number of Business Days to Review	**≤5 days**		*NA**	*NA**	*NA**	*NA**	*0.16*	*0.11*
**Began tracking in 2018 but not a full year's worth of data until 2019.*								
Utilization Management and Care Coordination – Field Care Coordination (FCC)								
Total Referrals to FCCs	**NA**	NA*	774	722	800	699	960	1604
Average Number of Days Case Open to FCC	**NA**	NA*	63.2	79.0	48.0	50.0	48.0	43.0
**Began tracking in 2015.*								
Inter-Rater Reliability Testing								
Care Advocate Audit Results	**≥ 88.0%**	NA	NA	93.8%	62.2%	99.0%	99.0%	100.0%
MD Peer Review Audit Results	**≥ 88.0%**	91.7%	99.5%	98.0%	98.3%	95.0%	95.0%	*See comment
**MD Peer review audit results were not received from the national team due to data systems issues.*								
Claims								
Claims Paid within 30 Calendar Days	**90.0%**	99.7%	99.9%	99.9%	99.9%	100.0%	99.9%	99.0%
Claims Paid within 90 Calendar Days	**99.0%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%
Dollar Accuracy	**99.0%**	99.8%	99.9%	99.9%	99.7%	100.0%	99.0%	99.0%
Procedural Accuracy	**97.0%**	100.0%	99.7%	99.9%	99.8%	100.0%	99.0%	99.0%

Met the goal. **Within 5 percentage points of the goal.** **Did not meet the goal.**

Outcomes Analysis

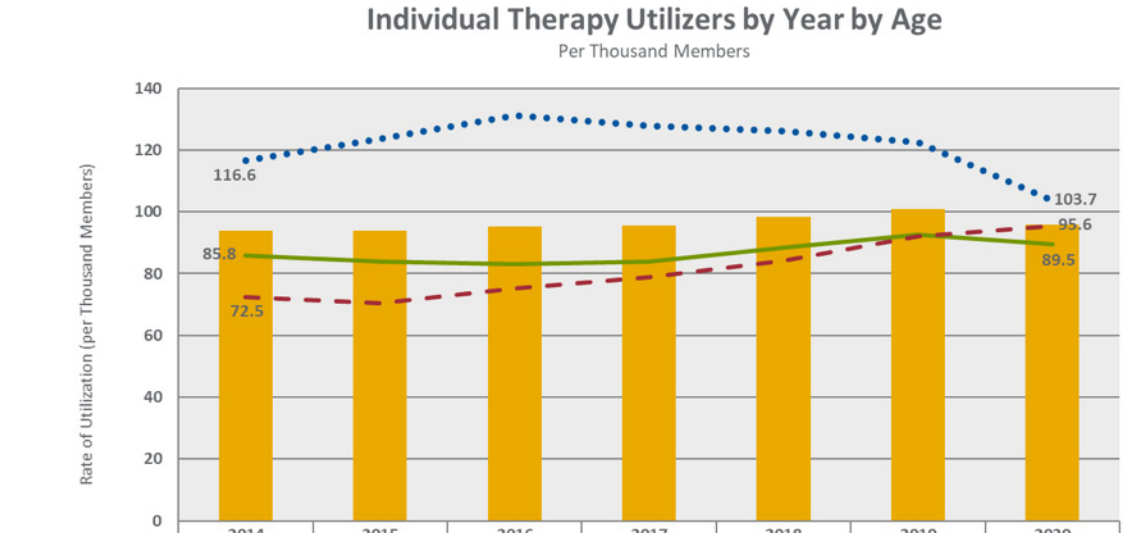
There are multiple outcomes that Optum Idaho follows to assess the extent to which the IBHP benefits its members. These include measures of clinical symptoms and functional impairments, appropriateness of service delivery and fidelity to evidence-based practices, impact on hospital admissions/discharges and hospital readmissions, and timeliness of outpatient behavioral health care following hospital discharges.

Utilization Rates

Methodology – Utilization rates are based on claims data. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims. The rate of utilization is calculated as follows: Numerator is the number of unique utilizers of service visits. Denominator is the total number of IBHP members, in thousands.

Individual Therapy

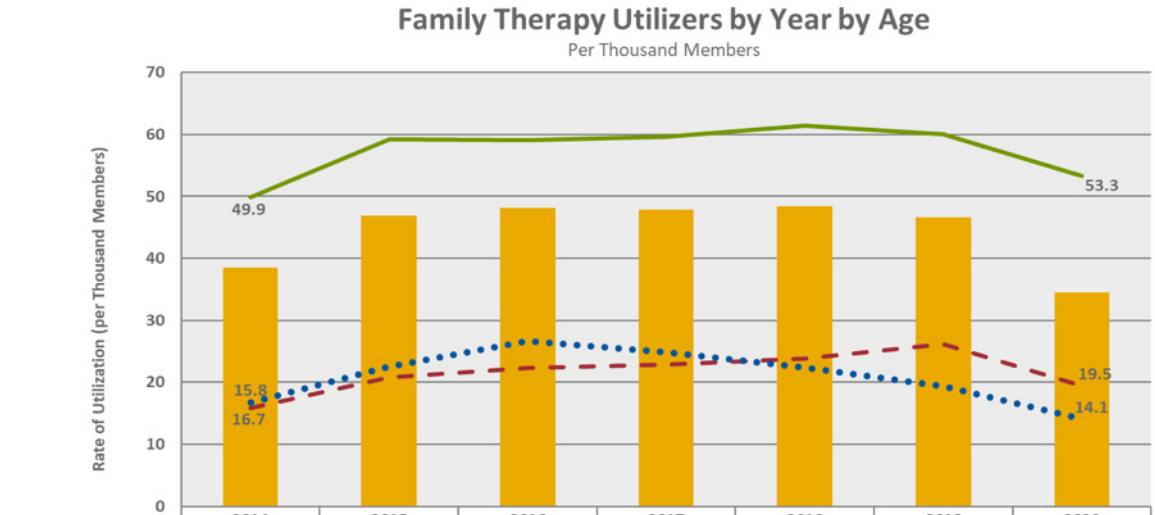
Figure 1



	2014	2015	2016	2017	2018	2019	2020
Total (All Ages)	93.8	93.8	95.3	95.7	98.5	100.9	95.9
Ages 0 to 17	85.8	83.9	83.0	83.9	88.3	92.7	89.5
Ages 18 to 20	72.5	70.5	75.2	78.9	84.3	92.1	95.6
Ages 21+	116.6	123.5	131.2	127.8	126.0	122.5	103.7

Family Therapy

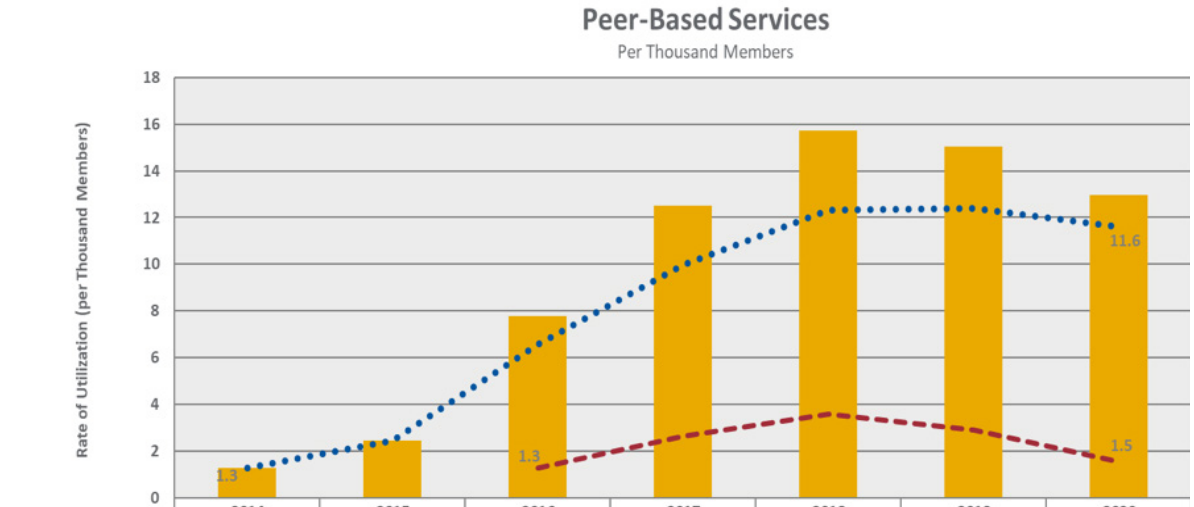
Figure 2



	2014	2015	2016	2017	2018	2019	2020
Total (All Ages)	38.5	46.9	48.2	47.8	48.4	46.6	34.5
Ages 0 to 17	49.9	59.3	59.1	59.6	61.4	60.0	53.3
Ages 18 to 20	15.8	20.8	22.3	22.8	23.8	26.2	19.5
Ages 21+	16.7	22.5	26.6	24.9	22.4	19.3	14.1

Peer-Based Services

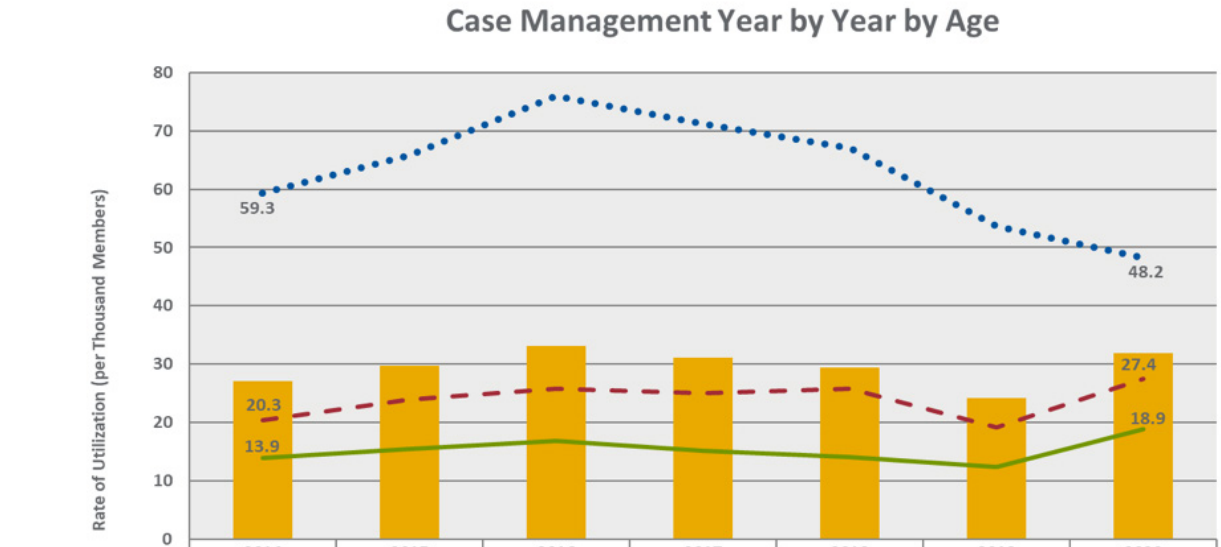
Figure 3



	2014	2015	2016	2017	2018	2019	2020
Total Utilization	1.3	2.4	7.8	12.5	15.7	15.0	13.0
Family Support			1.3	2.6	3.6	2.9	1.5
Peer Support	1.3	2.4	6.6	10.0	12.3	12.4	11.6

Case Management

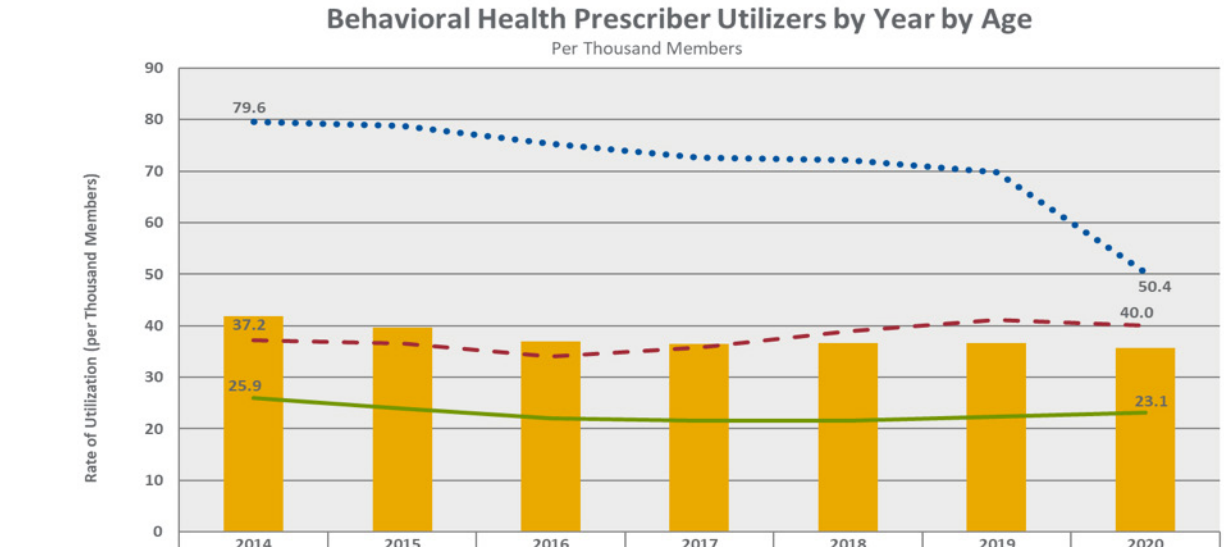
Figure 4



	2014	2015	2016	2017	2018	2019	2020
Total (All Ages)	27.2	29.6	33.1	31.2	29.4	24.2	31.8
Ages 0 to 17	13.9	15.4	16.8	15.2	14.1	12.3	18.9
Ages 18 to 20	20.3	24.0	25.8	25.1	25.7	19.2	27.4
Ages 21+	59.3	65.8	76.0	71.2	67.1	53.6	48.2

Prescriber Visits

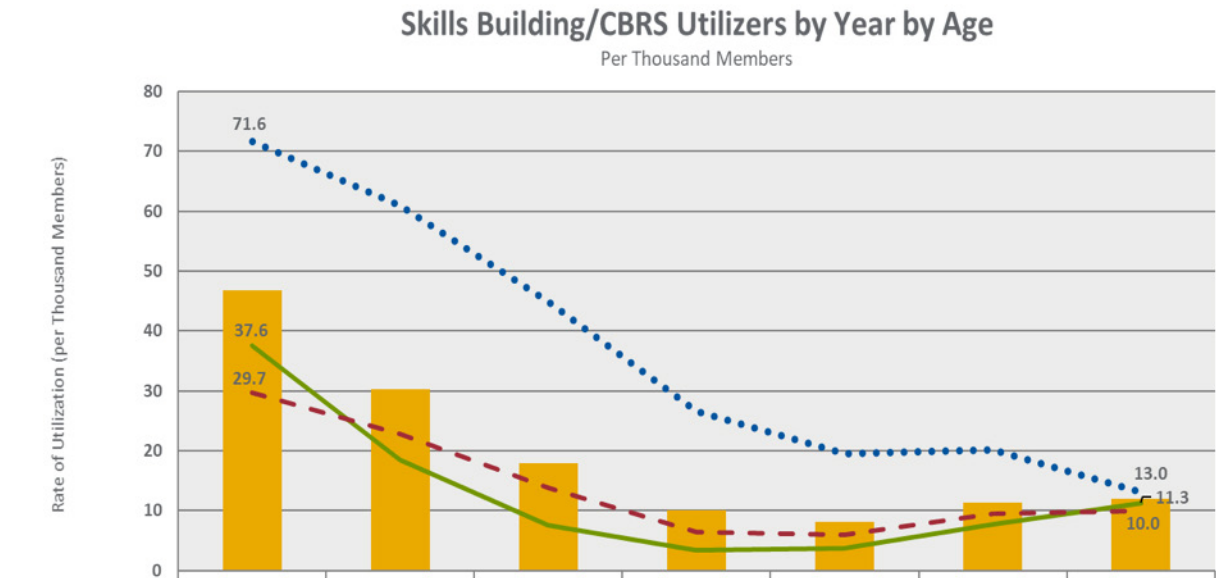
Figure 5



	2014	2015	2016	2017	2018	2019	2020
Total (All Ages)	41.8	39.6	37.0	36.5	36.6	36.6	35.7
Ages 0 to 17	25.9	23.9	22.0	21.6	21.6	22.3	23.1
Ages 18 to 20	37.2	36.5	34.0	35.8	38.9	41.2	40.0
Ages 21+	79.6	78.8	75.3	72.6	72.1	69.7	50.4

Skills-Building/Community-Based Rehabilitation Services (CSRS)

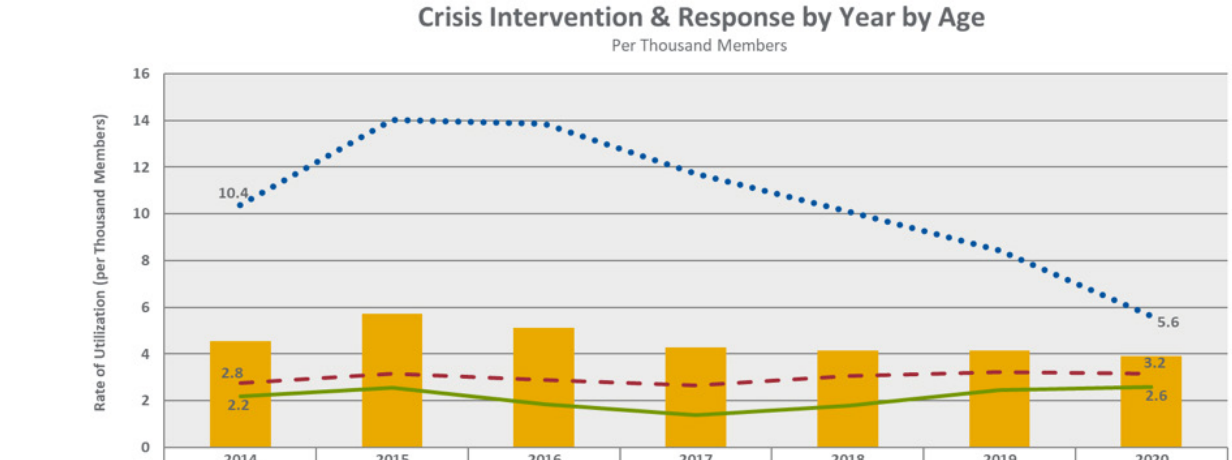
Figure 6



	2014	2015	2016	2017	2018	2019	2020
Total (All Ages)	46.8	30.2	17.9	10.0	8.1	11.3	11.9
Ages 0 to 17	37.6	18.4	7.6	3.5	3.6	7.7	11.3
Ages 18 to 20	29.7	22.9	13.8	6.5	5.9	9.4	10.0
Ages 21+	71.6	60.9	44.9	26.6	19.4	20.2	13.0

Crisis Intervention & Response by Year by Age

Figure 7



	2014	2015	2016	2017	2018	2019	2020
Total (All Ages)	4.6	5.7	5.1	4.3	4.2	4.1	3.9
Ages 0 to 17	2.2	2.6	1.9	1.4	1.8	2.5	2.6
Ages 18 to 20	2.8	3.2	2.9	2.7	3.1	3.2	3.2
Ages 21+	10.4	14.0	13.9	11.7	10.1	8.4	5.6

Analysis – Overall, Individual Therapy utilization decreased but increased for ages 18 – 20. Family Therapy utilization decreased. Peer Based services decreased slightly, and Case Management utilization increased. Prescriber Visits utilization remained consistent with a decrease in utilization in ages 21+. Skills Building/CBRS utilization rates remained consistent with a decrease in ages 21+. Crisis services decreased.

