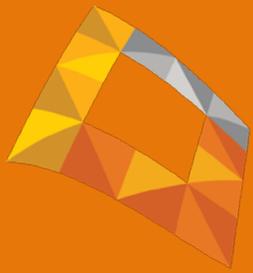# IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT ANNUAL EVALUATION

2018

OPTUM®

The Idaho Behavioral Health Plan (IBHP) Quality Management and Improvement (QMI) 2018 Annual Evaluation summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) for Calendar Year 2018. It provides an overview of outcomes data for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

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Idaho Behavioral Health Plan Quality Management and Improvement
2018 Annual Evaluation. Approved by Quality Assurance Performance Improvement Committee on 7/17/2019.
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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, 2018 through December 31, 2018 and provides comparative performance from 2014 – 2018.

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'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 2018 *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

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's performance, outcomes and improvement activities related to services we provide to IBHP members and contracted providers.

2018 Overall Effectiveness and Highlights

The results of Optum Idaho's efforts in 2018 have proven to be positive in achieving the right care, at the right time for our members. Performance targets are based on contractual, regulatory or operational standards.

Based on the overall average for 2018, Optum Idaho met or exceeded performance for 36 (92%) of the 39 total key measures. One (1) measure fell slightly below the performance goal but was still within 5% of meeting the goal. And, two (2) measures fell below the performance goal. This high level of operational effectiveness further validates Optum's commitment to IBHP members and families in transforming the behavioral health care system in the State of Idaho.

During 2018, Optum Idaho continued to strive to improve the health of IBHP members through better quality of care and increased access to evidence-based services. In addition to the 39 total performance measures, Optum Idaho provided these opportunities to further increase member access to care:

- Optum continued to be highly engaged across Idaho in statewide strategic planning for community engagement activities. The strategic framework ensures that Optum can provide education about access to behavioral health services for members and providers, understanding of new programs, provider engagement opportunities and continued strengthening of collaborative relationships with stakeholders that enhance behavioral health for Idahoans. In the first quarter of 2018, Optum staff participated in 73 statewide and regional events and media interviews that reached close to 75,000 people.
- Outreach efforts included hosting five Provider Meet and Greet events designed to deliver valuable information to providers and allow meaningful interaction with Optum regional staff. Four of those events included training on Integrated Behavioral Health which provided one Continuing Education Credit. Providers appreciated this model and requested more education to be held during meet and greets.
- Optum continued to attend Regional Behavioral Health Board meetings as well as participate in various committee and subcommittee meetings. Dr. Ronald Larsen, Optum Idaho Medical Director, presented information about the Intensive Outpatient Program (IOP) to the Behavioral Health Boards in Regions 2 and 3. He also met with healthcare leaders in Region 2 to explore IOP models for frontier regions of Idaho.
- As part of the Youth Empowerment Services (YES) System of Care, Respite became a Medicaid-reimbursed service for children and adolescents who meet functional, diagnostic, and Medicaid eligibility requirements. Critical to the successful implementation of all YES services, Optum has an increased focus on Education and Training development. All Respite workers will be required to complete training to be in-network Respite providers with Optum.
- There was continued interest in the screening of the documentaries, *Resilience* and *Paper Tigers*. Optum Idaho purchased the rights to screen these movies which deal with the effects of Adverse Childhood Experiences (ACEs) on physical health and learning in schools. Since January 1, 2018, more than 500 people viewed these films. Screenings happened at a variety of meetings including, statewide conferences such as Head Start and NAMI as well as local meetings including Panhandle Health and Meridian Middle School. Optum continued to work with stakeholders who are interested in

these films with the goal of advancing conversations about ACEs and connecting stakeholders with resources to help them develop action plans to address these issues.

- As part of continued efforts to build community programs and strengthen media outreach activities Optum Idaho engaged providers, stakeholders and Idahoans through statewide and regional events, media engagement and the implementation of our first Unified Regional Campaign to highlight Mental Health Awareness Month.
- Optum sponsored a wide variety of stakeholder and professional events and conferences during Q2 including:
  - The State Department of Education Prevention and Support Conference – Optum provided the keynote speaker and also hosted a screening of the documentary Resilience which deals with the effects of ACE on health and wellbeing.
  - The Idaho Association of Family Physicians – Optum hosted a screening of Resilience and began conversations with doctors about incorporating the ACE questionnaire into their regular office visit procedures in an effort to identify issues and develop early intervention plans to create better health outcomes.
  - The Idaho Healthcare Summit – Optum's Chief Medical Officer for Population Health, Dr. Ana Fuentevilla delivered a presentation about *Big Data and Population Health* and also participated in a panel discussion about the pros and cons of using Big Data in healthcare.
- Efforts also included the placement of byline articles by local Optum behavioral health experts and a partnership with the Idaho Department of Health and Welfare to create TV and radio Public Service Announcements, in both English and Spanish raising awareness about mental health issues and providing resources for people. Newspapers in Idaho Falls, Coeur d' Alene and Twin Falls published bylines by Dr. Ron Larsen that focused on reducing stigma among baby boomers regarding mental health. Public Service Announcements promoting mental health awareness ran on seven TV stations across the state, resulting in more than 77,000 impressions. Additional statewide community outreach activities included provider trainings, informational media coverage and organized events.
- During Quarter 3, 2018, Optum Idaho's Community Programs and Media Activities reached thousands of people throughout the state. Optum team members across the state participated in 75 meetings, events and media coverage that reached more than 220,000 people.
- In August and September, Optum Idaho partnered with stakeholders to create IROAR the Idaho Recovery Open Awareness Ride (Powered by Optum.) IROAR served as a fundraiser, celebrated National Recovery Month and shared the message that recovery is possible for everyone, while removing the stigma associated with substance use disorders and mental health issues. The 1,400 mile motorcycle ride stopped at every recovery center in Idaho. The centers hosted a variety of activities including: pancake breakfasts, picnics, concerts and parties to celebrate IROAR. Optum Idaho staff members were at each event and presented the recovery centers a check for $15,000 to support their work. Some staff members even road along for portions of the trip. A ten foot by four foot banner was created to be carried on the trip. Hundreds of people signed the banner with words of encouragement and added their names to those who are in recovery or supporting a friend or family member. The banner was presented on the steps of the state capitol building and will be shared across all recovery centers throughout the year so they can display it at their offices.
  - The results of the first IROAR included:
    - A total of 68 riders
    - Recovery centers raised more than $12,000 from donations at the events
    - Optum Idaho donated $15,000 to each recovery center in Idaho
    - The ride generated news stories across Idaho
- The Optum Idaho team pitched local media interviews in areas where riders would be traveling through parts of the state during the celebration. As a result, KIFI , KIDK , KIVI and EastIdahoNews.com covered the event as it made its way through their specific area of the state.

- Dr. Ronald Larsen conducted TV interviews about the increase in Senior Suicides in Idaho and around the nation. Dr. Larsen was invited to talk to reporters about this serious issue on Boise State Public Radio - Idaho Matters and KBOI.
- Optum sponsored and participated in a wide variety of stakeholder and professional events and conferences during Quarter 3 including:
  - Nampa Kindness Day - 1,300 Optum branded bags stuffed with Optum information were distributed.
  - The Region 4 Community Resource Fair - for people transitioning out of incarceration. More than 500 people attended.
  - NAMI Treasure Valley Walk – Optum sponsored this event that was attended by 300 people.
- The last quarter of 2018 concluded a powerful year of growth for community programs. From October to the end of December, Optum Idaho team members participated in 46 meetings, events and activities that reached more than 125,000 people. These events connected Optum Idaho with a wide variety of people including providers, stakeholders and members.
- Optum's Education and Training division delivered regional in-person meet and greet trainings for Providers. As part of the Youth Empowerment Services (YES) program the trainings offered were Navigation Part II and Motivational Interviewing. One hundred and eighty nine providers attended the meetings and received CEU credit. Critical to the successful implementation of all YES services, Optum will continue to focus on Education and Training development to offer additional trainings in the coming year.
- Optum transformed its annual In Touch Community Conversations into a statewide television broadcast designed to raise awareness about opioid use disorder plaguing our state and country. In December, Optum partnered with KIVI in Boise, the ABC affiliate, to develop a two-part Opioid project. Part one was a two and a half hour Facebook Live, Town Hall meeting. Material from that event was combined with reporter's stories and other content to produce an hour long TV special called Finding Hope which aired statewide on Sunday, December 9. Viewership for the special is estimated at 51,000 people statewide.
- During the final three months of 2018, Optum was engaged in giving back to the community. In October, Optum focused on recognizing National Domestic Violence Awareness month and made a $1,500 donation to eight domestic violence organizations across the state. In December, Optum donated $10,000 and a half ton of food to 7Cares Idaho Shares. This is the fourth year Optum has participated in this event that supports local charities in the Treasure Valley. Working with the Idaho Food Bank and other stakeholders across the state, Optum distributed 6,000 flyers with information and tips on handling holiday stress. The material was included in food boxes, shared at library information desks and with partner organizations throughout Idaho.

Optum Idaho is 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 will continue 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 - 2018. Those highlighted in green met or exceeded overall performance. 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	Comments
Member Satisfaction Survey Results (2014 - 2016)							
Experience with Optum Idaho Staff and Referral Process	≥85%	84%	85%	92%	NA	NA	New Survey Implemented, results below
Experience with the Behavioral Health Provider Network	≥85%	91%	91%	94%	NA	NA	New Survey Implemented, results below
Experience with Counseling or Treatment	≥85%	93%	94%	95%	NA	NA	New Survey Implemented, results below
Overall Experience	≥85%	90%	92%	94%	NA	NA	New Survey Implemented, results below
Member Satisfaction Survey Results (new survey 2017 - 2018)							
Optum Support for Obtaining Referrals or Authorizations	≥85%				80%	92%	
Counseling and Treatment	≥85%				95%	95%	
Accessibility, Availability, and Acceptability of the Clinician Network	≥85%				89%	93%	
Overall Satisfaction	≥85%				80%	92%	
Provider Satisfaction Survey Results							
Overall Provider Satisfaction	≥85%	69%	65%	75%	77%	78%	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	
Member Services Call Standards							
Total Number of Calls	NA	6,483	4,838	5,153	5,292	4,658	
Percent Answered within 30 seconds	≥80%	91%	91%	88%	84%	71%	
Average Speed of Answer (seconds)	≤30 Seconds	13	13	15	10	18	
Abandonment Rate	≤3.5% internal ≤7% contractual	1.5%	1.9%	2.2%	2.3%	3.1%	
Customer Service (Provider Calls) Standards							
Total Number of Calls	NA	16,323	14,205	12,220	13,016	12,036	
Percent Answered within 30 seconds	≥80%	84%	97%	97%	98%	98%	
Average Speed of Answer (seconds)	≤30 Seconds	NA*	6	1	3	3.4	*began tracking in 2015
Abandonment Rate	≤3.5% internal ≤7% contractual	2.9%	0.6%	0.3%	0.4%	0.2%	

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Measure	Goal	2014	2015	2016	2017	2018	Comments
Urgent and Non-Urgent Access Standards							
Urgent Appointment Wait Time (hours)	48 hours	18.5	22.8	24.2	23.1	22.4	
Non-Urgent Appointment Wait Time (days)	10 days	3.8	4.7	6	6	4.8	
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%	*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%	*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							
Number of Adverse Benefit Determinations	NA	2,266	2,038	2,139	2,164	1,325	
Clinical ABD's	NA	NA	NA	NA	930	773	began tracking Q3, 2017
Administrative ABD's	NA	NA	NA	NA	318	552	began tracking Q3, 2017
Written Notification	14 calendar days from request for services	NA	NA	NA	99.9%*	99.6%*	14 business days from request for services - implemented 7/1/17 *performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)
Written Notification Sent within 1 Business Day	100.0%	77.3%	98.4%	97.0%	NA	NA	New 14-day requirement tracked above
Member Appeals (formerly grievances)							
Number of Appeals	NA	278	92	73	113	53	
Member Appeals Turnaround time	≤30 days	10	12	16	NA	NA	now reporting Non-Urgent/Urgent separately
Non-Urgent Appeal Resolution Turnaround Time	≤30 days				9	8	
Urgent Appeal Resolution Turnaround Time	72 hours				25	53	
Complaint Resolution and Tracking							
Total Number of Complaints	NA	569	133	61	63	67	
Percent of Complaints Acknowleged within Turnaround time	100% within 5 days	100.0%	100.0%	100.0%	100.0%	100.0%	
Number of Quality of Service Complaints	NA	560	122	55	56	54	
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	100.0%	99.3%	100.0%	96.4%	100.0%	
Number of Quality of Care Complaints	NA	9	11	6	7	13	
Percent Quality of Care Resolved within Turnaround time	100% within ≤30 days	100.0%	100.0%	100.0%	100.0%	100.0%	

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Measure	Goal	2014	2015	2016	2017	2018	Comments
Critical Incidents							
Number of Critical Incidents Received	NA	**60**	**66**	67	61	49	
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%**	
Response to Written Inquiries							
Percent Acknowledged ≤2 business days	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Provider Monitoring and Relations							
Provider Quality Monitoring							
Number of Audits	NA	**210**	**287**	**368**	**519**	**717**	
Initial Audit (Percent overall score)	≥ 85.0%	**92.0%**	**97.0%**	**96.0%**	**94.0%**	**93.2%**	
Recredentialing Audit (Percent overall score)	≥ 85.0%	**96.0%**	**97.0%**	**94.0%**	**92.0%**	**92.7%**	
Monitoring (Percent overall score)	≥ 85.0%	**89.4%**	**90.1%**	**76.0%***	**94.4%**	**88.4%**	*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%**	
Percent of Audits w/passing score of 85% or higher	NA	**81%**	**83%**	**91%**	**89%**	**74%**	
Percent of Audits that Required a Corrective Action Plan	NA	**19%**	**18%**	**10%**	**11%**	**26%**	
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%**	
Percent documentation in member record that communication/ collaboration occurred betweem behavioral health provider and primary care provider	NA	**83%**	**80%**	**85%**	**78%**	**74%**	
Provider Disputes							
Number of Provider Disputes	NA	**156**	**57**	**52**	**88**	**111**	
Average Number of Days to Resolve Provider Disputes	≤30 days	**11.2**	**8.3**	**13.4**	**7.8**	**8.3**	
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%**	
Field Care Coordination							
Total Referrals to FCCs	NA	**NA***	**774**	**722**	**800**	**699**	*began tracking in 2015
Average Number of Days Case Open to FCC	NA	**NA***	**63.2**	**79.0**	**48.0**	**50.0**	*began tracking in 2015

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

Outcomes Analysis

There are multiple outcomes that Optum 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

Individual Therapy Utilizers by Year by Age
Per Thousand Members

	2014	2015	2016	2017	2018
Total (All Ages)	93.8	93.8	95.3	95.7	98.3
Ages 0 to 17	85.8	83.9	83.0	83.9	88.2
Ages 18 to 20	72.5	70.5	75.2	78.9	84.2
Ages 21+	116.6	123.5	131.2	127.8	125.9
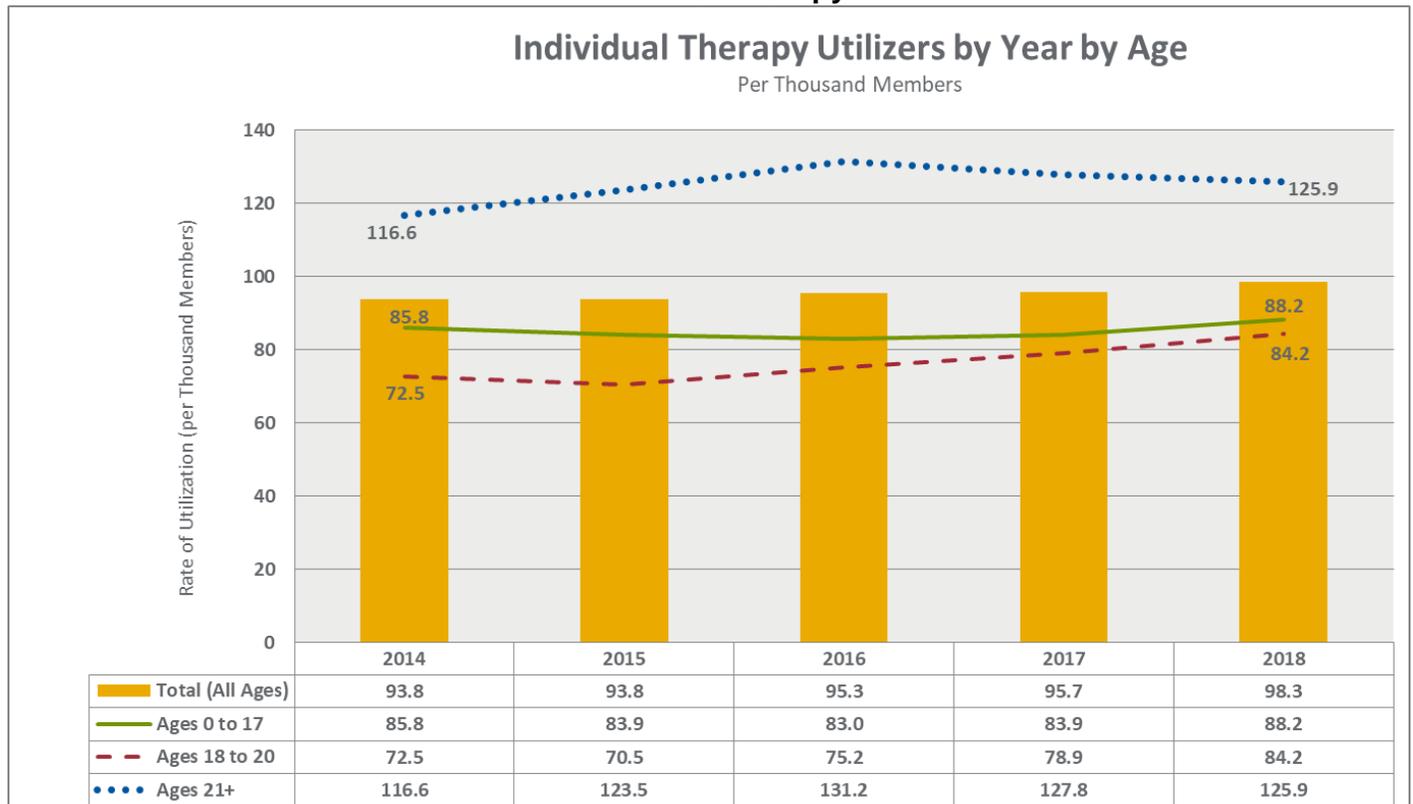
Figure 1

Family Therapy

Family Therapy Utilizers by Year by Age
Per Thousand Members

	2014	2015	2016	2017	2018
Total (All Ages)	38.5	46.9	48.2	47.8	48.3
Ages 0 to 17	49.9	59.2	59.1	59.6	61.4
Ages 18 to 20	15.8	20.8	22.3	22.8	23.8
Ages 21+	16.7	22.5	26.6	24.9	22.3

Figure 2

Peer Support

Peer Support Utilizers by Year by Age
Per Thousand Members

	2014	2015	2016	2017	2018
Total (All Ages)	1.3	2.4	6.6	10.0	12.3
Ages 18 to 20	0.9	1.4	5.4	8.4	10.2
Ages 21+	4.3	8.6	23.2	34.0	41.7
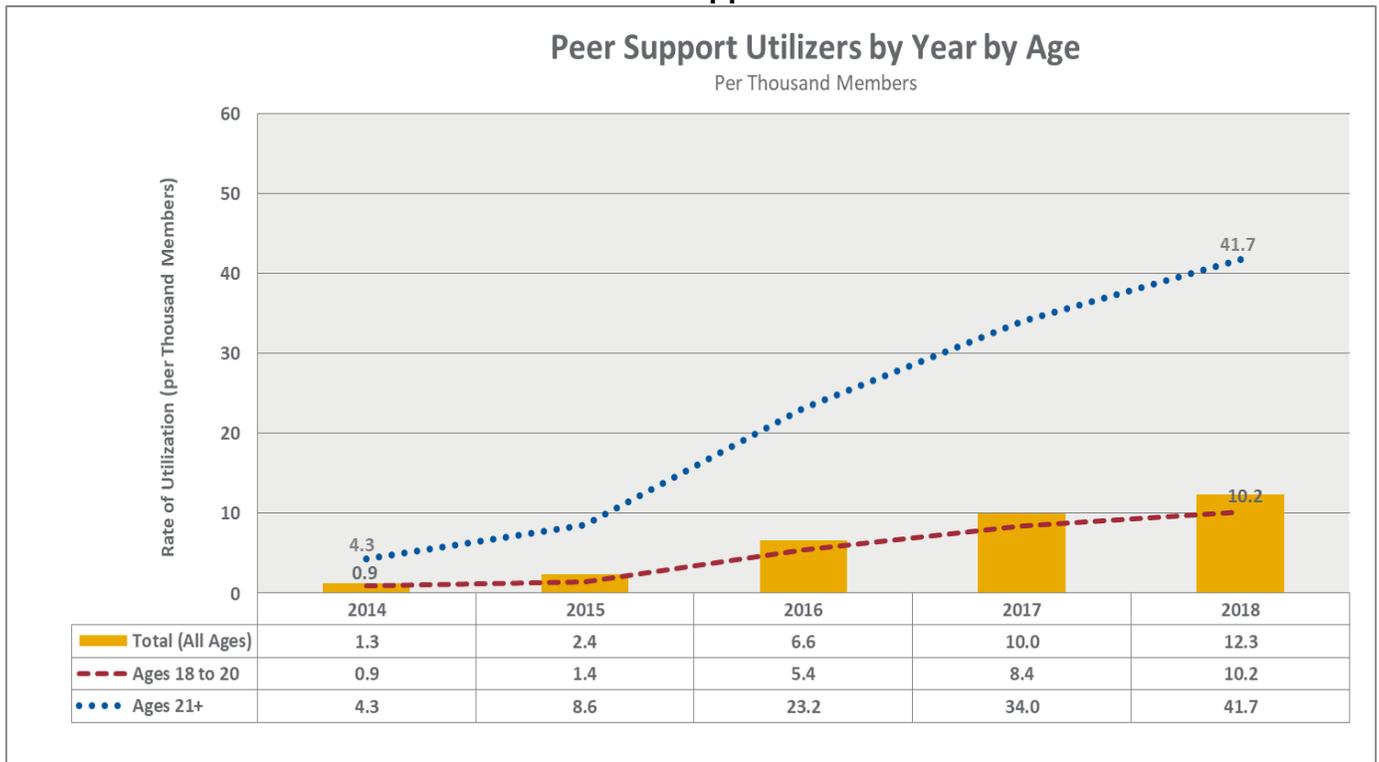
Figure 3

