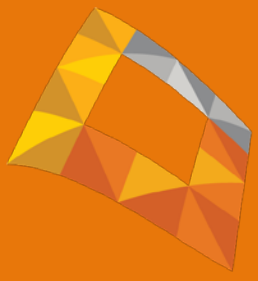
IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT ANNUAL EVALUATION



OPTUM®

2019

The Quality Management and Utilization Management (QMUM) 2019 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 an annual view of performance and outcomes data.

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Introduction and Overview

This written evaluation of Optum Idaho's Quality Management and Utilization Management (QMUM) Program 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, 2019 through December 31, 2019 and provides comparative performance from 2014 – 2019.

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 the *Outcomes Management & Quality Improvement Work Plan* which is a document that is reviewed, revised if necessary, and approved by the Quality Assurance and Performance Improvement (QAPI) Committee each year.

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. These contractual and regulatory requirements drive Optum Idaho's key measures and outcomes for the IBHP.

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.

Our *Quality Improvement (QI) Plan* document represents our blueprint for utilizing the Plan, Do, Study, Act (PDSA) model for continuous quality improvement (CQI) throughout the entire organization, as well as the provider network and in all our interactions with the community. The *QI Plan* establishes the groundwork that drives improvement for key measures identified in our *Work Plan*. Our 2019 *Work Plan* included the following key measure domains:

- Quality Management/Quality Improvement Program Structure
- Utilization Management

- Member Accessibility & Availability to Care and Services
- Member Satisfaction
- Performance Improvement
- Network Provider Relations
- Community Outreach

Measures from the Work Plan are monitored routinely via monthly, quarterly, and annual reports. This Annual Evaluation provides an assessment of the overall effectiveness of the IBHP's programs and services provided. The purpose of this Annual Evaluation 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

The results of Optum Idaho's efforts in 2019 have proven to be positive in achieving the right care, at the right time for our members. Each quarter, Optum Idaho monitored performance measures to ensure the needs of IBHP members and providers are 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 annual data, Optum Idaho met or exceeded performance for 32 (86%) of the 37 total key measures. Three (3) measures fell slightly below the performance goal but were still within 5% of meeting the goal and two (2) measures fell below the performance goal. 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 remains vital to establishing the voice of the member. Overall member satisfaction met the goal of ≥85% throughout 2019. 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 have also indicated that they are consistently satisfied with the time it takes to get an appointment and with the ability to find care that was respectful of their language, culture, and ethnic needs.

Throughout 2019, challenges were experienced in meeting the performance measure of answering member calls within 30 seconds. While the performance goal was not met, it continued to increase quarter over quarter. Optum Idaho continued to monitor member calls and implemented strategies to increase performance. Provider Customer Services calls metrics continued to meet performance in all domains.

Other areas in which Optum Idaho continued to meet and/or exceed performance standards are 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.

One new measure added to this report is Person-Centered Service Plans (PCSPs). Optum Idaho reviews PCSPs to ensure compliance between the service plan and federal requirements established in 42 CFR §441.725. These requirements include creating the service plan with a team chosen by the member and member's family, cultural considerations, strategies to address conflicts or disagreements, documented strengths and preferences, clinical and support needs as indicated through the member's clinical assessment of functional and health-related needs, and goals and desired outcomes. The Optum Idaho team reviewing

PCSPs has five (5) business days to review for CFR compliance. During 2019, Optum Idaho averaged a turnaround time of 0.16 days.

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, face-to-face discussions, 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 - 2019. 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.

Measure	Goal	2014	2015	2016	2017	2018	2019	Comments
Member Satisfaction Survey Results (2014 - 2016)								
Experience with Optum Idaho Staff and Referral Process	≥85%	84%	85%	92%	NA	NA	NA	New Survey Implemented, results below
Experience with the Behavioral Health Provider Network	≥85%	91%	91%	94%	NA	NA	NA	New Survey Implemented, results below
Experience with Counseling or Treatment	≥85%	93%	94%	95%	NA	NA	NA	New Survey Implemented, results below
Overall Experience	≥85%	90%	92%	94%	NA	NA	NA	New Survey Implemented, results below
Member Satisfaction Survey Results (new survey 2017 - 2019)								
Optum Support for Obtaining Referrals or Authorizations	≥85%	NA	NA	NA	80%	92%	94%	
Counseling and Treatment	≥85%	NA	NA	NA	95%	95%	95%	
Accessibility, Availability, and Acceptability of the Clinician Network	≥85%	NA	NA	NA	89%	93%	93%	
Overall Satisfaction	≥85%	NA	NA	NA	80%	92%	94%	
Provider Satisfaction Survey Results								
Overall Provider Satisfaction	≥85%	69%	65%	75%	77%	79%	76%	Additional information regarding performance improvement efforts are located in this report.
Accessibility & Availability								
Idaho Behavioral Healthplan Membership								
Membership Numbers	NA	314,538	330,474	336,394	342,357	336,997	318,331	
Member Services Call Standards								
Total Number of Calls	NA	6,483	4,838	5,153	5,292	4,658	4,641	
Percent Answered Within 30 Seconds	≥80%	91%	91%	88%	84%	71%	76%	
Average Daily Hold Time	≤120 Seconds	13	13	15	19	33	25	
Abandonment Rate	≤3.5% internal ≤7% contractual	1.5%	1.9%	2.2%	2.3%	3.1%	3.0%	
Customer Service (Provider) Call Standards								
Total Number of Calls	NA	16,323	14,205	12,220	13,016	12,036	12,332	
Percent Answered within 30 seconds	≥80%	84%	97%	97%	98%	98%	98%	
Average Daily Hold Time	≤120 Seconds	35	6	4	4	3	3	
Abandonment Rate	≤3.5% internal ≤7% contractual	2.9%	0.6%	0.3%	0.4%	0.2%	0.3%	
Urgent, Non-Urgent, and Critical Appointment Access Standards								
Urgent Appointment Wait Time	48 hours	18.5	22.8	24.2	23.1	22.4	19.0	
Non-Urgent Appointment Wait Time	10 days	3.8	4.7	6.0	6.0	4.8	4.0	
Critical Appointment Wait Time	6 hours	NA	NA	NA	5	3	3	began tracking in 2017

Measure	Goal	2014	2015	2016	2017	2018	2019	Comments
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%*	*performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)
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%*	*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	
Clinical ABDs	NA	NA	NA	NA	930	773	381	began tracking 2017
Administrative ABDs	NA	NA	NA	NA	318	552	94	began tracking 2017
Written Notification	100% w/in14 calendar days from request for services	NA	NA	NA	99.9%	99.6%	98.7%	NA
Written Notification Sent within 1 Business Day	100.0%	77.3%	98.4%	97.0%	NA	NA	NA	New 14-day requirement tracked above
Member Appeals								
Number of Appeals	NA	278	92	73	113	53	14	
Member Appeals Turnaround time	≤30 days	10	12	16	NA	NA	NA	now reporting Non-Urgent/Urgent separately
Non-Urgent Appeal Resolution Turnaround Time	≤30 days	NA	NA	NA	9	8	3	
Urgent Appeal Resolution Turnaround Time	72 hours	NA	NA	NA	25	53	19	
Complaint Resolution and Tracking								
Total Number of Complaints	NA	569	133	61	63	67	67	
Percent of Complaints Acknowleged within Turnaround time	100% within 5 business days	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	
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 business days	100.0%	99.3%	100.0%	96.4%	100.0%	96.0%	
Number of Quality of Care Complaints	NA	9	11	6	7	13	12	
Percent Quality of Care Resolved within Turnaround time	100% within ≤30 calendar days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Critical Incidents								
Number of Critical Incidents Received	NA	60	66	67	61	49	42	
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%	

Measure	Goal	2014	2015	2016	2017	2018	2019	Comments
Response to Written Inquiries								
Percent Acknowledged ≤2 business days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	
Provider Monitoring and Relations								
Provider Quality Monitoring								
Number of Audits	NA	210	287	368	519	717	439	
Initial Audit (Percent overall score)	≥ 85.0%	92.0%	97.0%	96.0%	94.0%	93.2%	93.0%	
Recredentialing Audit (Percent overall score)	≥ 85.0%	96.0%	97.0%	94.0%	92.0%	92.7%	91.0%	
Monitoring (Percent overall score)	≥ 85.0%	89.4%	90.1%	76.0%*	94.4%	88.4%	85.3%	*Only 9 monitoring audits were conducted in 2016, one of which scored at 58.3%, significantly impacting the overall score. All other audits met the performance goal.
Quality (Percent overall score)	≥ 85.0%	86.0%	94.0%	95.4%	85.0%	88.1%	86.3%	
Percent of Audits w/passing score of 85% or higher	NA	81%	83%	91%	89%	74%	80%	
Percent of Audits that Required a Corrective Action Plan	NA	19%	18%	10%	11%	26%	20%	
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%	
Percent documentation in member record that communication/collaboration occurred between behavioral health provider and PCP	NA	83%	80%	85%	78%	74%	78%	
Provider Disputes								
Number of Provider Disputes	NA	156	57	52	88	111	138	
Average Number of Days to Resolve Provider Disputes	≤30 days	11.2	8.3	13.4	7.8	8.3	8.0	
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%	
Person-Centered Service Plan (PCSP)								
Number of PCSPs Received	NA						925	
Average Number of Days to Review	≤5 business days	NA*	NA*	NA*	NA*	NA*	0.16	*began tracking in 2018 but not a full year's worth of data until 2019
Field Care Coordination (FCC)								
Total Referrals to FCCs	NA	NA*	774	722	800	699	960	*began tracking in 2015
Average Number of Days Case Open to FCC	NA	NA*	63.2	79.0	48.0	50.0	48.0	*began tracking in 2015

Measure	Goal	2014	2015	2016	2017	2018	2019	Comments
Inter-Rater Reliability Testing								
Care Advocate Audit Results	≥ 88.0%	NA	NA	93.8%	62.2%	99.0%	99.0%	
MD Peer Review Audit Results	≥ 88.0%	91.7%	99.5%	98.0%	98.3%	95.0%	95.0%	
Claims								
Claims Paid within 30 Calendar Days	90.0%	99.7%	99.9%	99.9%	99.9%	100.0%	99.9%	
Claims Paid within 90 Calendar Days	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Dollar Accuracy	99.0%	99.8%	99.9%	99.9%	99.7%	100.0%	99.0%	
Procedural Accuracy	97.0%	100.0%	99.7%	99.9%	99.8%	100.0%	99.0%	
KEY:		met goal	within 5 percentage points of goal		did not meet goal			

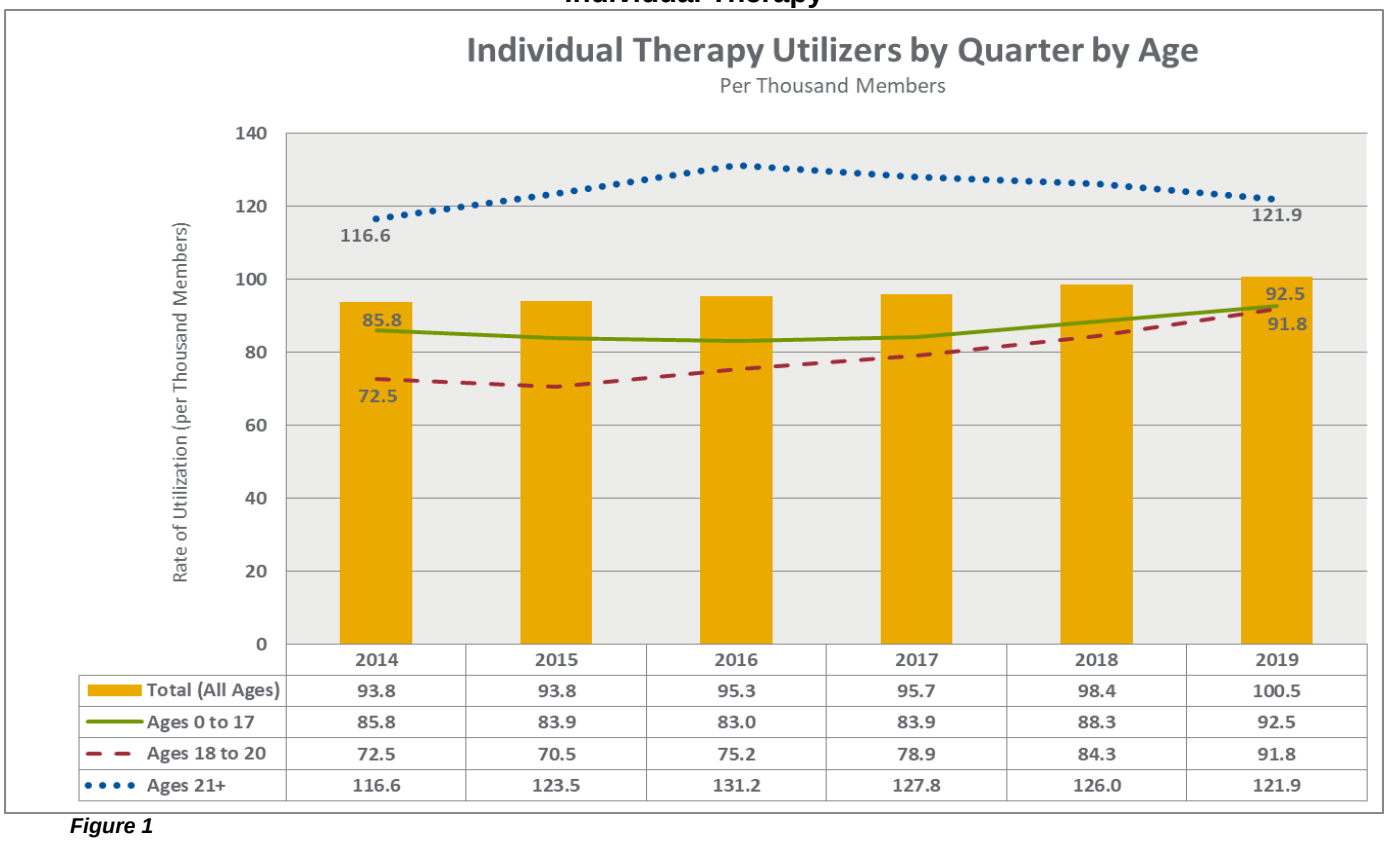
Outcomes Analysis

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.

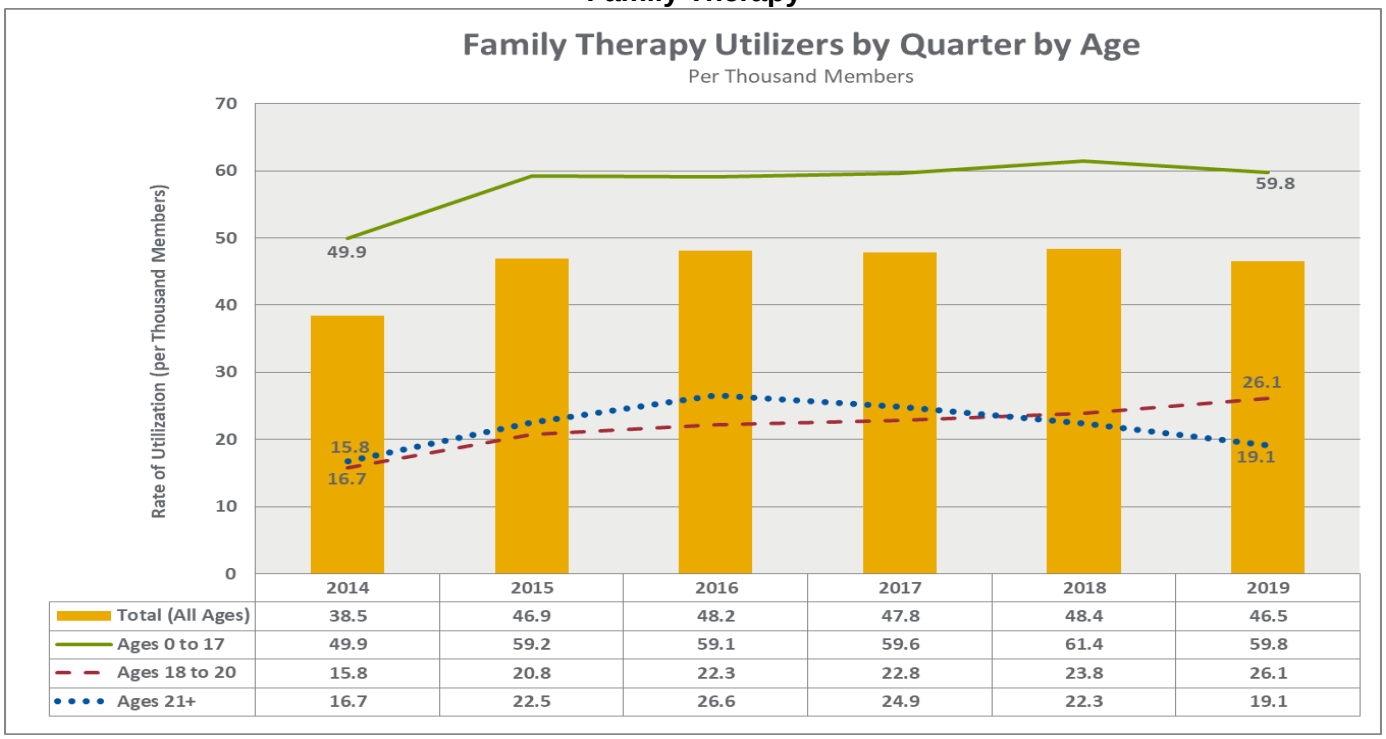
Individual Therapy



	2014	2015	2016	2017	2018	2019
Total (All Ages)	93.8	93.8	95.3	95.7	98.4	100.5
Ages 0 to 17	85.8	83.9	83.0	83.9	88.3	92.5
Ages 18 to 20	72.5	70.5	75.2	78.9	84.3	91.8
Ages 21+	116.6	123.5	131.2	127.8	126.0	121.9

Figure 1

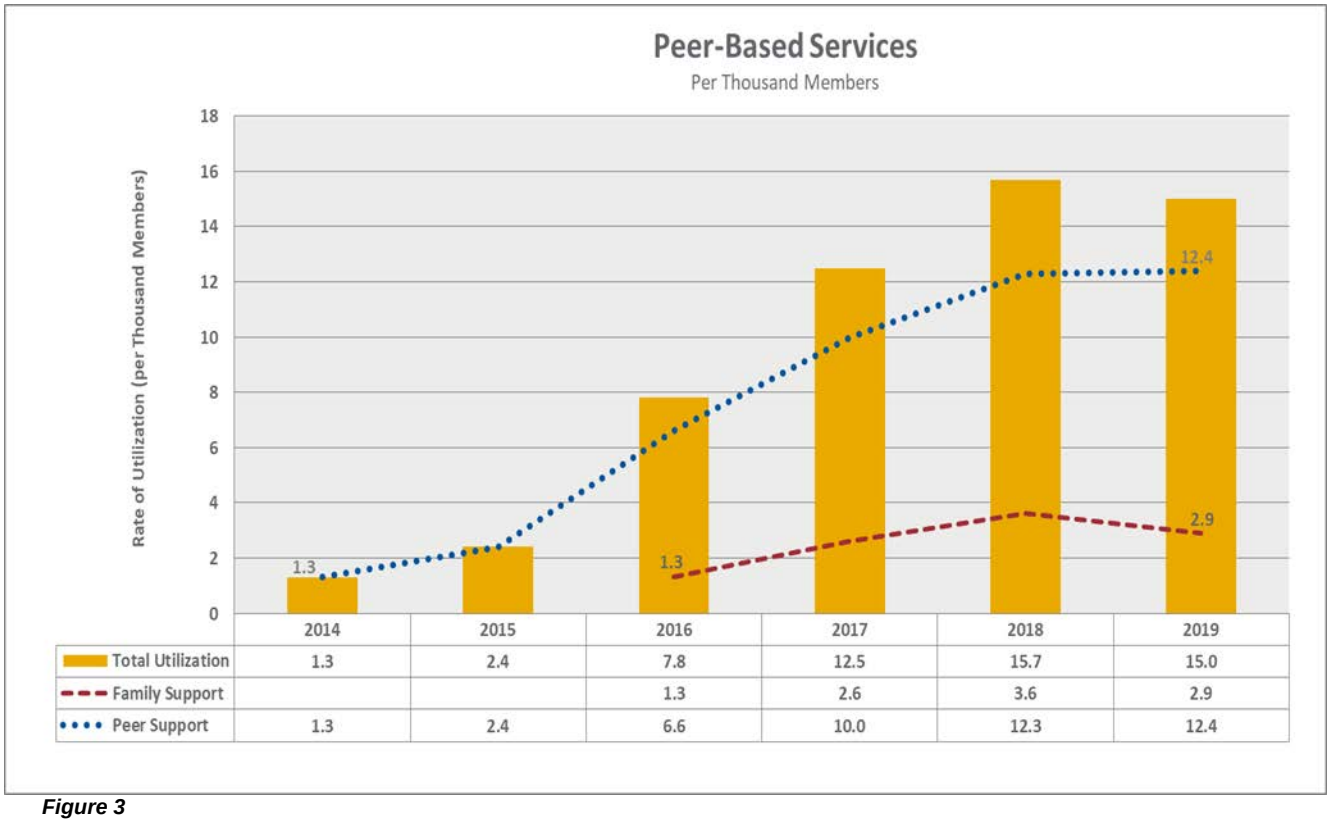
Family Therapy



	2014	2015	2016	2017	2018	2019
Total (All Ages)	38.5	46.9	48.2	47.8	48.4	46.5
Ages 0 to 17	49.9	59.2	59.1	59.6	61.4	59.8
Ages 18 to 20	15.8	20.8	22.3	22.8	23.8	26.1
Ages 21+	16.7	22.5	26.6	24.9	22.3	19.1

Figure 2

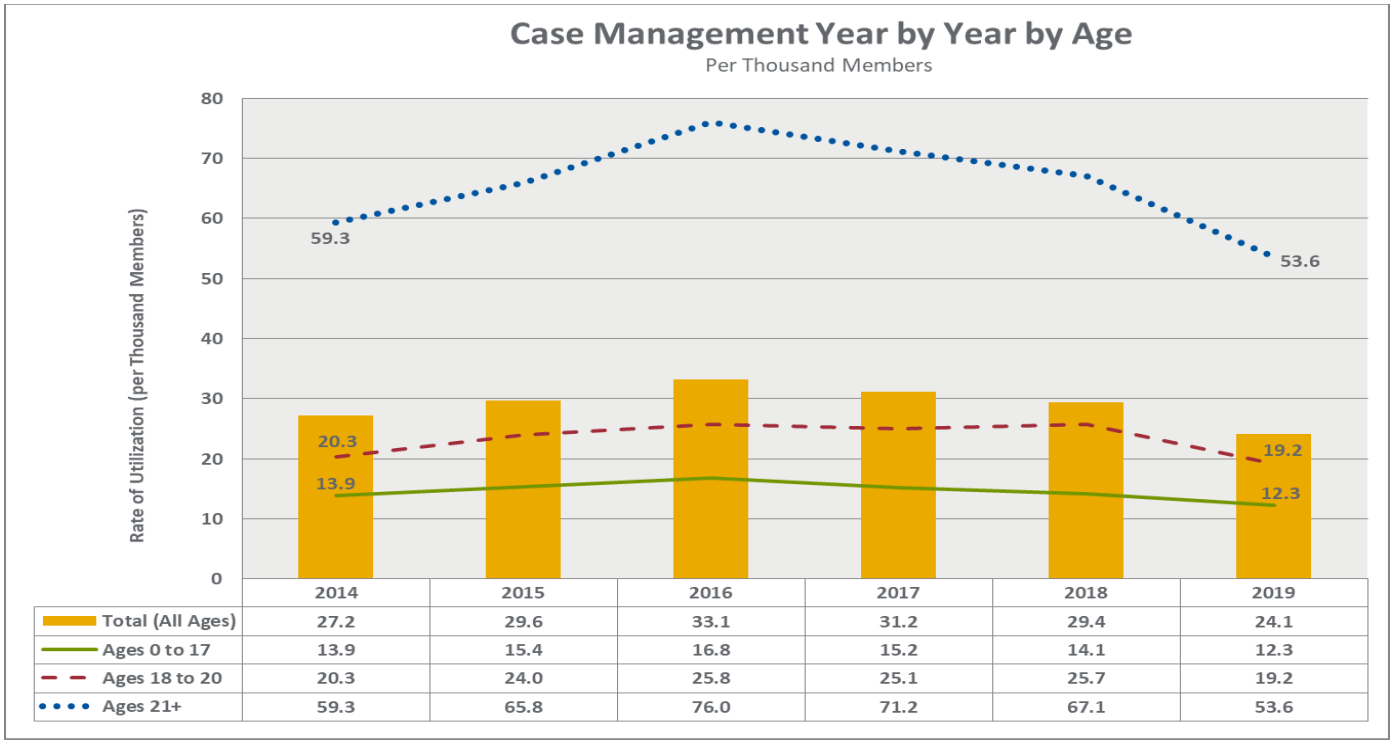
Peer-Based Services



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

Figure 3

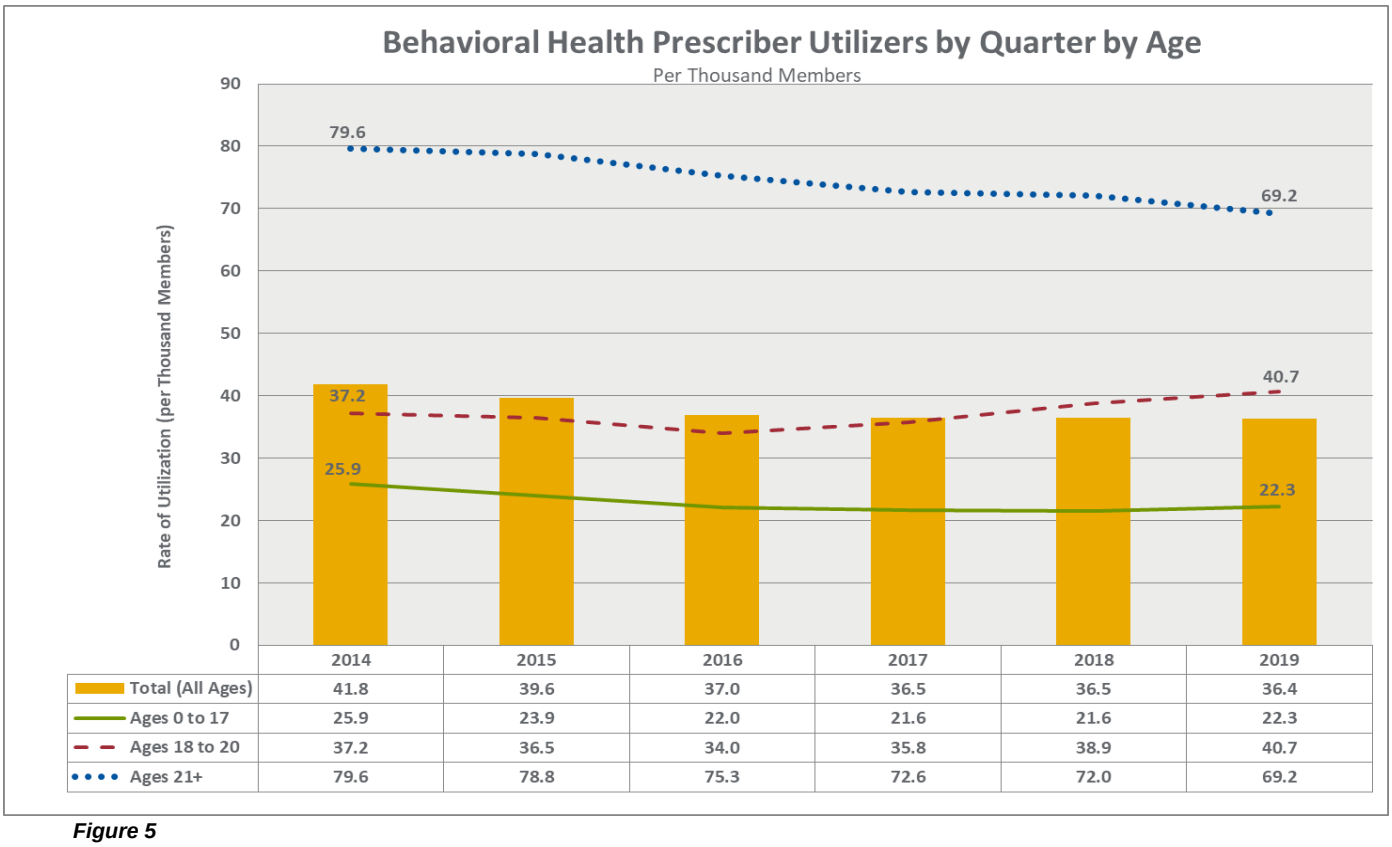
Case Management



	2014	2015	2016	2017	2018	2019
Total (All Ages)	27.2	29.6	33.1	31.2	29.4	24.1
Ages 0 to 17	13.9	15.4	16.8	15.2	14.1	12.3
Ages 18 to 20	20.3	24.0	25.8	25.1	25.7	19.2
Ages 21+	59.3	65.8	76.0	71.2	67.1	53.6

