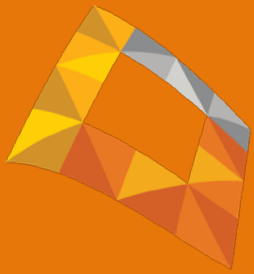# IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT

2016 ANNUAL EVALUATION

OPTUM®

The Idaho Behavioral Health Plan (IBHP) Quality Management and Improvement (QMI) 2016 Annual Evaluation summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) for Calendar Year 2016. 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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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, 2016 through December 31, 2016 and provides comparative performance from 2014 – 2016.

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 2016 *Work Plan* included the following key measure domains:

- Member Accessibility & Availability to Care and Services
- Member Satisfaction
- Performance Improvement
- Network Provider Relations
- Utilization Management

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.

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2016 Overall Effectiveness and Highlights

The results of Optum Idaho's efforts in 2016 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 2016, Optum Idaho met or exceeded performance for 30 (88%) of the 34 total key measures. 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 2016, 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 34 total performance measures, Optum Idaho provided these opportunities to further increase member access to care:

- Developed the Family Support Partner Program.
- Partnered with provider agencies across the state in their efforts to enhance member care with the focus on recovery and resiliency.
- Utilized a team approach that includes Field Care Coordinators, Provider Quality Specialists, Network Managers, and Community Liaisons. The team approach provides a collaborative process for meeting a member's health needs.
- Invested in Idaho's communities through programs and services with a focus on improving the behavioral health system in Idaho to help people reach recovery.
- Introduced the Community Health initiative Grant Program (CHI) to enhance the overall behavioral healthcare system to identify meaningful partnerships and initiatives that lead to improved access to care, better health outcomes, and healthier communities. The goal of the $420,000 grant was to improve behavioral health outcomes for child and adolescent Medicaid participants with Severe Emotional Disturbances (SED). The grant was awarded in October, 2016, to the REACH institute.
- Continued to partner with the Idaho Department of Health and Welfare on the system design of the Idaho Behavioral Health Plan and opportunities that can better serve stakeholder and member care.
- Educated others on the importance of appropriately managing members who have high-risk health needs. Through presentations and one-to-one conversations, Optum Idaho continued to inform key stakeholders on the various ways it assists members including those with significant health issues.
- Promoted our recovery and resiliency model through offering both Peer Support Services and Family Support Services.
- Collaborated with statewide agencies and organizations to bring education and awareness about mental health through community events, conferences, and educational programs.
- Worked with provider agencies across the state on their transformational efforts in how to best serve members in the evolving system.
- Partnered with media outlets across the state for placement of newspaper articles and on-air interviews.
- In collaboration with The Speedy Foundation, Idaho Federation of Families and the Idaho Children's Trust Fund, InTouch Community Conversations were initiated across

the state. The screening of the documentary, Paper Tigers, followed by a panel discussion about positive approaches of discipline, education, and engagement for children and adolescents affected by trauma, with local community experts, leaders, counselors, IDHW, representatives, teachers, Corrections Department, students, providers, and members took place.

- Along with investment partners and new residents, we celebrated the completion of The Springs II, the second phase of an apartment community in McCall, Idaho, that brings an additional 36 homes to the region, helping address a need for more affordable housing. The Springs II integrates three additional 2-story garden apartment buildings with a mix of studio, one-, two-, and three-bedroom apartments into the now 72-unit apartment community. Optum employees presented "welcome baskets" with household items, cleaning supplies and other amenities donated by the company to all the residents of the Springs community.
- Worked with Regional Behavioral health Boards to identify region specific community outreach opportunities.
- Participated in statewide Recovery Month resource fairs and presentations. Staff members shared information and insight on the benefits we provide to members as well as tips for recognizing when someone you care about may be struggling with a mental health issue.

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.

2016 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 quarterly outcomes and a final, overall performance outcome for 2016. 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 Overall Performance	2015 Overall Performance	2016 Overall Performance	Comments
Member Satisfaction Survey Results					
Experience with Optum Idaho 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%	

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Measure	Goal	2014 Overall Performance	2015 Overall Performance	2016 Overall Performance	Comments
Provider Satisfaction Survey Results					
Overall Provider Satisfaction	≥85.0%	69.3%	64.5%	75.0%	Additional information regarding performance improvement efforts are located on page 33 of this report.
Accessibility & Availability					
Idaho Behavioral Healthplan Membership					
Membership Numbers (overall average)	NA	267,378	286,151	296,741	
Member Services Call Standards					
Total Number of Calls	NA	6,483	4,838	5,153	
Percent Answered within 30 seconds	≥80.0%	91.4%	91.0%	87.8%	
Average Speed of Answer (seconds)	≤30 Seconds	13.0	12.6	14.9	
Abandonment Rate	≤3.5% internal ≤7.0% contractual	1.5%	1.9%	2.2%	
Customer Service (Provider Calls) Standards					
Total Number of Calls	NA	16,323	14,205	12,220	
Percent Answered within 30 seconds	≥80.0%	84.0%	97.0%	97.0%	
Average Speed of Answer (seconds)	≤30 Seconds	NA*	5.5	1.3	*began tracking in 2015
Abandonment Rate	≤3.5% internal ≤7.0% contractual	2.9%	0.62%	0.29%	
Urgent and Non-Urgent Access Standards					
Urgent Appointment Wait Time (hours)	48 hours	18.5	22.8	24.2	
Non-Urgent Appointment Wait Time (days)	10 days	3.8	4.7	6	
Geographic Availability of Providers					
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100.0%	99.9%*	99.8%*	99.8%*	*performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)
Area 2 - requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	100.0%	99.8%*	99.9%*	99.8%*	*performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)

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Measure	Goal	2014 Overall Performance	2015 Overall Performance	2016 Overall Performance	Comments
Member Protections and Safety					
Notification of Adverse Benefit Determinations					
Number of Adverse Benefit Determinations	NA	2,266	2,038	2,139	
Written Notification Sent within 1 Business Day	100.0%	77.3%	98.4%	97.0%	
Grievances (appeal of adverse determination)					
Number of Grievances	NA	278	92	73	
Member Grievance Turnaround time	≤30 days	10	12	16	
Complaint Resolution and Tracking					
Total Number of Complaints	NA	569	133	61	
Percent of Complaints Acknowleged within Turnaround time	100% within 5 days	100.0%	100.0%	100.0%	
Number of Quality of Service Complaints	NA	560	122	55	
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	100.0%	99.3%	100.0%	
Number of Quality of Care Complaints	NA	9	11	6	
Percent Quality of Care Resolved within Turnaround time	100% within ≤30 days	100.0%	100.0%	100.0%	
Critical Incidents					
Number of Critical Incidents Received	NA	60	66	67	
Percent Ad Hoc Reviews Completed within 5 business days from notification of incident	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%	

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Measure	Goal	2014 Overall Performance	2015 Overall Performance	2016 Overall Performance	Comments
Provider Monitoring and Relations					
Provider Quality Monitoring					
Number of Audits	NA	**210**	**287**	**368**	
Initial Audit (Percent overall score)	≥ 85.0%	**92.0%**	**97.0%**	**96.0%**	
Recredentialing Audit (Percent overall score)	≥ 85.0%	**96.0%**	**97.0%**	**94.0%**	
Monitoring (Percent overall score)	≥ 85.0%	**89.4%**	**90.1%**	**76%***	*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%**	
Percent of Audits that Required a Corrective Action Plan	NA	**18.7%**	**17.8%**	**9.5%**	
Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)					
Percent PCP is documented in member record	NA	**90.6%**	**93.0%**	**94.7%**	
Percent documentation in member record that communication/ collaboration occurred betweem behavioral health provider and primary care provider	NA	**83.4%**	**80.3%**	**85.1%**	
Provider Disputes					
Number of Provider Disputes	NA	**156**	**57**	**52**	
Average Number of Days to Resolve Provider Disputes	≤30 days	**11.2**	**8.3**	**13.4**	
Utilization Management and Care Coordination					
Service Authorization Requests					
Percentage Determination Completed within 14 days	100%	**No data available**	**98.8%**	**99.1%**	
Field Care Coordination					
Total Referrals to FCCs	NA	**NA***	**774**	**722**	*began tracking in 2015
Average Number of Days Case Open to FCC	NA	**NA***	**63.2**	**79.0**	*began tracking in 2015
Peer-Review Audits					
PhD Peer Review Audit Results	≥ 88.0%	**91.0%**	**97.1%**	**99.9%**	
MD Peer Review Audit Results	≥ 88.0%	**91.7%**	**99.5%**	**98.0%**	

Measure	Goal	2014 Overall Performance	2015 Overall Performance	2016 Overall Performance	Comments
Inter-Rater Reliability					
Inter-Rater Reliabililty Testing	NA	NA	NA	93.8%	
Claims					
Claims Paid within 30 Calendar Days	90.0%	99.7%	99.9%	99.9%	
Claims Paid within 90 Calendar Days	99.0%	100.0%	100.0%	100.0%	
Dollar Accuracy	99.0%	99.8%	99.9%	99.9%	
Procedural Accuracy	97.0%	100.0%	99.7%	99.9%	
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, use of emergency room visits to address behavioral health needs, and timeliness to outpatient behavioral health care following hospital discharges.

ALERT Outcomes

Methodology: : 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. The Idaho Standardized Assessment is a key component of the Idaho ALERT program and for that reason providers are required to ask Members to complete the Assessment at the initiation of treatment and to monitor treatment progress whenever the provider requests authorization to continue treatment.

Wellness Assessments

Methodology: An important part 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.

Use of the Wellness Assessment can provide useful information about the IBHP's member composition over time. Although all providers are required to ask members and families to complete a Wellness Assessment as Optum Idaho's primary clinical outcomes measure, not all members submit the completed instrument.

The following analysis looks at the averaged 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 averaged 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.

ADULT global distress scores are described as follows:

Total Score	Severity Level	Description
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.

Wellness Assessments: Average Global Distress Scores - Adult

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Initial WA	21.7	21.7	21.5	21.8
Follow-up WA	19.0	18.5	19.0	19.0

Figure 1: For adults, initial assessments display a flat curve over the 4 quarters from Q1 2016 through Q4 2016.

YOUTH global distress scores are described as follows:

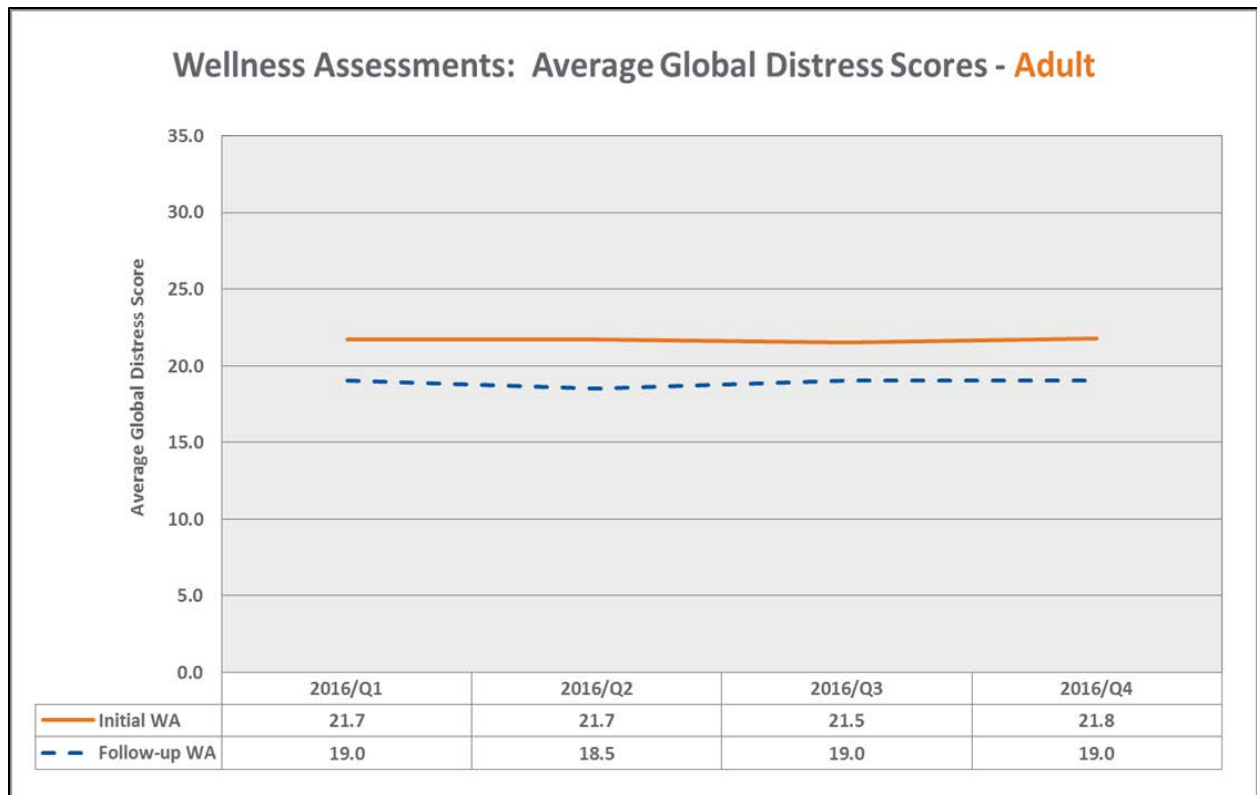| Total Score	Severity Level	Description
0-6	Low	Low level of distress *(below clinical cut-off score of 7)*
7-12	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
13-20	Severe	Approximately one in four clients has an initial score in this elevated range 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 - Youth

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Initial WA	11.1	10.9	11.1	10.8
Follow-up WA	9.9	9.7	9.8	10.0
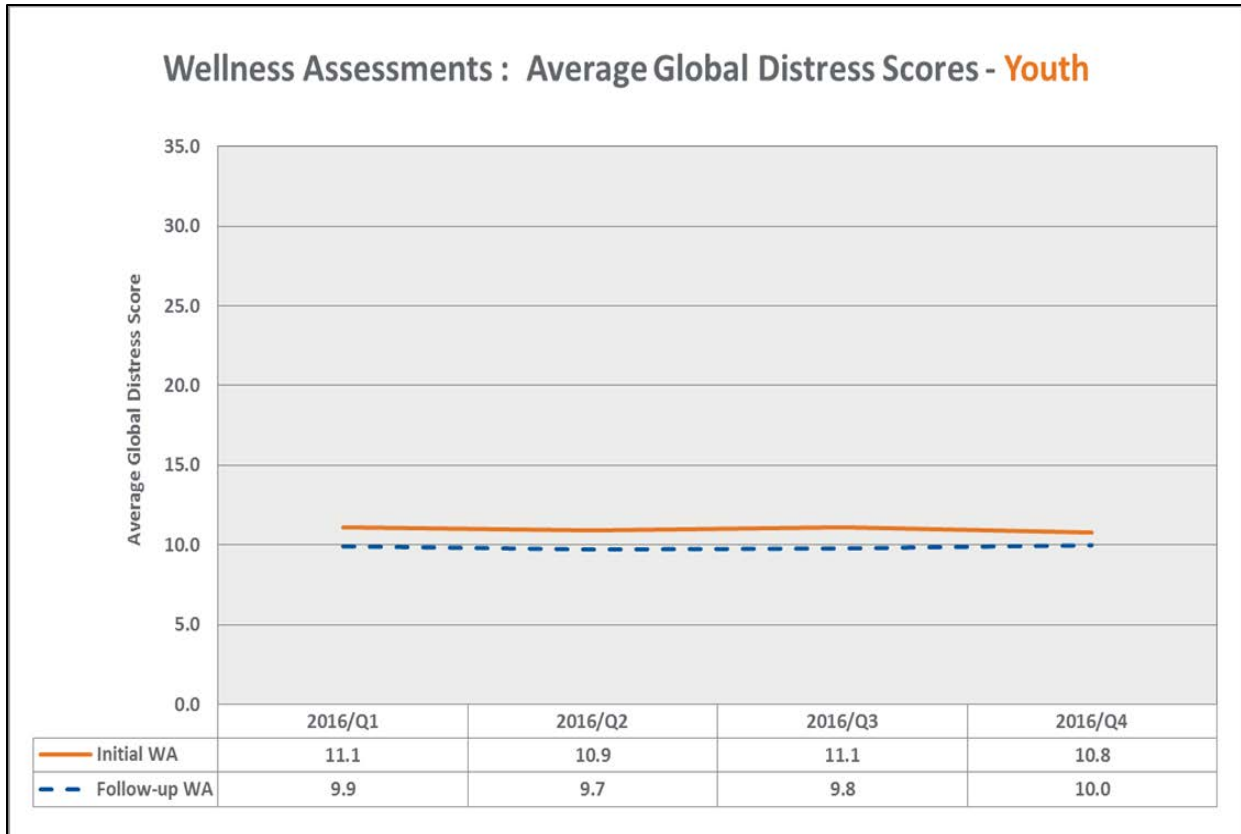
Figure 2: For children and youth, between Q1 2016 through Q4 2016, Global Distress scores have remained flat across time.