Case Management

Case Management Year by Year by Age

	2014	2015	2016	2017	2018
Total (All Ages)	27.2	29.6	33.1	31.2	29.4
Ages 0 to 17	13.9	15.4	16.8	15.2	14.1
Ages 18 to 20	20.3	24.0	25.8	25.1	25.7
Ages 21+	59.3	65.8	76.0	71.2	67.1
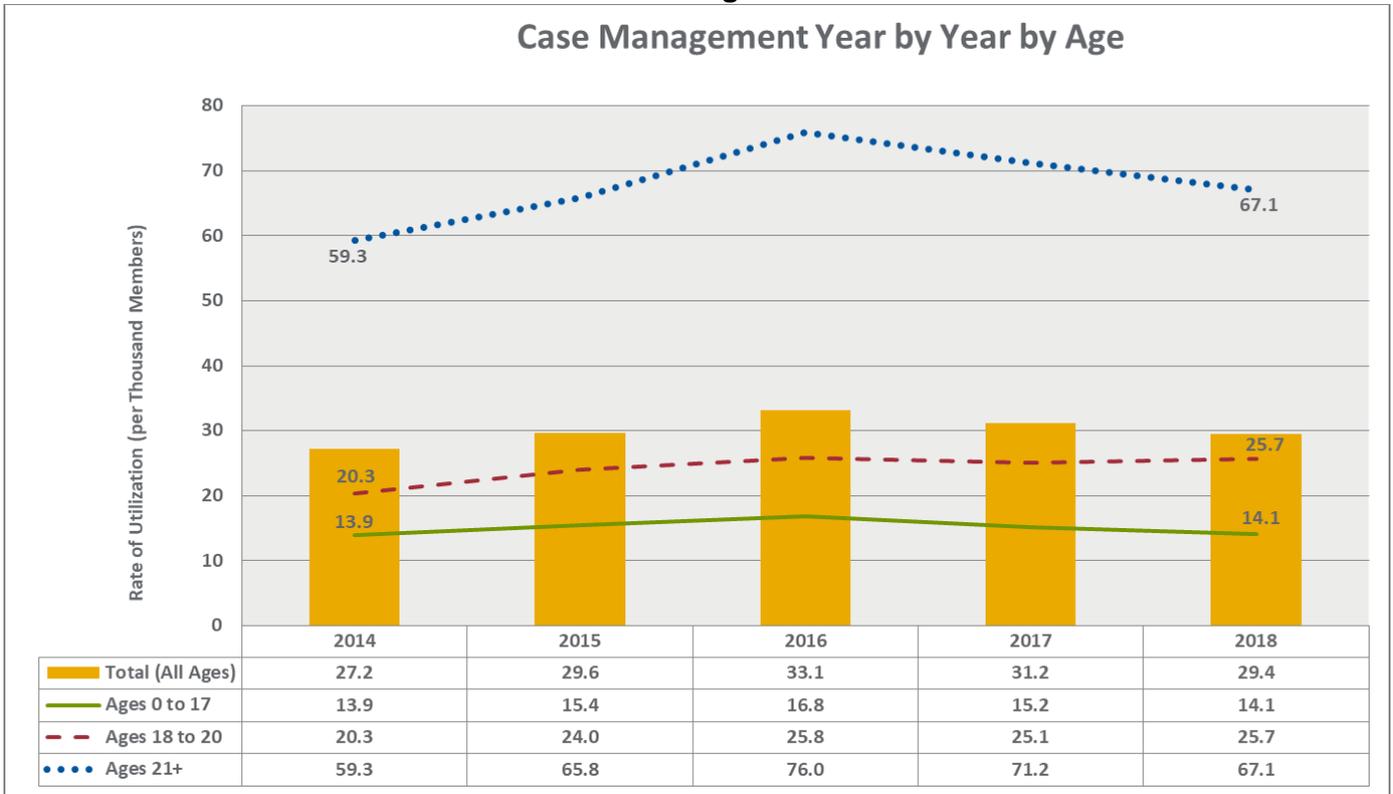
Figure 4

Prescriber Visits

Behavioral Health Prescriber Utilizers by Year by Age
Per Thousand Members

	2014	2015	2016	2017	2018
Total (All Ages)	41.8	39.6	37.0	36.5	36.5
Ages 0 to 17	25.9	23.9	22.0	21.6	21.5
Ages 18 to 20	37.2	36.5	34.0	35.8	38.8
Ages 21+	79.6	78.8	75.3	72.6	72.0
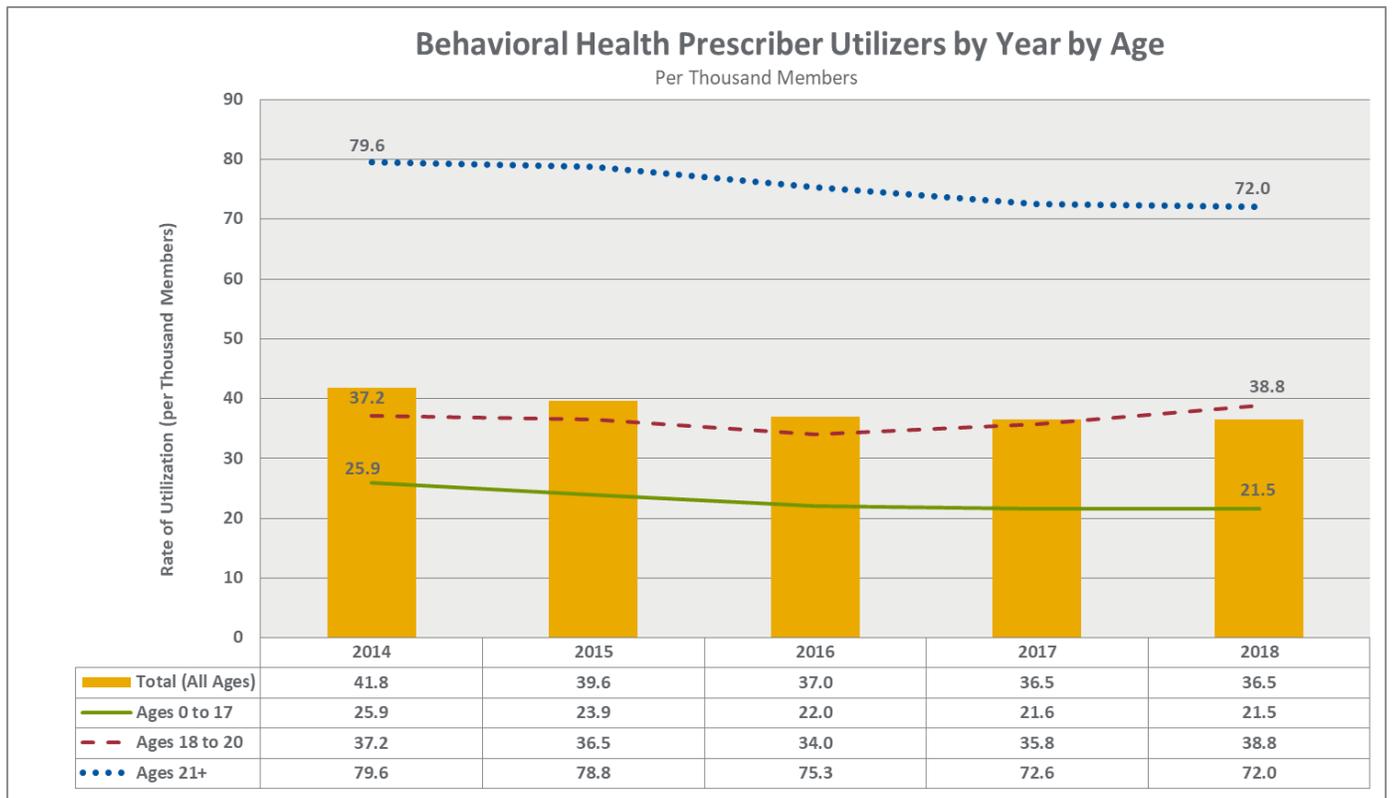
Figure 5

Skills Building/Community Based Rehabilitation Services (CBRS)

Skills Building/CBRS Utilizers by Year by Age
Per Thousand Members

	2014	2015	2016	2017	2018
Total (All Ages)	46.8	30.2	17.9	10.0	8.1
Ages 0 to 17	37.6	18.4	7.6	3.5	3.6
Ages 18 to 20	29.7	22.9	13.8	6.5	5.9
Ages 21+	71.6	60.9	44.9	26.6	19.4
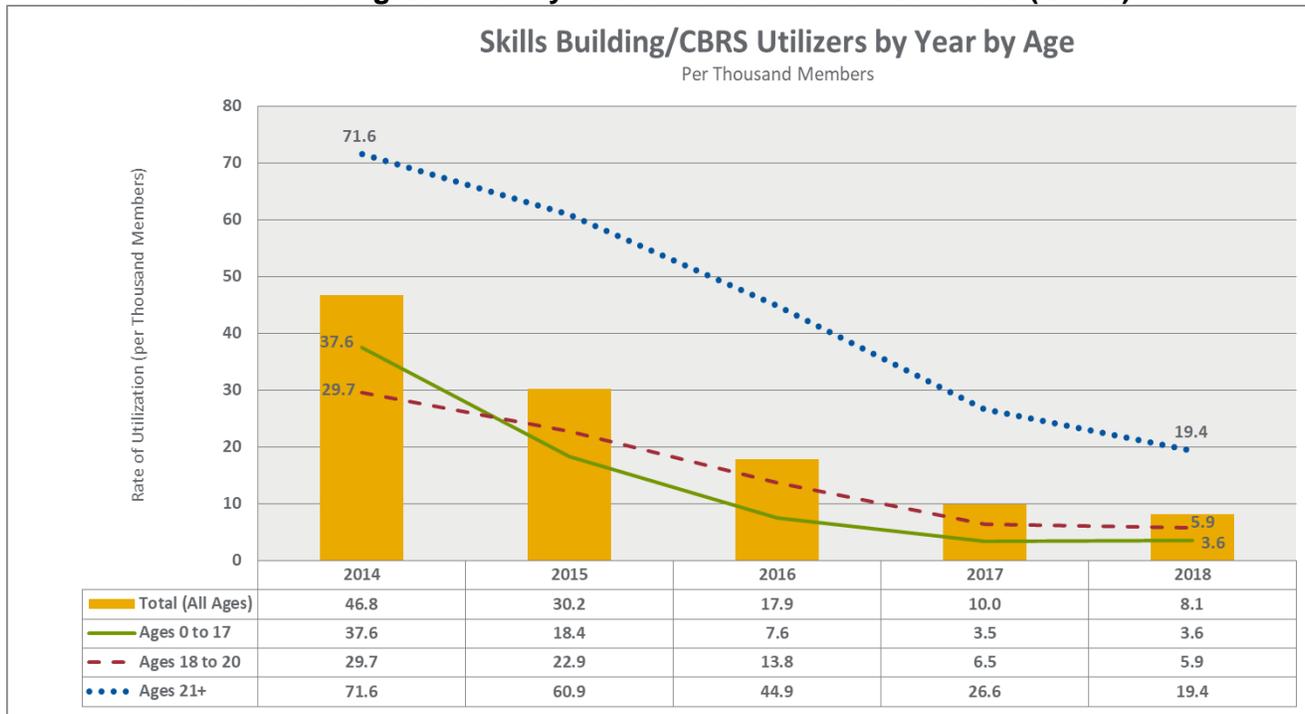
Figure 6

Analysis: Utilization rates fell within Optum Idaho expectations for 2018. Peer Support rates continued to rise as the Skills Building/CBRS utilization rates decreased. Starting in Q3 2018, CBRS was transformed from CBRS to Skills Building/CBRS for both adults and youth. This enhanced service focuses on competency in social, communication, and behavioral skills, and allows providers to deliver a structured process for addressing members' functional deficits in a timelier manner.

Barriers: No identified barriers**.** Skills Building/CBRS is authorized according to medical necessity; utilizing evidence based nationally recognized treatment(s) for the member's documented condition.

Opportunities and Interventions: No opportunities for improvement were identified.

Services Received Post CBRS Adverse Benefit Determination
Methodology: Based on Adverse Benefit Determination and Claims data, the graph below identifies members that received evidence based service(s) after receiving an Adverse Benefit Determination (ABD) letter.

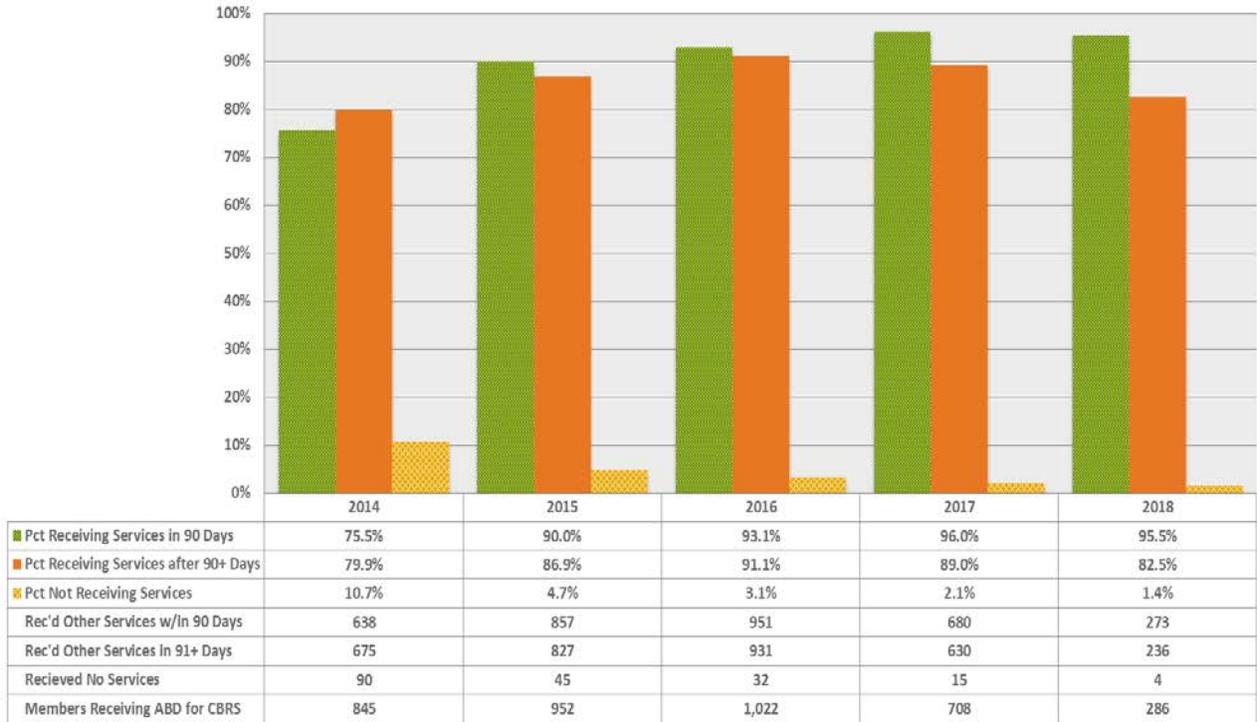**Services Received after a Denial for Skills Building/CBRS**

	2014	2015	2016	2017	2018
■ Pct Receiving Services in 90 Days	75.5%	90.0%	93.1%	96.0%	95.5%
■ Pct Receiving Services after 90+ Days	79.9%	86.9%	91.1%	89.0%	82.5%
■ Pct Not Receiving Services	10.7%	4.7%	3.1%	2.1%	1.4%
Rec'd Other Services w/in 90 Days	638	857	951	680	273
Rec'd Other Services in 91+ Days	675	827	931	630	236
Recieved No Services	90	45	32	15	4
Members Receiving ABD for CBRS	845	952	1,022	708	286

Figure 7

Analysis: 96% 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 1,000 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.
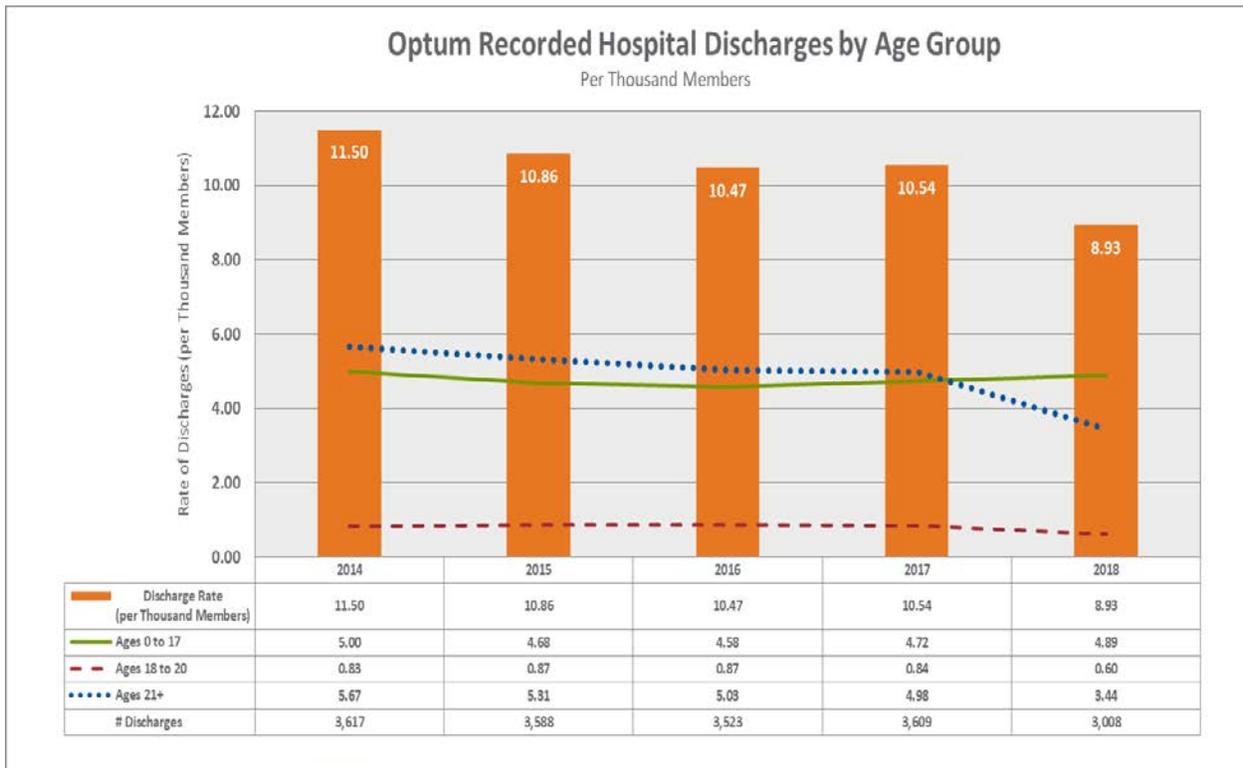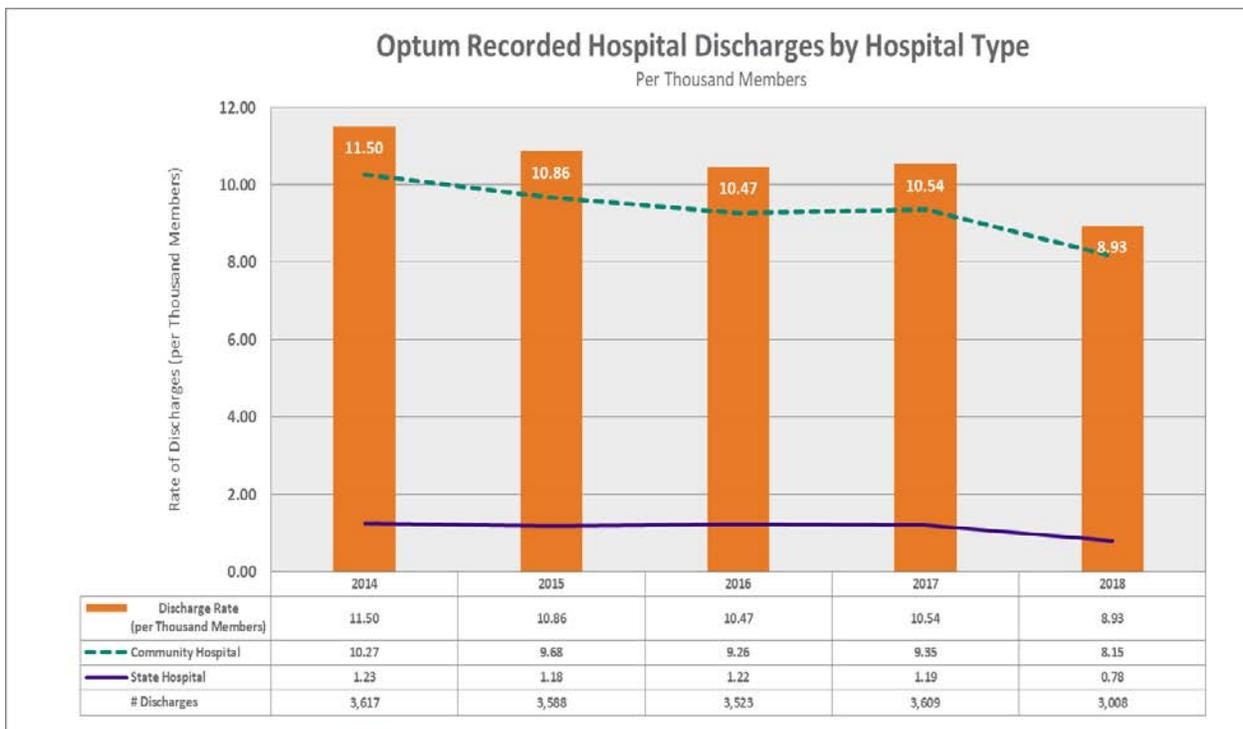
Optum Recorded Hospital Discharges by Age Group
Per Thousand Members

	2014	2015	2016	2017	2018
Discharge Rate (per Thousand Members)	11.50	10.86	10.47	10.54	8.93
Ages 0 to 17	5.00	4.68	4.58	4.72	4.89
Ages 18 to 20	0.83	0.87	0.87	0.84	0.60
Ages 21+	5.67	5.31	5.03	4.98	3.44
# Discharges	3,617	3,588	3,523	3,609	3,008

Figure 8

Optum Recorded Hospital Discharges by Hospital Type
Per Thousand Members

	2014	2015	2016	2017	2018
Discharge Rate (per Thousand Members)	11.50	10.86	10.47	10.54	8.93
Community Hospital	10.27	9.68	9.26	9.35	8.15
State Hospital	1.23	1.18	1.22	1.19	0.78
# Discharges	3,617	3,588	3,523	3,609	3,008

Figure 9

Figures 8 and 9 show the overall rate of discharges decreased year-over-year from 10.54 to 8.93 per 1,000 members, which represents a 15.3% decrease in hospitalizations.
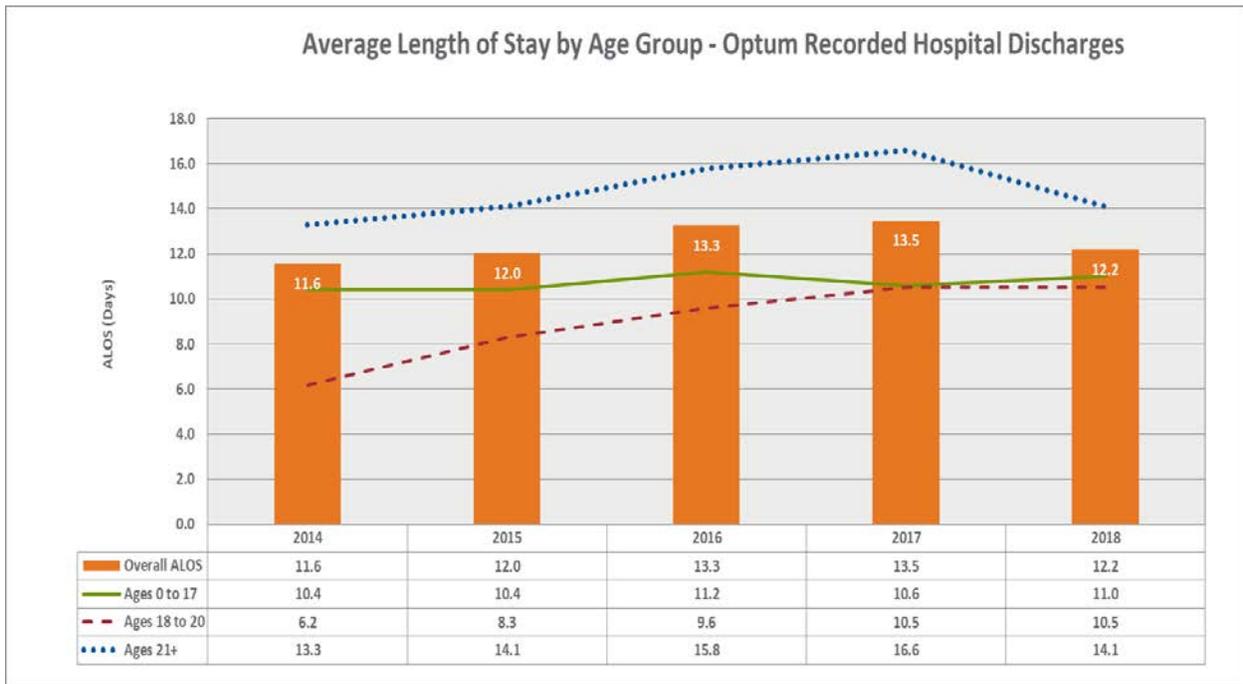
Average Length of Stay by Age Group - Optum Recorded Hospital Discharges

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

Figure 10

Figure 10 indicates the overall average length of stay decreased 9.6% from 2017 to 2018.