Figure 4

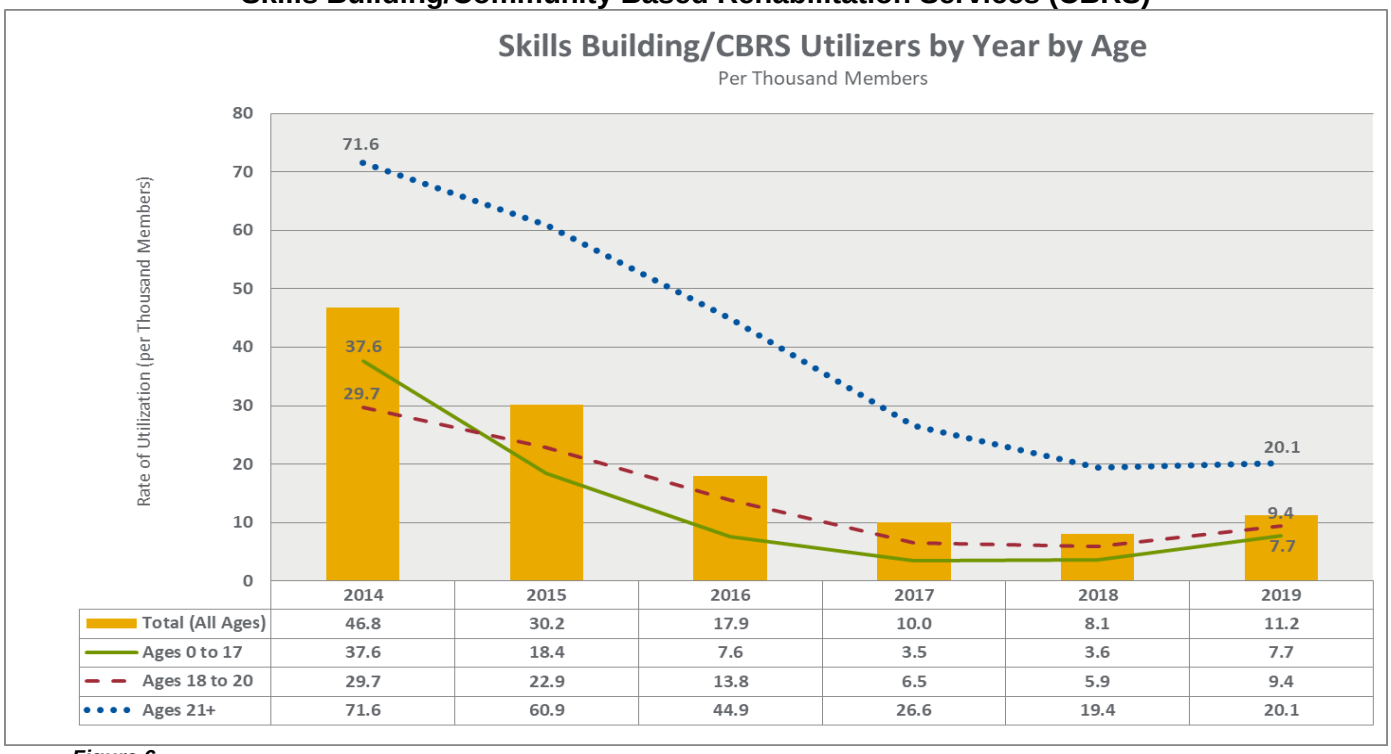
Prescriber Visits



	2014	2015	2016	2017	2018	2019
Total (All Ages)	41.8	39.6	37.0	36.5	36.5	36.4
Ages 0 to 17	25.9	23.9	22.0	21.6	21.6	22.3
Ages 18 to 20	37.2	36.5	34.0	35.8	38.9	40.7
Ages 21+	79.6	78.8	75.3	72.6	72.0	69.2

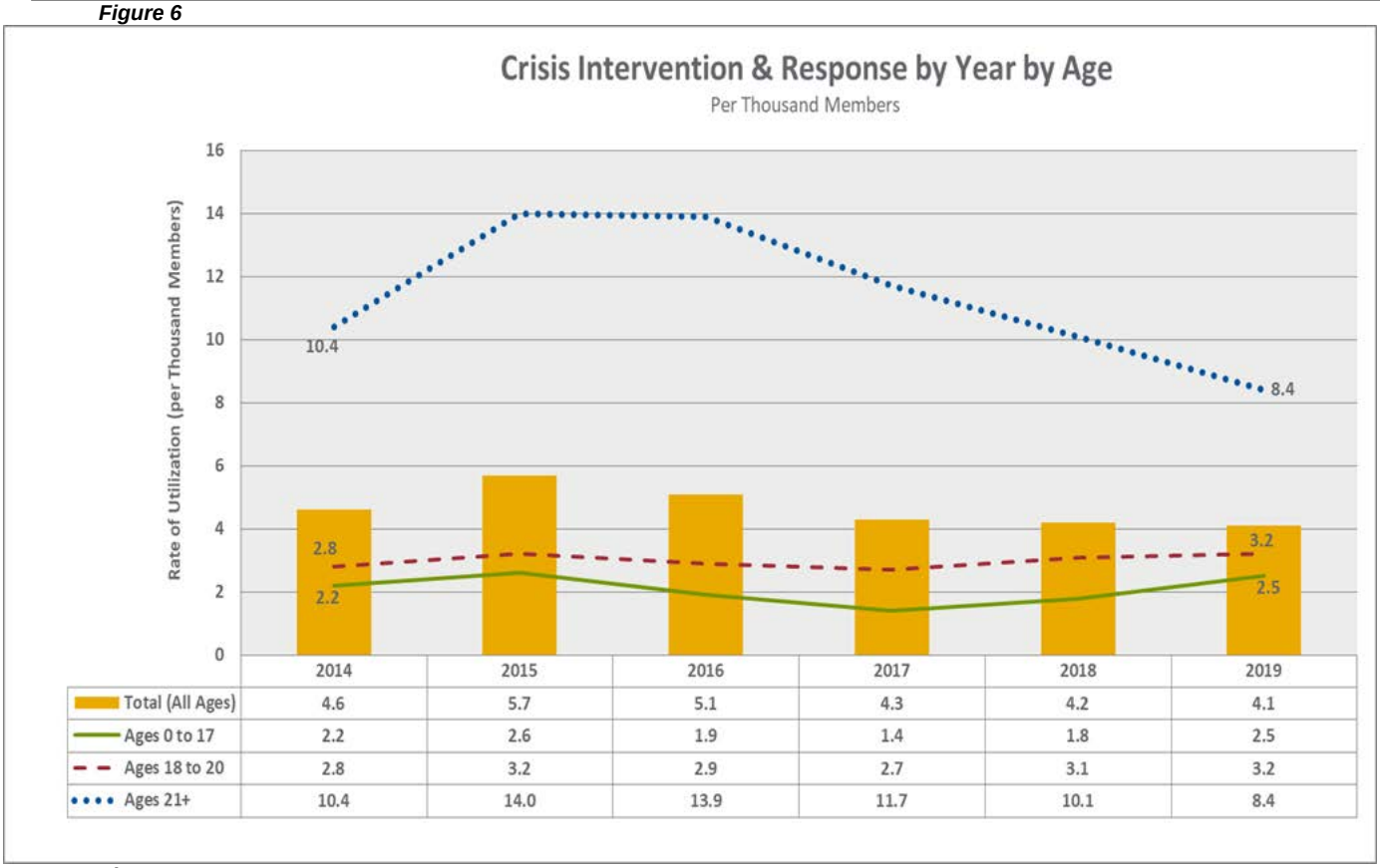
Figure 5

Skills Building/Community Based Rehabilitation Services (CBRS)



	2014	2015	2016	2017	2018	2019
Total (All Ages)	46.8	30.2	17.9	10.0	8.1	11.2
Ages 0 to 17	37.6	18.4	7.6	3.5	3.6	7.7
Ages 18 to 20	29.7	22.9	13.8	6.5	5.9	9.4
Ages 21+	71.6	60.9	44.9	26.6	19.4	20.1

Figure 6



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

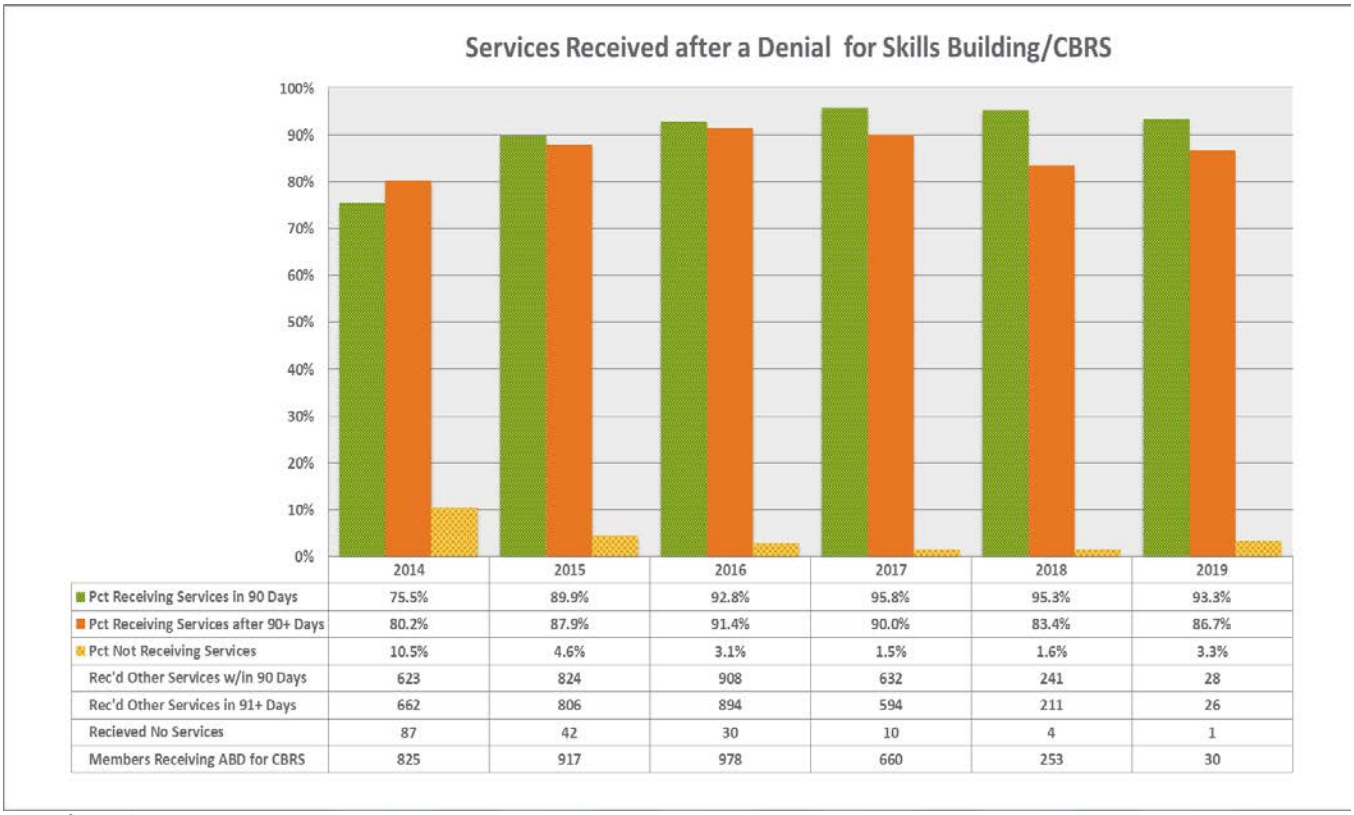
Figure 7

Analysis: Overall, service utilization remained consistent in 2019. Individual Therapy utilization increased, while Family Therapy slightly decreased. Skills Building/CBRS utilization rates increased slightly. Crisis services decreased, resulting in the lowest level of crisis service utilization since Optum began managing Behavioral Health services in Idaho.

Barriers: No identified barriers***.*** Skills Building/CBRS is prior authorized according to medical necessity; utilizing evidence based nationally recognized treatment(s) for the member's documented condition. All other services listed above do not require a prior authorization.
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.



	2014	2015	2016	2017	2018	2019
Pct Receiving Services in 90 Days	75.5%	89.9%	92.8%	95.8%	95.3%	93.3%
Pct Receiving Services after 90+ Days	80.2%	87.9%	91.4%	90.0%	83.4%	86.7%
Pct Not Receiving Services	10.5%	4.6%	3.1%	1.5%	1.6%	3.3%
Rec'd Other Services w/in 90 Days	623	824	908	632	241	28
Rec'd Other Services in 91+ Days	662	806	894	594	211	26
Recieved No Services	87	42	30	10	4	1
Members Receiving ABD for CBRS	825	917	978	660	253	30

Figure 8

Analysis: The number of members receiving a full CBRS ABD dropped drastically in 2019 due to changes 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. Ninety-three percent (93%) of members who received an ABD for CBRS services received evidenced-based therapeutic services within 90 days of the ABD. An unknown percentage of these members receiving "no services" may in fact be receiving medication services from non-network prescribers that would not be reportable from Optum's claims database.

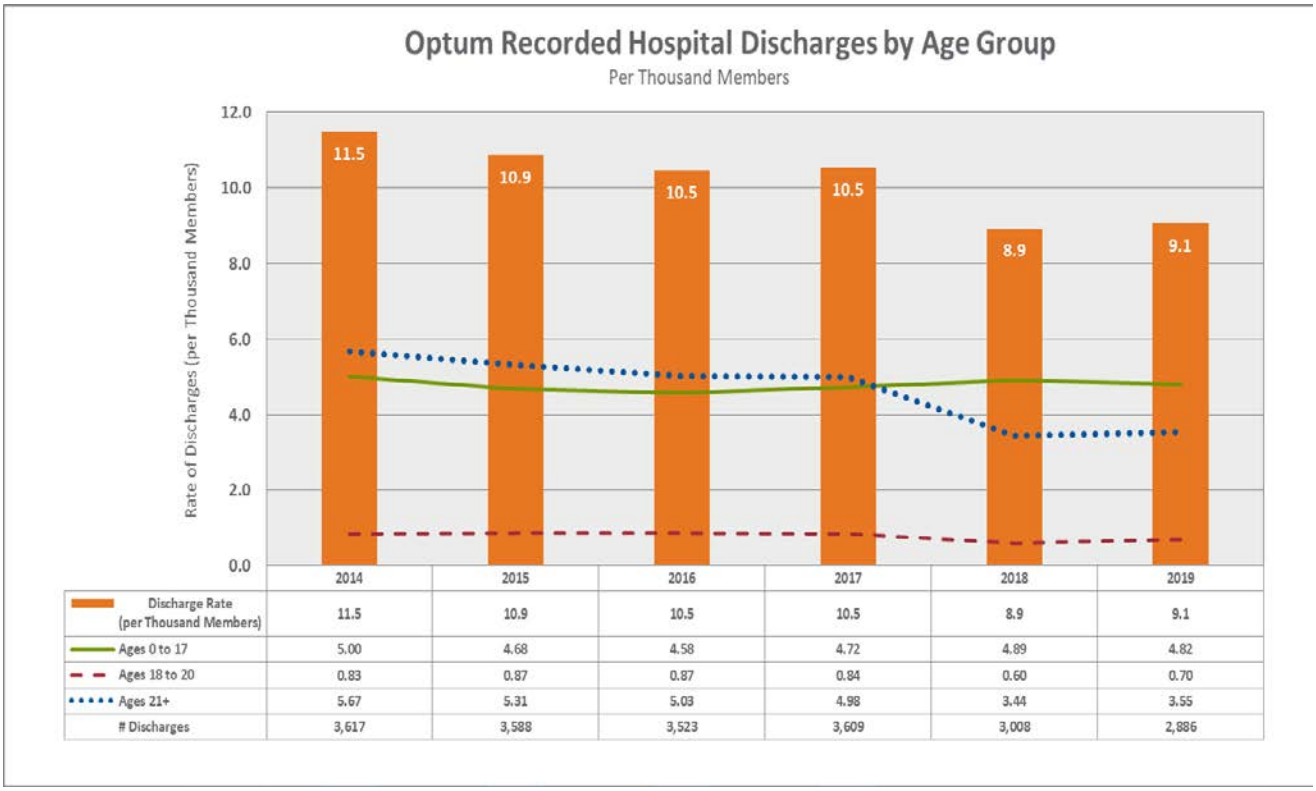
Barriers: No identified barriers***.***

Opportunities and Interventions: No opportunities for improvement were identified.

Psychiatric Inpatient Utilization

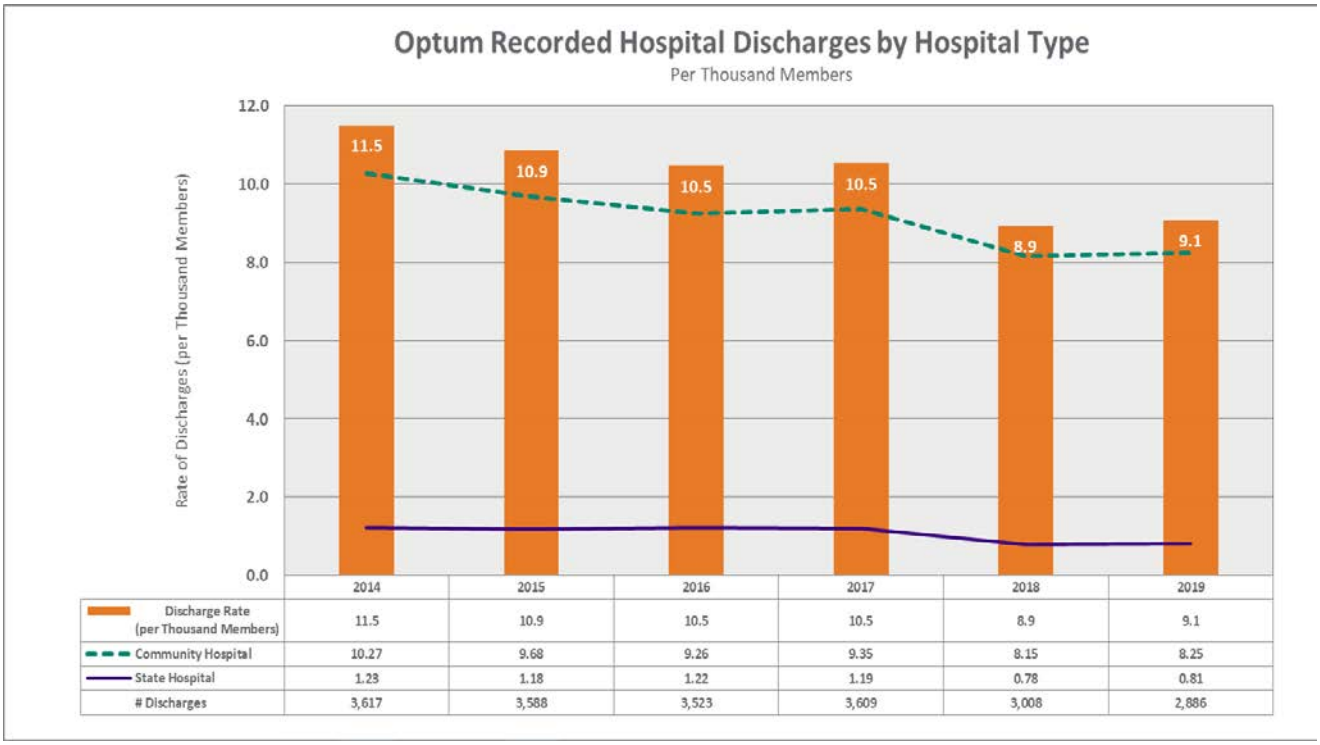
Methodology: Information is obtained from IDHW and other community resources using hospital discharge data. A hospital stay is considered a readmission if the admission date occurred within 30-days of discharge. The data displayed indicates the rate of hospital discharges per quarter. To control for 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.



	2014	2015	2016	2017	2018	2019
Discharge Rate (per Thousand Members)	11.5	10.9	10.5	10.5	8.9	9.1
Ages 0 to 17	5.00	4.68	4.58	4.72	4.89	4.82
Ages 18 to 20	0.83	0.87	0.87	0.84	0.60	0.70
Ages 21+	5.67	5.31	5.03	4.98	3.44	3.55
# Discharges	3,617	3,588	3,523	3,609	3,008	2,886

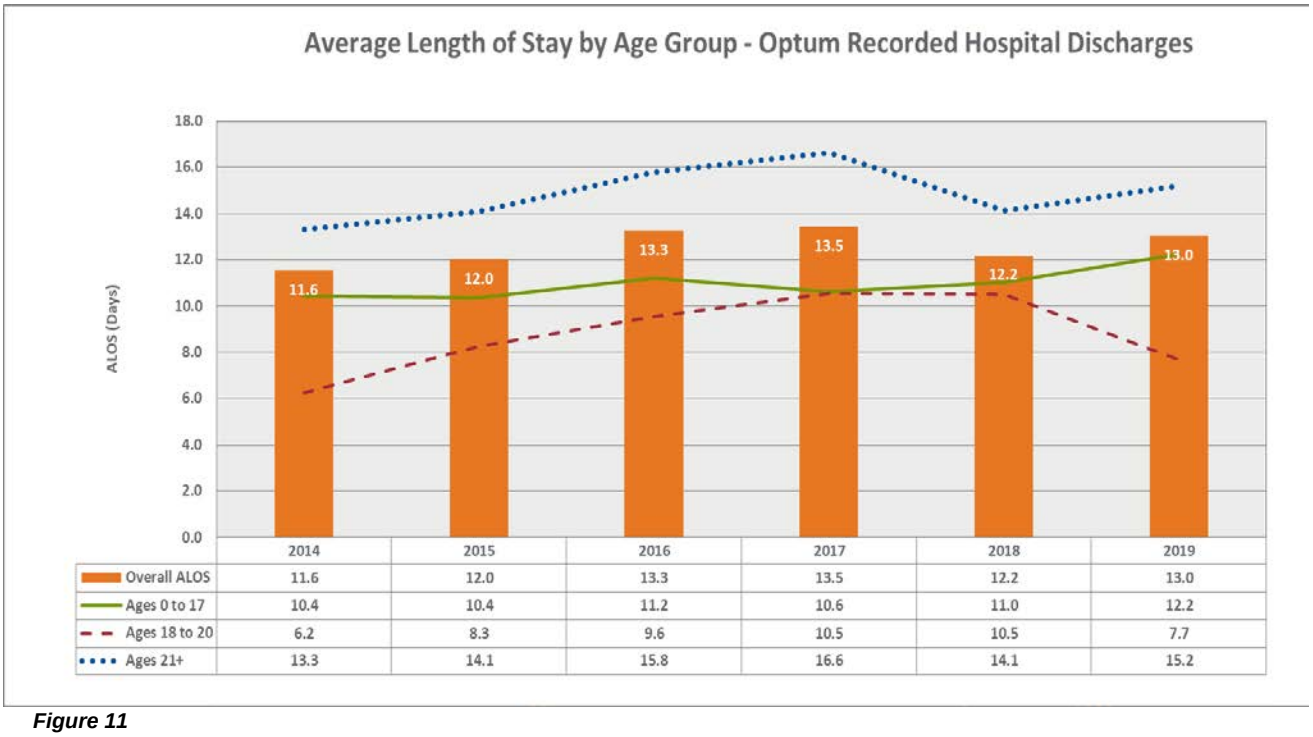
Figure 9



	2014	2015	2016	2017	2018	2019
Discharge Rate (per Thousand Members)	11.5	10.9	10.5	10.5	8.9	9.1
Community Hospital	10.27	9.68	9.26	9.35	8.15	8.25
State Hospital	1.23	1.18	1.22	1.19	0.78	0.81
# Discharges	3,617	3,588	3,523	3,609	3,008	2,886

Figure 10

Figures 9 and 10 show the overall rate of discharges increased slightly from 2018 to 9.1 per thousand members but decreased from 11.5 in 2014.