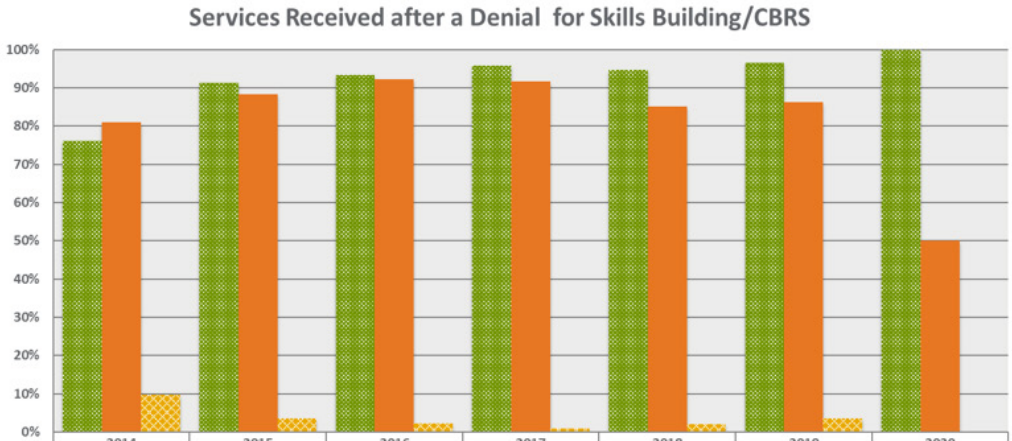
Barriers – No identified barriers.

Opportunities and Interventions – No opportunities for improvement were identified.

Services Received Post Skills Building/CBRS Adverse Benefit Determination

Methodology – Based on ABD and claims data, the graph below identifies members that received evidence- based service(s) after receiving a full ABD for CBRS.

Figure 8



	2014	2015	2016	2017	2018	2019	2020
Pct Receiving Services in 90 Days	76.1%	91.3%	93.3%	95.9%	94.6%	96.6%	100.0%
Pct Receiving Services after 90+ Days	81.0%	88.3%	92.3%	91.7%	85.1%	86.2%	50.0%
Pct Not Receiving Services	9.7%	3.5%	2.2%	0.9%	2.1%	3.4%	0.0%
Rec'd Other Services w/in 90 Days	494	679	796	557	228	28	2
Rec'd Other Services in 91+ Days	526	657	787	533	205	25	1
Recieved No Services	63	26	19	5	5	1	0
Members Receiving ABD for CBRS	649	744	853	581	241	29	2

Analysis – The number of members receiving a full CBRS ABD dropped again in 2020 (2 ABDs for CBRS in 2020) due to the previous changes (in 2019) in the CBRS prior authorization process. These changes include improvements to the service request form that resulted in a significant reduction in administrative ABDs. Additionally, the default authorization period was extended from 90 days to 180 days, limiting the amount of prior authorizations and ABDs. Both of members who received an ABD for CBRS services received evidenced-based therapeutic services within 90 days of the ABD.

Barriers – No identified barriers.

Opportunities and Interventions – No opportunities for improvement were identified.

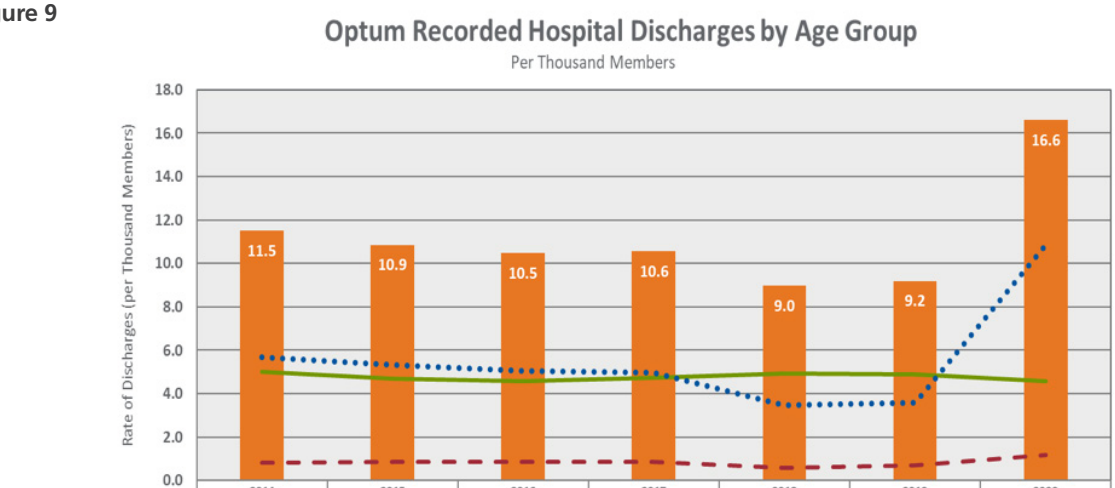
Psychiatric Inpatient Utilization

Methodology – Information is obtained from IDHW and other community resources using hospital discharge data. A hospital stay is considered a readmission if the admission date occurred within 30-days of discharge. The data displayed indicates the rate of hospital discharges per quarter. To control for an increase in IBHP members over this time frame, the data has been standardized by displaying the numbers per thousand members.

Analysis – A well-performing outpatient behavioral health system is generally expected to provide members with appropriate services in the least restrictive settings. The following data tracks the actual rates of psychiatric hospitalization, as a type of outcome measure for the plan's performance as a whole.

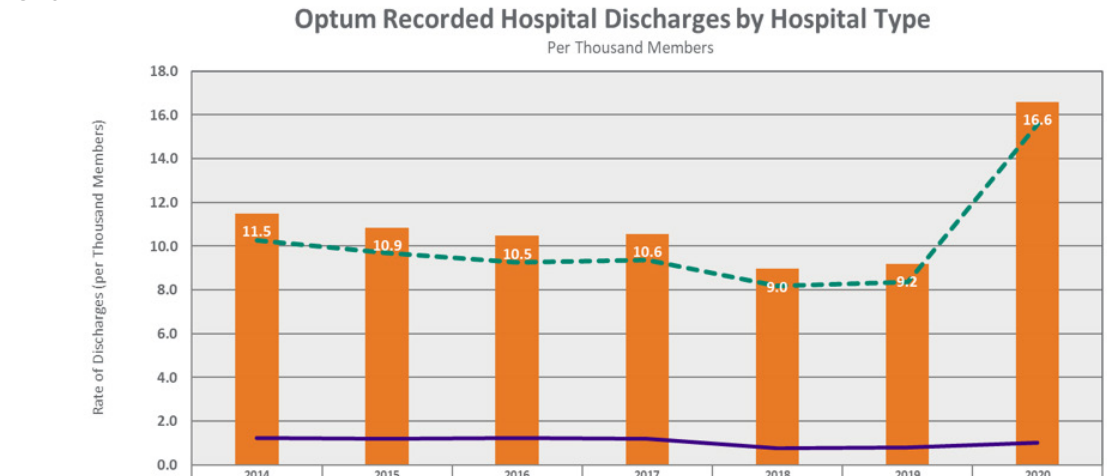
Figures 9 and 10 below show the overall rate of discharges increased. Optum Idaho will continue to monitor and identify any trends.

Figure 9



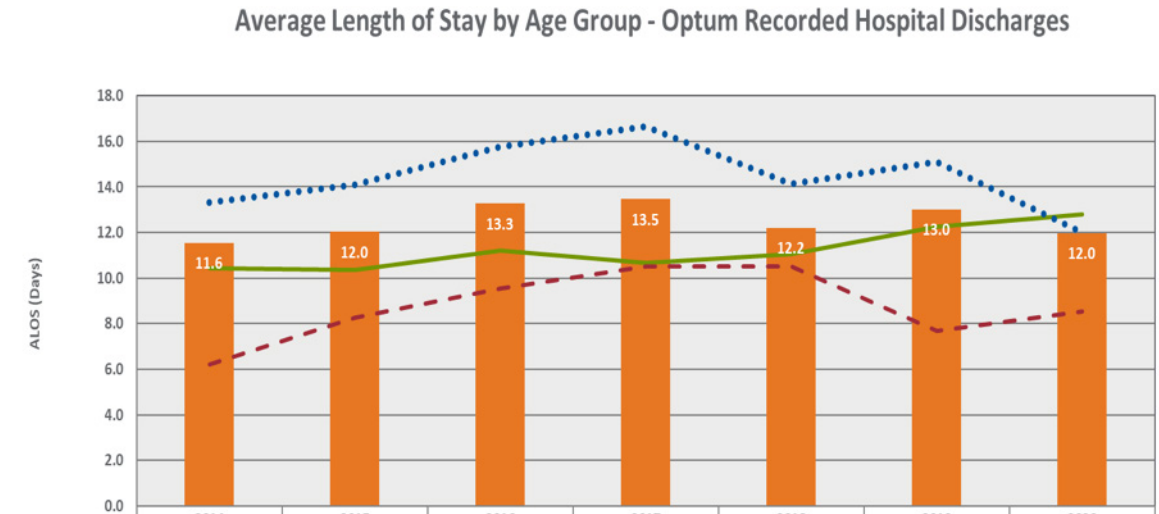
	2014	2015	2016	2017	2018	2019	2020
Discharge Rate (per Thousand Members)	11.5	10.9	10.5	10.6	9.0	9.2	16.6
Ages 0 to 17	5.0	4.7	4.6	4.7	4.9	4.9	4.6
Ages 18 to 20	0.8	0.9	0.9	0.8	0.6	0.7	1.2
Ages 21+	5.7	5.3	5.0	5.0	3.4	3.6	10.8
# Discharges	3,617	3,588	3,524	3,613	3,020	2,924	6,368

Figure 10



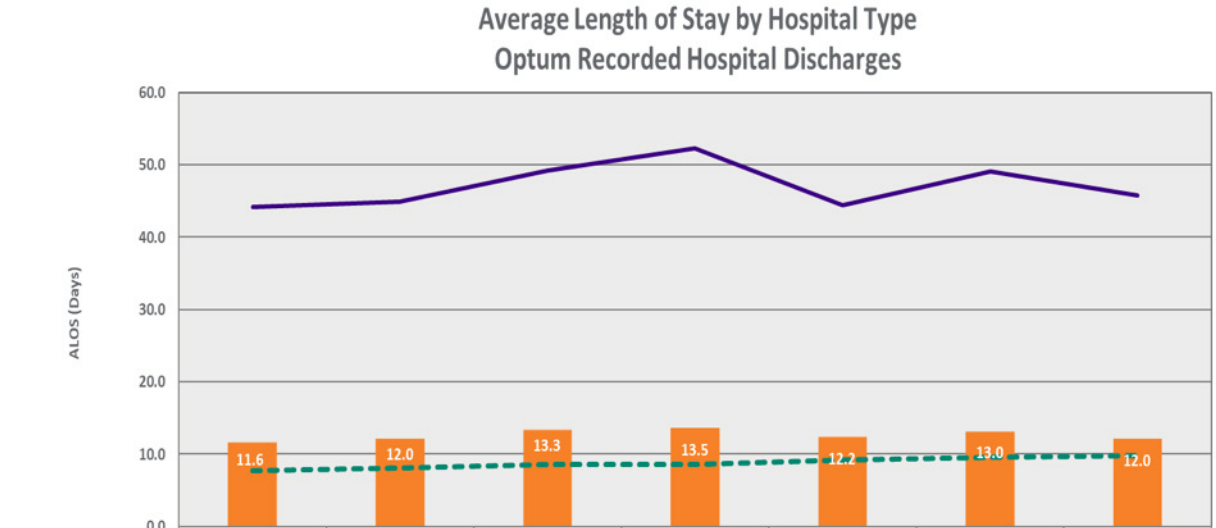
	2014	2015	2016	2017	2018	2019	2020
Discharge Rate (per Thousand Members)	11.5	10.9	10.5	10.6	9.0	9.2	16.6
Community Hospital	10.3	9.7	9.3	9.4	8.2	8.4	15.6
State Hospital	1.2	1.2	1.2	1.2	0.8	0.8	1.0
# Discharges	3,617	3,588	3,524	3,613	3,020	2,924	6,368

Figure 11 indicates the average length of stay decreased overall but increased in the 0 to 17 and 18 to 20 age groups.



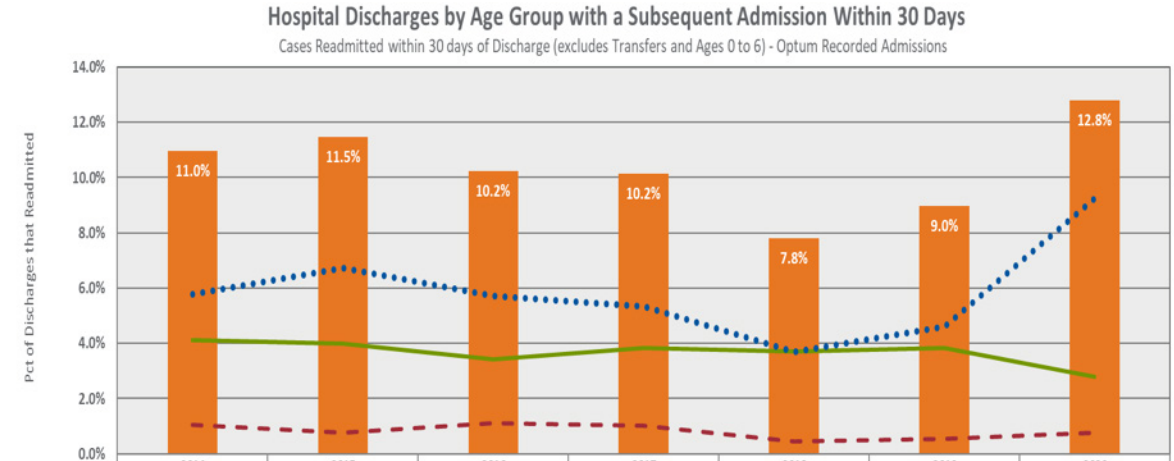
	2014	2015	2016	2017	2018	2019	2020
Overall ALOS	11.6	12.0	13.3	13.5	12.2	13.0	12.0
Ages 0 to 17	10.4	10.4	11.2	10.7	11.1	12.3	12.8
Ages 18 to 20	6.2	8.3	9.6	10.5	10.5	7.7	8.5
Ages 21+	13.3	14.1	15.8	16.6	14.1	15.1	12.0

Figure 12 shows the average length of stay by hospital type and remained consistent.



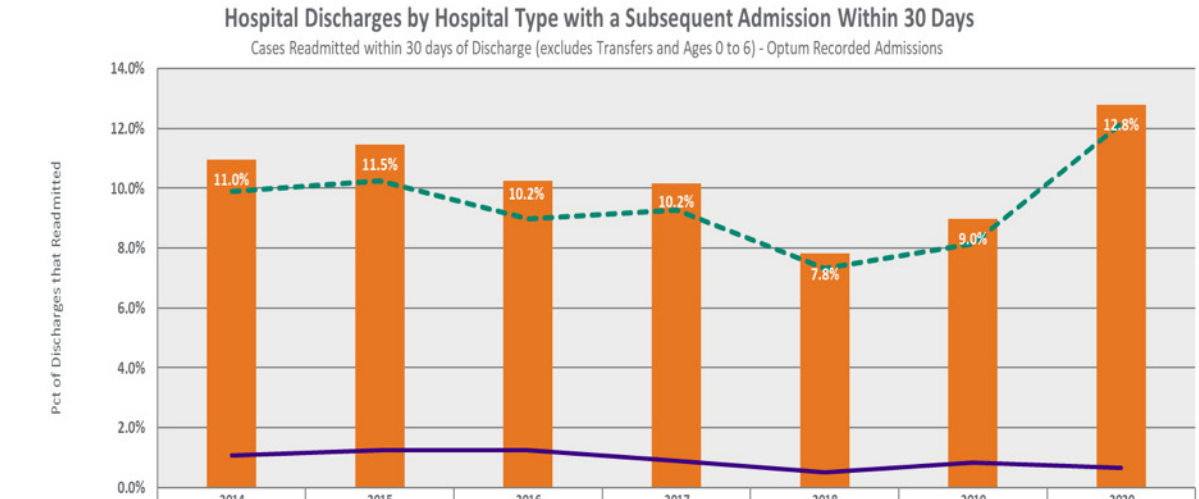
	2014	2015	2016	2017	2018	2019	2020
Overall ALOS	11.6	12.0	13.3	13.5	12.2	13.0	12.0
Community Hospital	7.6	8.0	8.5	8.5	9.2	9.5	9.8
State Hospital	44.2	44.9	49.2	52.3	44.4	49.1	45.7

Figure 13 shows the readmission percentages by age group. According to the Healthcare Effectiveness Data and Information Set (HEDIS) definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals. Overall total readmissions within 30 days increased in 2020 but saw a decrease in the 7 to 17 age group.



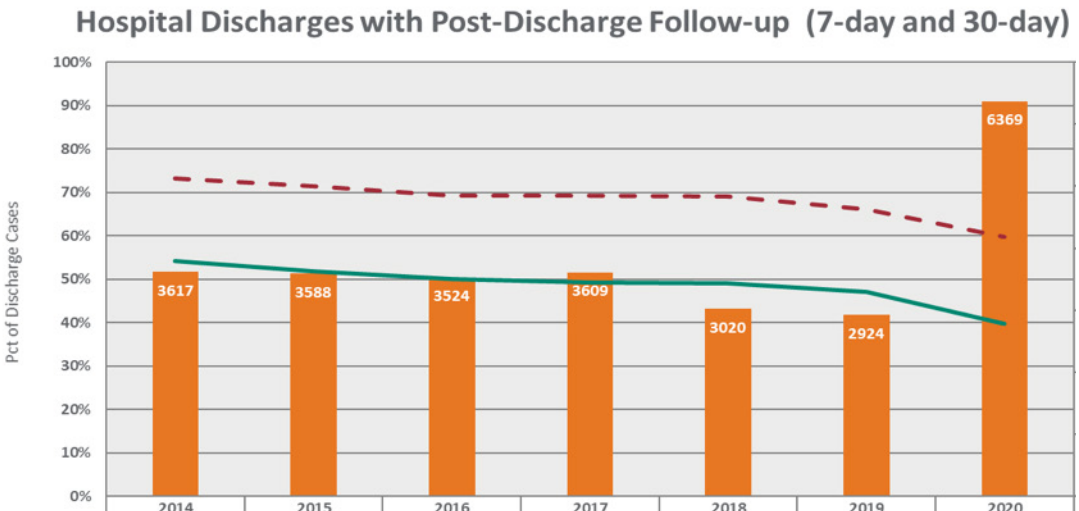
	2014	2015	2016	2017	2018	2019	2020
% of Total	11.0%	11.5%	10.2%	10.2%	7.8%	9.0%	12.8%
Ages 7 to 17	4.1%	4.0%	3.4%	3.8%	3.7%	3.8%	2.8%
Ages 18 to 20	1.1%	0.8%	1.1%	1.0%	0.4%	0.6%	0.8%
Ages 21+	5.8%	6.7%	5.7%	5.3%	3.7%	4.6%	9.3%
# Discharges	3,593	3,574	3,514	3,604	3,008	2,907	6,356

Figure 14 shows readmissions percentages by hospital type and shows state hospital data remained consistent while community hospital data shows the increase.



	2014	2015	2016	2017	2018	2019	2020
% of Total	11.0%	11.5%	10.2%	10.2%	7.8%	9.0%	12.8%
Community Hospital	9.91%	10.24%	8.99%	9.27%	7.31%	8.15%	12.16%
State Hospital	1.06%	1.23%	1.25%	0.89%	0.50%	0.83%	0.65%
# Discharges	3,593	3,574	3,514	3,604	3,008	2,907	6,356

Figure 15 shows hospital discharges with post-discharge follow-up. One of the goals of care coordination is the continuity of care and the successful transition of members from inpatient to outpatient care, similar to the HEDIS metric that examines the percentage of members who are discharged from inpatient care and subsequently receive an outpatient behavioral health visit within 7 days and 30 days. The follow-up rates for post-discharge outpatient services continued to decrease for the both the 7 day and 30-day follow-up rates.