Average Length of Stay by Hospital Type Optum Recorded Hospital Discharges

	2014	2015	2016	2017	2018
Overall ALOS	11.6	12.0	13.3	13.5	12.2
Community Hospital	7.6	8.0	8.5	8.5	9.1
State Hospital	44.2	44.9	49.2	52.3	44.4
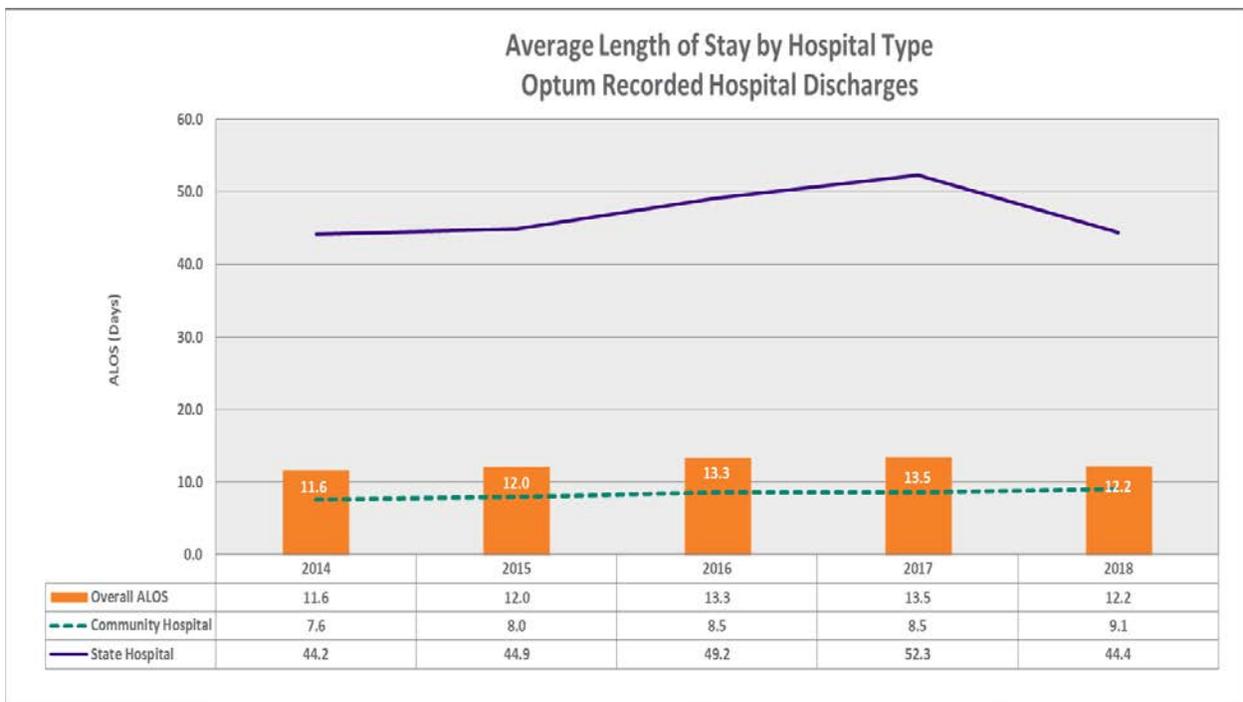
Figure 11

Figure 11 shows the average length of stay by hospital type. State hospitals experienced a marked decline in 2018, with the average length of stay decreasing 15.1%. Community hospital rates have steadily increased through the study period.

Hospital Discharges by Age Group with a Subsequent Admission Within 30 Days

Cases Readmitted within 30 days of Discharge (excludes Transfers and Ages 0 to 6) - Optum Recorded Admissions

	2014	2015	2016	2017	2018
% of Total	10.97%	11.47%	10.25%	10.11%	7.08%
Ages 7 to 17	4.12%	4.00%	3.42%	3.81%	3.34%
Ages 18 to 20	1.06%	0.76%	1.11%	1.00%	0.37%
Ages 21+	5.79%	6.72%	5.72%	5.31%	3.37%
# Discharges	3,593	3,574	3,513	3,600	2,996
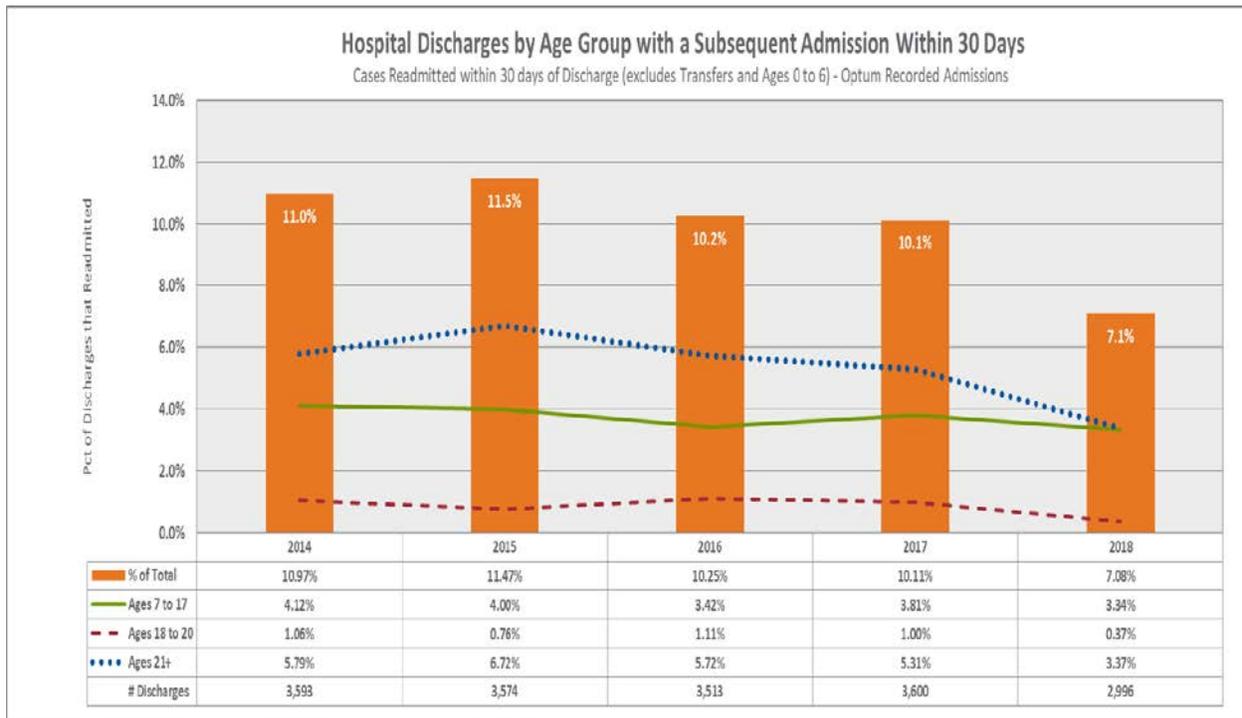
Figure 12

Figure 12 shows the readmission percentages by age group. The total readmissions significantly decreased by 30% in 2018. According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals.

Hospital Discharges by Hospital Type with a Subsequent Admission Within 30 Days

Cases Readmitted within 30 days of Discharge (excludes Transfers and Ages 0 to 6) - Optum Recorded Admissions

	2014	2015	2016	2017	2018
% of Total	10.97%	11.47%	10.25%	10.11%	7.08%
Community Hospital	9.91%	10.24%	9.00%	9.25%	6.61%
State Hospital	1.06%	1.23%	1.25%	0.86%	0.47%
# Discharges	3,593	3,574	3,513	3,600	2,996
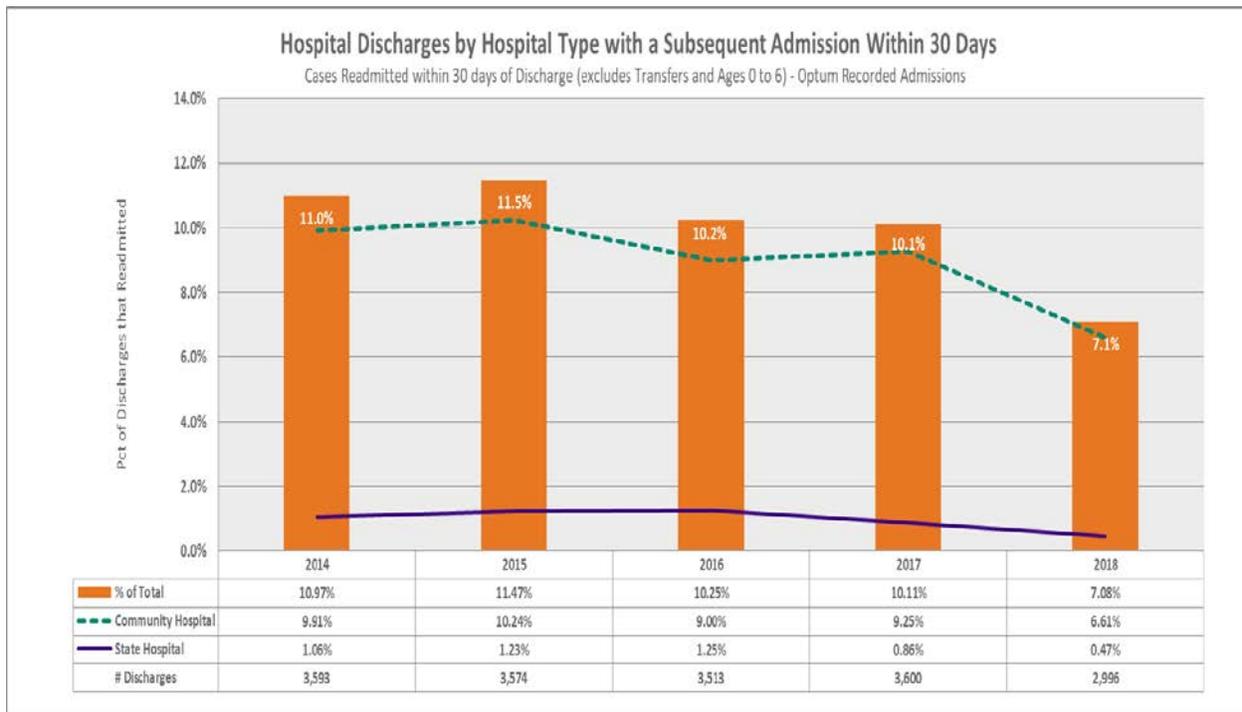
Figure 13

Figure 13 shows readmissions percentages by hospital type. Community hospital readmissions rates decreased by 29% and State Hospital readmission rates decreased by 45%.

Figure 14

	2014	2015	2016	2017	2018
Number of DC Cases	3617	3588	3523	3609	3008
% 7 Day Follow-up	54.19%	51.90%	50.07%	49.29%	49.14%
% 30 Day Follow-up	73.21%	71.49%	69.23%	69.24%	69.08%
DC cases with visit w/in 7-days	1960	1862	1764	1779	1478
DC Cases with visit w/in 30-days	2648	2565	2439	2499	2078
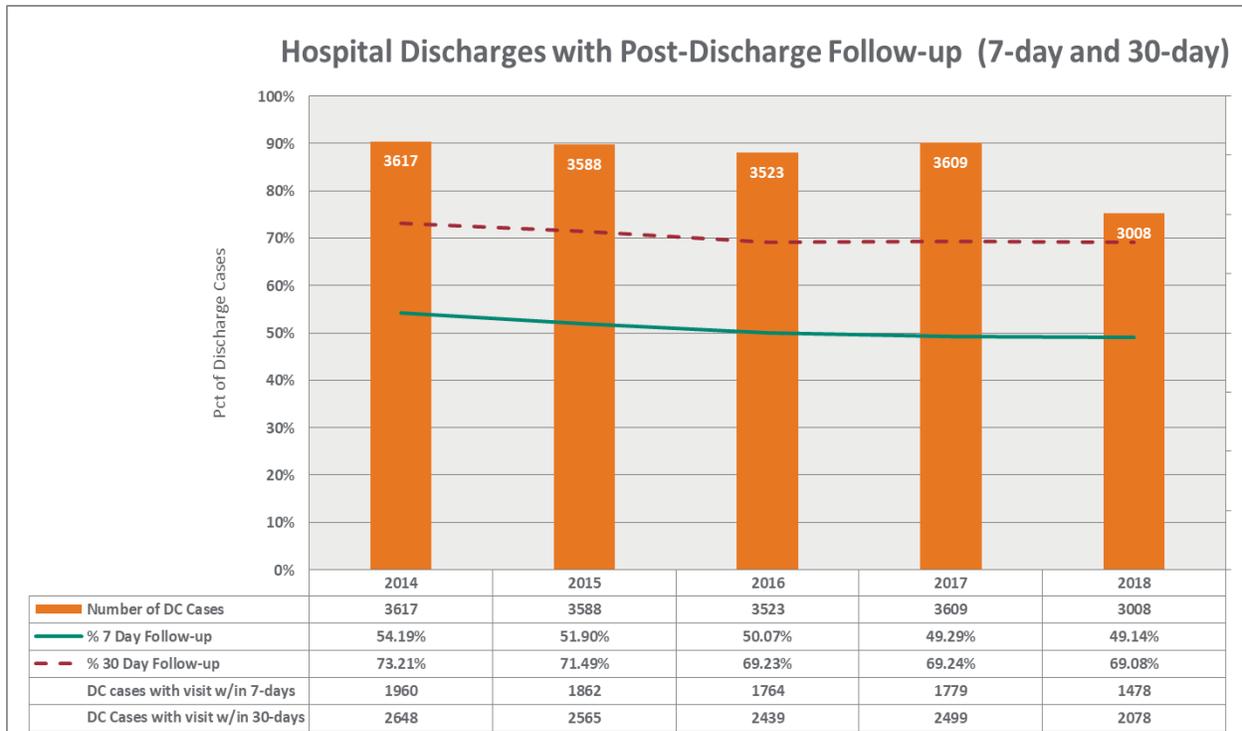
Figure 14 shows Hospital Discharges with Post-Discharge Follow-up. One of the goals of care coordination is the continuity of care and the successful transition of members from inpatient to outpatient care. One of the measures for this is a HEDIS metric that examines the percentage of members who are discharged from inpatient care and subsequently receive an outpatient behavioral health visit within 7 days and 30 days. The attendance rates for post-discharge outpatient services remain nearly consistent from 2017, but have decreased slightly through the study period.

Barriers: Responsibility for arranging post-discharge outpatient appointments for behavioral health services rests with hospital discharge planners. Optum has an outpatient-only contract; as a result, hospitals and their staff responsible for discharge planning fall outside our management. However, within the Optum Idaho care coordination system, Optum discharge coordinators attempt to verify that appointments are scheduled and attended, but do not ensure—and sometimes are unable to ensure—that these appointments are done due to timely hospital discharge information.

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 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 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 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

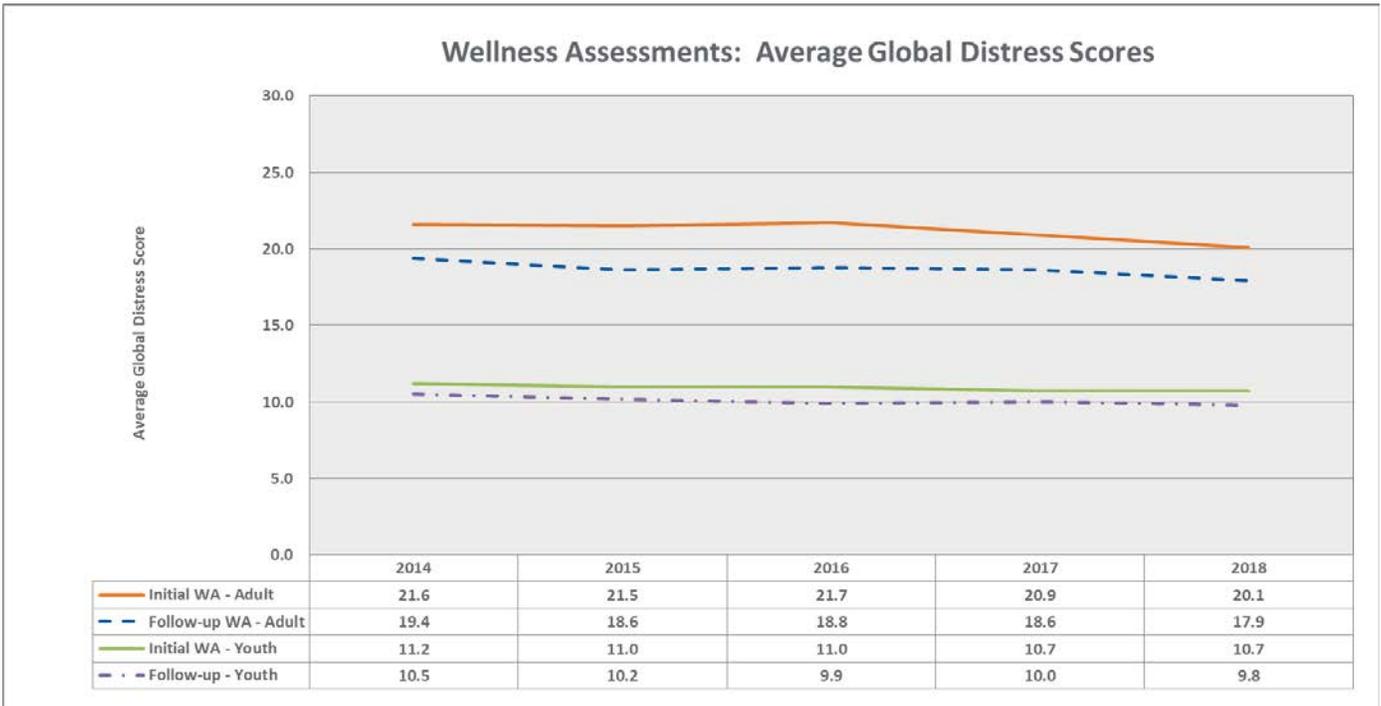| Total Score	Severity Level	ADULT Global Distress Score Descriptions
0-11	Low	Low level of distress (*below clinical cut-off score of 12*).
12-24	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
25-38	Severe	Approximately one in four clients has scores 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.

Wellness Assessments: Average Global Distress Scores

	2014	2015	2016	2017	2018
Initial WA - Adult	21.6	21.5	21.7	20.9	20.1
Follow-up WA - Adult	19.4	18.6	18.8	18.6	17.9
Initial WA - Youth	11.2	11.0	11.0	10.7	10.7
Follow-up - Youth	10.5	10.2	9.9	10.0	9.8

Figure 15

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.