	2014	2015	2016	2017	2018	2019
Overall ALOS	11.6	12.0	13.3	13.5	12.2	13.0
Ages 0 to 17	10.4	10.4	11.2	10.6	11.0	12.2
Ages 18 to 20	6.2	8.3	9.6	10.5	10.5	7.7
Ages 21+	13.3	14.1	15.8	16.6	14.1	15.2

Figure 11

Figure 11 indicates the average length of stay increased overall, but decreased in the 18 to 20 age group.

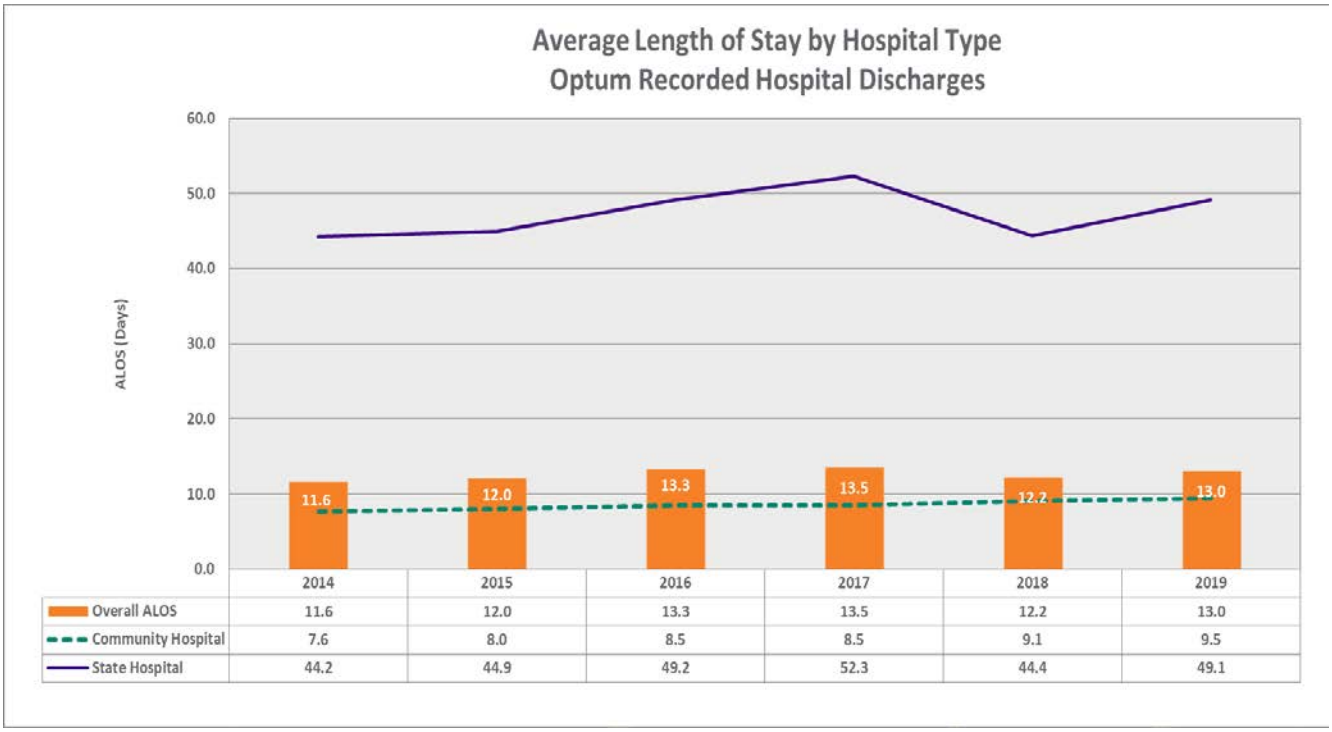


Figure 12

Figure 12 shows the average length of stay by hospital type. Overall average length of stay increased 6.6% from 2018.

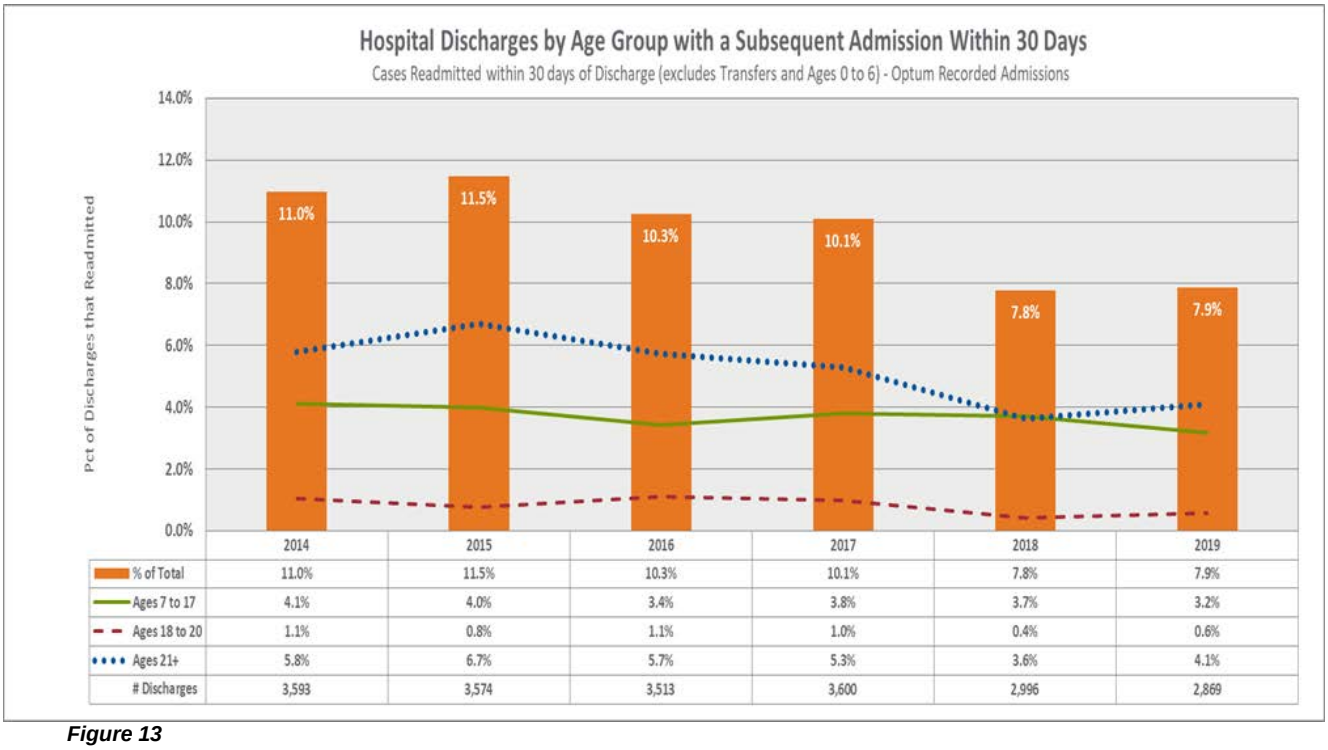


Figure 13

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. The total readmissions remained consistent in 2019.

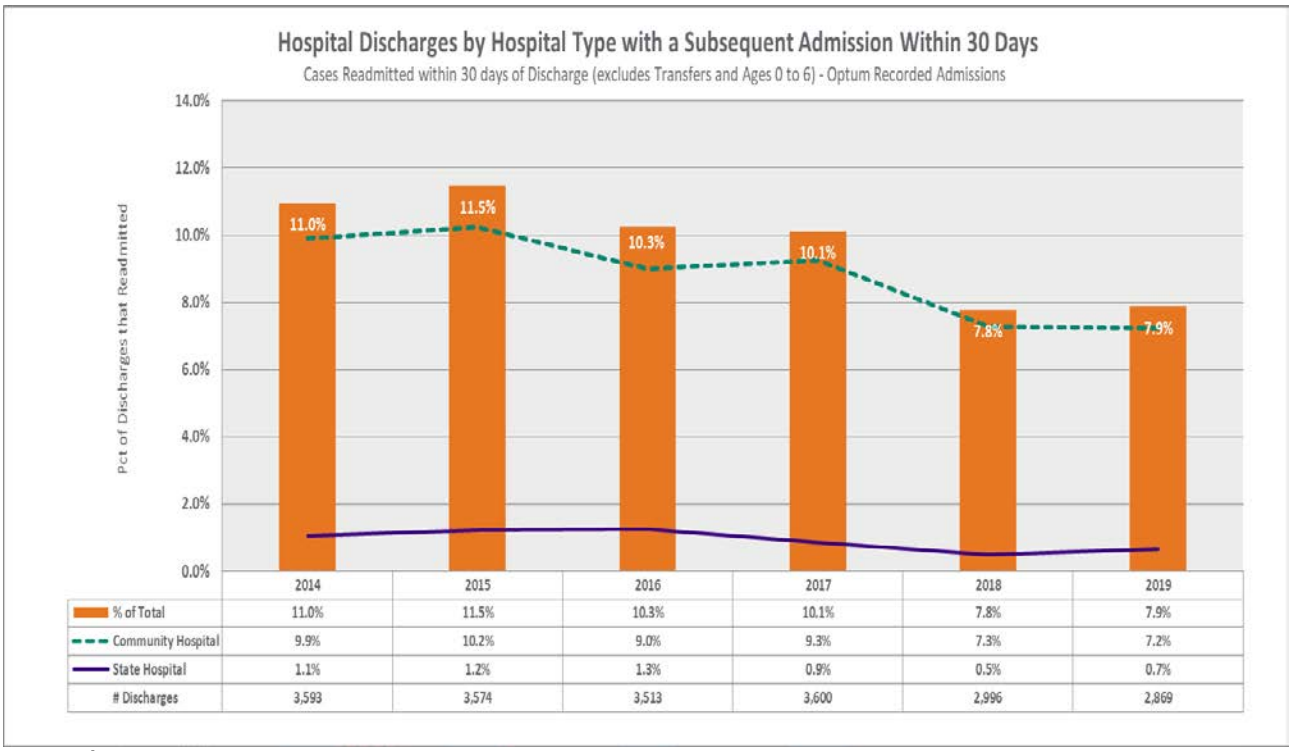


Figure 14

Figure 14 shows readmissions percentages by hospital type. The rates remained consistent in 2019.

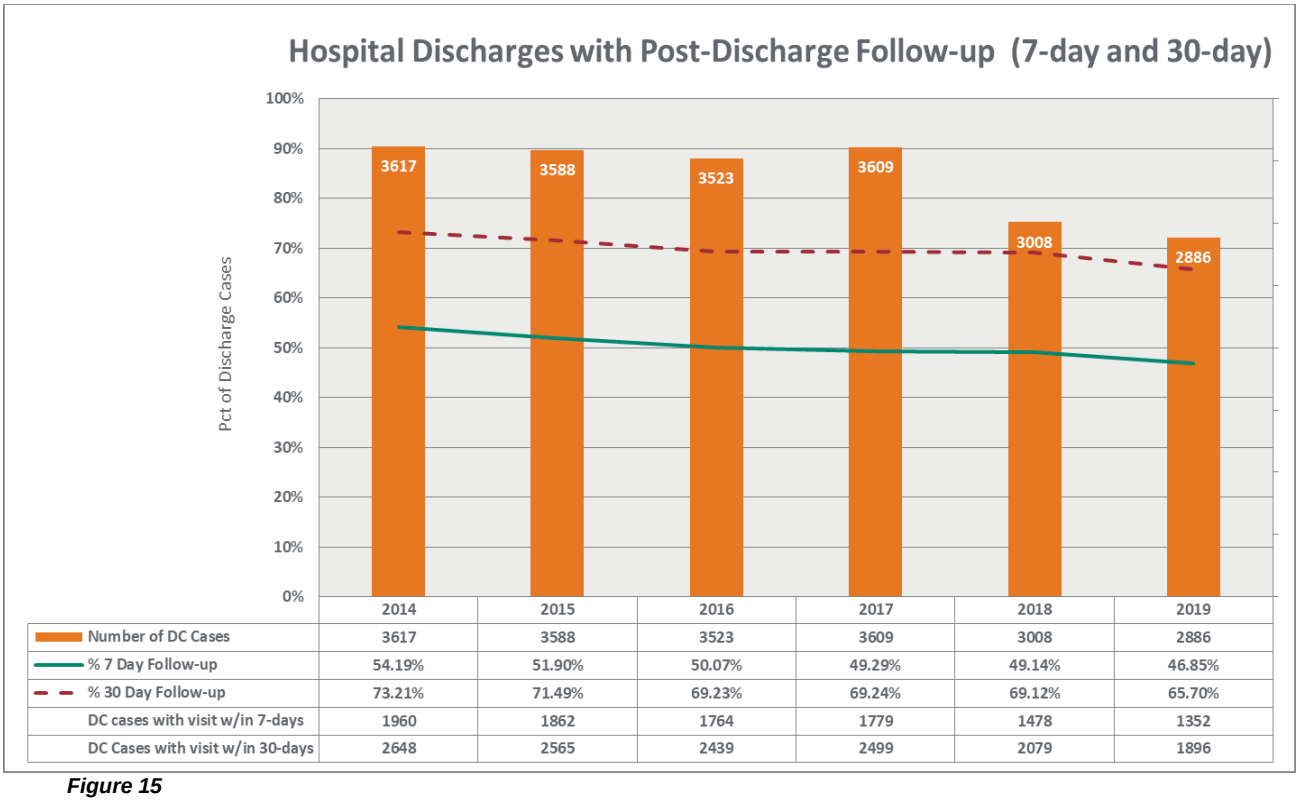


Figure 15

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 slightly decrease for the both the 7 day and 30 day follow-up rates.

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 discharge coordinators attempt to verify that appointments are scheduled and attended.

Opportunities and Interventions: Optum Idaho has implemented an Appointment Reminder Program to help members discharged from an inpatient psychiatric unit seek appropriate outpatient follow-up care. Optum Idaho data indicates that those members signed up for the program are more likely to attend a follow-up appointment following discharge than those who do not participate in the program. Optum Idaho continues to work with all Idaho psychiatric hospitals to engage in the program.

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.

Global Distress Scores

Total Score	Severity Level	ADULT Global Distress Score Descriptions
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.

Total Score	Severity Level	YOUTH Global Distress Score Descriptions
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.

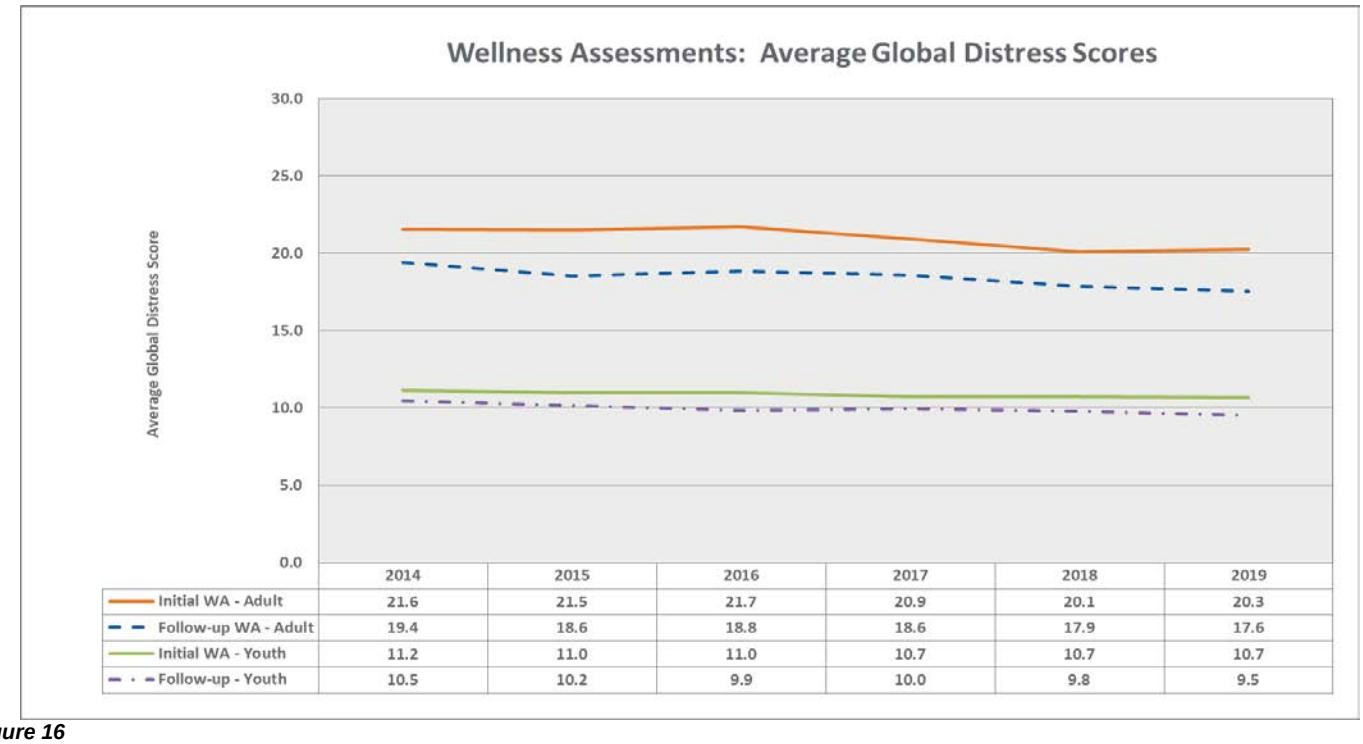


Figure 16

Caregiver Strain Scores

Score	Severity Level	Caregiver Strain Level Description
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.

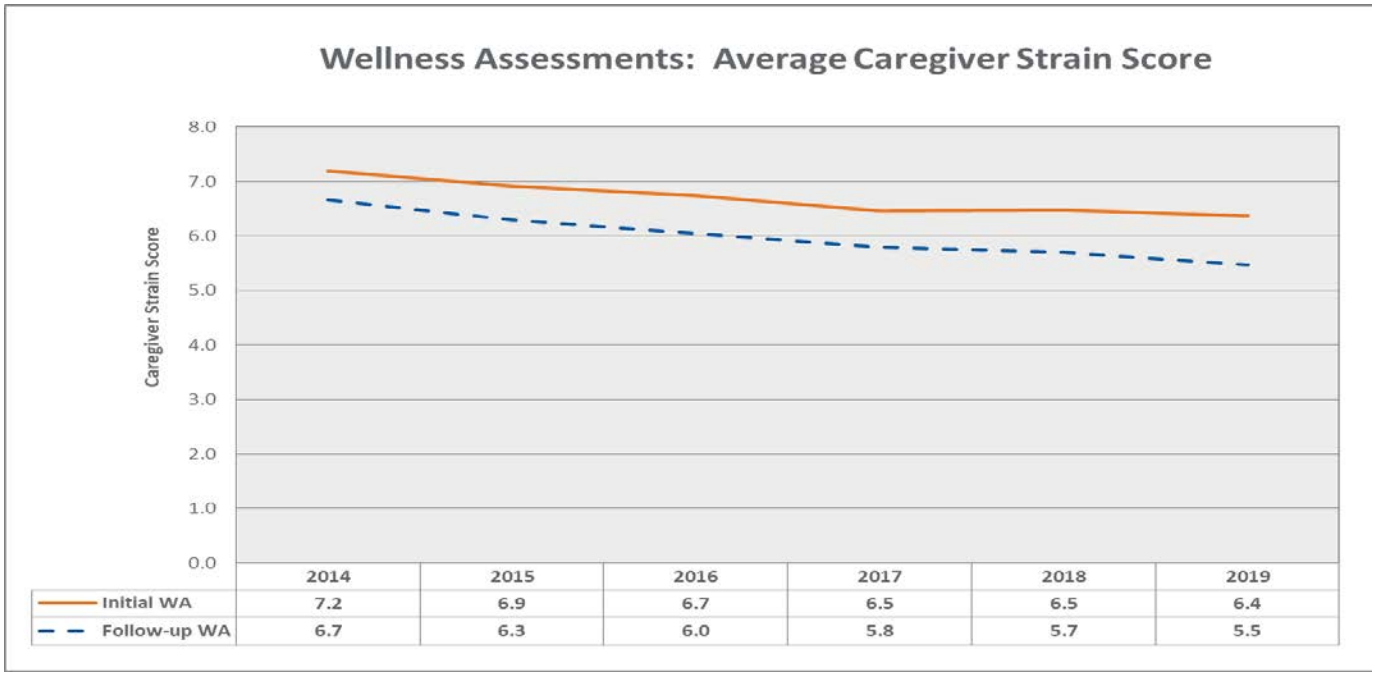


Figure 17

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

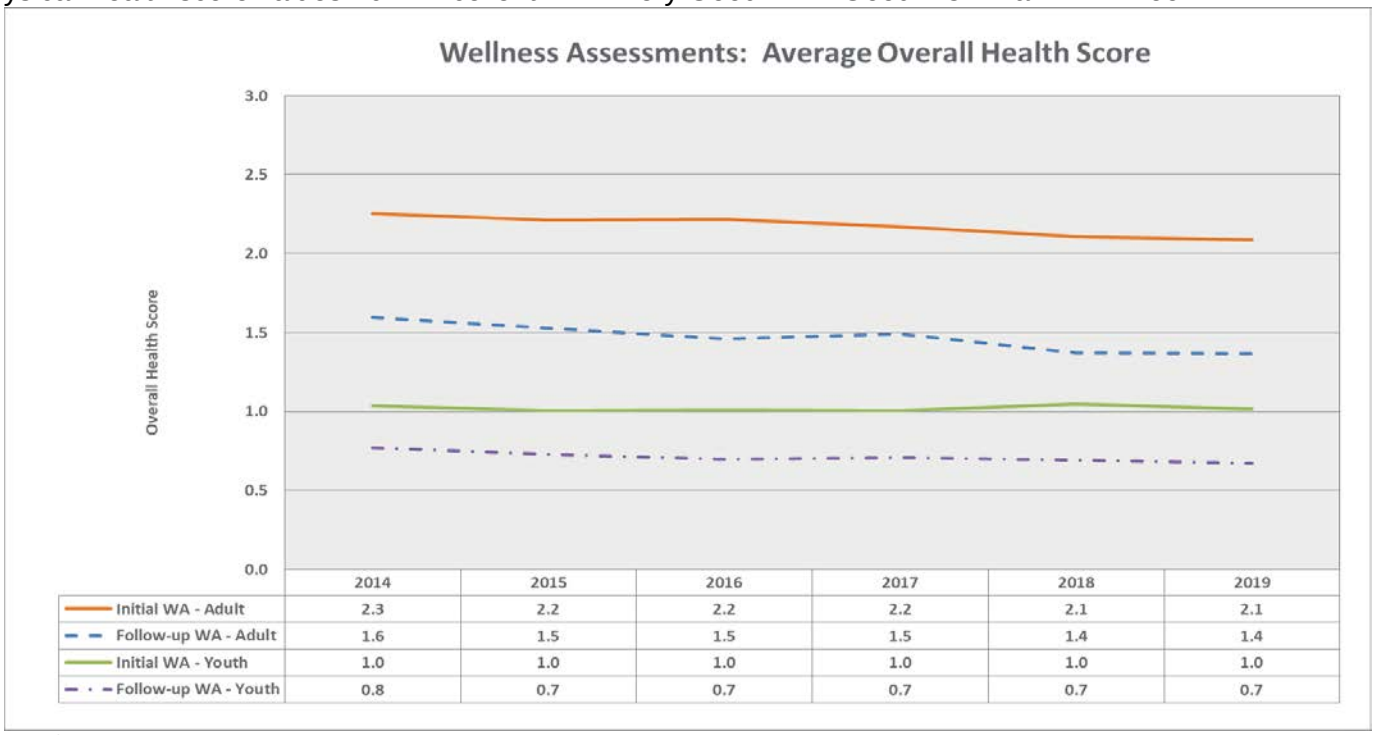


Figure 18

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 of time after the quarter in which the services were rendered.