Caregiver Strain Level Descriptions:

Score	Severity 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

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Initial WA	6.69	6.69	6.74	6.88
Follow-up WA	6.02	5.96	6.19	6.02
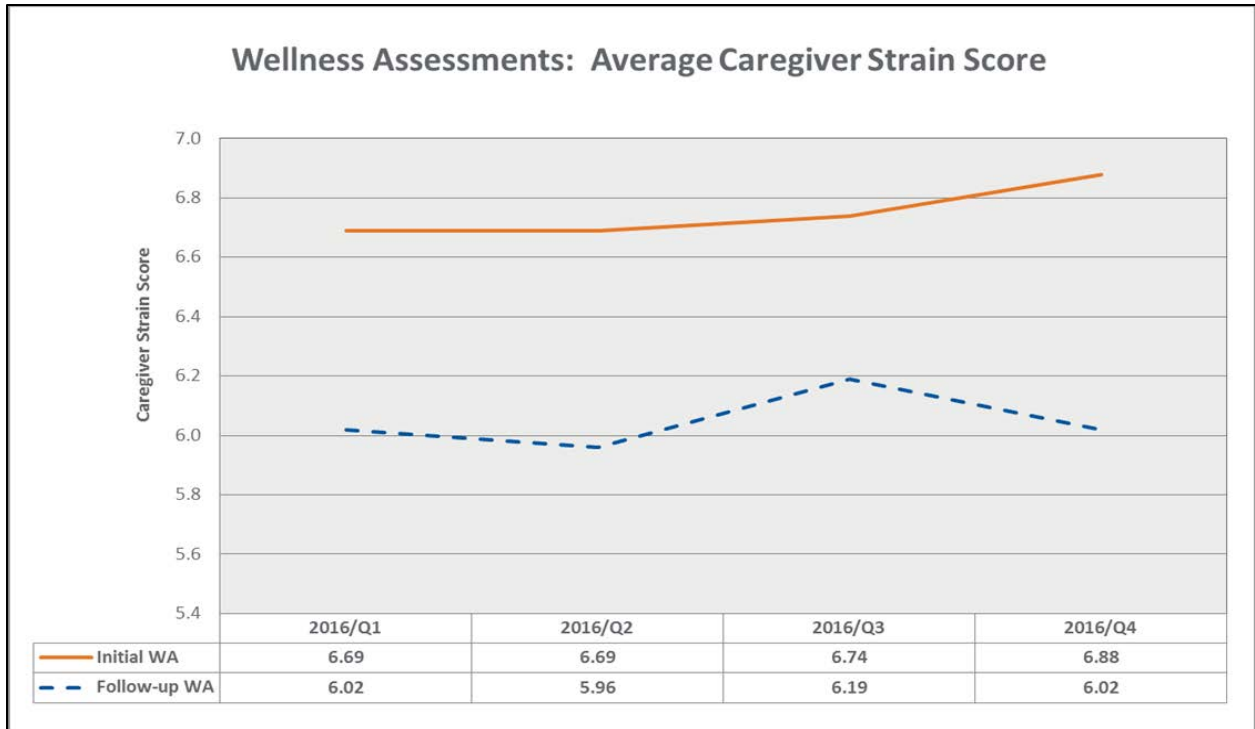
Figure 3: For children and youth, average initial Caregiver Strain scores have increased 2.8% over time. When follow-up scores in the population are reviewed, these have remained generally flat over time. Overall severity levels remained in the moderate range through the study period.

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Wellness Assessments: Average Overall Health Score - Adult

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Initial WA	2.2	2.2	2.2	2.1
Follow-up WA	1.5	1.5	1.5	1.5
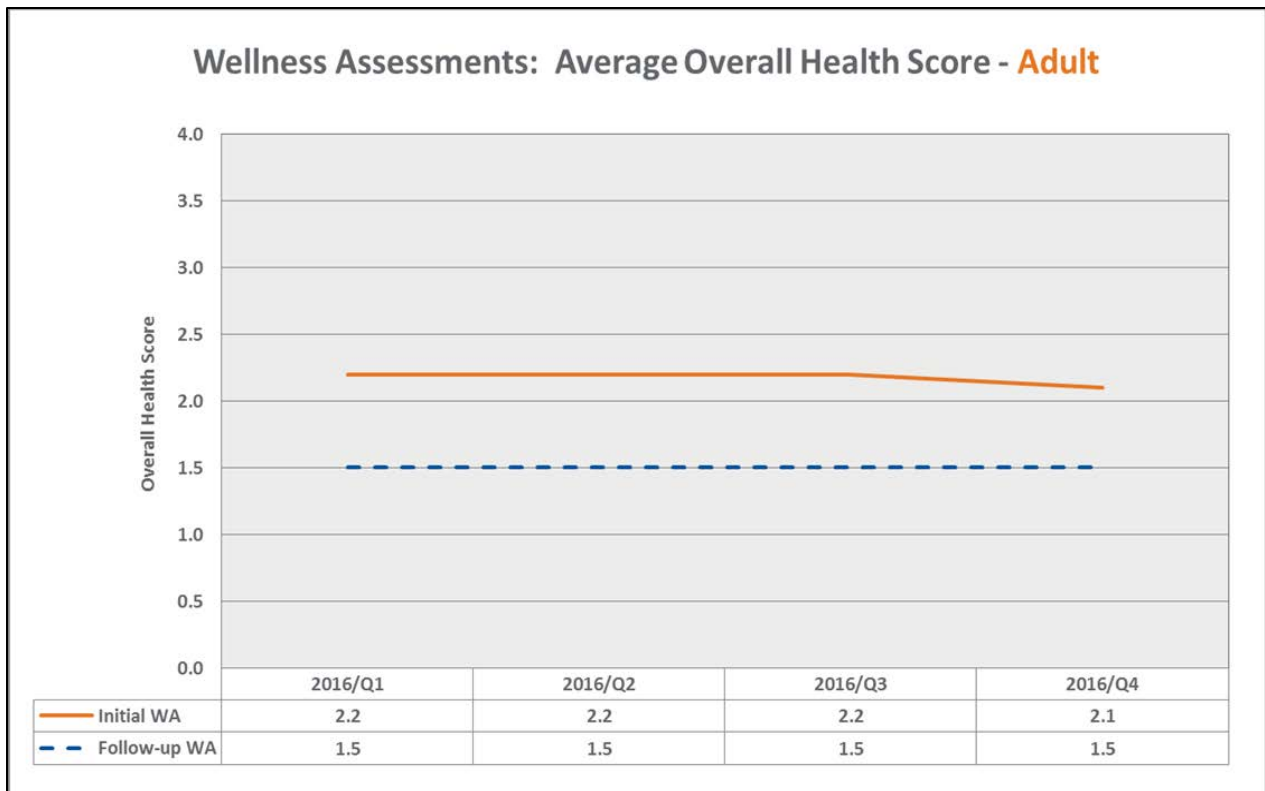
Figure 4: Adult Physical Health score values are as follows:

0 = Excellent   1 = Very Good   2 = Good   3 = Fair   4 = Poor

Overall physical health status is an important predictor of risk. Persons with coexisting physical health issues and behavioral health problems tend to do worse. Between Q1 2016 through Q4 2016, adults at baseline on initial assessment showed an unchanged occurrence of physical health issues that varied between "fair" and "good." On follow-up assessment for the same period, adults showed lower scores in the range between "good" and "very good." These lower scores for the population remained in the same approximate range throughout the study period.

Wellness Assessments: Average Overall Health Score - Youth

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Initial WA	1.0	1.0	1.0	1.0
Follow-up WA	0.7	0.7	0.7	0.7

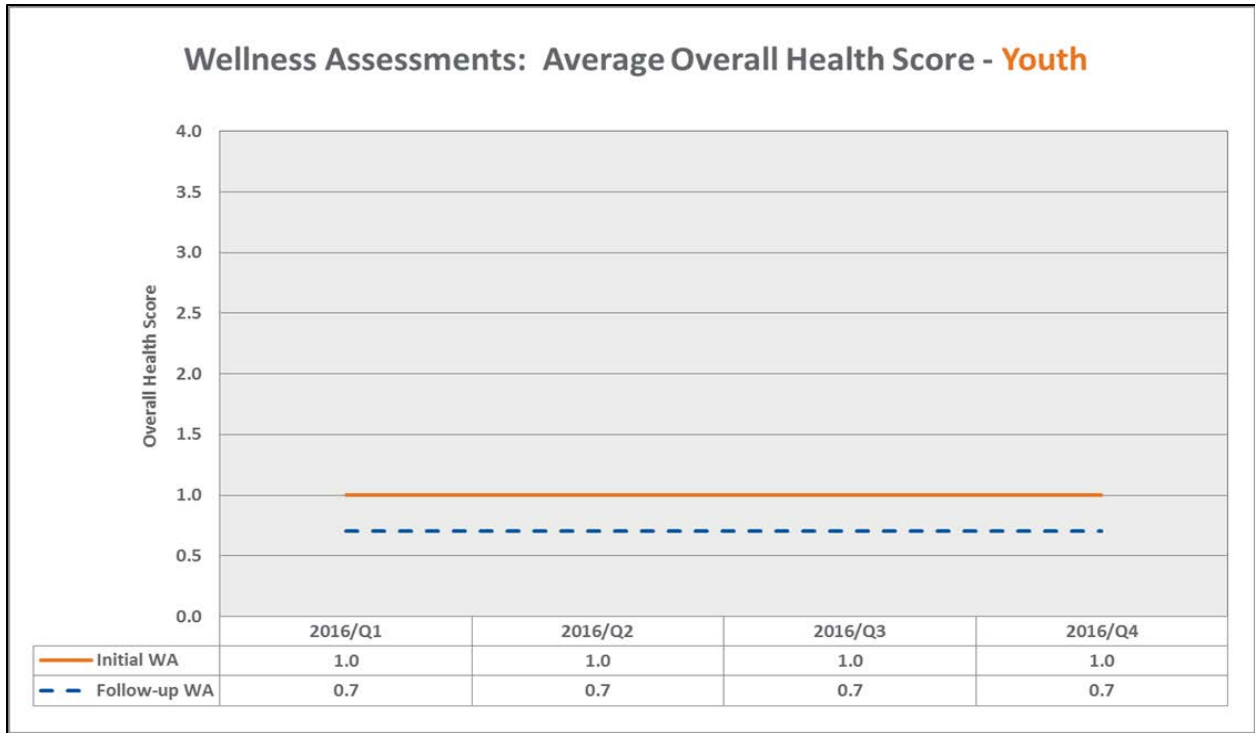**_Figure 5:_** Child and Youth Physical Health score values are as follows:

0 = Excellent   1 = Very Good   2 = Good   3 = Fair   4 = Poor

Between Q1 2016 through Q4 2016, children and youth at baseline on initial assessment showed a flat occurrence of physical health issues that averaged "very good." On follow-up assessment for the same period, children and youth showed lower scores in the range between "very good" and "excellent." These lower scores for the population remained in the same approximate range throughout the study period.

Individual Therapy 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 Individual and Extended Therapy visits for a specific quarter.
Denominator is the total number of IBHP members for the same quarter, in thousands.

Analysis: Individual Therapy is important for many behavioral health disorders. In general, according to the Treatment Guidelines of the American Psychiatric Association, Individual Therapy is an expected, evidence-based practice for adult mental disorders except for dementia. According to the Practice Parameters of the American Academy of Child and Adolescent Psychiatry, Individual Therapy is a central part of treatment in only some disorders, such as Post-Traumatic Stress Disorder, and in limited respects for others. For some disorders,

for instance, Individual Therapy is limited to Problem-Solving Skills Training only for children of school age. In contrast to adults, family-based interventions are the most important and the most commonly expected for children and youth. It is expected, therefore, that there should be more adult utilizers of Individual Therapy than what would be seen with children.

Examination of the data for the age groups 0-17 years, 18-20 years, and 21+ years, shows a clear predominance of utilizers of Individual Therapy in the adult group and many fewer for children and transitioning youth. Overall utilization of Individual Therapies decreased 7.1% between Q1 2016 and Q4 2016.

Individual Therapy Utilizers by Quarter by Age
Per Thousand Members

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Total (All Ages)	68.8	68.9	64.9	63.9
Ages 0 to 17	56.6	56.5	51.8	51.5
Ages 18 to 20	57.5	62.1	54.8	55.4
Ages 21+	106.1	105.8	103.5	99.7

Figure 6

Barriers: No identified barriers

Opportunities and Interventions: Continued recommendation for evidence based individual psychotherapy for appropriate diagnostic categories.

Family Therapy 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 Family Therapy visits for a specific quarter.
Denominator is the total number of IBHP members for the same quarter, in thousands.

Analysis: Over 4 quarters beginning Q1 2016 for which there are reliable claims data, there is overall a decrease of 10.4% in the utilizer rates for Family Therapy for all age groups combined. The 0-17 year group decreased 10.6%, the 18-20 year group decreased 15.0%, and the adult 21+ year group decreased 5.0%.

Family Therapy Utilizers by Quarter by Age
Per Thousand Members

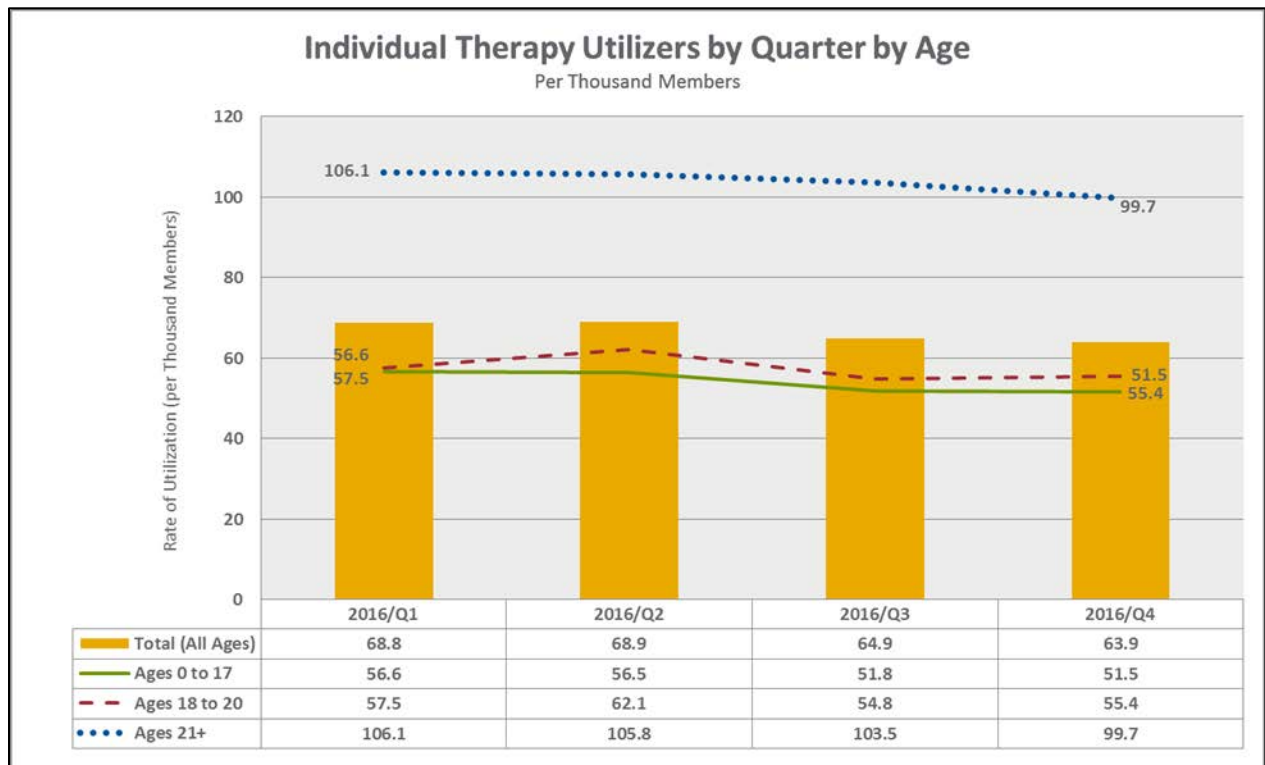|	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Total (All Ages)	28.8	29.2	26.8	25.8
Ages 0 to 17	34.9	35.4	31.9	31.2
Ages 18 to 20	15.3	14.5	15.0	13.0
Ages 21+	13.8	14.1	14.7	13.1
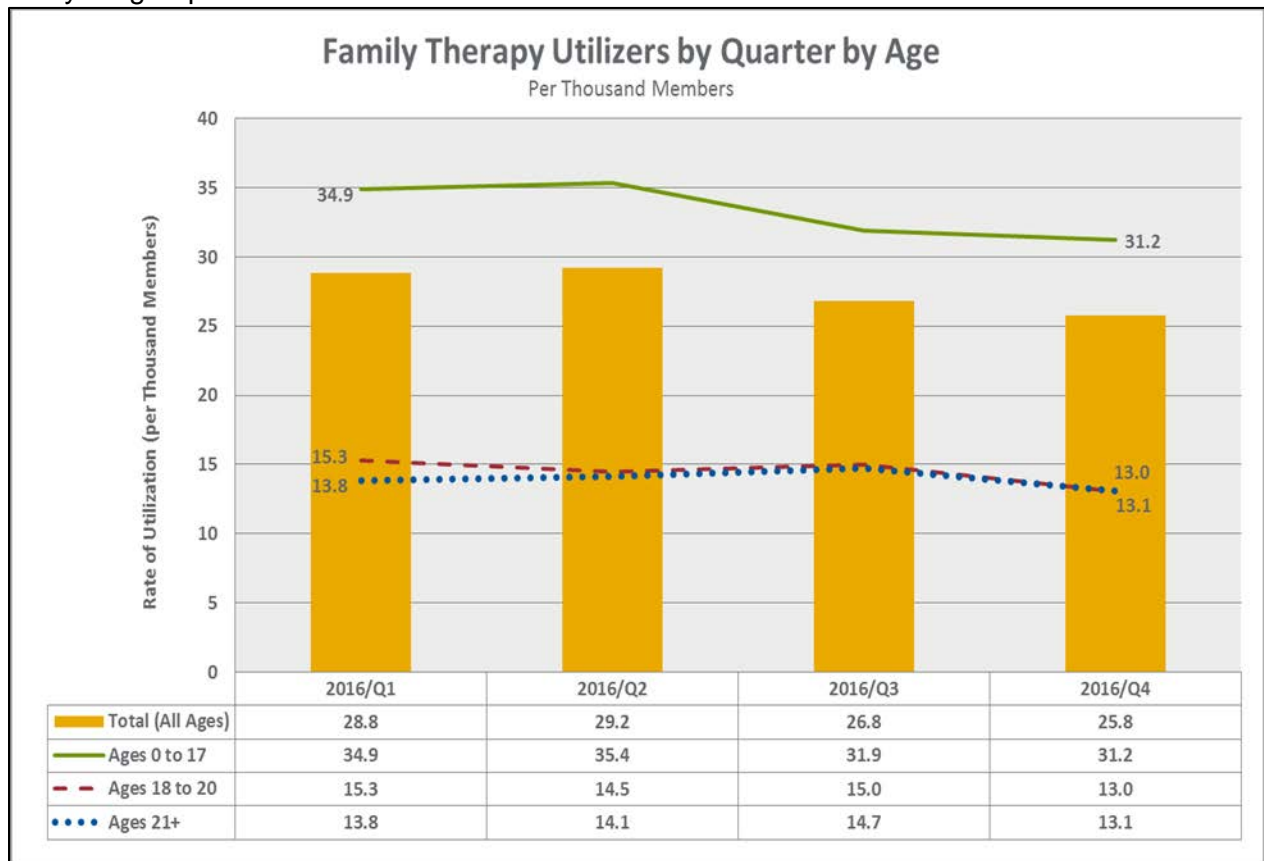
Figure 7

Barriers: No identified barriers

Opportunities and Interventions: Continued recommendation for evidence based family psychotherapy for appropriate diagnostic categories.