Wellness Assessments: Average Caregiver Strain Score

	2014	2015	2016	2017	2018
Initial WA	7.2	6.9	6.8	6.5	6.5
Follow-up WA	6.7	6.3	6.0	5.8	5.7
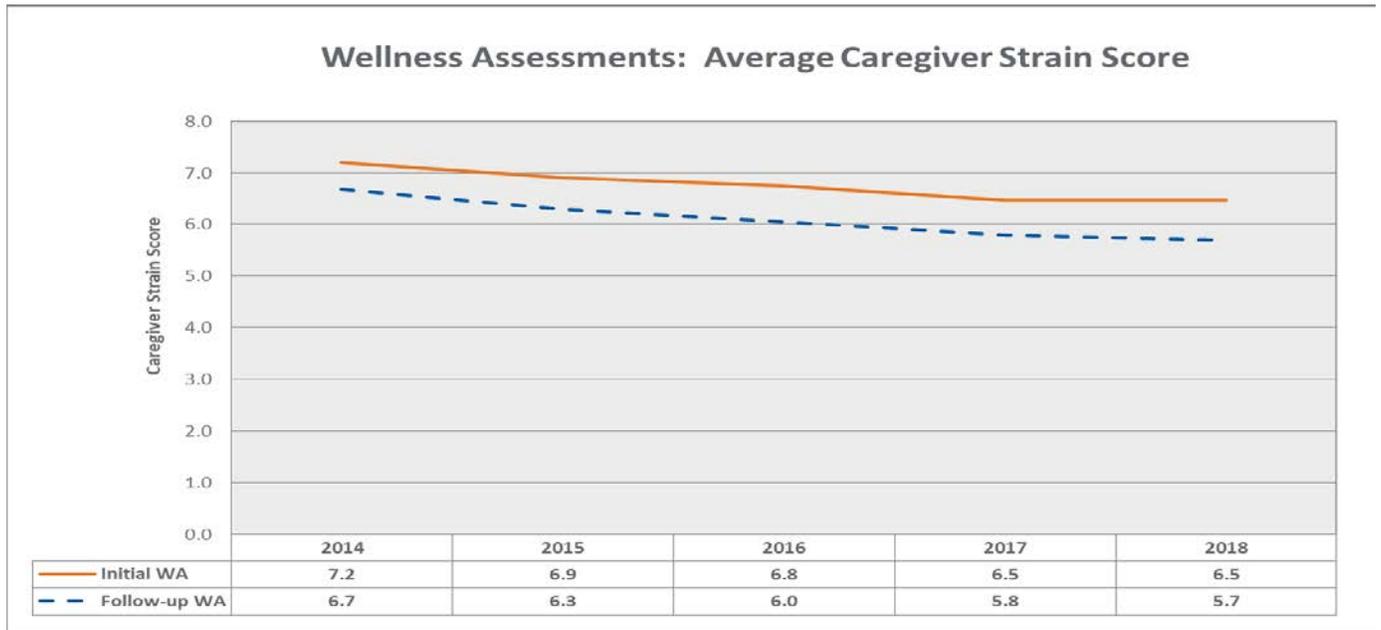
Figure 16

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

Wellness Assessments: Average Overall Health Score

	2014	2015	2016	2017	2018
Initial WA - Adult	2.3	2.2	2.2	2.2	2.1
Follow-up WA - Adult	1.6	1.5	1.5	1.5	1.4
Initial WA - Youth	1.0	1.0	1.0	1.0	1.0
Follow-up WA - Youth	0.8	0.7	0.7	0.7	0.7
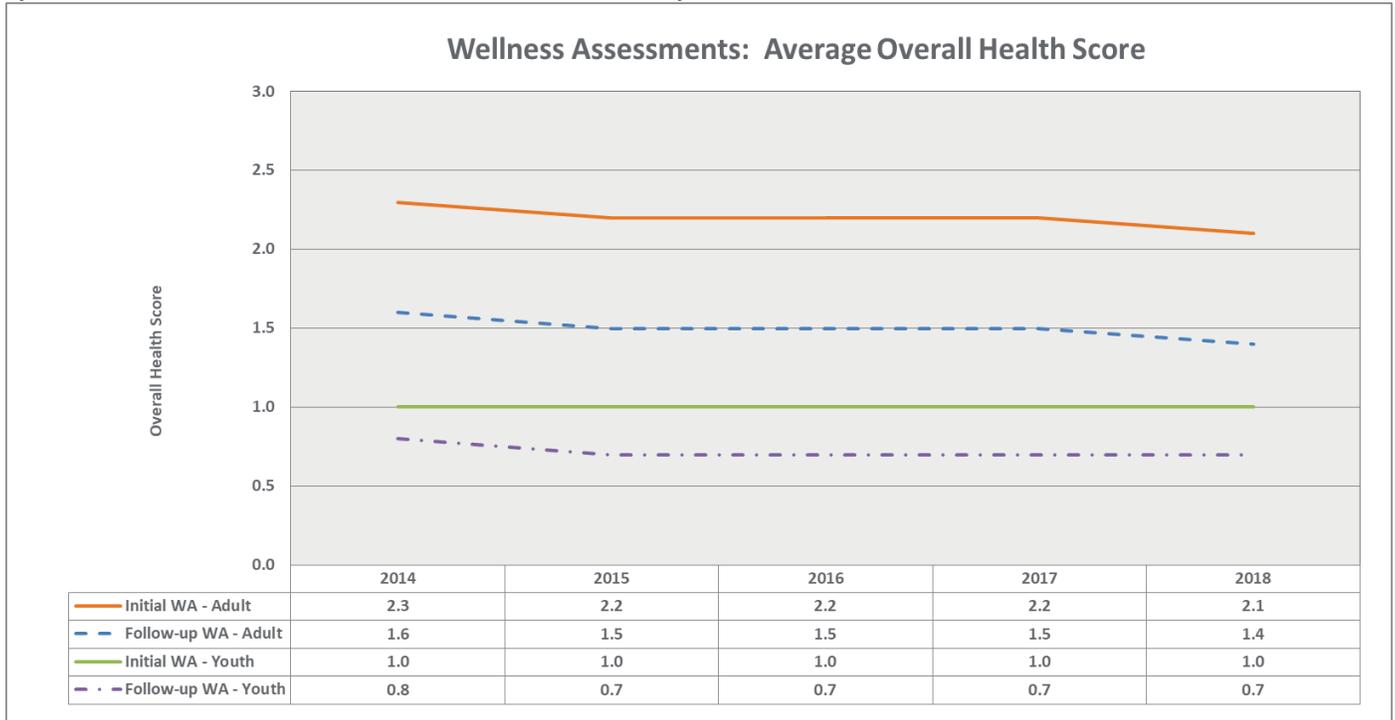
Figure 17

Analysis: Average Global Distress scores for adults and youth (Figure 15), initial and follow-up assessment scores remained consistent. Average Caregiver Strain (Figure 16) measured within Moderate levels during the same period, and on average improved more than 10% between initial and follow-up assessments. For the Average Overall Health Score (Figure 17), 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 17), 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 Behavioral Health monitors member satisfaction with behavioral health services. Beginning with Quarter 1, 2017, a new Member Satisfaction Survey was implemented.   Optum surveys Optum Idaho Behavioral Health Plan 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 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
Overall Satisfaction (Goal: ≥85.0%)	≥85%	80%	92%
Optum support for obtaining referrals or authorizations	≥85%	80%	92%
Accessibility, availability, and acceptability of the clinician network	≥85%	89%	93%
Counseling and Treatment	≥85%	95%	95%

Analysis: As stated above, a new Member Satisfaction Survey was implemented in 2017. Results are presented in this Annual Evaluation from previous surveys (2014 - 2016) and the 2017 and 2018 results based on the new survey.

Surveys are now completed by telephone. The number of Optum Idaho members that were contacted during 2018 was 1,853 with a response rate of 10%. Translation services were offered but none were requested resulting in 100% of the surveys being conducted in English. Member overall satisfaction was consistently met during 2018 as was member satisfaction with counseling and treatment.
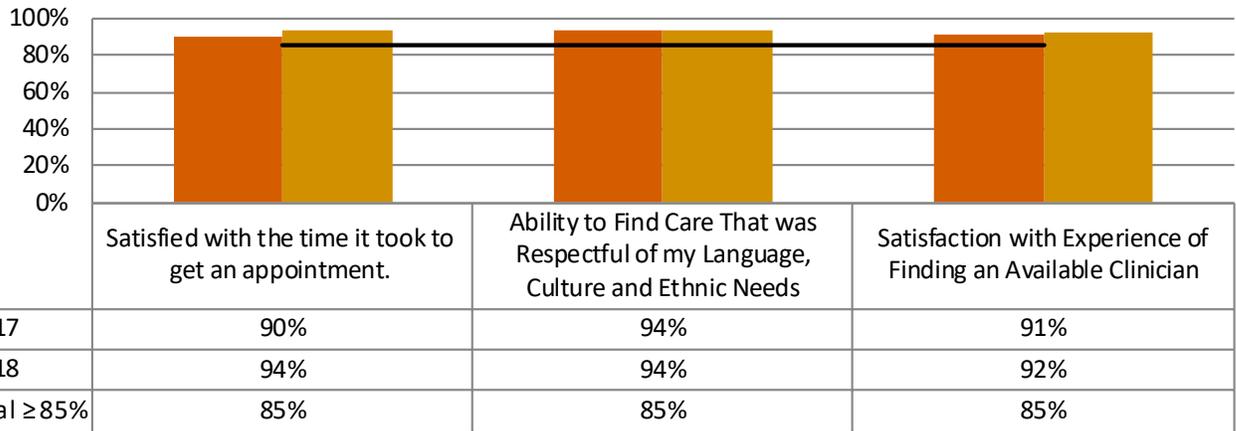
2014 - 2016 Member Overall Satisfaction

	Experience w/ Optum ID Staff and Referral Process	Experience with the Behavioral Health Provider Network	Experience with Counseling or Treatment	Overall Experience
2014	84%	91%	93%	90%
2015	85%	91%	94%	92%
2016	92%	94%	95%	94%
Goal ≥85%	85%	85%	85%	85%
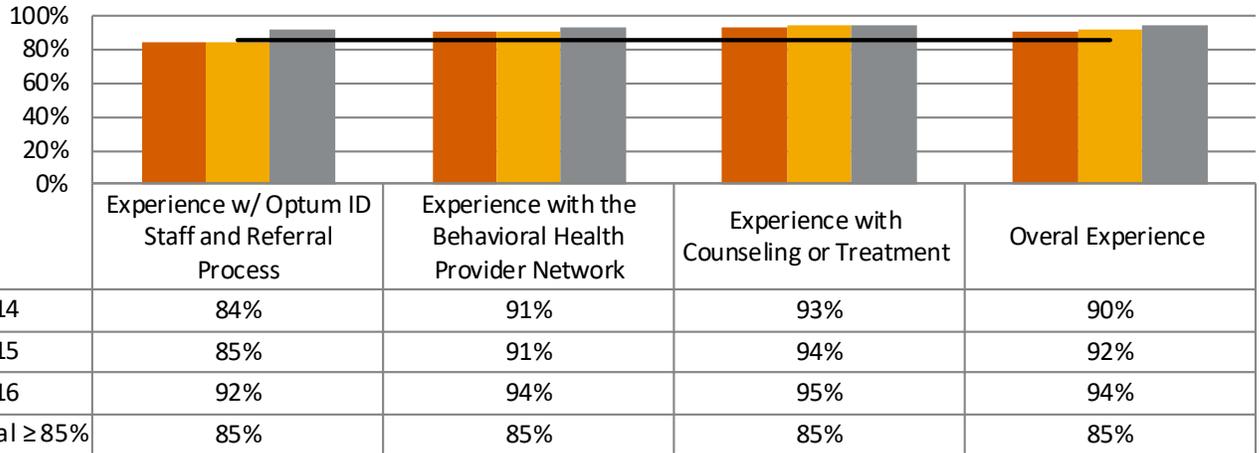
2017 - 2018 Member Overall Satisfaction

	Optum Support for Obtaining Referrals or Authorizations	Counseling and Treatment	Accessibility, Availability, and Acceptability of the Clinician Network	Overall Satisfaction
2017	80%	93%	89%	80%
2018	92%	95%	93%	92%
Goal ≥85%	85%	85%	85%	85%
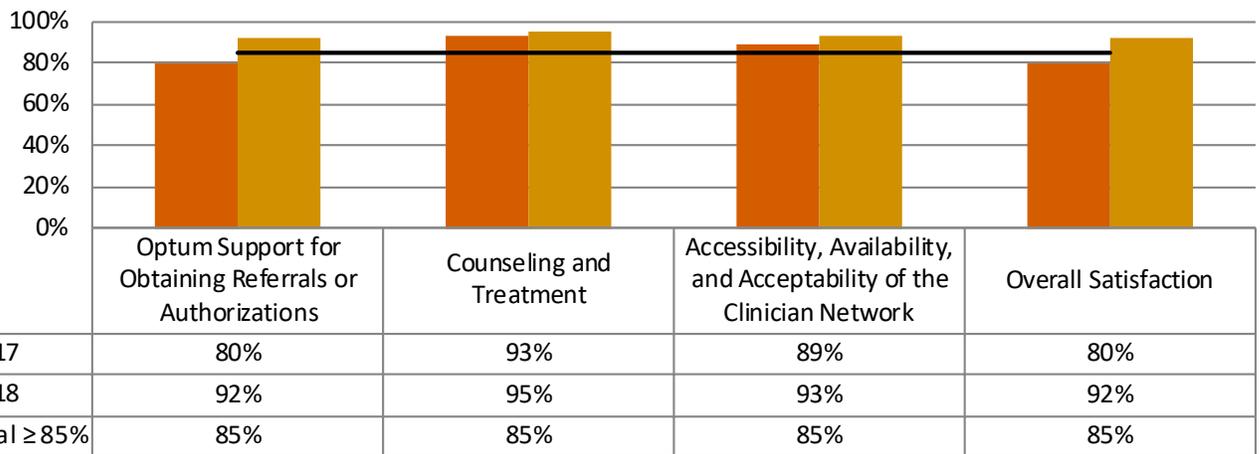
2014 - 2016 Member Experience with Counseling or Treatment

	I was satisfied with the time it took to get an appointment with my primary provider	The care I received was respectful of my language, cultural, and ethnic needs.	I was satisfied with the choice of providers available to me.	My provider helps me get the services I need when I need them.
2014	88%	98%	92%	92%
2015	90%	97%	91%	91%
2016	89%	99%	94%	94%
Goal ≥85%	85%	85%	85%	85%
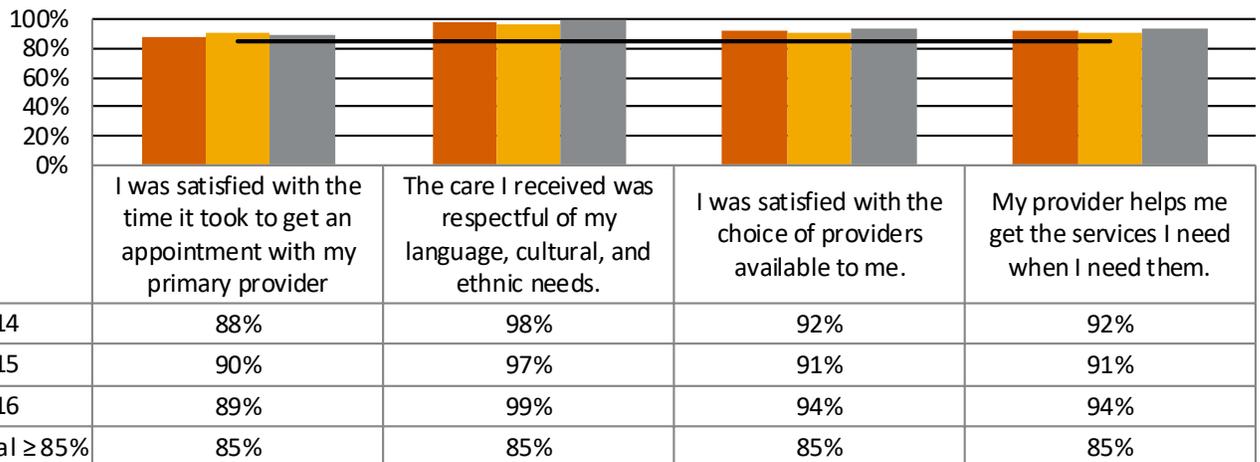
2017 - 2018 Member Experience with Counseling or Treatment

	Satisfied with the time it took to get an appointment.	Ability to Find Care That was Respectful of my Language, Culture and Ethnic Needs	Satisfaction with Experience of Finding an Available Clinician
2017	90%	94%	91%
2018	94%	94%	92%
Goal ≥85%	85%	85%	85%

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 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 2018 was 78%, a slight increase from 2017 at 77%, but below the established target of 85%.

Provider Overall Satisfaction with Optum

	2016	2017	2018
Satisfied/Very Satisfied	75%	77%	78%
Dissatisfied/Very Dissatisfied	23%	19%	17%
No Opinion	2%	4%	4%
Goal ≥85%	85%	85%	85%
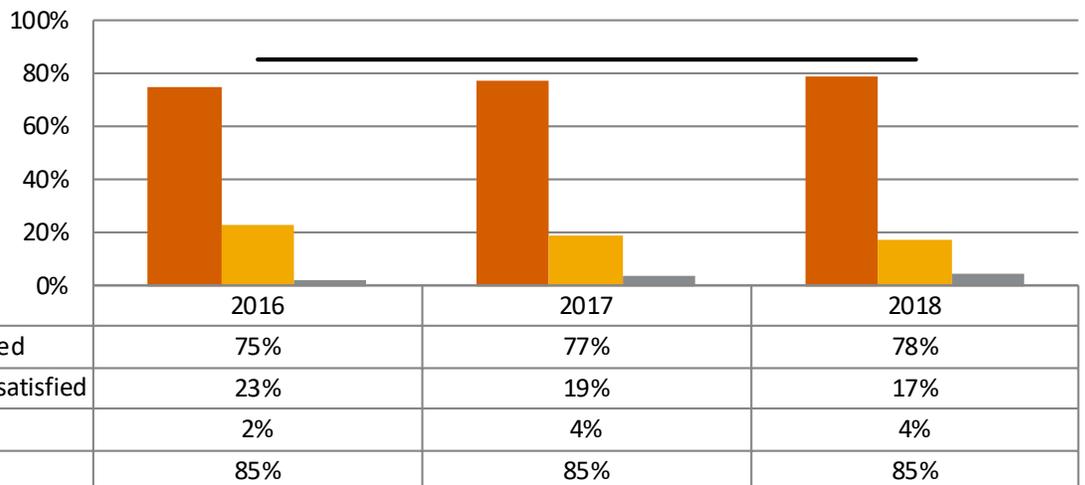
Barriers: While the annual survey results fell below ≥85.0%, Optum Idaho continued to monitor and identify trends.

Opportunities and Interventions: Action plans for 2019 include:
- Continue process for regular piloting initiatives with provider and seeking input.
- Create subcommittees of the Provider Advisory Committee for special topics.
- Increase visits and meetings with provider associations and offices.
- Introduce and educate providers on the use of the Net Promotor Score.
- Create trainings/webinars on specific issues identified within survey.

Performance Improvement

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 2018, there were 4 PIPs in progress.

Behavioral Health Interventions at Medical Appointment
The purpose of this project was to add additional codes to Provider Fee schedules to include behavioral health intervention at medical visits. The codes are for services intended to assess factors that may affect the recovery or progression of a diagnosed physical health problem or illness. After meeting all project goals, this project closed.

Appointment Reminder Program
The purpose of this PIP 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. In February, 2018, 10 hospitals were trained on the program. Optum Idaho continues to work with hospitals who were not responding or who were having difficulty with the process. Optum data indicates that those participating in the program are more likely to attend an outpatient behavioral health appointment than those not participating in the program. This project remains open.

Utilization Management (UM) Clinical Review Documentation
The goal of the PIP was to streamline the UM clinical review process. The project aimed to improve communication and collaboration between the Care Advocates and Peer Reviewers and to improve member facing documentation. After meeting all project goals, this project closed.

Substance Abuse American Society of Addiction Medicine (ASAM) Expansion
The purpose of this PIP was to align with the efforts of the ASAM project within Optum, adapting to Idaho Behavioral Health Plan (IBHP) specific requirements, as needed. Project initiatives were addressed through modification of key documents (policies, clinical documents, job aids, etc.), staff training, and provider materials (Provider Manual, alerts). After meeting all project goals, this project closed.

Accessibility & Availability

Idaho Behavioral Health Plan Membership
Methodology: The Idaho Department of Health and Welfare (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 Idaho Behavioral Health Plan services.