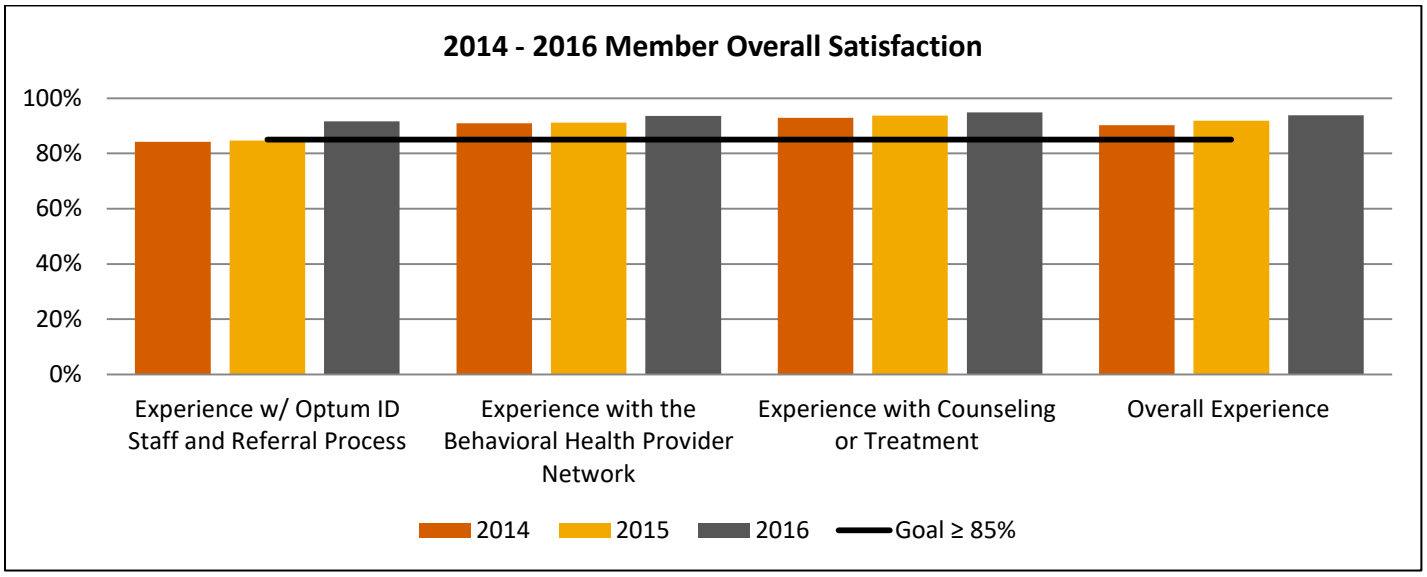
2014 – 2016 Overall Performance Results

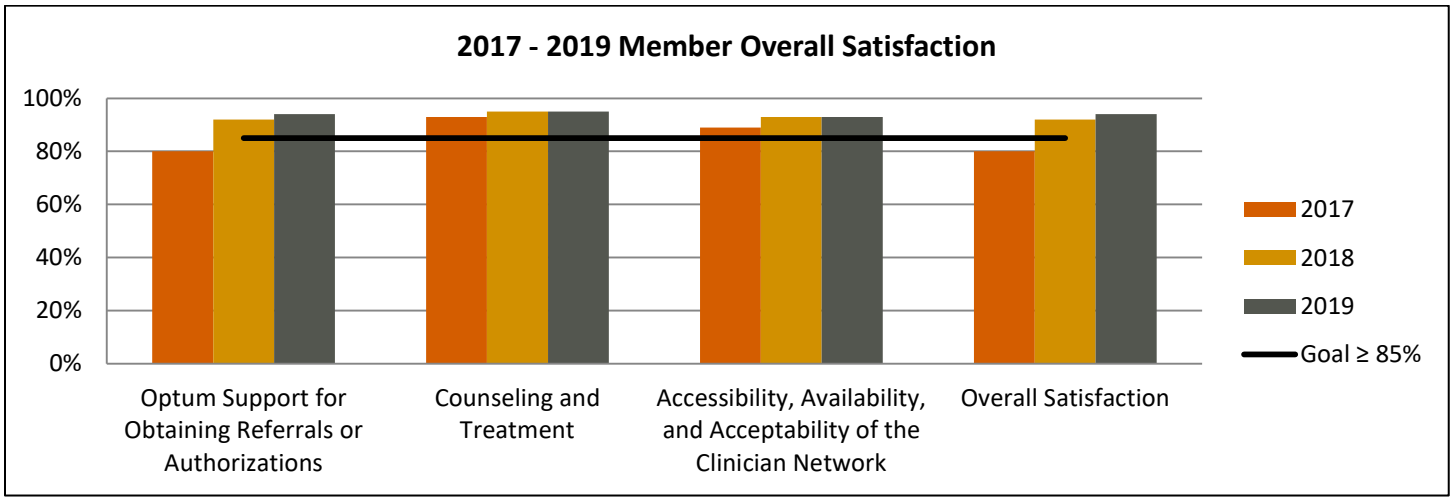
Member Satisfaction Survey	Performance Goal	2014 (n=458)	2015 (n=402)	2016 (n=417)
Experience w/Optum ID Staff and Referral Process	≥85.0%	84.2%	85.0%	91.6%
Experience with the Behavioral Health Provider Network	≥85.0%	90.9%	91.1%	93.6%
Experience with Counseling or Treatment	≥85.0%	92.9%	94.0%	94.8%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

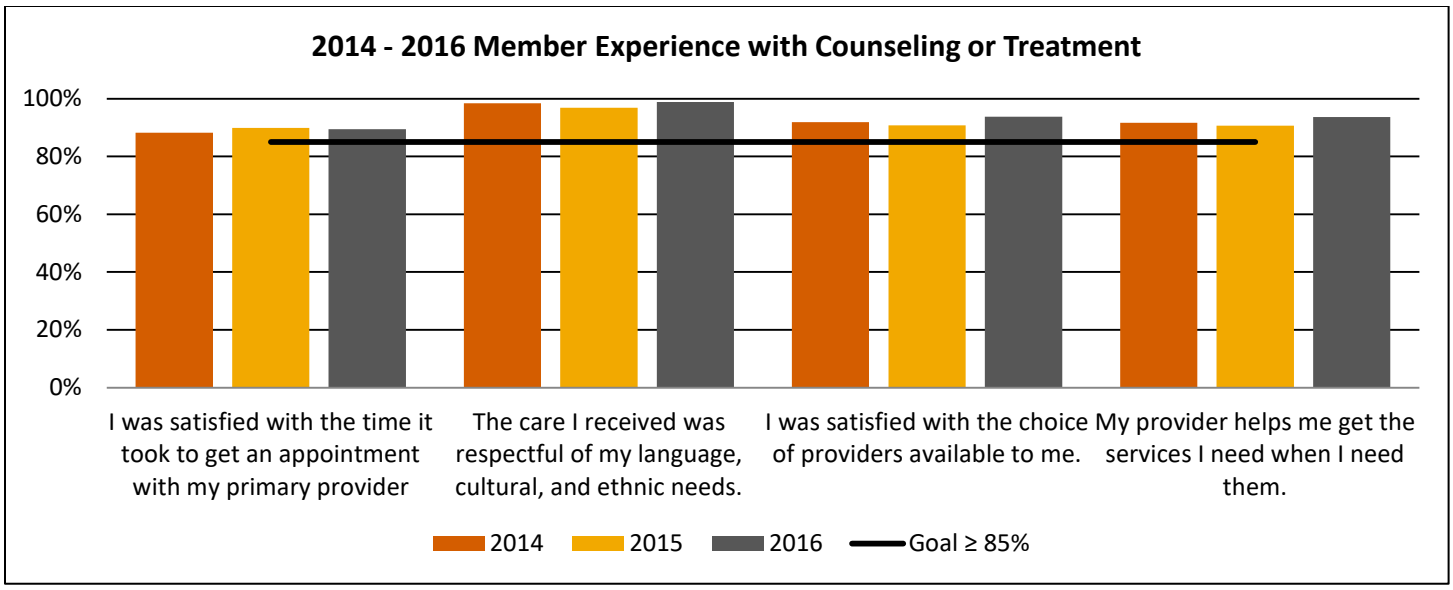
2017 - 2018 Overall Performance Results

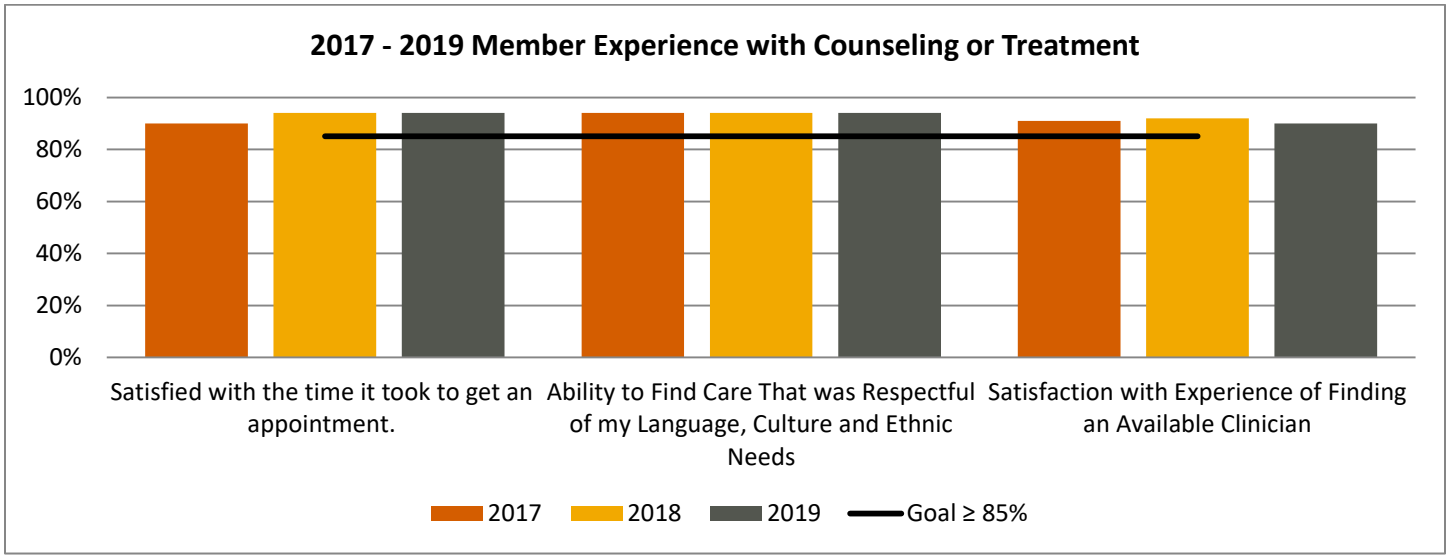
Member Satisfaction Survey	Performance Goal	2017	2018	2019
Overall Satisfaction (Goal: ≥85.0%)	≥85%	80%	92%	94%
Optum support for obtaining referrals or authorizations	≥85%	80%	92%	94%
Accessibility, availability, and acceptability of the clinician network	≥85%	89%	93%	93%
Counseling and Treatment	≥85%	95%	95%	95%

Analysis: Member satisfaction performance goals were met in 2019 for all survey domains.









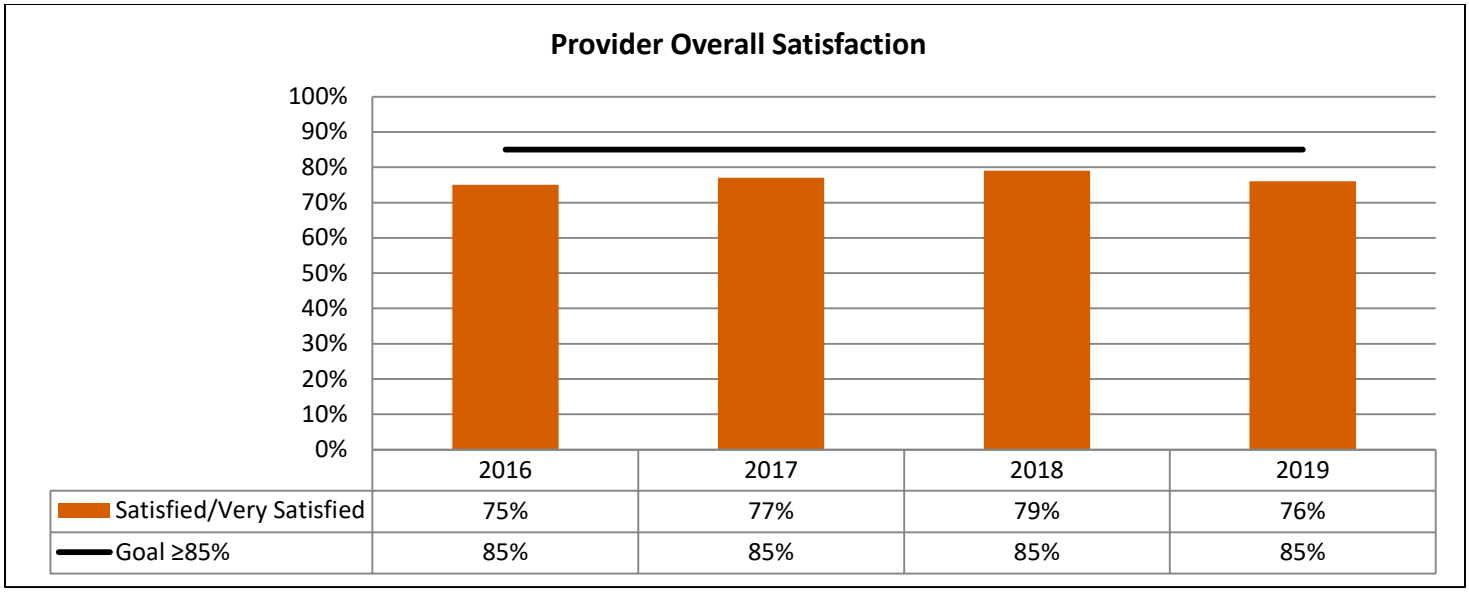
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified

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 2019 was 76%.



Barriers: While the annual survey results fell below ≥85.0%, Optum Idaho continued to monitor and identify trends.

Opportunities and Interventions: Action plans for 2020 include:

- Create trainings/webinars on specific issues identified with survey.
- Continue process for seeking provider input on initiatives-pilot as appropriate.
- Increase provider visits and meetings with providers and provider associations.
- Educate providers on the use of the Net Promotor Score.
- Collaborate with Optum Customer Service on surveys conducted during provider calls.
- Trend Customer Service calls to identify quality improvement opportunities.
- Trend provider requests and inquiries to identify process improvement opportunities.
- Quarterly Meet and Greets.
- Quarterly Provider Newsletter.
- Regional Network Managers complete a minimum of 4 provider visits per quarter using the Provider Engagement Checklist to ensure consistency with provider visits throughout the state.
- Ongoing collaboration with the national claims processing team.
- Project plan for Phase II of Telemental Health Program which includes identifying resources to provide hands on assistance for providers interested in providing Telemental Health Services (technical and clinical).
- Develop resources for members and communities to access Telemental Health in the community when internet and/or technology isn't available for the member.

Youth Empowerment Services (YES)

The State of Idaho developed a new children's mental health system of care called YES – Youth Empowerment Services. YES provides a new way for families to find the mental health help they need for their children and youth. It 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. In order 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 have been 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

Performance Improvement Projects

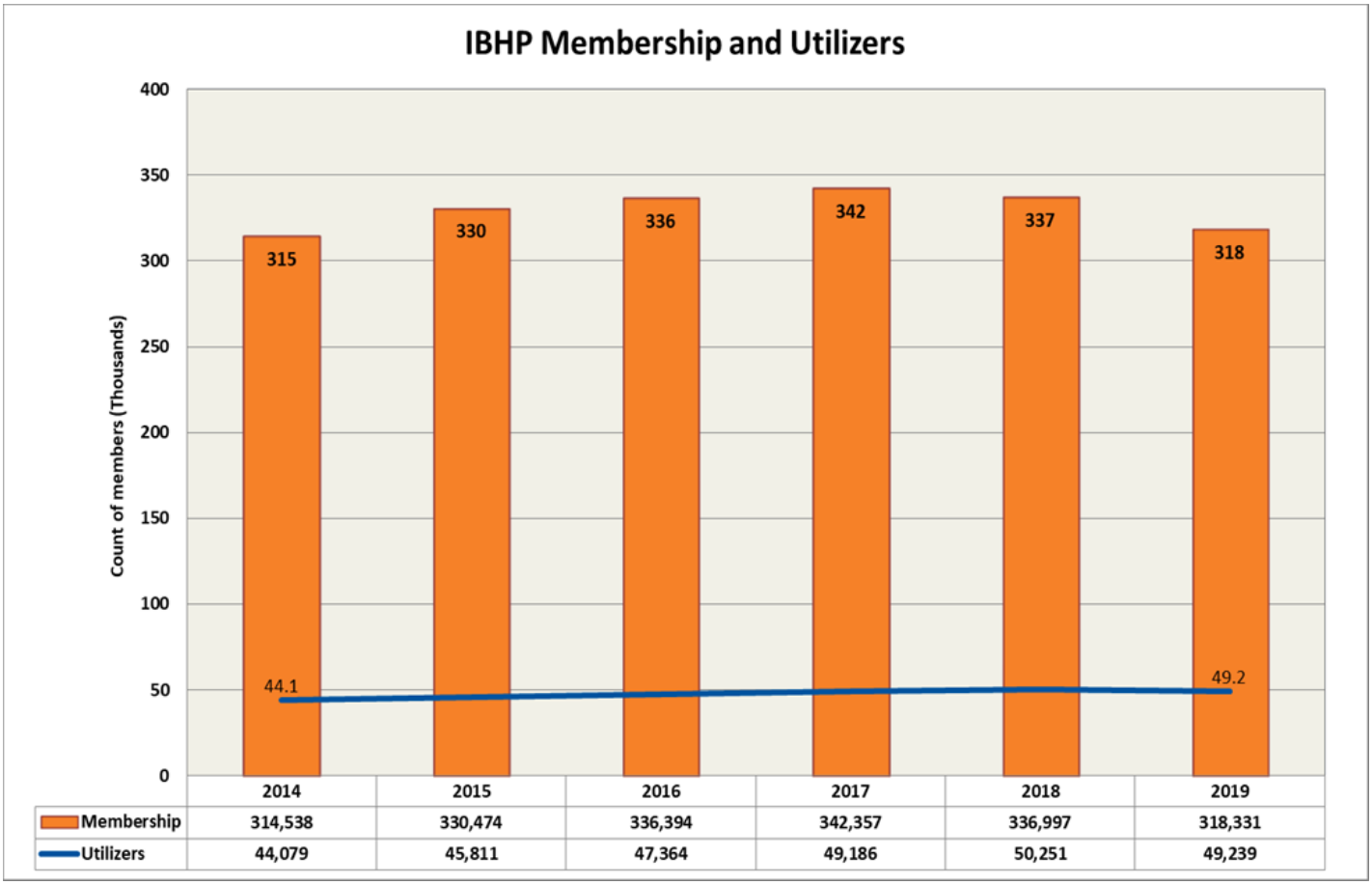
Performance Improvement Projects (PIPs) are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. During 2019, there were 2 PIPs in progress.

Appointment Reminder Program (ARP)
The purpose of this project is to improve outcomes for Members who have been hospitalized to ensure they have a behavioral health appointment within 30 days of inpatient discharge. 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. Optum data indicated that those participating in the program were more likely to attend an outpatient behavioral health appointment than those not participating in the program. This project remains open.

Follow-Up After Hospitalization (FUH)
The purpose of this project is 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 seeks 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 in a given 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. The project remains open.

Idaho Behavioral Health Plan Membership

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



	2014	2015	2016	2017	2018	2019
Membership	314,538	330,474	336,394	342,357	336,997	318,331
Utilizers	44,079	45,811	47,364	49,186	50,251	49,239

Analysis: During 2019 membership and utilizer numbers decreased. The Idaho Medicaid Plus program, which is for Dual Eligible participants who are 21 years of age or older and are eligible and enrolled in both Medicare (Parts A, B, and D) and Enhanced Medicaid, contributed to the reduced membership volume. Members eligible for this program used to be under Optum's membership but as they enroll in the new program, are removed from Optum's membership count.

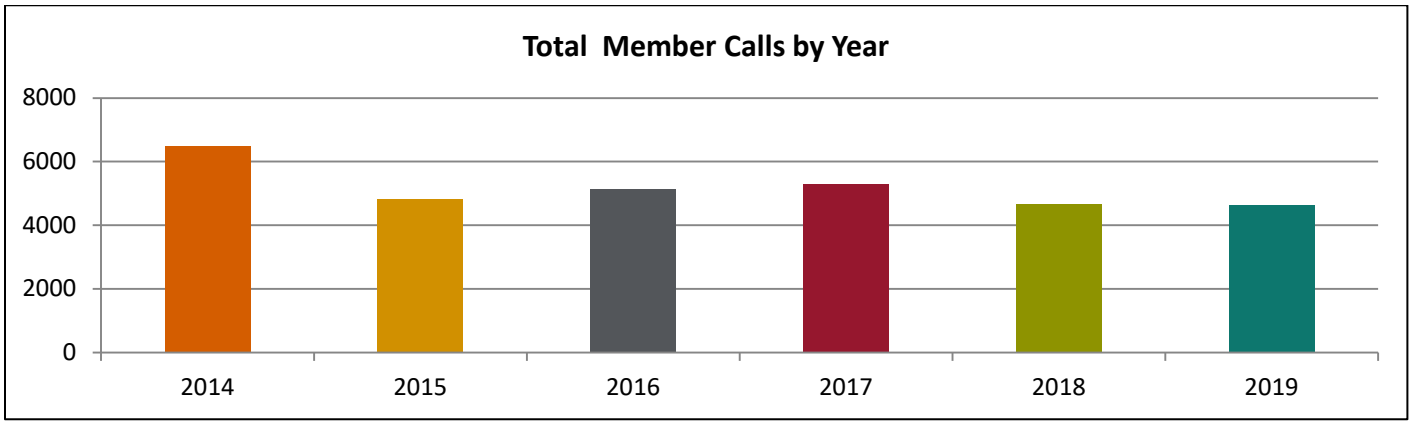
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified

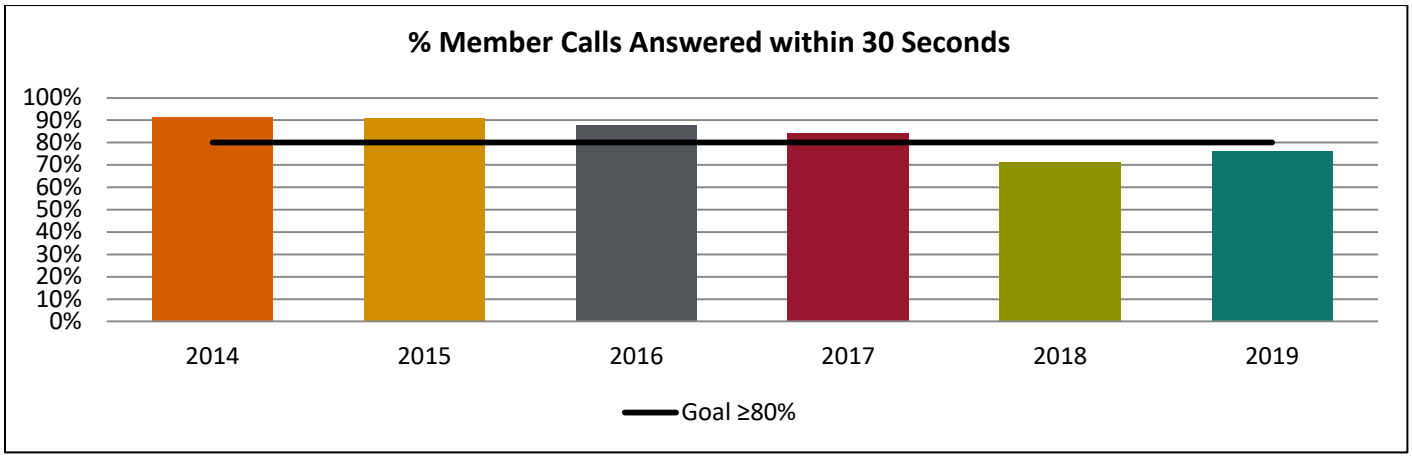
Member Services Call Standards

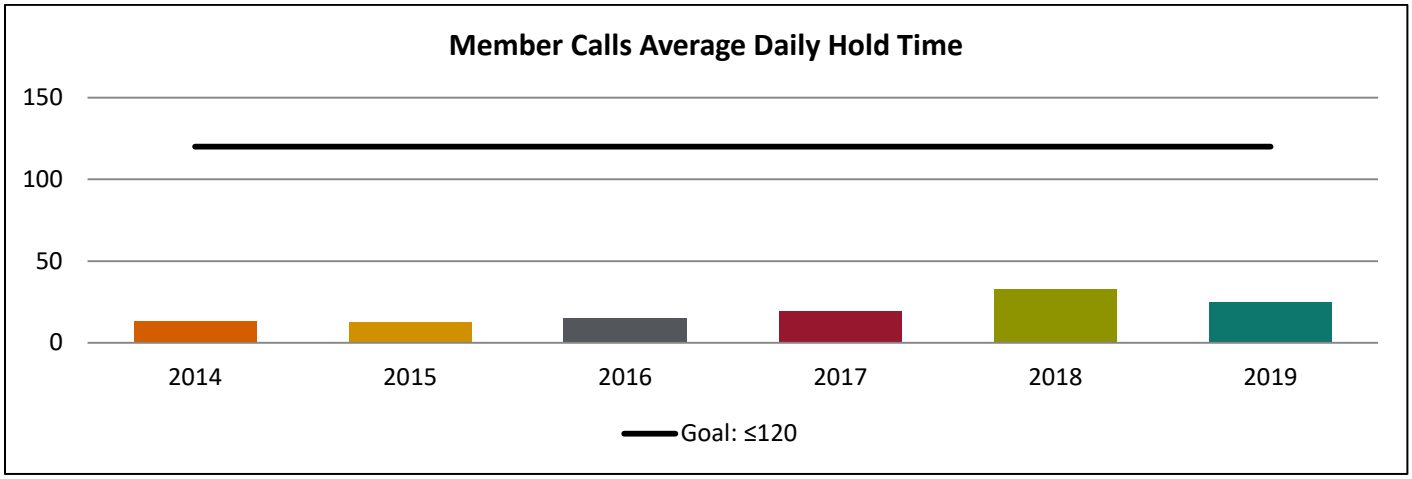
Methodology: Optum Idaho telephone access is provided 24 hours a day, seven days a week, 365 days per year through our toll-free Member Access and Crisis Line. Optum Idaho is contractually obligated to track the percent of member calls answered within 30 seconds, daily average hold time and call abandonment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

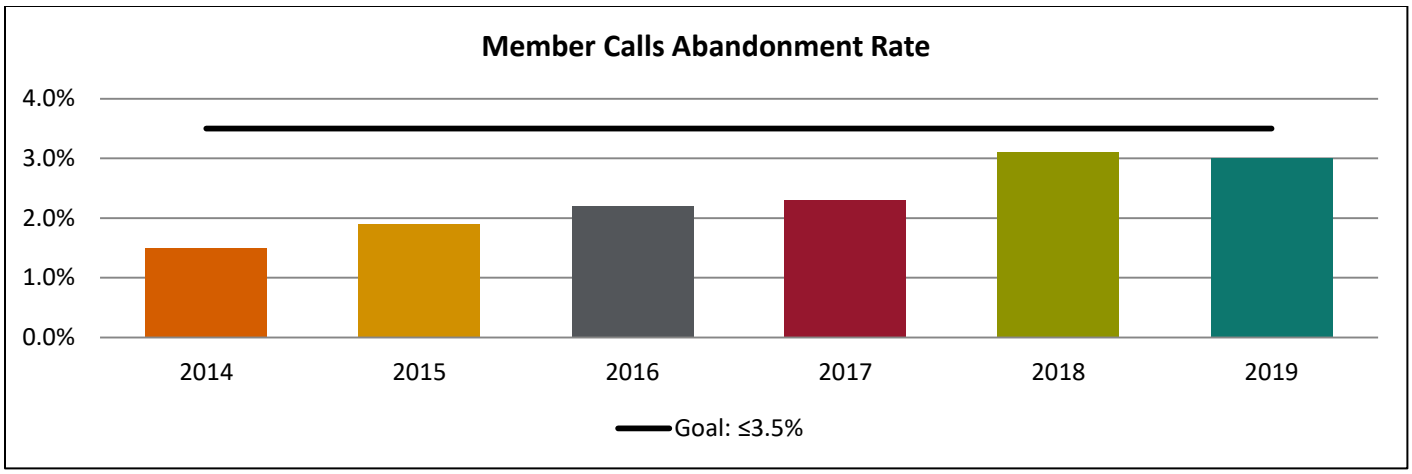
Analysis: The Member Services and Crisis Line received a total of 4,641 calls during 2019. The percentage of calls answered within 30 seconds fell below the goal for a second straight year. Optum continued to

implement improvement strategies and saw improvement during all four quarters. The daily average hold time and the call abandonment rate goals were met.