	2014	2015	2016	2017	2018	2019	2020
Number of DC Cases	3617	3588	3524	3609	3020	2924	6369
% 7 Day Follow-up	54.19%	51.90%	50.09%	49.29%	49.04%	46.99%	39.77%
% 30 Day Follow-up	73.21%	71.49%	69.24%	69.24%	69.04%	66.01%	59.82%
DC cases with visit w/in 7-days	1960	1862	1765	1779	1481	1374	2533
DC Cases with visit w/in 30-days	2648	2565	2440	2499	2085	1930	3810

Barriers – Responsibility for arranging post-discharge outpatient appointments for behavioral health services rests with hospital discharge planners. Optum Idaho has an outpatient-only contract, as a result, hospitals and their staff responsible for discharge planning fall outside our management. However, Optum Idaho relies on hospitals to notify Optum Idaho when a member is discharged, which they're not obligated to do. Optum Idaho continues to establish and build those relationships to better serve members. When Optum Idaho is notified of a discharge, the Optum Idaho wellness coordinators attempt to verify that appointments are scheduled and attended.

Opportunities and Interventions – Optum Idaho implemented a Performance Improvement Project (PIP) to more efficiently and effectively identify high risk members who need more intensive care management. Areas that will be monitored include, but not limited to, re-hospitalization rates and discharge follow-up to ensure that members receive the follow-up care necessary.

Algorithms for Effective Reporting and Treatment (ALERT)

Optum's proprietary Algorithms for Effective Reporting and Treatment (ALERT®) outpatient management program quantifiably measures the effectiveness of services provided to individual patients, to identify potential clinical risk and "alert" practitioners to that risk, track utilization patterns for psychotherapeutic services, and measure improvement of Member well-being. ALERT Online is an interactive dashboard that is available to network providers. Information from the Idaho Standardized Assessments completed by the provider's patients is available in ALERT Online both as a provider group summary and also individual Member detail.

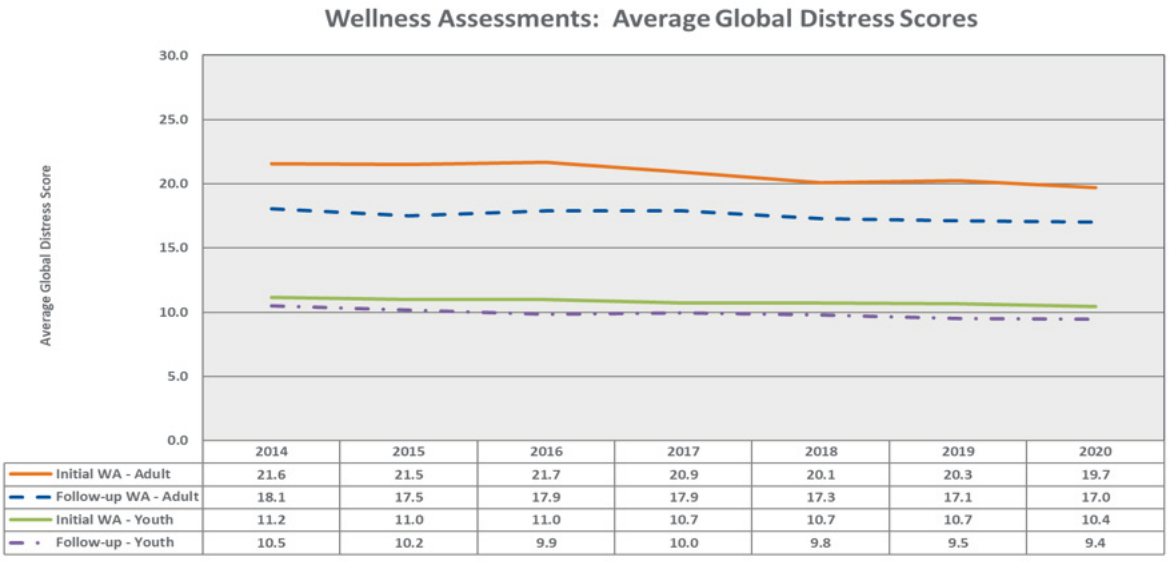
Methodology – The Idaho Standardized Assessment is a key component of the Idaho ALERT program—providers are required to ask Members to complete the Wellness Assessment at the initiation of treatment and to monitor treatment progress whenever the provider requests authorization to continue treatment. An important part of the assessment when engaging in population health is to monitor the severity of symptoms and functional problems among those being treated. One concept for understanding population health as an outcome is to monitor whether utilizers as a group are getting healthier or sicker.

The following analysis looks at the average baseline Wellness Assessment scores for all Wellness Assessments completed during the first and/or second visits during a quarter. It then follows up by looking at the average Wellness Assessment scores for all

instruments submitted for subsequent visits during that quarter. The "follow-up assessments" may or may not include scores from the same members who completed the initial assessments in a quarter. Therefore, the following data should not be interpreted as showing before-and-after comparisons for individual members.

Total Score	Severity Level	Global Distress Score Descriptions
Adult Global Distress Scores		
0-11	Low	Low level of distress (below clinical cut-off score of 12).
12-24	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
25-38	Severe	Approximately one in four clients has scores in this elevated range of distress.
39+	Very Severe	This level represents extremely high distress. Only 2% of clients typically present with scores in this range.
Youth Global Distress Scores		
0-6	Low	Low level of distress (below clinical cut-off score of 7)
7-12	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
13-20	Severe	Approximately one in four clients has an initial score in this elevated range of distress.
21+	Very Severe	This level represents extremely high distress. Only 2% of clients typically present with scores in this range.

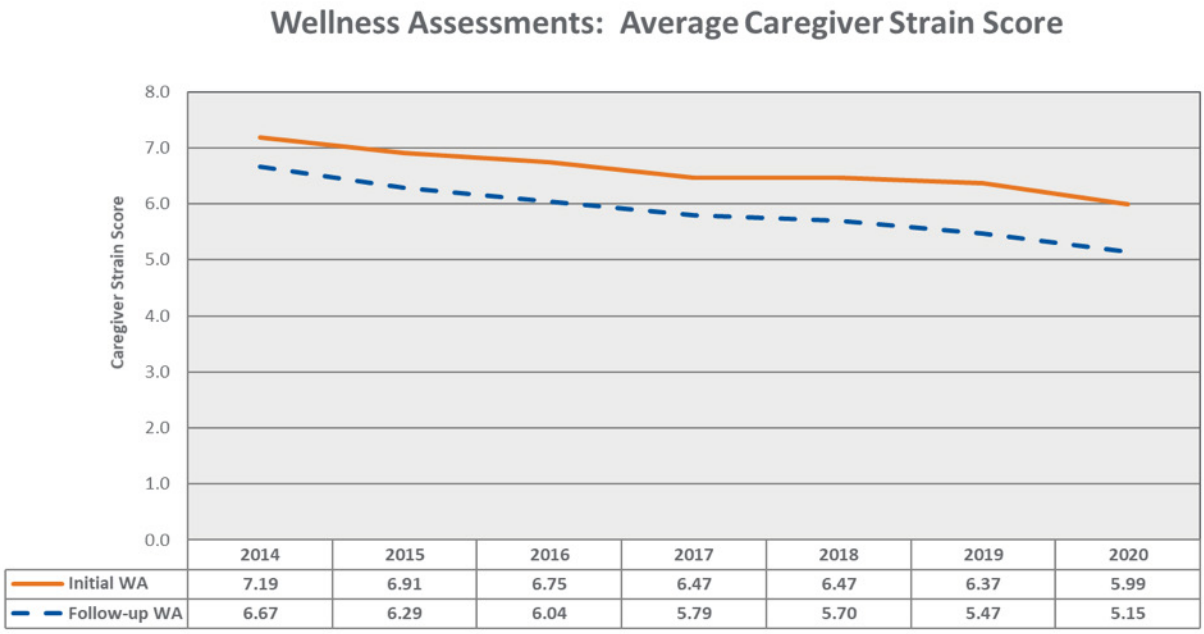
Figure 16



	2014	2015	2016	2017	2018	2019	2020
Initial WA - Adult	21.6	21.5	21.7	20.9	20.1	20.3	19.7
Follow-up WA - Adult	18.1	17.5	17.9	17.9	17.3	17.1	17.0
Initial WA - Youth	11.2	11.0	11.0	10.7	10.7	10.7	10.4
Follow-up - Youth	10.5	10.2	9.9	10.0	9.8	9.5	9.4

Total Score	Severity Level	Caregiver Strain Level Description
Caregiver Strain Scores		
0-4	Low	No or mild strain (below clinical cut-off score of 4.7)
5-14	Moderate	The most common range of scores for caregivers with a child initiating outpatient psychotherapy.
15+	Severe	This level represents serious caregiver strain. Fewer than 10% of caregivers of children initiating outpatient psychotherapy report this level of strain.

Figure 17



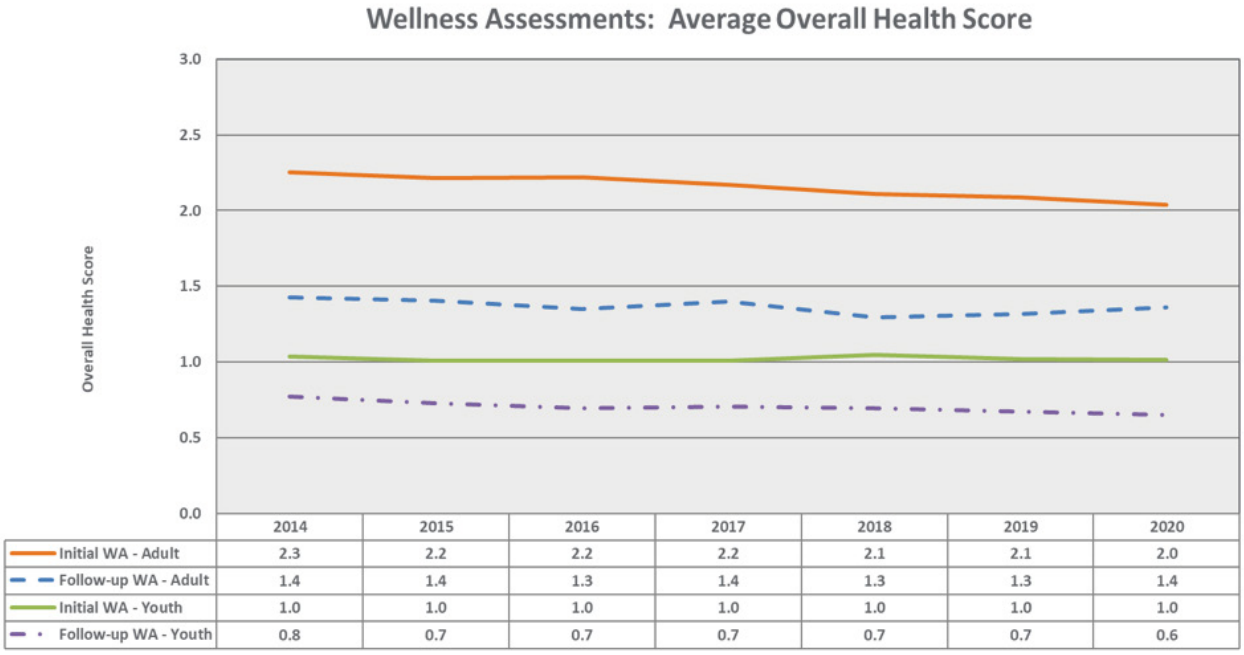
	2014	2015	2016	2017	2018	2019	2020
Initial WA	7.19	6.91	6.75	6.47	6.47	6.37	5.99
Follow-up WA	6.67	6.29	6.04	5.79	5.70	5.47	5.15

Average Overall Health Scores

Overall physical health status is an important predictor of risk. Persons with coexisting physical and behavioral health problems tend to do worse than people with only behavioral health conditions.

Physical Health score values: 0 = Excellent 1 = Very Good 2 = Good 3 = Fair 4 = Poor

Figure 18



	2014	2015	2016	2017	2018	2019	2020
Initial WA - Adult	2.3	2.2	2.2	2.2	2.1	2.1	2.0
Follow-up WA - Adult	1.4	1.4	1.3	1.4	1.3	1.3	1.4
Initial WA - Youth	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Follow-up WA - Youth	0.8	0.7	0.7	0.7	0.7	0.7	0.6

Analysis – Average Global Distress Scores for adults and youth (Figure 16), for initial and follow-up assessments remained consistent. Average Caregiver Strain Scores (Figure 17) measured within moderate levels during the same period. For the Average Overall Health Score (Figure 18), adults scored on average between "fair" and "good" on the initial assessments. On follow-up assessments conducted over the same period, adults scored on average between "good" and "very good." These scores have remained consistent.

During the same period of time (Figure 18), children and youth at baseline on initial assessment showed a consistent occurrence of physical health issues that averaged "very good." On follow-up assessment for the same period, children and youth showed improved scores in the range between "very good" and "excellent." These improved scores have remained consistent throughout the study period.

Barriers – No identified barriers.

Opportunities and Interventions – No opportunities for improvement were identified.

Member Satisfaction Survey Results

Optum Idaho monitors member satisfaction with behavioral health services. Beginning with Quarter 1, 2017, a new Member Satisfaction Survey was implemented. Optum Idaho surveys IBHP adults 18 years of age and older and parents of children aged 11 years and younger. The survey is administered through a live telephone interview. Translation services are available to members upon request. Due to various Privacy Regulations, members between the ages of 12 and 17 are not surveyed.

To be eligible for the survey, the member must have received services during the 90 days prior to the survey and have a valid telephone number on record. A random sample of individuals eligible for the survey is selected and called until the desired quota was met, or the sample was exhausted. Members who have accessed services in multiple quarters are eligible for the survey only once every six months. The surveys are conducted over a 3-month period after the quarter in which the services were rendered.

Member Satisfaction Survey	Performance Goal	2014 (n=458)	2015 (n=402)	2016 (n=417)
2014 – **2016** Overall Performance Results				
Experience w/ Optum ID Staff and Referral Process	≥85.0%	84.2%	85.0%	91.6%
Experience with the Behavioral Health Provider Network	≥85.0%	90.9%	91.1%	93.6%
Experience with Counseling or Treatment	≥85.0%	92.9%	94.0%	94.8%
Overall Experience	≥85.0%	90.2%	92.0%	93.8%

Member Satisfaction Survey	Performance Goal	2017	2018	2019	2020
2017 – **2020** Overall Performance Results					
Overall Satisfaction (Goal: ≥85.0%)	≥85%	80%	92%	94%	90%
Optum Support for Obtaining Referrals or Authorizations	≥85%	80%	92%	94%	91%
Accessibility, Availability, and Acceptability of the Clinician Network	≥85%	89%	93%	93%	93%
Counseling and Treatment	≥85%	93%	95%	95%	94%

Analysis – Member satisfaction performance goals were met in 2020 for all survey domains.