IBHP Membership and Utilizers

	2014	2015	2016	2017	2018
Membership	314,538	330,474	336,394	342,357	336,997
Utilizers	44,079	45,811	47,364	49,186	50,182
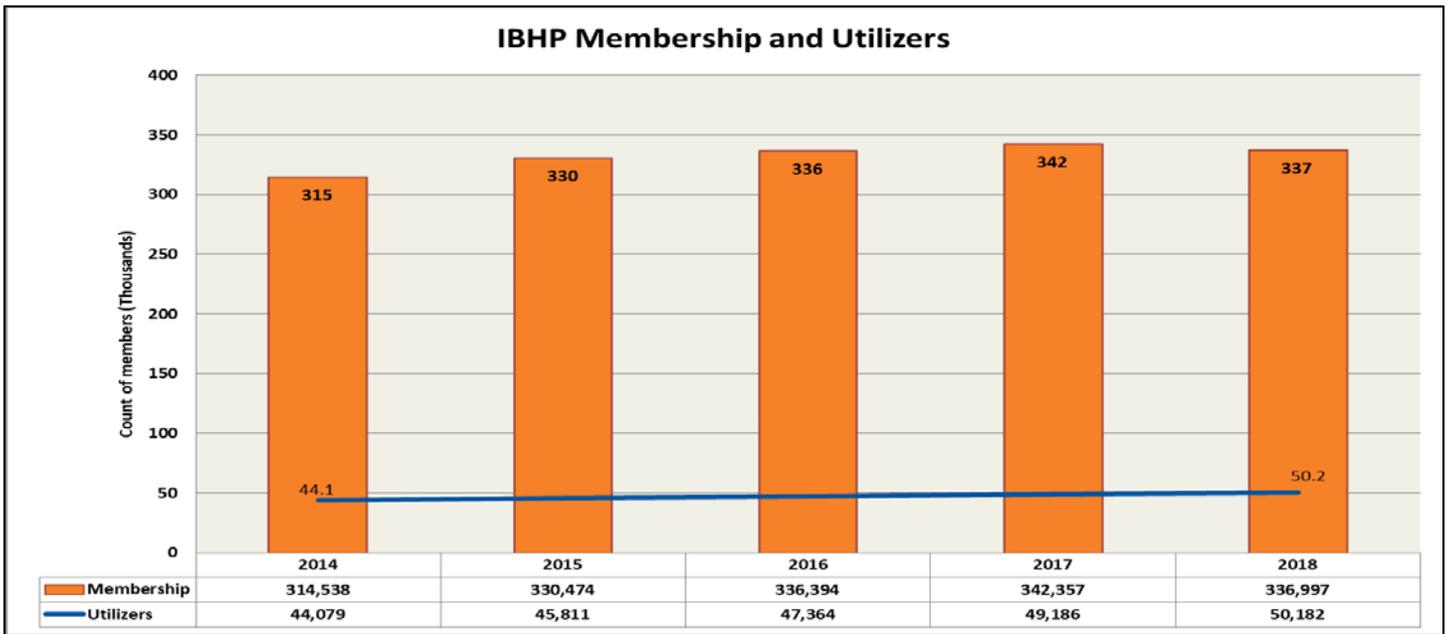
Analysis: During 2018 membership numbers decreased slightly and utilizers increased slightly.
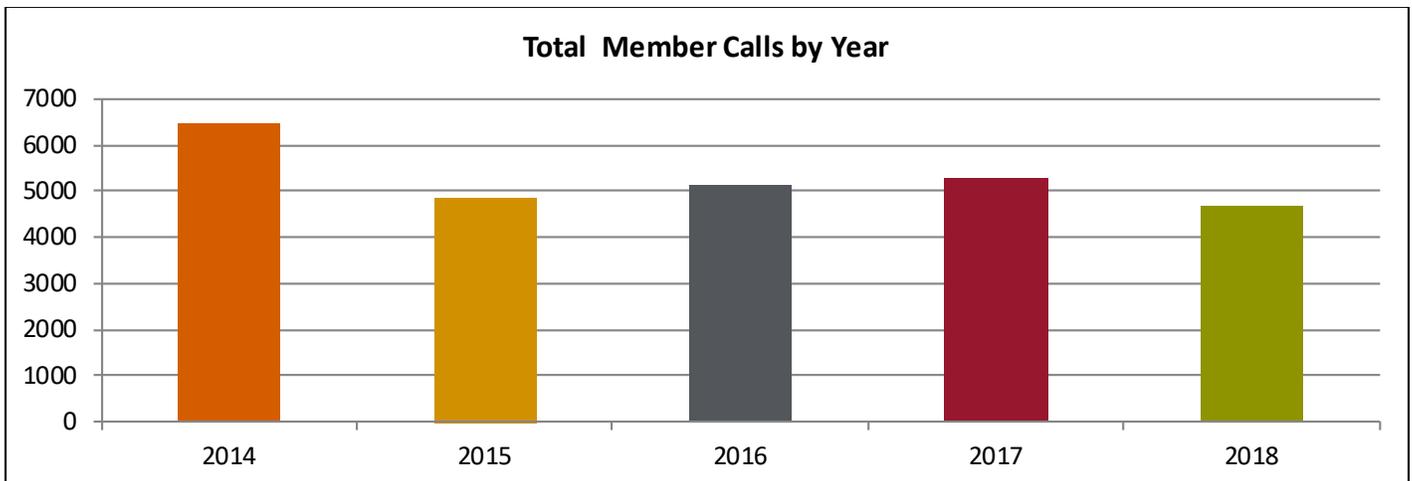
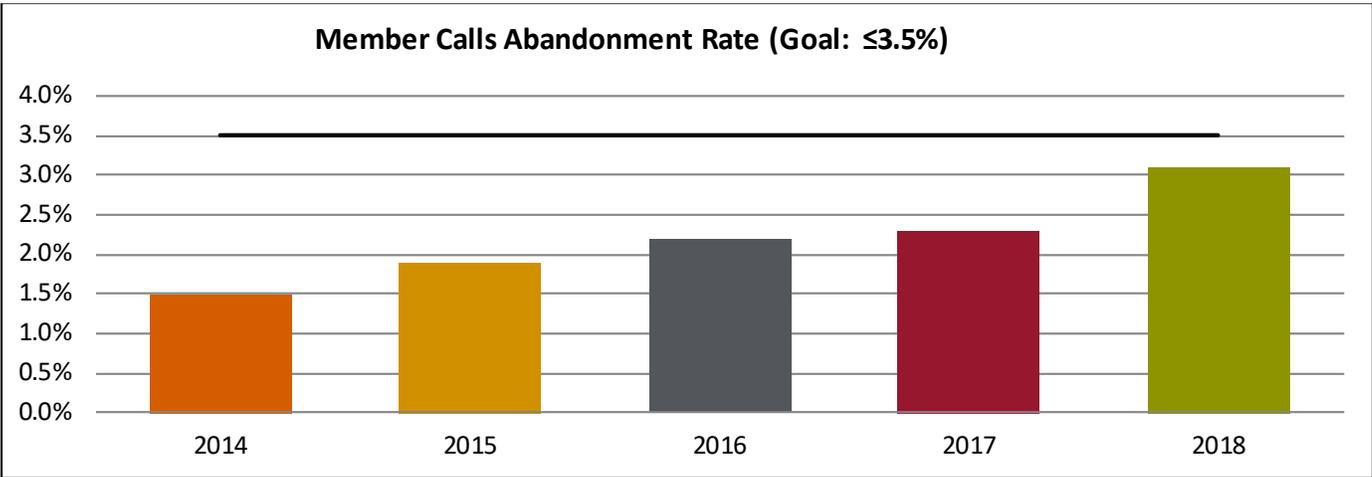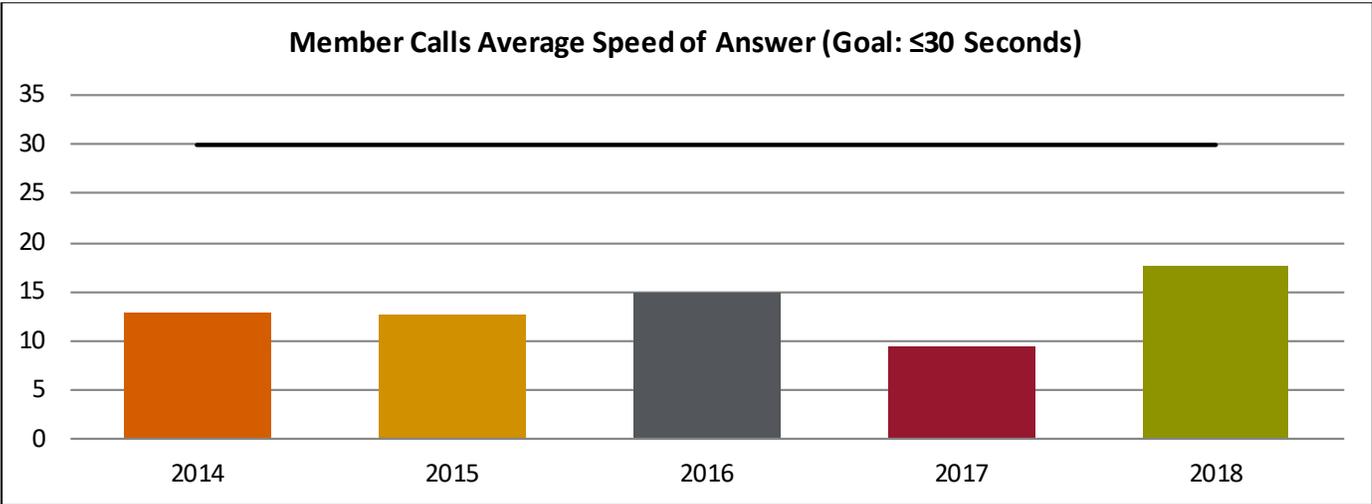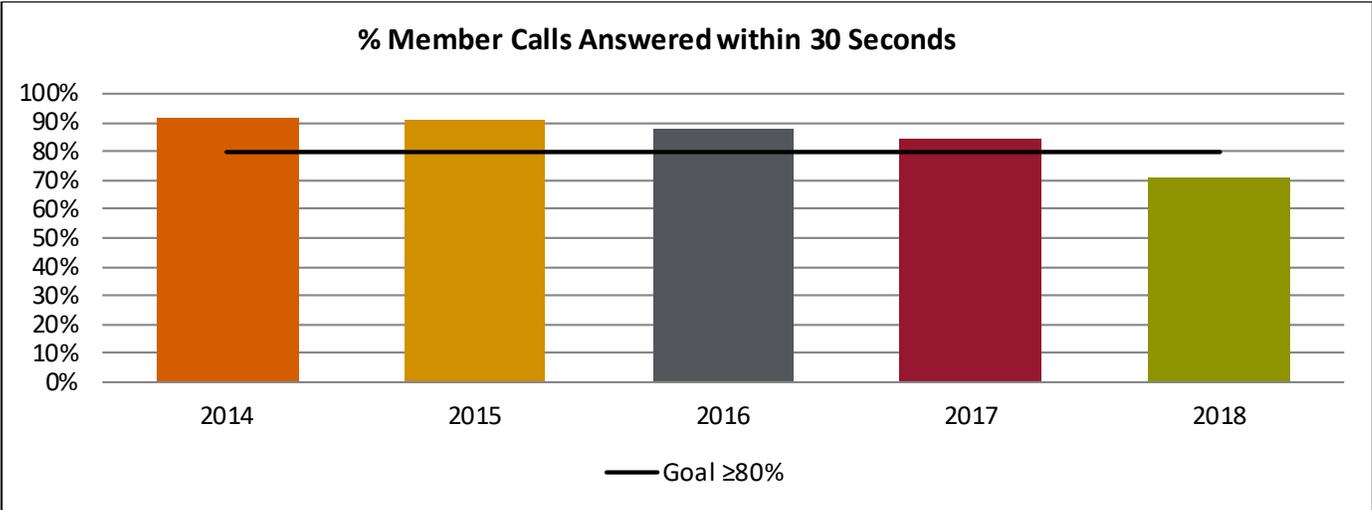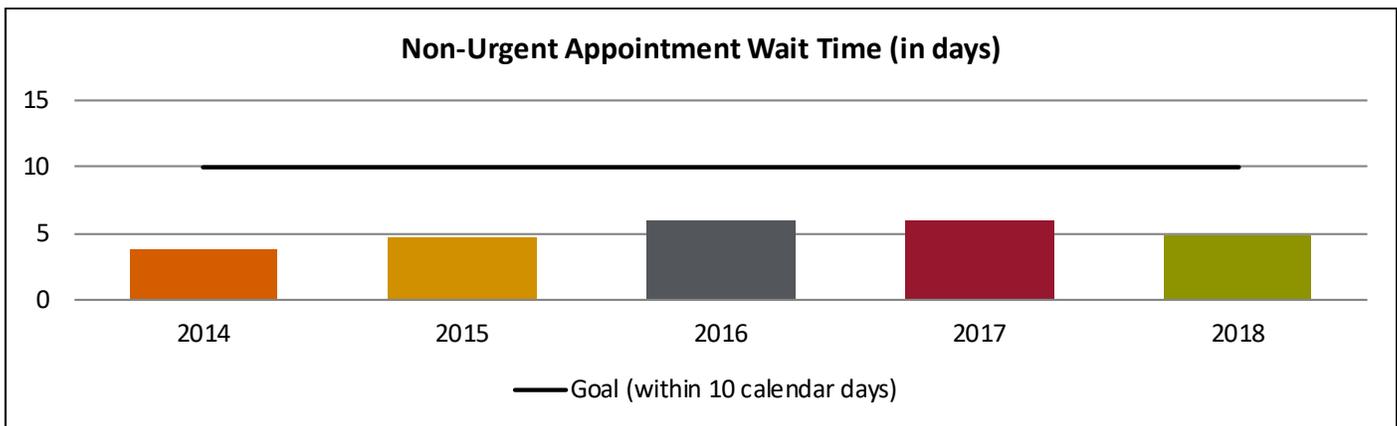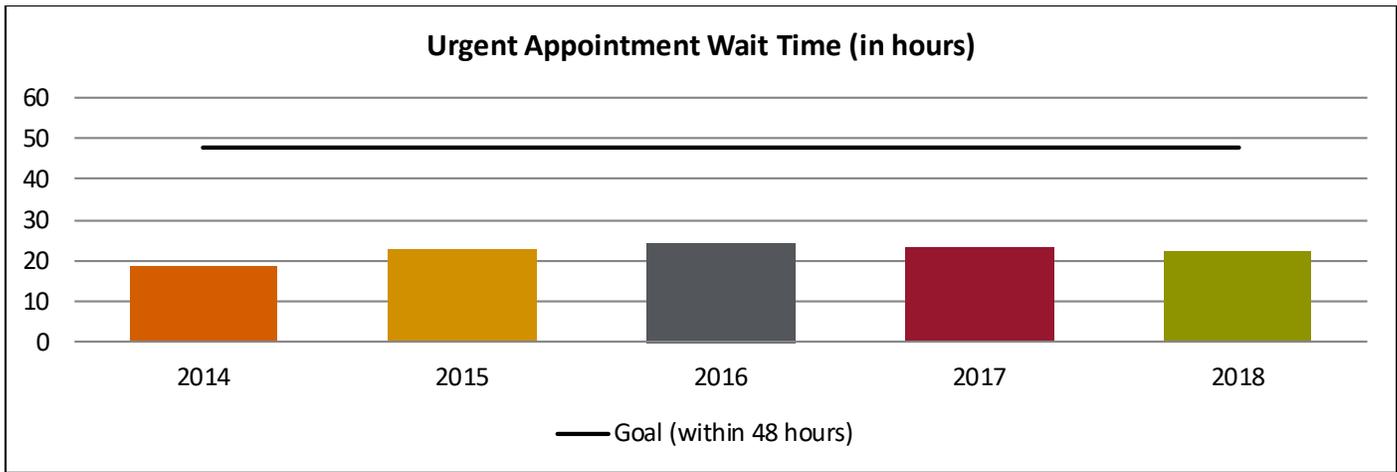***Barriers:*** Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified

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 4,658 calls during 2018. The percentage of calls answered within 30 seconds fell below the goal. The average speed to answer and call abandonment rate goals were met.

Total Member Calls by Year

% Member Calls Answered within 30 Seconds

Goal ≥80%

Member Calls Average Speed of Answer (Goal: ≤30 Seconds)

Member Calls Abandonment Rate (Goal: ≤3.5%)

Barriers: Performance goal was not met for Percent of Calls Answered within 30 Seconds.

Idaho Behavioral Health Plan Quality Management and Improvement
2018 Annual Evaluation. Approved by Quality Assurance Performance Improvement Committee on 7/17/2019.
ID-246-2019

Opportunities and Interventions: An Improvement Action Plan (IAP) has been implemented to improve performance standards. The performance standards and improvement strategies are monitored on a weekly basis.

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 12,036 calls during 2018. Optum Idaho again exceeded all established performance call standards during 2018, including calls answered within 30 seconds, average speed of answer, and call abandonment rate.
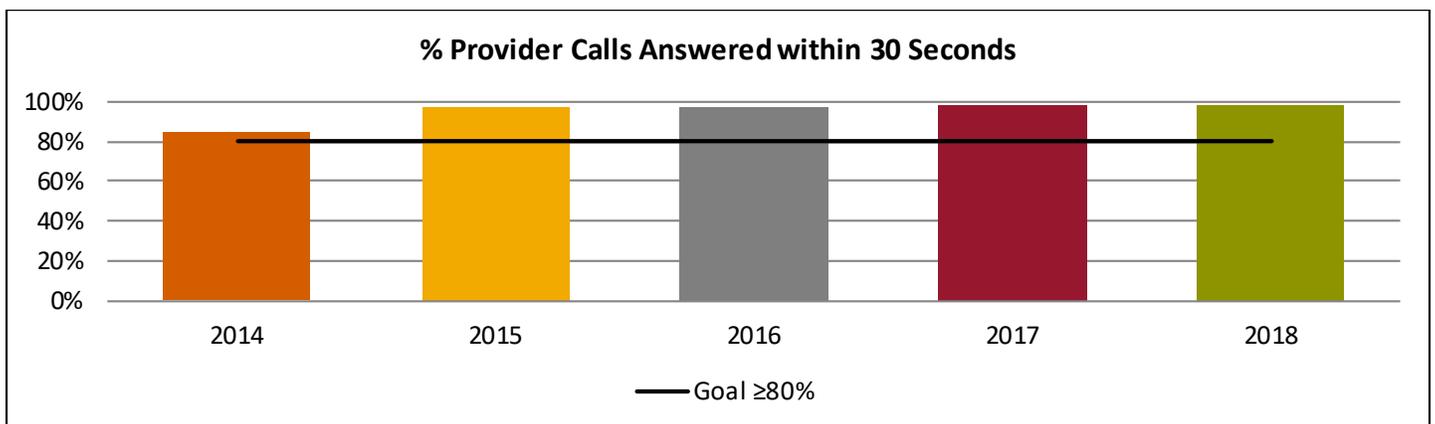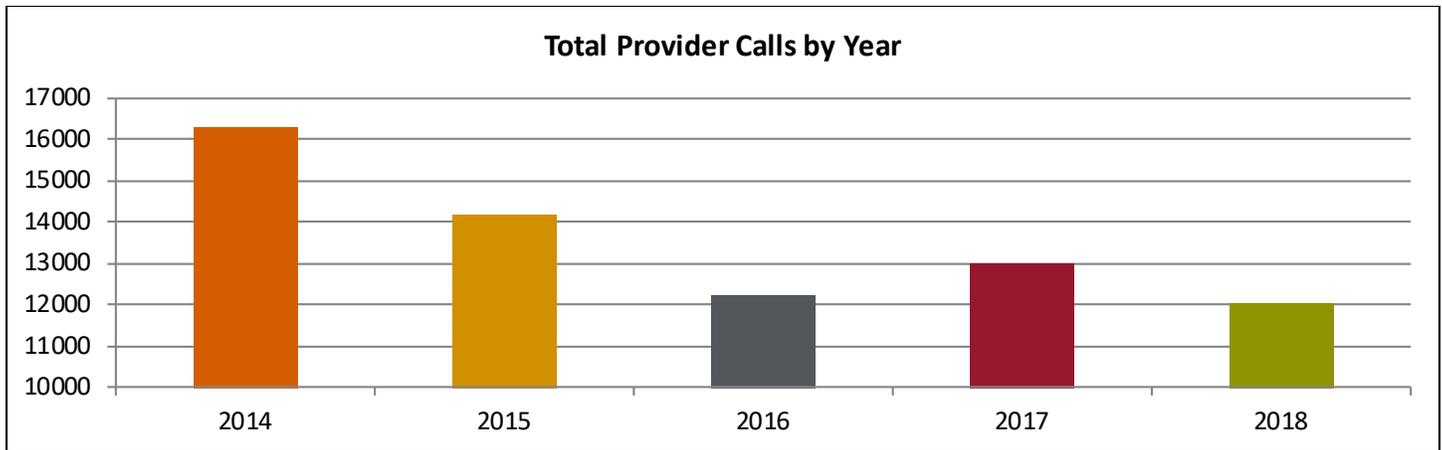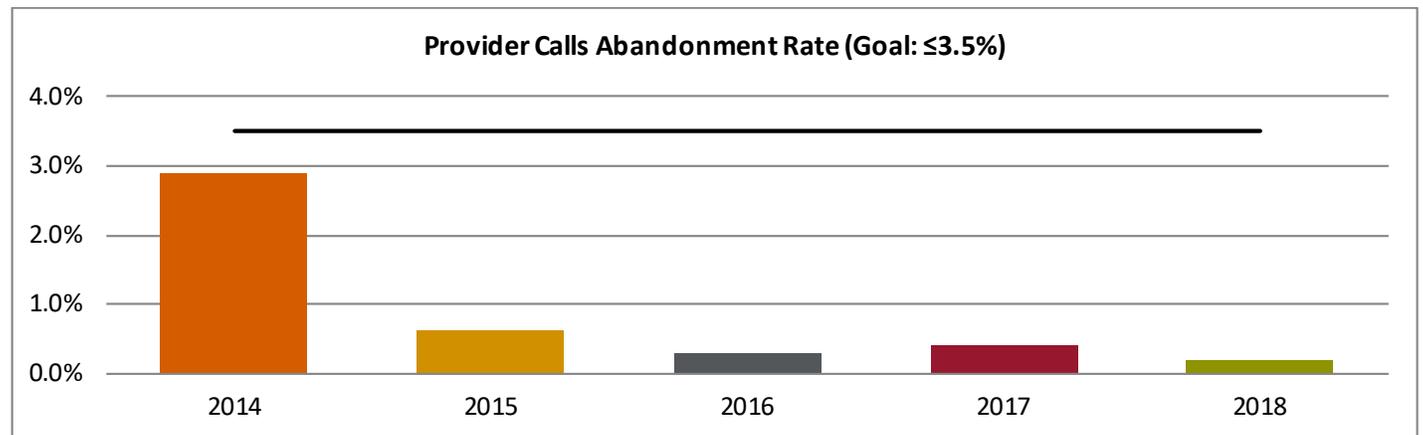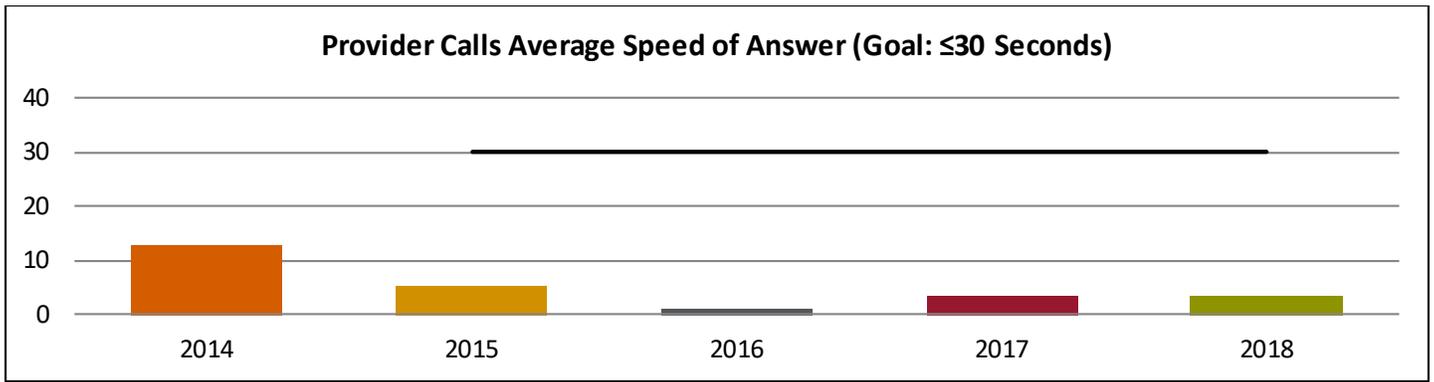
Total Provider Calls by Year

% Provider Calls Answered within 30 Seconds

Goal ≥80%

Idaho Behavioral Health Plan Quality Management and Improvement
2018 Annual Evaluation. Approved by Quality Assurance Performance Improvement Committee on 7/17/2019.
ID-246-2019

Provider Calls Average Speed of Answer (Goal: ≤30 Seconds)

Provider Calls Abandonment Rate (Goal: ≤3.5%)

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

Urgent and Non-Urgent 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 developed, maintains, and monitors a network with adequate numbers and types of clinicians and outpatient programs. Optum requires that network providers adhere to specific access standards for *Urgent Appointments* being offered within 48 hours, *Non-urgent Appointments* being offered within 10 business 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 2018 at 22.4 hours. The overall performance goal for Non-Urgent Appointment wait times was also met at 4.8 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 2018 at 2.9 hours.

Urgent Appointment Wait Time (in hours)

A bar chart with a y-axis scaled from 0 to 60 (increments of 10) showing:
- 2014: approximately 19
- 2015: approximately 23
- 2016: approximately 24
- 2017: approximately 24
- 2018: approximately 22

—— Goal (within 48 hours)

Non-Urgent Appointment Wait Time (in days)

A bar chart with a y-axis scaled from 0 to 15 (increments of 5) showing:
- 2014: approximately 4
- 2015: approximately 5
- 2016: approximately 6
- 2017: approximately 6
- 2018: approximately 5

—— Goal (within 10 calendar days)

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. Performance standards are determined by calculating the percentage of unique members who have availability of each level of /service provider and type of provider/service within the established standards.

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 in 45 miles.

Analysis: During 2018, 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).