Peer Support Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed, since reliable data requires waiting for the 90-daysallowed providers to file claims.

The rate of utilization is calculated as follows:
The numerator is the number of unique utilizers of Peer Support visits for a specific quarter. The denominator is the total number of members 18 and over for the same quarter, in thousands.

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Analysis: Per Optum Idaho's Level of Care Guidelines, only members 18 years and over meet criteria for Peer Support Services. When all members 18 and over are examined, the utilization rate for Peer Support has increased by 93.1% between Q1 2016 and Q4 2016.

Peer Support Utilizers by Quarter by Age
Per Thousand Members

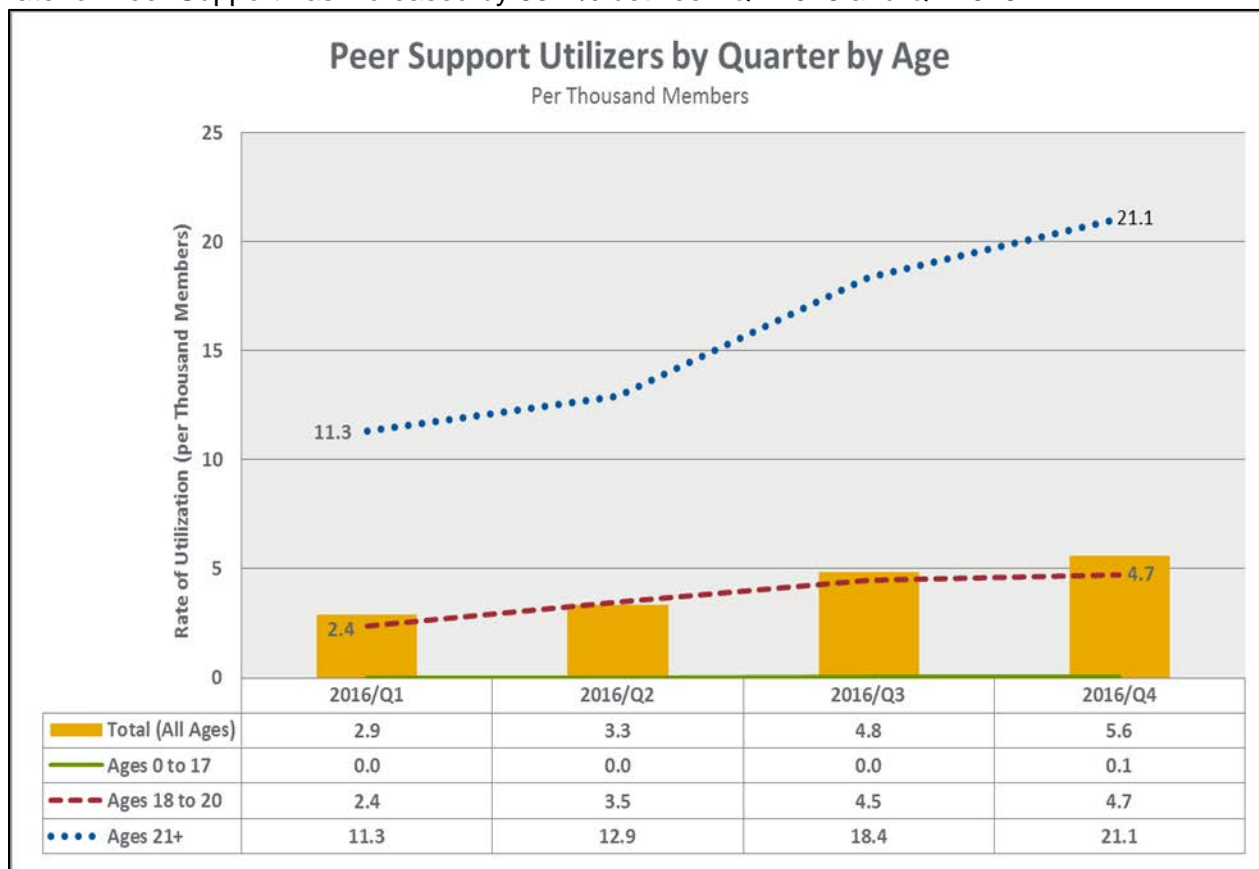|	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Total (All Ages)	2.9	3.3	4.8	5.6
Ages 0 to 17	0.0	0.0	0.0	0.1
Ages 18 to 20	2.4	3.5	4.5	4.7
Ages 21+	11.3	12.9	18.4	21.1

Figure 8

Barriers: The chief barrier to utilization of Peer Support Services has been the limited number of certified specialists. A separate barrier has been variation of provider agencies across the state offering this service. The lack of extensive historical experience with Peer Support for providers in the State of Idaho is also a likely factor, as the benefits of using Peer Support are unfamiliar to some providers.

Opportunities and Interventions: Peer support is an evidence-based intervention that has demonstrated benefit for reducing hospital readmissions for persons with Serious Mental Illness and for reducing depressive symptoms. Optum Idaho favors increased utilization of this service, particularly in those groups for which the medical literature describes medical necessity, specifically members with Serious Mental Illness who have been hospitalized and those with depression who underutilize outpatient services.

Optum Idaho has made changes in the utilization management program to make authorization of Peer Support Services easier for providers. Providers have received training about Peer Support Services and Recovery and Resiliency benefits through use of Peer Support.

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Case Management 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 case management services for a specific quarter.
Denominator is the total number of IBHP members for the same quarter, in thousands.

Analysis: Between Q1 2016 and Q4 2016 utilization rate, total over all ages, of Case Management Services decreased 7.1%.

Case Management Utilizers by Quarter by Age
Per Thousand Members

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Total (All Ages)	25.1	25.8	24.9	23.3
Ages 0 to 17	11.4	11.9	11.0	10.5
Ages 18 to 20	20.6	21.7	18.9	17.6
Ages 21+	65.5	66.4	65.0	59.8
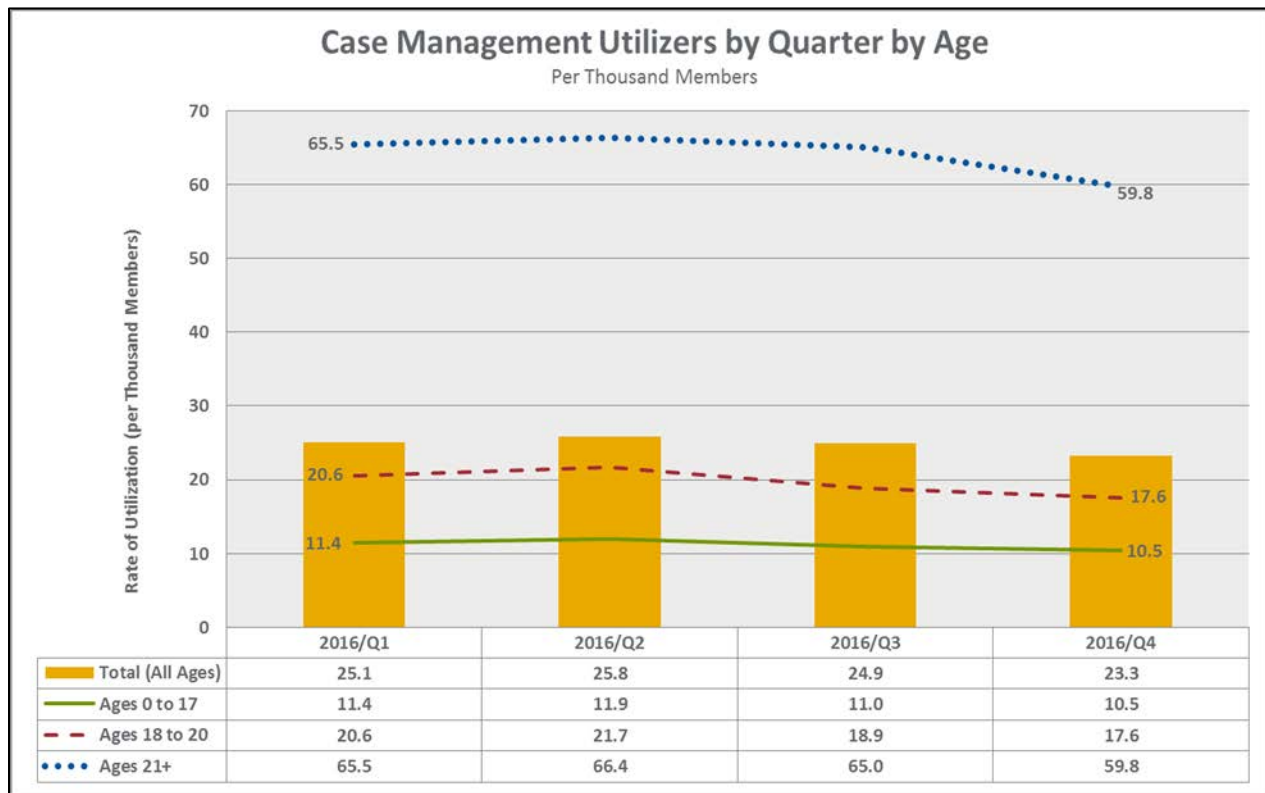
Figure 9

Barriers: No barriers were identified.

Opportunities and Interventions: Case Management Services were changed in mid-August 2015 to a status that allows a predetermined number of case management hours before requiring clinical review. Further monitoring is needed to see whether Case Management services should be returned to a Category 3 status that would require prior review before authorization of service requests. We will continue to work with educating our Provider network concerning appropriate use of Case Management services.

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Prescriber Visit Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed, since reliable data requires waiting for the 90-day claims lag allowed providers to file claims. Rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of prescriber visits, i.e. medication management, to a behavioral health prescriber for a specific quarter. Denominator is the total number of IBHP members for the same quarter, in thousands.

Analysis: Overall, the utilization rate for behavioral health prescription visits decreased 13.1% between Q1 2016 and Q4 2016.

Utilization of prescriber visits is much greater for adults than for children. The severity of adult behavioral health conditions often requires medication management. Child and youth disorders are often heavily shaped by family issues, often making medication management less necessary.

Behavioral Health Prescriber Utilizers by Quarter by Age
Per Thousand Members

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Total (All Ages)	27.3	26.1	24.7	23.7
Ages 0 to 17	15.3	14.5	13.4	12.9
Ages 18 to 20	28.2	26.8	24.8	24.1
Ages 21+	61.9	59.3	56.6	53.9
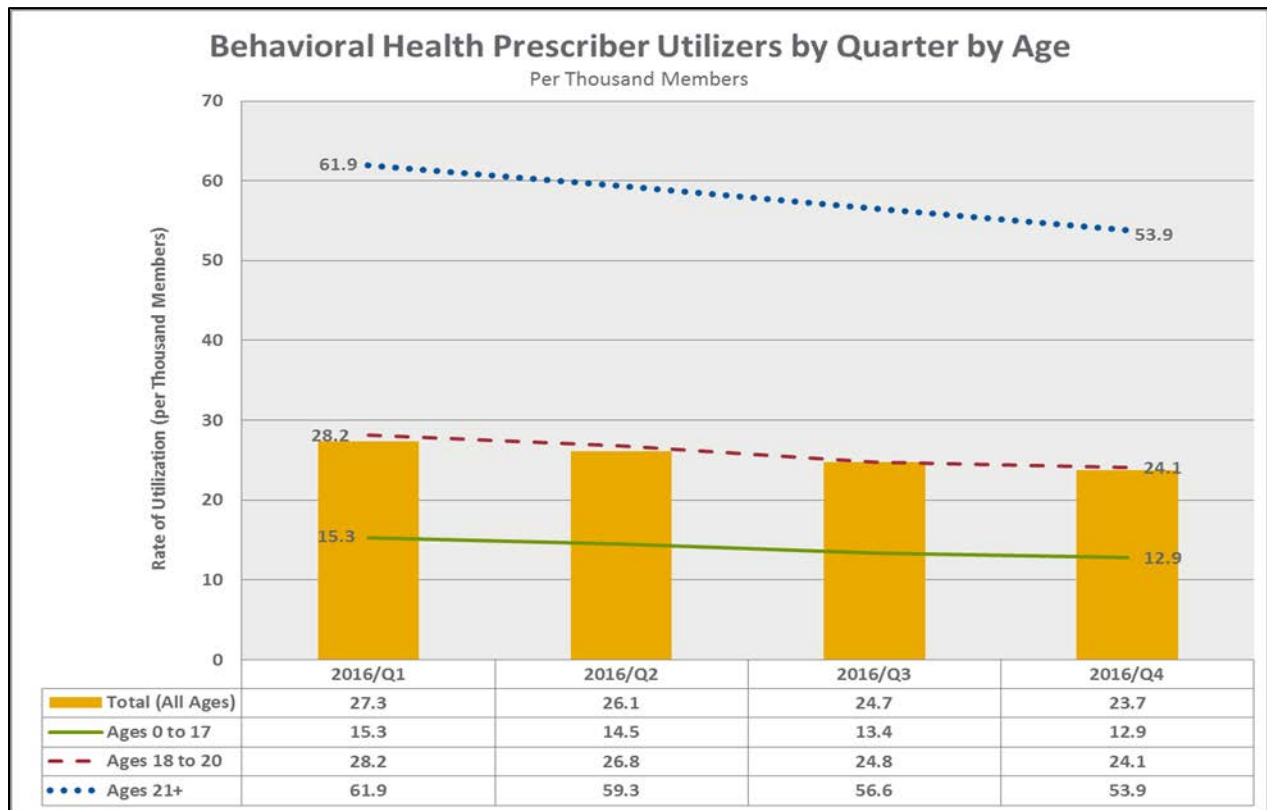
Figure 10

Barriers: Members have a right to choose which prescriber to use among a wide choice of psychiatrists, psychiatric nurse practitioners, physician assistants, primary care providers, pediatricians, family nurse practitioners, and family physician assistants. At present, only data for prescribers enrolled as network providers with the Idaho Behavioral Health Plan is available

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for analysis. The actual number of members receiving prescriptions from non-network providers is unknown.

Opportunities and Interventions: Further analysis is needed to clarify the penetration of prescription services for the utilizer population, including non-network prescribers with data from non-Optum sources. Planning further system interventions will require more information.

CBRS Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed. 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 CBRS visits for a specific quarter.
Denominator is the total number of IBHP members for the same quarter, in thousands.

Analysis: Community-Based Rehabilitative Services, CBRS, is a set of rehabilitation services originally developed to support adults diagnosed with Schizophrenia and severe and persistent Bipolar Disorder. Those two diagnoses are the only two diagnostic groupings for which the Treatment Guidelines of the American Psychiatric Association recognize psychosocial rehabilitation as appropriate.

Between Q1 2016 and Q4 2016, the reduction in CBRS for all age groups combined was 39.4%. All three age groups demonstrated a reduction in utilizer rates, with the 0-17 year group, the 18-20 year group, and the 21+ year group showing reductions of 54.0%, 50.3%, and 35.1% respectively within the study period of Q1 2016 and Q3 2016. These changes have sustained a more clinically appropriate use of CBRS for different age groups.
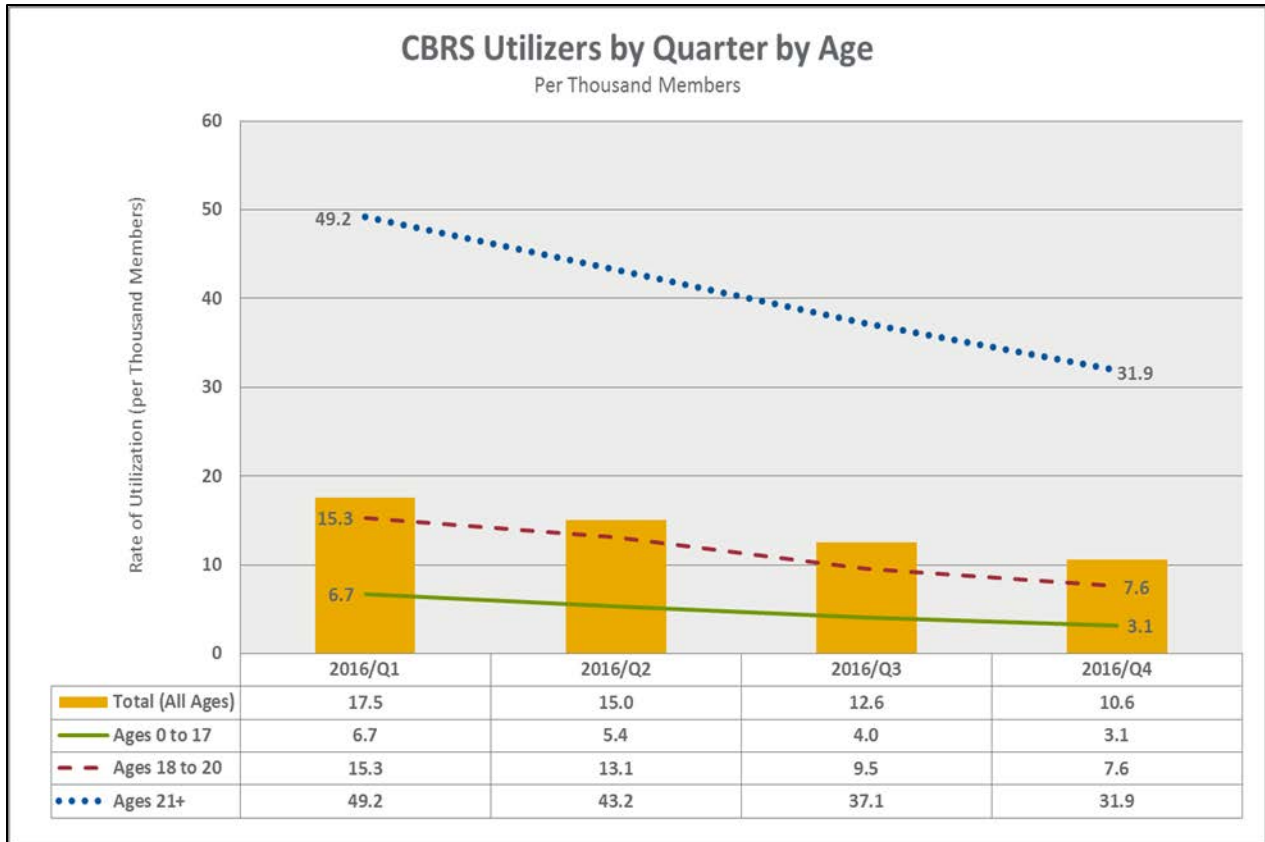
CBRS Utilizers by Quarter by Age
Per Thousand Members

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Total (All Ages)	17.5	15.0	12.6	10.6
Ages 0 to 17	6.7	5.4	4.0	3.1
Ages 18 to 20	15.3	13.1	9.5	7.6
Ages 21+	49.2	43.2	37.1	31.9

Figure 11

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

Opportunities and Interventions: Continued utilization management of CBRS services and recommendation for increased use of evidence based treatment(s).