Figure 19

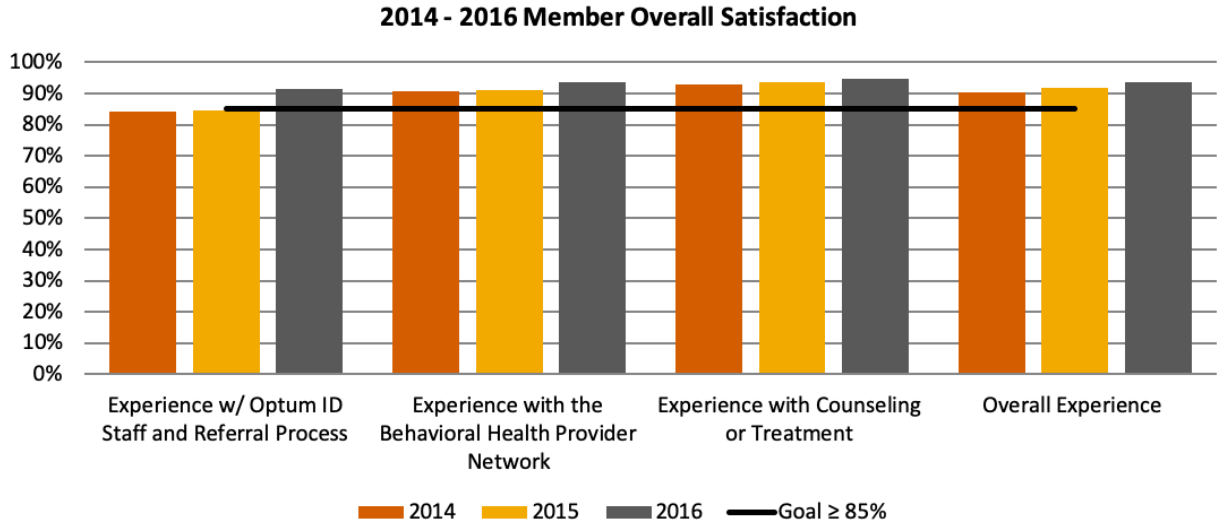


Figure 20

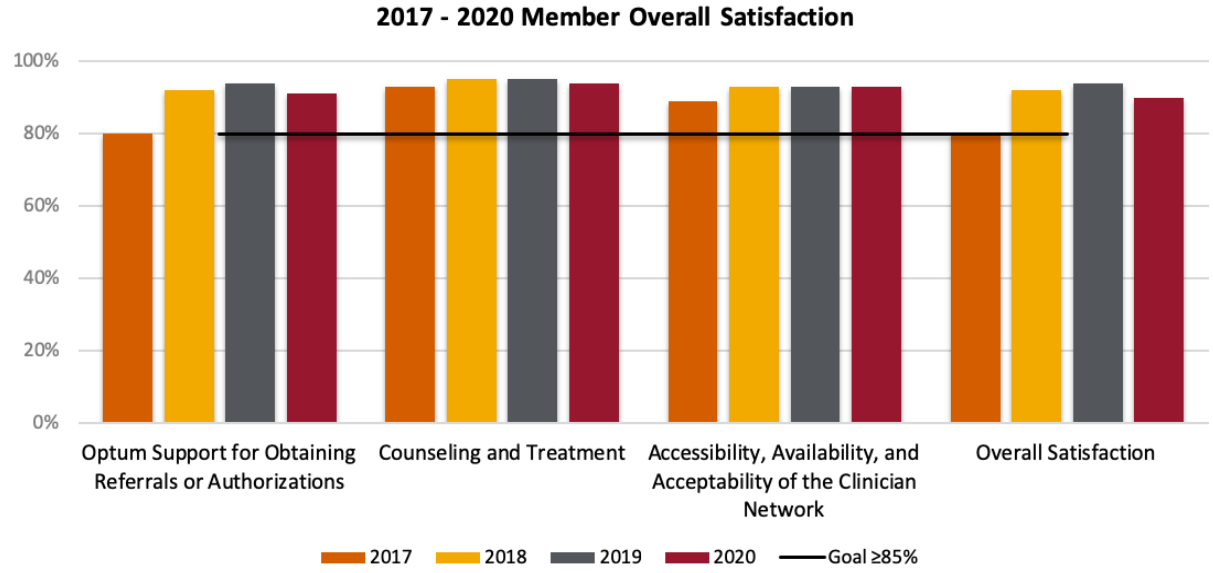


Figure 21

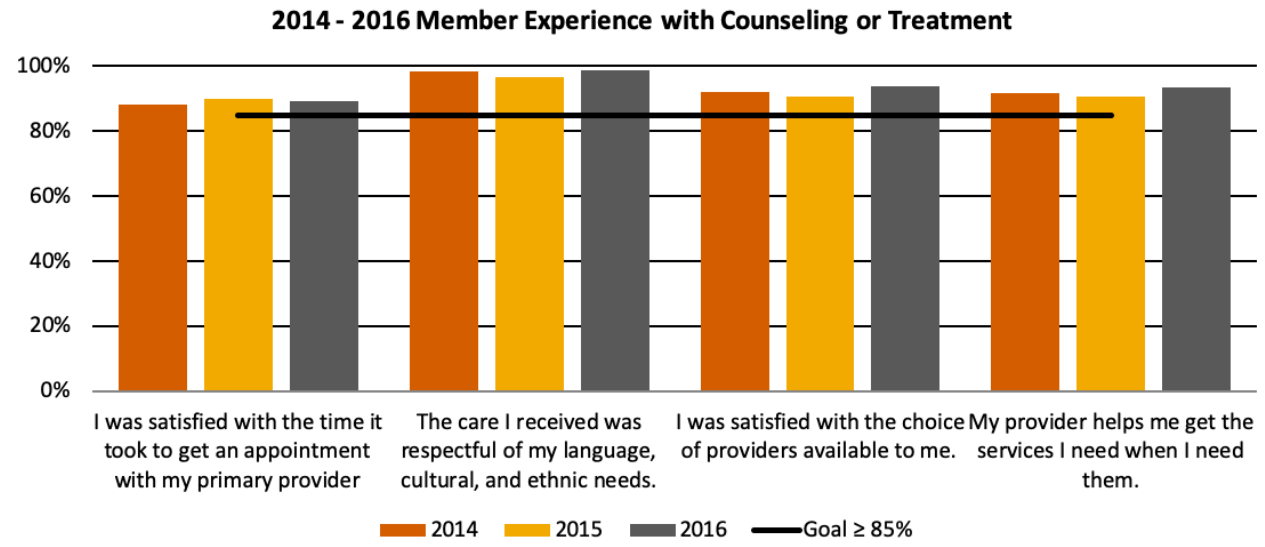
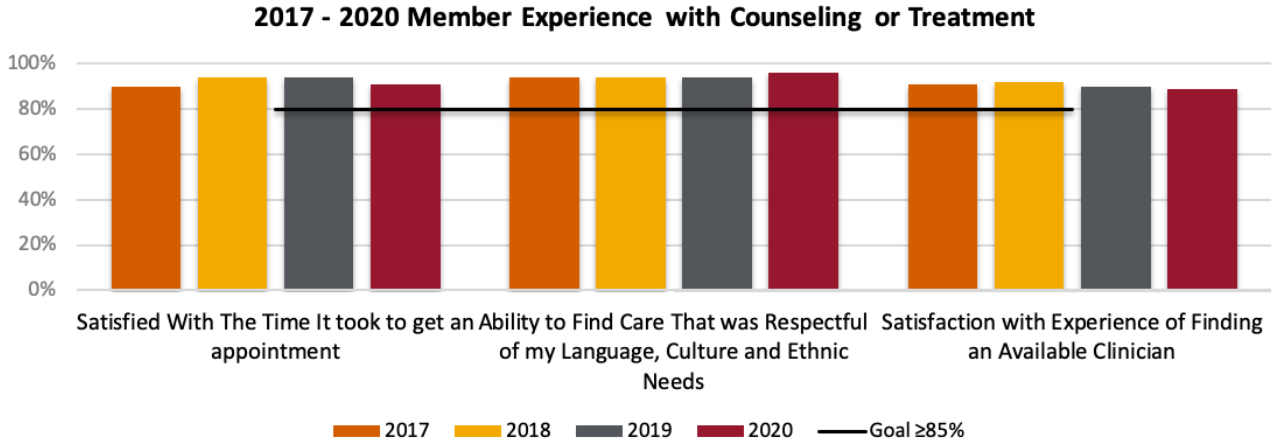


Figure 22



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Provider Satisfaction Survey Results

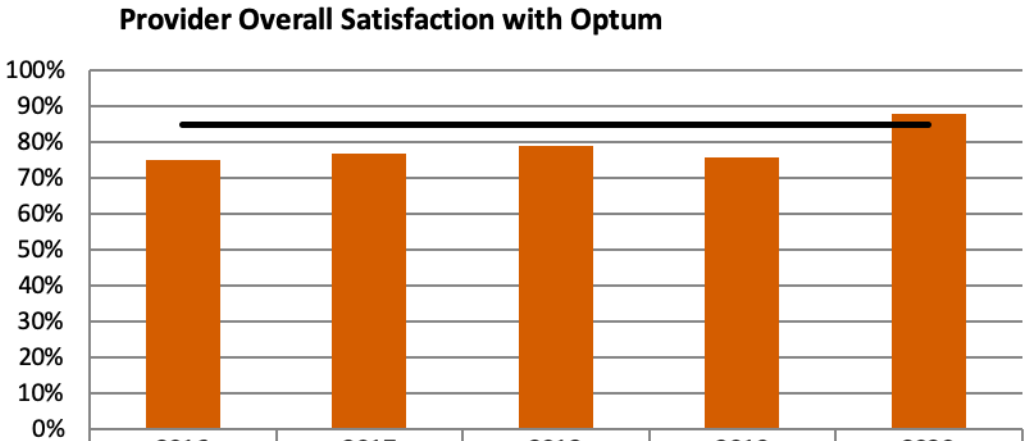
The goal of the research design of the Provider Satisfaction Survey is to provide a representative and reliable measurement of providers' experiences with, attitudes toward, and suggestions for Optum Idaho.

Methodology – Optum Idaho's Provider Satisfaction Survey is designed to connect with all Optum Idaho network providers to give them an opportunity to participate in the research. There are 3 modes for providers to complete the survey: Outbound Telephone Call from Fact Finders, Inbound Telephone from Provider to Fact Finders, Online Survey.

Analysis – Overall provider satisfaction for 2020 was 88% and increase from 76% in 2019. Several interventions were put in place during 2020 to impact Provider Satisfaction. These interventions included:

- Created trainings/webinars on specific issues identified with survey.
- Continued process for seeking provider input on initiatives.
- Increased provider visits and meetings with providers and provider associations.
- Collaborated with Optum Customer Service on surveys conducted during provider calls.
- Trend provider requests and inquiries to identify process improvement opportunities.
- Quarterly Provider Newsletter.
- Ongoing collaboration with the national claims processing team.
- Project plan for Phase II of Telemental Health Program which included identifying resources to provide hands on assistance for providers interested in providing Telemental Health Services (technical and clinical).
- Developed resources for members and communities to access Telemental Health in the community when internet and/or technology isn't available for the member.

Figure 23



	2016	2017	2018	2019	2020
Satisfied/Very Satisfied	75%	77%	79%	76%	88%
Goal ≥85%	85%	85%	85%	85%	85%

Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Performance Improvement Projects

Performance Improvement Projects (PIPs) are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. During 2020, there were 4 PIPs in progress.

Appointment Reminder Program (ARP)

The purpose of this project was to improve outcomes for Members who have been hospitalized to ensure they have a behavioral health appointment within 30 days of inpatient discharge. Optum Idaho found that research indicates that individuals who receive a follow-up appointment within 7 and 30 days of discharge are less likely to be admitted in the future. During 2019, hospitals were trained on the program. Optum Idaho continued to work with hospitals who were not responding or who were having difficulty with the process.

Data from the initial pilot indicated that members who received a reminder were 20-30% more likely to attend a follow-up appointment. Thus, the team moved forward with implementing ARP. However, data from January 2019 to May 2020 showed that there were 142 participants in the ARP program and 2413 individuals who were not part of the ARP program. The data showed there was no difference from those individuals participating in the ARP program and those that were not participating in the ARP program. Whether an individual was in the ARP program or not, the follow up rate for them to attend their appointment within 30 days was around 50%. The onset of COVID-19 in early 2020, had an impact on the ability to visit hospitals to assist and support hospitals with follow-up appointments.

While data did not show expected results, Optum Idaho believes that continued engagement with hospitals and members to ensure appointments are available after discharge is critical to providing quality care to members. Therefore, the recommendation was to close the ARP as a PIP and integrate the program into clinical operations within the care coordination process.

Follow-Up After Hospitalization (FUH)

The purpose of this project was to assess adults and children 6 years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The project sought to improve the percentage of members who received follow-up outpatient care within 30 days of discharge from an inpatient facility. According to the National Committee on Quality Assurance (NCQA) HEDIS Measure, approximately one in four adults in the United States suffer from mental illness each year. Nearly half of U.S. adults will develop at least one mental illness in their lifetime. There are over 2,000,000 hospitalizations each year for mental illness. Patients hospitalized for mental health issues are vulnerable after their discharge. Follow-up care by trained mental health clinicians is critical for their health and well-being. During 2019, the workgroup identified data important to determining improvement in this measure. The ARP is integral to this project and field staff visited inpatient facilities to discuss FUH rates and ways Optum Idaho can support facilities in ensuring members are scheduled for and attend follow-up appointments within 30 days of inpatient discharge.

During 2020, it was determined that the data did not show consistent and expected results and much of the work being completed by this PIP workgroup overlapped with the interventions being developed in the new Care Coordination PIP (described below). Therefore, at the 10/21/2020 QAPI meeting, a decision was made to integrate the FUH PIP into the Care Coordination PIP.

Care Coordination

This PIP was chosen to effectively identify high risk members which include children, adolescents, and adults, who need more intensive care management, coordination, and intervention. The improvement strategy was implemented to identify how to use meaningful data to align with national quality standards defined by the Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance (NCQA) which include: to assist with coordination of care transitions and to improve member and family engagement.

Prior to implementing the PIP, Optum Idaho relied on a manual process to combine data, inpatient hospitalization data and emergency department admit data and claims that would identify members who showed high utilization that were not referred

into the care coordination program. In the PIP, Optum Idaho expanded the data collection to include non-readmit data, along with inpatient hospitalization data, emergency department admit data, and claims data.

The major barrier that initiated this PIP was that the data was housed in multiple databases, both internal and external, which provided a technical challenge to combining, comparing, and analyzing the data. Several Optum Idaho staff members were involved in identifying the problem along with stakeholders including the Idaho Department of Health and Welfare and the Optum Idaho Provider Advisory Committee.

The question Optum Idaho asked in developing the PIP was: Would the implementation of a high-risk algorithm increase the number of members identified as high risk and increase the numbers referred into the field care coordination program? A high-risk algorithm was developed that identifies children, adolescents, and adult members who are high risk by categorizing data points into the following general indicators: utilization, crisis/emergency, complexity, social determinants, and interactions that rank members based on risk factors to prioritize and identify members and improve member outcomes and engagement in the system of care. The algorithm included the following criteria: multiple behavioral health hospitalizations, high utilization of services, multiple crisis intervention claims, foster care admissions, psychiatric residential treatment facility admissions, repeated urgent and emergent calls to the Member Access & Crisis Line, high risk member algorithms triggered by ALERT (Algorithms for Effective Reporting and Treatment) clinical model, multiple emergency department visits for behavioral health reasons and the member has multi-system involvement.

Performance Measures include:

- Number of members identified that were not identified by previous manual process.
- Number of members referred into the care coordination program.

By implementing these performance measures, Optum Idaho hopes the impact to beneficiary health or functional status will include:

- Member feeling empowered and engaged in treatment, and their recovery and resiliency.
- Member having access to individualized, culturally competent, medically necessary and timely treatment emphasizing the use of evidence-based behavioral health services in a timely manner.
- Member to increase knowledge of, and engagement in, community resources, and foster member choice and independent living that is developmentally appropriate.
- Improve member experience of navigating a seamless transition to levels of care within the system of care.

This project remains open.

Respite

Implementation of the Respite PIP is to ensure appropriate payment of respite claims. Optum is required to process Respite claims in accordance with prompt payment requirements and with the correct benefit amount, duration or scope requirements described in the contract, mutually agreed terms or as referenced in the applicable State Plan, State Plan Amendment or Waiver.

This project remains open.

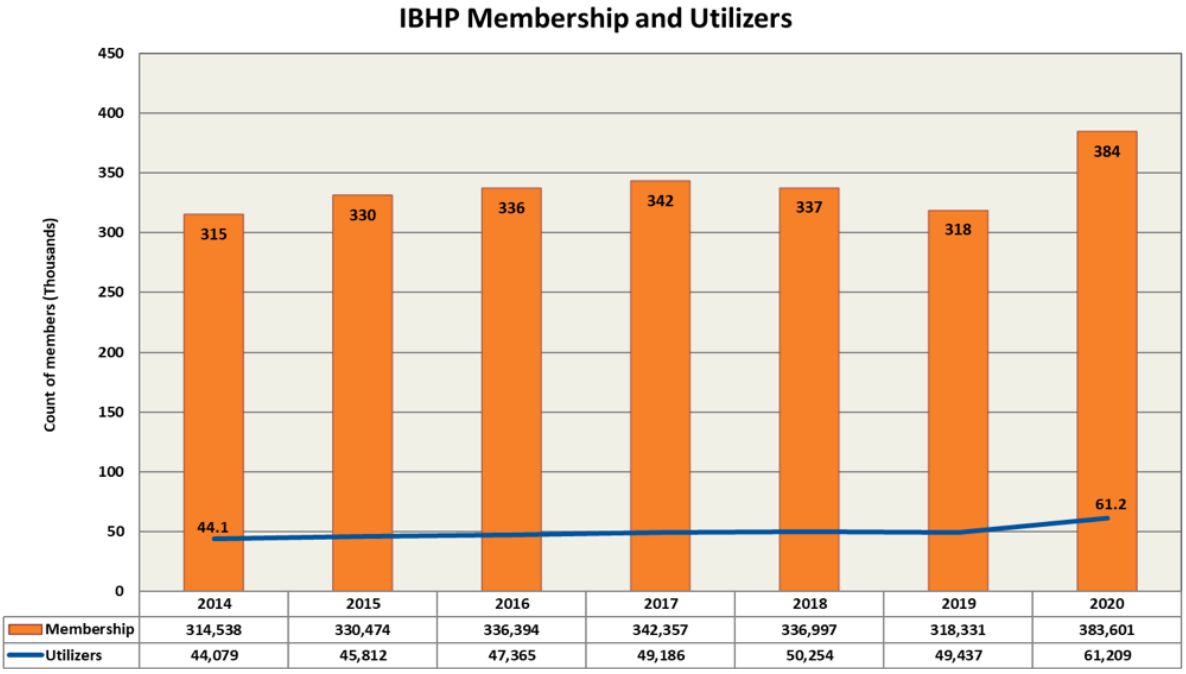
Accessibility & Availability

Idaho Behavioral Health Plan Membership

Methodology – The IDHW sends IBHP Membership data to Optum Idaho monthly. "Membership" refers to IBHP members with the Medicaid benefit. "Utilizers" refers to the number of Medicaid members who use IBHP services.

Analysis – During 2020 membership and utilizer numbers increased.

Figure 24



	2014	2015	2016	2017	2018	2019	2020
Membership	314,538	330,474	336,394	342,357	336,997	318,331	383,601
Utilizers	44,079	45,812	47,365	49,186	50,254	49,437	61,209

Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Member Services Call Standards

Methodology – Optum Idaho telephone access is provided 24 hours a day, seven days a week, 365 days per year through our toll-free Member Access and Crisis Line. Optum Idaho is contractually obligated to track the percent of member calls answered within 30 seconds, daily average hold time and call abandonment rate.

Analysis – The Member Services and Crisis Line received a total of 6,999 during 2020, up from 4,641 calls during 2019. Overall, the percentage of calls answered within 30 seconds met the goal, however, there were 2 quarters where this measure fell slightly below the goal. ProtoCall is the vendor Optum partners with for the Member access and crisis services line available 24/7/365. During the quarters where performance was not met (Q3 and Q4), ProtoCall indicated significant clinician resource constraints being exacerbated by the ongoing nature of COVID-19. During this time, Optum remained in close contact with ProtoCall to ensure their Idaho information and processes remained up to date for their phone clinicians, implemented performance guarantees within the contract, and remained apprised of onboarding and training of new staff. It is worth noting that the performance did improve over time with the diligent and dedicated efforts of the ProtoCall team. It is fully expected that compliance with this metric will continue to improve. The daily average hold time and the call abandonment rate goals were met.

Figure 25

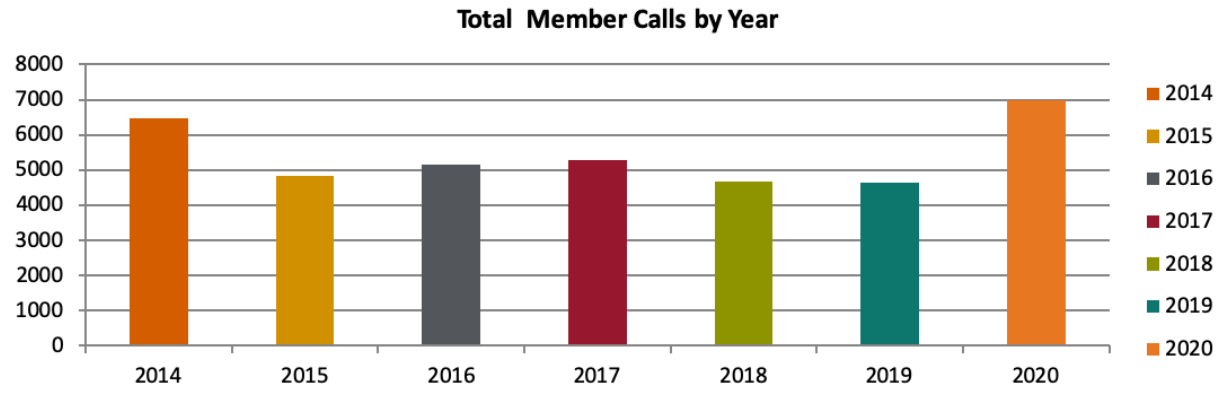


Figure 26

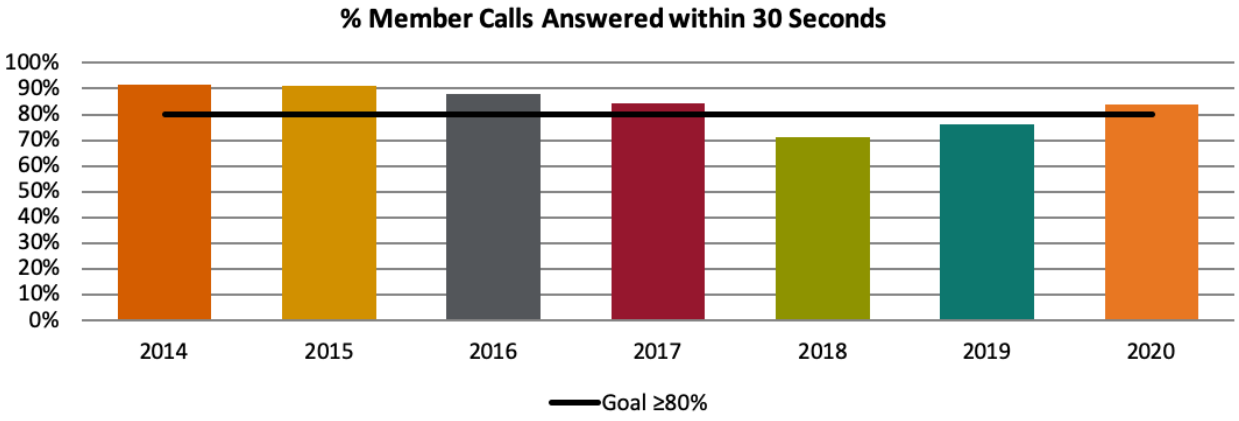


Figure 27

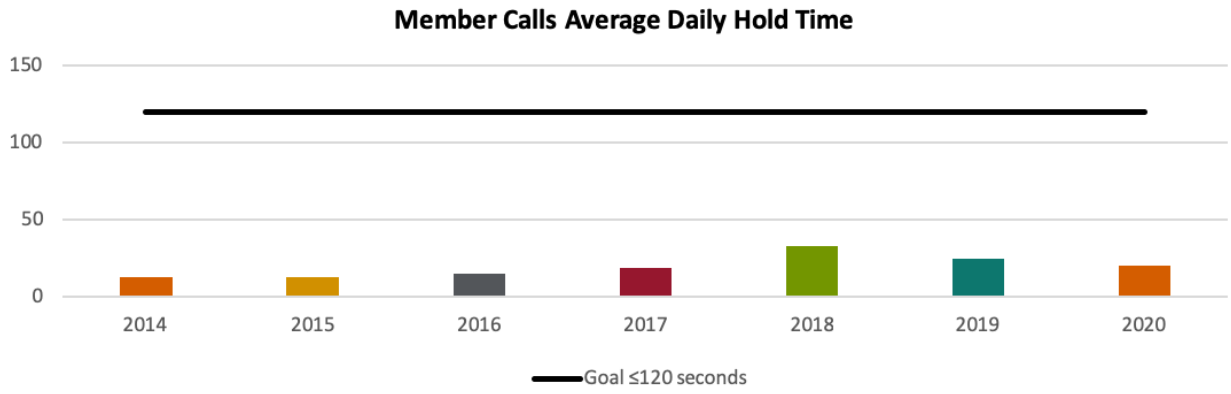
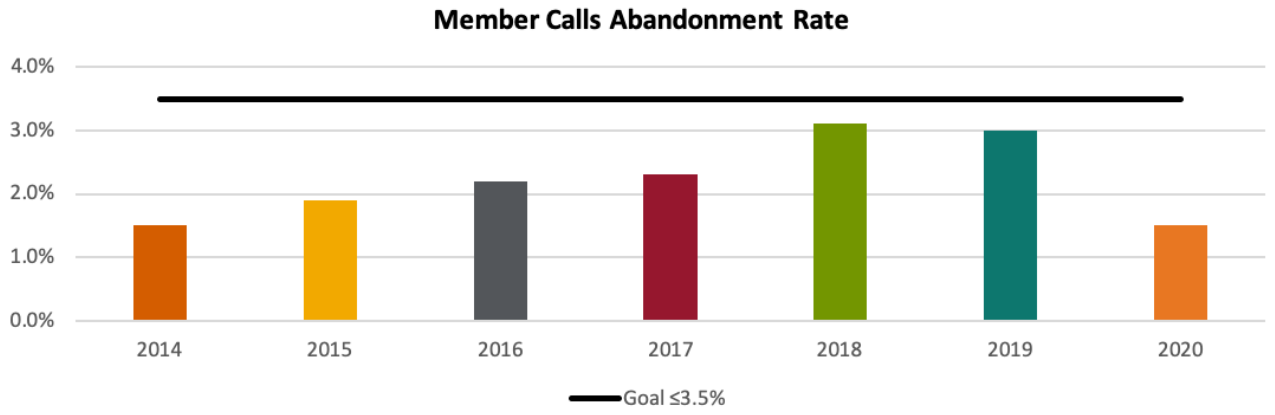


Figure 28



Barriers – Overall, the percentage of calls answered within 30 seconds met the goal, however, there were 2 quarters where this measure fell slightly below the goal due to significant clinician resource constraints by ProtoCall being exacerbated by the ongoing nature of COVID-19.

