

## Idaho Behavioral Health Plan Quality Management and Utilization Management **Annual Evaluation**



**The Quality Management and Utilization Management (QMUM) 2021 Annual Evaluation summarizes Optum Idaho's performance in accordance with the contract between the Idaho Department of Health and Welfare (IDHW), Division of Medicaid and Optum. This report highlights the outpatient behavioral health services covered by the State of Idaho and provided on behalf of Medicaid members, also known as the Idaho Behavioral Health Plan (IBHP). This QMUM report provides a year-over-year annual view of performance and outcomes data.**

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## Introduction and Overview

The *Quality Management Utilization Management (QMUM) Annual Evaluation* provides an analysis of the Medicaid outpatient mental health and substance use disorder services managed by the Idaho Behavioral Health Plan (IBHP) in the State of Idaho. The time frame of this evaluation includes activities beginning Jan. 1, 2021, through Dec. 31, 2021, and provides comparative performance from 2014–2021.

### Our Mission

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

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

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

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

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

Optum Idaho deploys a dedicated program structure and appropriate resources to meet the QI Program goals and objectives. Oversight of the Optum Idaho QAPI Program is provided through a committee structure that includes input from Members, Families, Providers, and other Stakeholders and is accountable to Optum Idaho Executive

Leadership and to the IDHW. The executive leadership of Optum Idaho fully delegates oversight of the QAPI Program to the QAPI Committee, which is co-chaired by the chief medical officer and the quality manager and includes providers, the IDHW staff and Optum Idaho staff. The QAPI Committee, including the quality manager, has the responsibility for oversight of Member care and services and for selecting QI activities undertaken to meet the needs of Members, families and other stakeholders.

## **Leadership and Staffing**

The QAPI Program includes leadership from executive staff, including the chief medical officer, clinical director, deputy director, quality manager and provider relations director. The QI Program personnel and information resources are adequate to meet program needs and dedicated to, and available for, QI activities.

## **Support/Corporate Resources**

In addition to the local staff listed above, Optum Idaho is supported by corporate resources that provide a full spectrum of physical health, mental health and chemical dependency services, including state-of-the-art clinical assessment, referral and tracking information systems, statistical analysis software, a national provider network, research and health informatics and an established QI Program structure. These resources are available to Optum Idaho, in addition to the quality and clinical oversight mechanisms that encourage sharing of best practices and new technologies.

## **Governing Body**

Oversight of our QI Program is provided through a committee structure that is accountable to the Executive Leadership Team (ELT). The ELT fully delegates responsibility for oversight of the QI Program to quality management, who provides the ELT with an annual evaluation on the QI Program. The ELT fully delegates oversight of the QI Program to the QAPI Committee. The QAPI Committee has delegated full authority for the day-to-day operations and implementation of the program to appropriate committees/subcommittees.

## **Designated Behavioral Healthcare Practitioner**

The Optum Idaho chief medical officer plays an essential role in the QI process and ensures that clinical activities are planned and developed within that framework. The chief medical officer is the designated senior leader responsible for QI Program oversight, ensuring overall alignment of the program with the organization's clinical vision and strategic goals. The chief medical officer works in collaboration with the quality manager, to routinely advise the QI Program through chairing and/or participating in committees and subcommittees where they contribute to the analysis, prioritization, and implementation of QI activities, including review and improvement of clinical safety.

## **Quality Improvement Program**

The QI Program covers all QI processes. Participation and input from staff and network practitioners contribute to the QI Program. Functional area leaders have substantial involvement in the QI Program, along with other staff within the Clinical Operational Center and cross-site functional areas.

## **Quality Committees**

Oversight of the Optum Idaho QI Program is provided through a committee structure that is accountable to Optum Idaho's executive leadership and to the IDHW. The executive leadership of Optum Idaho delegates oversight of the QAPI Program to the Optum Idaho QAPI Committee, co-chaired by the chief medical officer and quality manager. The QAPI Committee reports up through the governance structure to senior leadership.

## **Key Roles (functional areas) and Responsibilities**

The deputy director is responsible for providing overall leadership to the behavioral health QI Program and for ensuring organization-wide implementation of the program structure.

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The manager for QI is responsible for providing leadership to the behavioral health QI Program and ensuring organization-wide implementation of the program structure. The manager for QI reports to the deputy director. The manager for QI directs the behavioral health QI Program structure at its various levels of implementation and directs the professional QI staff responsible for its daily operations.

## Preparation for Independent Reviews

The Quality Department is responsible for coordinating efforts to prepare for External Quality Reviews (EQR) performed by an IDHW-approved independent assessor. The EQR takes place annually to ensure compliance with the IDHW standards and contract requirements.

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

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

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

This *Annual Evaluation* provides an assessment of the overall effectiveness of the IBHP's programs and services provided. The purpose of this *Annual 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.

## Summary and Highlights

The results of Optum Idaho's efforts in 2021 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 were being met. Performance targets are based on contractual, regulatory or operational standards. Included in this report is an analysis of Optum Idaho's 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 2021 annual data, Optum Idaho met or exceeded performance for 31 (94%) of the 33 total key measures. Two (2) measures fell below the performance goal: 1) Provider Overall Satisfaction at 72% and 2) Members Calls Answered within 30 Seconds at 68%. 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 Idaho.

Monitoring member satisfaction with behavioral health services remained vital to establishing the voice of the member. Overall member satisfaction met the goal of  $\geq 85\%$  in 2021. The goal was also met for member satisfaction with *Counseling and Treatment; Optum Support for Obtaining Referrals or Authorization; and Accessibility, Availability and Acceptability of the Clinician Network*. Members also indicated that they were consistently satisfied with the time it took to get an appointment and with the ability to find care that was respectful of their language, culture and ethnic needs.

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Monitoring provider satisfaction with Optum Idaho is vital to establishing the voice of the provider. The results of the 2021 Provider Satisfaction survey fell below the goal of  $\geq 85\%$  overall provider satisfaction at 72%. Action plans will be implemented during 2022 to address provider satisfaction.

## Telemental Health

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

During 2021, Optum Idaho continued to inform members and providers of the availability of this service to ensure members had the ability to receive continued care during the pandemic.

## Hello Idaho!

**Hello Idaho!** was developed in 2020 and continued in 2021 to help reduce isolation and encourage everyone to reach out and connect with those around them. This year-round campaign provides tools for students, businesses and community members to talk about mental health and help reduce both emotional and physical isolation.

## Youth Empowerment Services

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

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

The YES Program refers to a specific population within the YES System of Care. These are individuals who are eligible for Medicaid under the 1915(i) State Plan Option. To be eligible for Medicaid under the 1915(i) State Plan Option, individuals must undergo an independent assessment that will be used to determine if the child or adolescent has an SED. If it is determined that the child or adolescent has an 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.

Throughout 2021, Optum Idaho remained dedicated to raising awareness about mental health and wellness and the resources that are available to help people reach recovery. Through community engagement activities, informational media coverage or organized events, Optum Idaho continued its focus on an outcome-driven, recovery-centered system of care for Idaho members.

### **Youth Support Training**

Three Youth Support endorsement opportunities were provided in 2021, and Optum trained a total of 46 providers as a result. Optum contracted with the Idaho Federation of Families mid-2021 to provide the training and coaching (below) that was started several years ago with En Route. In addition, two trainees currently working in an apprentice role were identified as people who could eventually be able to train on their own. The goal is to grow the pool of eligible trainers within Idaho, and then they can then help further develop the local workforce.

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## Coaching

Throughout 2021, Peer Services Coaching opportunities were offered to providers who are credentialed/endorsed Peer Services providers (including Youth Support, Peer Support, Family Support, Recovery Coaching). Coaching was provided to agencies seeking opportunities for their supervisors and peer providers to think about how to put into practice what was learned in training and to offer the opportunity to improve implementation and delivery of Peer Services in a more informal setting. The goals included:

- Identifying strengths and needs related to implementation and delivery of services.
- Providing constructive feedback about organizational structure that supports implementation and service delivery.
- Noting specific strategies for Peer Services professionals for applying skills learned to real-world experiences.
- Developing additional training and workforce development plans based on needs.

## Targeted Care Coordination

Targeted Care Coordination (TCC) includes coordination and facilitation of the interdisciplinary Child and Family Team (CFT) meetings to develop an outcome-focused, strengths-based, Person-Centered Service Plan (PCSP) that includes both formal and informal services and support. Optum Supports and Services Manager (OSSM) is the tool that providers use to submit the PCSPs to Optum. During 2021, a new project was initiated with a goal to enhance and restructure TCC training, increase the amount of PCSPs being submitted and find ways to increase the workforce for both TCC and Respite. Listening sessions were held to gather feedback from providers on ways to improve TCC Services.

## Therapeutic After-School and Summer Programs

As part of YES, Therapeutic After-School and Summer Programs (TASSP) are structured programs that consist of a range of individualized therapeutic, recreational and socialization activities for youth. These individual and group therapeutic experiences assist youth in developing social, communication, behavior and basic living skills, as well as psychosocial and problem-solving skills. TASSP are a collaboration between provider agencies, community-based organizations, professional and/or other entities. Informational sessions were offered to internal Optum Idaho staff and providers throughout 2021:

- State Department of Education Prevention Conference
- Idaho Out of Schools Network Statewide Roundtables (five total)
- Optum Provider Trainings
- Idaho School Counselor Associate (ISCA) Stronger Together Conference
- Optum Idaho sponsored six Think Make Create (TMC) mobile STEM/STEAM labs that can be incorporated into TASSP with collaborating Optum Providers.

A recording of the TASSP training was created and became available on Relias in 2021.

## Optum Conference

The Optum Conference took place April 13-14, 2021, and was 100% virtual due to the COVID-19 pandemic. The conference was open to Optum network providers, non-network providers and other interested community stakeholders. It was free of charge to participants, and CEU credit was offered for most sessions. The keynote speaker was Katherine Hopps Knutson, MD, MPH, Senior Vice President at UnitedHealth Group and CEO of Optum Behavioral Care. Through Optum Behavioral Care, Dr. Hobbs Knutson is redesigning behavioral health care delivery, creating a scalable model to improve efficiency, quality and access. Other topics included:

- Integrating CANS (The Child and Adolescent Needs and Strengths assessment) into practice
- Ethics and the Law
- Medication Assisted Treatment
- LGBTQIA+

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- ASAM (American Society of Addiction Medicine) as an Evidence-Based Tool
- Diversity and Culture
- Behavioral Health Challenges in Tribal Communities

For the conference, 798 people attended. A post-conference survey was completed by 133 attendees, netting an average score of 8.7 out of 10 for the question: “How likely are you to recommend the Optum Conference to a friend or colleague?” Some of the goals of the conference were to:

- Provide a venue for providers and community stakeholders to attend panels, listen to keynote speakers and attend workshops around developing skill and discovering solutions for improved professional satisfaction and client care.
- Give providers an opportunity to voice concerns and feel heard.
- Create an avenue for ideas and solutions to be brainstormed among providers.

The 2022 Optum Conference will take place again October 18-19, 2022.

## **External Quality Review**

An External Quality Review (EQR) is the evaluation by an External Quality Review Organization (EQRO) of aggregated information over time. Each year, the IDHW requires the external review organization, Telligen, to review Optum Idaho to assure acceptable standards of care are being delivered. This requirement originates with the Centers for Medicare & Medicaid (CMS). The following areas were reviewed during the 2021 review:

- Performance Measures: Optum Idaho received a “fully compliant” (measure was fully compliant with State Specifications) rating on Performance Measures.
- Performance Improvement Projects: Optum Idaho received a “developing” (documentation supports some but not all components were present) rating on Performance Improvement Projects.
- Compliance Review of Quality Standards: Optum Idaho received a “proficient” (documentation supports that all components were implemented, reviewed, revised and/or further developed, and responses were provided to reviewers that were consistent with the standard and with the documentation) rating. For this review period, Optum Idaho was rated as proficient in all 10 standards, which was an improvement from the previous review period when six standards were rated as proficient and four were rated as developing.
- Network Adequacy: A review of this protocol was completed to gather baseline data regarding the current network of Optum Idaho providers. Optum Idaho provided responses to questions from Telligen related to network adequacy, including but not limited to tracking and monitoring of appointment wait times, assisting members to find a provider and ensuring an adequate number of providers are available for the population being served. As CMS is still developing this protocol, no rating was given to Optum Idaho during this review period.

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# 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 2014-2021. Those highlighted in green met or exceeded overall performance goals; those highlighted in yellow fell within 5% of the performance goal. Those highlighted in red fell below the performance goal.

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

Measure	Goal	2014	2015	2016	2017	2018	2019	2020	2021
<b>2014 – 2016 Member Satisfaction Survey Results*</b>									
Experience with Optum Idaho Staff and Referral Process	≥85%	84%	85%	92%	NA	NA	NA	NA	NA
Experience with the Behavioral Health Provider Network	≥85%	91%	91%	94%	NA	NA	NA	NA	NA
Experience with Counseling or Treatment	≥85%	93%	94%	95%	NA	NA	NA	NA	NA
<b>Overall Experience</b>	≥85%	90%	92%	94%	NA	NA	NA	NA	NA
<i>*New Survey Implemented, results below</i>									
<b>2017 – 2021 New Survey: Member Satisfaction Survey Results</b>									
Optum Support for Obtaining Referrals or Authorizations	≥85%	NA	NA	NA	80%	92%	94%	91%	90%
Counseling and Treatment	≥85%	NA	NA	NA	95%	95%	95%	94%	93%
Accessibility, Availability, and Acceptability of the Clinician Network	≥85%	NA	NA	NA	89%	93%	93%	93%	90%
<b>Overall Satisfaction</b>	≥85%	NA	NA	NA	80%	92%	94%	90%	90%
<b>Provider Satisfaction Survey Results</b>									
<b>Overall Provider Satisfaction</b>	≥85%	69%	65%	75%	77%	79%	76%	88%	72%

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Measure	Goal	2014	2015	2016	2017	2018	2019	2020	2021
<b>Accessibility &amp; Availability - Idaho Behavioral Health Plan Membership</b>									
Membership Numbers	NA	314,538	330,474	336,394	342,357	336,997	318,331	383,601	419,467
<b>Accessibility &amp; Availability - Member Service Call Standards</b>									
Total Number of Calls	NA	6,483	4,838	5,153	5,292	4,658	4,641	6,999	5,544
Percent Answered Within 30 Seconds	≥80%	91%	91%	88%	84%	71%	76%	84%	68%
Average Daily Hold Time	≤120 Seconds	13	13	15	19	33	25	20	44
Abandonment Rate	≤3.5% internal, ≤7% contractual	1.5%	1.9%	2.2%	2.3%	3.1%	3.0%	1.5%	4.1%
<b>Accessibility &amp; Availability - Customer Service (Provider) Call Standards</b>									
Total Number of Calls	NA	16,323	14,205	12,220	13,016	12,036	12,332	13,597	11,778
Percent Answered within 30 seconds	≥80%	84%	97%	97%	98%	98%	98%	98%	98%
Average Daily Hold Time	≤120 seconds	35	6	4	4	3	3	4	5
Abandonment Rate	≤3.5% internal, ≤7% contractual	2.9%	0.6%	0.3%	0.4%	0.2%	0.3%	0.4%	0.4%
<b>Accessibility &amp; Availability - Appointment Access Standards</b>									
Urgent Appointment Wait Time	48 hours	18.5	22.8	24.2	23.1	22.4	19.0	15.0	10.5
Non-Urgent Appointment Wait Time	10 days	3.8	4.7	6.0	6.0	4.8	4.0	3.5	2.8
Critical Appointment Wait Time*	6 hours	NA	NA	NA	5	3	3	3	2
*Began tracking in 2017.									

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Measure	Goal	2014	2015	2016	2017	2018	2019	2020	2021
<b>Geographic Availability of Providers</b>									
<b>Area 1</b> – Requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties	100%	99.9%*	99.8%*	99.8%*	99.9%*	100.0%	99.8%*	99.9%*	99.9%*
<b>Area 2</b> – Requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	100%	99.8%*	99.9%*	99.8%*	99.8%*	100.0%	99.8%*	99.7%*	99.8%*
<i>*Performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number).</i>									
<b>Member Protections and Safety – Notification of Adverse Benefit Determinations (ABDs)</b>									
Number of ABDs	NA	2,266	2,038	2,139	2,164	1,325	475	78	136
Clinical ABDs*	NA	NA	NA	NA	930	773	381	22	22
Administrative ABDs*	NA	NA	NA	NA	318	552	94	56	114
<i>*Began tracking in 2017.</i>									
Written Notification	<b>100% w/in 14 calendar days from request for services</b>	NA	NA	NA	99.9%	99.6%	98.7%	98.5%	100%
Written Notification Sent within 1 Business Day	<b>100.0%</b>	77.3%	98.4%	97.0%	NA*	NA*	NA*	NA*	NA*
<i>*New 14-day requirement tracked above.</i>									

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

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Measure	Goal	2014	2015	2016	2017	2018	2019	2020	2021
<b>Member Protections and Safety – Member Appeals</b>									
Number of Appeals	NA	278	92	73	113	53	14	3	4
Member Appeals Turnaround Time*	≤30 days	10	12	16	NA	NA	NA	NA	NA
<i>*Now reporting Non-Urgent/Urgent separately. See below.</i>									
Non-Urgent Appeal Resolution Turnaround Time	≤30 days	NA	NA	NA	9	8	4	16	14
Urgent Appeal Resolution Turnaround Time	72 hours	NA	NA	NA	25	53	19	18	49
<b>Member Protections and Safety – Complaint Resolution and Tracking</b>									
Total Number of Complaints	NA	569	133	61	63	67	67	45	29
Percent of Complaints Acknowledged within Turnaround time	100% w/in 5 business days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Quality of Service Complaints	NA	560	122	55	56	54	55	34	23
Percent Quality of Service Resolved within Turnaround Time	100% w/in ≤10 business days	100.0%	99.3%	100.0%	96.4%	100.0%	96.0%	100.0%	100.0%
Number of Quality of Care Complaints	NA	9	11	6	7	13	12	11	6
Percent Quality of Care Resolved within Turnaround Time	100% w/in ≤30 calendar days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Member Protections and Safety – Critical Incidents</b>									
Number of Critical Incidents Received	NA	60	66	67	61	49	42	60	51
Percent Ad Hoc Reviews Completed within 5 Business Days from Notification of Incident	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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Measure	Goal	2014	2015	2016	2017	2018	2019	2020	2021
<b>Member Protections and Safety – Response to Written Inquiries</b>									
Percent Acknowledged ≤2 Business Days*	<b>100.0%</b>	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	99.0%	100.0%
*One response was out of compliance due to customer services staff having to wait for information from another team prior to responding to provider.									
<b>Provider Monitoring and Relations – Provider Quality Monitoring</b>									
Number of Audits	<b>NA</b>	210	287	368	519	717	439	458	593
Percent of Audits that Received Passing Score of ≥85%	<b>≥85%</b>	81%	82%	90%	89%	74%	80%	84%	77%
Percent of Audits that Required a Corrective Action Plan	<b>NA</b>	19%	18%	10%	11%	26%	20%	16%	33%
<b>Provider Monitoring and Relations – Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)</b>									
Percent PCP is Documented in Member Record	<b>NA</b>	91%	93%	95%	96%	96%	97%	98%	100%
Percent Documentation in Member Record that Communication/ Collaboration Occurred Between Behavioral Health Provider and PCP	<b>NA</b>	83%	80%	85%	78%	74%	78%	76%	80%
<b>Provider Monitoring and Relations – Provider Disputes</b>									
Number of Provider Disputes	<b>NA</b>	156	57	52	88	111	138	579	375
Average Number of Days to Resolve Provider Disputes	<b>≤30 days</b>	11.2	8.3	13.4	7.8	8.3	8.0	9.0	15.0
<b>Utilization Management and Care Coordination – Service Authorization Requests</b>									
Percentage Determination Completed within 14 Days	<b>100%</b>	No data available	98.8%	99.1%	99.2%	99.1%	100.0%	100.0%	100.0%