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 ABD letter.

Analysis: Between Q1 2016 and Q4 2016, the use of medically necessary services has increased following denials of authorization for CBRS. Over the three quarters of this study, in the first 90 days following the ABD, approximately 90-94% of members have received therapeutic services. The overall pattern has been one of sustained openness to acceptance of alternative services to CBRS over the study period. 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.
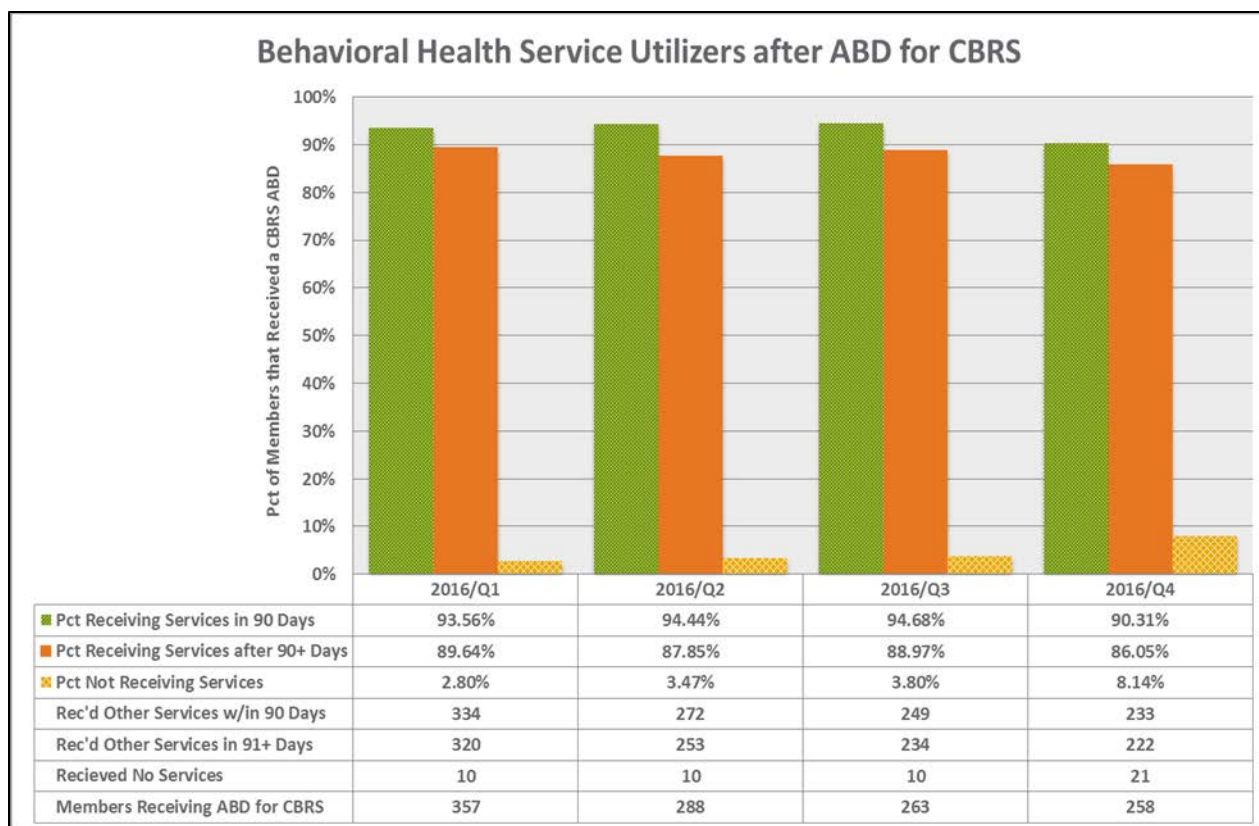
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Behavioral Health Service Utilizers after ABD for CBRS

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
■ Pct Receiving Services in 90 Days	93.56%	94.44%	94.68%	90.31%
■ Pct Receiving Services after 90+ Days	89.64%	87.85%	88.97%	86.05%
✕ Pct Not Receiving Services	2.80%	3.47%	3.80%	8.14%
Rec'd Other Services w/in 90 Days	334	272	249	233
Rec'd Other Services in 91+ Days	320	253	234	222
Recieved No Services	10	10	10	21
Members Receiving ABD for CBRS	357	288	263	258

Figure 12

Barriers: Although progressively changing, limited provider familiarity with evidence-based therapies as well has historically underdeveloped Family Therapy workforce have constrained patterns of clinical practice consistent with national guidelines.

Opportunities and Interventions: The key to provider adoption of clinical practices consistent with national guidelines has been education and encouragement of the use of evidence based treatments. Provider trainings on medical necessity, promotion of use of national guidelines from the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry, care management contacts by Care Advocates, Field Care Coordinators, Medical Directors, and the Utilization Management have all shown a positive effect. Optum's use of its ACE program (Achievement in Clinical Excellence) also rewards providers who adopt use of treatments recommended in national clinical guidelines and use of the Wellness Assessment through the ALERT program. Providers recognized as high excellence in the ACE program receive a bonus for excellent performance and stars on the Provider Locator Tool to direct members and families to their agencies.

Optum promotes the continued increase in Peer Support Services in adults and transitioning youth. With Family Support Services, we anticipate the increased use of these value-added Recovery and Resiliency services for the benefit of children and their families.

Optum promotes member and family education to increase awareness of medically necessary treatments.

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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: In general, a well performing outpatient behavioral health system is 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 operation as a whole. The overall rate of discharges, decreased from 3.25 to 2.75 per 1,000 members. This change represents a 15.4% reduction in hospitalizations (Fig. 13). And, from Q1 2016 through Q4 2016, discharges from the state decreased 25.6% and decreasing 19.6% in 2016 for community hospitals (Fig. 14). The overall average length of stay returned to near Q1 level (Fig. 15).

According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals. Because of possible seasonal fluctuations in hospital readmissions, the year-over-year changes between Q4 2015 and Q4 2016 were examined. For Q4 2015, readmission rates were 10.8%. In comparison with Q4 2016, readmission rates were 9.7% (Fig. 17).
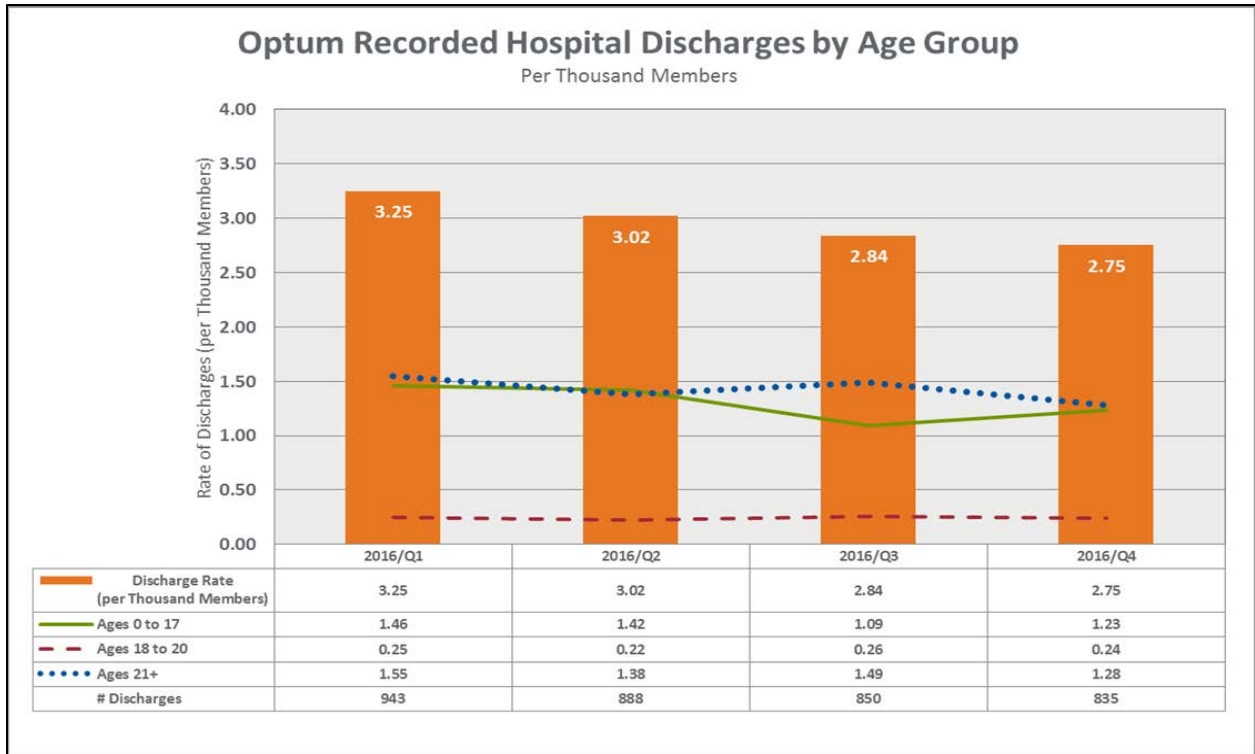
Optum Recorded Hospital Discharges by Age Group
Per Thousand Members

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Discharge Rate (per Thousand Members)	3.25	3.02	2.84	2.75
Ages 0 to 17	1.46	1.42	1.09	1.23
Ages 18 to 20	0.25	0.22	0.26	0.24
Ages 21+	1.55	1.38	1.49	1.28
# Discharges	943	888	850	835

Figure 13

Optum Recorded Hospital Discharges by Hospital Type
Per Thousand Members

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Discharge Rate (per Thousand Members)	3.25	3.02	2.84	2.75
Community Hospital	2.86	2.68	2.49	2.30
State Hospital	0.39	0.35	0.35	0.29
# Discharges	943	888	850	835

Figure 14

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Average Length of Stay by Age Group - Optum Recorded Hospital Discharges

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Overall ALOS	14.1	12.5	12.7	13.7
Ages 0 to 17	11.2	10.8	10.5	12.3
Ages 18 to 20	8.2	8.4	11.1	10.2
Ages 21+	17.7	15.0	14.6	15.8

Figure 15

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Average Length of Stay by Hospital Type
Optum Recorded Hospital Discharges

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Overall ALOS	14.1	12.5	12.7	13.7
Community Hospital	8.7	8.6	8.0	8.9
State Hospital	53.8	42.8	46.1	54.3

Figure 16

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

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
% of Total	9.1%	10.0%	11.3%	9.7%
Ages 0 to 17	3.3%	4.4%	2.8%	2.9%
Ages 18 to 20	1.2%	0.9%	1.1%	1.3%
Ages 21+	4.7%	4.7%	7.4%	5.5%
# Discharges	943	888	850	835

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Figure 17

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

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
% of Total	9.1%	10.0%	11.3%	9.7%
Community Hospital	7.6%	8.7%	10.1%	9.2%
State Hospital	1.5%	1.4%	1.2%	0.5%
# Discharges	943	888	850	835

Figure 18

Psychiatric Emergency Room Utilization Rates

Methodology: Data is provided by IDHW and is for September 2016 to December 2016. Utilization is given as visits per 1,000 members in the IBHP for each month.

Analysis: This graph displays the utilization of Idaho Emergency Room visits for psychiatric care. Over the 4 month period, for the period for which data is available, emergency room utilization remains consistent.
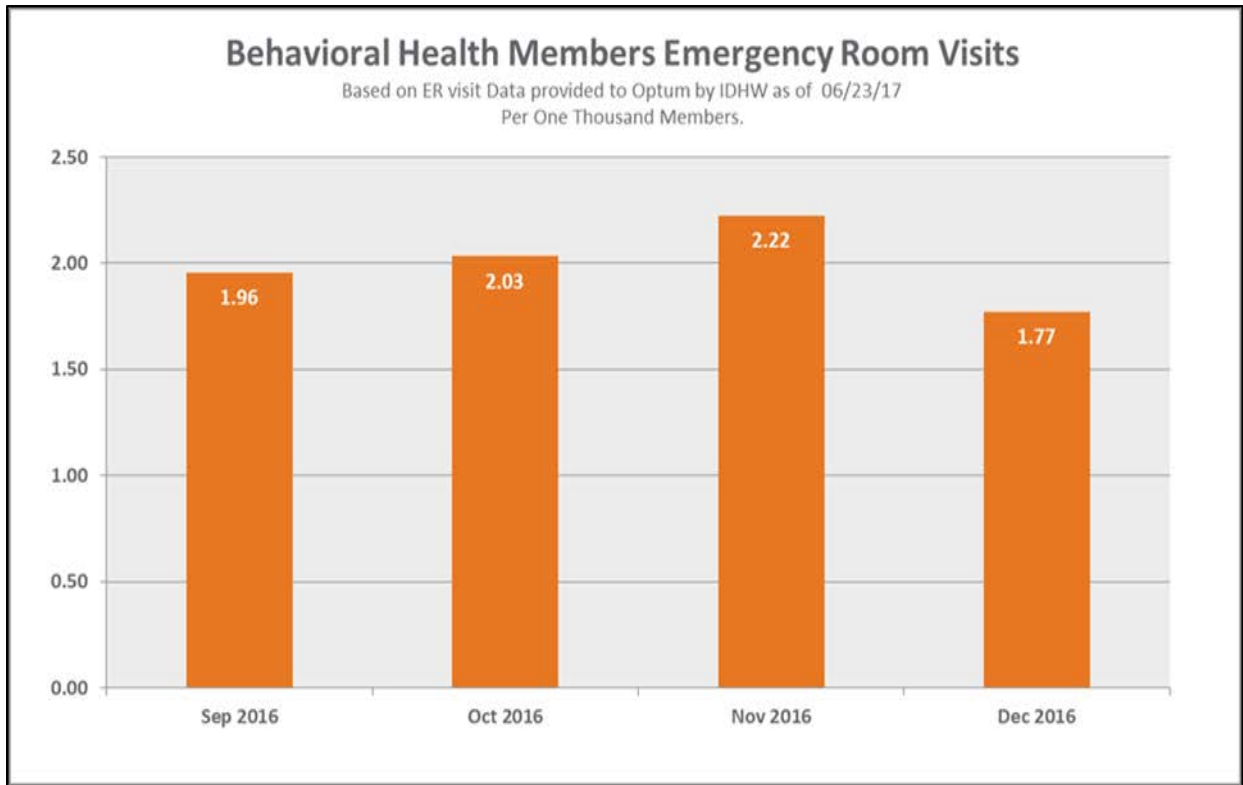
Figure 19

Hospital Discharges with Post Discharge Follow-up

Methodology: Data is stored in LINX. Discharge information is tracked by the Discharge Coordinators and is manually uploaded to LINX. The Post-Discharge appointment data is based on claims data.