Opportunities and Interventions – Optum Idaho will continue to monitor and work with ProtoCall and fully expects that compliance with this metric will continue to improve.

Customer Service (Provider Calls) Standards

Methodology – Optum Idaho is contractually obligated to track the percent of provider calls answered within 30 seconds, daily average hold time and call abandonment rate. The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho to ensure the needs of our providers and stakeholders are met in a timely and efficient manner.

Analysis – The Customer Service Line received 13,597 calls during 2020, up from 12,332 calls during 2019. Optum Idaho exceeded all established performance call standards during 2020, including calls answered within 30 seconds, average daily hold time, and call abandonment rate.

Figure 29

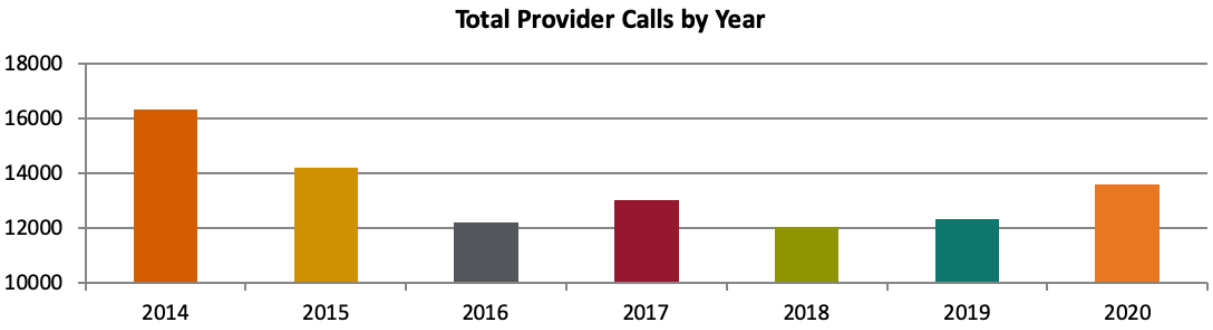


Figure 30

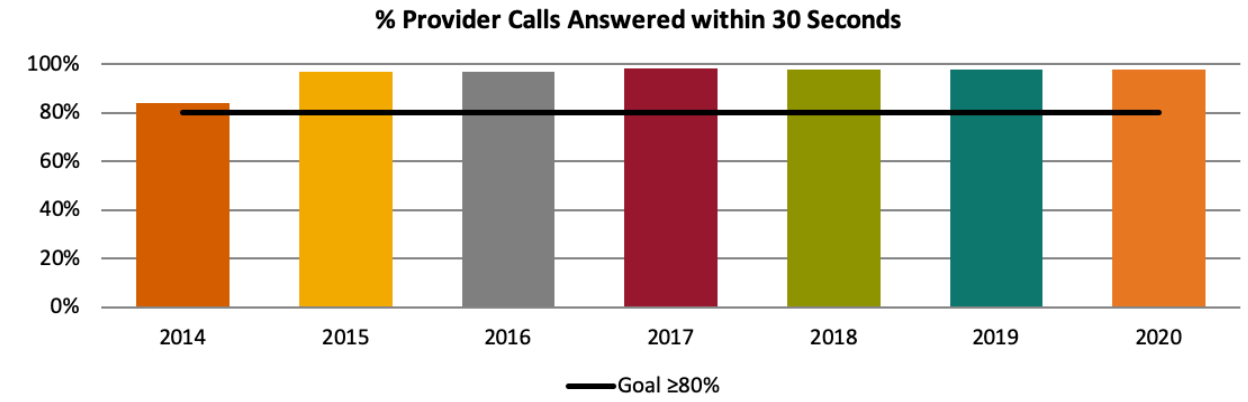


Figure 31

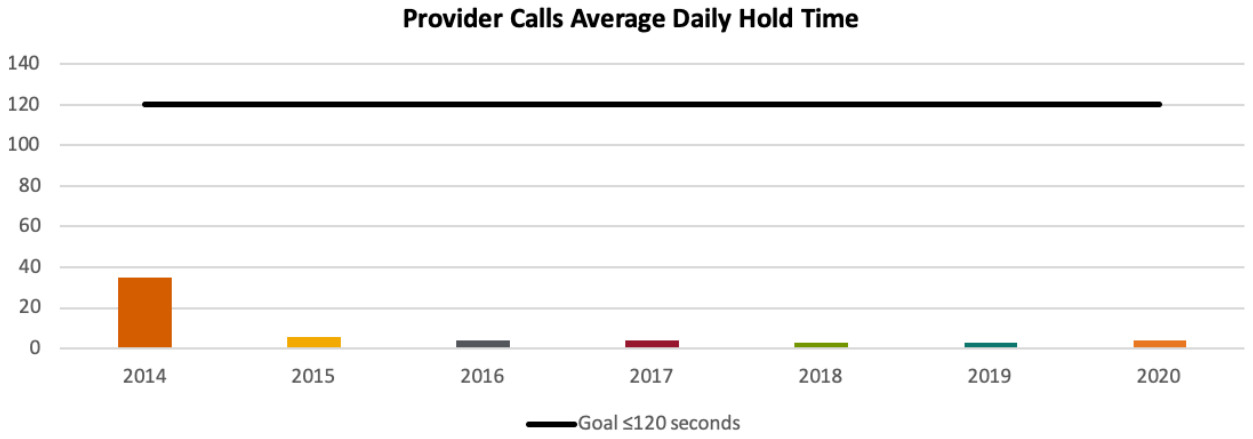
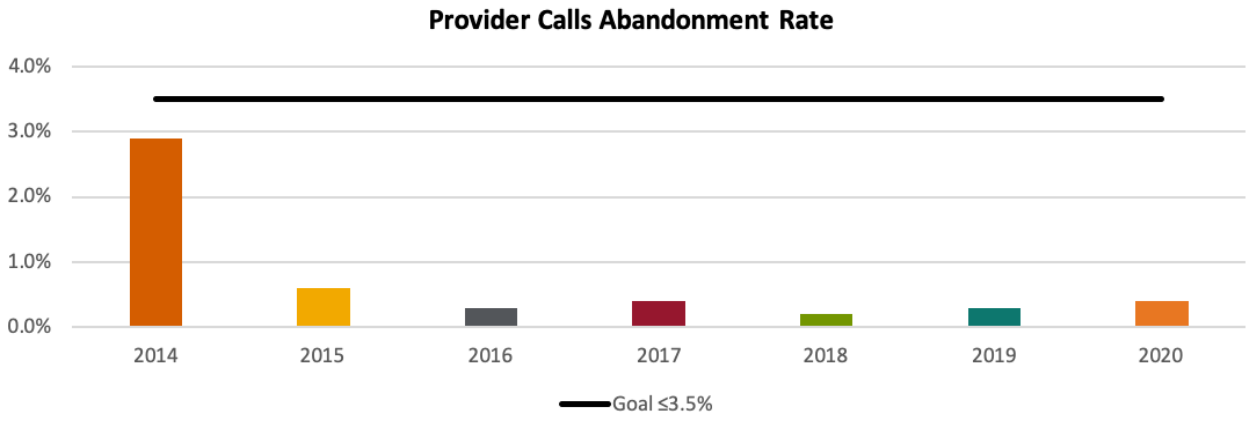


Figure 32



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Urgent, Non-Urgent, and Critical Appointment Access Standards

Methodology – As part of Optum Idaho's Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, Optum Idaho developed, maintains, and monitors a network with adequate numbers and types of clinicians and outpatient programs. Optum Idaho requires that network providers adhere to specific access standards for Urgent Appointments being offered within 48 hours, Non-urgent Appointments being offered within 10 days of request, and Critical Appointments being offered within 6 hours. Access to care is monitored via monthly provider telephone polling by the Network team.

Analysis – Optum Idaho again exceeded the performance goal for Urgent Appointment wait times during 2020 with an average of 15 hours (goal within 48 hours). The overall performance goal for Non-Urgent Appointment wait times was also met with an average of 3.5 days (goal within 10 days). Optum Idaho initially began tracking data for Critical Appointment wait times in July 2017. Critical Appointment wait times met the goal of being offered within 6 hours in 2020 with an average of 3 hours (goal within 6 hours).

Figure 33

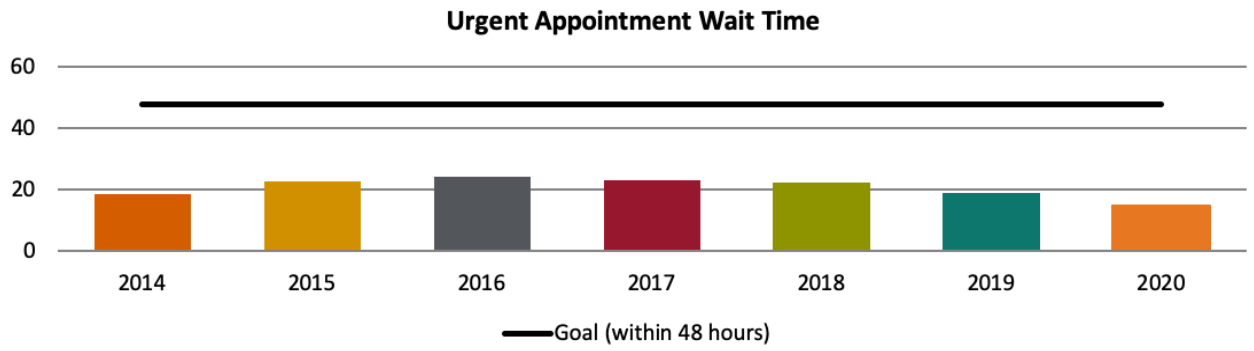


Figure 34

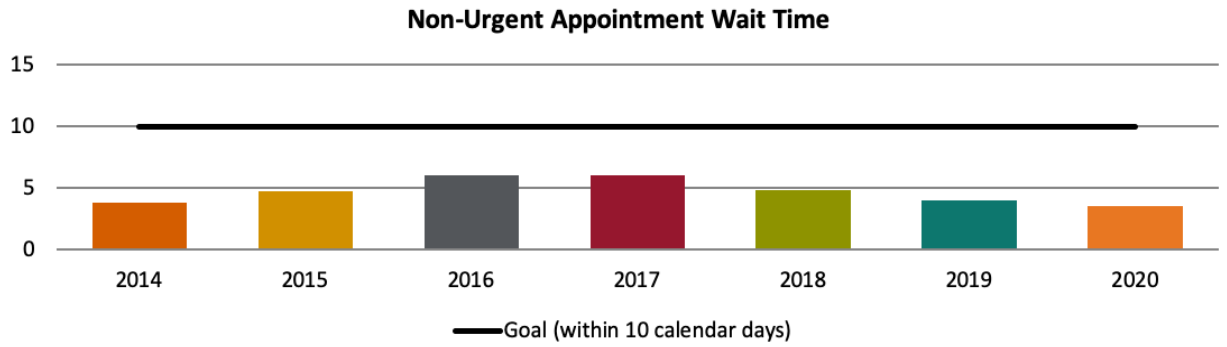
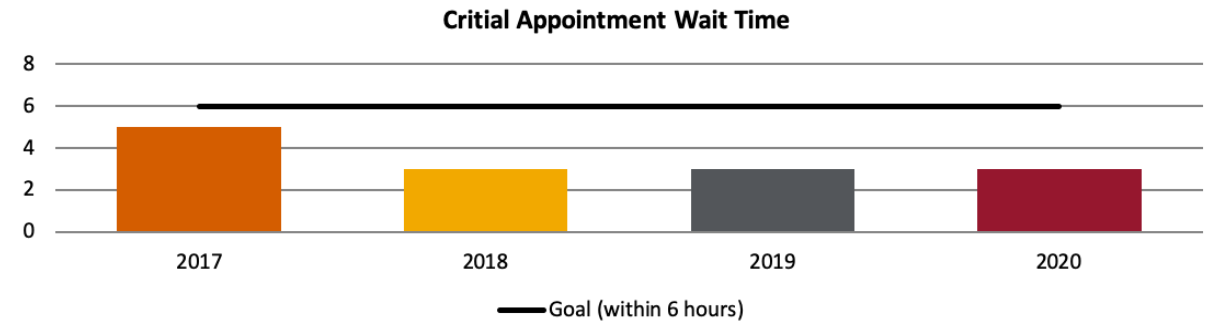


Figure 35



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

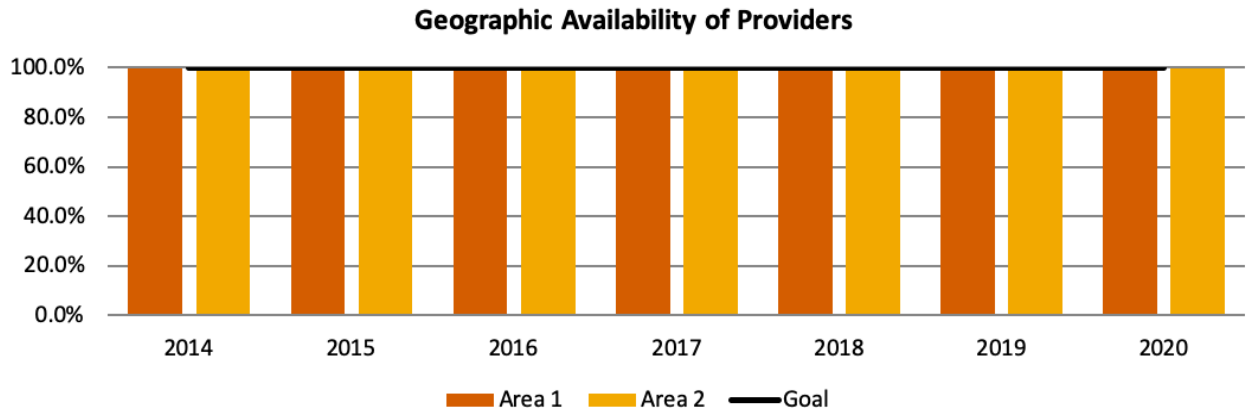
Geographic Availability of Providers

Methodology – GeoAccess reporting enables the accessibility of health care networks to be accurately measured based on the geographic locations of health care providers relative to those of the members being served. On a quarterly basis, Optum Idaho runs a report using GeoAccess™ software to calculate estimated drive distance, based on zip codes of unique members and providers/facilities.

Optum Idaho's contract availability standards for "Area 1" requires one (1) provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties. For the remaining 41 counties (37 remaining within the state of Idaho and 4 neighboring state counties) in "Area 2" Optum Idaho's standard is one (1) provider within 45 miles.

Analysis – During 2020, Optum Idaho continued to meet contract provider availability standards. Area 1 availability standards were met at 99.9% and Area 2 availability standards were also met at 99.7%. (Performance is viewed as meeting the goal due to established rounding methodology – rounding to the nearest whole number).

Figure 36



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Member Protections and Safety

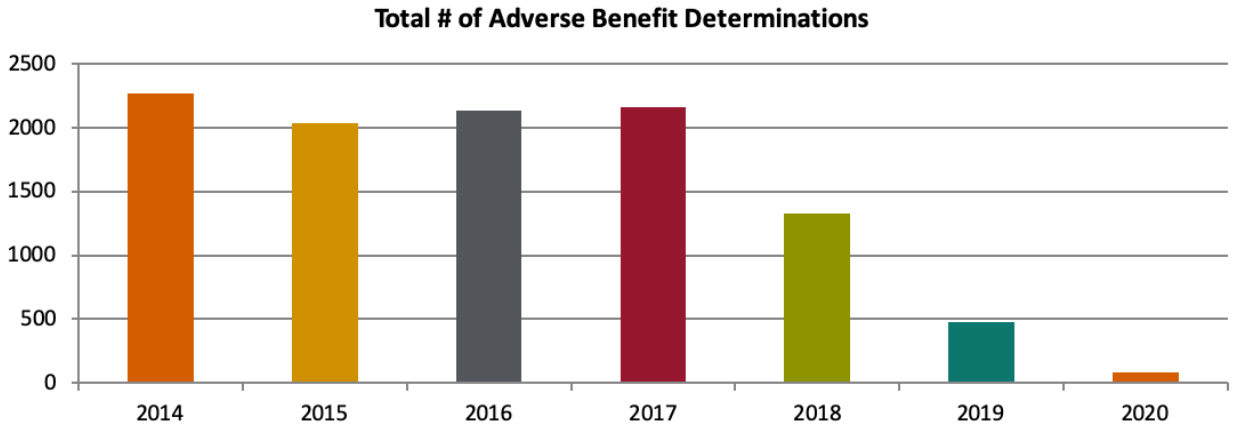
Optum Idaho's policies & procedures, guidelines, along with the quality monitoring programs, are designed to help ensure the health, safety and appropriate treatment of Optum Idaho members. These guiding documents are informed by national standards such as NCQA (National Committee for Quality Assurance) and URAC (Utilization Review Accreditation Commission).

Notification of Adverse Benefit Determination (ABD)

Methodology – An ABD is defined as the denial or limited authorization of a requested service. When a request for service is received, Optum Idaho has 14 calendar days to review a standard or non-urgent authorization case, make a determination to authorize or deny services in total or in part, and mail the ABD notification letter—if applicable. An ABD can be based on clinical or administrative guidelines.