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Measure	Goal	2014	2015	2016	2017	2018	2019	2020	2021
<b>Utilization Management and Care Coordination – Person-Centered Service Plan (PCSP)</b>									
Number of PCSPs Received	NA						925	863	619
Average Number of Business Days to Review	≤5 days		NA*	NA*	NA*	NA*	0.16	0.11	0.49
<i>*Began tracking in 2018 but not a full year's worth of data until 2019.</i>									
<b>Utilization Management and Care Coordination – Field Care Coordination (FCC)</b>									
Total Referrals to FCCs	NA	NA*	774	722	800	699	960	1604	629
Average Number of Days Case Open to FCC	NA	NA*	63.2	79.0	48.0	50.0	48.0	43.0	37.0
<i>*Began tracking in 2015.</i>									
<b>Inter-Rater Reliability Testing</b>									
Care Advocate Audit Results	≥ 88.0%	NA	NA	93.8%	62.2%	99.0%	99.0%	100.0%	97.0%
MD Peer Review Audit Results	≥ 88.0%	91.7%	99.5%	98.0%	98.3%	95.0%	95.0%	*	95.0%
<i>*Data unavailable.</i>									
<b>Claims</b>									
Claims Paid within 30 Calendar Days	90.0%	99.7%	99.9%	99.9%	99.9%	100.0%	99.9%	99.0%	99.0%
Claims Paid within 90 Calendar Days	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	99.0%
Dollar Accuracy	99.0%	99.8%	99.9%	99.9%	99.7%	100.0%	99.0%	99.0%	99.0%
Procedural Accuracy	97.0%	100.0%	99.7%	99.9%	99.8%	100.0%	99.0%	99.0%	99.0%

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

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# Outcomes Analysis

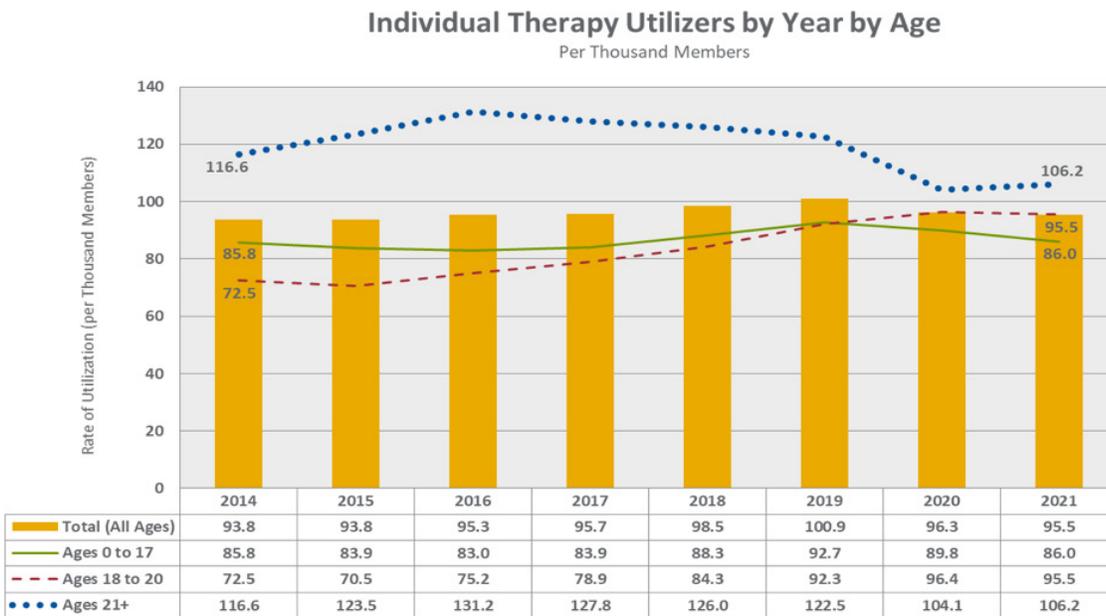
There are multiple outcomes that Optum Idaho follows to assess the extent to which the IBHP benefits its members. These include measures of clinical symptoms and functional impairments; appropriateness of service delivery and fidelity to evidence-based practices; impact on hospital admissions/discharges 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 to providers for filing claims. The rate of utilization is calculated as follows: Numerator is the number of unique utilizers of service visits. Denominator is the total number of IBHP members, in thousands.

## Individual Therapy

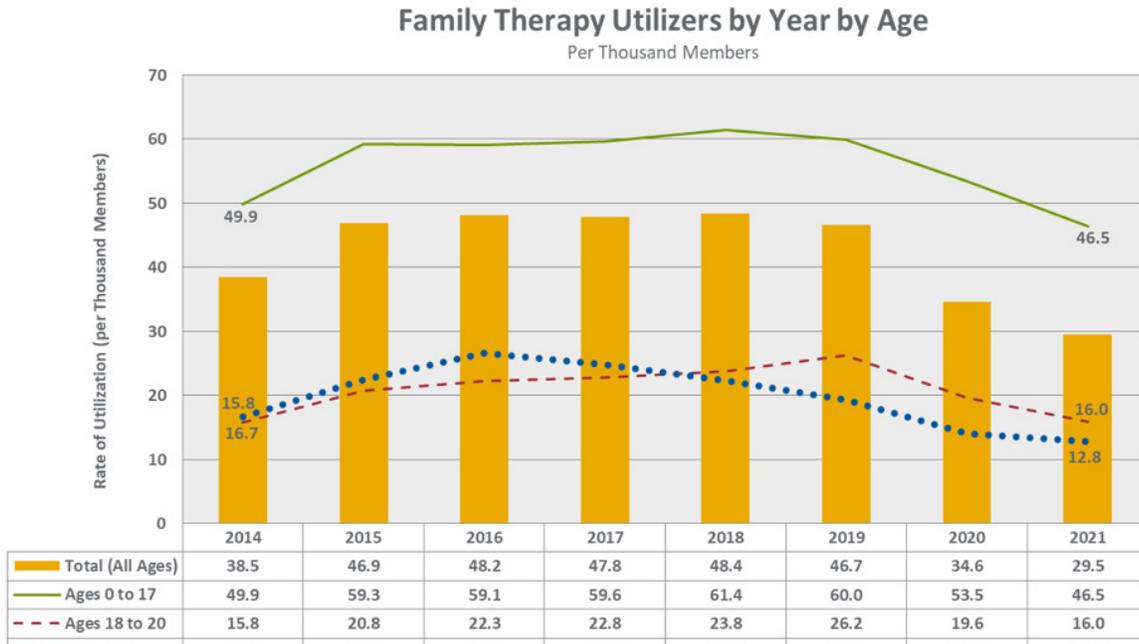
Figure 1



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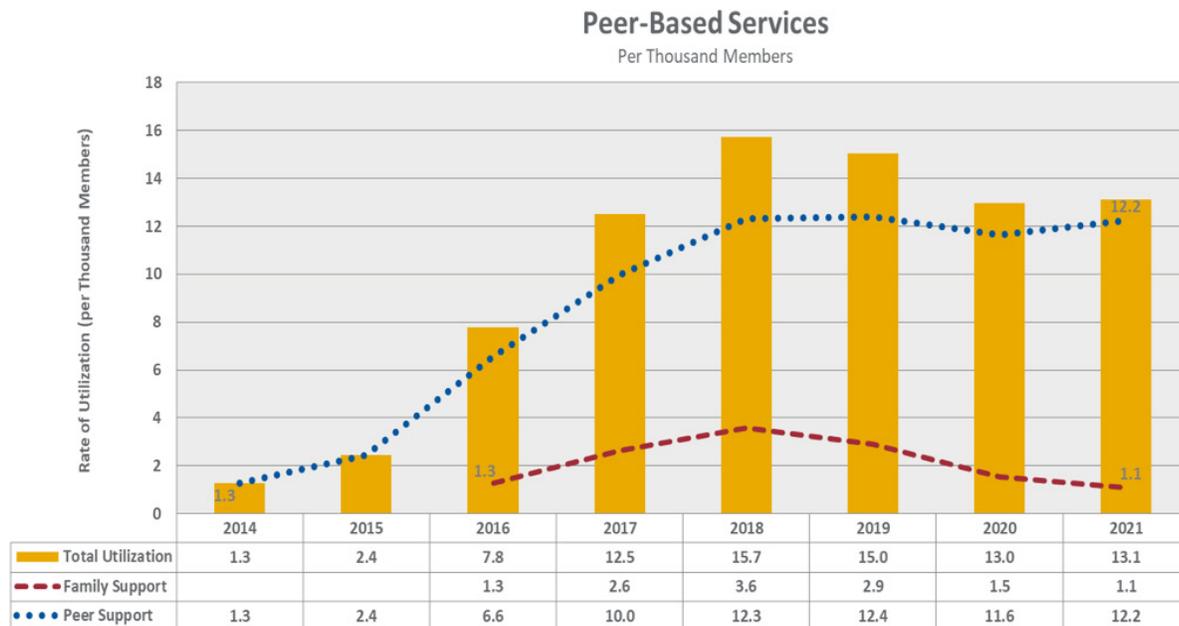
## Family Therapy

Figure 2



## Peer-Based Services

Figure 3

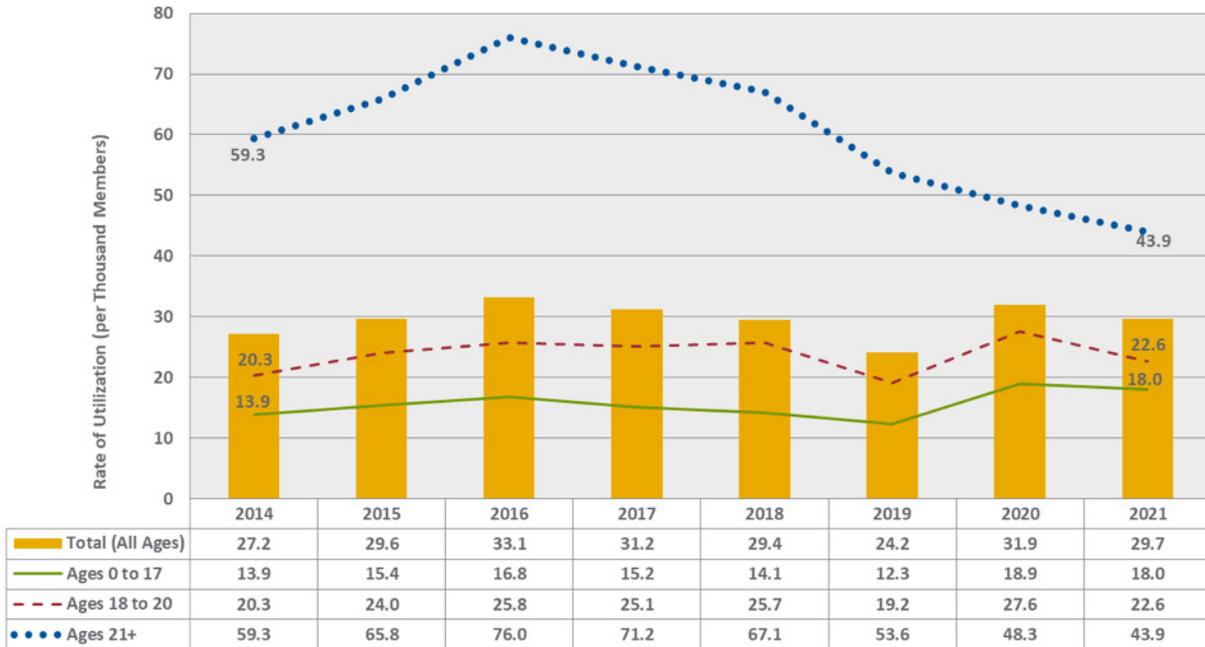


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## Case Management

Figure 4

### Case Management Year by Year by Age

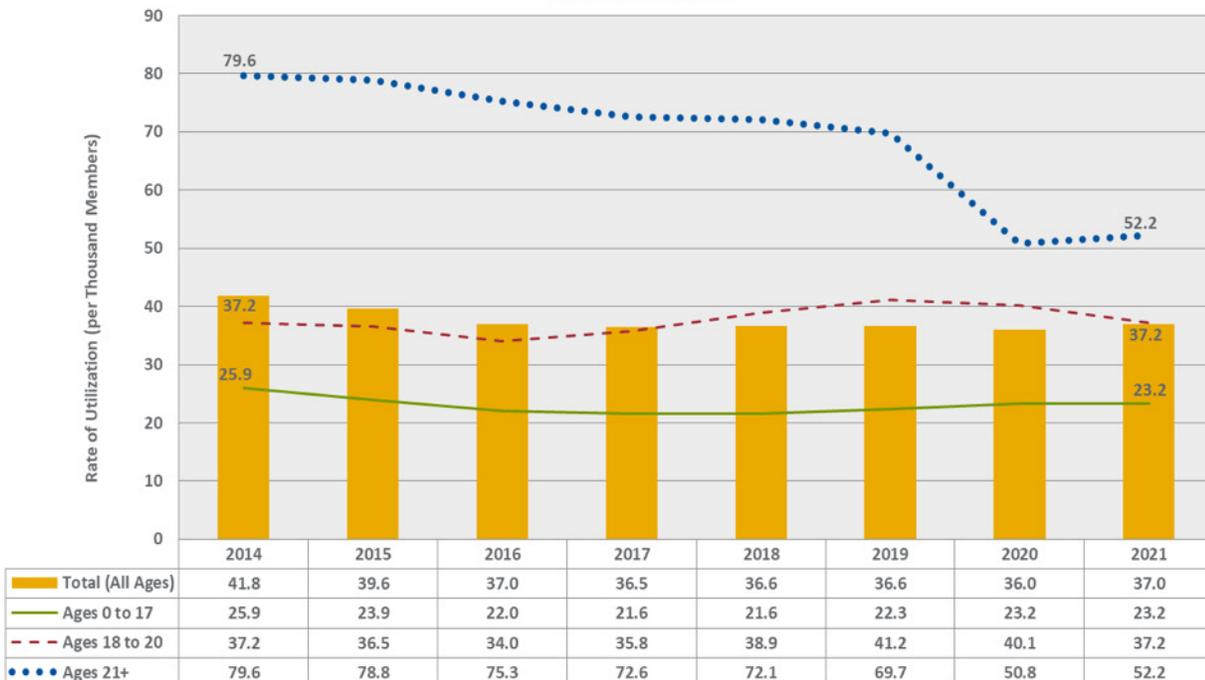


## Prescriber Visits

Figure 5

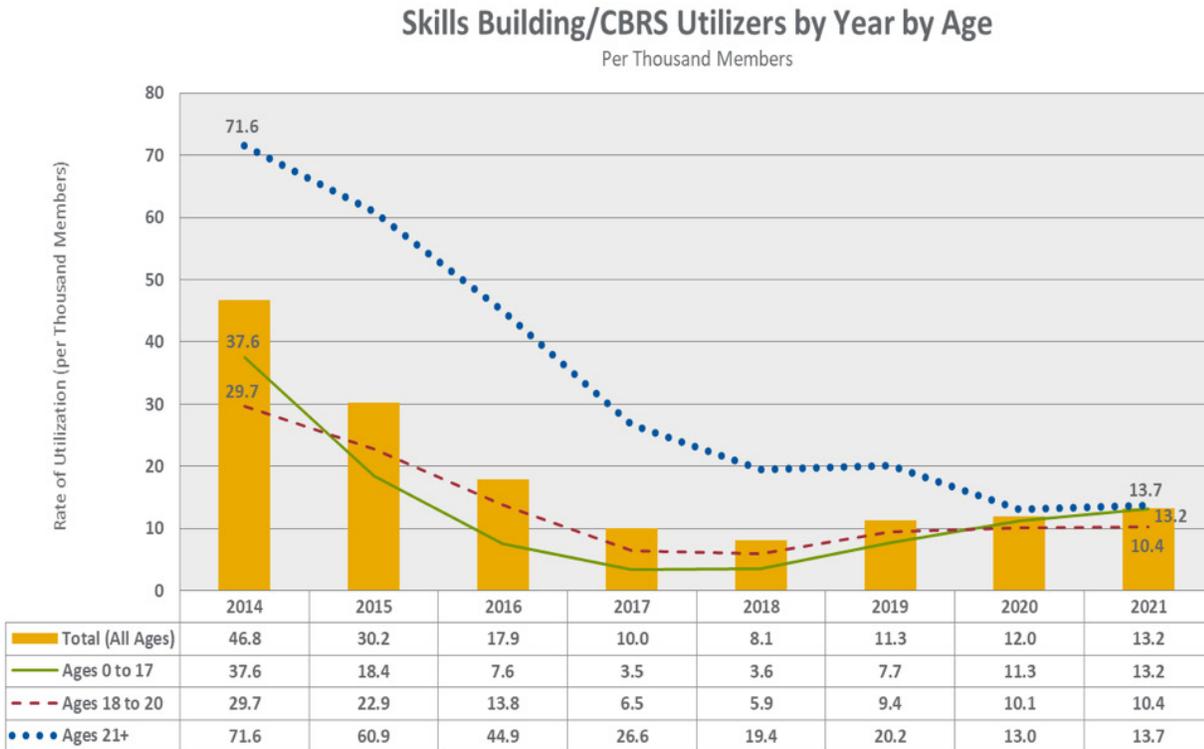
### Behavioral Health Prescriber Utilizers by Year by Age

Per Thousand Members



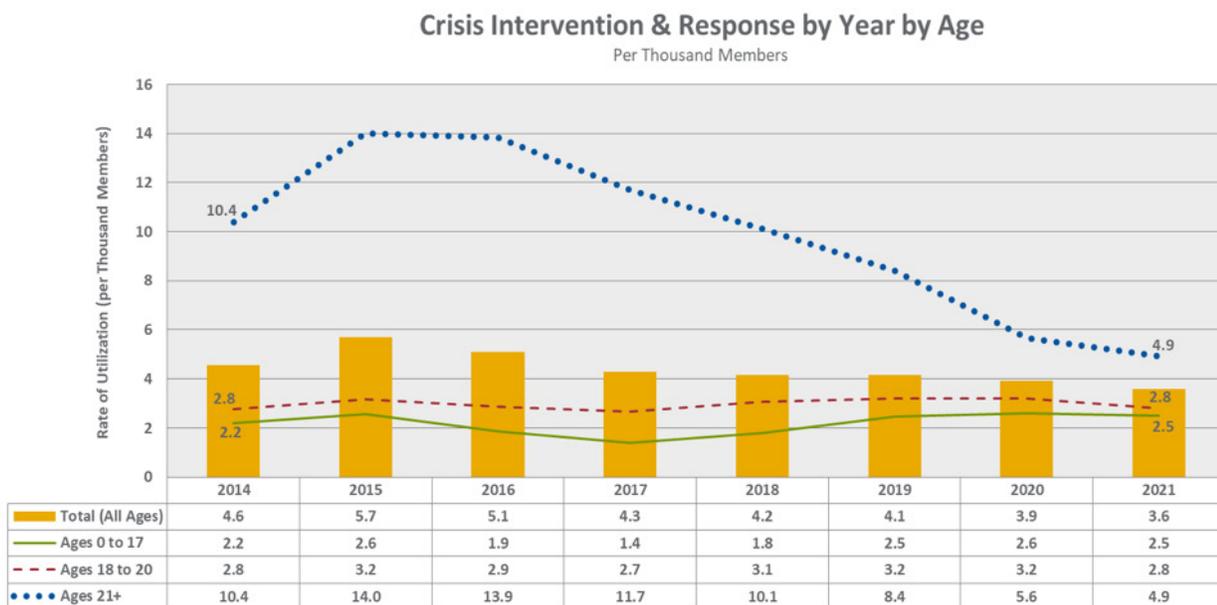
## Skills-Building/Community-Based Rehabilitation Services (CSRS)

Figure 6



## Crisis Intervention & Response by Year by Age

Figure 7



**Analysis** – Overall, Individual Therapy utilization decreased slightly but increased for ages 21 and over. Family Therapy utilization decreased. Peer Based services increased slightly, including a slight increase in Peer Support Services. Case Management utilization decreased. Prescriber Visits utilization remained consistent but with a slight increase. Skills Building/CBRS utilization rates remained consistent. Crisis services remained consistent.