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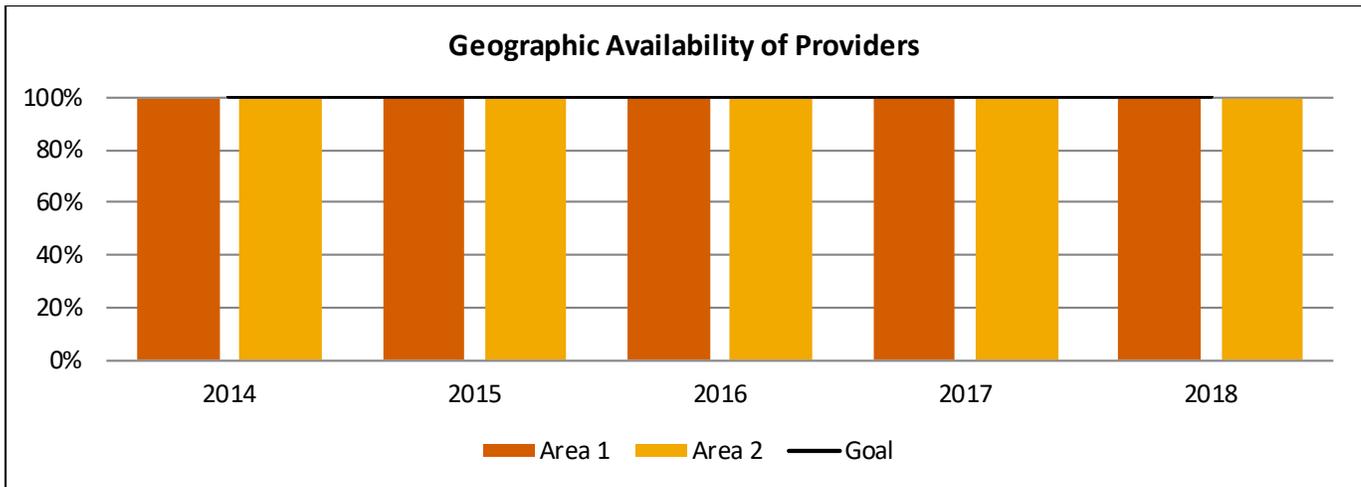
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Member Protections and Safety

Optum'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 (National Committee for Quality Assurance) 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'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

Methodology: An Adverse Benefit Determinations (ABD's) is defined as the denial or limited authorization of a requested service. When a request for services is received, Optum 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: Optum Idaho's performance ABD goals were revised at the beginning of Q3, 2017, as a result of new federal regulations and Optum performance initiatives. Optum eliminated the requirement for verbal notifications for standard service requests and revised the timeframe of ABD notifications to be mailed within 14 calendar days from receipt of the service request. Additionally, Optum began issuing Administrative Denials in Q3. Administrative denials are issued when service requests fall outside of administrative guidelines set by Optum Idaho. There were 1,325 Adverse Benefit Determinations during 2018. Overall written compliance (14 calendar days from request) was at 99.6%
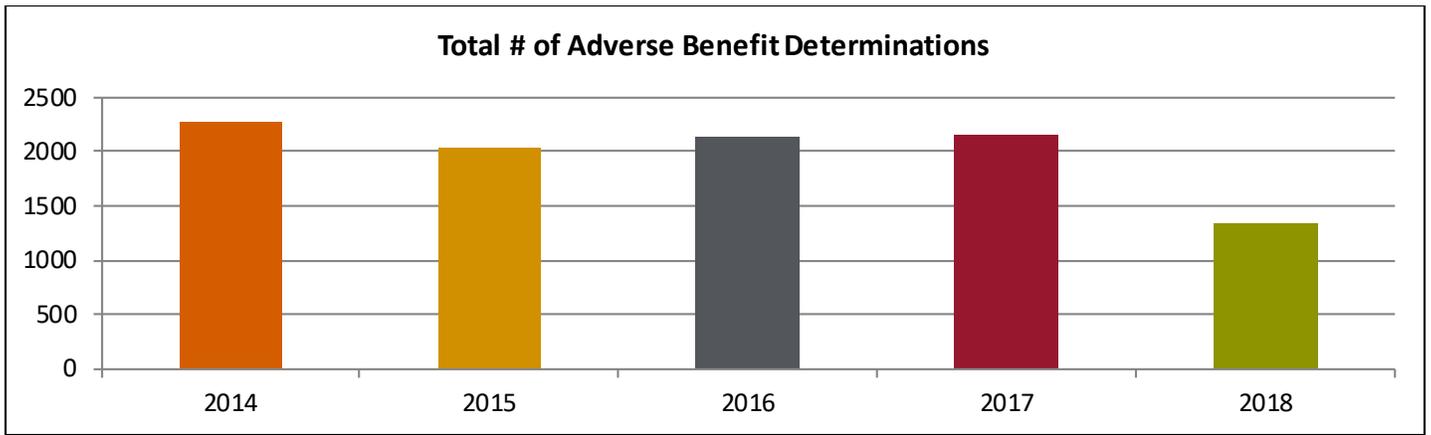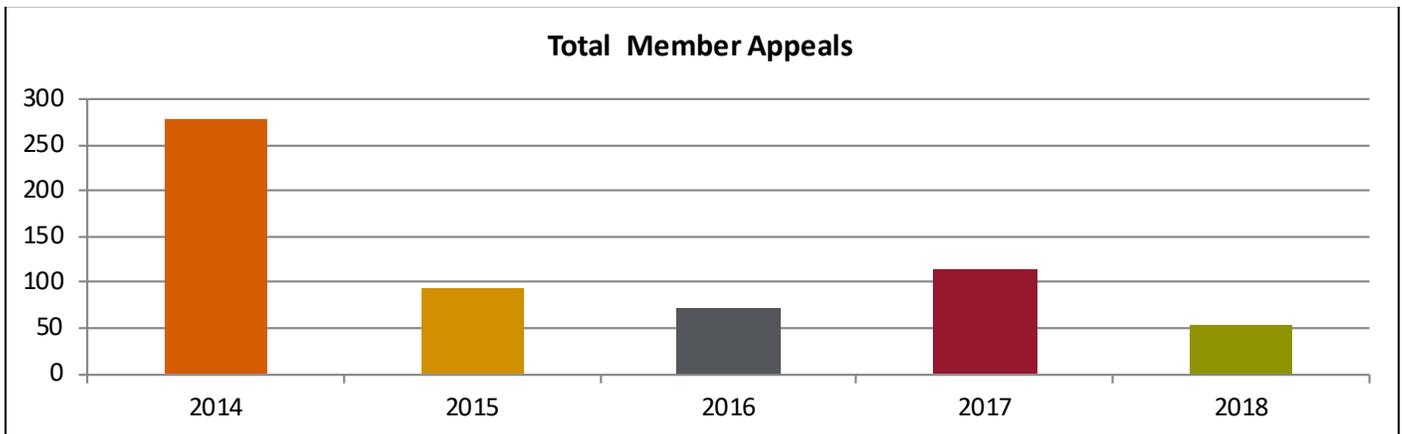
Total # of Adverse Benefit Determinations

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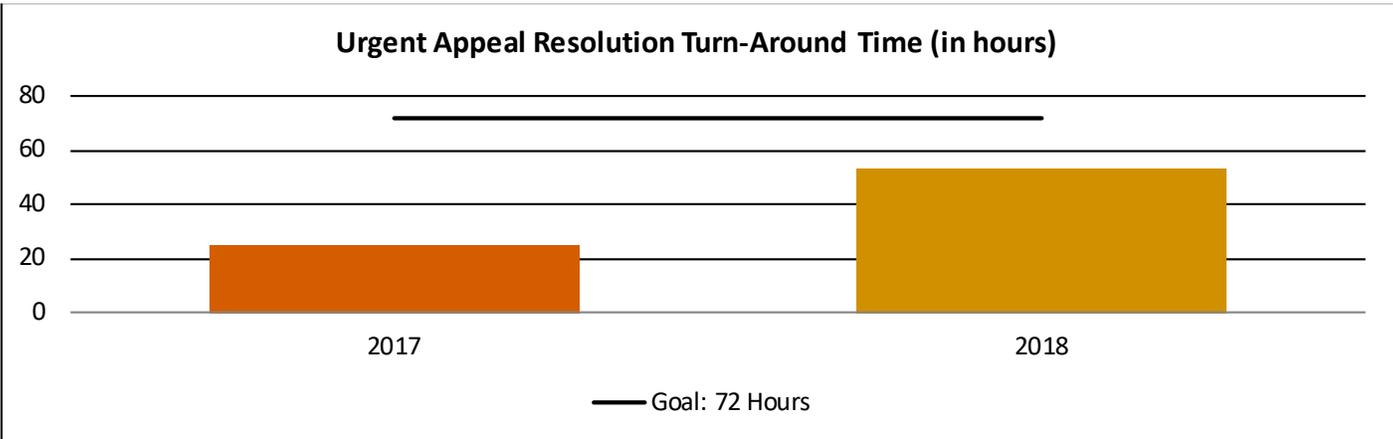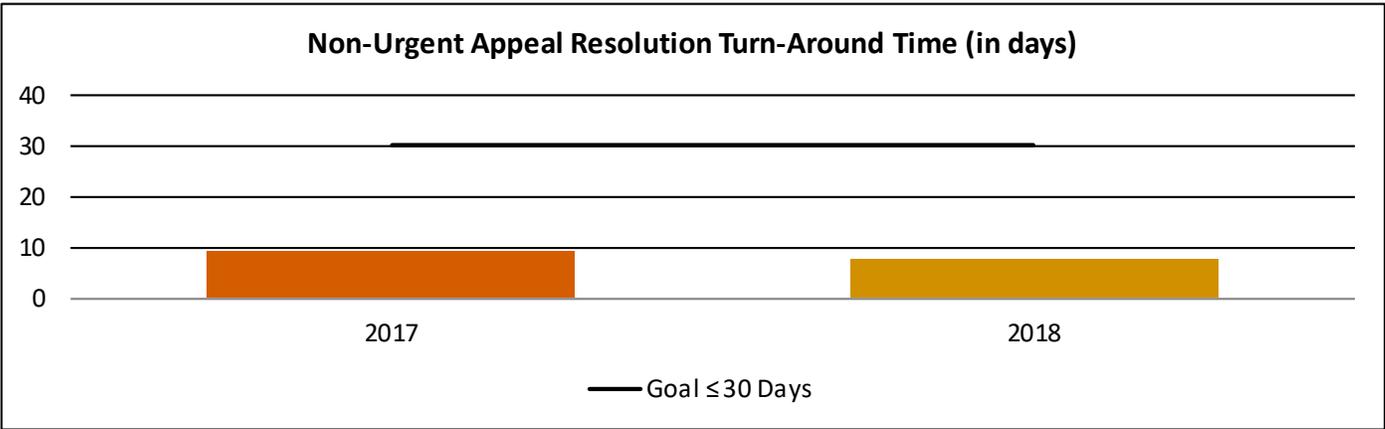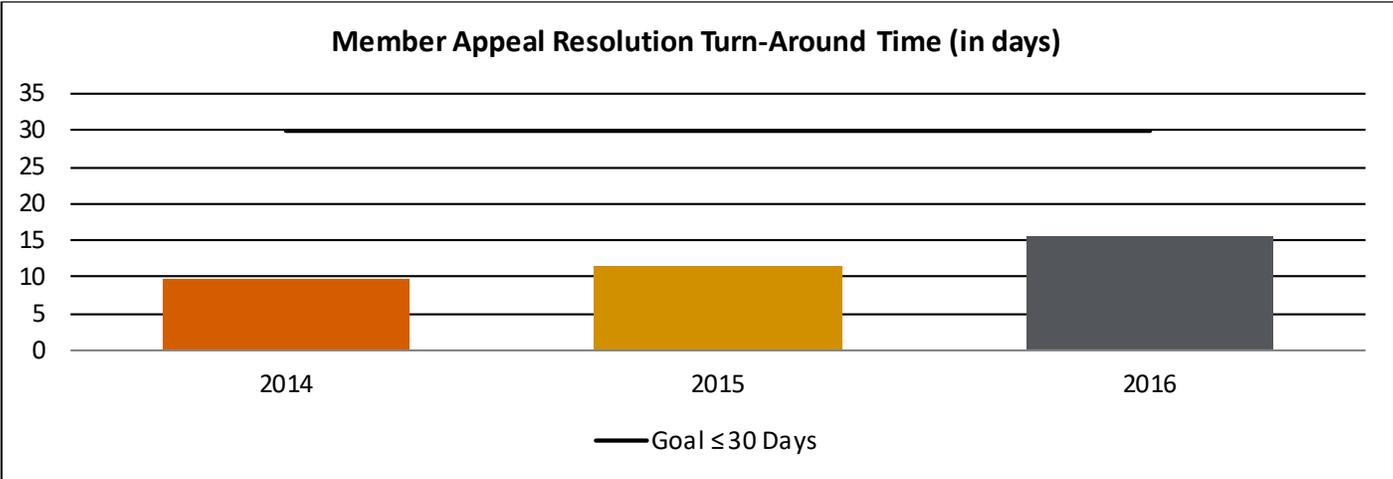**Opportunities and Interventions:** No opportunities for improvement were identified.
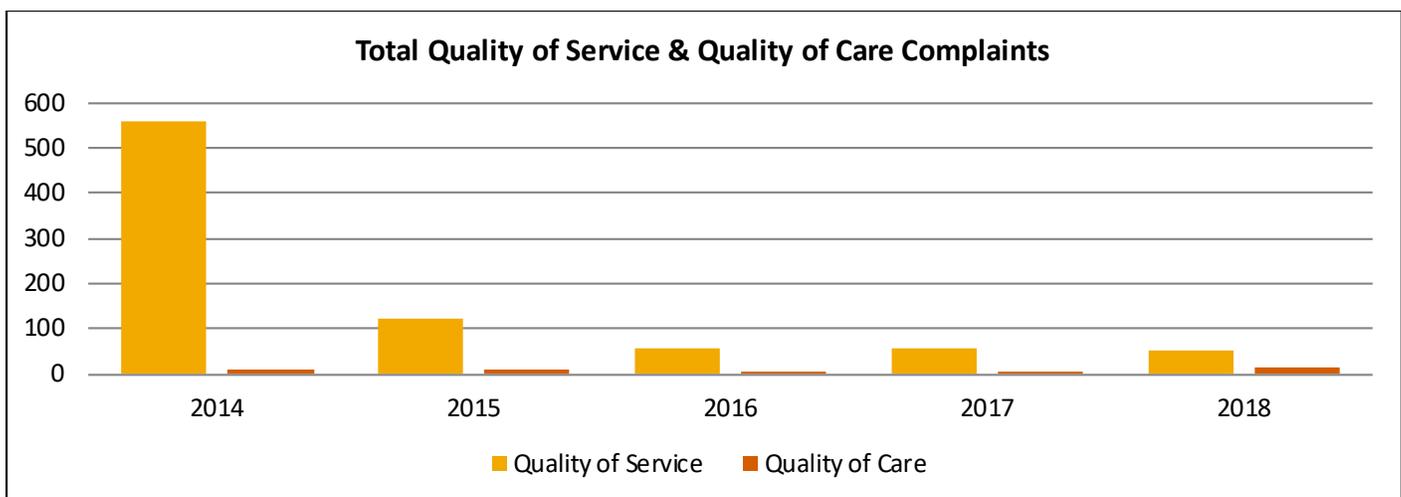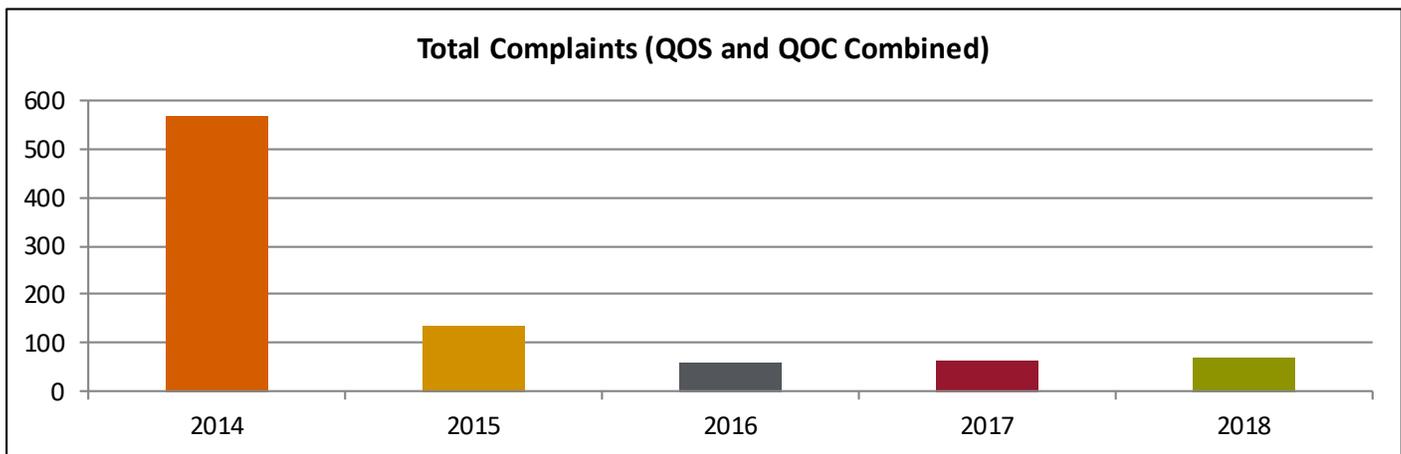
Member Appeals

Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an adverse benefit determination 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 complaint with an acknowledgement letter. Urgent appeal requests do not require an acknowledgement letter. All appeals are upheld, overturned, or partially overturned.

Analysis: The CMS Mega Rule, released July 1, 2017, impacted Optum Idaho's appeal process by allowing easier requests for urgent appeals and adjusting turnaround time requirements. As of July 1, 2017 members get 60 days from the date of the Adverse Benefit Determination letter to file an appeal – up from the previous deadline of 30 days. All turnaround time requirements and performance goals were met in 2018.

Total Member Appeals

Member Appeal Resolution Turn-Around Time (in days)

Goal ≤ 30 Days

Non-Urgent Appeal Resolution Turn-Around Time (in days)

Goal ≤ 30 Days

Urgent Appeal Resolution Turn-Around Time (in hours)

Goal: 72 Hours

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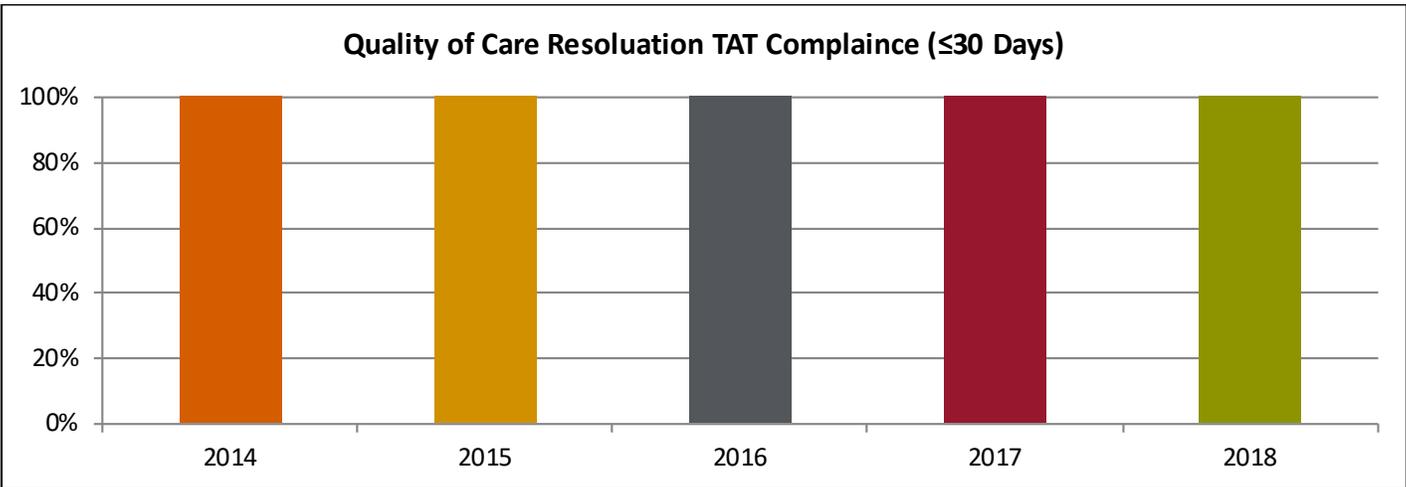**Opportunities and Interventions:** No opportunities for improvement were identified.

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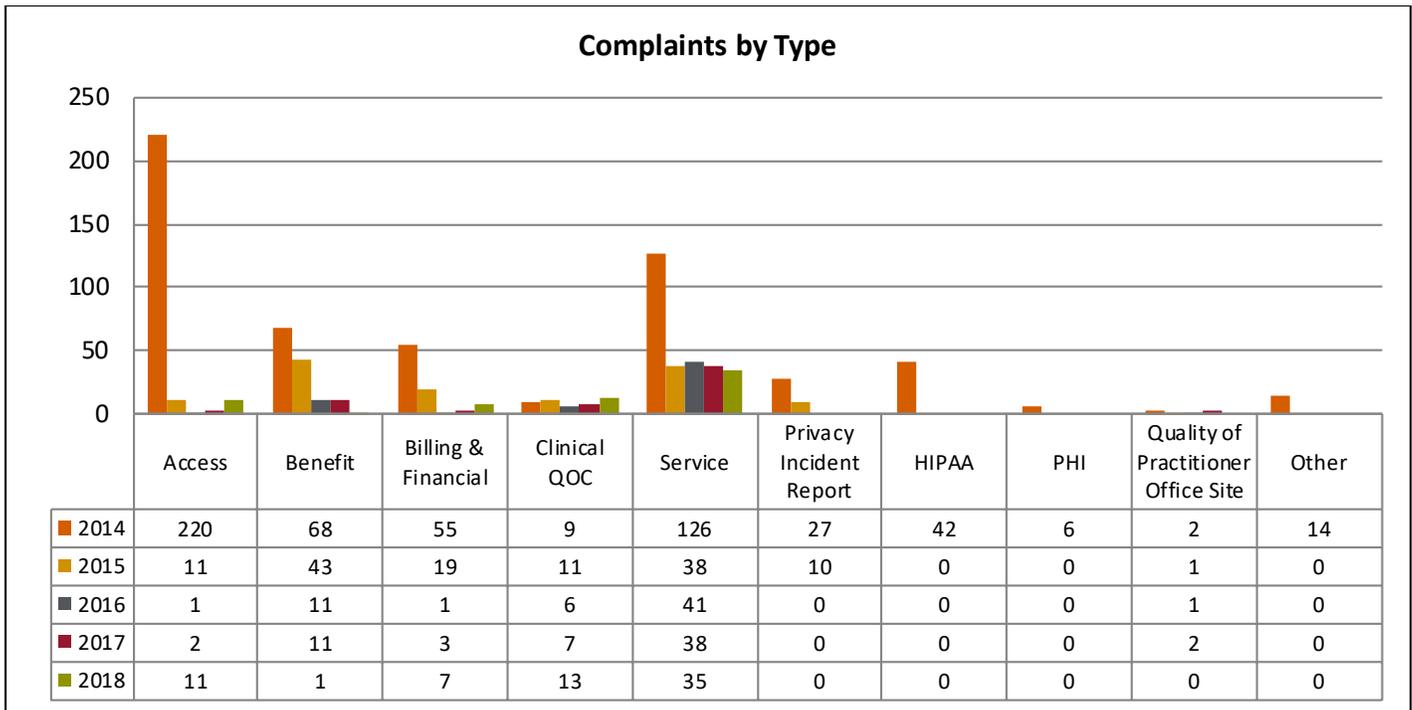
Complaints are collected and grouped into the following broad categories: Benefit, Service (and Attitude), Access (and Availability), Billing & Financial, Quality of Care, Privacy Incident, and Quality of Practitioner Office Site.

Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (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 2018. Of the total complaints received during 2018, 54 were identified as Quality of Service and 13 were identified as Quality of Care. Optum met the goal of QOS and QOC complaints resolved within established timeframes.

Total Complaints (QOS and QOC Combined)

Total Quality of Service & Quality of Care Complaints

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Quality of Service Resolution TAT Compliance (≤10 Days)

Quality of Care Resoluation TAT Complaince (≤30 Days)

Complaints by Type

	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

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 employs peer reviews for occurrences related to members that have been identified as Critical Incidents (CI). Providers are required to report CI's to Optum Idaho within 24 hours of being made aware of the occurrence. A CI is a serious, unexpected occurrence involving a member that is believed to represent a possible Quality of Care 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 has a Sentinel Events Committee (SEC) to review CI's identified as having a Quality of Care Concern and that meet Optum's definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review CI's identified as having a Quality of Care Concern and that do not meet Optum's definition of sentinel event. The SEC and PRC make 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 SEC and 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 review is completed within 5 business days from notification of incident.