Analysis – There were 78 ABDs during 2020. The written compliance (14 calendar days from request) goal is 100%. During 2020, it was 98.5% due to 1 ABD being routed to the wrong LINX worklist and therefore, written notification timeframe was missed. Education and training were provided to ensure future ABDs were routed to the correct worklist. Optum Idaho continued to see a decrease in clinical and administrative ABDs. This can be attributed to Optum Idaho suspending prior authorization requirements for services to reduce the administrative burden on providers due to COVID-19.

Figure 37



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Member Appeals

Methodology – Optum Idaho recognizes the right of a member or authorized representative to appeal an ABD that resulted in member financial liability or denied services. All non-urgent appeals are required to be reviewed and resolved within 30 calendar days. Urgent appeals are required to be reviewed and resolved within 72 hours. Additionally, all non-urgent appeals are required to be acknowledged within 5 calendar days from receipt of the appeal request with an acknowledgment letter. Urgent appeal requests do not require an acknowledgment letter. All appeals are upheld, overturned, or partially overturned.

Analysis – There were 3 Member Appeals. All turnaround time requirements and performance goals were met in 2020. The reduction in appeal volume is directly attributed to the reduction in the number of ABDs. Of note, Optum Idaho began tracking Urgent Appeals and Non-Urgent Appeals turnaround time separately beginning in 2017, indicated in the graphs below.

Figure 38

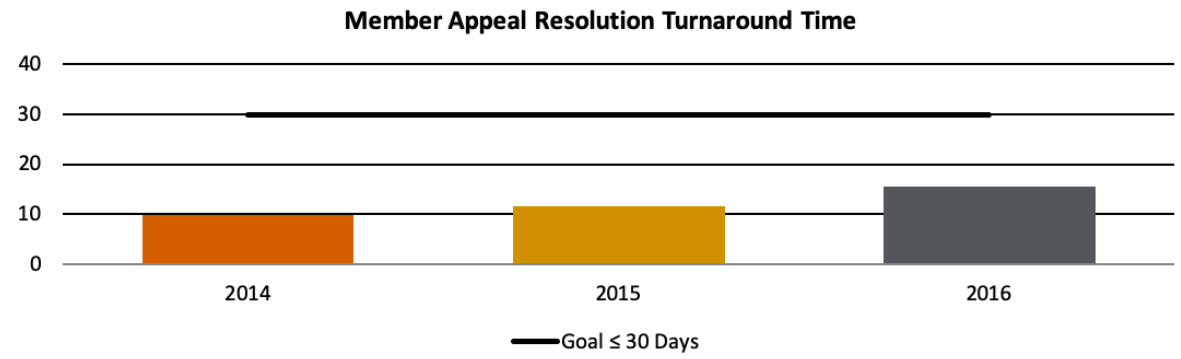


Figure 39

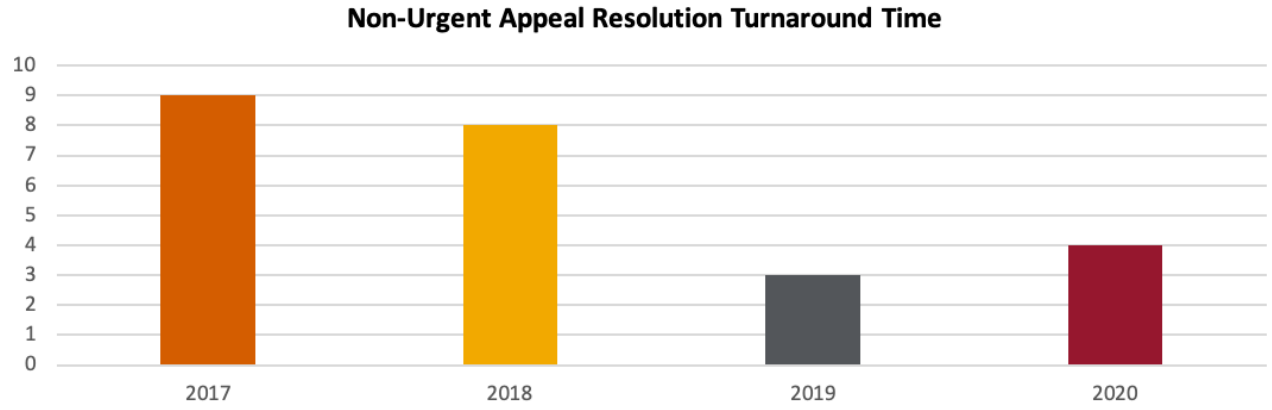
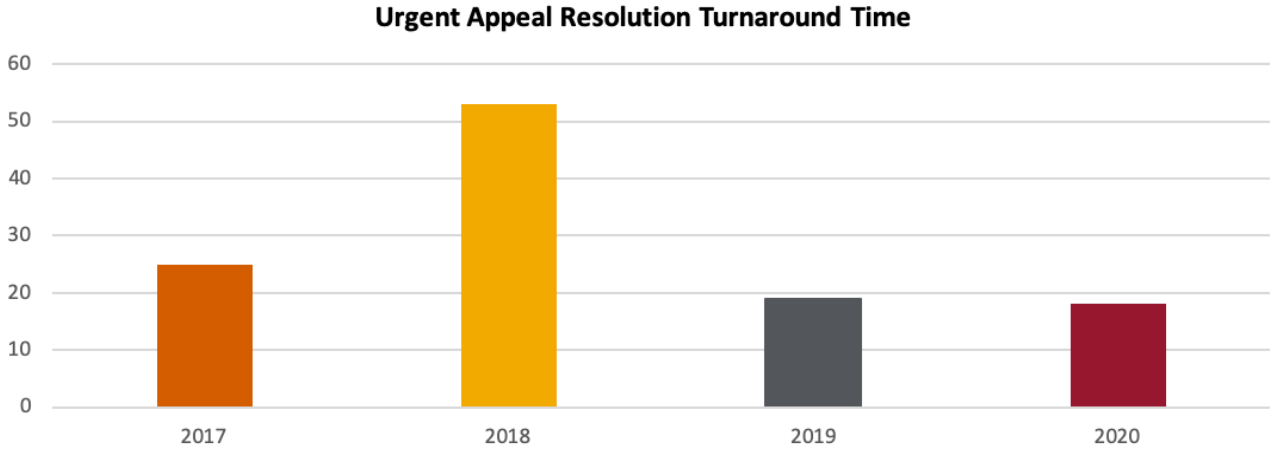


Figure 40



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Complaint Resolution and Tracking

Methodology – A complaint is an expression of dissatisfaction logged by a member, a member's authorized representative or a provider concerning the administration of the plan and services received. This is also known as a Quality of Service (QOS) complaint. A concern that relates to the quality of clinical treatment services provided by an individual provider or agency in the Optum Idaho network is a Quality of Care (QOC) concern.

Complaints are collected and grouped into the following broad categories: Benefit, Service (and Attitude), Access (and Availability), Billing & Financial, Quality of Care, Privacy Incident, and Quality of Practitioner Office Site.

Optum Idaho maintains a process for recording and triaging QOC Concerns and QOS complaints to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. Both QOS complaints and QOC concerns are to be acknowledged within 5 business days. QOS complaints are to be resolved within 10 business days and QOC concerns are to be resolved within 30 calendar days.

Analysis – There were 45 total complaints (QOS and QOC combined) received during 2020. Of the total complaints received, 34 were identified as QOS and 11 were identified as QOC. Optum Idaho met resolution compliance for QOS complaints and QOC concerns turnaround times.

Figure 41

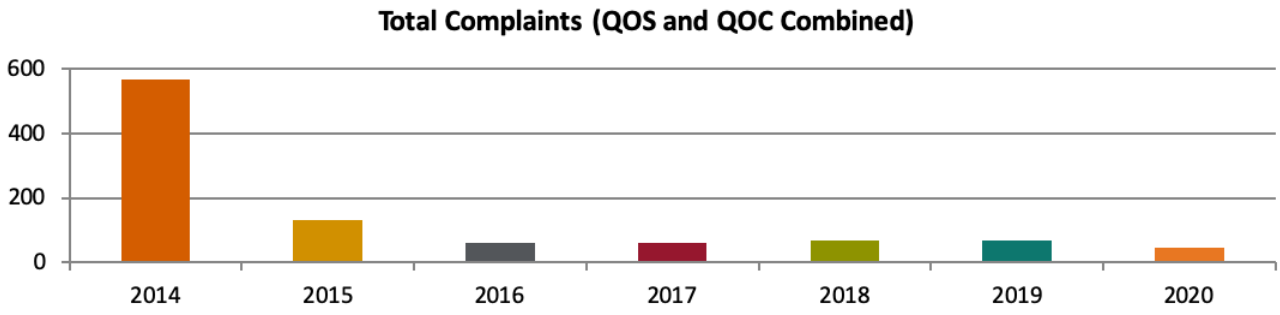


Figure 42

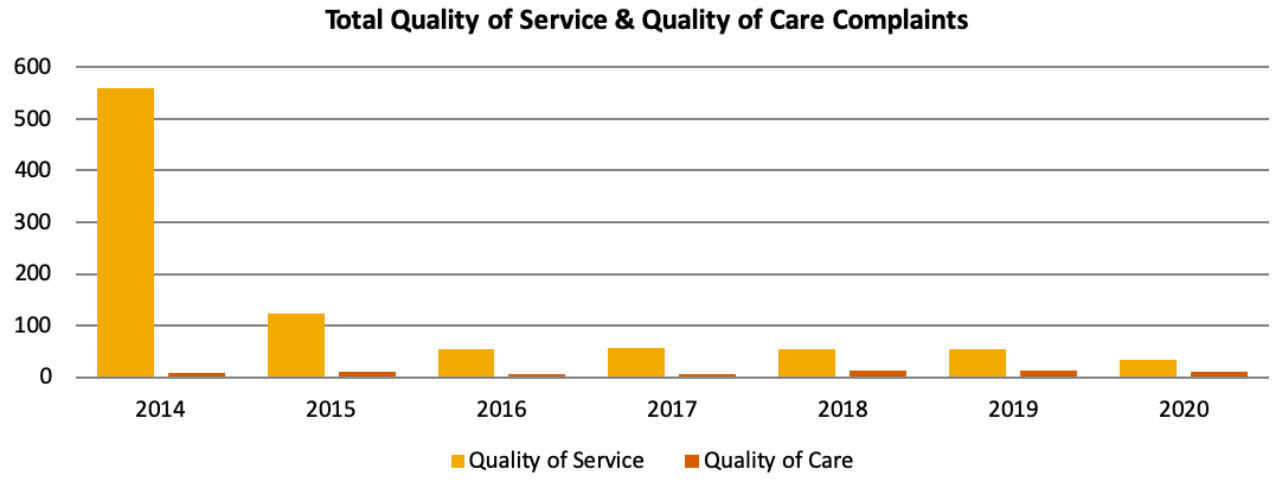


Figure 43

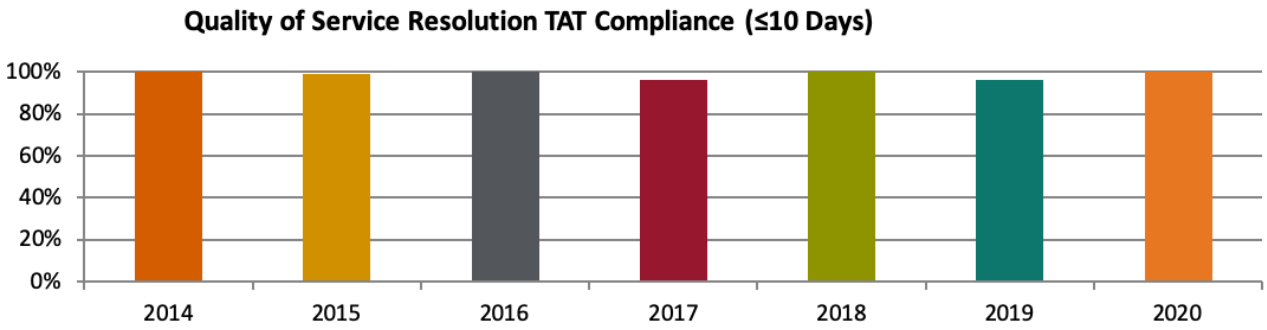


Figure 44

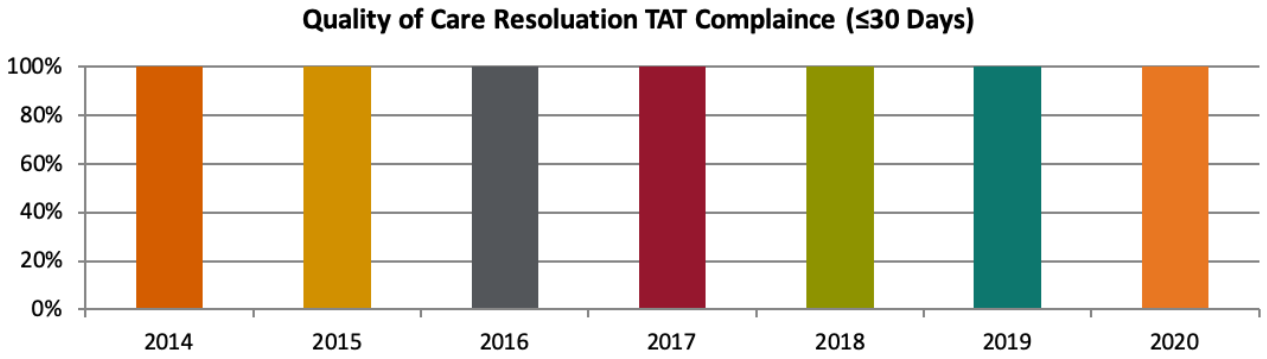
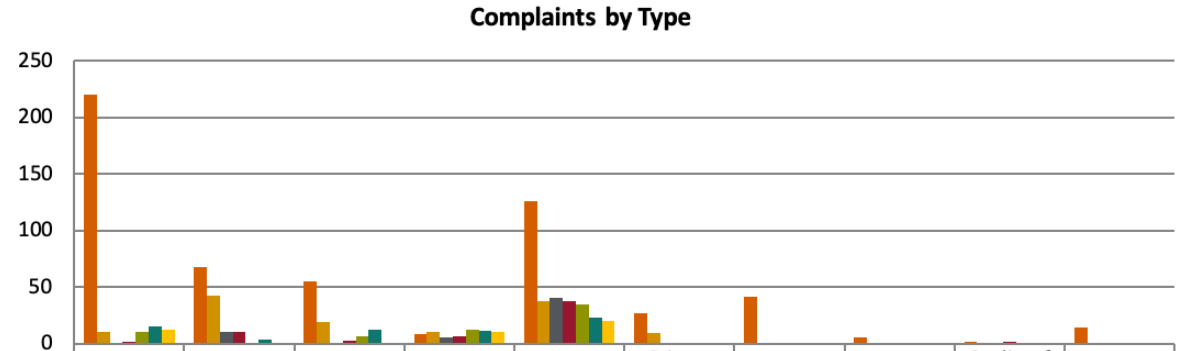


Figure 45



	Access	Benefit	Billing & Financial	Clinical QOC	Service	Privacy Incident Report	HIPAA	PHI	Quality of Practitioner Office Site	Other
2014	220	68	55	9	126	27	42	6	2	14
2015	11	43	19	11	38	10	0	0	1	0
2016	1	11	1	6	41	0	0	0	1	0
2017	2	11	3	7	38	0	0	0	2	0
2018	11	1	7	13	35	0	0	0	0	0
2019	15	4	13	12	23	0	0	0	0	0
2020	13	0	1	11	20	0	0	0	0	0

Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

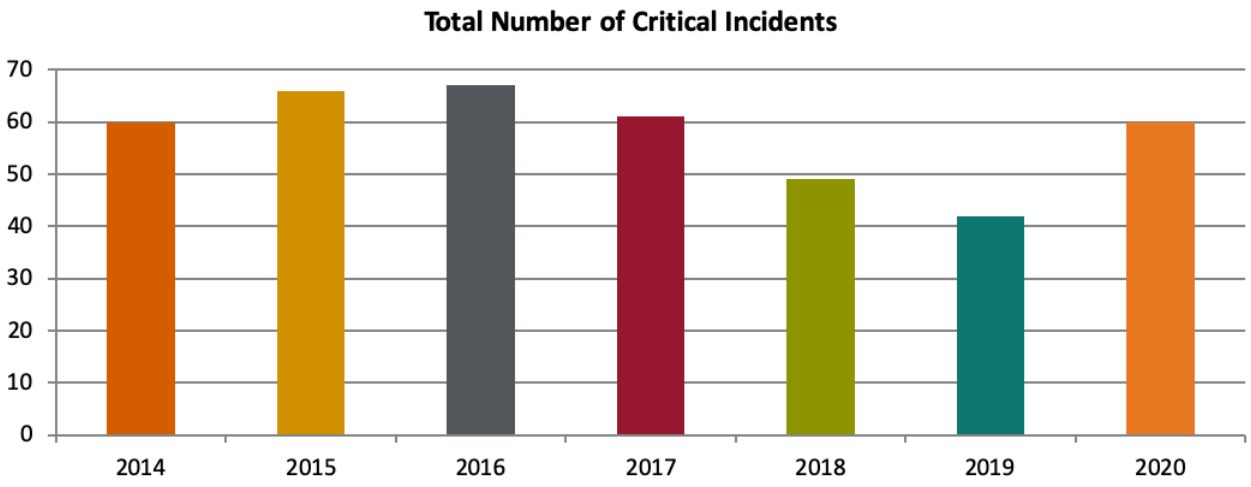
Critical Incidents

Methodology – To improve the overall quality of care provided to our members, Optum Idaho utilizes peer reviews for occurrences related to members that have been identified as Critical Incidents (CIs). Providers are required to report CIs to Optum Idaho within 24 hours of being made aware of the incident. A CI is a serious, unexpected occurrence involving a member that is believed to represent a possible QOC concern on the part of the provider or agency providing services, which has, or may have, detrimental effects on the member, including death or serious disability, that occurs during the course of a member receiving behavioral health treatment.

Optum Idaho has a Peer Review Committee (PRC) to review CIs identified as having a QOC concern. The PRC makes recommendations for improving patient care and safety, including recommendations that the Provider Quality Specialists conduct site audits and/or record reviews of providers in the Optum Idaho network as well as providers working under an accommodation agreement with Optum Idaho to provide services to members. The PRC may provide providers with written feedback related to observations made as a result of the review of the CI. An internal CI Ad-Hoc Committee review is completed within 5 business days from notification of incident.

Analysis – There were 60 CIs reported during 2020. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was consistently met. The highest numbers of CIs reported in 2020 were in the category of Unexpected Deaths (65%). Coordination of care occurred between the behavioral health provider and the member's PCP in 28% which was an increase from 17% of cases in 2019. Of the 60 reported CIs, 65% involved members with co-morbid health conditions. Of the cases reported in 2020, 90% of the cases were adults (18+) and 10% were children/adolescents (17 and below). Further analysis showed that the average age for adult males was 42 and females 43. The average age for child/adolescents was 15 for females and 13 for males. The highest number of CIs per region (top 3) were Region 7 with 15 CIs, Region 4 with 13 CIs, and Region 1 with 12 CIs.

Figure 46



Barriers – Based on the above analysis, no barriers were identified.