**Barriers** – No identified barriers.

**Opportunities and Interventions** – No opportunities for improvement were identified.

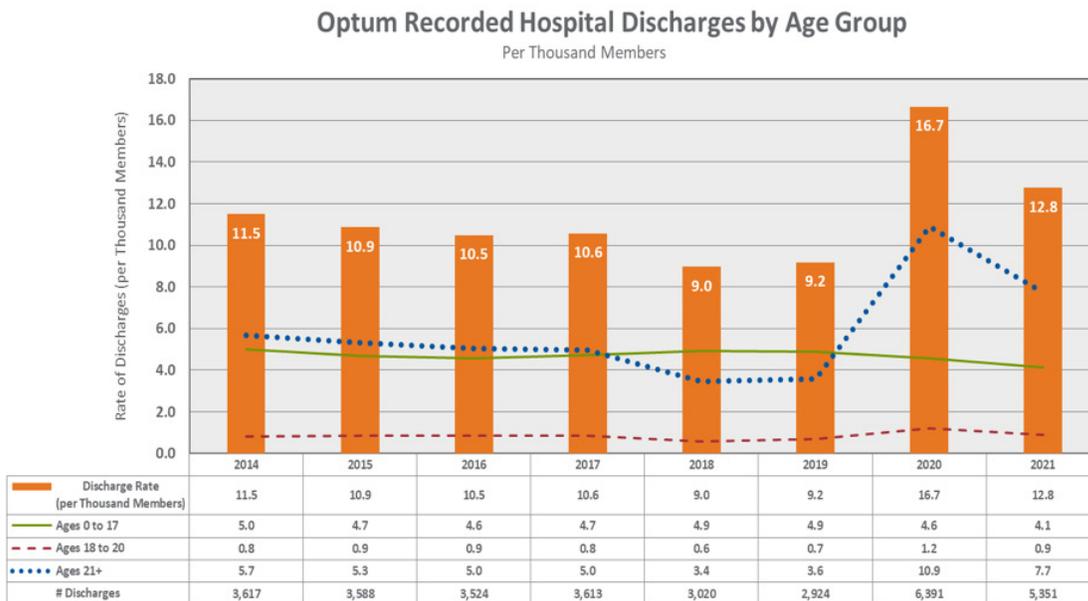
## Psychiatric Inpatient Utilization

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

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

**Figures 8 and 9** show the overall rate of discharges increased. Optum Idaho will continue to monitor and identify any trends.

Figure 8



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Figure 9

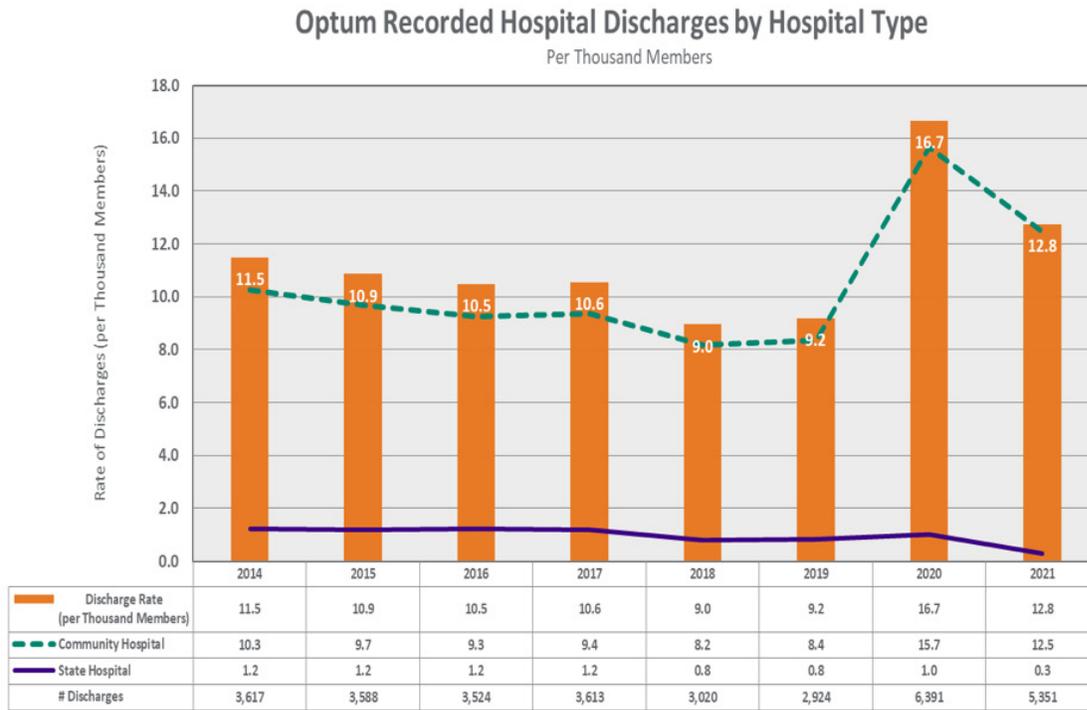
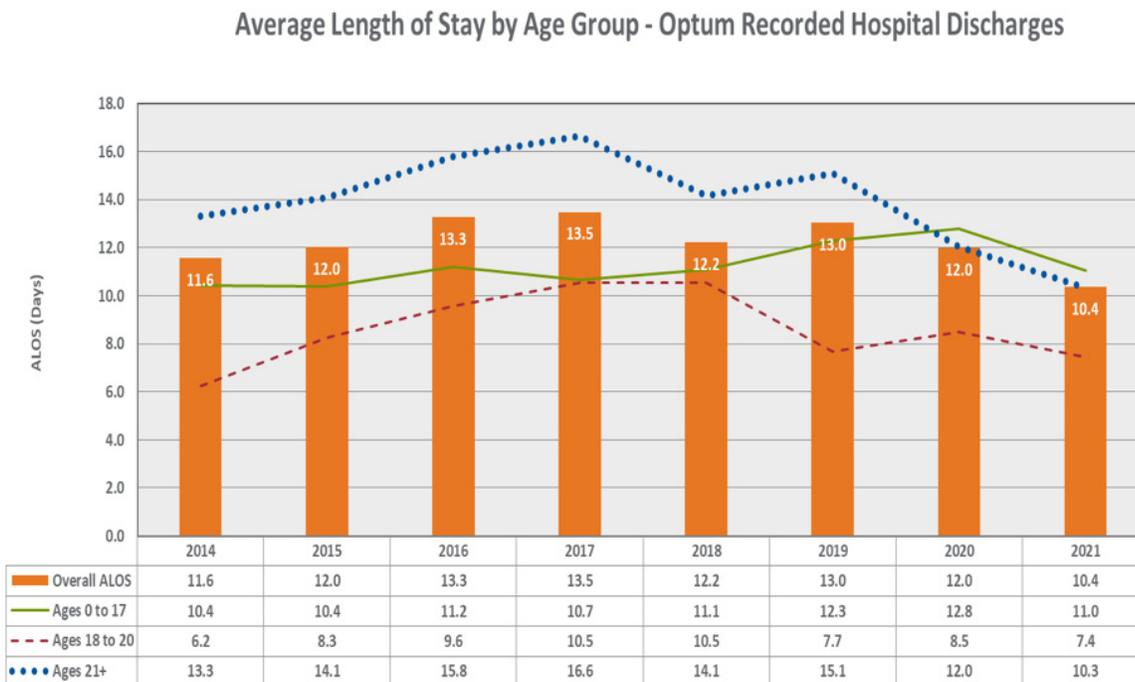


Figure 10 indicates the average length of stay decreased overall.



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Figure 11 shows the average length of stay by hospital type and remained consistent.

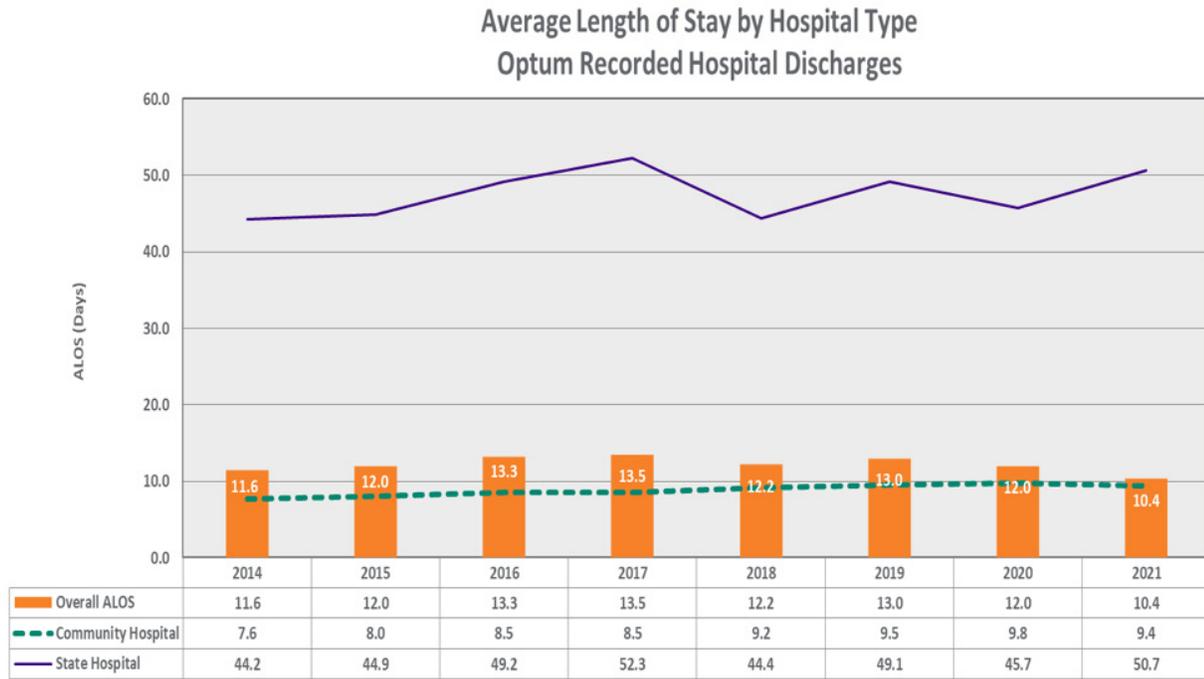
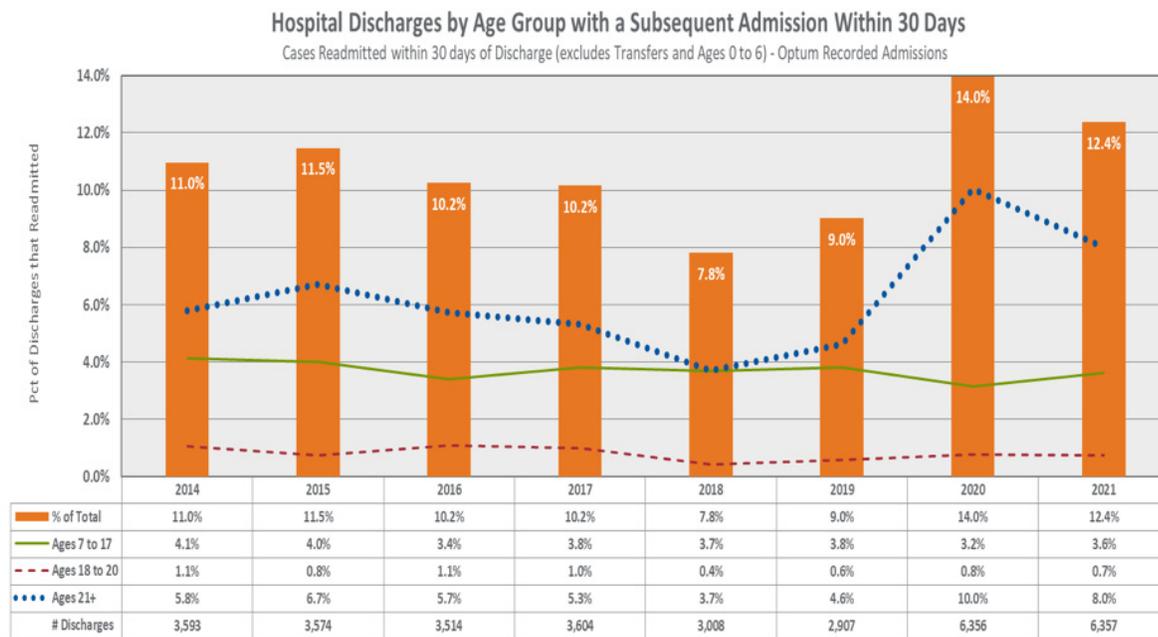


Figure 12 shows the readmission percentages by age group. According to the Healthcare Effectiveness Data and Information Set’s (HEDIS) definition, a readmission to a hospital is counted for all persons ages six years and over and excludes transfers between hospitals. Overall total readmissions within 30 days decreased in 2021.



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Figure 13 shows readmissions percentages by hospital type decreased.

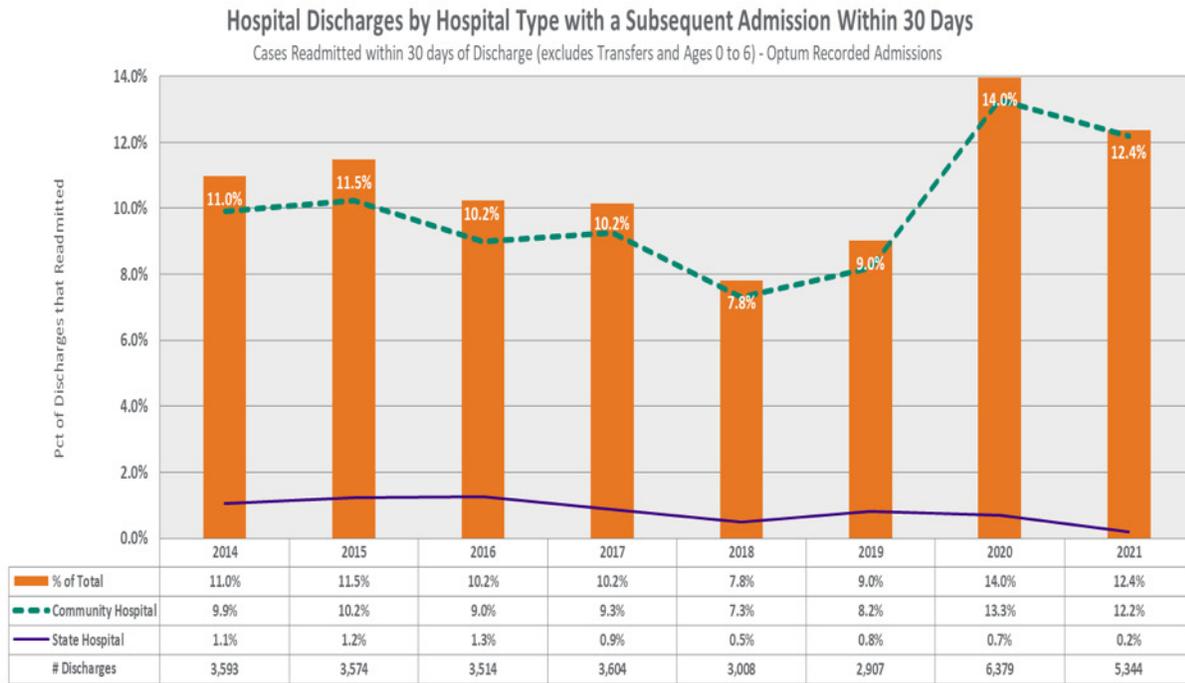
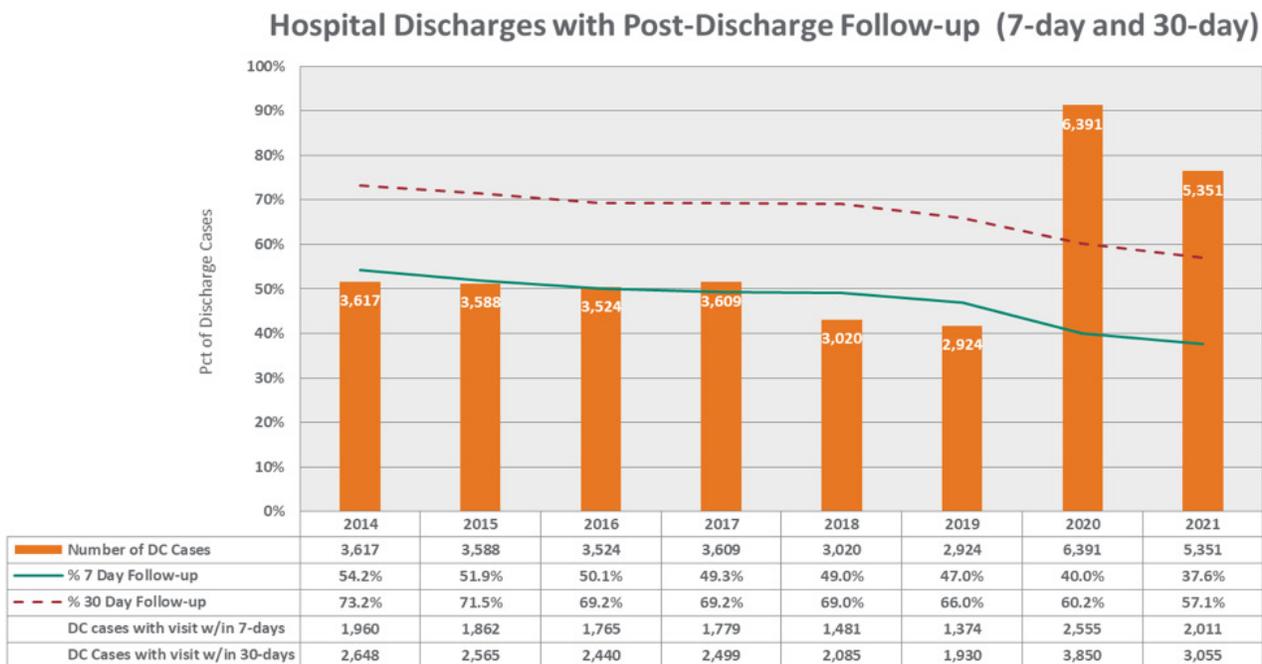


Figure 14 shows hospital discharges with post-discharge follow-up. One of the goals of care coordination is the continuity of care and the successful transition of members from inpatient to outpatient care, similar to the HEDIS metric that examines the percentage of members who are discharged from inpatient care and subsequently receive an outpatient behavioral health visit within seven days and 30 days. The follow-up rates for post-discharge outpatient services remained consistent for the both the seven-day and 30-day follow-up rates.