Analysis: There were 49 Critical Incidents reported during 2018. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was again met.
The highest numbers of Critical Incidents reported in 2018 were in the category of Unexpected Deaths. Coordination of care occurred between the behavioral health provider and the member's primary care provider (PCP) in 81.6% (40 of 49) of cases. Of the 49 reported Critical Incidents, 71.4% involved members with co-morbid health conditions. Of the cases reported in 2018, 94% of the cases were adults (18+) and 6% were

children/adolescents (17 and below). Further analysis showed that the average age for males was 45 and females 46. No providers were put on unavailable status due to a Critical Incident.
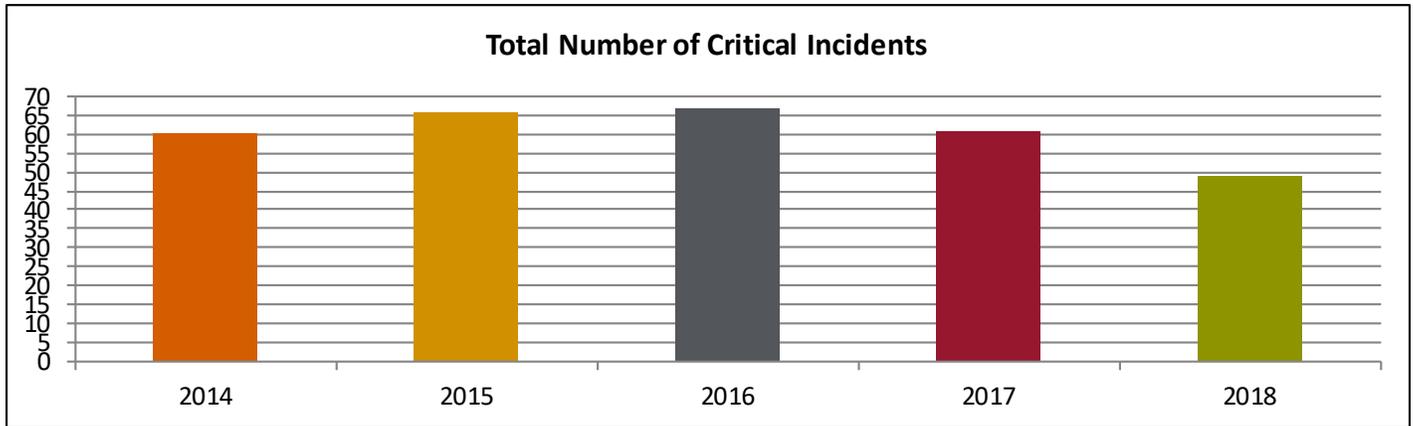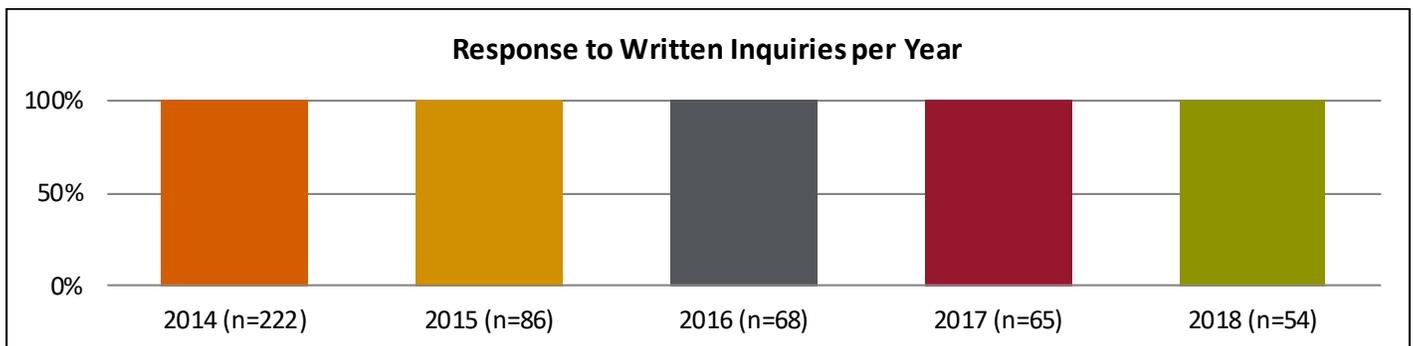
Total Number of Critical Incidents

Year	
2014	~60
2015	~66
2016	~67
2017	~61
2018	~48

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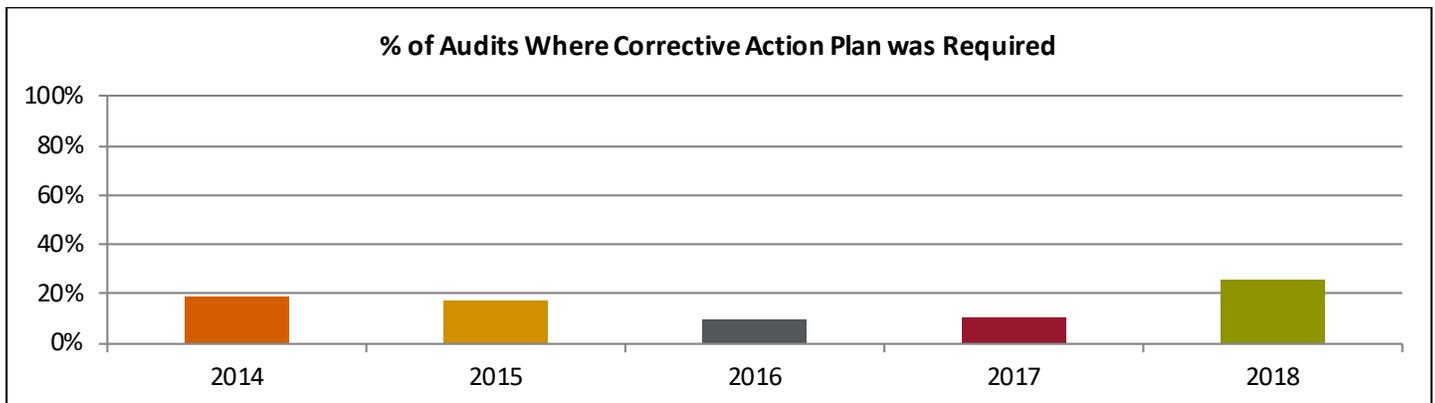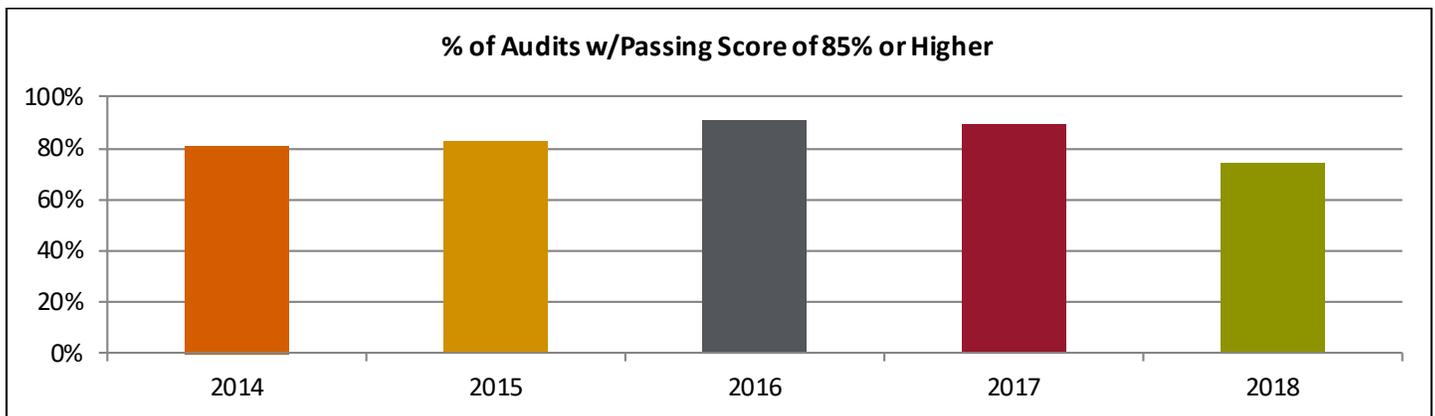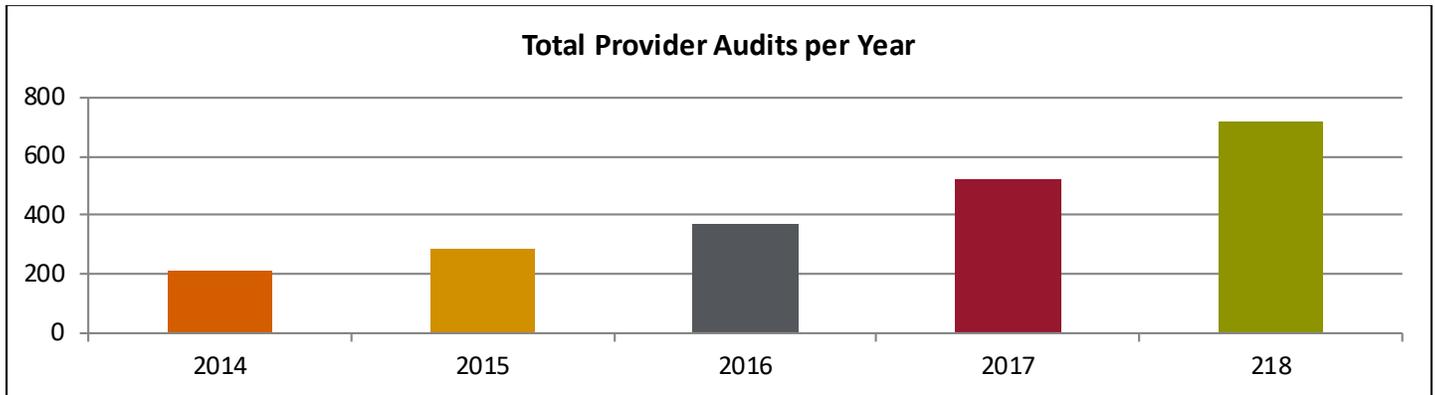*Opportunities and Interventions:* No opportunities for improvement were identified.

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's Customer Service Department.

Analysis: The data indicated that the standard of 100% acknowledged within 2 business days was again consistently met during 2018.

Response to Written Inquiries per Year

2014 (n=222)	2015 (n=86)	2016 (n=68)	2017 (n=65)	2018 (n=54)
100%	100%	100%	100%	100%

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. A score of 79% or below requires submission of a corrective action plan and participation in a re-audit within 4 – 6 months. Audit types and scores are tracked in an internal Excel tracking spreadsheet.

Analysis: A total of 717 audits were conducted during 2018, which is an increase from 519 audits completed during 2017. During 2018, 73.9% (533) of audits received a passing score (≥85%) and did not require a Corrective Action Plan. Corrective Action Plans were implemented for 26.1% (184) of the audits that were completed during 2018.

Total Provider Audits per Year

% of Audits w/Passing Score of 85% or Higher

% of Audits Where Corrective Action Plan was Required

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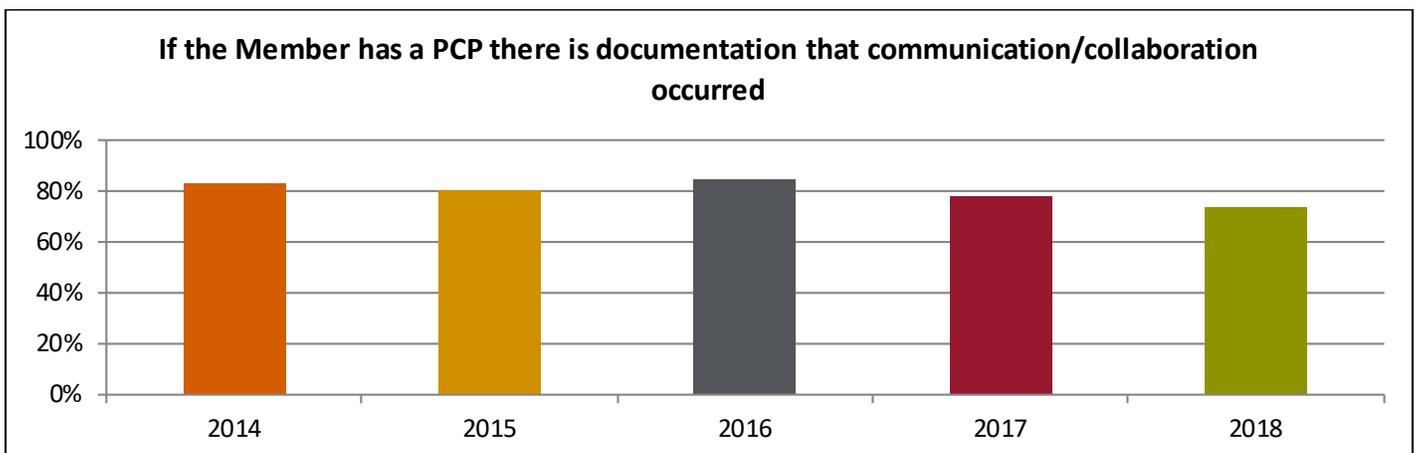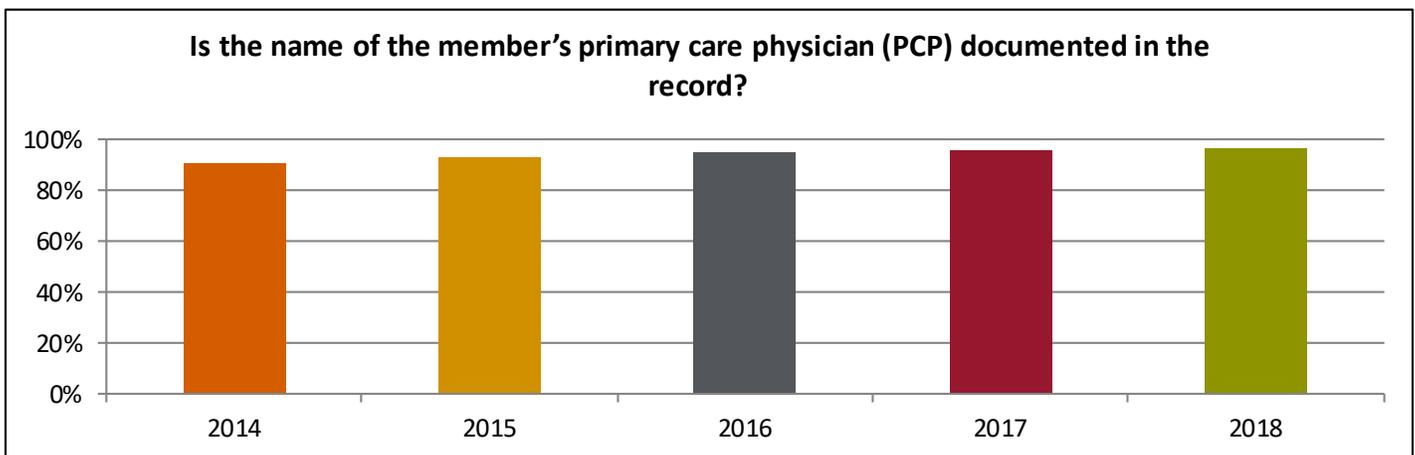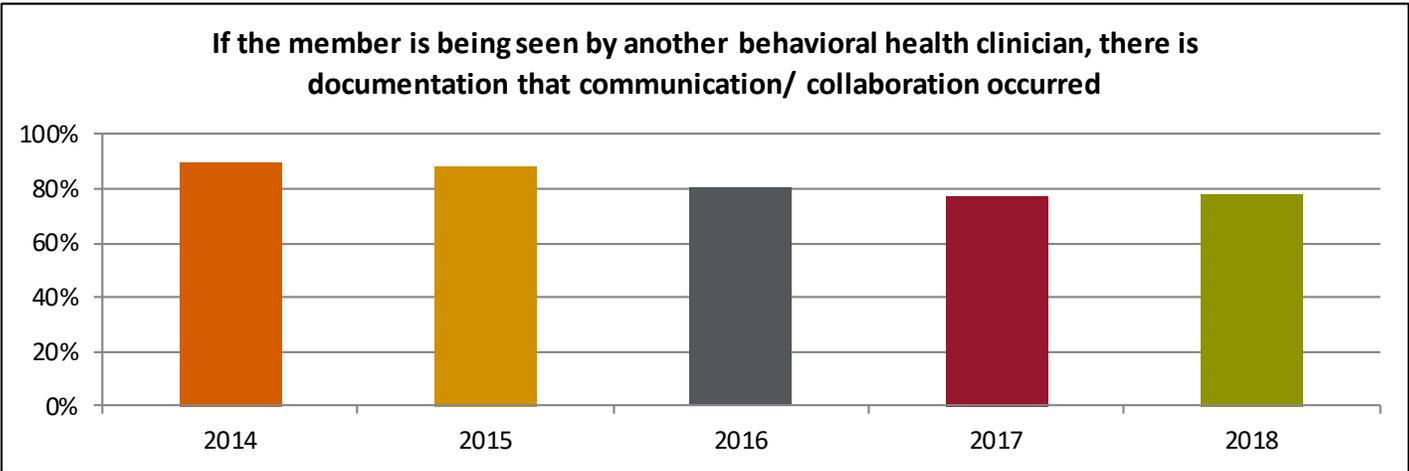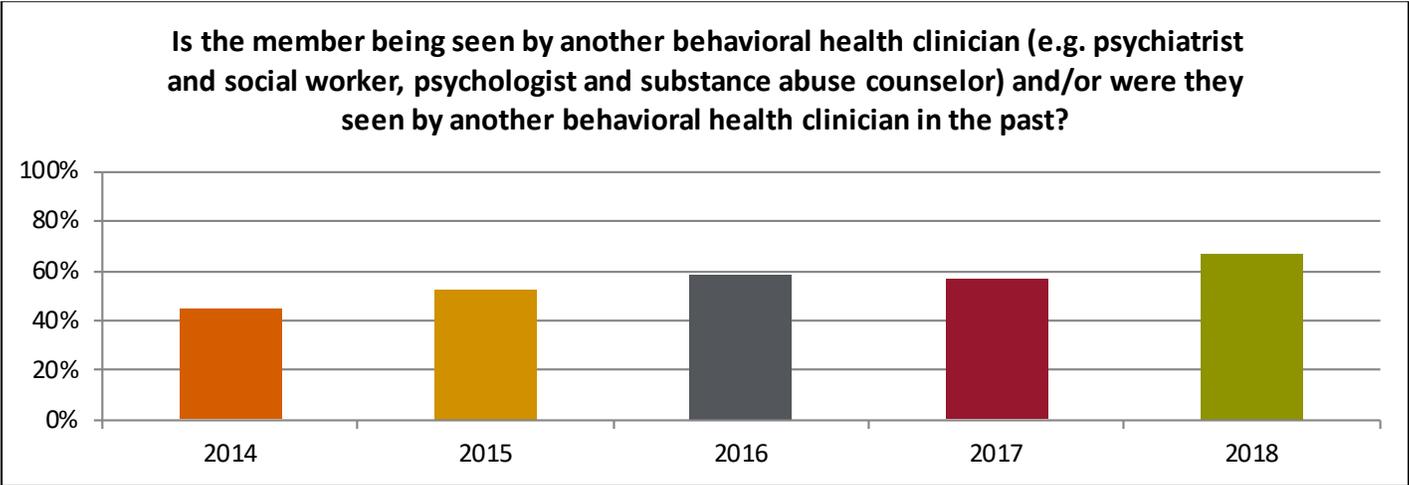ID-246-2019

Coordination of Care

Methodology: To coordinate and manage care between behavioral health and medical professionals, Optum 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 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, as well as accrediting organizations, expect 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 2018 revealed that 96% of member records reviewed had documentation of the name of the member's PCP. Of those, 74% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. The results also revealed that that 67% of the records indicated that 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 communication/collaboration had occurred.
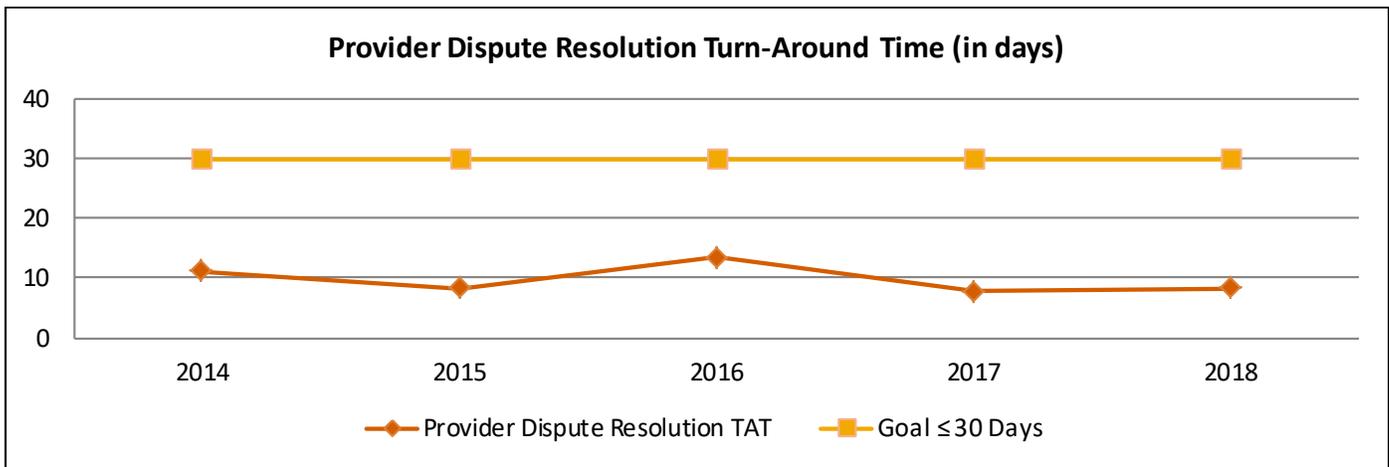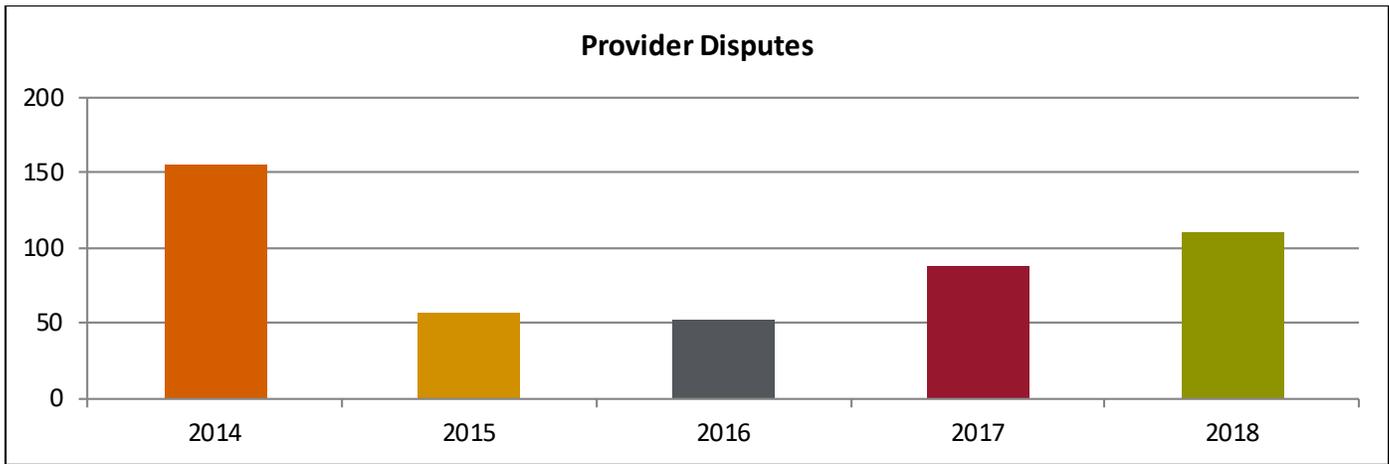
Is the name of the member's primary care physician (PCP) documented in the record?

If the Member has a PCP there is documentation that communication/collaboration occurred

Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor) and/or were they seen by another behavioral health clinician in the past?

A bar chart showing percentages for years 2014 through 2018. Values approximately: 2014 = 45%, 2015 = 53%, 2016 = 59%, 2017 = 57%, 2018 = 67%.

If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred

A bar chart showing percentages for years 2014 through 2018. Values approximately: 2014 = 90%, 2015 = 88%, 2016 = 81%, 2017 = 77%, 2018 = 78%.

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 notice be sent within 30 calendar days following the request for consideration.

Analysis: During 2018, there were 111 provider disputes, an increase from 88 in 2017. All were resolved within the goal of ≤30 days.

Provider Disputes

Year	Disputes
2014	~155
2015	~56
2016	~52
2017	~88
2018	~110

Provider Dispute Resolution Turn-Around Time (in days)

Legend: ◆ Provider Dispute Resolution TAT   ■ Goal ≤ 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, concurrent and post-service 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 2018, the percentage of determinations completed within 14 days was 99.1%.