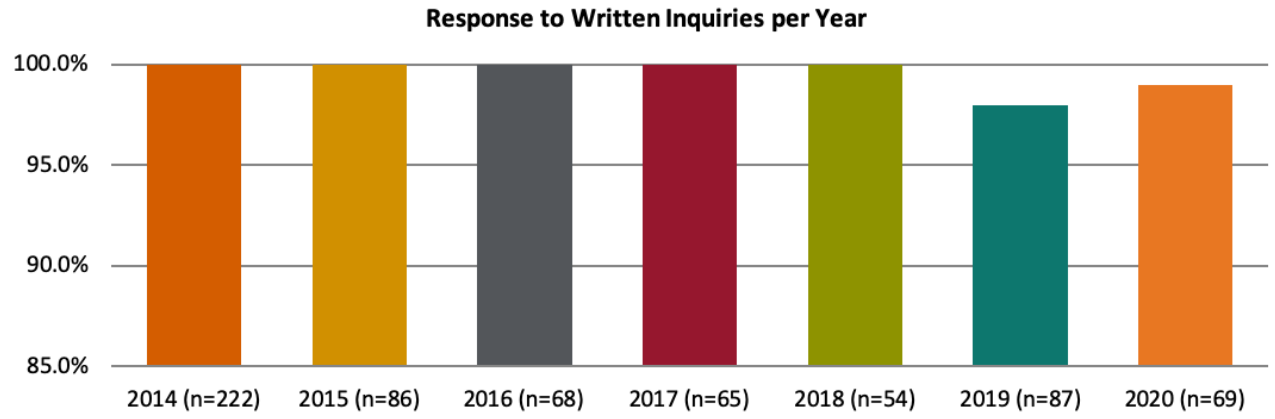
Opportunities and Interventions – No opportunities for improvement were identified.

Response to Written Inquiries

Methodology – Optum Idaho's policy is to respond to all member and provider phone calls, voice mails and email/written inquiries within two (2) business days. This data is maintained and tracked in an internal database by Optum Idaho's Customer Service Department.

Analysis – Performance fell slightly below that goal of 100% acknowledged within 2 business days at 99%. One response fell out of compliance due to customer service staff having to wait for information from another team prior to responding to provider.

Figure 47



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Provider Monitoring and Relations

Provider Quality Monitoring

Optum Idaho monitors provider adherence to quality standards via site visits. The Optum Idaho Provider Quality Specialists complete treatment record reviews and site audits to facilitate communication, coordination and continuity of care and to promote efficient, confidential and effective treatment, and to provide a standardized review of practitioners and facilities on access, clinical record keeping, quality, and administrative efficiency in their delivery of behavioral health services.

Methodology – Following an audit, the provider will receive initial verbal feedback and written feedback within 30 days of the site visit. Scores above 85% are considered passing. A score between 80-84% requires submission of a corrective action plan (CAP). A score of 79% or below requires submission of a CAP and participation in a re-audit within 4- 6 months. Audit types and scores are tracked in an internal Excel tracking spreadsheet.

Analysis – During 2020, a total of 458 audits were conducted and 84% (384) of audits received a passing score (≥85%) and did not require a CAP. CAPs were implemented for 16% (74) of the audits that were completed during 2020.

Figure 48

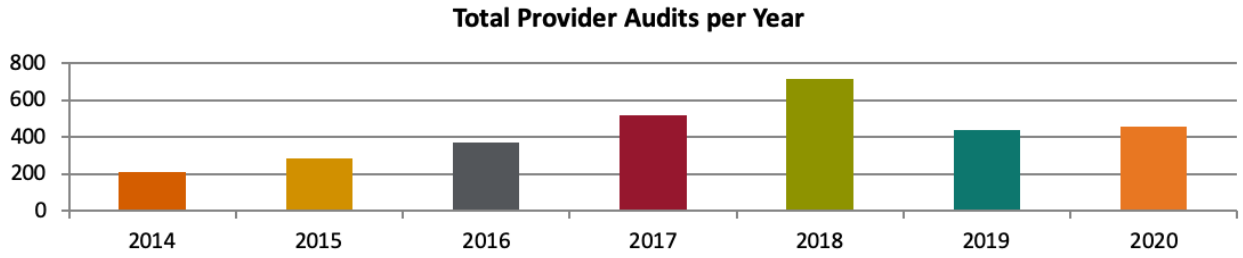
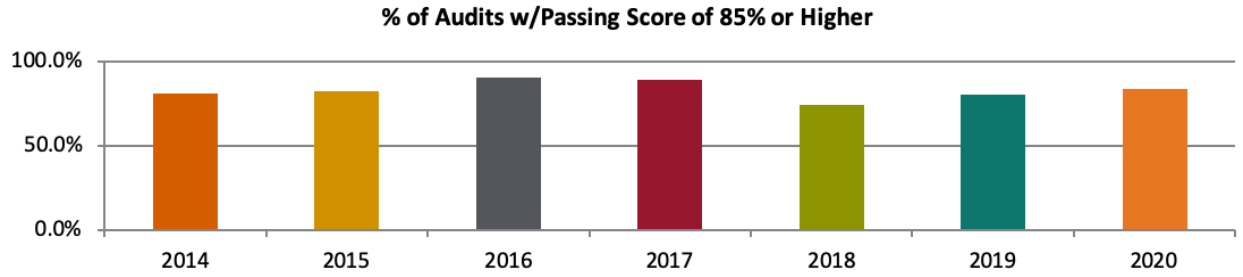


Figure 49



Coordination of Care

Methodology – To coordinate and manage care between behavioral health and medical professionals, Optum Idaho requires providers to obtain the member's consent to exchange appropriate treatment information with medical care professionals (e.g. primary care physicians, medical specialists). Optum Idaho requires that coordination and communication take place at the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate.

Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum Idaho, as well as accrediting organizations, expects providers to make a "good faith" effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member as part of an overall approach to coordinating care.

The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff.

Analysis – Coordination of Care audits completed during 2020 revealed that 98% of member records reviewed had documentation of the name of the member's PCP. Of those, 76% indicated that collaboration had occurred between the behavioral health provider and the member's PCP. The results also revealed that 55% of the records indicated the member was being seen (or had been seen in the past) by another behavioral health clinician (psychiatrist, social worker, psychologist, substance abuse counseling). Of those, 80% indicated that collaboration had occurred.

Figure 50

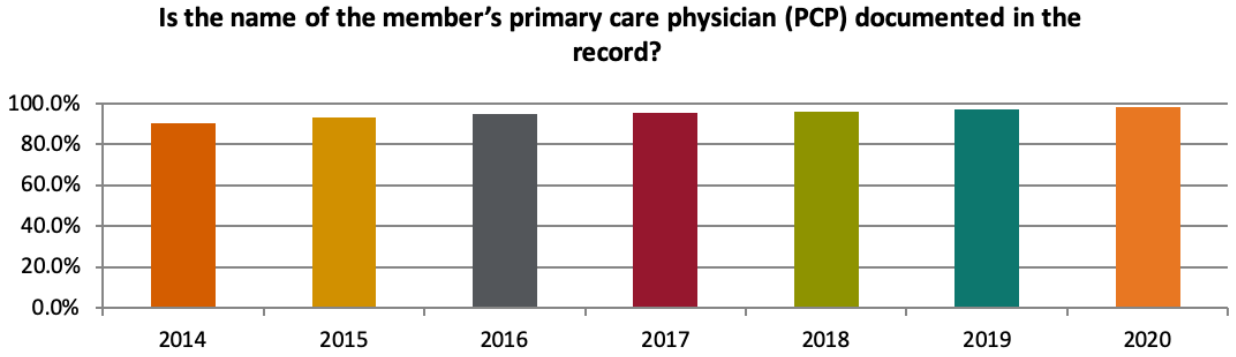


Figure 51

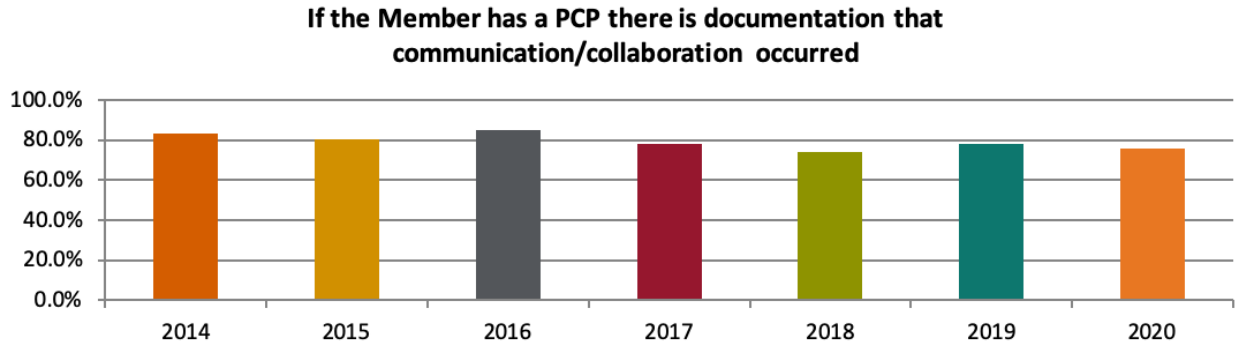


Figure 52

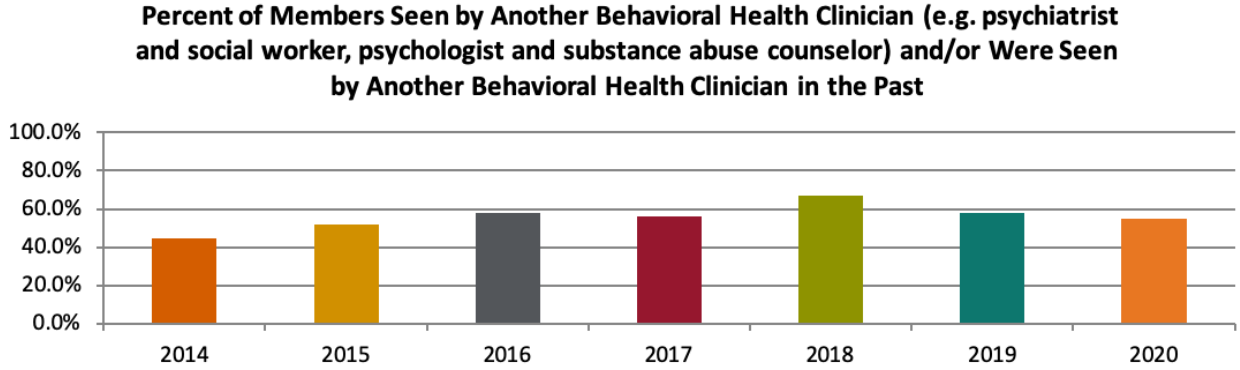
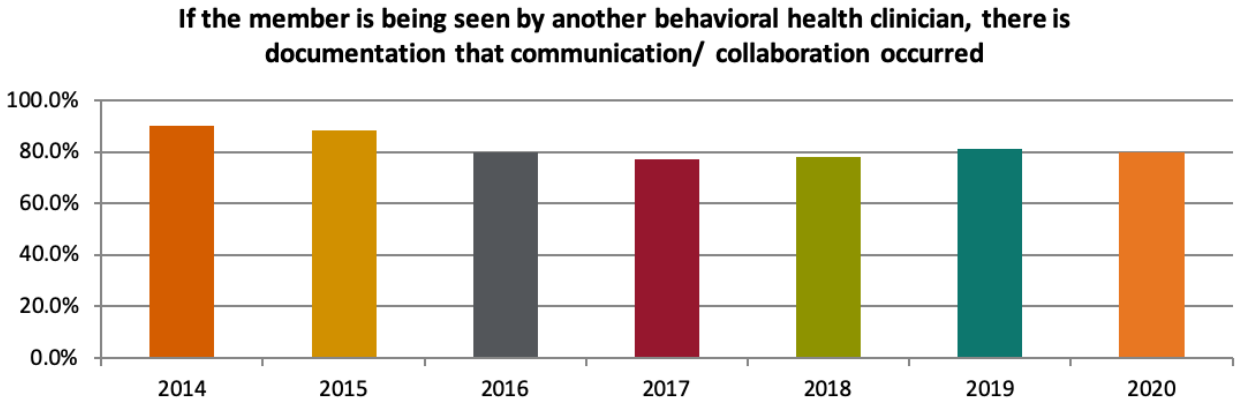


Figure 53



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Provider Disputes

Methodology – Provider disputes are requests by a practitioner for review of a non-coverage determination when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is believed to have been incorrectly issued. A denied claim or an administrative ABD are the two most common disputed items. Provider disputes require that a written resolution be sent within 30 calendar days following the request for consideration.

Analysis – During 2020, there were 579 provider disputes which was up from 138 in 2019. This is attributed to the provider express submission implementation that happened late in 2019. All were resolved within the contractual turnaround time of ≤30 days.

Figure 54

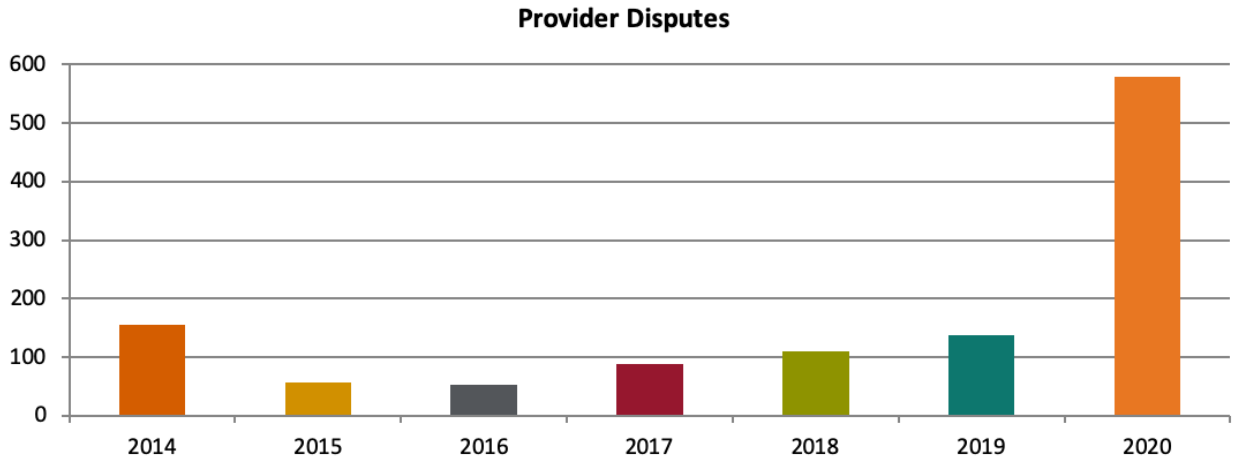
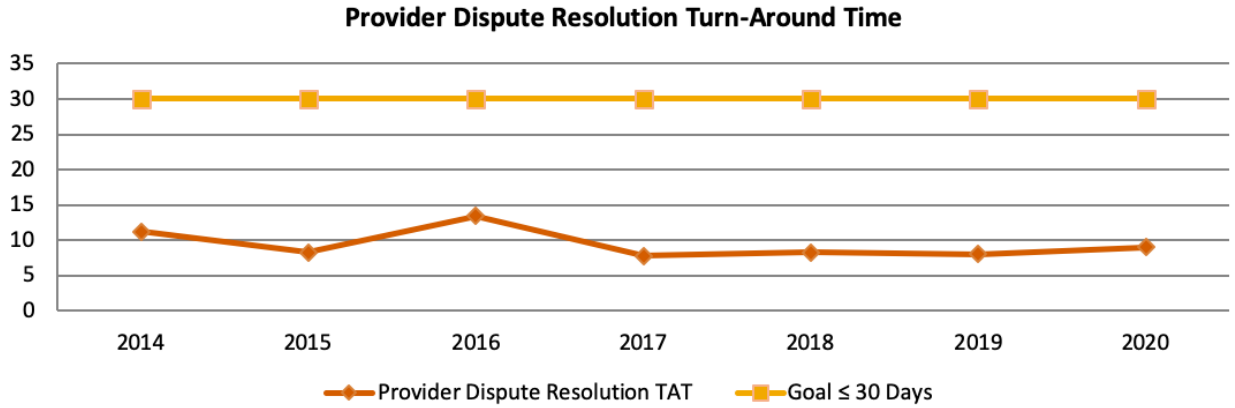


Figure 55



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

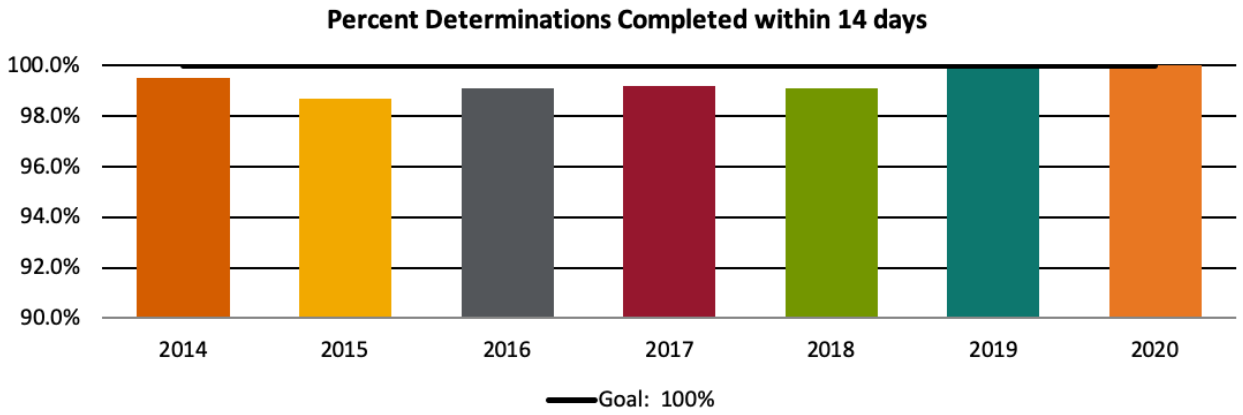
Utilization Management and Care Coordination

Service Authorization Requests

Methodology – Optum Idaho has formal systems and workflows designed to process pre-service and concurrent requests for benefit coverage of services, for both in-network and out-of- network (OON) providers and agencies. Optum Idaho adheres to a 14-day turnaround time for processing requests for non-urgent pre-service requests.

Analysis – During 2020, there were 4,412 service authorization requests. The performance goal of 100% of determinations completed within 14 days was met.

Figure 56



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

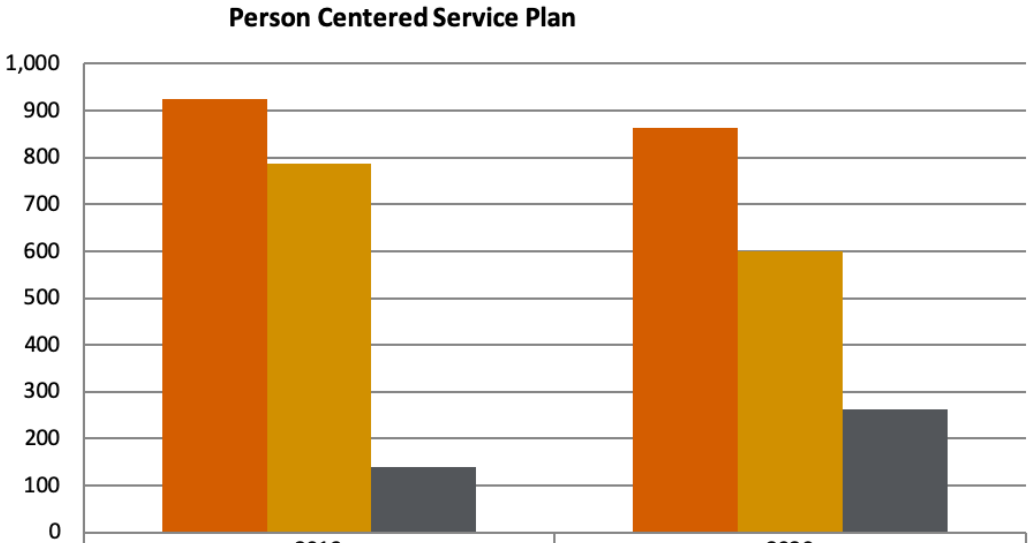
Person-Centered Service Plan (PCSP)

A person-centered service plan (PCSP or "plan") is directed by the individual, is ongoing, and focuses on the strengths, interests, and needs of the whole person. The person is supported to use their own power to choose what they will do and who will help them to achieve a life meaningful to them. A plan is developed jointly with the individual, the individual's authorized representative, and the individual's treatment providers. It reflects the services and supports that are important to the child and family to meet needs identified through a functional needs assessment.