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**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 are not obligated to do. Optum Idaho continues to establish and build those relationships to better serve members. When Optum Idaho is notified of a discharge, the Optum Idaho wellness coordinators attempt to verify that appointments are scheduled and attended.

**Opportunities and Interventions** – Optum Idaho will continue to monitor.

## 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 individual Member detail.

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

The following analysis looks at the average baseline Wellness Assessment scores for all Wellness Assessments completed during the first and/or second visits during a quarter. It then follows up by looking at the average Wellness Assessment scores for all instruments submitted for subsequent visits during that quarter. The follow-up assessments may or may not include scores from the same members who completed the initial assessments in a quarter. Therefore, the following data should not be interpreted as showing before-and-after comparisons for individual members.

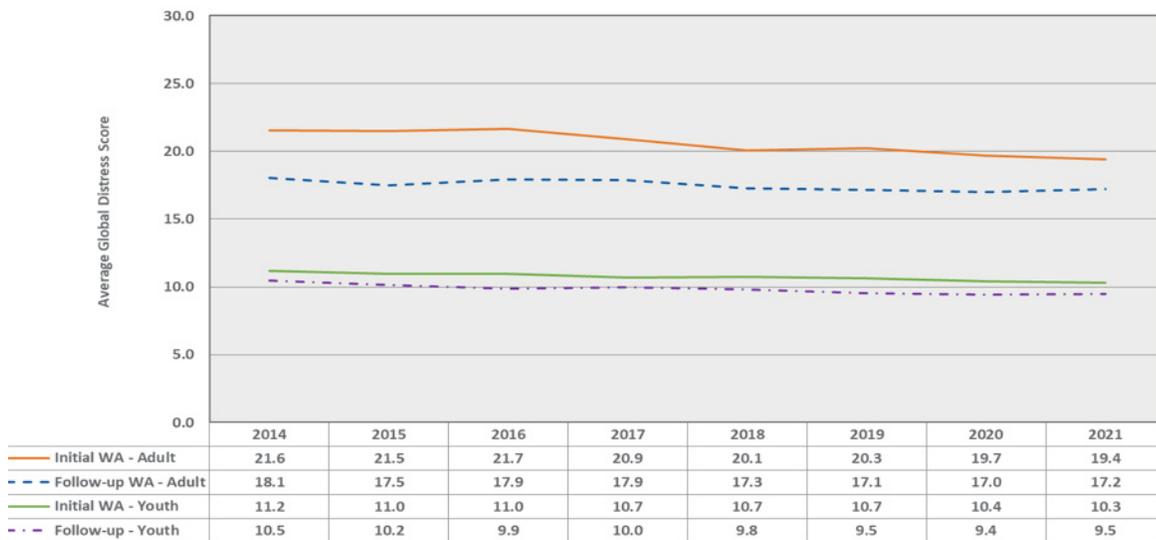
Total Score	Severity Level	Global Distress Score Descriptions
<b>Adult Global Distress Scores</b>		
0-11	Low	Low level of distress (below clinical cut-off score of 12).
12-24	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
25-38	Severe	Approximately 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.

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Total Score	Severity Level	Global Distress Score Descriptions
<b>Youth Global Distress Scores</b>		
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 15

**Wellness Assessments: Average Global Distress Scores**

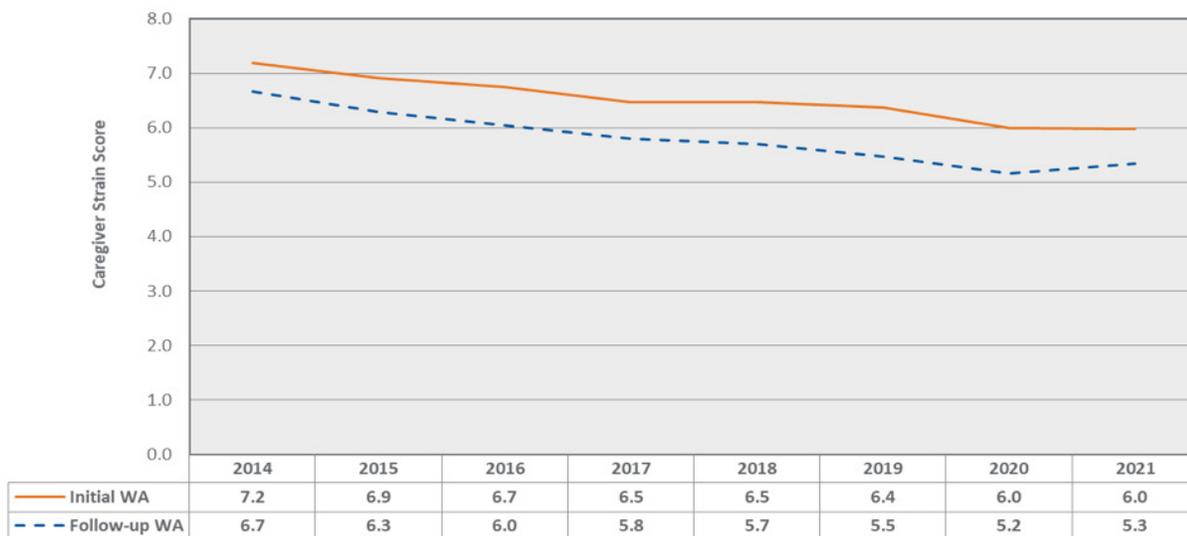


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Total Score	Severity Level	Caregiver Strain Level Description
Caregiver Strain Scores		
0-4	Low	No or mild strain (below clinical cut-off score of 4.7)
5-14	Moderate	The most common range of scores for caregivers with a child initiating outpatient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

Figure 16

Wellness Assessments: Average Caregiver Strain Score



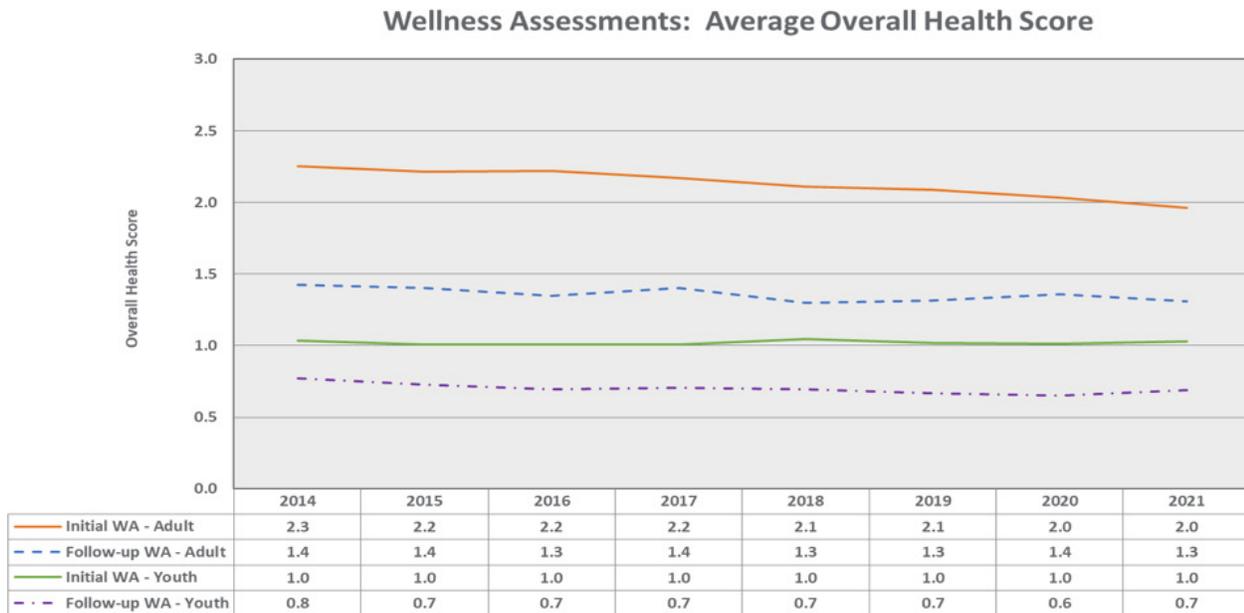
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## Average Overall Health Scores

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 17



**Analysis** – Average Global Distress Scores for adults and youth (Figure 15) for initial and follow-up assessments remained consistent. Average Caregiver Strain Scores (Figure 16) measured within moderate levels during the same period. 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 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. The survey was initially implemented in 2014. A new survey with different questions was implemented in 2017. The reporting data below is reflective of both surveys.

Optum Idaho surveys IBHP adults 18 years of age and older and parents of children ages 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 was 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 three-month period after the quarter in which the services were rendered.

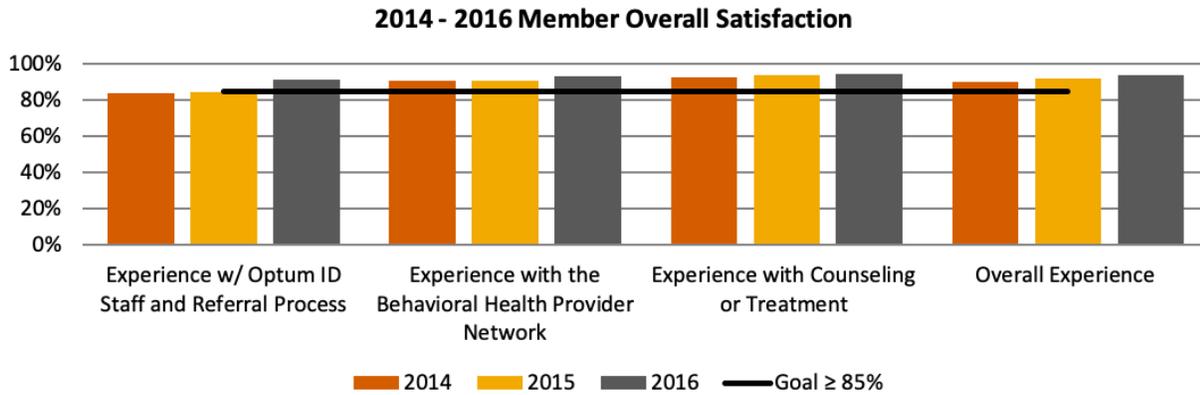
Member Satisfaction Survey	Performance Goal	2014 (n=458)	2015 (n=402)	2016 (n=417)
<b>2014 - 2016 Overall Performance Results</b>				
Experience w/ Optum ID Staff and Referral Process	≥85.0%	84.2%	85.0%	91.6%
Experience with the Behavioral Health Provider Network	≥85.0%	90.9%	91.1%	93.6%
Experience with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

Member Satisfaction Survey	Performance Goal	2017	2018	2019	2020	2021
<b>2017 - 2021 Overall Performance Results</b>						
Overall Satisfaction (Goal: ≥85.0%)	≥85%	80%	92%	94%	90%	90%
Optum Support for Obtaining Referrals or Authorizations	≥85%	80%	92%	94%	91%	90%
Accessibility, Availability, and Acceptability of the Clinician Network	≥85%	89%	93%	93%	93%	90%
Counseling and Treatment	≥85%	93%	95%	95%	94%	93%

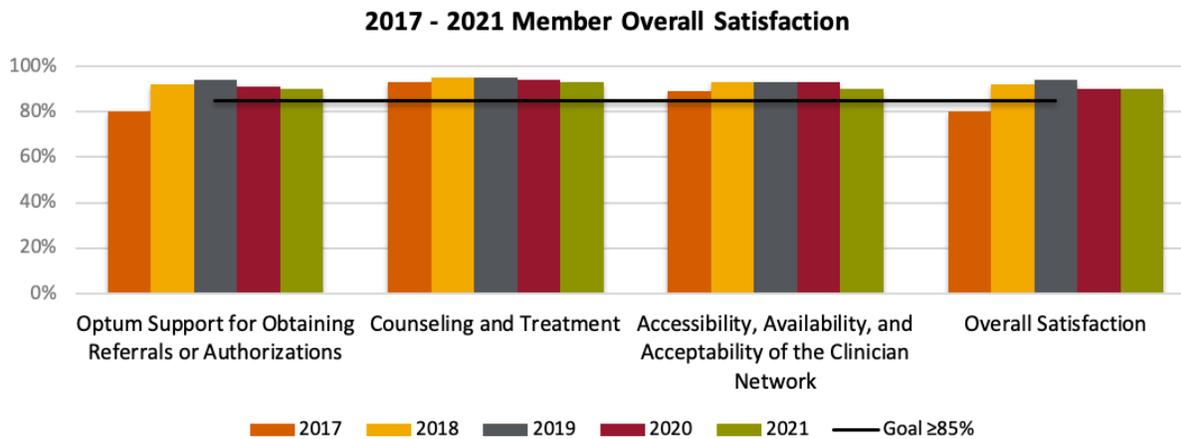
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**Analysis** – Member satisfaction performance goals were met in 2021 for all survey domains.

**Figure 18**



**Figure 19**



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Figure 20

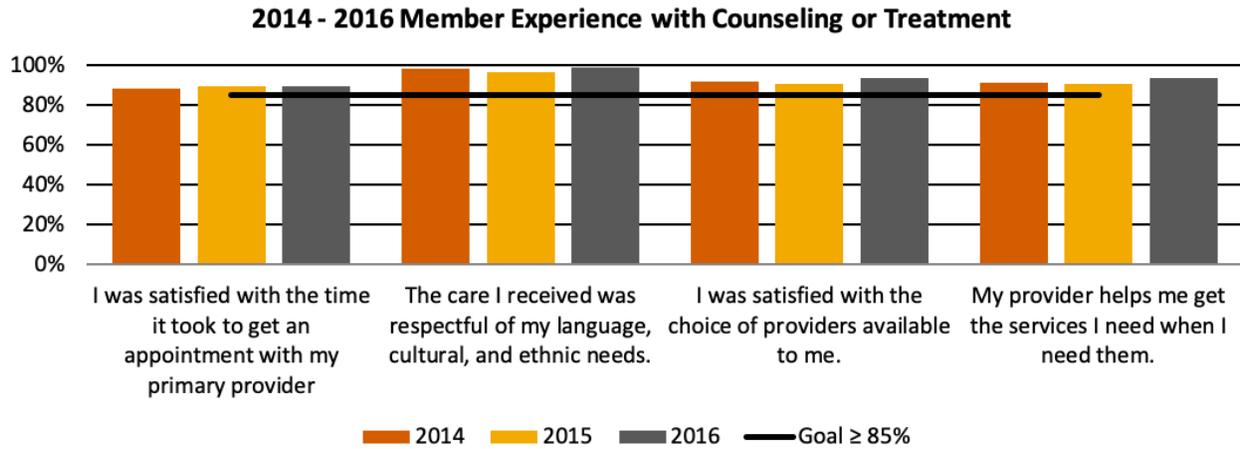


Figure 21



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

**Opportunities and Interventions** - No opportunities for improvement were identified.

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## Provider Satisfaction Survey Results

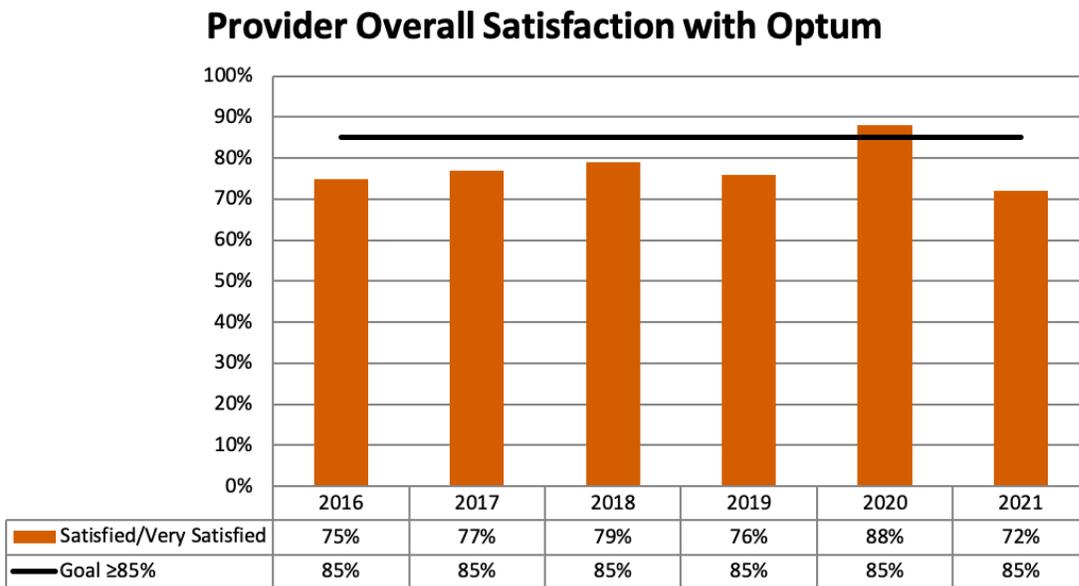
The goal of the research design of the Provider Satisfaction Survey is to provide a representative and reliable measurement of providers’ experiences with, attitudes toward, and suggestions for Optum Idaho.

**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. The survey was conducted online. Optum alerted providers to the survey prior to Market Probe sending out email invitations.

**Analysis** – : For the 2021 survey, Market Probe sent a total of 1,500 emails with survey links to eligible respondents. The survey was fielded from Nov. 1-30, 2021. In addition to original invitations, respondents received two email reminders, spread across all weeks of fielding. In total, 188 completes were returned, resulting in a 13% response rate.

The Overall provider satisfaction results for 2021 fell below the goal of ≥85% at 72%. Optum Idaho will implement action plans during 2022 to address provider satisfaction.

Figure 22



**Barriers** – Overall Provider Satisfaction was not met during 2021.

**Opportunities and Interventions** – During Q1, 2022, Optum Idaho will develop action plans to address provider satisfaction.

## 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.

### Care Coordination Performance Improvement Project (PIP)

The improvement strategy for this PIP was to use meaningful data to align with national quality standards defined by Agency for Healthcare Research and Quality (AHRQ) and National Committee for Quality Assurance (NCQA). This included assisting with coordination of care transitions and to improve member and family engagement. During Phase 1, a high-risk algorithm was created that categorized high-risk member ranking using the following data points: utilization, crisis/emergent, complexity, social determinants, and interactions unique to all members in the IBHP. The algorithm automatically referred high-risk members into the Care Coordination Program versus relying on manual referrals.

At the conclusion of Phase 1, the implementation of the high-risk algorithm did result in identification of additional high-risk members that resulted in an increase in FCC referrals. A two-sample t-test was conducted to compare the mean daily FCC referrals in 2020 to 2019 for the date range of the PIP. There was a significant difference in the mean daily referrals. These results suggested that implementing the high-risk algorithm had a statistically significant impact on the number of referrals in the program.

During 2021, Optum Idaho identified additional opportunities for a second phase of this PIP that included 1) developing a clinical analytic portal to improve clinical operations, documentation and activities for more effective data collection and analysis; 2) identifying member segmentation opportunities that would allow for improved care coordination outreach to specific sub-populations; and 3) using data to monitor and evaluate outcomes of the Care Coordination Program that may result in predicting rehospitalization, service utilization and an appropriate service array based on member acuity. Moving forward, the work group decided to focus on re-focusing the PIP to increase members in the FCC Program. This change was made to focus on measuring outcomes to look specifically at how increasing referrals into the FCC Program could increase member engagement in outpatient services and decrease re-admission back into inpatient (IP) services within 30 days of being discharged from IP care.

An analysis was completed to identify barriers to engaging members in outpatient care. Opportunities to identify and implement interventions will continue as this PIP moves forward into the next measurement year.