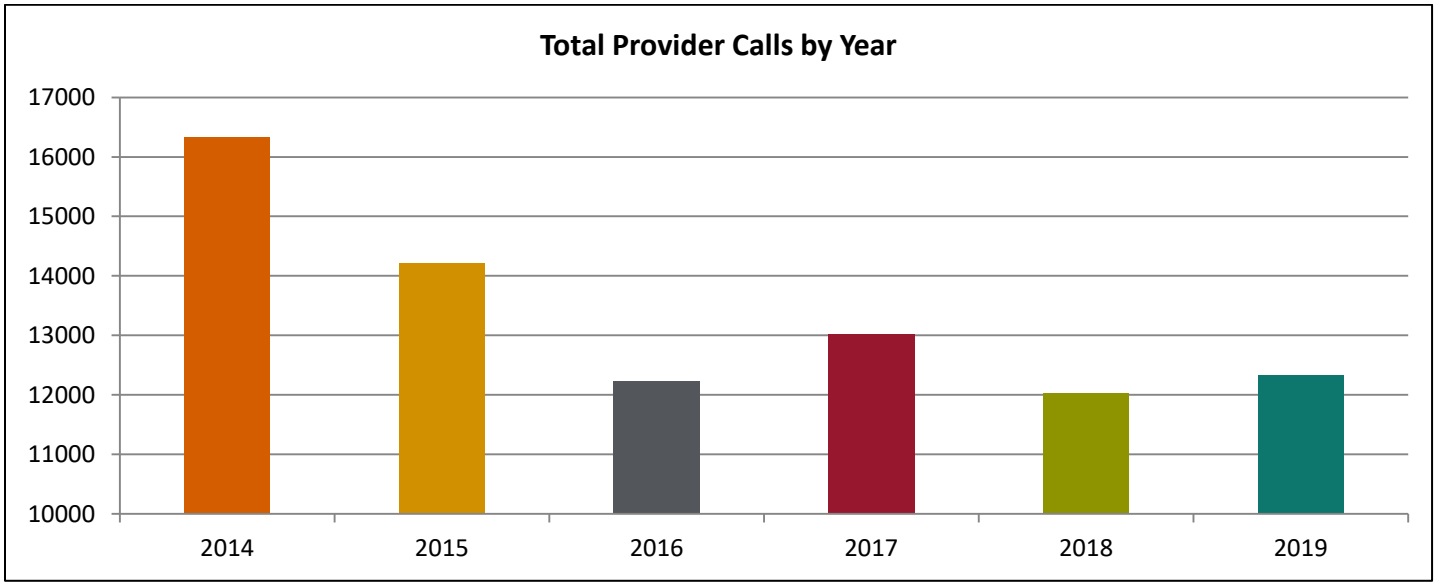


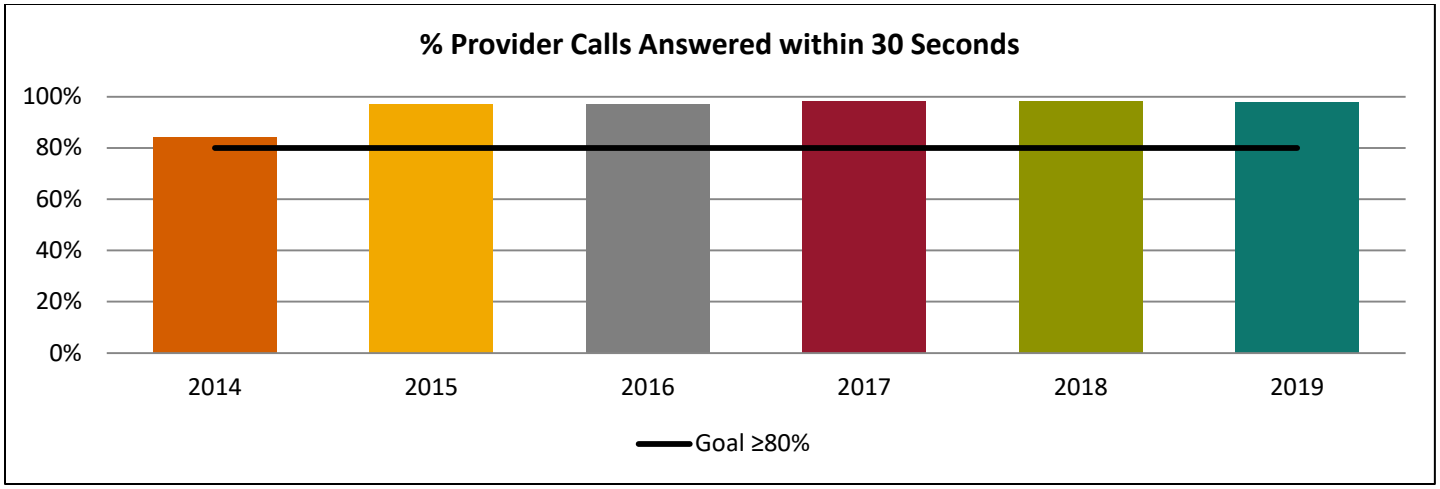
Barriers: Performance goal was not met for Percent of Calls Answered within 30 Seconds.
Opportunities and Interventions: Optum will continue to closely monitor these targets to evaluate existing improvement measures, and if necessary, implement new improvement interventions.

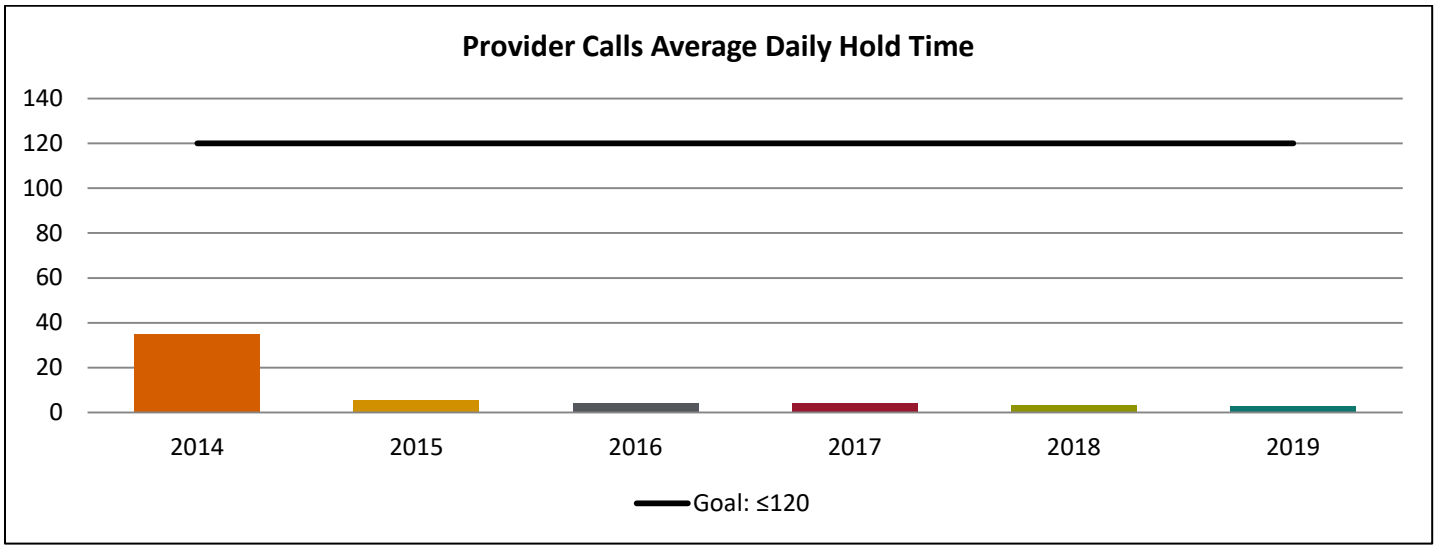
Customer Service (Provider Calls) Standards

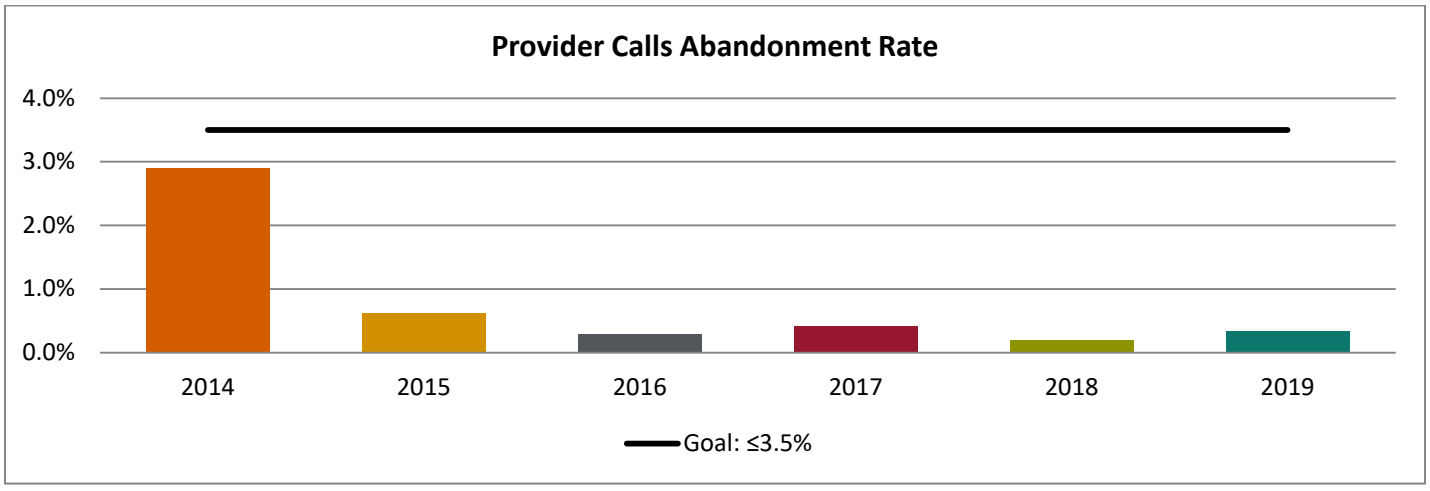
Methodology: Optum Idaho is contractually obligated to track the percent of provider calls answered within 30 seconds, daily average hold time and call abandonment rate. The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho to ensure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

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







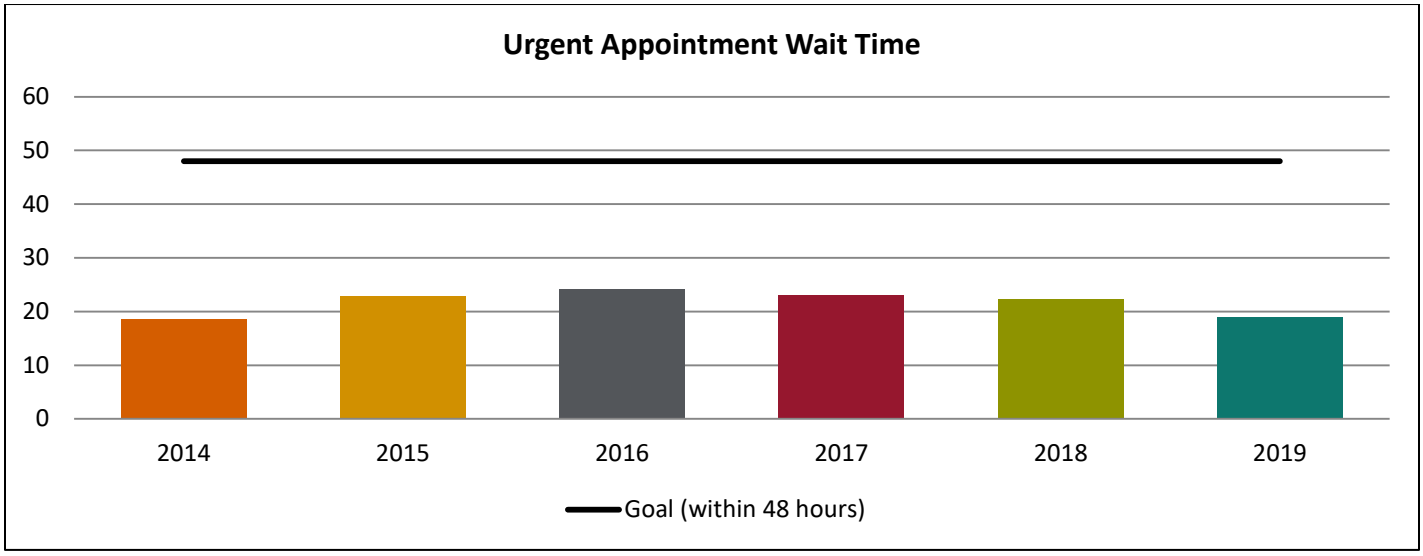


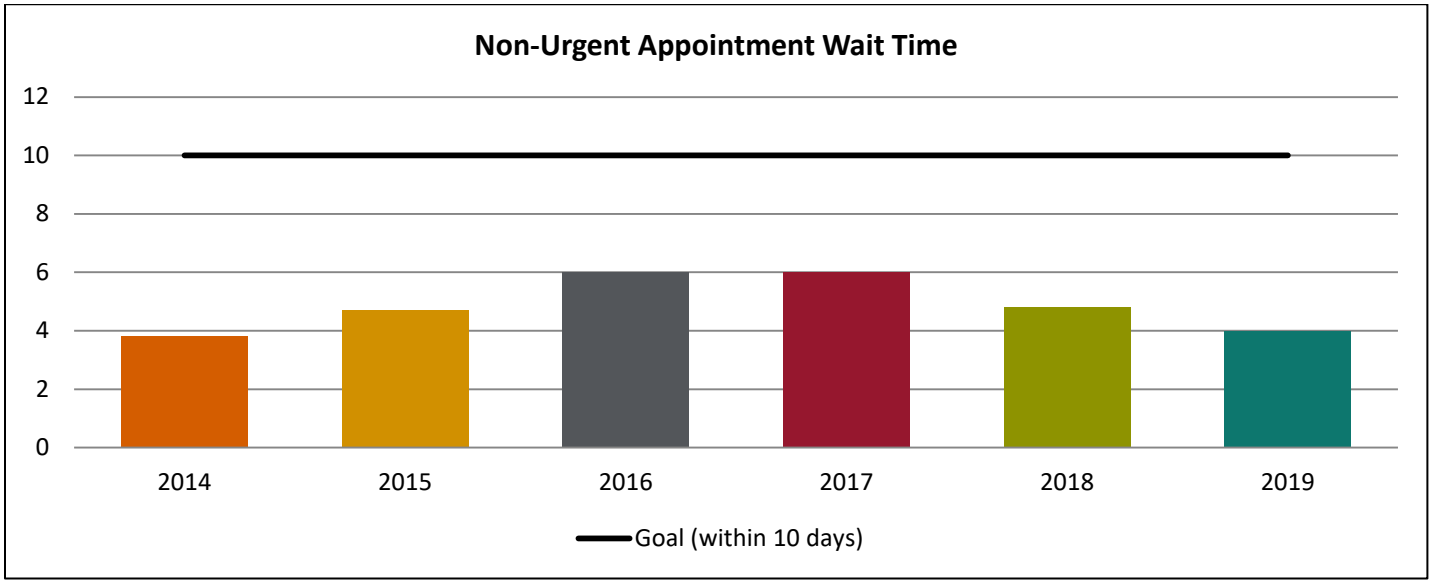
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified

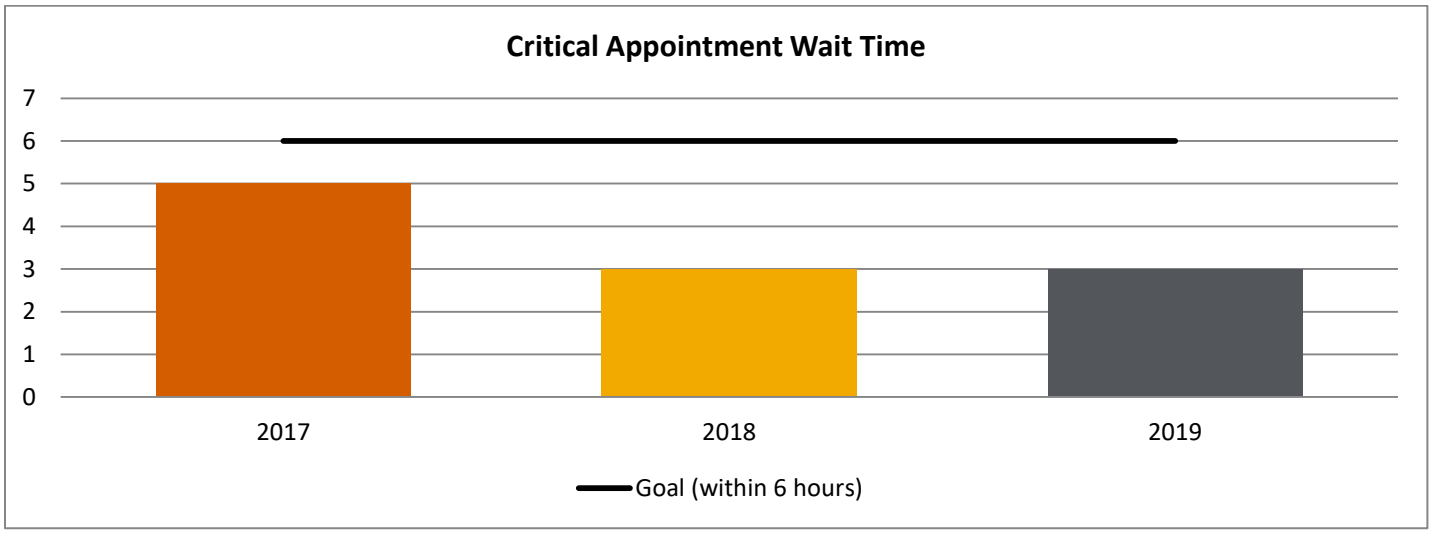
Urgent, Non-Urgent, and Critical Appointment Access Standards

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 2019 with an average of 19 hours. The overall performance goal for Non-Urgent Appointment wait times was also met with an average of 4 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 2019 with an average of 3 hours.







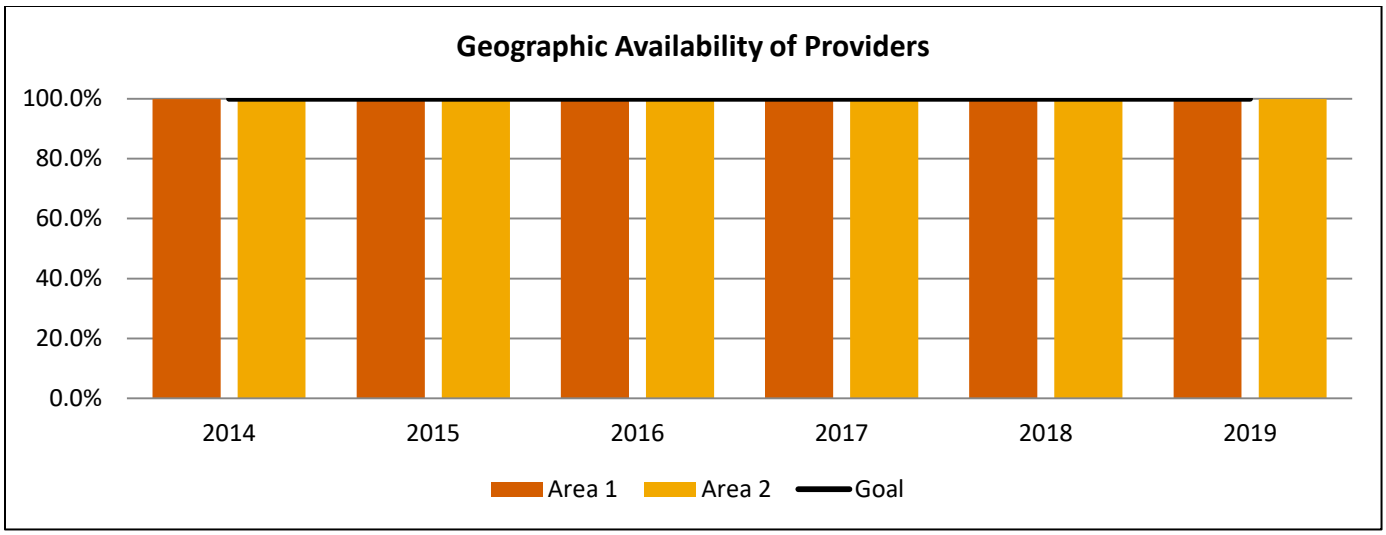
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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 2019, Optum Idaho continued to meet contract provider availability standards. Area 1 availability standards were met at 99.8% and Area 2 availability standards were also met at 99.8%. (Performance is viewed as meeting the goal due to established rounding methodology – rounding to the nearest whole number).



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 and 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 and URAC (Utilization Review Accreditation Commission).

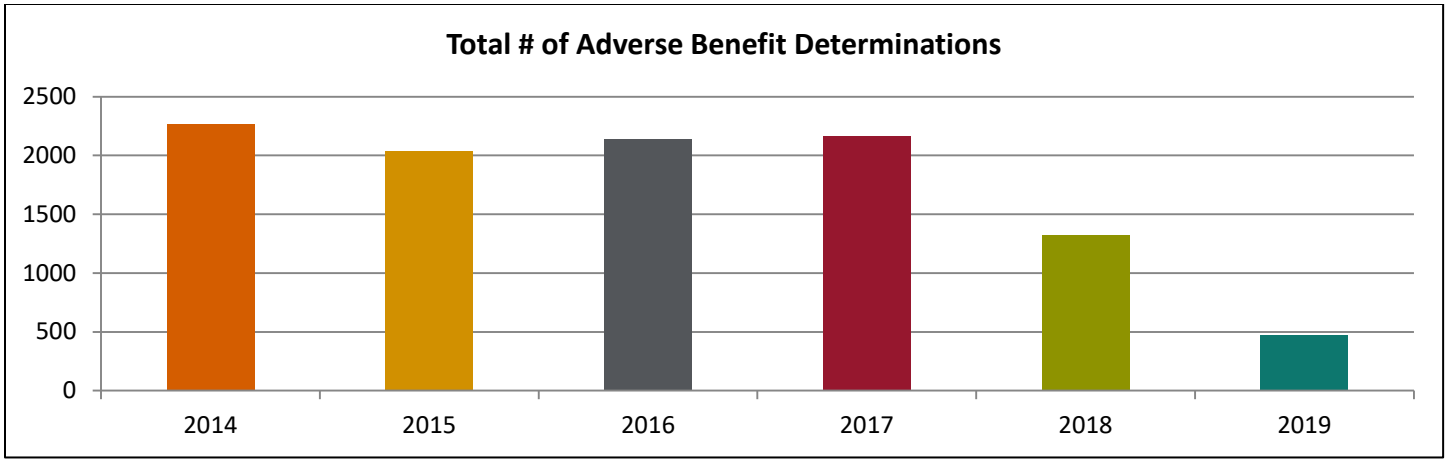
Case reviews are conducted in response to requests for coverage for treatment services. They may occur prior to a member receiving services (pre-service), or subsequent to a member receiving services (post-service or retrospective). Case reviews are conducted in a focused and time-limited manner to ensure that the immediate treatment needs of members are met, to identify alternative services in the service system to meet those needs, and to ensure the development of a person-centered plan, including advance directives.