Methodology – Optum Idaho reviews completed PCSPs according to standards established in 42 CFR 441.725 to ensure that the planning process includes people that were chosen by the child or youth and family, that the meetings are scheduled at the times and locations that are convenient for the child and family, that the process reflects cultural considerations, that the process includes strategies to address conflicts or disagreements, including clear conflict-of-interest guidelines for all planning participants, that the process provides a method for the person/family to request updates to the plan, that the plan documents strengths and preferences as noted by the child/youth and/or family, that the plan documents the person's clinical and support needs as identified through an assessment of functional and health-related needs, that the plan documents the person's/family's goals and desired outcomes, that the plan documents the risk factors for the person including specific back-up plans and strategies, and that the plan is written in plain language in a manner that is accessible to the person/family. The PCSP team does not review for medical necessity.

Analysis – During 2020, Optum Idaho received 863 PCSPs to review. Of those, 601 (70%) met CFR standards and 262 (30%) did not meet CFR standards. All were reviewed within the performance goal of 5 business days, with an average turnaround of 0.11 days.

Figure 57



	2019	2020
Total Number of Cases	925	863
Number of Cases Met	786	601
Number of Cases Not Met	139	262

Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Field Care Coordination

Methodology – The Field Care Coordination (FCC) program includes regionally based clinicians across the state of Idaho. They provide locally based care coordination and discharge planning support. Field Care Coordinators work with providers to help members. The FCC team focuses on member wellness, recovery, resiliency, and an increase in overall functioning. They do this through:

- Focusing on consumers and families who are at greatest clinical risk.
- Focusing on consumer's wellness and the consumer's responsibility for his/her own health and well-being.
- Improved care coordination for consumers moving between services, especially those being discharged from 24-hour care settings.

Analysis – During 2020, FCCs received 1604 referrals and increase from 960 in 2019. This may be attributed to the implementation of the Care Coordination PIP which increased the identification of high-risk members and referrals of these members to FCCs. The number of days that a Field Care Coordinator keeps a case open varies by case. The average length of an FCC case was 43 days.

Figure 58

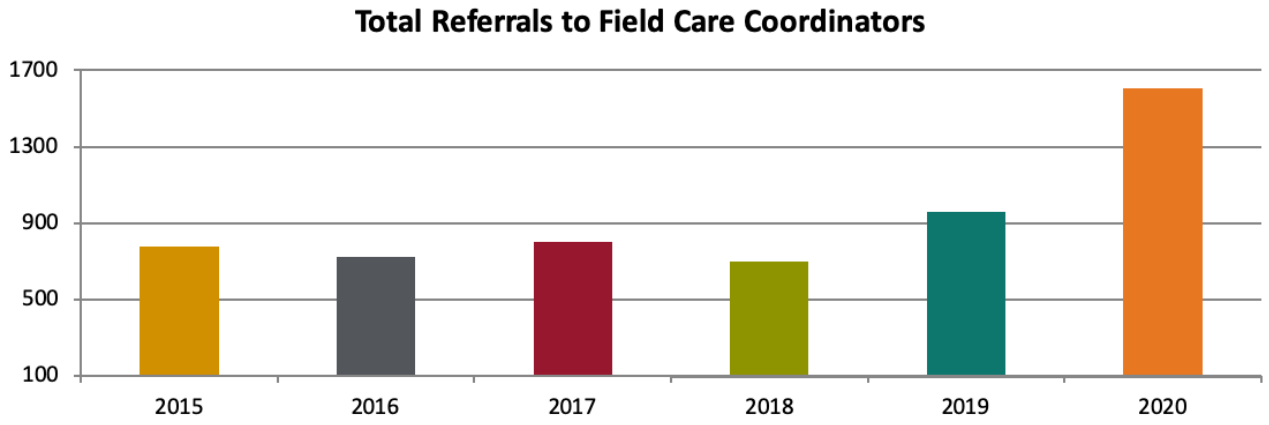
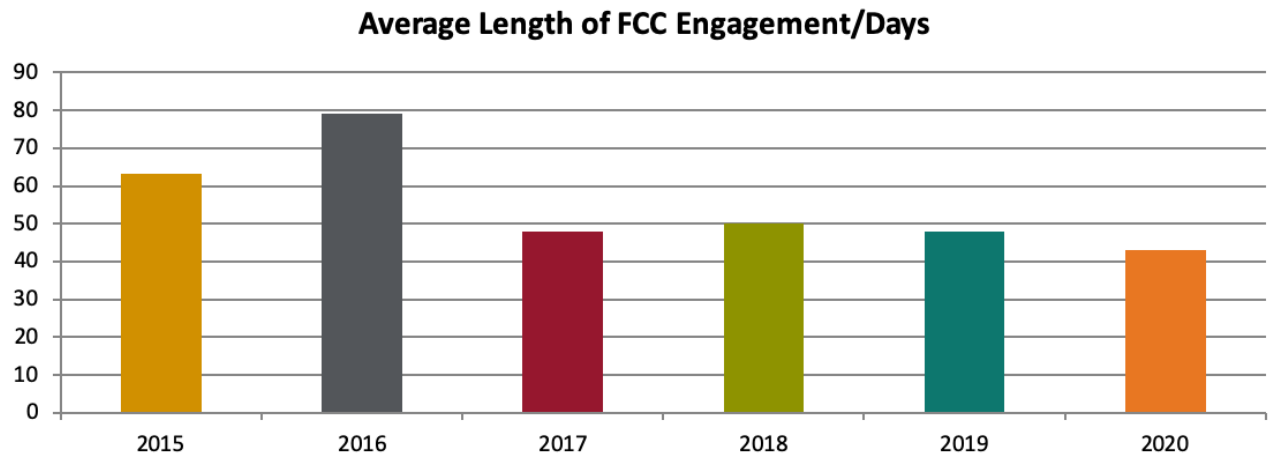


Figure 59



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Inter-Rater Reliability

Optum Idaho evaluates and promotes the consistent application of the Level of Care Guidelines (LOCG) and the Coverage Determination Guidelines by clinical personnel by providing orientation and training, routinely reviewing documentation of clinical transactions in member records, providing ongoing supervision and consultation and administering an assessment of inter-rater reliability (IRR). Results are summarized and reviewed for trends. Optum Idaho also promotes a process for review and evaluation of the clinical documentation of ABDs by Optum Idaho physicians in their role as Peer Reviewers, for completeness, quality and consistency in the use of medical necessity criteria, coverage determination guidelines and adherence to standard Care Advocacy policies.

Methodology – For the Care Advocate audits, the assessment includes a question to determine IRR which states: Does clinical determination reflect that correct application of LOCG, or state specific criteria was met? For the Peer Reviewer audits, a random sample of ABD cases are identified and assigned to a Regional Medical Director. The audits are conducted to review and evaluate the clinical documentation by Optum Idaho physicians in their role as Peer Reviewers. The established goal is ≥88%.

Analysis – During 2020, Care Advocate audits Inter-Rater Reliability results were 100%. MD Peer Review Audits results are through 2019. The national team was unable to provide MD Peer Reviewer audit results for 2020 due to data system issues.

Figure 60

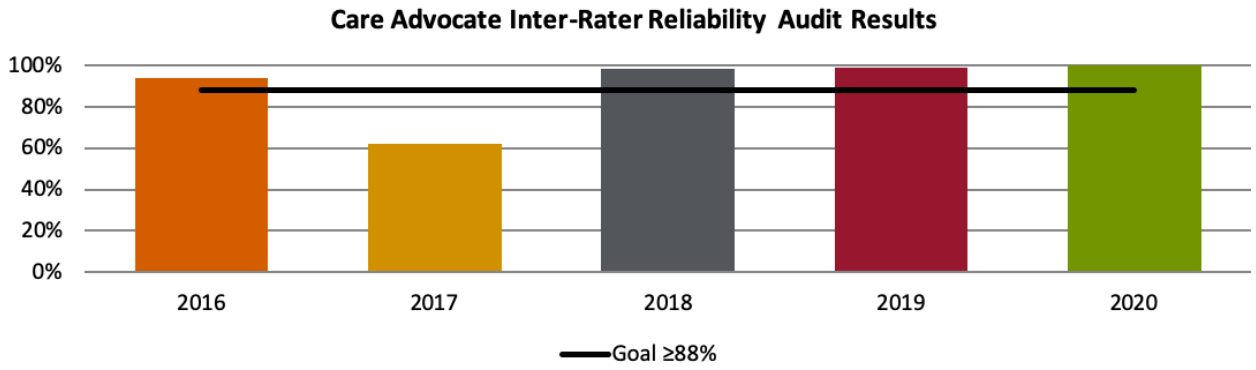
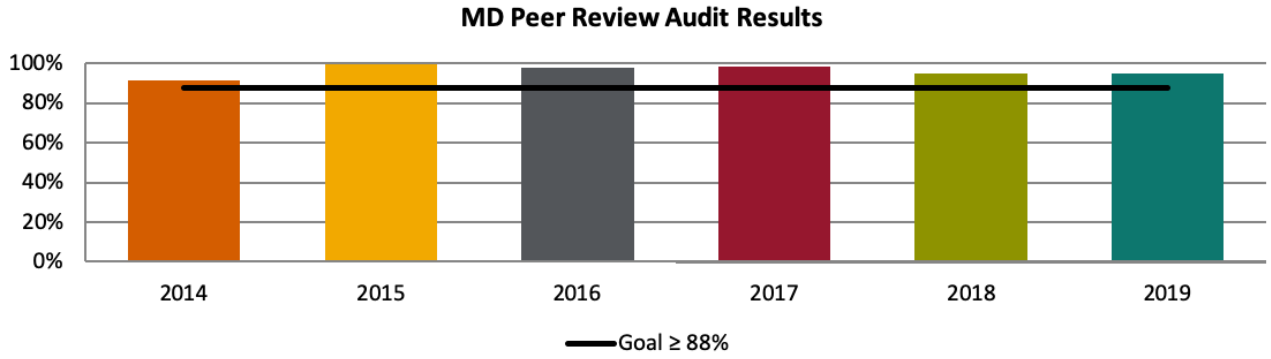


Figure 61



Barriers – MD Peer review audit results were not received from the national team due to data systems issues.

Opportunities and Interventions – Optum Idaho will continue to work with national team to gain access to the 2020 results.

Population Analysis

Language and Culture

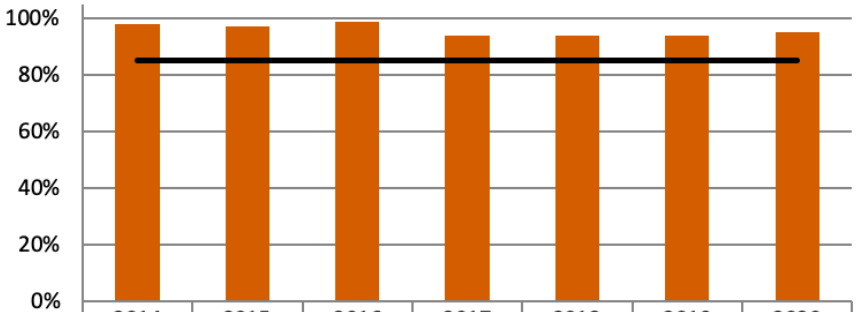
Methodology – Optum Idaho strives to provide culturally competent behavioral health services to its Members. Optum Idaho uses U. S. Census results to estimate the ethnic, racial, and cultural distribution of our membership. Below is a table listing the 2019* results for ethnic, racial, and cultural distribution of the Idaho population. Optum uses the Member Satisfaction Survey to gage whether the care that the member receives is respectful to their cultural and linguistic needs.

Total Population (Estimate)	Hispanic or Latino	White	Black	American Indian & Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander	Two or more races
2019 Idaho Census Results for Ethnic, Racial and Cultural Distribution of Population*							
1,787,065	12.8%	93.0%	0.9%	1.7%	1.6%	0.2%	2.6%
**2019 was the most current data available.*							

Analysis – Hispanic or Latino counted for 12.8% of the Idaho population. This is the second highest population total, with White consisting of 93.0% (ethnic and racial backgrounds can overlap which explains for the percentage total > 100%). Again during 2020, the Member Satisfaction Survey results consistently showed that members believe the care they received was respectful of their language, cultural, and ethnic needs.

Figure 62

Member Satisfaction Survey: Cultural, Language and Ethnic Needs



	2014	2015	2016	2017	2018	2019	2020
The care I received was respectful of my language, cultural, and ethnic needs.	98%	97%	99%	94%	94%	94%	95%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Results for Language and Culture

Methodology – Optum Idaho provides language assistance that is relevant to the needs of our members who (a) speak a language other than English, (b) are deaf or have hearing impairments, (c) are blind or have visual impairments, and/or (d) have limited reading ability. These services are available 24 hours a day, 365 days per year.

Requests by Type	2020
Language Assistance Requests	
Member Written Communication	2
Member Written Communication Formatted to Large Print	1
Language Service Associates	3
Languages Represented	1
Do Not Mail List	36

Analysis – During 2020, Optum Idaho responded to requests for language assistance as shown in the grid above.

Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.

Claims

Methodology – The data source for claims is Cosmos via Webtrax. Data extraction is the number of "clean" claims paid within 30 and 90 calendar days. A clean claim excludes adjustments (adjustments are any transaction that modifies (increase/ decrease) the original claims payment; the original payment must have dollars applied to the deductible/ copay/ payment to provider or member) and/or resubmissions (a resubmission is a correction to an original claim that was denied by Optum Idaho). A claim will be considered processed when the claim has been completely reviewed and a payment determination has been made; this is measured from the received date to the paid date (check), plus two days for mail time. Company holidays are included.

Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid dollars minus overpayments and underpayments divided by the total paid dollars).

Procedural Accuracy Rate (PAR) is measured by collection of a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial errors (total number of claims audited minus the number of claims with non-financial errors divided by the total claims audited).

Analysis – All claims performance goals have consistently been met.

Figure 63

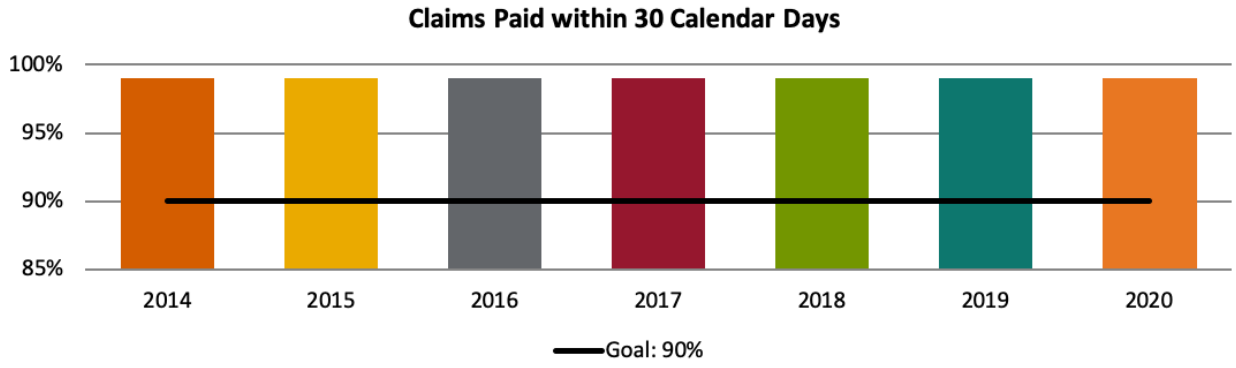


Figure 64

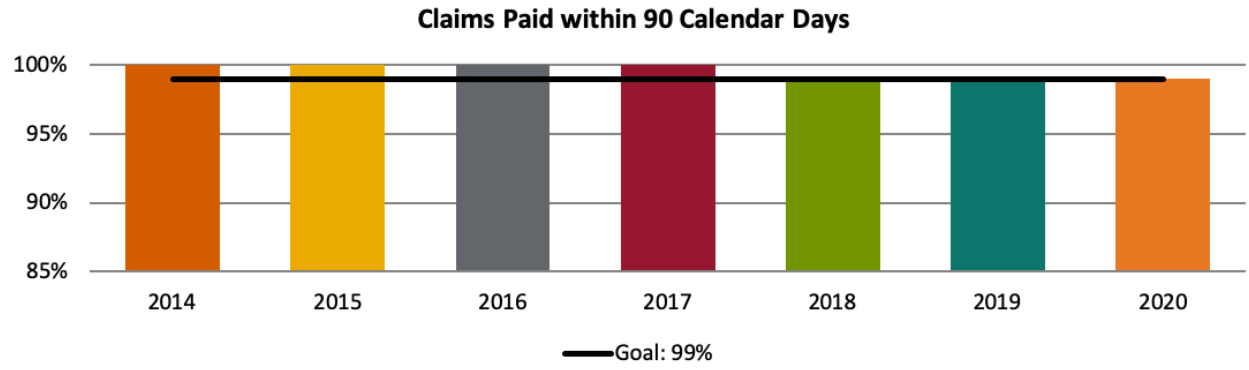


Figure 65

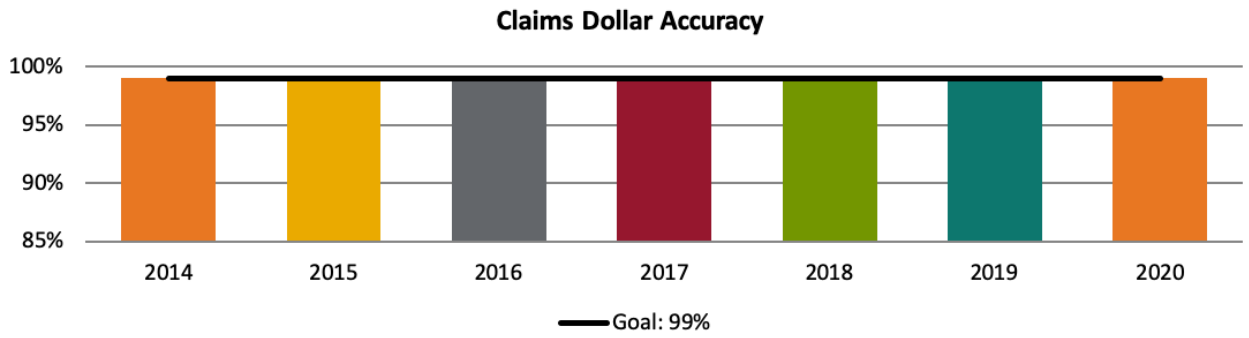
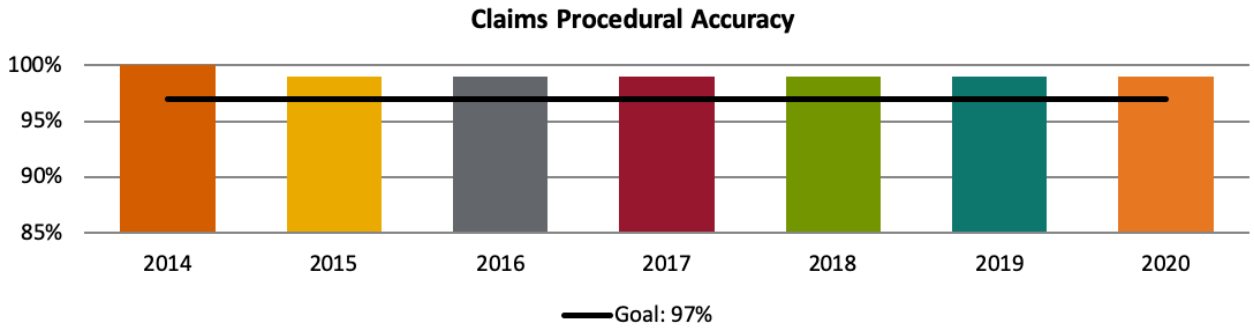


Figure 66



Barriers – Based on the above analysis, no barriers were identified.

Opportunities and Interventions – No opportunities for improvement were identified.