### Respite Performance Improvement Project

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

The PIP variables included decreasing the number of errors on respite claims by running claims data on a quarterly basis and auditing the claims. If errors were found, identifying interventions that needed to be implemented—i.e., reaching out to provider, correcting the claim or providing education to provider and internal staff.

The Performance Measure is a  $\leq 1\%$  error rate for respite claims. Throughout the PIP period, July 1, 2020, to June 31, 2021, the error rate of  $\leq 1\%$  was met. Optum Idaho will continue to monitor.

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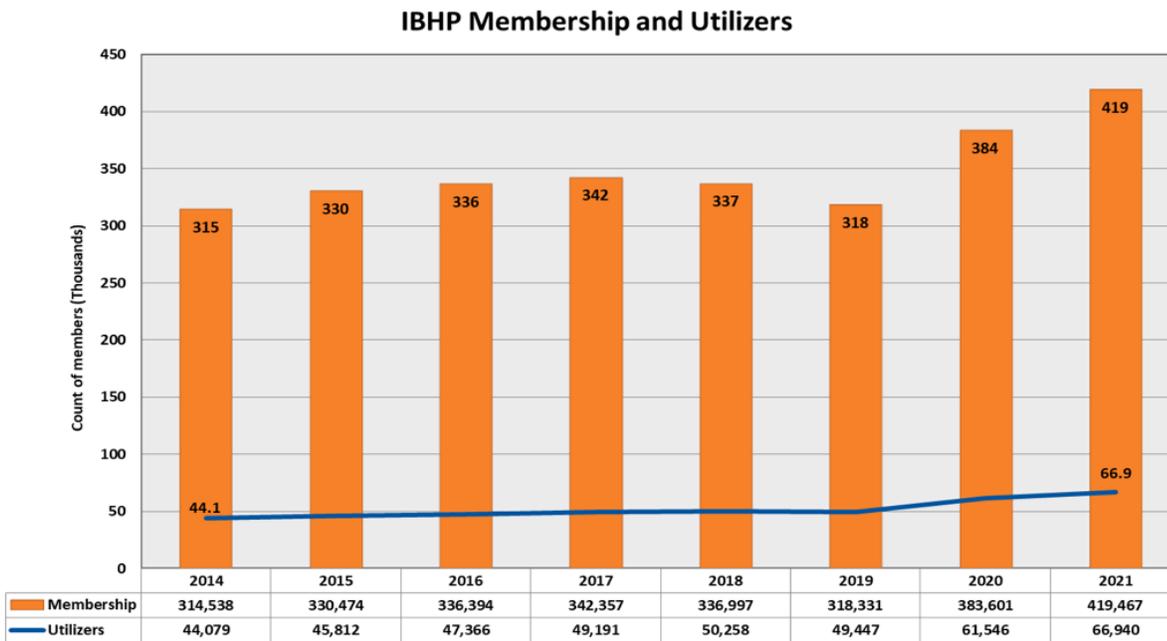
# Accessibility & Availability

## Idaho Behavioral Health Plan Membership

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

**Analysis** – During 2021 membership and utilizer numbers increased.

Figure 23



**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 5,544 calls during 2021. The percentage of calls answered within 30 seconds fell below the goal of  $\geq 80\%$  at 68%. Optum Idaho partners with the vendor, ProtoCall, for the Member access and crisis services line available 24 hours, seven days a week, 365 days per year. ProtoCall provides service by answering calls from members. During 2021, ProtoCall reported to Optum Idaho that they have continued to be challenged by staff retention and increased demand on their services from other clients. They are working on increasing recruitment efforts. ProtoCall has continued to cite the impact that COVID-19 has had on the behavioral health industry and the ensuing strain across multiple sectors they support. Optum Idaho Clinical and Customer Service Teams met and will continue to meet with ProtoCall to identify ways that Optum Idaho can support ProtoCall in this area. This included identifying calls that can be transferred to Optum Idaho staff. Optum Idaho will continue to monitor this performance measure and work with ProtoCall to ensure members are receiving excellent customer service.

Figure 24

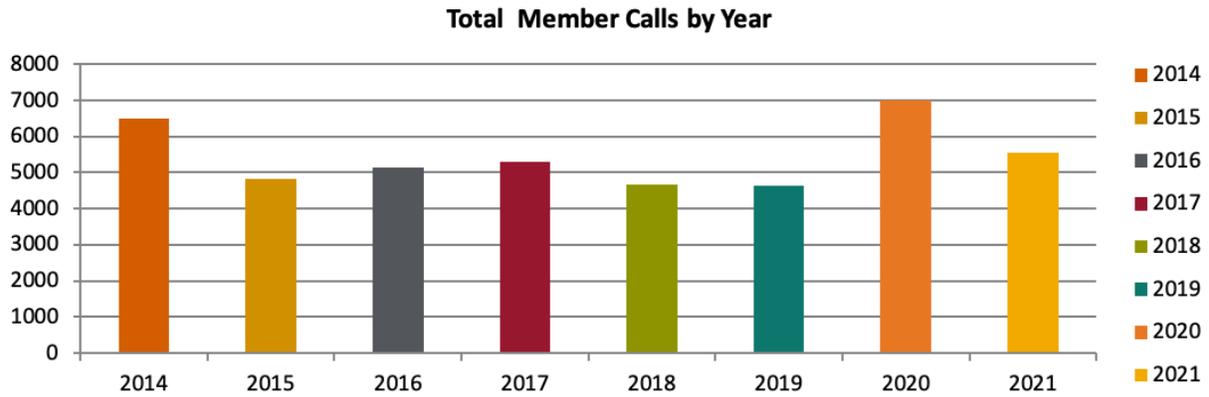


Figure 25

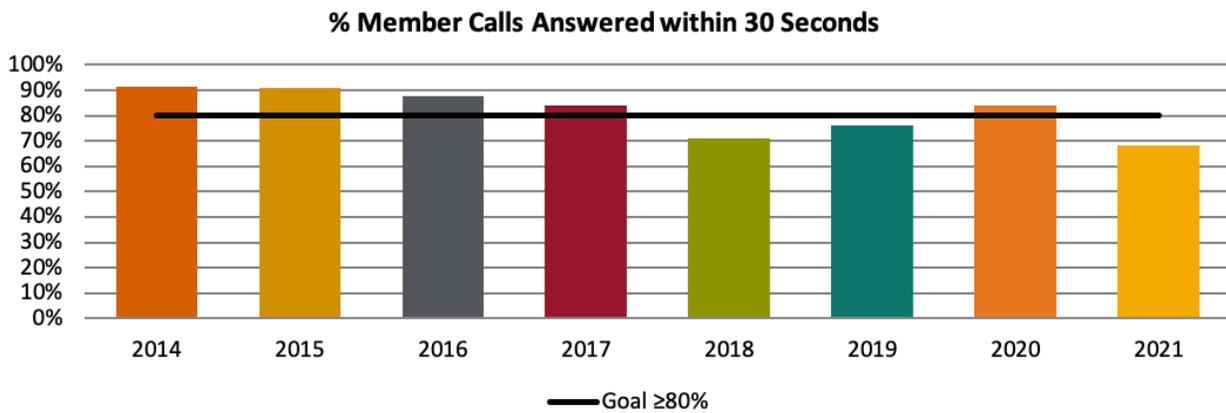
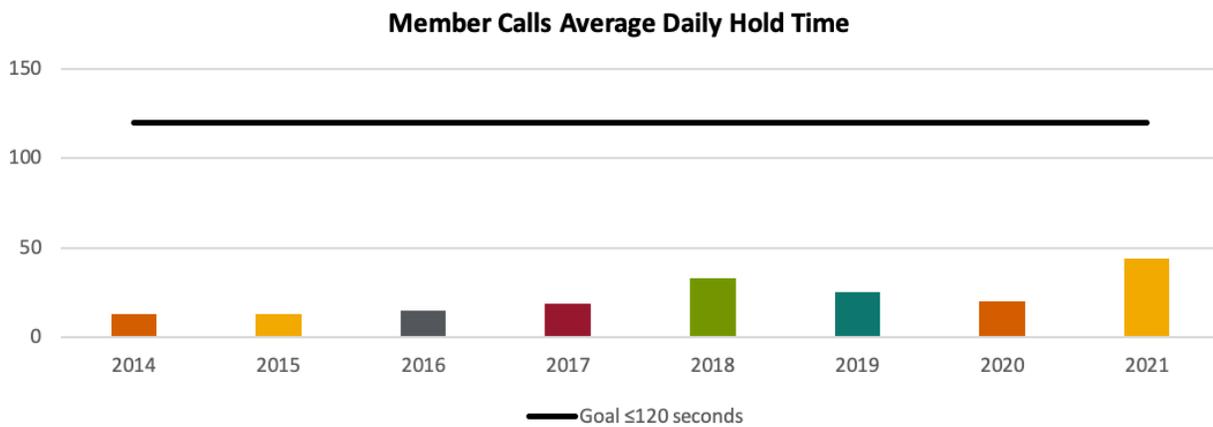
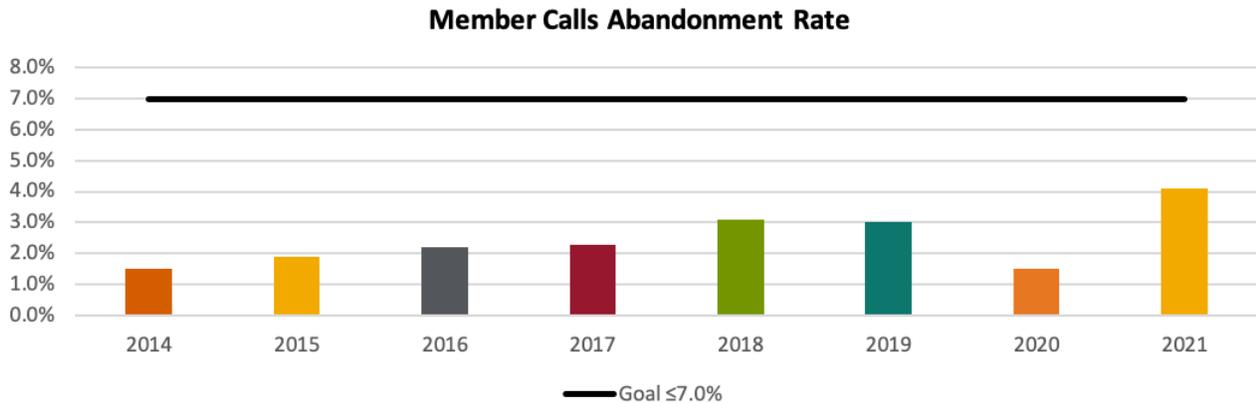


Figure 26



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Figure 27



**Barriers** – The percentage of calls answered within 30 seconds did not meet the goal.

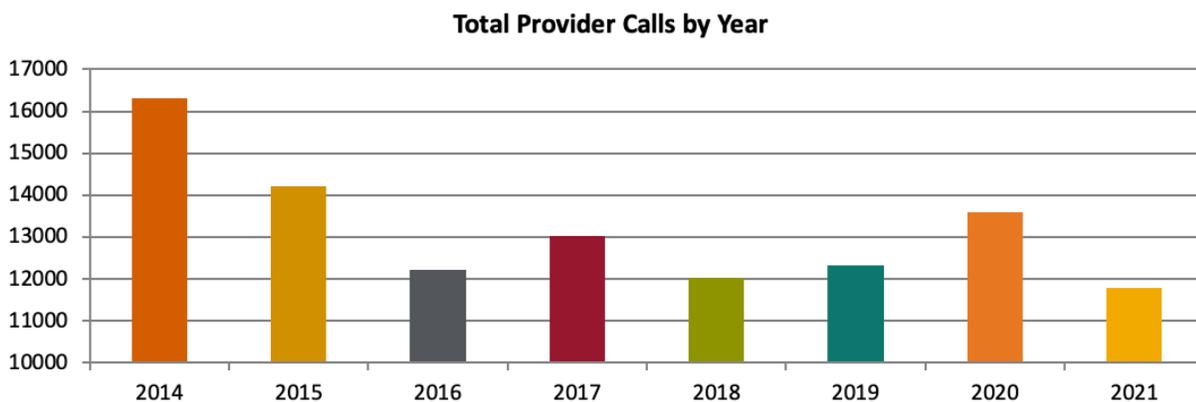
**Opportunities and Interventions** – Optum Idaho will continue to monitor and work with ProtoCall to ensure members are receiving excellent customer services.

## 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, the 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 11,778 calls during 2021. Optum Idaho exceeded all established performance call standards during 2021, including calls answered within 30 seconds, average daily hold time and call abandonment rate.

Figure 28



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Figure 29

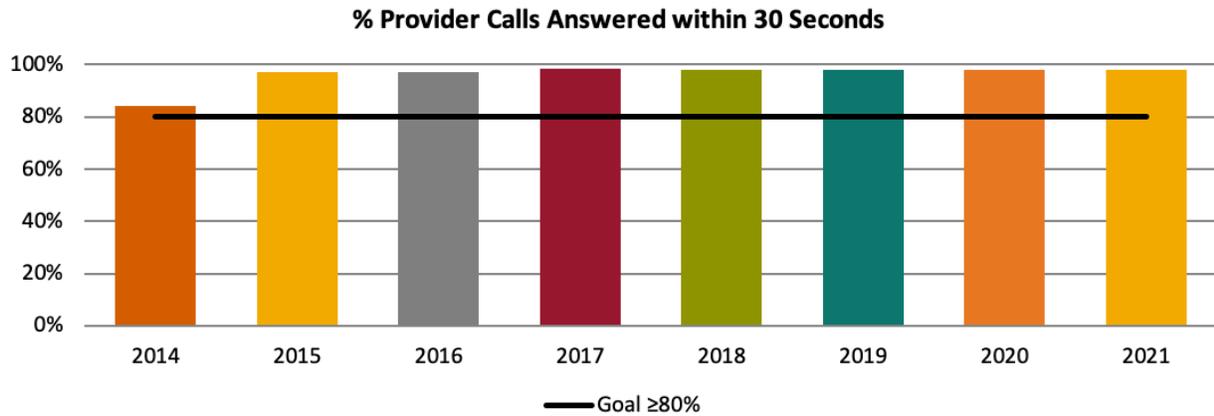


Figure 30

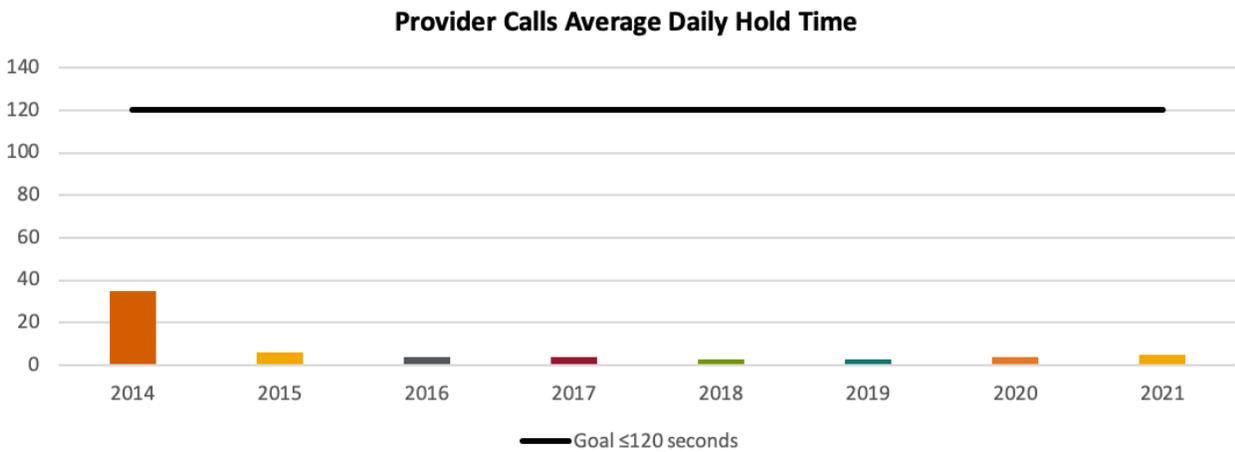
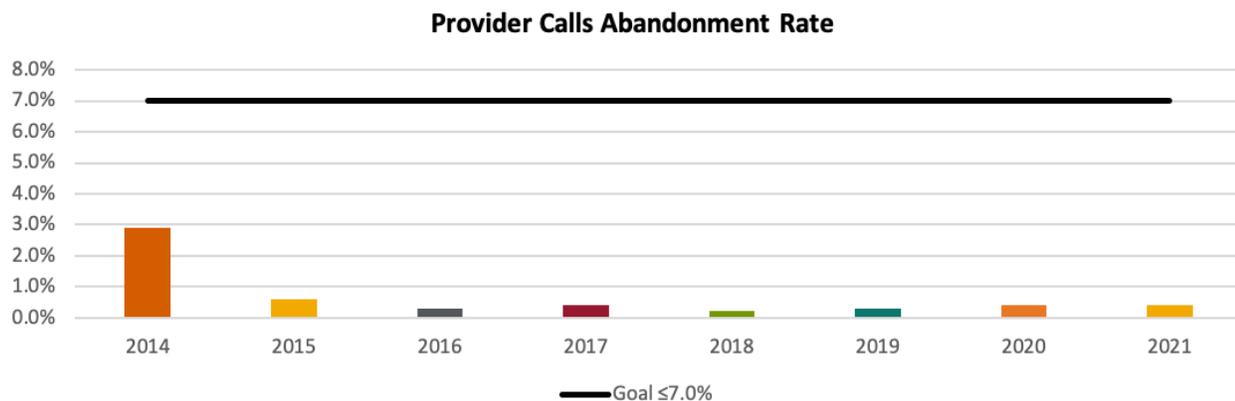


Figure 31



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

**Opportunities and Interventions** – No opportunities for improvement were identified.

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## 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 six 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 2021, with an average of 10.5 hours (goal within 48 hours). The overall performance goal for Non-Urgent Appointment wait times was also met with an average of 2.8 days (goal within 10 days). Optum Idaho initially began tracking data for Critical Appointment wait times in July 2017. Critical Appointment wait times met the goal of being offered within six hours in 2021, with an average of two hours (goal within six hours).