As part of Optum Idaho's ongoing assessment of the overall network, Optum Idaho evaluates, audits, and reviews the performance of existing contracted providers, programs, and facilities.

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 services is received, Optum Idaho has 14 calendar days to review the case, make a determination to authorize services 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 475 Adverse Benefit Determinations during 2019. Overall written compliance (14 calendar days from request) was at 98.7%. Optum Idaho continued to see a decrease in clinical and administrative ABDs. This can be attributed to three factors: 1) Optum Idaho has reduced the number of services requiring pre-service authorizations, 2) Network Providers are more cognizant of what's required to get an authorization and less likely to submit a request that could potentially get denied and 3) an update to the Service Request Form preventing administrative errors that result in an administrative ABD.

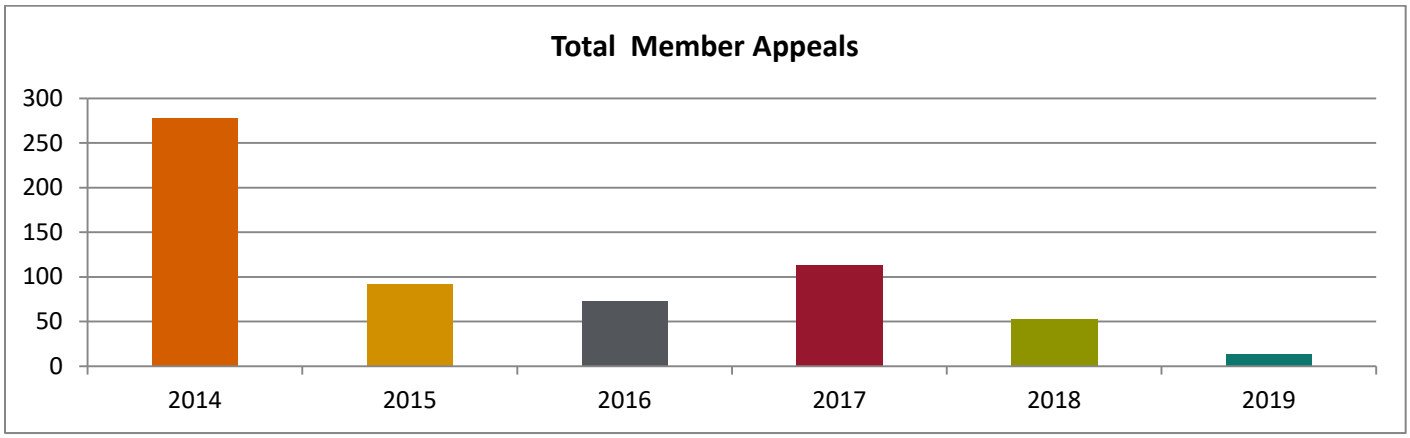


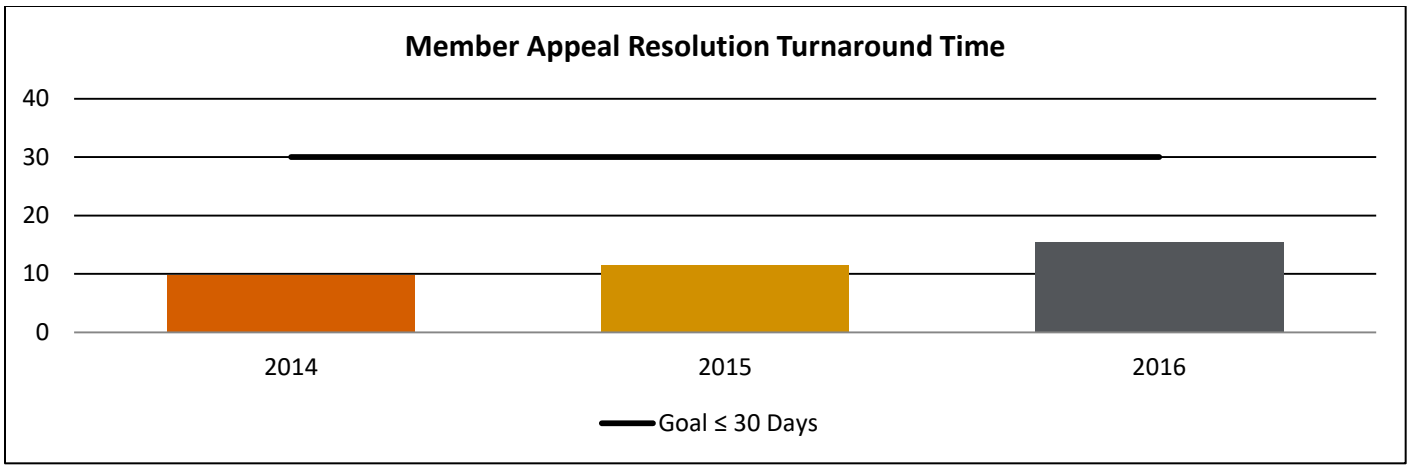
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

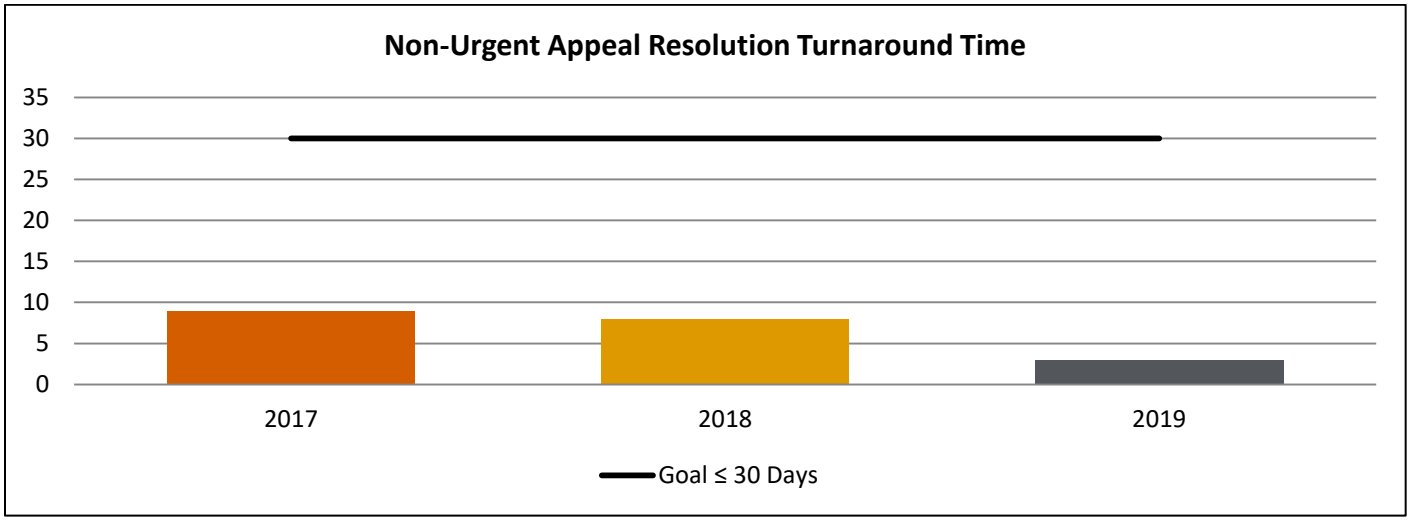
Member Appeals

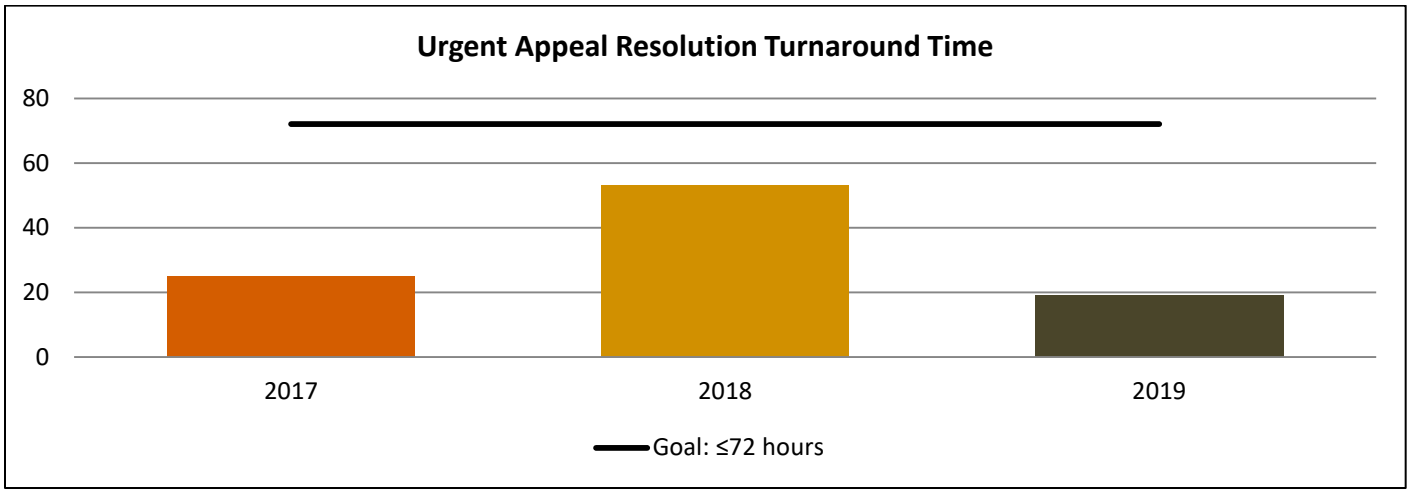
Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an ABD that resulted in member financial liability or denied services. All non-urgent appeals are required to be reviewed and resolved within 30 calendar days. Urgent appeals are required to be reviewed and 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 acknowledgement letter. Urgent appeal requests do not require an acknowledgement letter. All appeals are upheld, overturned, or partially overturned.

Analysis: There were 14 Member Appeals. All turnaround time requirements and performance goals were met in 2019. The reduction in appeal volume is directly attributed to the reduction in the number of ABDs.









Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

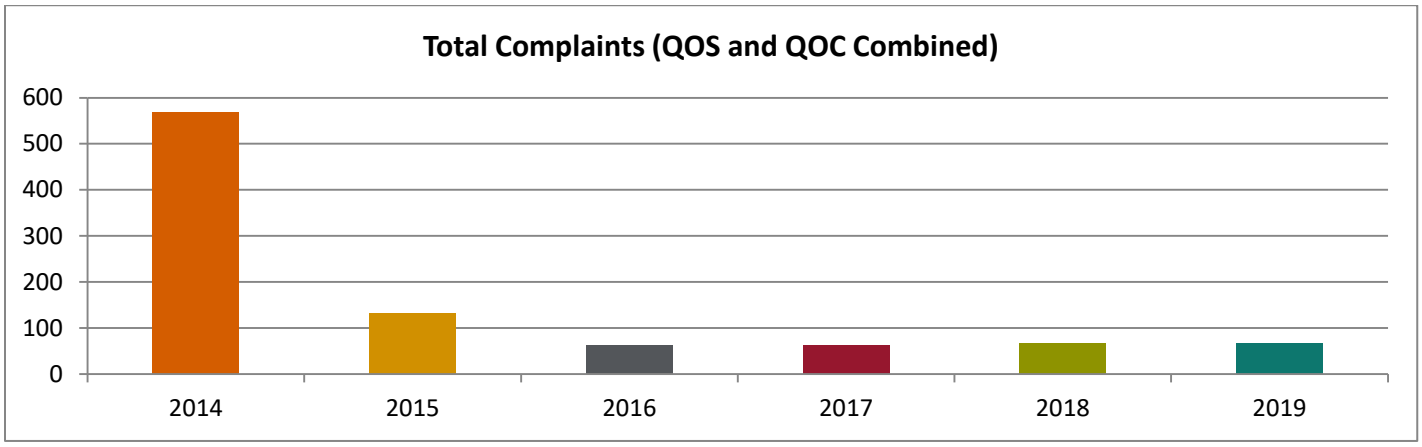
Complaint Resolution and Tracking

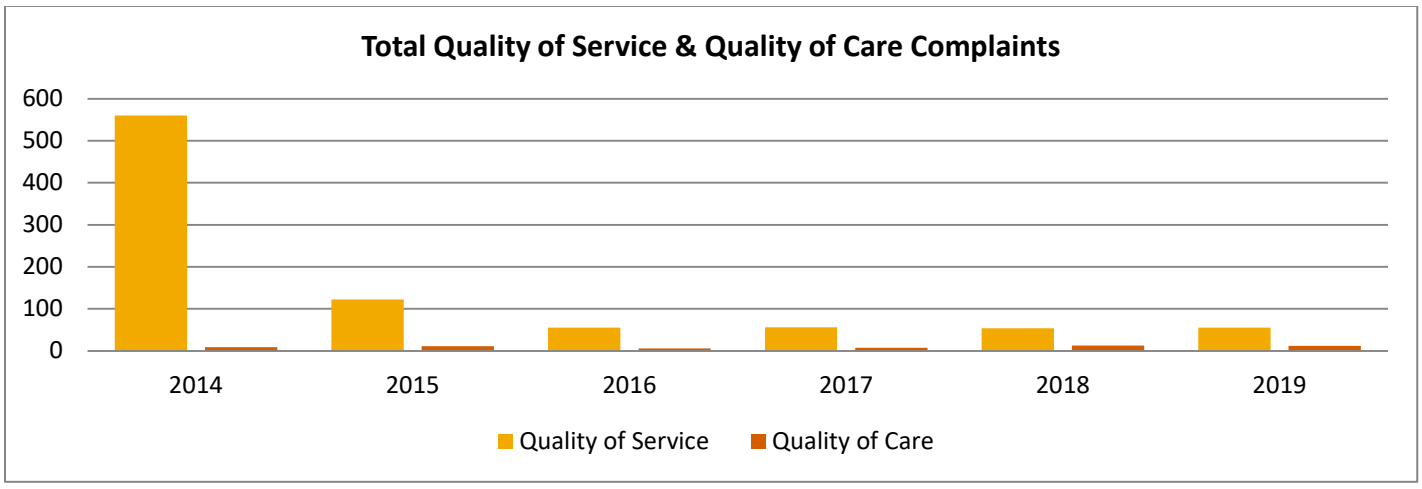
Methodology: A complaint is an expression of dissatisfaction logged by a member, a member's authorized representative or a provider concerning the administration of the plan and services received. This is also known as a Quality of Service (QOS) complaint. A concern that relates to the quality of clinical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

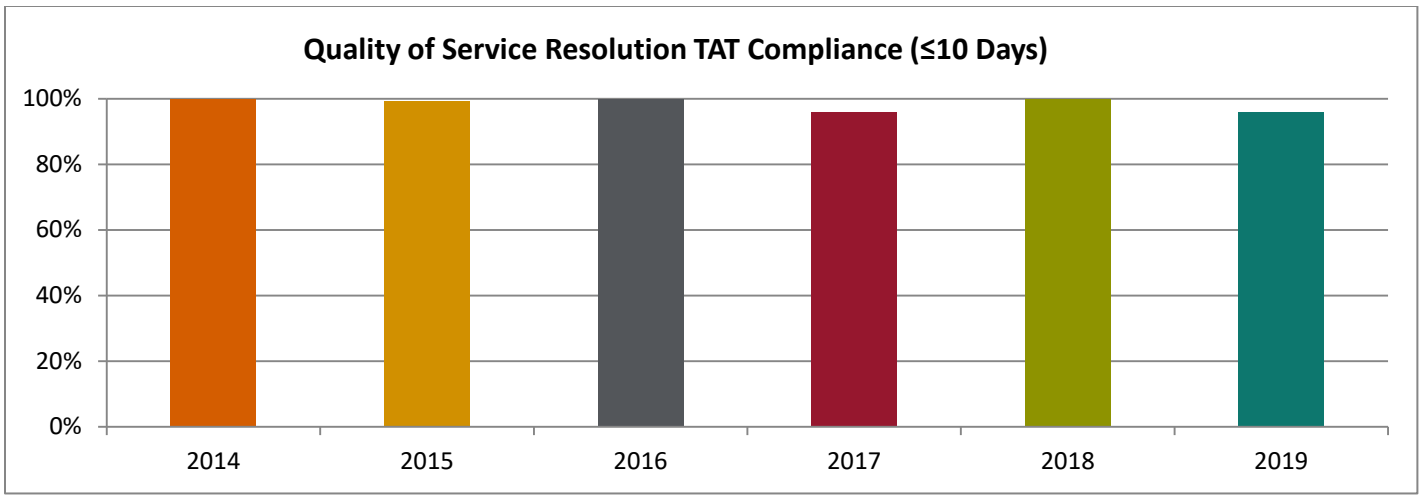
Complaints are collected and grouped into the following broad categories: Benefit, Service (and Attitude), Access (and Availability), Billing & Financial, Quality of Care, Privacy Incident, and Quality of Practitioner Office Site.

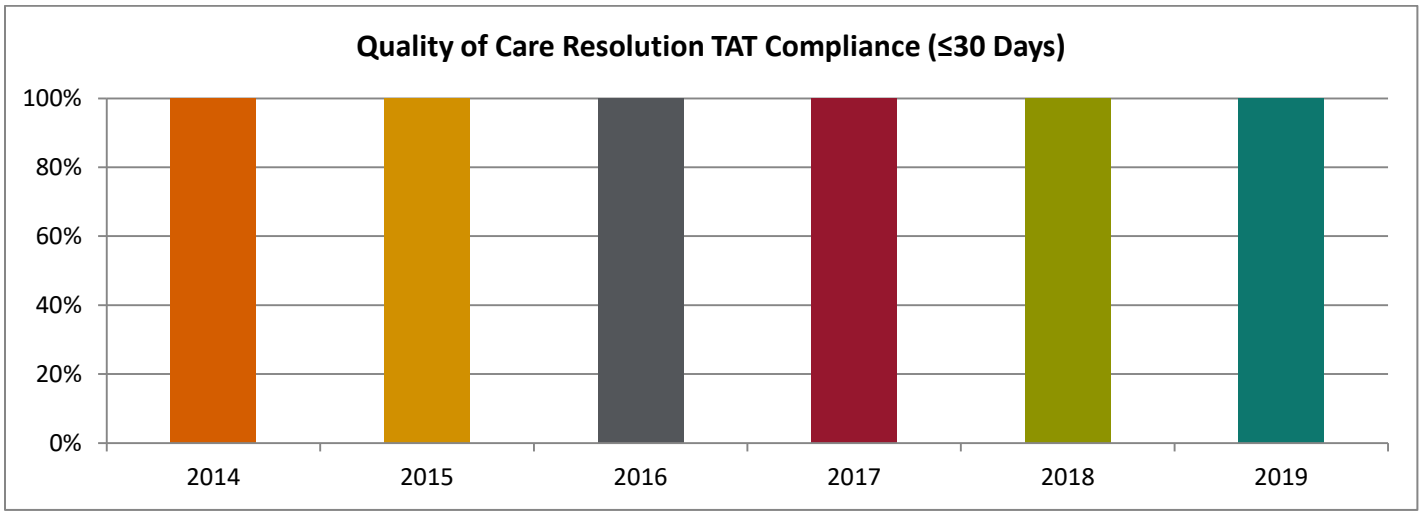
Optum Idaho maintains a process for recording and triaging QOC Concerns and QOS complaints to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. Both QOS complaints and QOC concerns are to be acknowledged within 5 business days. QOS complaints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

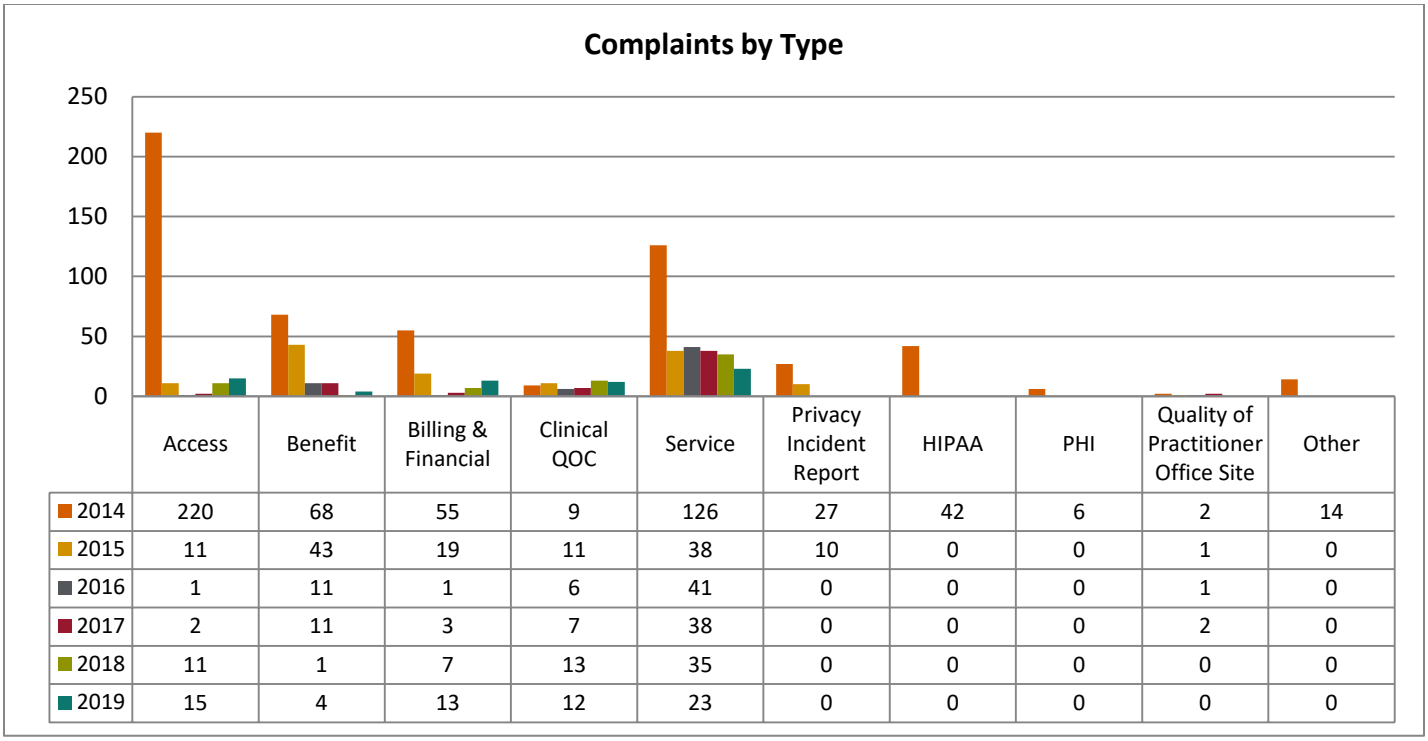
Analysis: There were 67 total complaints (QOS and QOC combined) received during 2019. Of the total complaints received during 2019, 55 were identified as QOS and 12 were identified as QOC. Two (2) QOS complaints fell out of compliance for resolutions turnaround times. This was due to a delay in solving claims issues that were required to be completed before the complaint could be resolved. Optum Idaho met resolution compliance for QOC concern turnaround times.






Quality of Service Resolution TAT Compliance (≤10 Days)
100%
80%
60%
40%
20%
0%
2014
2015
2016
2017
2018
2019


Quality of Care Resolution TAT Compliance (≤30 Days)
100%
80%
60%
40%
20%
0%
2014
2015
2016
2017
2018
2019



	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

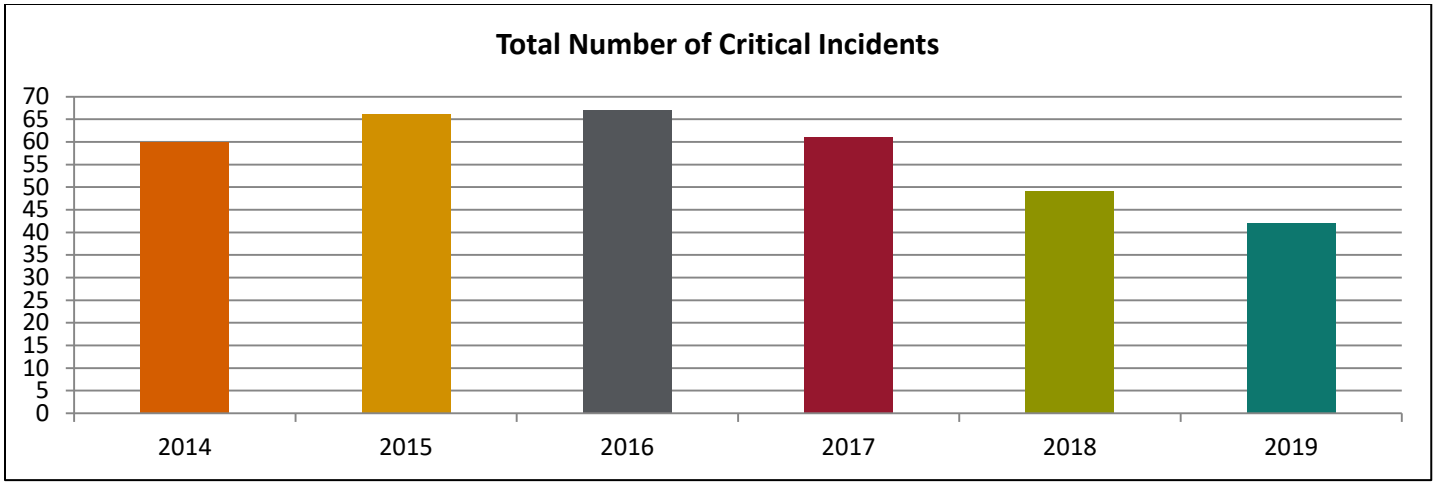
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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 42 CIs reported during 2019. 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 2019 were in the category of Unexpected Deaths (55%). Coordination of care occurred between the behavioral health provider and the member's PCP in 17% of cases. Of the 42 reported CIs, 55% involved members with co-morbid health conditions. Of the cases reported in 2019, 74% of the cases were adults (18+) and 26% were children/adolescents (17 and below). Further analysis showed that the average age for males was 39 and females 40.