Analysis: One of the goals for care coordination is improvement in the transition of members from inpatient to outpatient care, to support improved continuity of care. One of the measures for this is a HEDIS measure that examines the percentage of discharged members who are

seen for an outpatient behavioral health visit within 7 days. Examination of 30 day outpatient visit attendance rates is also common. The 7 day follow-up decreased 7% from Q1 to Q4. The 30 day follow-up decreased 10%.
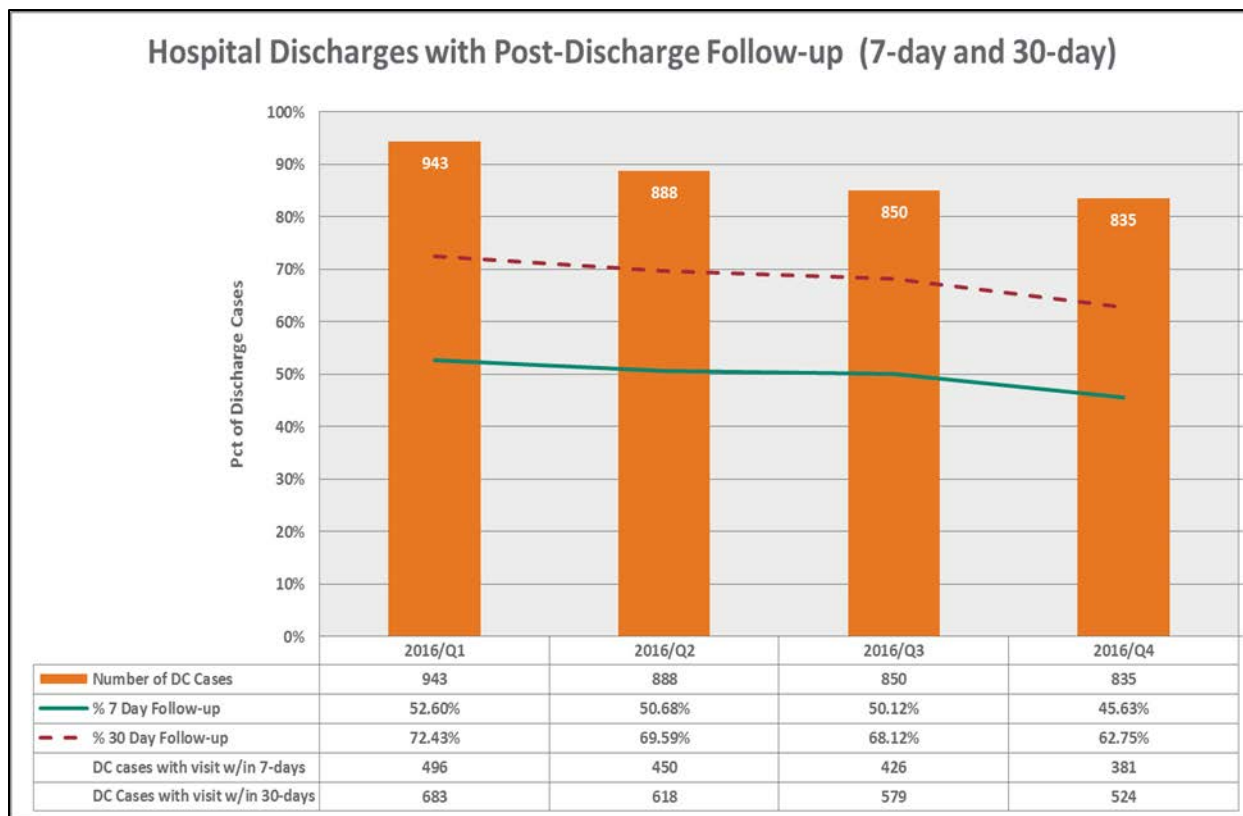

Hospital Discharges with Post-Discharge Follow-up (7-day and 30-day)

	2016/Q1	2016/Q2	2016/Q3	2016/Q4
Number of DC Cases	943	888	850	835
% 7 Day Follow-up	52.60%	50.68%	50.12%	45.63%
% 30 Day Follow-up	72.43%	69.59%	68.12%	62.75%
DC cases with visit w/in 7-days	496	450	426	381
DC Cases with visit w/in 30-days	683	618	579	524

Figure 20
Note: DC is an abbreviation for discharge.

Barriers: The historical responsibility for arranging post-discharge outpatient appointments for behavioral health services has rested with hospital discharge planners. Optum has an outpatient-only contract that results in our not managing hospitals or their staff or discharge planning.

Within the Optum Idaho care coordination system, discharge coordinators check to see whether a member has kept scheduled appointments but do not ensure and often are unable to ensure that there are scheduled appointments to keep due to hospitals' not releasing discharge information in a timely way.
Opportunities and Interventions: There were favorable outcomes for hospital discharge rates and readmission rates for all age groups.

There are two main opportunities for further change remains to strengthen the capacity of outpatient services to keep members in community-based care. The first is an on-going pilot program first with the state hospitals and then community hospitals to use an Appointment Reminder Program based on information about scheduled aftercare appointments that Optum

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will use to electronically notify members or their families of an upcoming appointment visit. The second is a resetting of the Community Transition Support Service to help with post-discharge timeliness and overall treatment adherence. These programs are in preparation, so data are currently unavailable to report.

Member Satisfaction Survey Results

Methodology: Optum monitors Idaho Medicaid enrollees' satisfaction with behavioral health services using the online and mailed versions of the Optum Idaho Member Satisfaction Survey. The surveys were designed in collaboration with IDHW. The mailed version is fielded quarterly, while the online version is accessible to members 24 hours a day on the Optum Idaho and Optum Idaho Live and Work Well websites.

The member survey is outsourced to the Center for the Study of Services (CSS), which is a NCQA-certified vendor. Mailed surveys are administered quarterly in English with Spanish translation available. The mailed survey is administered via two mailings, with second mailing being sent as a reminder to non-respondents.

Members who have received outpatient or services within the Optum network in the last 90 days are eligible to participate. Members 18 years of age and older and members 15 years of age and younger are eligible to be surveyed (please note that for members 15 years of age and younger, the survey packet is addressed to the parent of the member not to the youth directly). Members must be eligible for services at the time of the survey and have granted permission to mail to their address on record. Members who have accessed services in multiple quarters are eligible to participate in the survey only once every 12 months.

Random samples of eligible individuals are selected to participate in the survey. Only mailed survey responses are used in our annual data analysis due to the limitations in validating the members who respond to our online survey methods. However, all responses submitted from our online portal are reviewed.

The member survey tool includes 26 items. Survey questions represent the following experience domains.

- *Experience with Optum Idaho staff and referral process*
- *Experience with provider network*
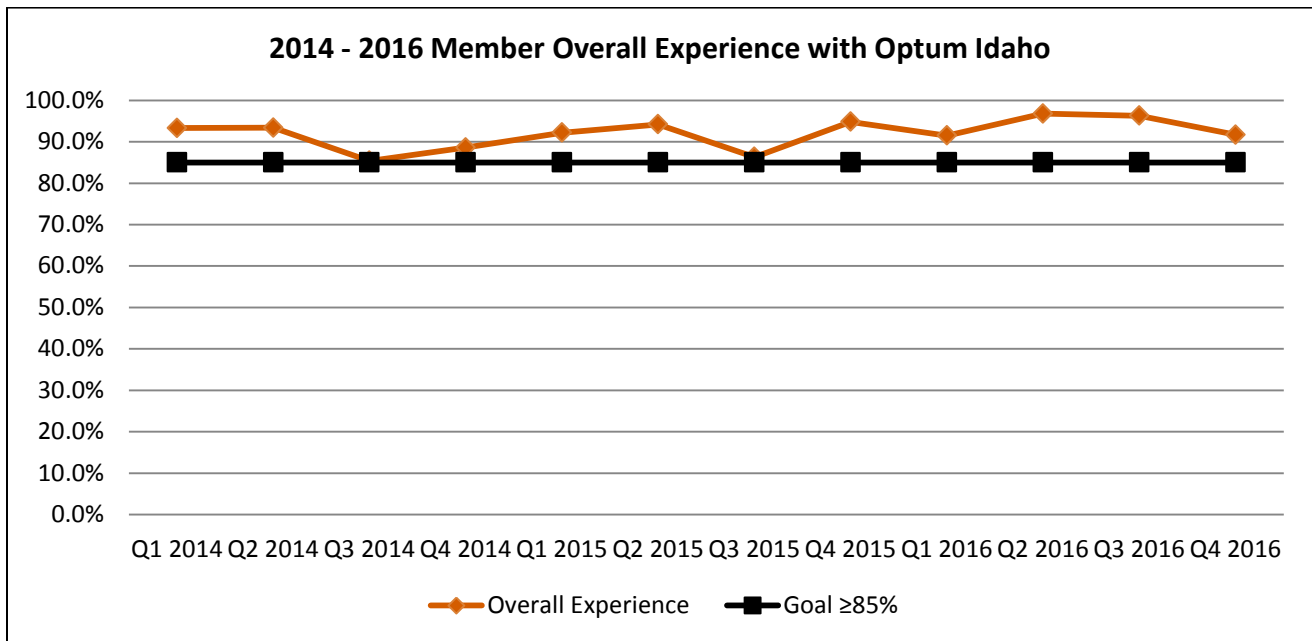- *Experience with counseling and treatment*
- *Overall experience*

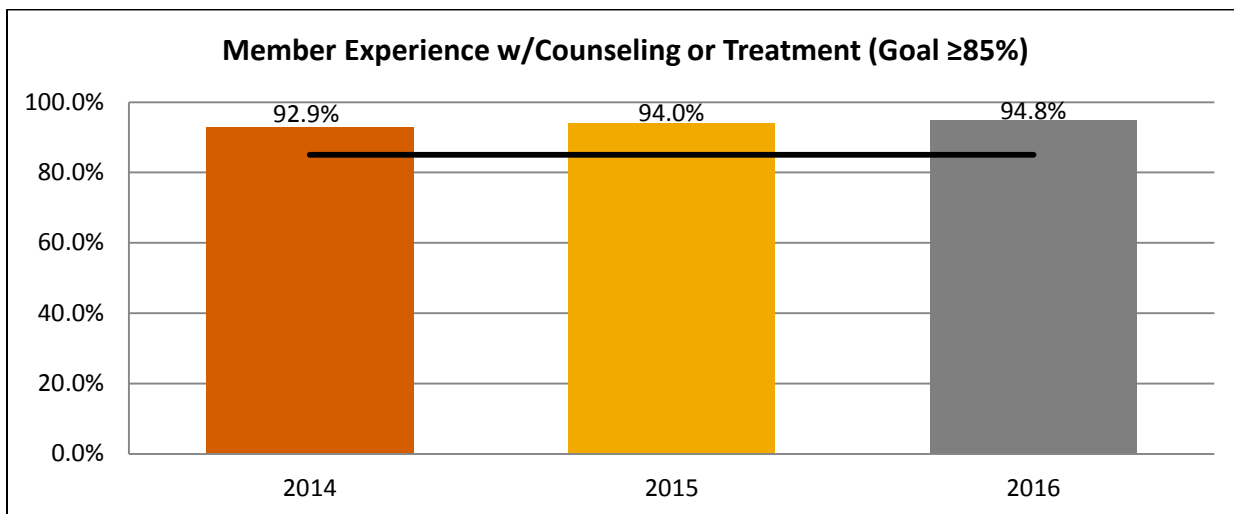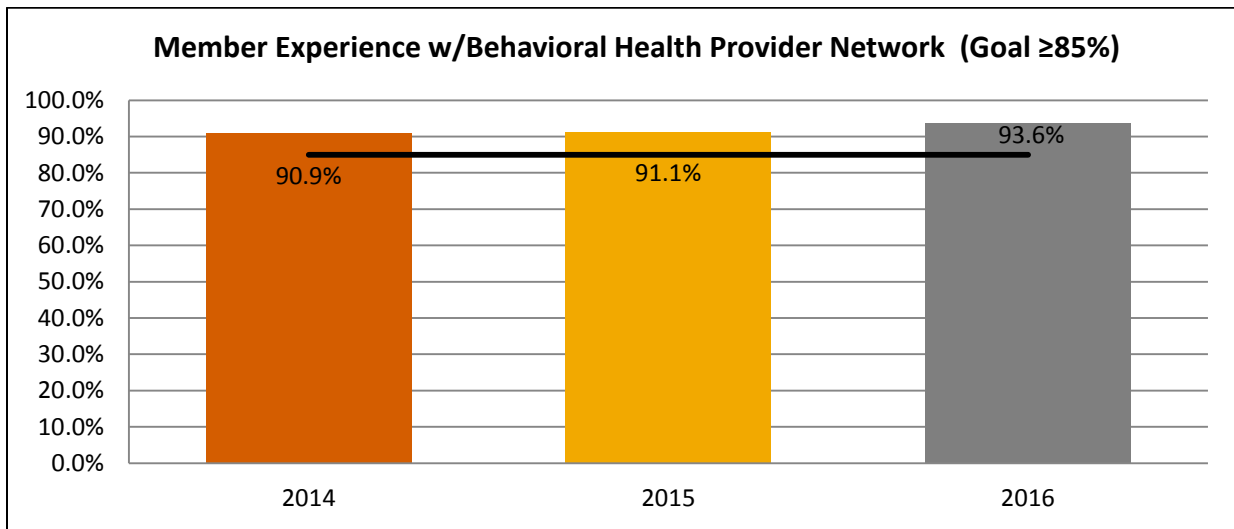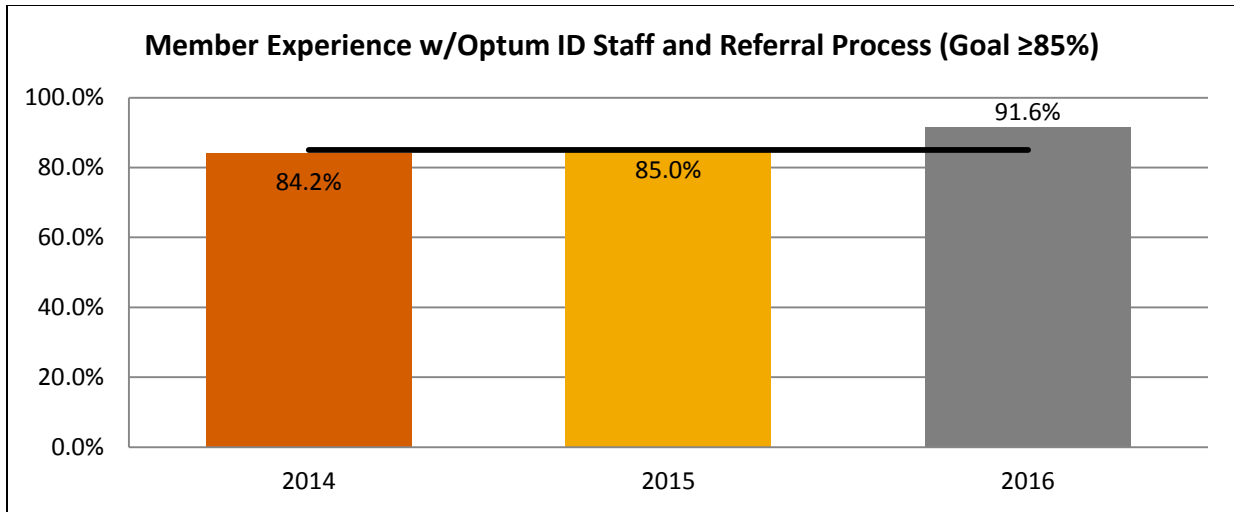2014 – 2016 Overall Performance Results:

Member Overall Satisfaction Survey	Performance Goal	2014 (n=458)	2015 (n=402)	2016 (n=417)

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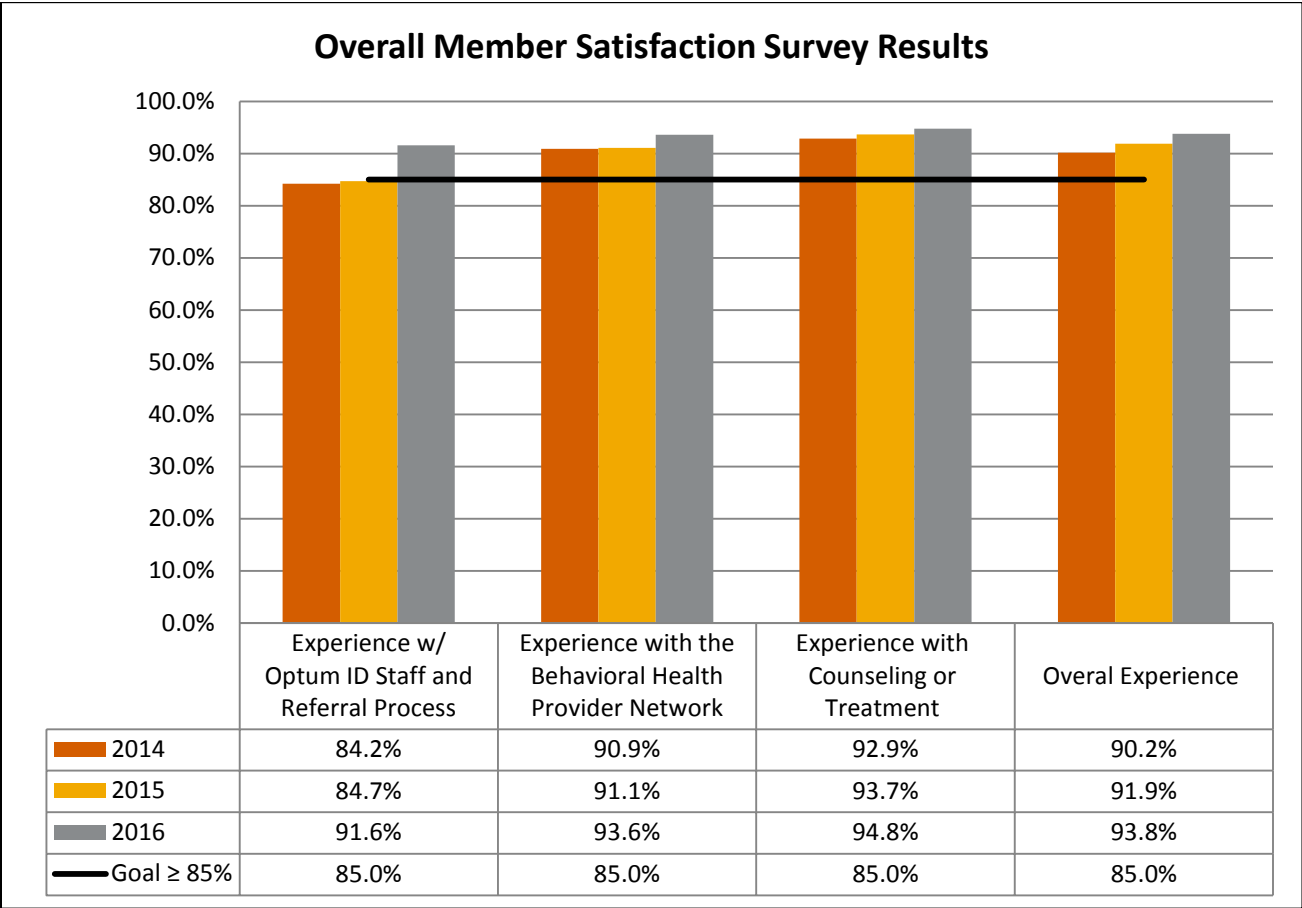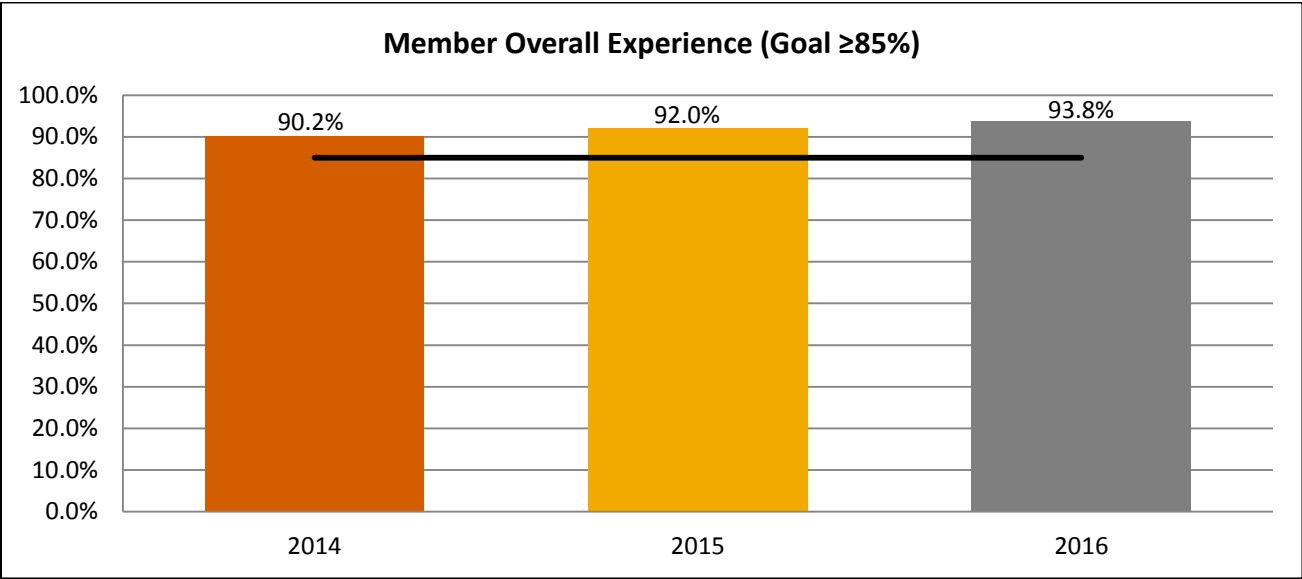7.18.17