Percent Determinations Completed within 14 days
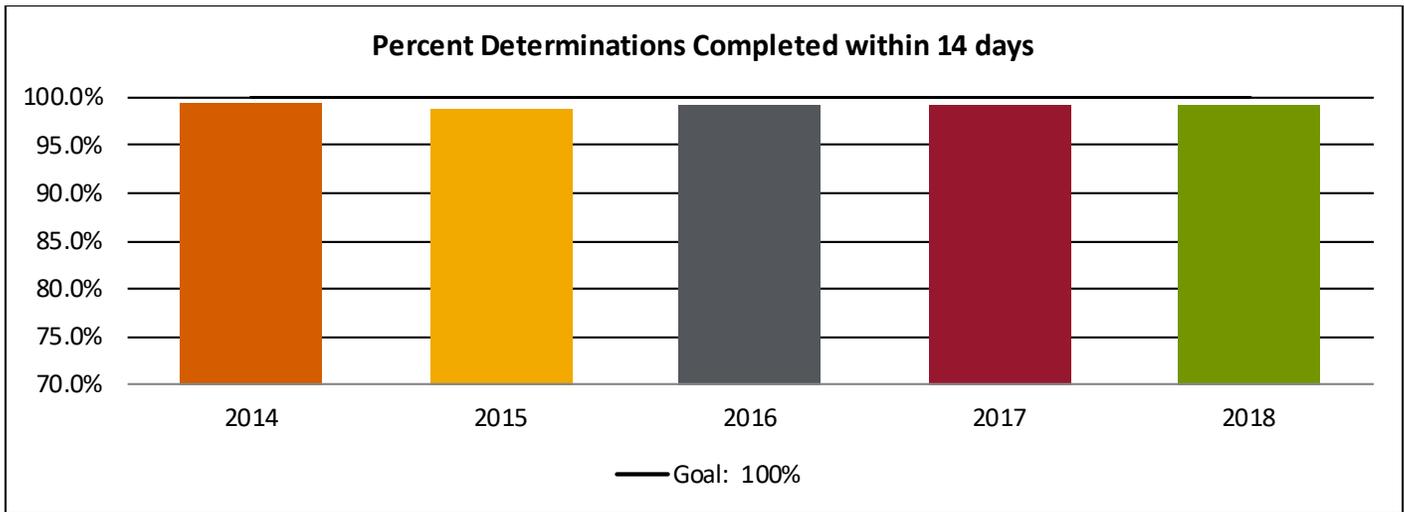
Barriers: Optum continues to fall short of the establish target of 100%. This is mostly due to complex EPSDT requests requiring intensive clinical review.
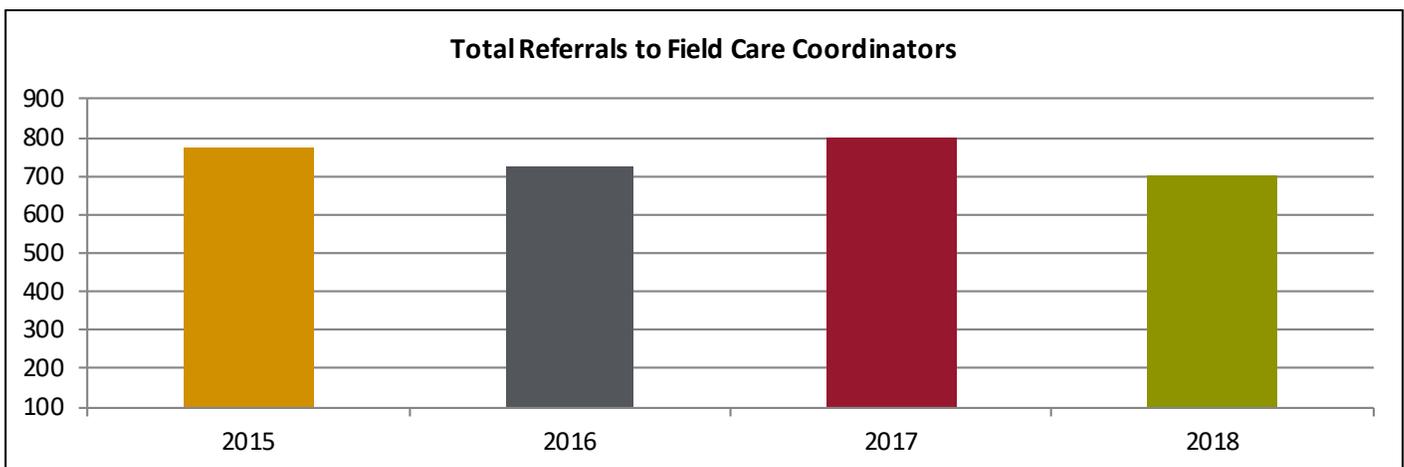
Opportunities and Interventions: We continue to monitor these utilization patterns as they relate to appropriate member care and provider usage. Policies and procedures have been adjusted to improve the completion rate to 100%.
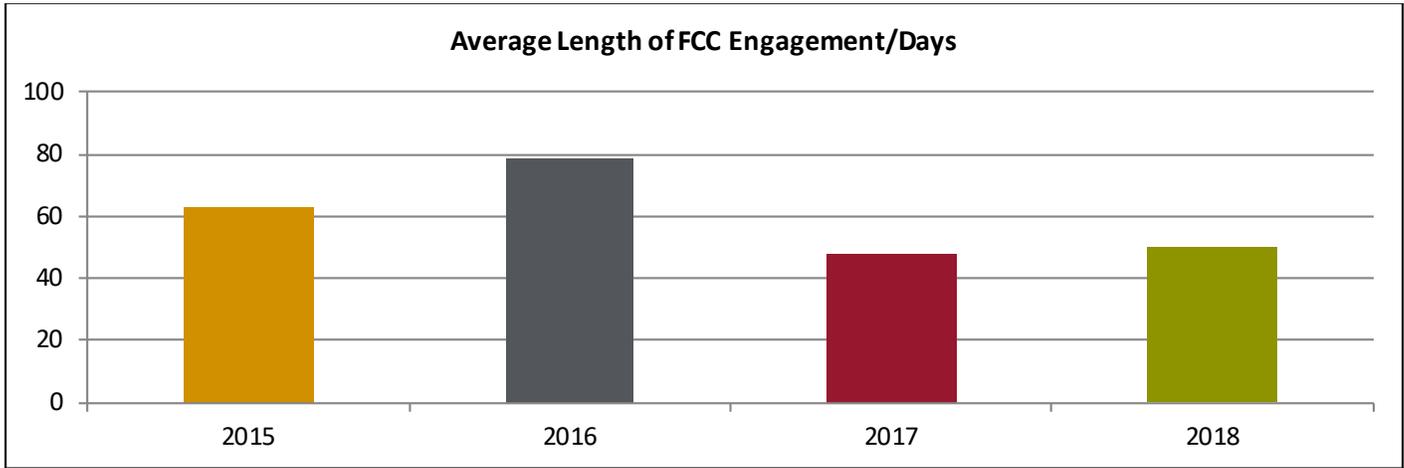
Field Care Coordination

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 2018, Field Care Coordinators received 699 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 50 days.

Total Referrals to Field Care Coordinators

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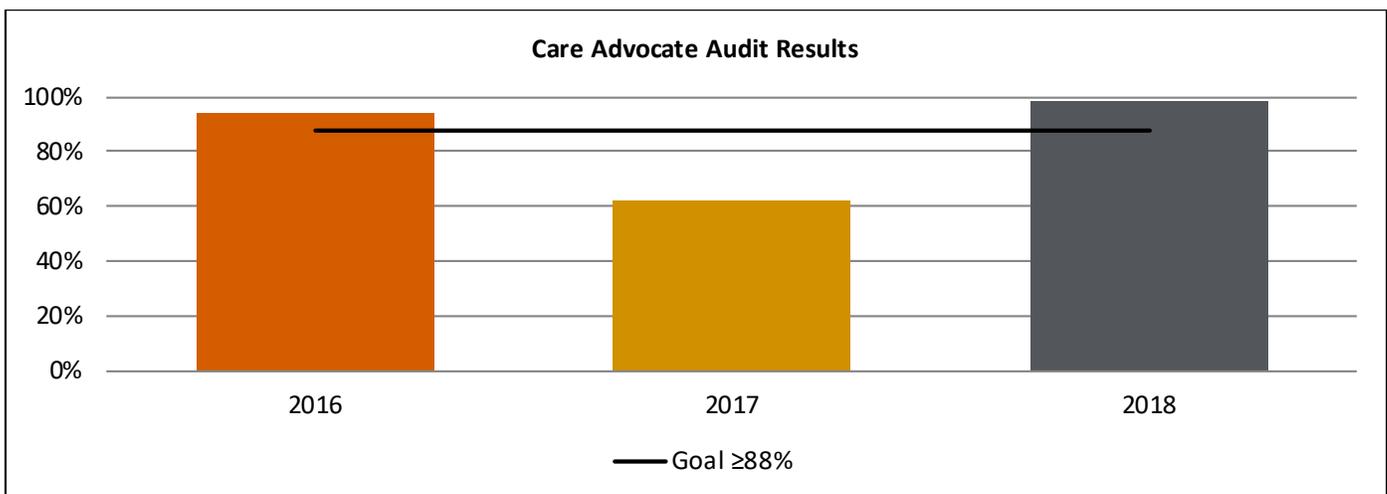
Average Length of FCC Engagement/Days

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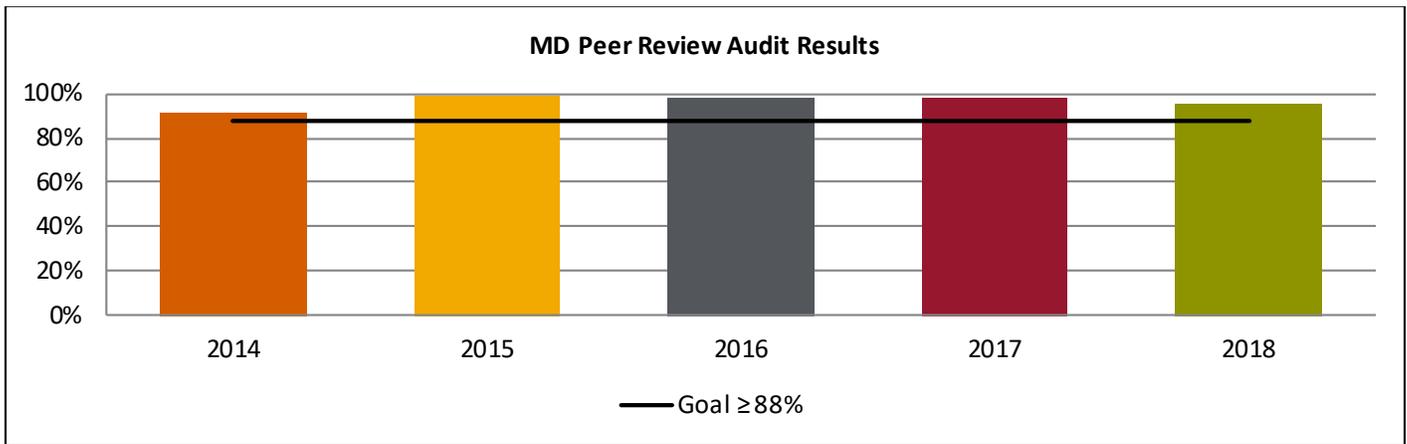**Opportunities and Interventions:** No opportunities for improvement were identified.

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 adverse benefit determinations by Optum 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 correct application of LOCG or state specific criteria was met? For the Peer Reviewer Audits, a random sample of adverse benefit determination cases are identified and assigned to a Regional Medical Director. The audits are conducted to review and evaluate the clinical documentation by Optum Physicians in their role as Peer Reviewers. The established goal is ≥88%.

Care Advocate Audit Results

MD Peer Review Audit Results

Goal ≥88%

Analysis: During 2018, 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 strives to provide culturally competent behavioral health services to its Members. Optum 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 2018, the Member Satisfaction Survey results consistently showed that members believe the care they received was respectful of their language, cultural, and ethnic needs.

Member Satisfaction Survey: Cultural, Language and Ethnic Needs
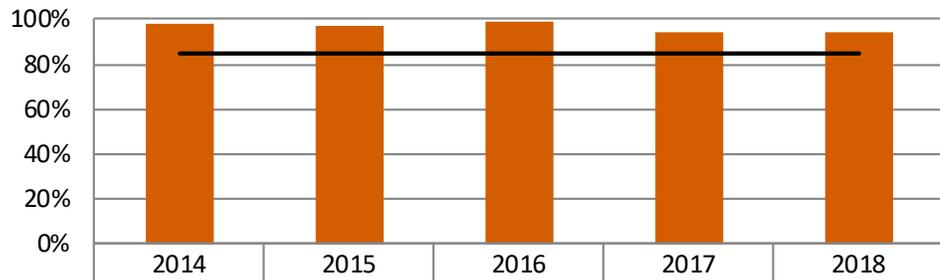
	2014	2015	2016	2017	2018
▬ The care I received was respectful of my language, cultural, and ethnic needs.	98%	97%	99%	94%	94%
—— Goal ≥85%	85%	85%	85%	85%	85%

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

Results for Language and Culture

Methodology: Optum provides language assistance that is relevant to the needs of our members who (a) speak a language other than English, (b) are deaf or having 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.

Lanuguage Assistance Requests by Type	Q1	Q2	Q3	Q4
Member Written Communication	1	6	4	1
Member Written Communication Formatted to Large Print	2	5	4	5
Language Service Associates	26	45	12	15
Languages Represented	6	10	5	5
Do Not Mail List	4	12	1	6

Analysis: During 2018, Optum responded to requests for language assistance as shown in the grid above. Predominant language requests assistance were in the following languages: Spanish, Farsi, and Arabic..
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.
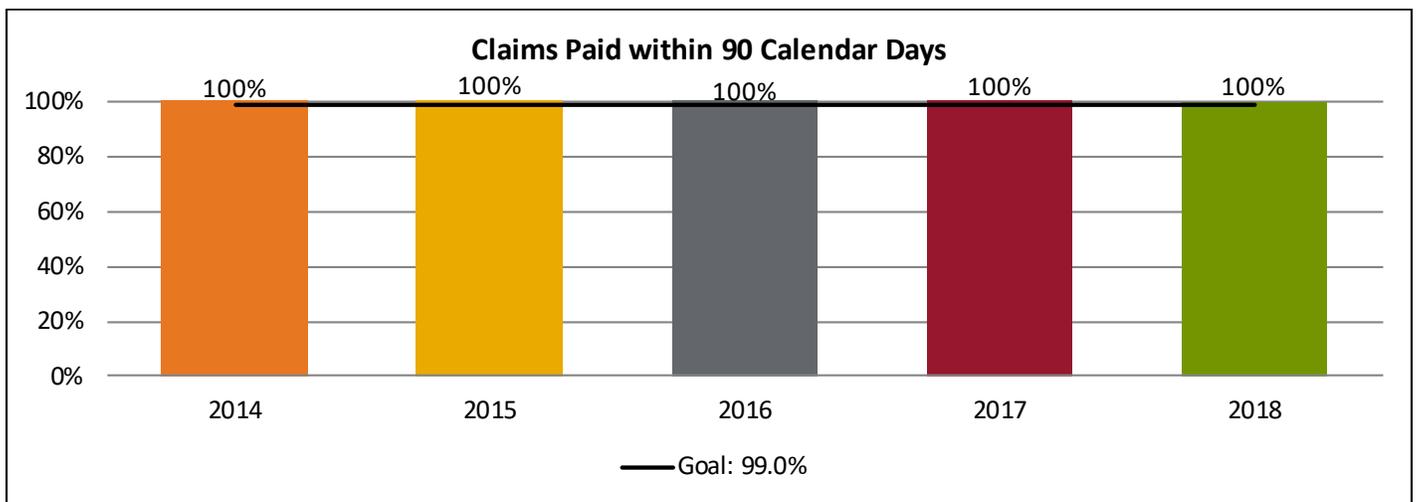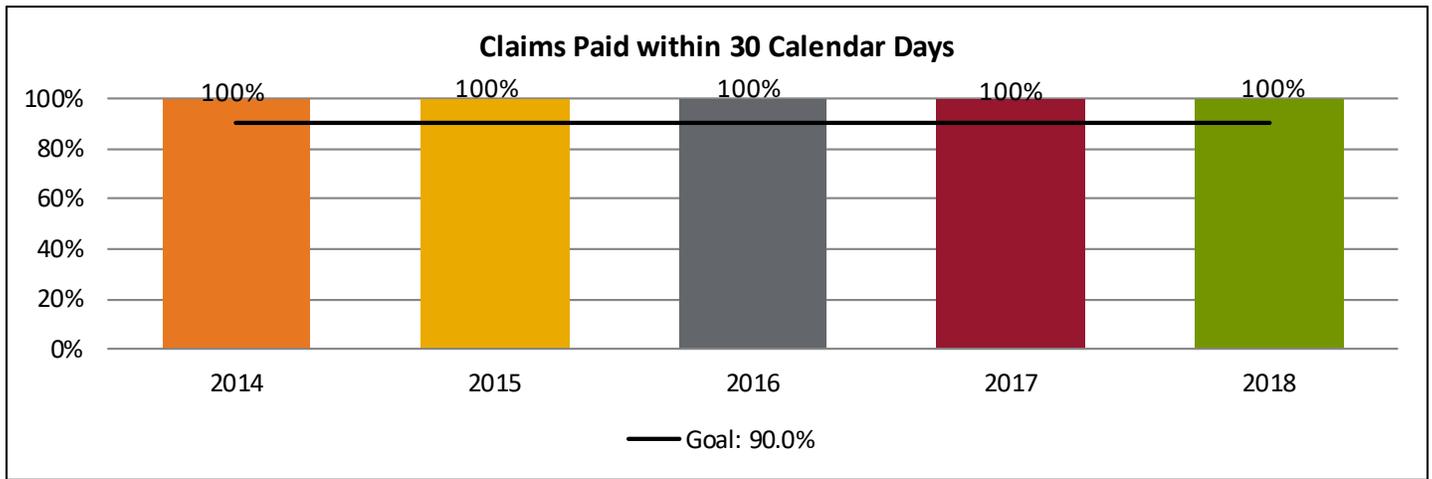
Claims

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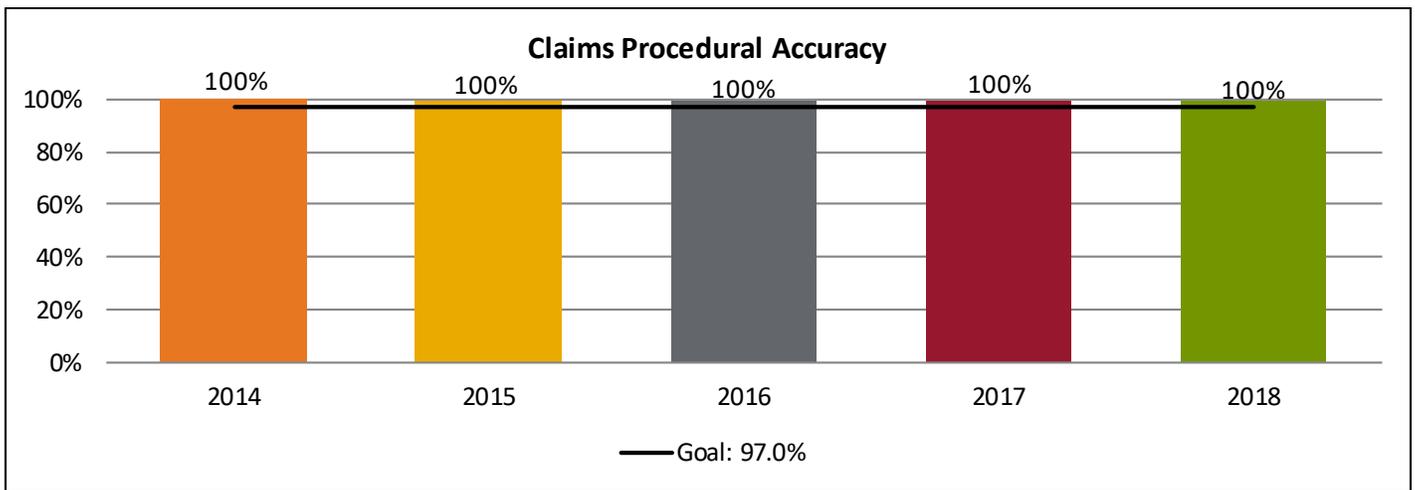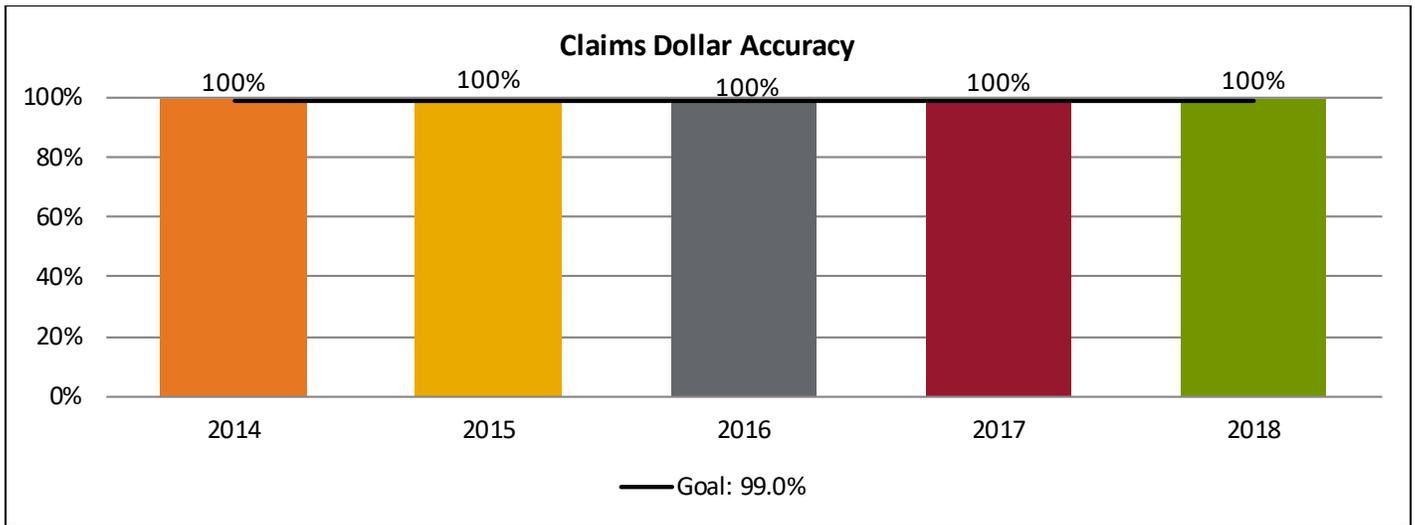
measured from the received date to the paid date (check), plus two days for mail time. Company holidays are included.

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 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: The data shows that all performance goals were met again during 2018.

Claims Paid within 30 Calendar Days

Goal: 90.0%

Claims Paid within 90 Calendar Days

Goal: 99.0%

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Claims Dollar Accuracy

Year	Value
2014	100%
2015	100%
2016	100%
2017	100%
2018	100%

Goal: 99.0%

Claims Procedural Accuracy

Year	Value
2014	100%
2015	100%
2016	100%
2017	100%
2018	100%

Goal: 97.0%

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