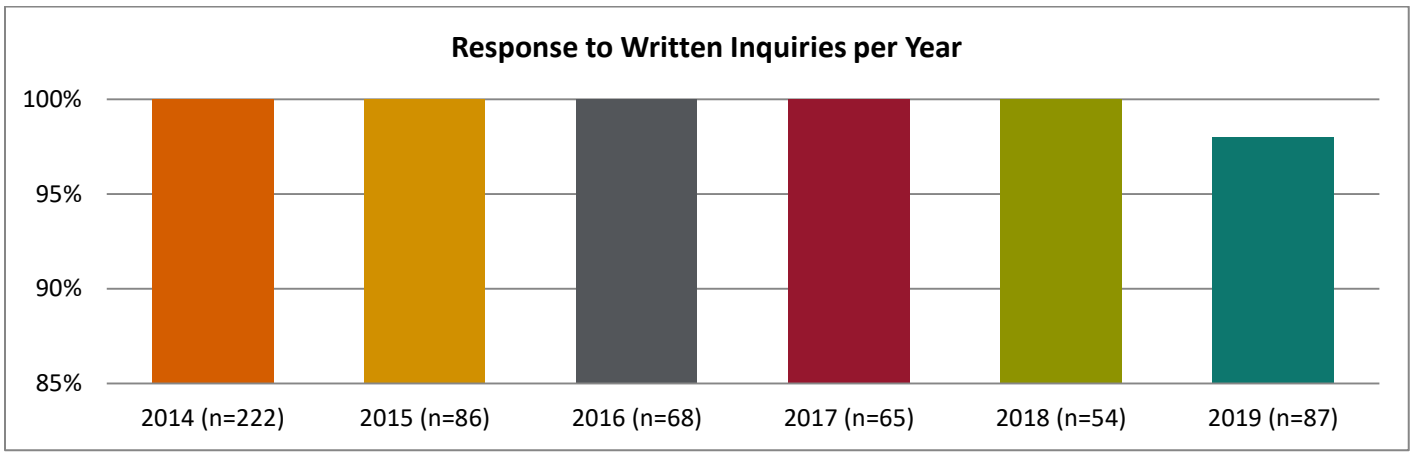


Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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: The data indicated that the standard of 100% acknowledged within 2 business days was not met during 2019; two (2) responses fell out of compliance.



Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Provider Monitoring and Relations

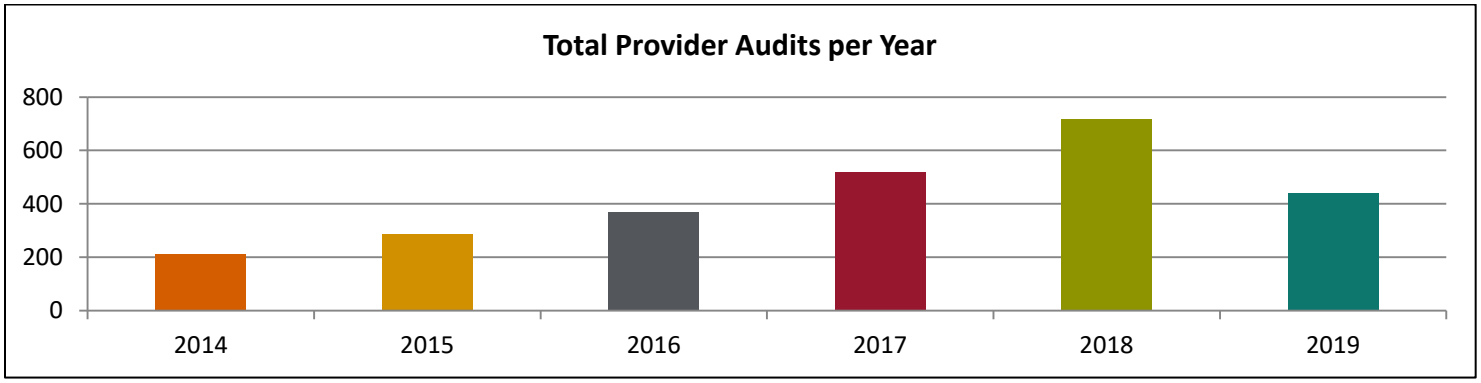
Provider Quality Monitoring

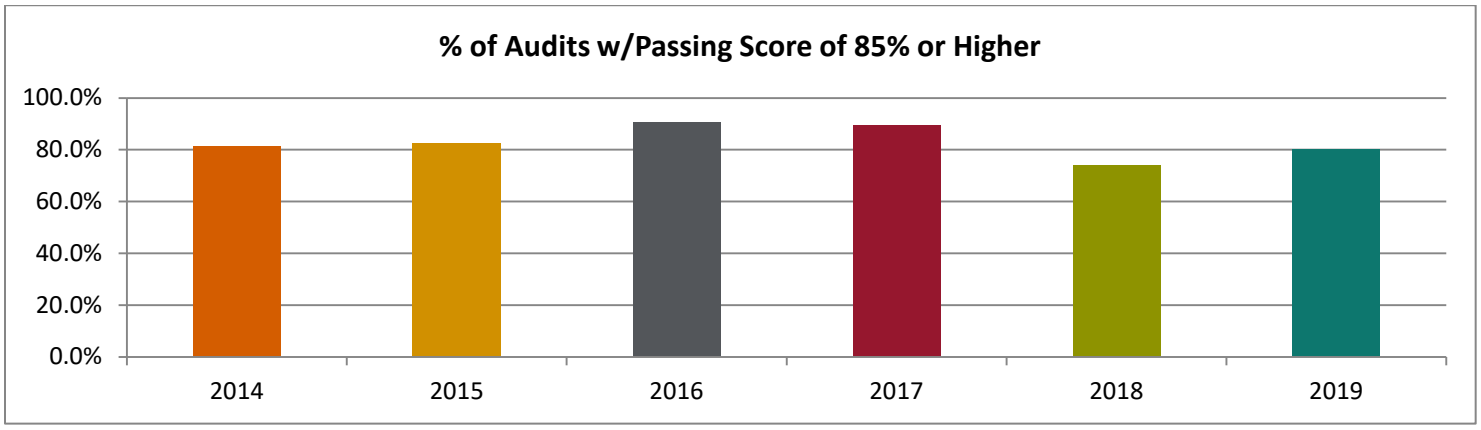
Optum Idaho monitors provider adherence to quality standards via site visits. The Optum Idaho Provider Quality Specialists complete treatment record reviews and site audits to facilitate communication, coordination and continuity of care and to promote efficient, confidential and effective treatment, 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 2019, a total of 439 audits were conducted and 80% (350) of audits received a passing score (≥85%) and did not require a CAP. CAPs were implemented for 20% (89) of the audits that were completed during 2019.





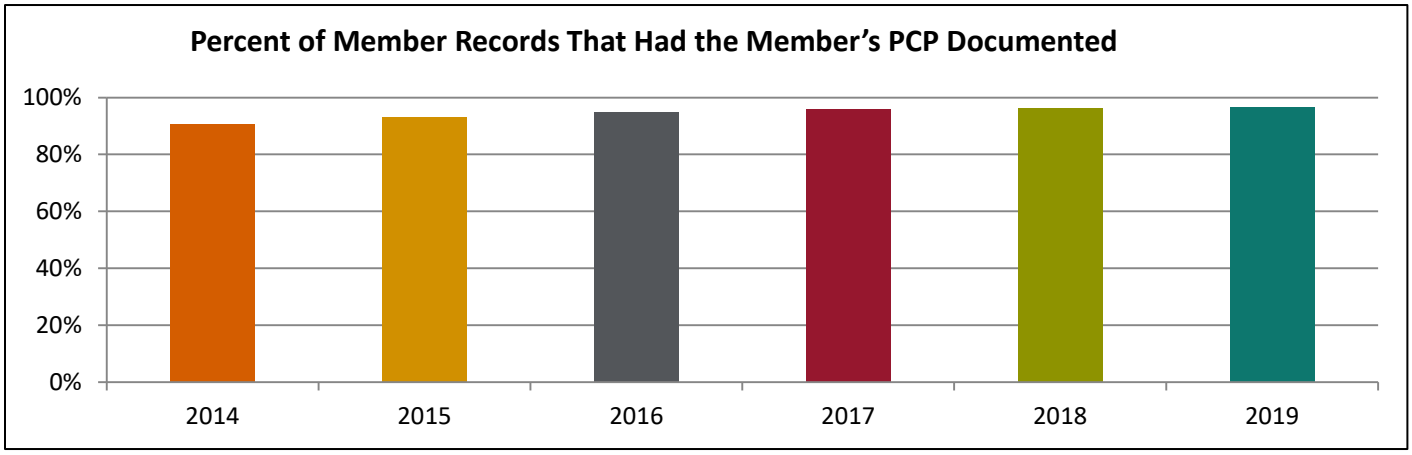
Coordination of Care

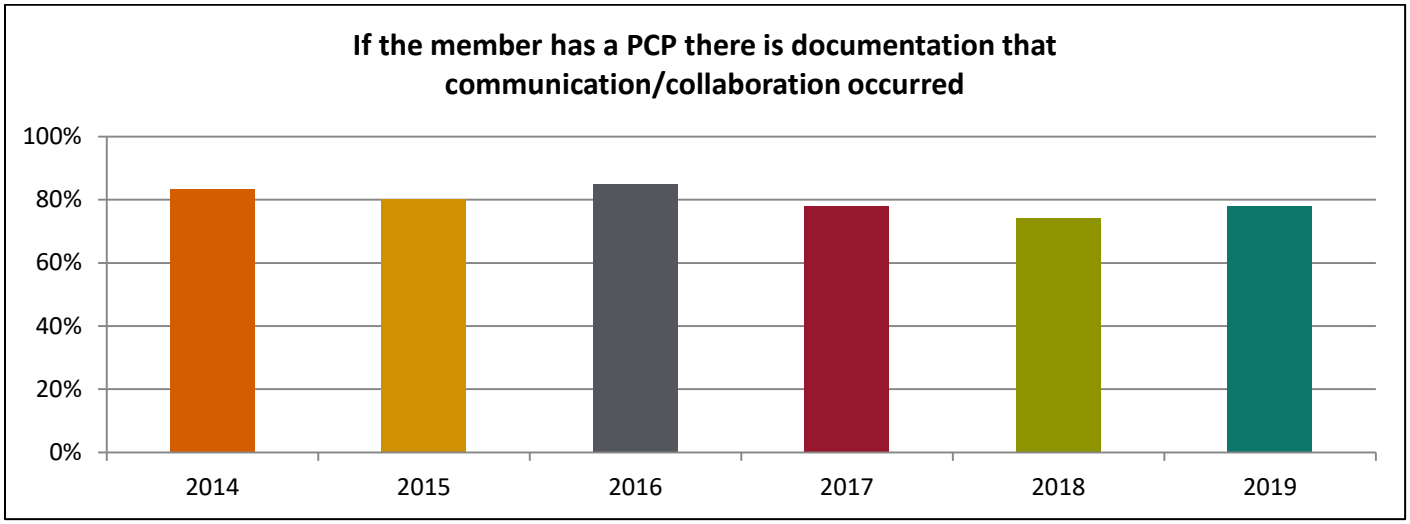
Methodology: To coordinate and manage care between behavioral health and medical professionals, Optum Idaho requires providers to obtain the member's consent to exchange appropriate treatment information with medical care professionals (e.g. primary care physicians, medical specialists). Optum Idaho 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.

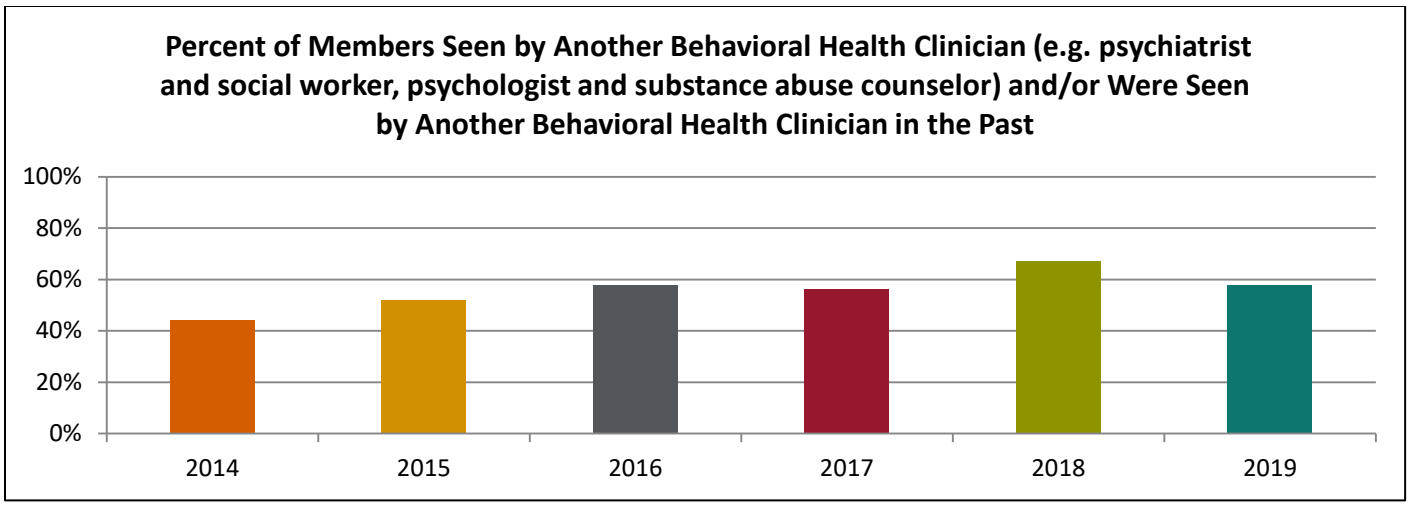
Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum Idaho, as well as accrediting organizations, expects providers to make a "good faith" effort at communicating with 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.

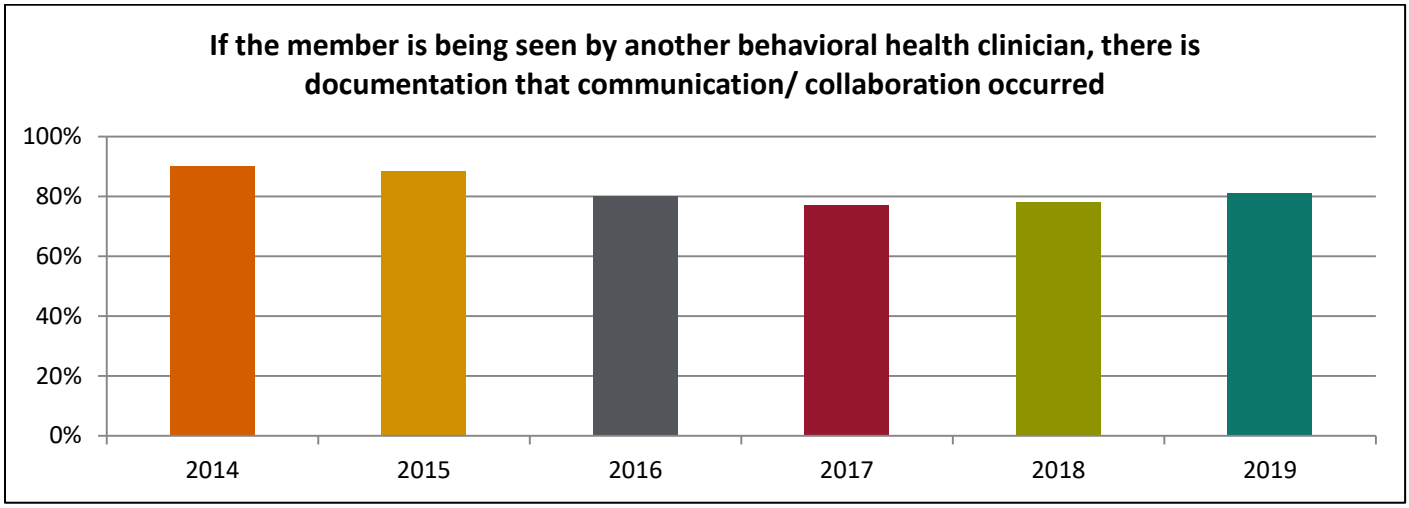
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff.

Analysis: Coordination of Care audits completed during 2019 revealed that 97% of member records reviewed had documentation of the name of the member's PCP. Of those, 78% indicated that collaboration had occurred between the behavioral health provider and the member's PCP. The results also revealed that 58% 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, 81% indicated that collaboration had occurred.







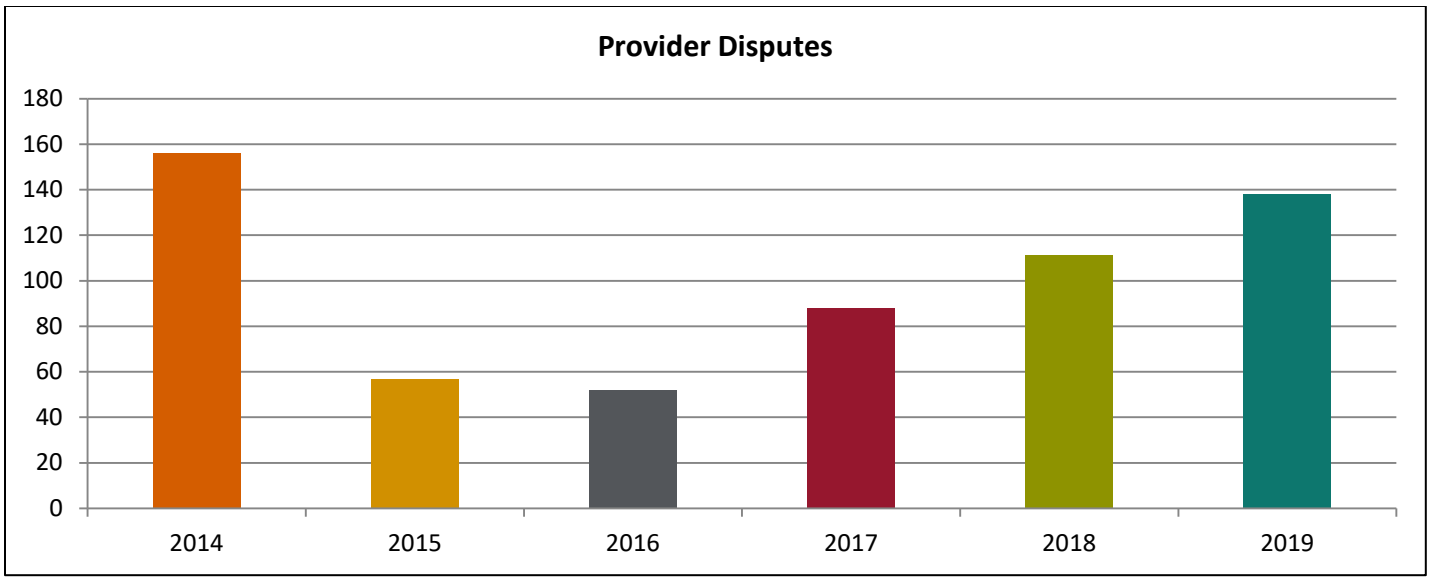


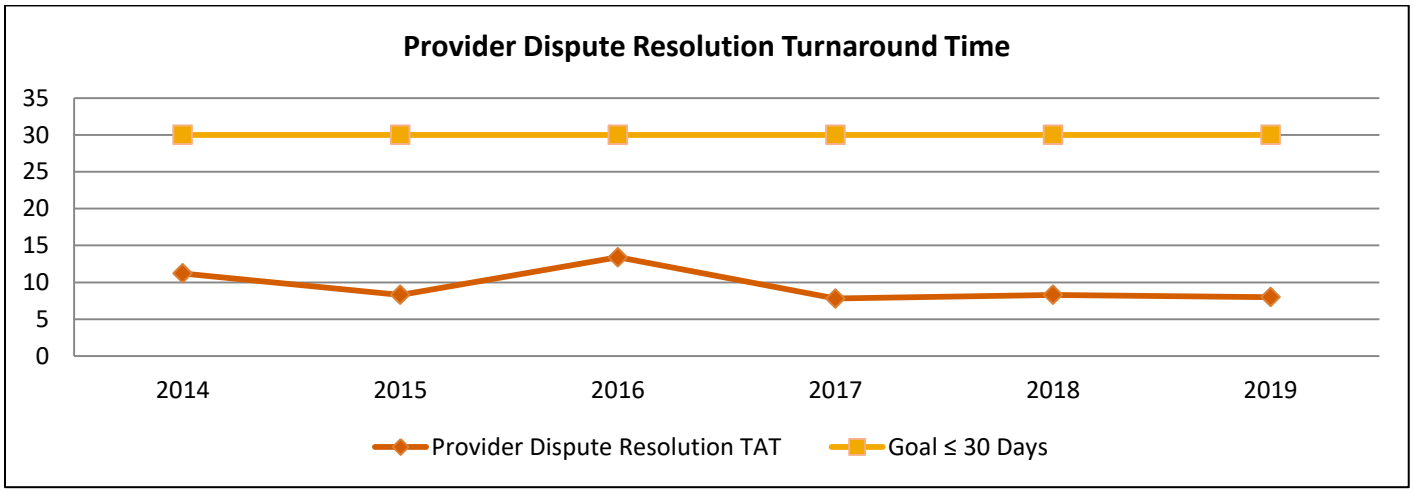
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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 2019, there were 138 provider disputes. All were resolved within the contractual turnaround time of ≤30 days.





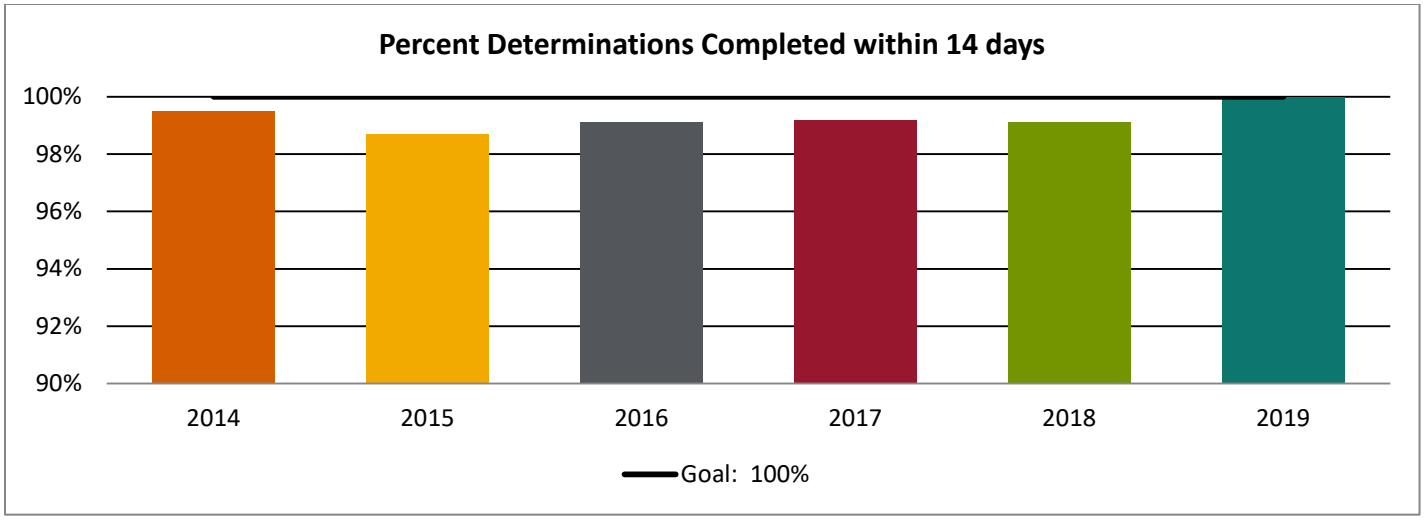
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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 2019, there were 7,435 service authorization requests, a decrease from 8,458 in 2018. The performance goal of 100% of determinations completed within 14 days was met.