Figure 32

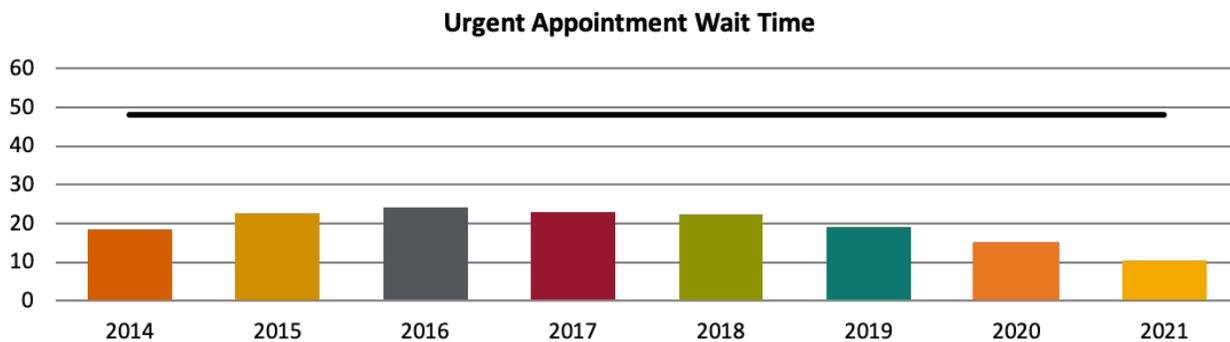
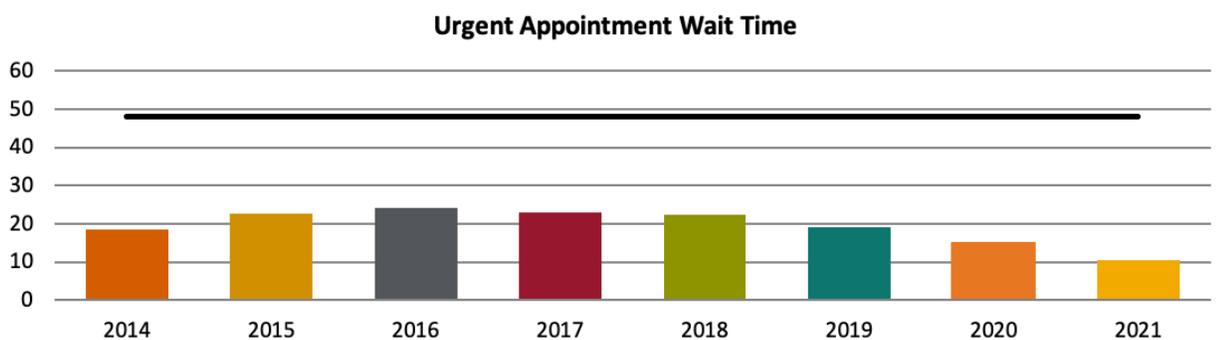
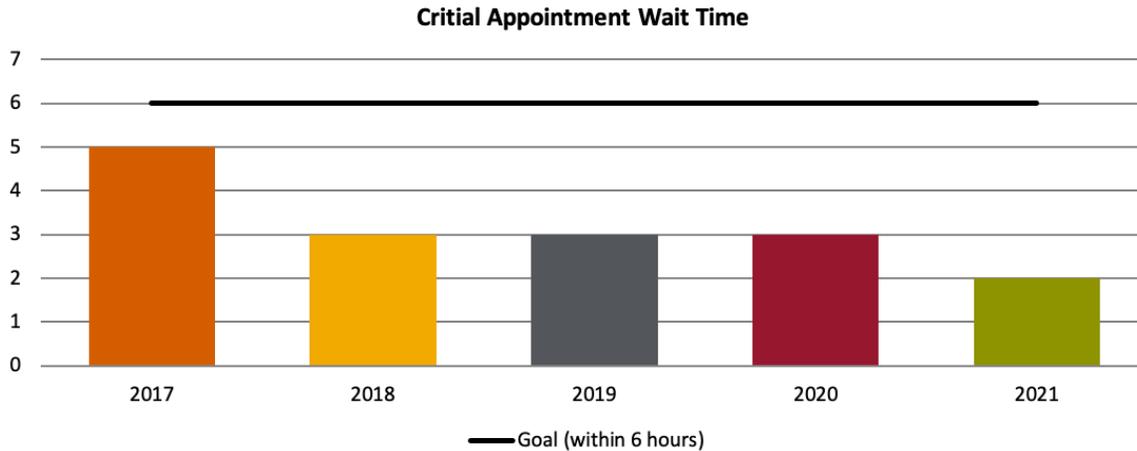


Figure 33



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Figure 34



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

**Opportunities and Interventions** - No opportunities for improvement were identified.

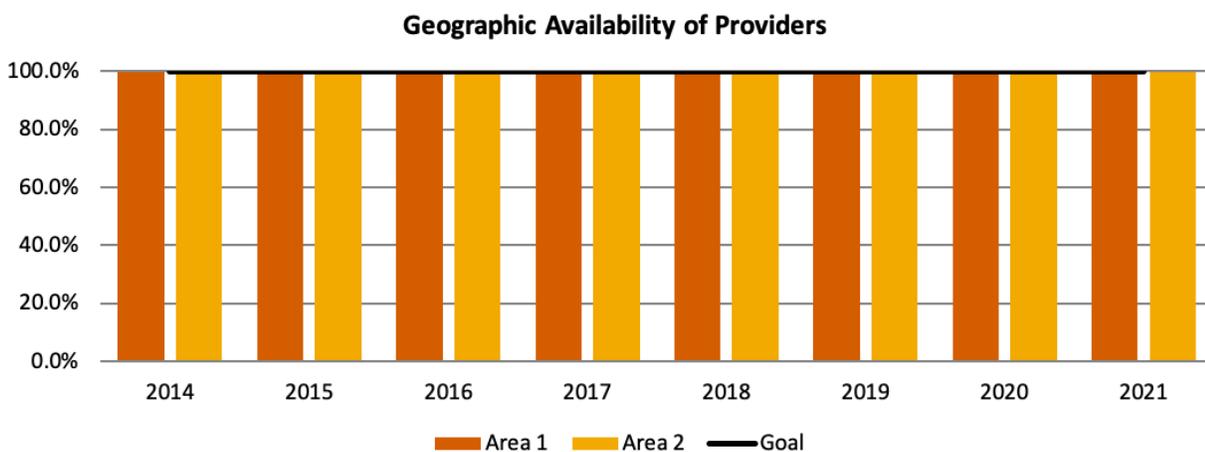
## Geographic Availability of Providers

**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 2021, Optum Idaho continued to meet contract provider availability standards. Area 1 availability standards were met at 99.9%, and Area 2 availability standards were also met at 99.8% (Performance is viewed as meeting the goal due to established rounding methodology - rounding to the nearest whole number).

Figure 35



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

**Opportunities and Interventions** - No opportunities for improvement were identified.

# Member Protections and Safety

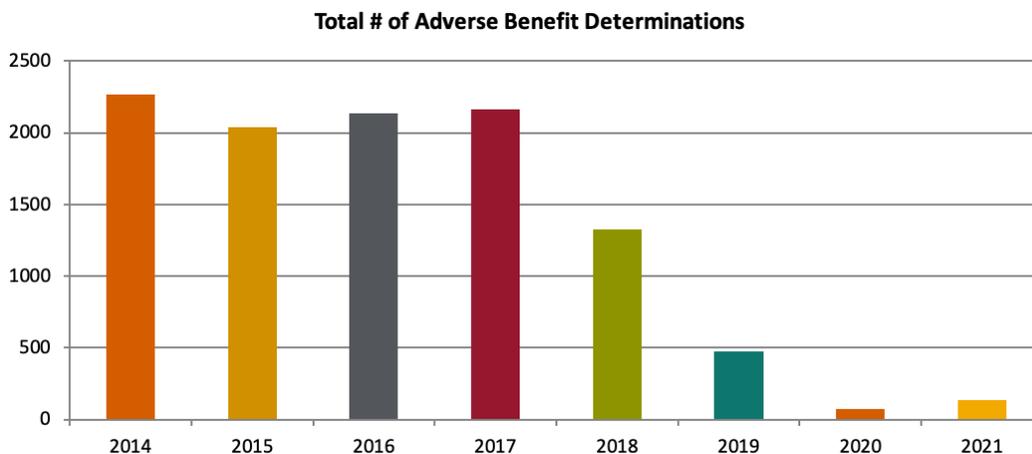
Optum Idaho’s policies and procedures and guidelines, along with the quality monitoring programs, are designed to help ensure the health, safety, and appropriate treatment of Optum Idaho members. These guiding documents are informed by national standards such as National Committee for Quality Assurance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

## 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 136 ABDs during 2021. The written notification (14 calendar days from request) goal was met throughout the year at 100%. The low number of ABDs again during 2021 can be attributed to Optum Idaho suspending prior authorization requirements for services to reduce the administrative burden on providers due to COVID-19.

Figure 36



**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 five 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** – During 2021, there were four Member Appeals. All turnaround time requirements and performance goals were met. The reduction in appeal volume is directly attributed to the reduction in the number of ABDs. Of note: Optum Idaho began tracking urgent appeals and non-urgent appeal’s turnaround time separately beginning in 2017, which is indicated in the graphs below.

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Figure 37

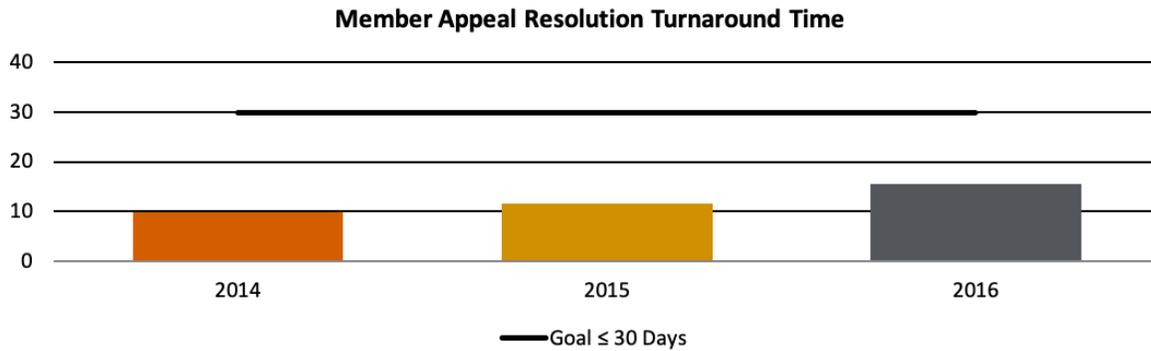


Figure 38

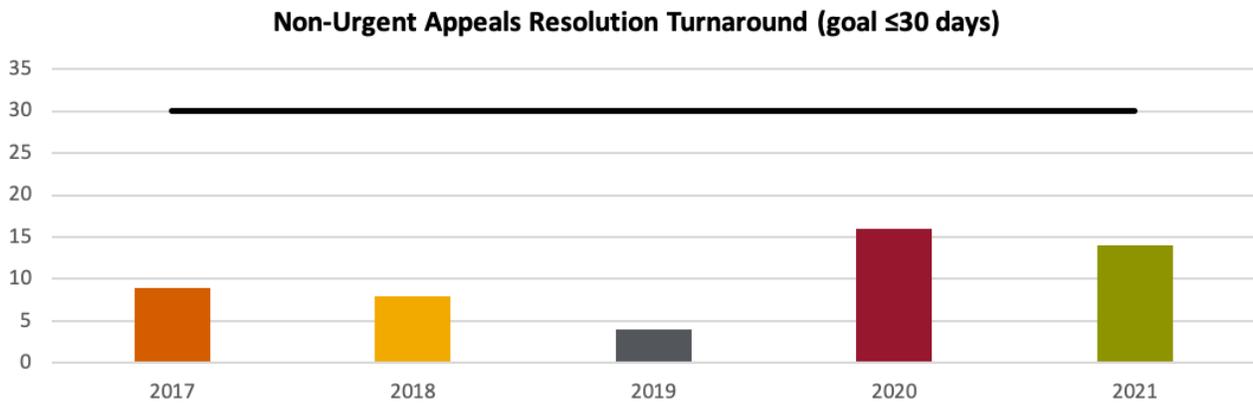
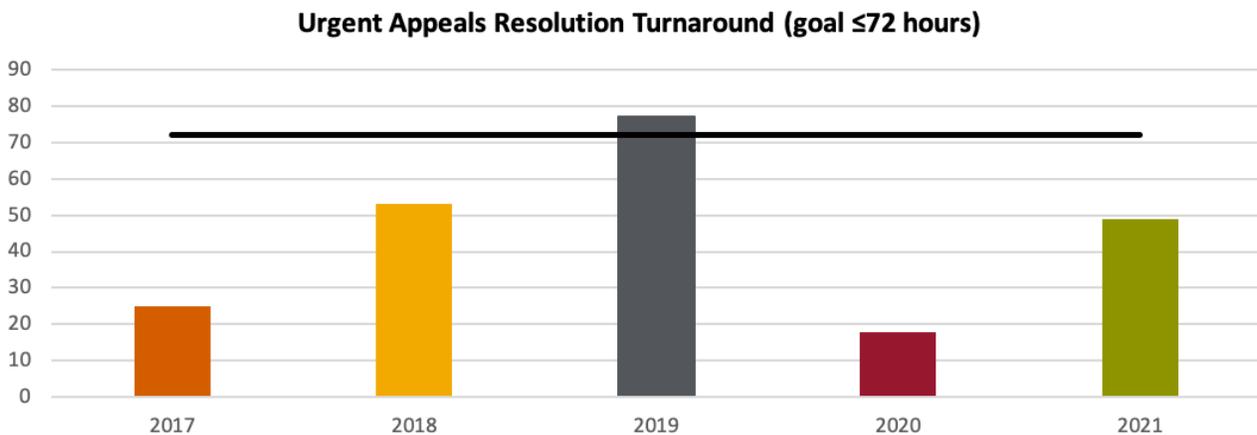


Figure 39



**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 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 five 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 29 total complaints (QOS and QOC combined) received during 2021. Of the total complaints received, 23 were identified as QOS and six were identified as QOC. Optum Idaho met resolution compliance for QOS complaint’s and QOC concern’s turnaround times.

Figure 40

**Total Complaints (QOS and QOC Combined)**

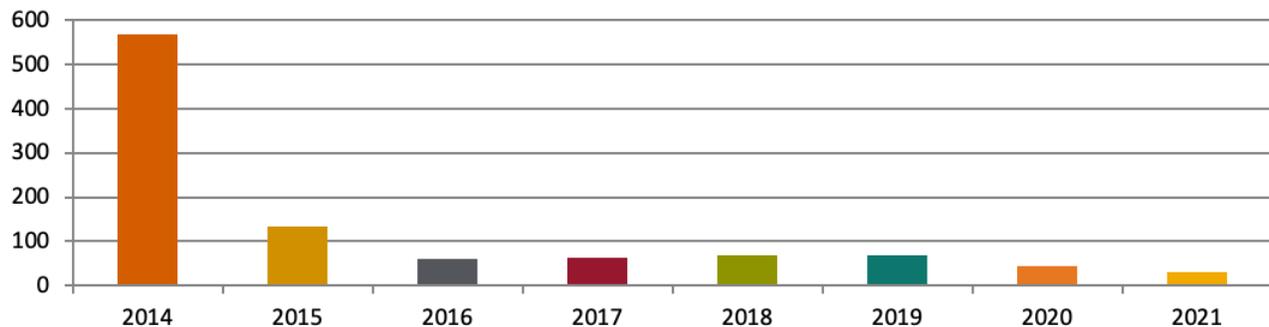
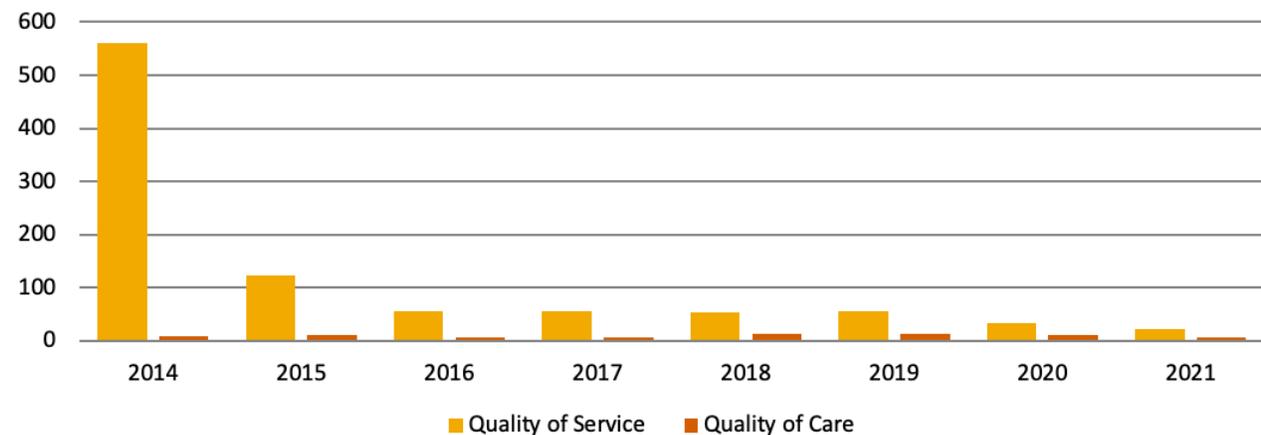


Figure 41

**Total Quality of Service & Quality of Care Complaints**



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Figure 42

Quality of Service Resolution TAT Compliance (≤10 Days)

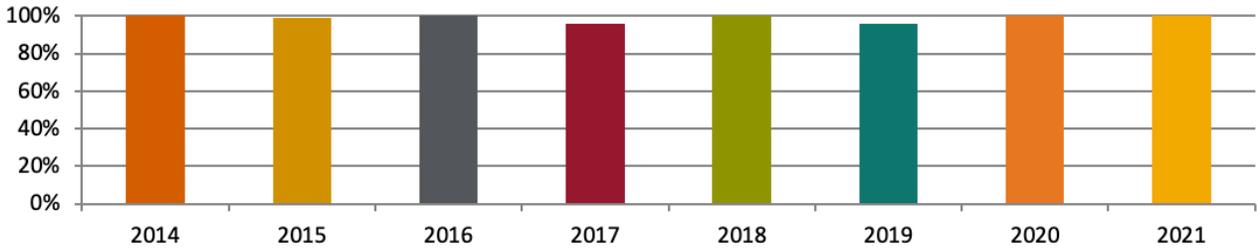


Figure 43

Quality of Care Resolution TAT Compliance (≤30 Days)

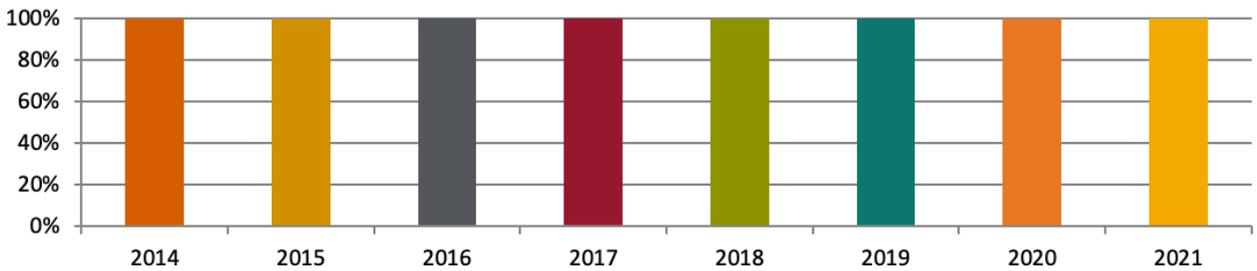
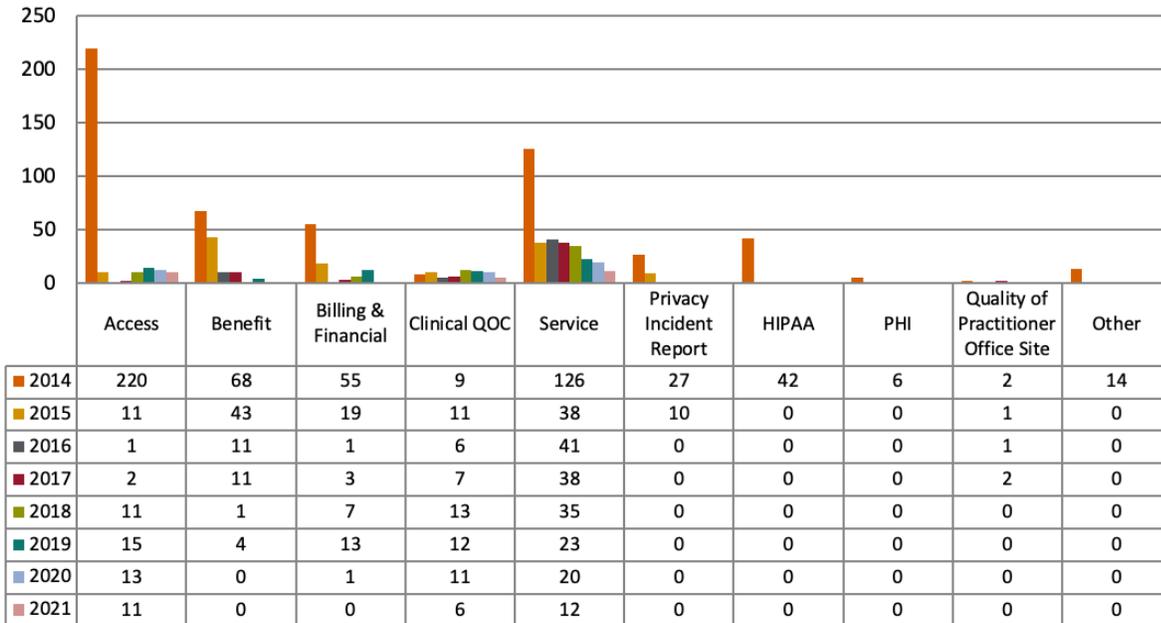


Figure 44

Complaints by Type



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

**Opportunities and Interventions** - No opportunities for improvement were identified.

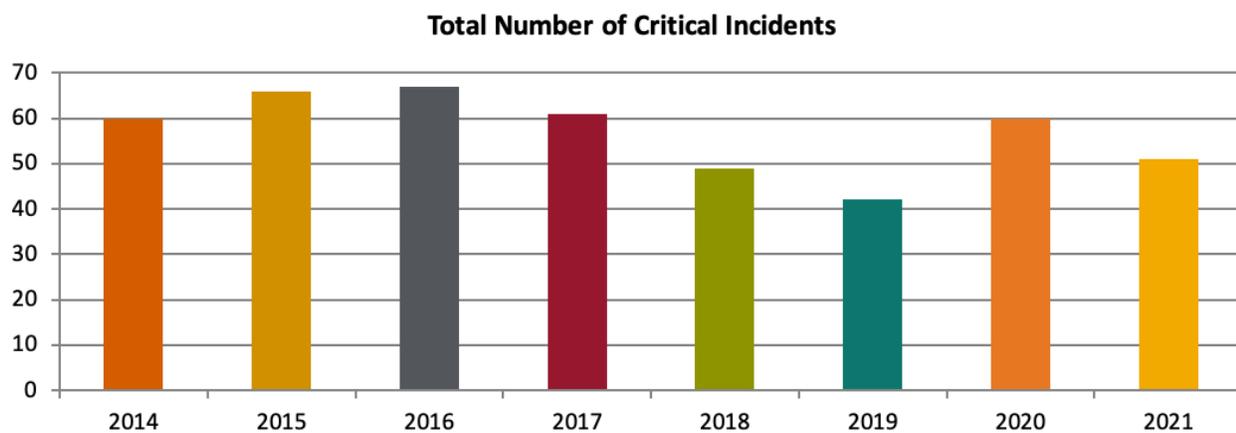
## Critical Incidents

**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. An internal goal has been established that this review will take place within five business days from notification of incident.