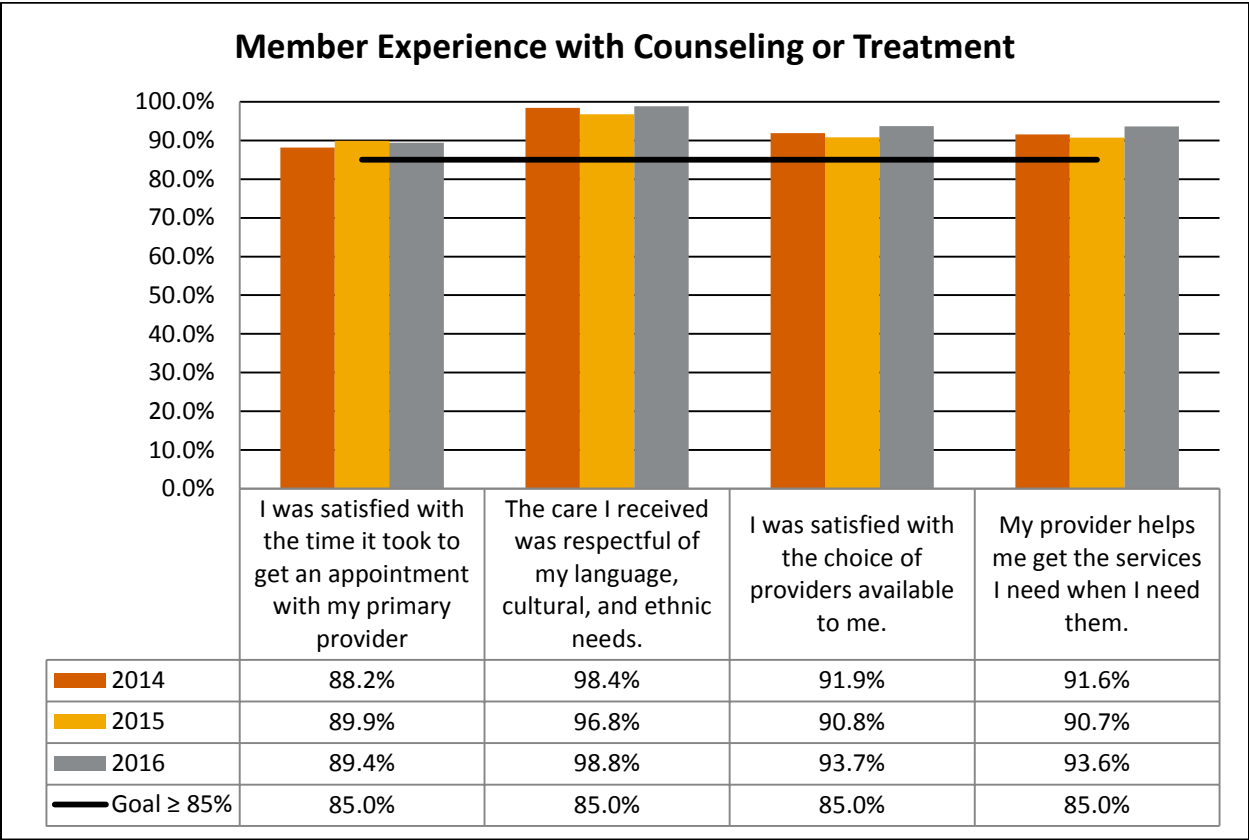|				
Experience w/Optum ID Staff and Referral Process	≥85.0%	84.2%	85.0%	91.6%
Experience with the Behavioral Health Provider Network	≥85.0%	90.9%	91.1%	93.6%
Experience with Counseling or Treatment	≥85.0%	92.9%	94.0%	94.8%
Overall Experience	≥85.0%	90.2%	92.0%	93.8%

Analysis: The survey was offered in English and Spanish. During 2016, 3,961 surveys were mailed. Of the surveys mailed, 534 (13.5%) were returned as undeliverable. The overall response rate for 2016 was 12.2%. Member Satisfaction rates again increased during 2016 in all four categories; all meeting or exceeding the goal of ≥85.0%.

In addition, the Member Satisfaction Survey includes specific questions related to the member's experiences with counseling and treatment. During 2014, 2015, and 2016 the overall average for these questions remained stable and continued to meet the goal of ≥85.0%.

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Member Experience w/Optum ID Staff and Referral Process (Goal ≥85%)

Year	Value
2014	84.2%
2015	85.0%
2016	91.6%

Member Experience w/Behavioral Health Provider Network (Goal ≥85%)

Year	Value
2014	90.9%
2015	91.1%
2016	93.6%

Member Experience w/Counseling or Treatment (Goal ≥85%)

Year	Value
2014	92.9%
2015	94.0%
2016	94.8%

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Member Overall Experience (Goal ≥85%)

Year	Value
2014	90.2%
2015	92.0%
2016	93.8%

Overall Member Satisfaction Survey Results

	Experience w/ Optum ID Staff and Referral Process	Experience with the Behavioral Health Provider Network	Experience with Counseling or Treatment	Overal Experience
2014	84.2%	90.9%	92.9%	90.2%
2015	84.7%	91.1%	93.7%	91.9%
2016	91.6%	93.6%	94.8%	93.8%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%

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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	88.2%	98.4%	91.9%	91.6%
2015	89.9%	96.8%	90.8%	90.7%
2016	89.4%	98.8%	93.7%	93.6%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%

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

Provider Satisfaction Survey Results

In 2016, Optum Idaho changed from a quarterly provider satisfaction survey to an annual survey to align with national standards.   The new survey was executed during the 4th Quarter of 2016.

Methodology: Optum Idaho contracted with the vendor, Fact Finders, to conduct the 2016 Provider Satisfaction Survey.   The survey was designed to contact every provider to give them an opportunity to participate in the research.

To accommodate the schedules of busy providers and include in the research as many of the providers as possible, a multi-stage, multi-mode coordinated data collection effort was employed.

There are 3 modes for providers to complete the survey:
1. Outbound Telephone Call from Fact Finders
2. Inbound Telephone from Provider to Fact Finders
3. Online Survey

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2016 Overall Performance Results:

Overall Provider Satisfaction Survey	Performance Goal	2016
Satisfied/Very Satisfied	≥85.0%	75%
Dissatisfied/Very Dissatisfied	NA	23%
No Opinion	NA	2%

Analysis: Since sampling methodology changed in the 2016 Annual Survey, only 2016 results are presented in this Annual Evaluation. The second Annual survey will be sent to providers in November of 2017. A comparative analysis of the 2016 and 2017 results will be presented in the 2017 Annual Evaluation.

Overall Provider satisfaction was 75%.

Overall Provider Satisfaction (goal ≥85%)
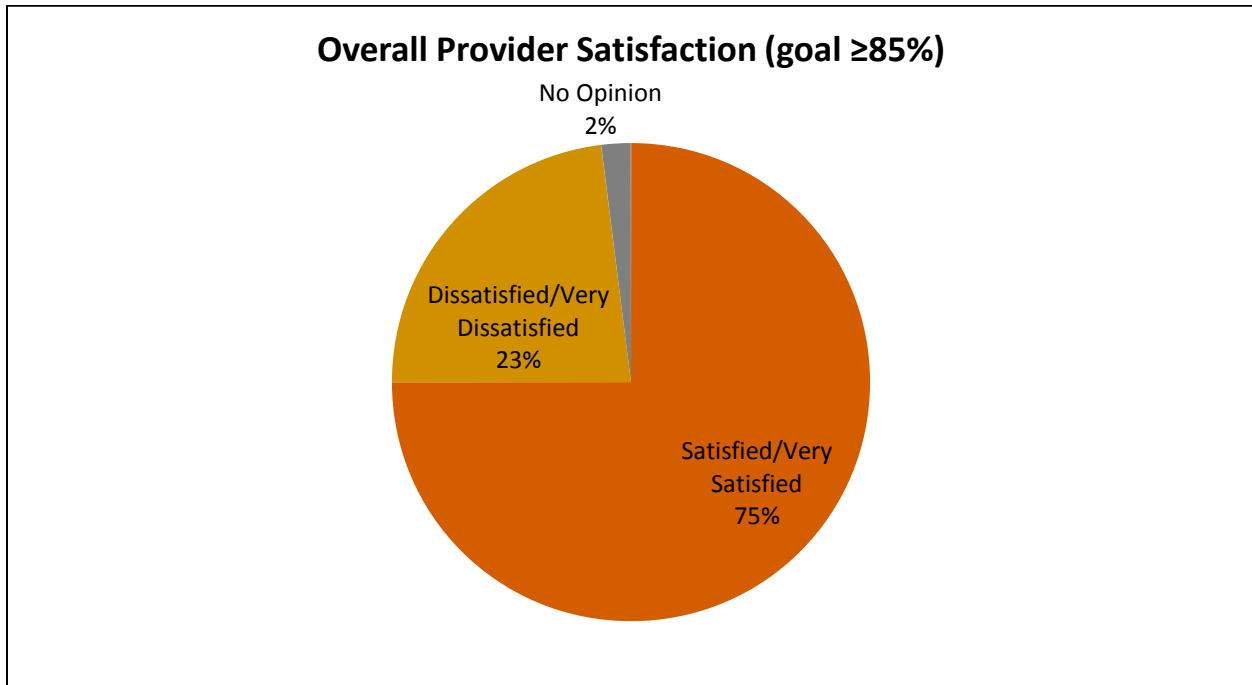
Barriers: The Optum Idaho performance goal for Overall Satisfaction is ≥85.0%. While the annual survey results fell below ≥85.0%, it was the first annual survey of this type so results from future surveys will be monitored to identify trends. Optum Idaho will look at the areas within the survey that need improvement and identify interventions.

Opportunities and Interventions: The network team has developed action plans to address deficiencies. Action plans include the following:
- Training on Clinical Model and authorization process to provide education.
- Provide information on the complaint process in the provider newsletter.

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- Hold Recovery & Resiliency events in locations around the state to further advance understanding in provider community.
- Hold "Meet and Greet" events in each region to promote dialogue and obtain feedback from providers.
- Engage the Optum Idaho Provider Advisory Committee in piloting new services and reviewing issues of concern by the provider community.

The results will be monitored and reported in the 2017 Annual Evaluation.

Performance Improvement

A continuous quality improvement (CQI) process is embedded within the structure of Optum Idaho's QI program.   The CQI process provides the mechanism by which improvement projects and initiatives are developed so that barriers to delivering optimal behavioral health care and services can be identified, opportunities prioritized, and interventions implemented and evaluated for their effectiveness in improving performance.   The following improvement activities or Improvement Action Plans (IAP) were in progress during 2016. The Optum Idaho quality committee structure routinely oversees and monitors these Improvement Action Plans until completion or closure.

The following is a list of the **_open_** improvement action plans and key accomplishments during 2016:

Improvement Action Plan Description	Date Initiated	Quality Committee Oversight	Key Accomplishments
ALERT Peer Review – initiated to define the peer review workflow, define the necessary tools to implement ALERT resources and to describe the training to Optum Idaho internal staff and the ALERT Care Advocate.	10/2/2015	Quality Assurance Performance Improvement Committee and Clinical and Services Advisory Committee	•Case staffing with doctors and ALERT Care Advocate (CA) Staff scheduled on a monthly basis. •Dr. Hummel participated in staffing meetings to clarify ALERT CA questions. •ALERT CA's sent cases to Regional Network Managers when providers not responding to the ALERT CA's review calls. •Continued to refine internal process flows with Network Team.
Appointment Reminder – initiated to work with an outside vendor, Clientell, to explore the implementation of a system to text Optum members advising them of their outpatient behavioral health appointments with the goal of reducing no show rates.	2/23/16	Clinical and Services Advisory Committee	• In cooperation with Clientele and the hospitals using this service, Field Care Coordination (FCC) lead Discharge Coordinator team continued to monitor the progress of this program and data was collected about its effectiveness. •FCC Team Assistant made regular presentations to CSAC on data results.

Improvement Action Plan Description	Date Initiated	Quality Committee Oversight	Key Accomplishments
FCC Familiarity – initiated to increase awareness of FCC role and availability.	3/22/16	Clinical and Services Advisory Committee and Provider Advisory Committee	•Field Care Coordinators (FCC's) put together a webinar to talk about the FCC role and availability by region •FCC's made additional efforts to identify themselves by their titles and explanation of their roles and availability when communicating to providers, members, and stake holders. •FCC Training slides in development.
Communication Plan for Youth Transition – initiated to send letters to members turning 18 advising them of available resources for transitioning into adulthood.	6/28/16	Clinical and Services Advisory Committee	•Letters were completed and tested for mail merge functionality. •Letters approved by customer. •First run of letters scheduled for January, 2017.
Task Force for Youth Transition – initiated to establish and maintain collaborative relationship with community stake holders engaged in addressing needs of Optum members transitioning to adulthood.	6/28/16	Clinical and Services Advisory Committee	• Field Care Coordinator's (FCC) attended meetings to address Youth Transitions needs. •FCC's promoted the development of initiatives. •FCC's are captured their contacts and efforts in the form of reports. •Developed additional talking points.

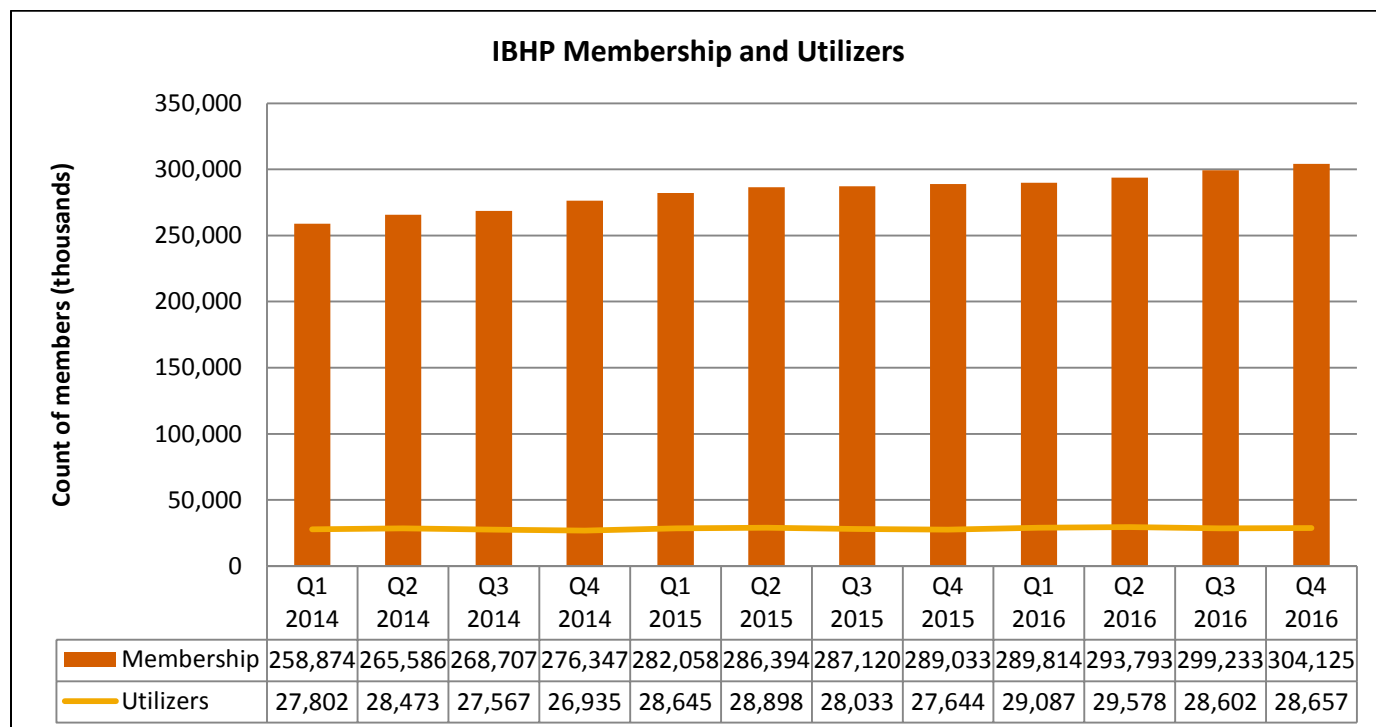Following are the Improvement Action Plans that were **_closed_** during 2016:

Inprovement Action Plan Description	Key Accomplishments	Date Closed
Provider Website – initiated to Reconstruct the Optum Idaho website portal to increase ease of use for providers.	• Initial website updates included easier to navigate sub-menus and archiving system. • Fewer provider comments related to not being able to locate information were received. • Improved provider satisfaction scores and a history of scores increasing toward target were measured.	1/20/2016
Clinical Model 2.1 – initiated to ensure that the 14-day authorization turnaround time was met. Work was focused on how to triage the high volume of authorization requests, establish consistency n approval decisions, and prioritize staff responsibilities.	• Results showed that compliance with the 14-day turnaround time has consistently increased to 99% compliance. • Tracking methods in combination with reporting provided the clinical team with detailed information regarding cases and required follow-up. • Ability to track and report cases where the turnaround time was missed and why.	2/23/2016
Authorizations: Provider Service Line – Ease of getting through – initiated to increase provider satisfaction when calling Optum Idaho on the provider line.	• Moved to a portal based authorization process. • Staff increases to eliminate hold times.	3/1/2016
Authorizations: Resolution of Questions – initiated to increase provider satisfaction in being able to obtain information from the Optum Provider line during their	• Internal training provided on appropriately handling provider calls to ensure all provider questions are answered prior to ending a call. • Systems improvement.	3/1/2016

Inprovement Action Plan Description	Key Accomplishments	Date Closed
first call.		
Complaint Acknowledgement – initiated to increase provider satisfaction related to complain acknowledgement.	• Contents of the entire Provider Survey including "Receipt of Complaint Acknowledgement Letter" were being reviewed by the Provider Advisory Committee. Due to the lack of improvement, PAC indicated that the questions on the survey may not be clear or meaningful. Recommendation was to close this IAP and role it into larger improvement activities related to Overall Provider Satisfaction with Optum in the new Annual Provider Satisfaction Survey.	3/1/2016
7 Day Post-Discharge Monitoring – initiated to monitor that a member has attended the first post-discharge appointment to occur within 7 days of discharge.	• Policies & Procedures regarding Discharge Coordination for monitoring post-hospital outpatient follow-up appointments by members was changed to be in line with NCQA HEDIS standards of 7 days. • The monthly report (SR26) was modified to track post-hospital outpatient follow-up appointments by members within 7 days.	2/9/2016

Provider Overall Satisfaction with Optum – initiated to review the provider satisfaction survey to determine measurability of the questions as well as review surveying frequency and methodology to determine true measure of change.	• To meet the deliverables, the Provider Advisory Committee reviewed Optum's national provider survey tool, reworking non-measurable questions back to objective and measurable points of inquiry.
	  o Included a call with the survey vendor Fact Finders who outlined sampling options.
	  o It was agreed the a new annual Provider Satisfaction survey would be implemented with measurable validity.
	  o New Annual Provider Satisfaction Survey implemented in October, 2016.
		9/6/2016

Provider Satisfaction with Peer Review Process – initiated to improve provider satisfaction with peer review process.	• Care Advocates were trained and systematically oriented providers to expectations of the peer to peer process and how to prepare for it. • Peer reviews were conducted more frequently internally and less frequently externally. • A survey was built in Epi-info 7.0 to further clarify provider dissatisfaction with the peer review process.	3/11/2016

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

	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Membership	258,874	265,586	268,707	276,347	282,058	286,394	287,120	289,033	289,814	293,793	299,233	304,125
Utilizers	27,802	28,473	27,567	26,935	28,645	28,898	28,033	27,644	29,087	29,578	28,602	28,657

Analysis: During 2016, membership numbers increased slightly and the utilizers remained steady.

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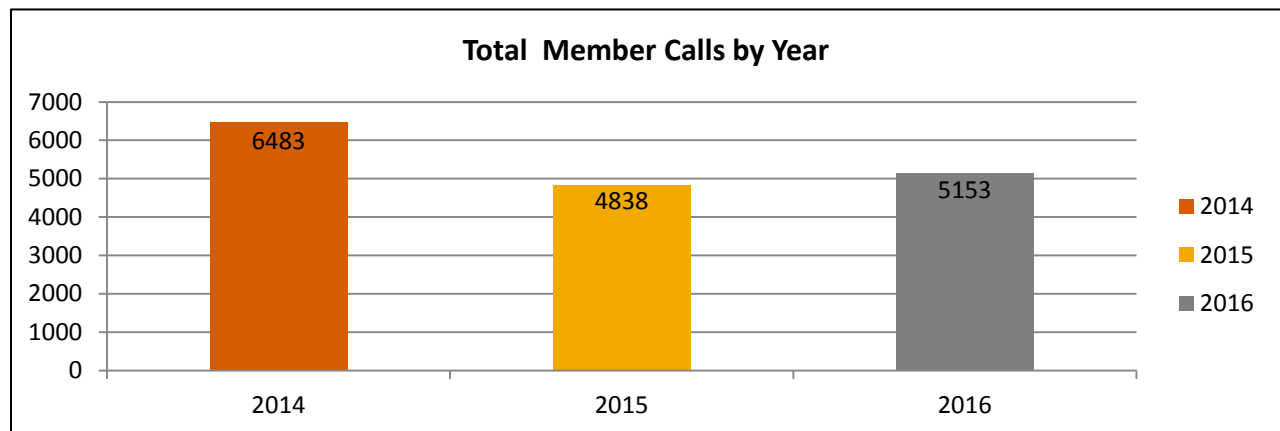
Member Services Call Standards

Methodology: Optum provides access to care 24 hours a day, seven days a week, 365 days per year through our toll-free Member Access and Crisis Line. This line is answered by a team of Masters-level behavioral health clinicians who are trained to assess the member's needs, provide counseling as appropriate, and refer the member to the most appropriate resources based on the member's needs.
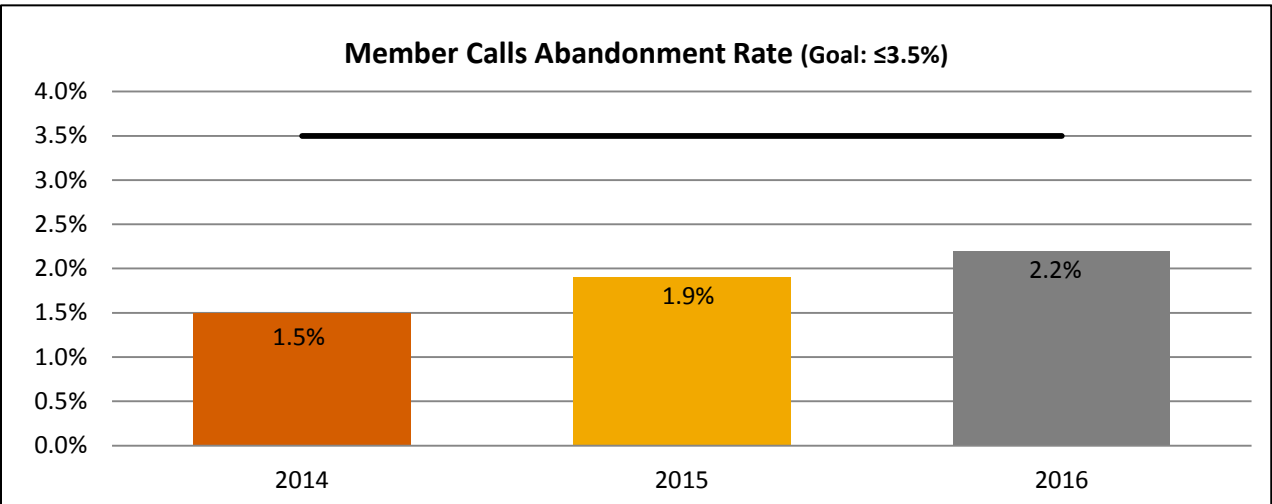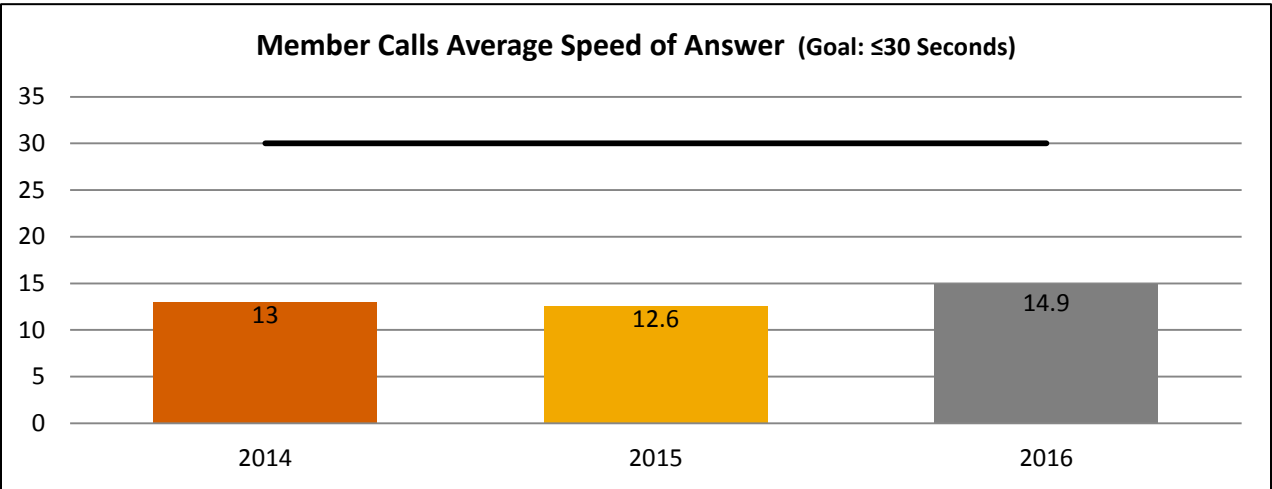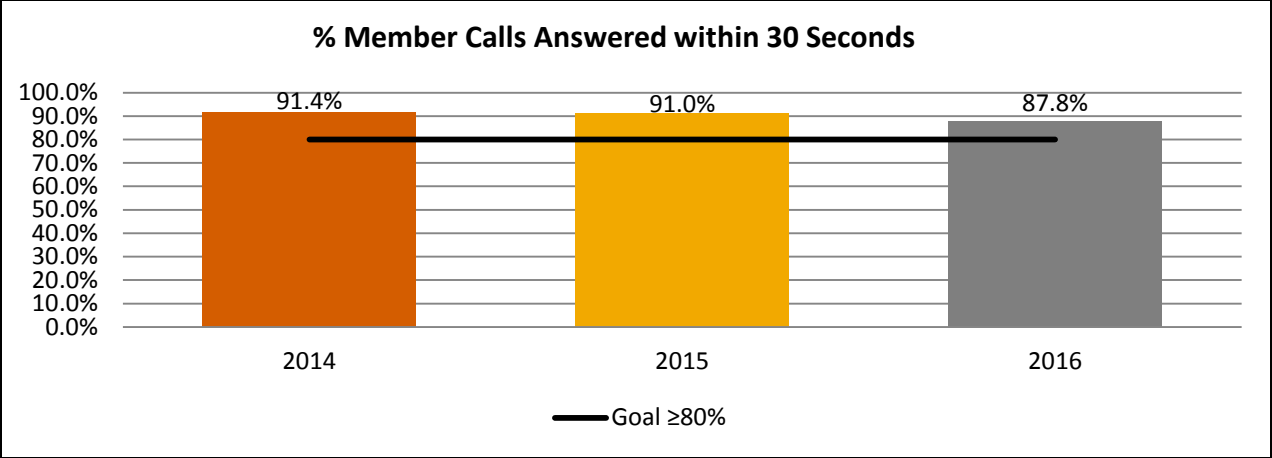
To ensure we meet our member's needs in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to answer and call abandoned rate. Data source is Avaya's Communication system (ProtoCall).

2014 – 2016 Overall Performance Results

Member Service Line	Optum Idaho Standards	IBHP Contract Standards	2014	2015	2016
Total Number of Calls	NA	NA	6483	4838	5153
Percent of Calls Answered Within 30 Seconds	≥80.0%	None	91.4%	91.0%	87.8%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	13.0 sec	12.6 sec	14.9 sec
Abandonment Rate	≤3.5%	≤7%	1.5%	1.9%	2.2%

Analysis: The Member Services and Crisis Line received a total of 5,153 calls during 2016. Optum Idaho again exceeded all established performance call standards during 2016, including calls answered within 30 seconds, average speed to answer, and call abandonment rate.

Total Member Calls by Year

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% Member Calls Answered within 30 Seconds

Year	Value
2014	91.4%
2015	91.0%
2016	87.8%

Goal ≥80%

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

Year	Value
2014	13
2015	12.6
2016	14.9

Member Calls Abandonment Rate (Goal: ≤3.5%)

Year	Value
2014	1.5%
2015	1.9%
2016	2.2%

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

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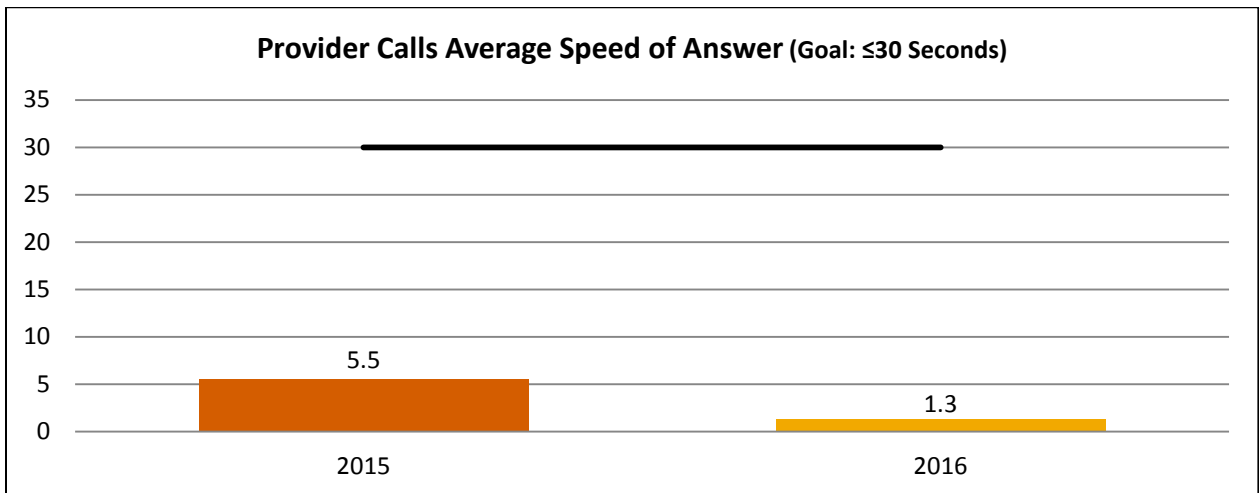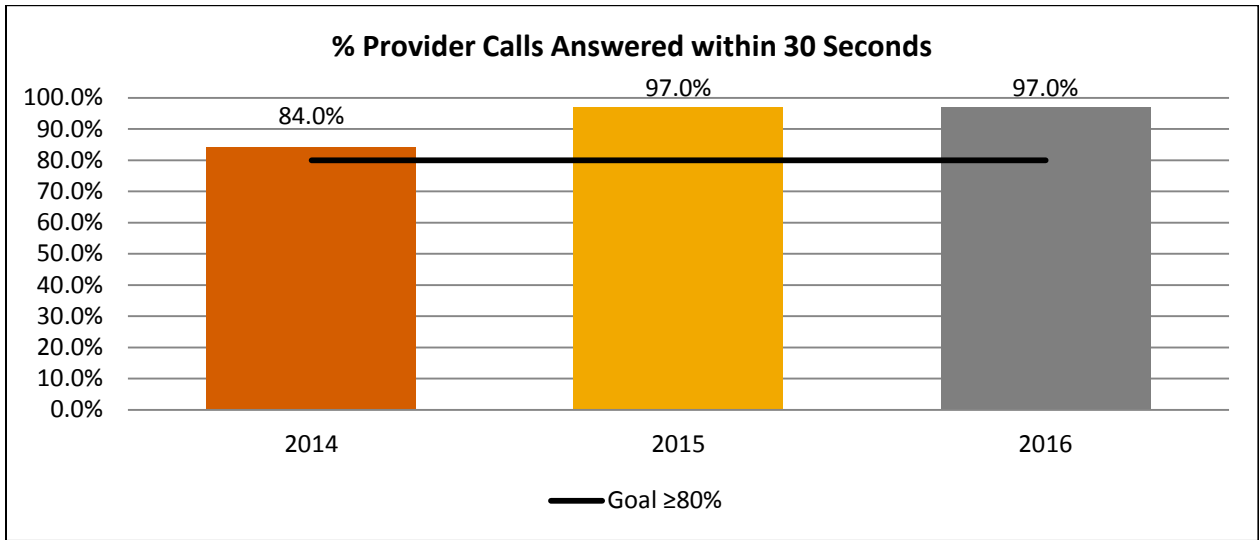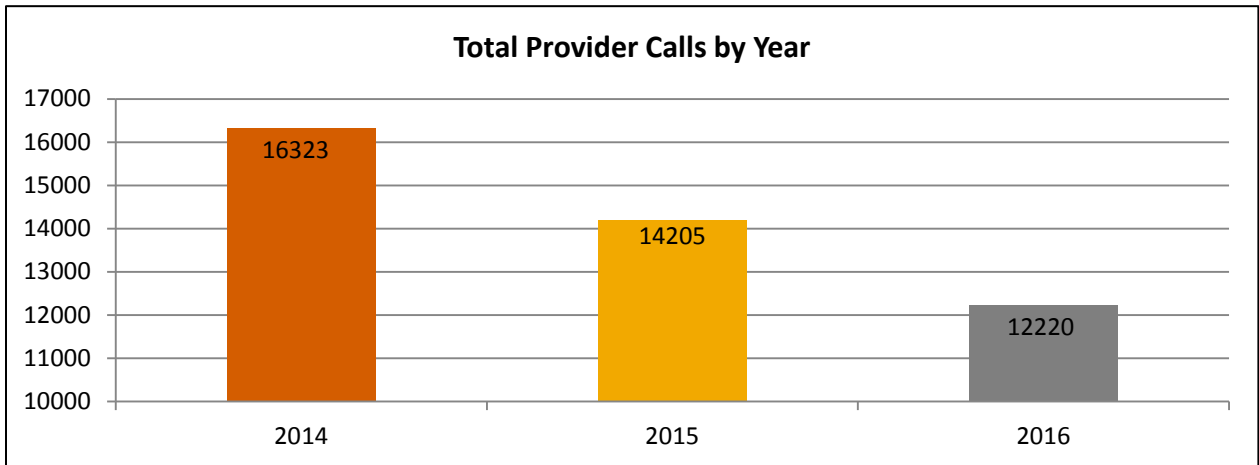7.18.17

Customer Service (Provider Calls) Standards

Methodology: 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, Optum established performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate (≤7%) as shown in the grid below.