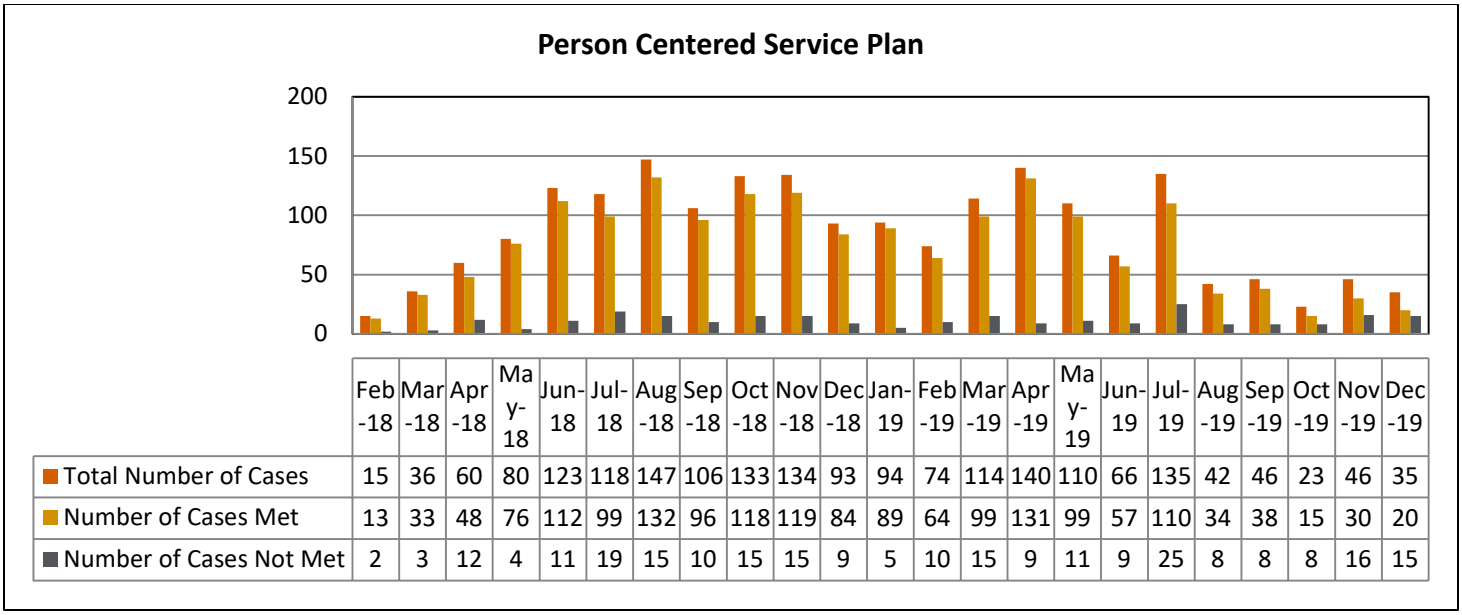
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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: Between implementation of the PCSP program in January, 2018 and December, 2019, Optum Idaho has received 1,970 PCSPs to review. Of those, 1,716 (87.1%) met CFR standards and 254 (12.9%) did not meet CFR standards. All were reviewed within the performance goal of 5 business days, with an average turnaround of 0.16 days.



	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Total Number of Cases	15	36	60	80	123	118	147	106	133	134	93	94	74	114	140	110	66	135	42	46	23	46	35
Number of Cases Met	13	33	48	76	112	99	132	96	118	119	84	89	64	99	131	99	57	110	34	38	15	30	20
Number of Cases Not Met	2	3	12	4	11	19	15	10	15	15	9	5	10	15	9	11	9	25	8	8	8	16	15

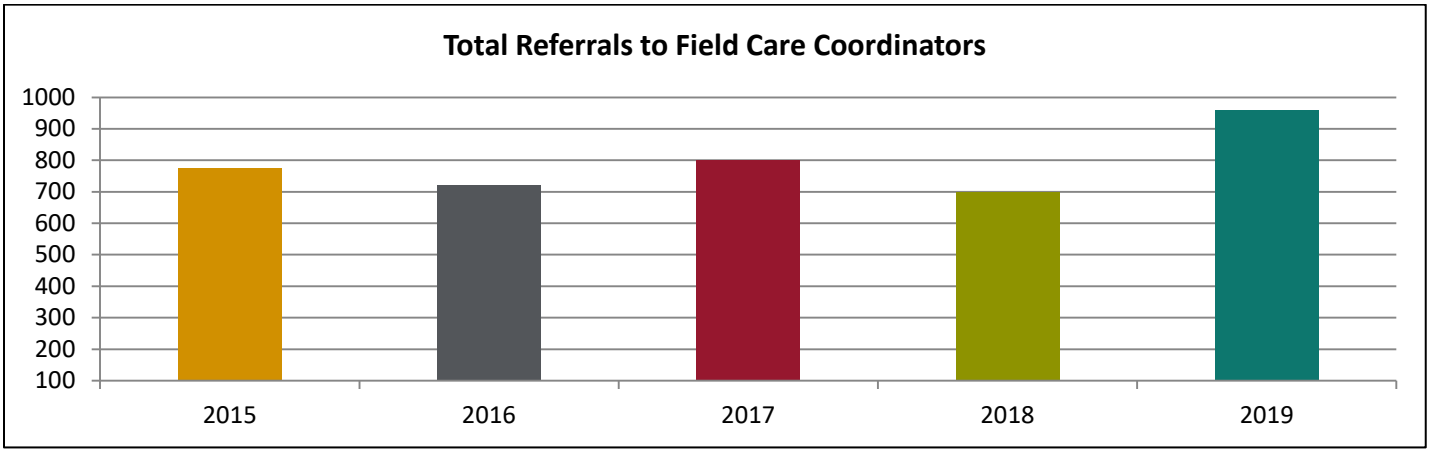
Barriers: No identified barriers.
Opportunities and Interventions: No opportunities for improvement were identified.

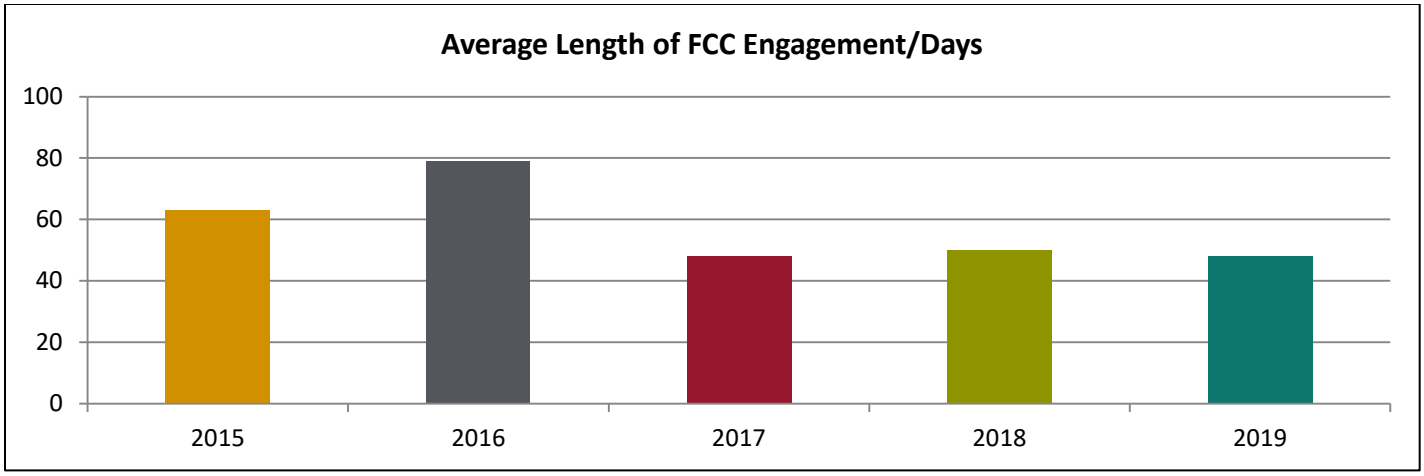
Field Care Coordination

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 2019, Field Care Coordinators received 960 referrals. The number of days that a Field Care Coordinator keeps a case open varies by case. The average length of an FCC case was 48 days.



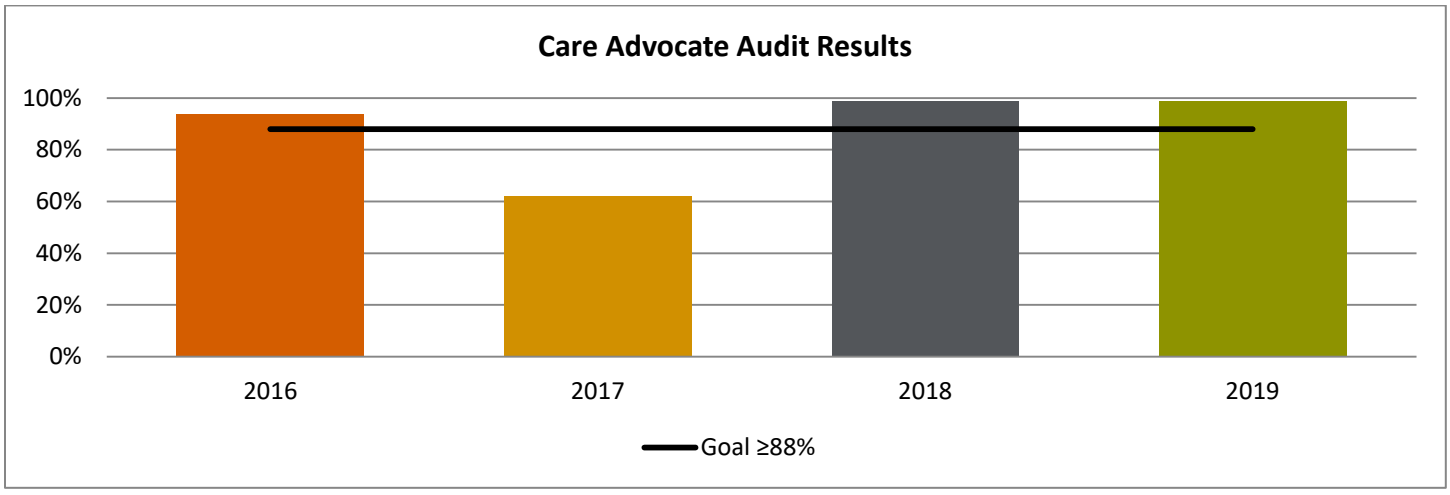


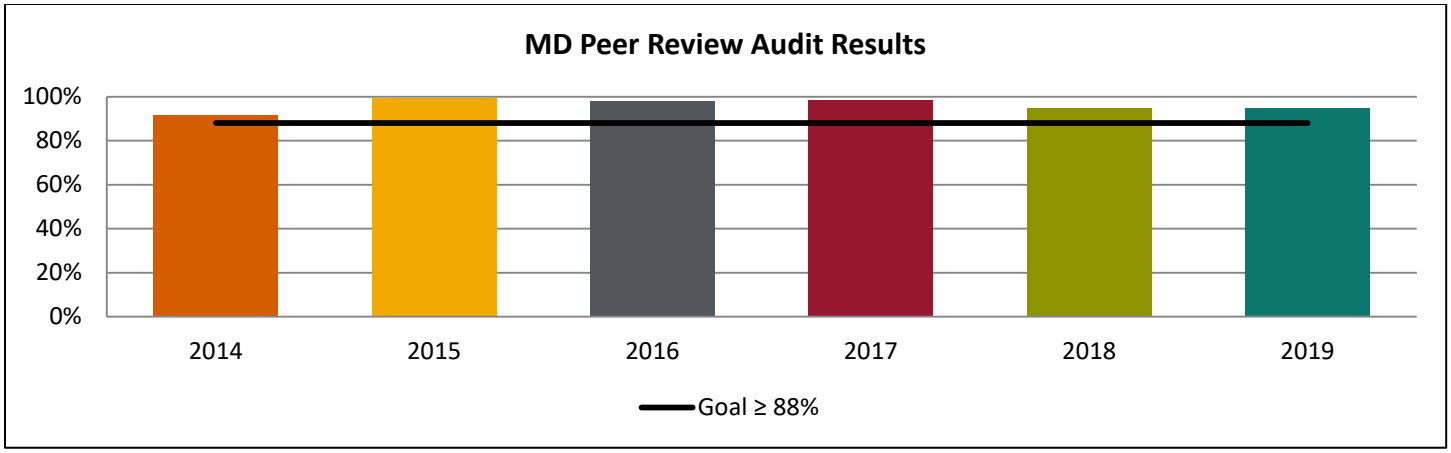
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Inter-Rater Reliability

Optum Idaho evaluates and promotes the consistent application of the Level of Care Guidelines 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 2019, Care Advocate audits Inter-Rater Reliability results were 99%. Peer Reviewer audit results were 95%.

Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Population Analysis

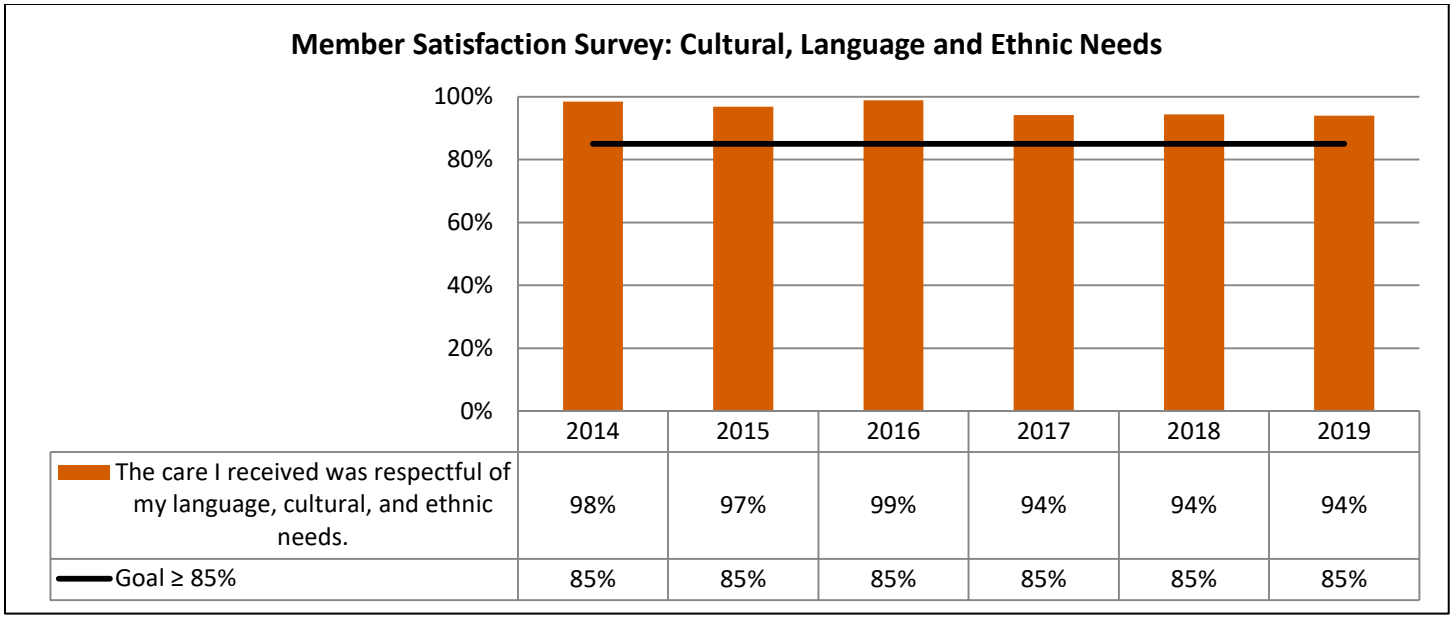
Language and Culture

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 2015* census 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.

2015* Idaho Census Results for Ethnic, Racial and Cultural Distribution of Population							
Total Population (Estimate)	Hispanic or Latino	White	Black	American Indian & Alaska Native	Asian	Native Hawaiian & Other Pacific Islander	Two or more races
1,634,464	**12.2%**	**93.4%**	**0.8%**	**1.7%**	**1.5%**	**0.2%**	**2.3%**

*most current data available

Analysis: Hispanic or Latino counted for 12.2% of the Idaho population. This is the second highest population total, with White consisting of 93.4% (ethnic and racial backgrounds can overlap which explains for the percentage total > 100%). Again during 2019, the Member Satisfaction Survey results consistently showed that members believe the care they received was respectful of their language, cultural, and ethnic needs.



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.

Language Assistance Requests by Type	2019
Member Written Communication	8
Member Written Communication Formatted to Large Print	0
Language Service Associates	8
Languages Represented	1
Do Not Mail List	16

Analysis: During 2019, 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

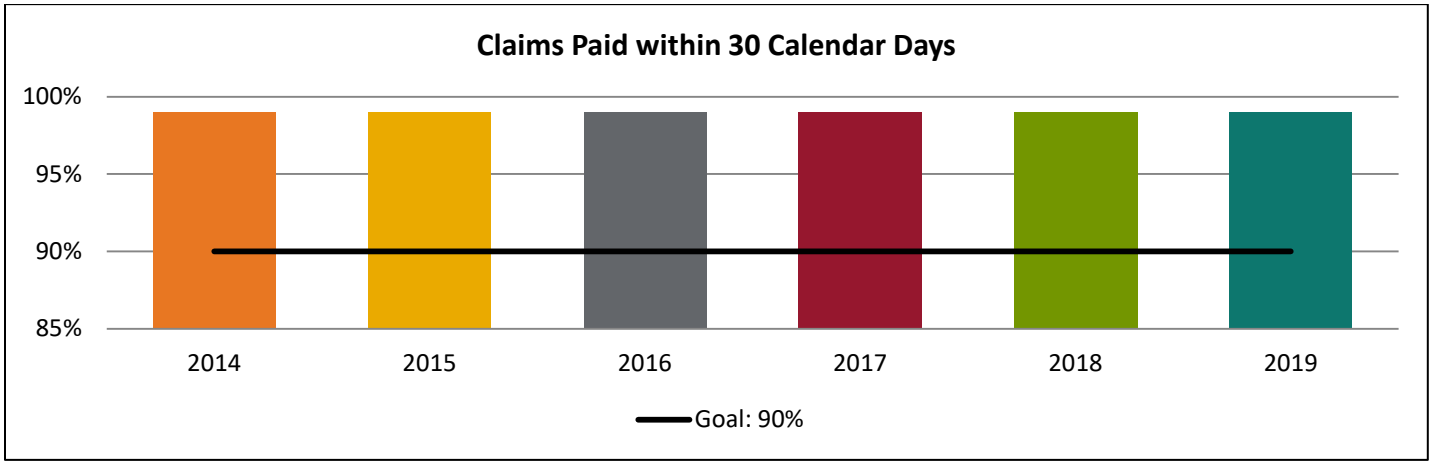
Methodology: The data source for claims is Cosmos via Webtrax. Data extraction is the number of "clean" claims paid within 30 and 90 calendar days. A clean claim excludes adjustments (adjustments are any transaction that modifies (increase/decrease) the original claims payment; the original payment must have dollars applied to the deductible/ copay/ payment to provider or member) and/or resubmissions (a

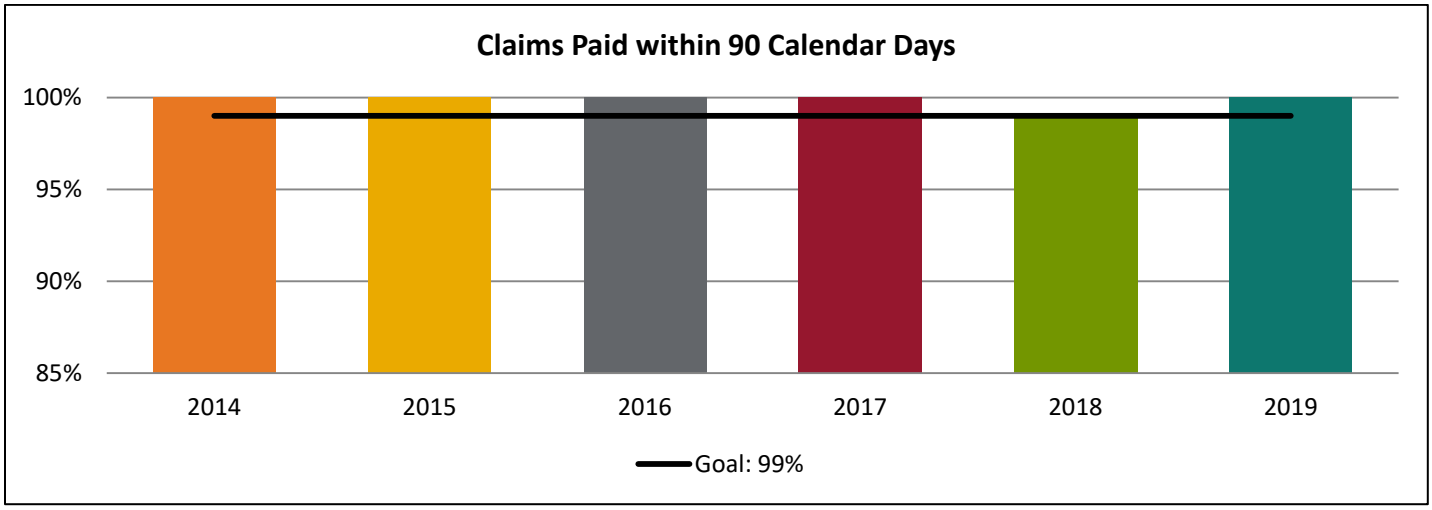
resubmission is a correction to an original claim that was denied by Optum Idaho). A claim will be considered processed when the claim has been completely reviewed and a payment determination has been made; this is measured from the received date to the paid date (check), plus two days for mail time. Company holidays are included.

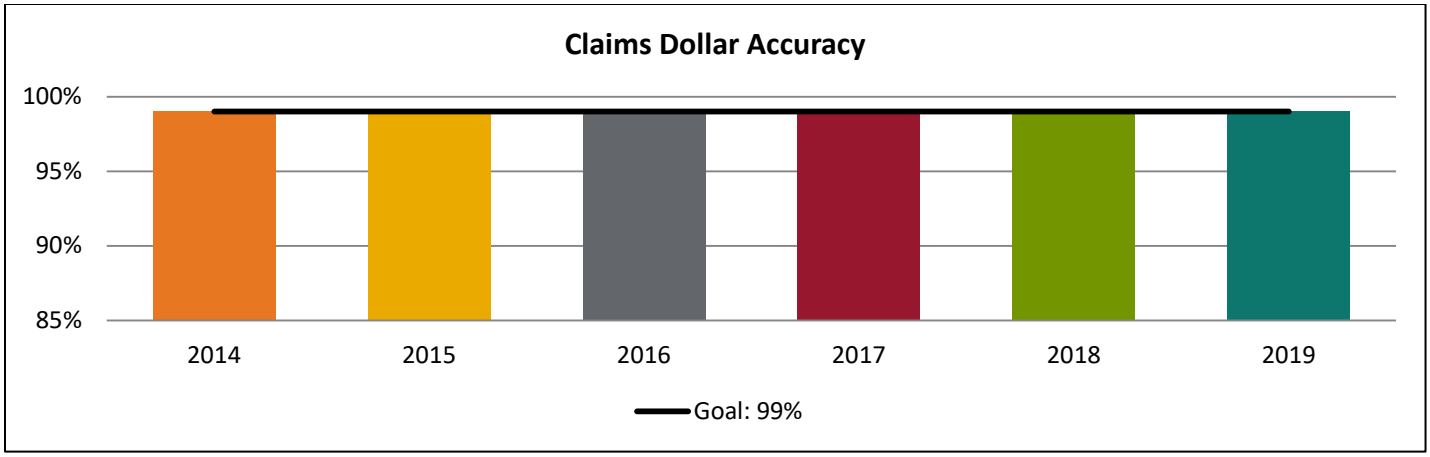
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid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

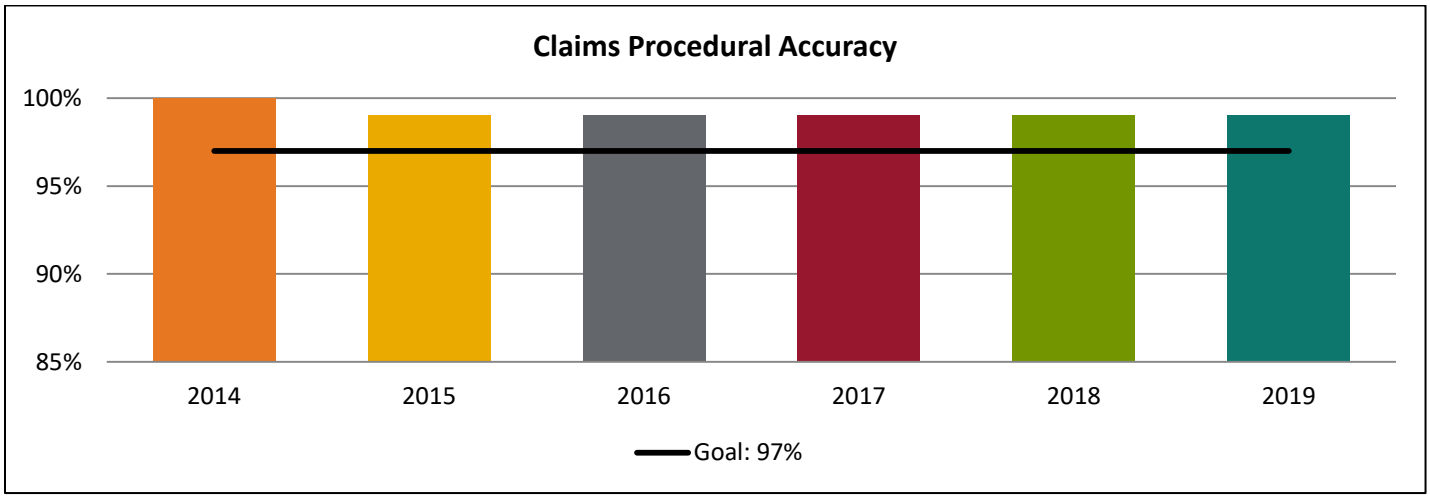
Procedural Accuracy Rate (PAR) is measured by collection of a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial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

Analysis: All performance goals were met again during 2019.









Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.