**Analysis** – There were 51 CIs reported during 2021. The turnaround time for Ad-Hoc Committee review within five business days from notification of incident was met at 100%. The highest numbers of CIs reported in 2021 were in the category of unexpected deaths (73%). Of the 51 reported CIs, 55% involved members with co-morbid health conditions. Of the cases reported in 2021, 88% of the cases were adults (ages 18 and over) and 12% were children/adolescents (ages 17 and below). Further analysis showed that the average age for adult males was 38 and females 40. The highest number of CIs per region (top 3) were Region 4 and 7 with 13 CIs and Region 6 with nine CIs.

Figure 45



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

**Opportunities and Interventions** – No opportunities for improvement were identified.

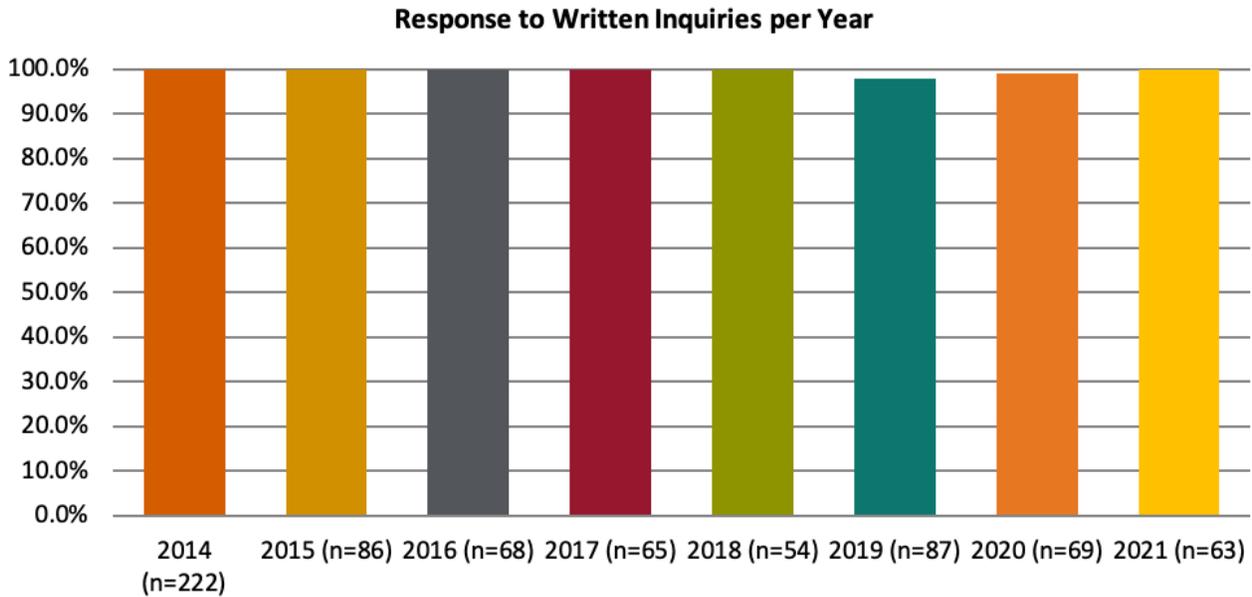
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## Response to Written Inquiries

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

**Analysis** – Performance was met for acknowledgement within two business days at 100%.

Figure 46



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

**Opportunities and Interventions** – No opportunities for improvement were identified.

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# 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. They work 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 four to six months. Audit types and scores are tracked in an internal Excel tracking spreadsheet.

**Analysis** - During 2021, a total of 593 audits were conducted, and 77% (460) of audits received a passing score ( $\geq 85\%$ ) and did not require a CAP. CAPs were implemented for 23% (133) of the audits that were completed during 2021.

Figure 47

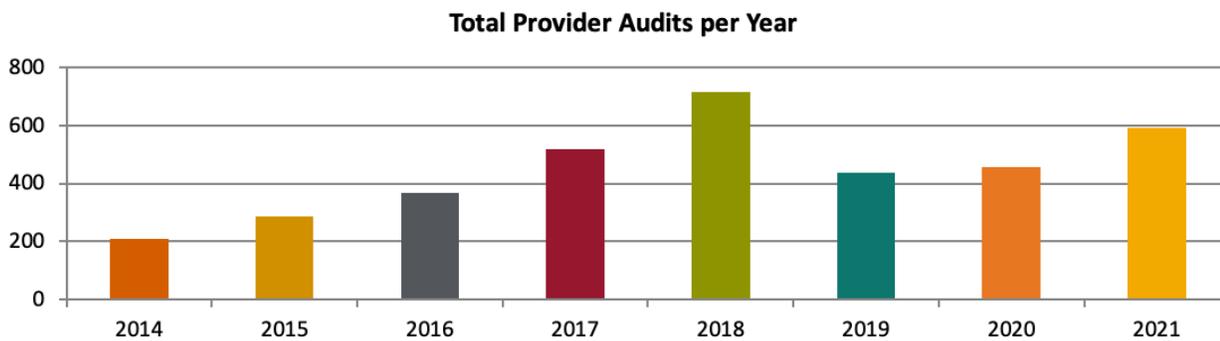
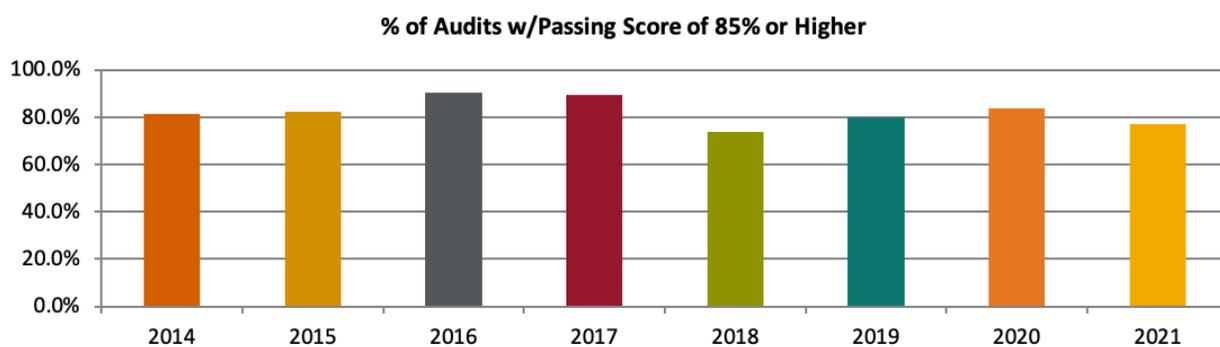


Figure 48



## 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.

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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 2021 revealed that 100% of member records reviewed had documentation of the name of the member’s primary care provider (PCP). Of those, 80% indicated that collaboration had occurred between the behavioral health provider and the member’s PCP.

Figure 49

**Is the name of the member’s primary care physician (PCP) documented in the record?**

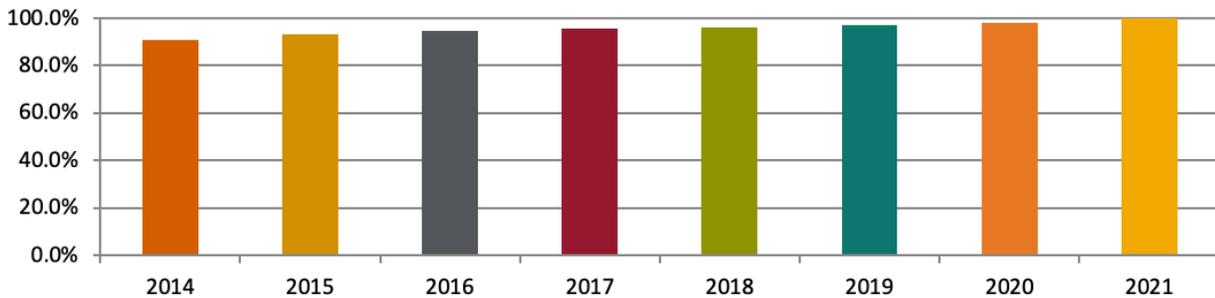
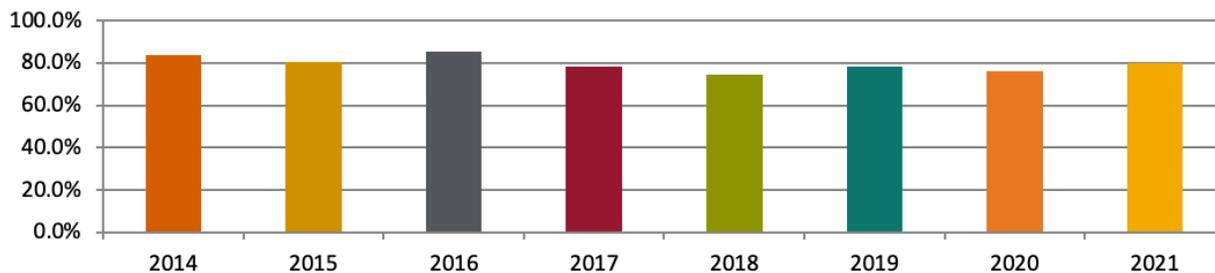


Figure 50

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



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

**Opportunities and Interventions** – No opportunities for improvement were identified.

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## 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 2021, there were 375 provider disputes. All were resolved within the contractual turnaround time of ≤30 days.

Figure 51

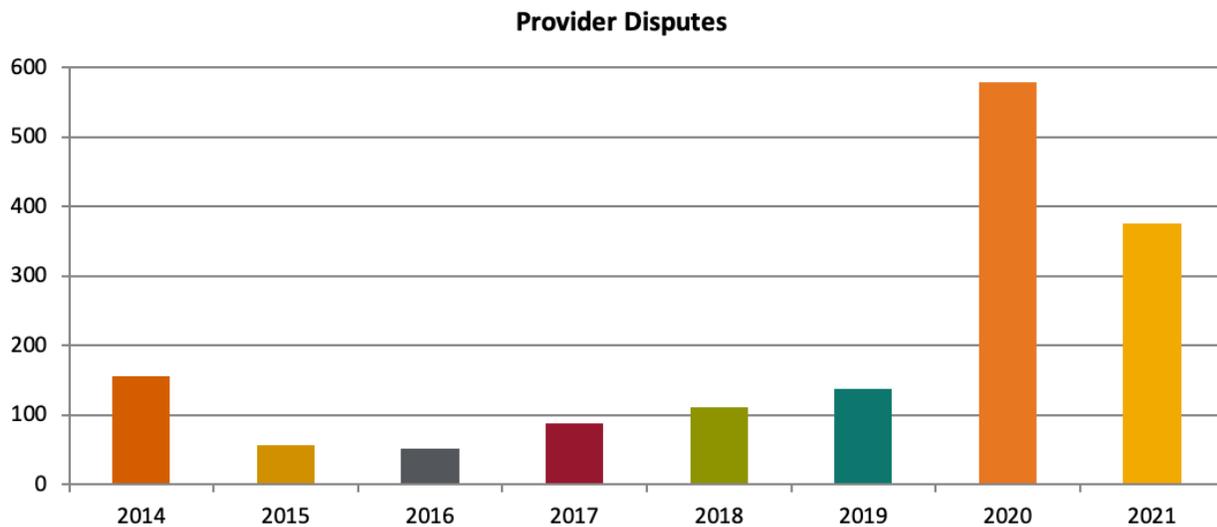
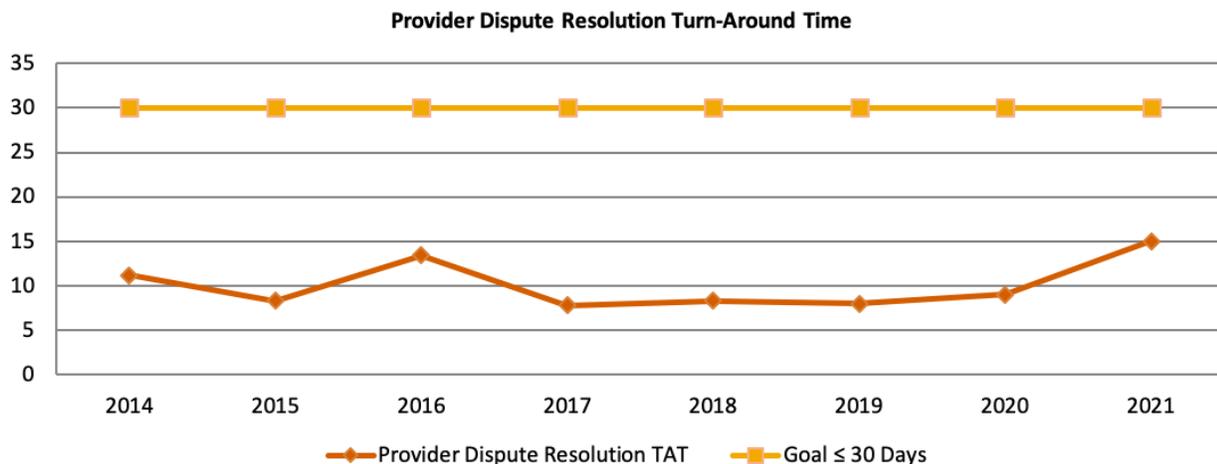


Figure 52



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

**Opportunities and Interventions** – No opportunities for improvement were identified.

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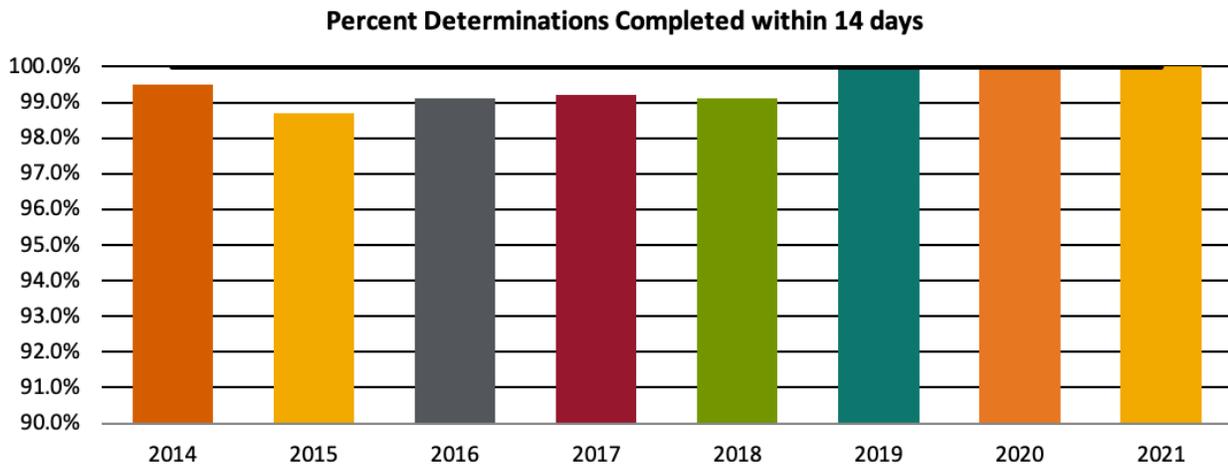
# Utilization Management and Care Coordination

## 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 2021, there were 6,070 service authorization requests. The performance goal of 100% of determinations completed within 14 days was met.

Figure 53



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

**Opportunities and Interventions** – No opportunities for improvement were identified.

## Person-Centered Service Plan (PCSP)

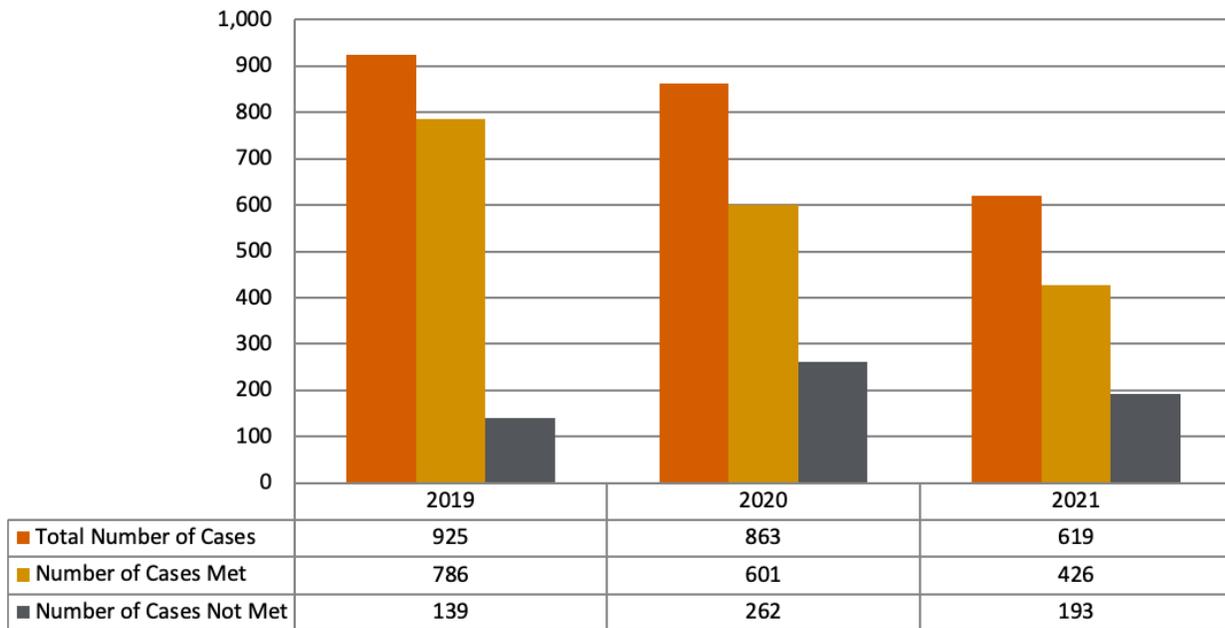
A PCSP (“plan”) is directed by the individual, is ongoing and focuses on the strengths, interests, and needs of the whole person. The person is supported to use their own power to choose what they will do and who will help them to achieve a life meaningful to them. A plan is developed jointly with the 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 the planning process includes people that were chosen by the child or youth and family; the meetings are scheduled at the times and locations that are convenient for the child and family; the process reflects cultural considerations; the process includes strategies to address conflicts or disagreements, including clear conflict-of-interest guidelines for all planning participants; the process provides a method for the person/family to request updates to the plan; the plan documents strengths and preferences as noted by the child/youth and/or family; the plan documents the person’s clinical and support needs, as identified through an assessment of functional and health-related needs; the plan documents the person’s/family’s goals and desired outcomes; the plan documents the risk factors for the person including specific back-up plans and strategies; and the plan is written in plain language in a manner that is accessible to the person/family. The PCSP Team does not review for medical necessity.

**Analysis** – During 2021, Optum Idaho received 619 PCSPs to review. Of those, 426 (69%) met CFR standards and 193 (31%) did not meet CFR standards. All were reviewed within the performance goal of five business days, with an average turnaround of 0.49 days.

Figure 54

**Person Centered Service Plan**



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

**Opportunities and Interventions** – No opportunities for improvement were identified.

## Field Care Coordination

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

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

**Analysis** – During 2021, FCCs received 629 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 37 days.

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Figure 55

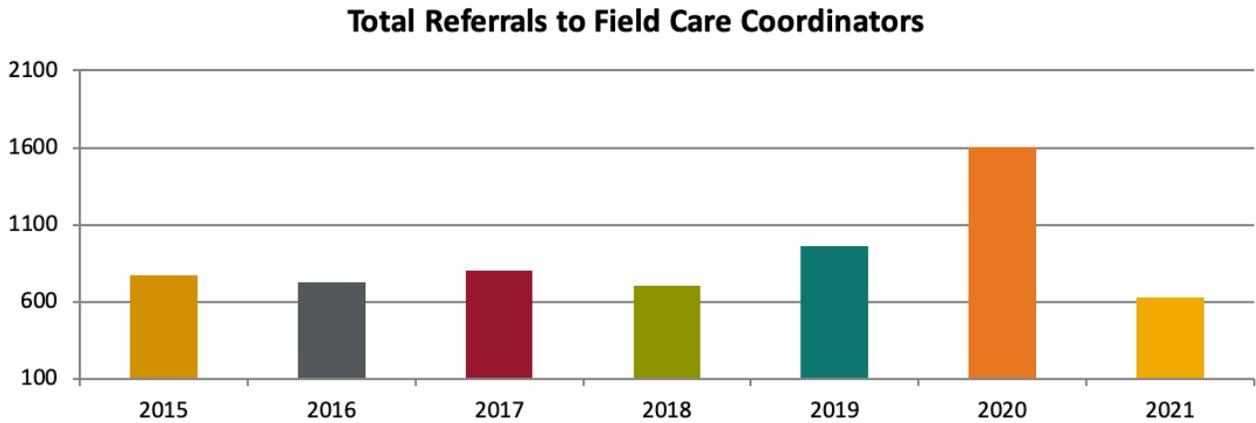
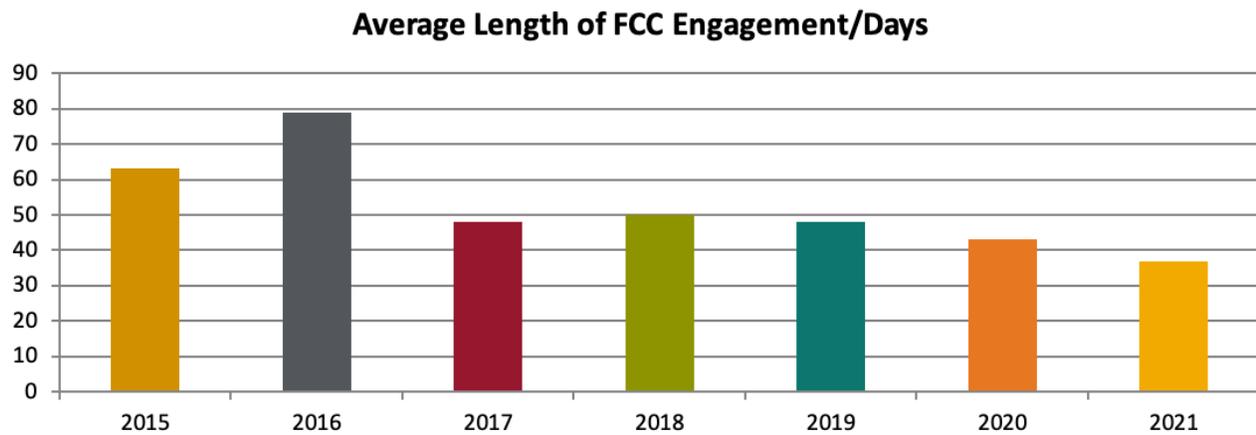


Figure 56



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

**Opportunities and Interventions** - No opportunities for improvement were identified.

## Inter-Rater Reliability

**Methodology** - Inter-Rater Reliability (IRR) is used to measure the consistency and accuracy of application of clinical guideline criteria for utilization management (UM) decisions and recommendations by UM Care Advocates and Peer Reviewers, including MD and PhD psychologist peer reviewers. The assessment consists of 10 questions, and participants must obtain a minimum of 90% or higher score to pass. Participants who do not pass on the first attempt are required to immediately conduct self-led training by reviewing available resources and questions missed. Participants who do not pass on the second attempt are required to notify a supervisory and manager for further remediation. Results are summarized and reviewed for trends.

**Analysis** - During 2021, Care Advocate audits IRR results were 97%. MD Peer Review audit results were 95%.

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Figure 57

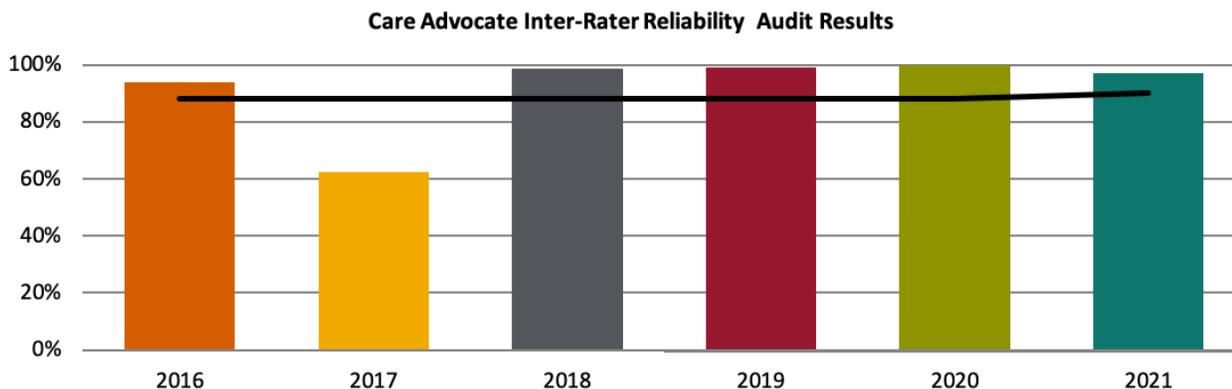
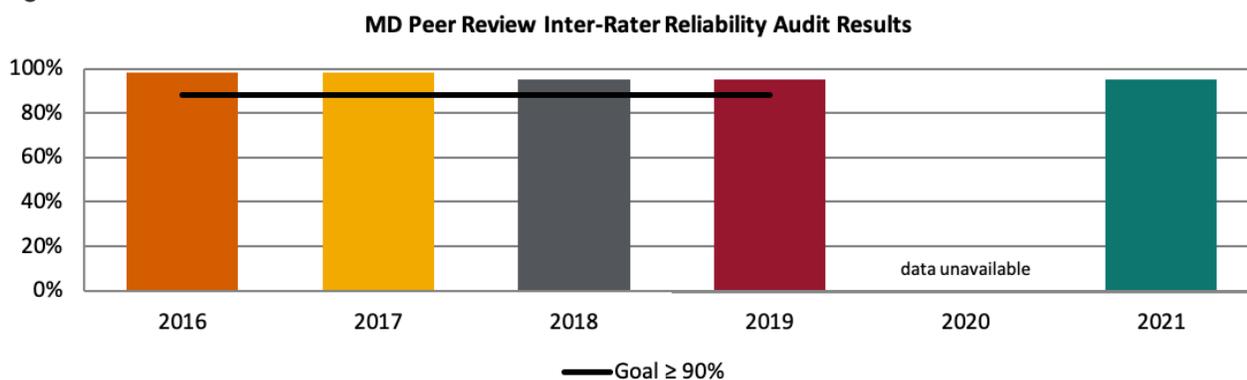


Figure 58



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

**Opportunities and Interventions** -No opportunities for improvement were identified.

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# Population Analysis

## Language and Culture

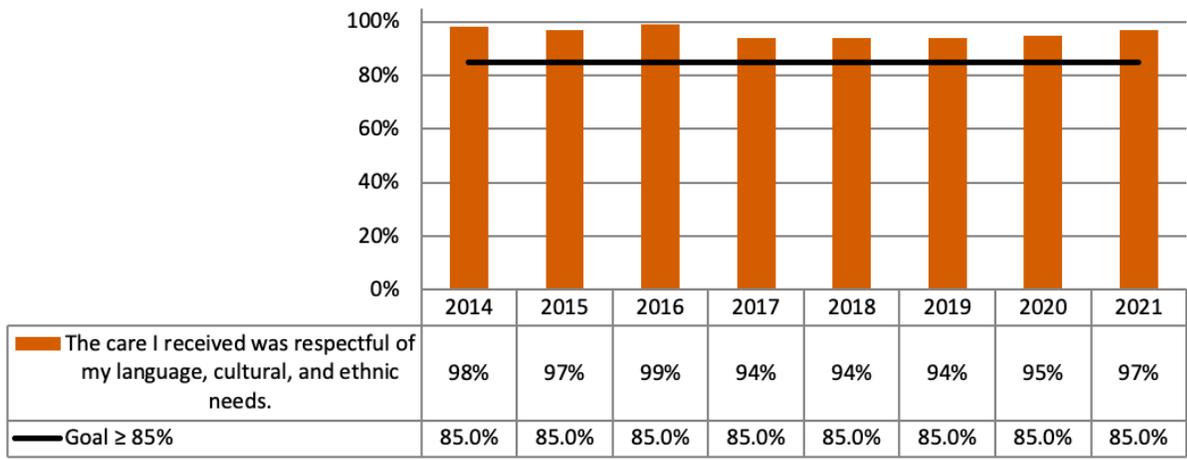
**Methodology** – Optum Idaho strives to provide culturally competent behavioral health services to its Members. Optum Idaho uses U.S. Census results to estimate the ethnic, racial and cultural distribution of our membership. Below is a table listing the 2019\* results for ethnic, racial and cultural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

Total Population (Estimate)	Hispanic or Latino	White	Black	American Indian & Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander	Two or more races	Other races alone
2020 Idaho Census Results for Ethnic, Racial and Cultural Distribution of Population*								
1,839,106	18.7%	61.9%	12.4%	1.1%	6%	0.2%	10.2%	8.4%
*Most current data available.								

**Analysis** – Hispanic or Latino counted for 18.7% of the Idaho population. This is the second highest population total, with White consisting of 61.9% (ethnic and racial backgrounds can overlap, which explains for the percentage total >100%). Again, during 2021, the Member Satisfaction Survey results consistently showed that members believe the care they received was respectful of their language, cultural and ethnic needs.

Figure 59

Member Satisfaction Survey: Cultural, Language and Ethnic Needs



Optum Idaho provides language assistance that is relevant to the needs of our members who 1. speak a language other than English; 2. are deaf or have hearing impairments; 3. are blind or have visual impairments; and/or 4. have limited reading ability. These services are available 24 hours a day, 365 days per year.

**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 the original claims payment; the original payment must have dollars applied to the deductible/ copay/ payment to provider or member) and/or resubmissions (a resubmission is a correction to an original claim that was denied by Optum Idaho). A claim will be considered processed when the claim has been completely reviewed and a payment determination has been made; this is measured from the received date to the paid date (check), plus two days for mail time. Company holidays are included.

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

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

**Analysis** – All claims performance goals have consistently been met.

Figure 60

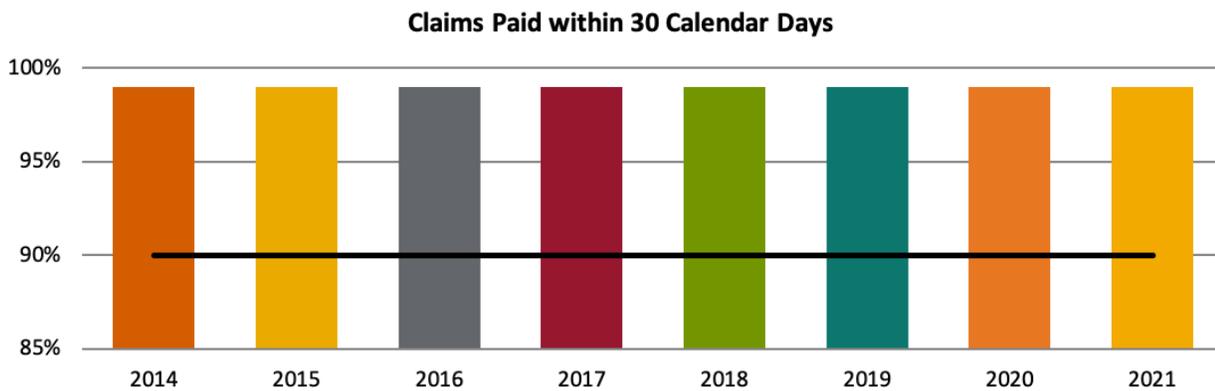
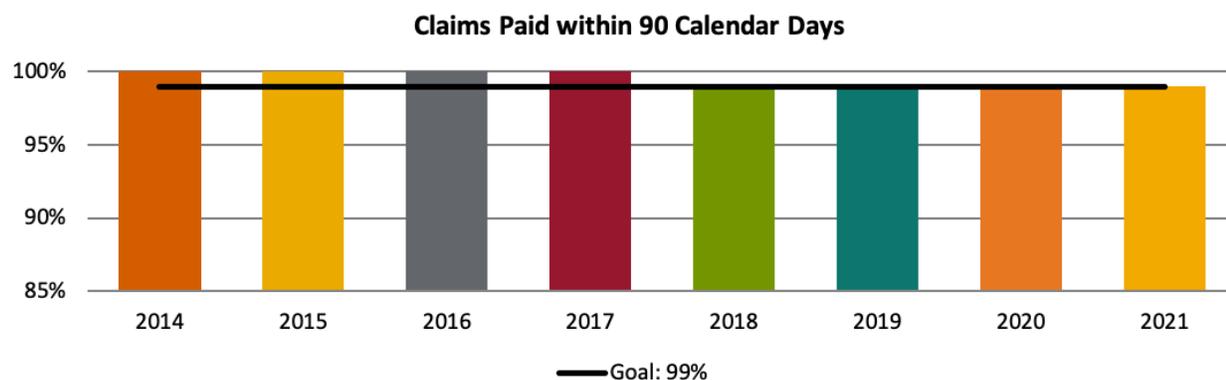


Figure 61



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Figure 62

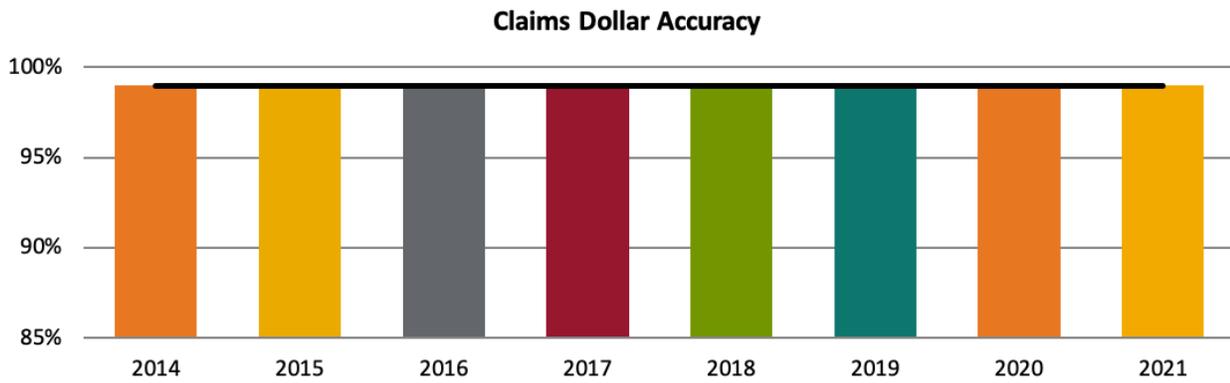
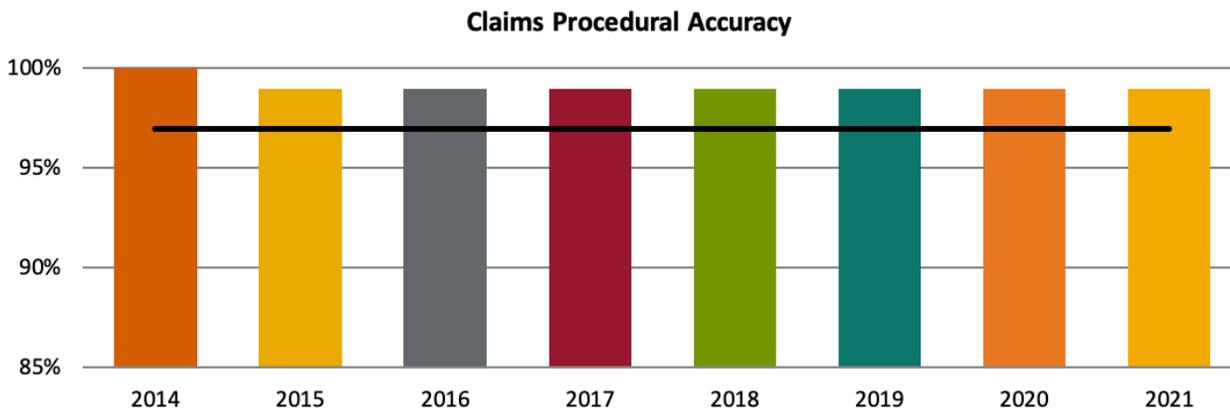


Figure 63



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

**Opportunities and Interventions** – No opportunities for improvement were identified.

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