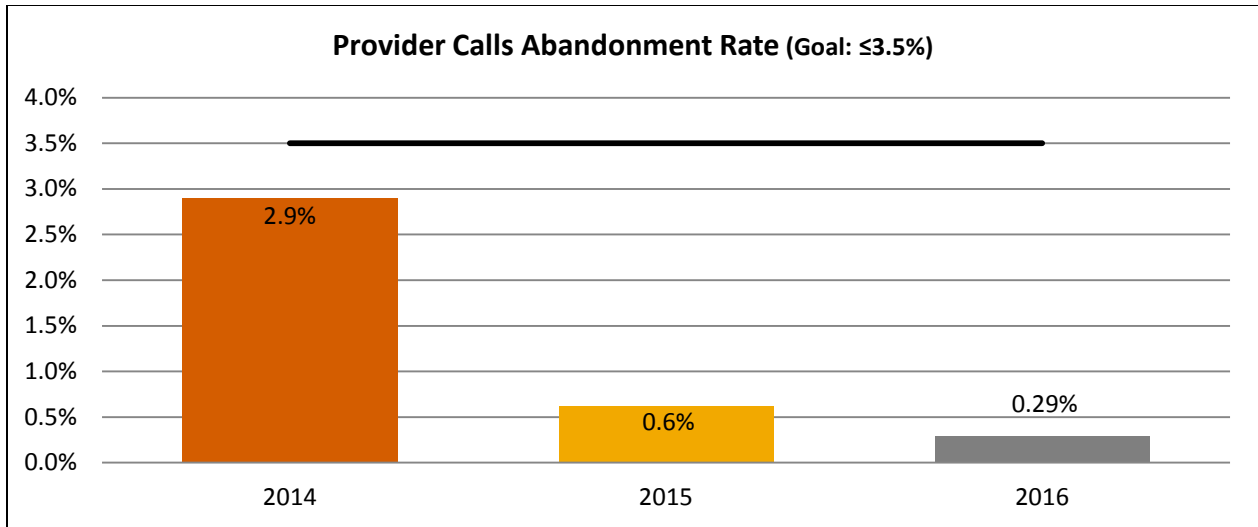2014 – 2016 Overall Performance Results

Customer Service (Provider) Line	Optum Idaho Standards	IBHP Contract Standards	2014	2015	2016
Total Number of Calls	NA	NA	16,323	14,205	12,220
Percent of Calls Answered Within 30 Sec	≥80.0%	None	84.0%	97.0%	97.0%
Average Speed of Answer*	≤30 Seconds	120 seconds (2 minutes)	NA*	5.5 sec	1.3 sec
Abandonment Rate	≤3.5%	≤7%	2.9%	0.62%	0.29%

*began tracking in 2015

Analysis: The Customer Service Line received 12,220 calls during 2016. Optum Idaho again exceeded all established performance call standards during 2016, including calls answered within 30 seconds, average speed of answer, and call abandonment rate.

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Total Provider Calls by Year

Year	Total Calls
2014	16323
2015	14205
2016	12220

% Provider Calls Answered within 30 Seconds

Year	% Answered
2014	84.0%
2015	97.0%
2016	97.0%

Goal ≥80%

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

Year	Average Speed of Answer
2015	5.5
2016	1.3

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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
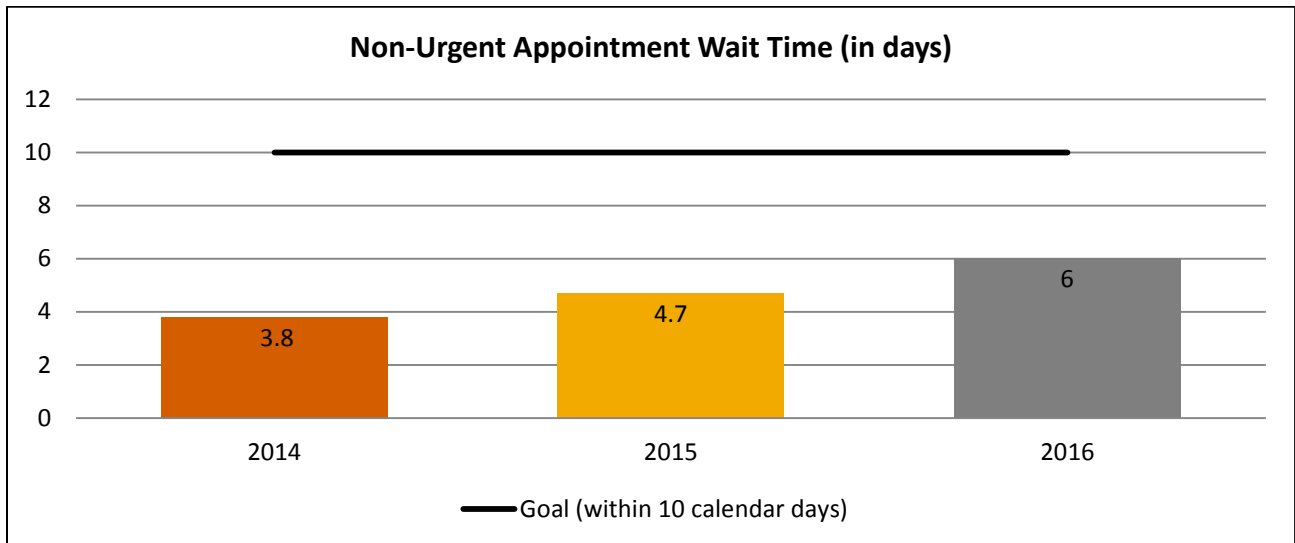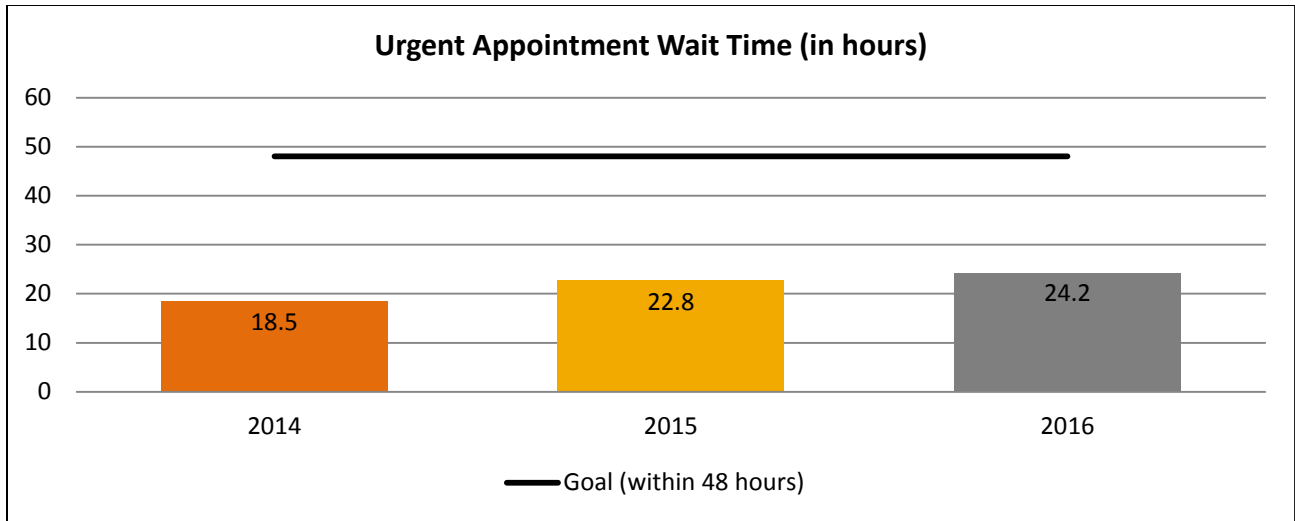
Urgent and Non-Urgent Access Standards

Methodology: To ensure that all members have access to appropriate treatment as needed, Optum developed, maintains, and monitors a provider network with adequate clinicians and outpatient programs. Optum requires that the network providers offer *Urgent Appointments* within 48 hours of request and *Non-urgent Appointments* within 10 business days of request. Urgent and non-urgent access to care is monitored via monthly provider telephone polling by the Network team.

2014 – 2016 Overall Performance Results

Urgent/Non-Urgent Appointment Wait Time	Performance Goal	2014	2015	2016
Urgent Appointment Wait Time	Within 48 hours (hrs) from request	18.5 hrs	22.8 hrs	24.2 hrs
Non-Urgent Appointment Wait Time	Within 10 days from request	3.8 days	4.7 days	6 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. Optum Idaho again exceeded the performance goal during 2016. The overall average wait time for an urgent appointment in 2016 was 24.2 hours. The performance goal for Non-Urgent appointment wait time is 10 business days. Optum Idaho again exceeded the performance goal during 2016. The average wait time for a non-urgent appointment during 2016 was 6 days.

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Urgent Appointment Wait Time (in hours)

Year	Value
2014	18.5
2015	22.8
2016	24.2

— Goal (within 48 hours)

Non-Urgent Appointment Wait Time (in days)

Year	Value
2014	3.8
2015	4.7
2016	6

— 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.

2014 – 2016 Overall Performance Results:

Geographic Availability of Providers	Performance Goal	2014	2015	2016
Area 1 (within 30 miles)	100.0%	99.9	99.8	99.8
Area 2 (within 45 miles)	100.0%	99.8	99.9	99.8

Analysis: During 2016, Optum Idaho continued to meet contract provider availability standards.   Area 1 availability standards were met at 99.8% and Area 2 availability standards were met at 99.8%. (Performance is viewed as meeting the goal due to established rounding methodology – rounding to the nearest whole number). As of December 2016, the IBHP had 4,359 providers practicing in 671 locations, which consist of individually credentialed, and roster clinicians and agencies.
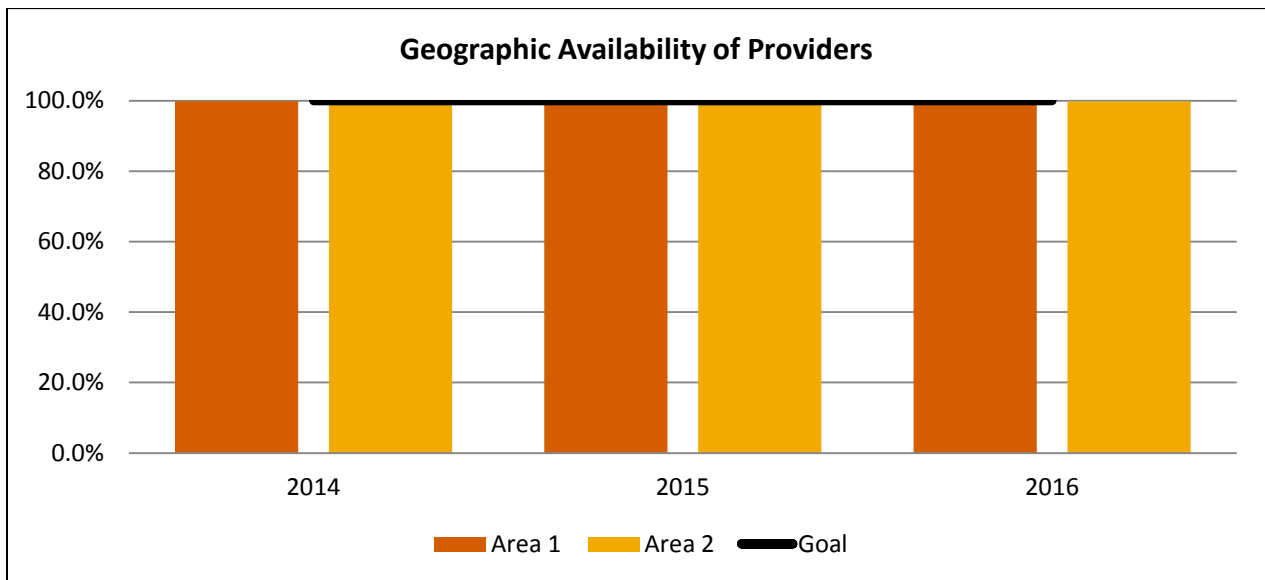
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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 members. These guiding documents are supported by national standards such as NCQA (National Committee for Quality Assurance) and URAC (Utilization Review Accreditation Commission).

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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 evaluates, audits, and reviews the performance of existing contracted providers, programs, and facilities.
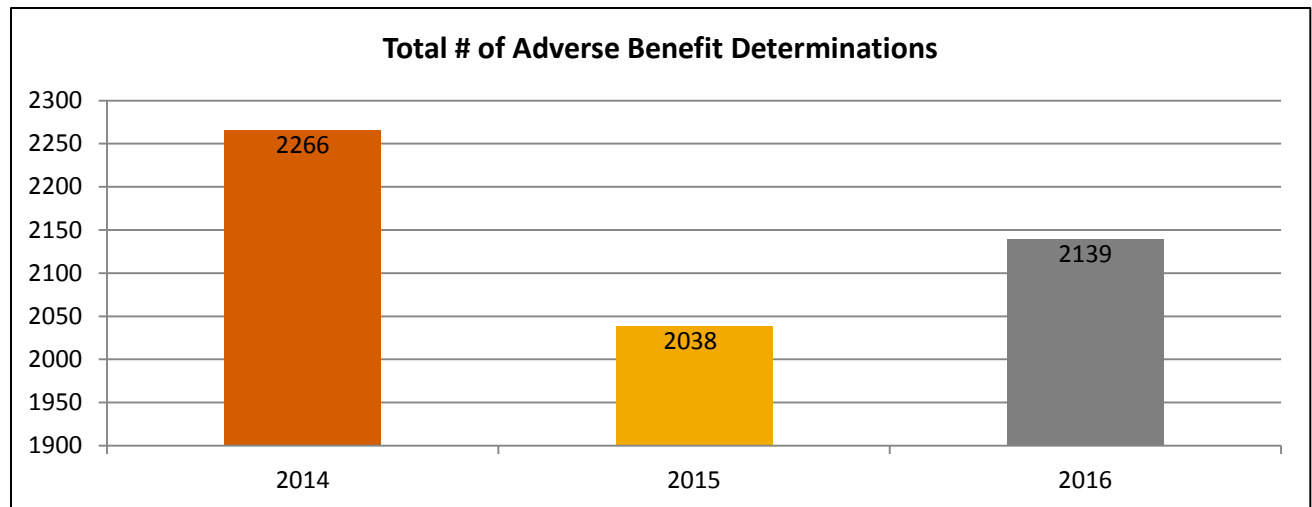
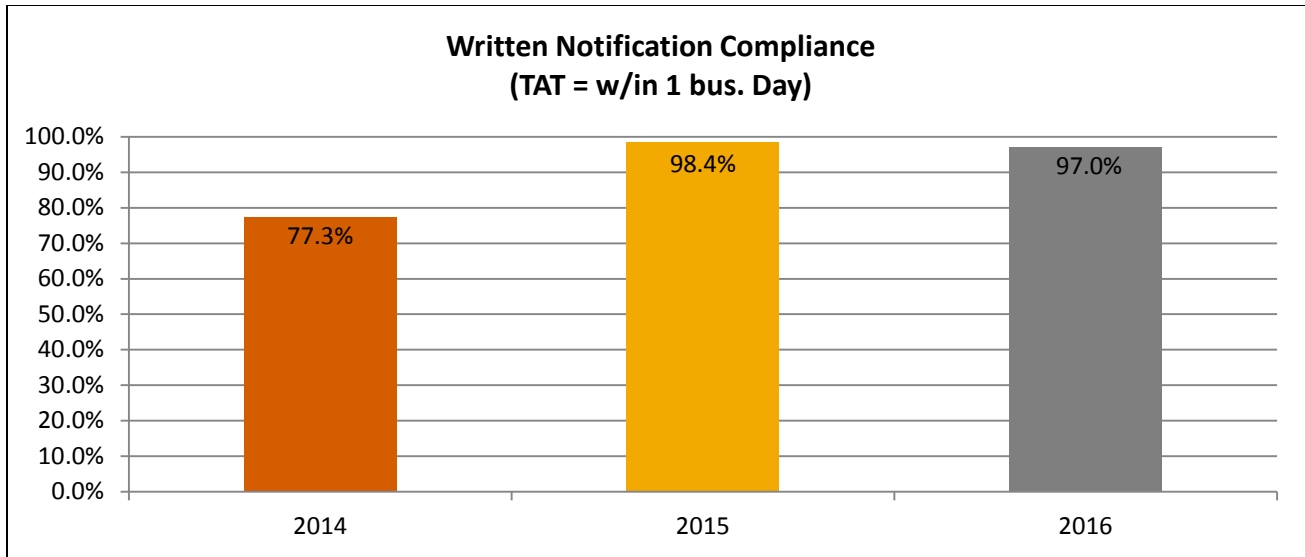## Notification of Adverse Benefit Determination

Methodology: Adverse Benefit Determinations (ABD's) are maintained in the Linx database. When a request for services is received, Optum has 14 days to review the case and make a determination to authorize services or deny services in total or in part. Once a determination is made to deny or reduce services, Optum has one (1) day following the verbal notification of the decision to mail a written notice informing the member and provider of the denial.

2014 – 2016 Overall Performance Results

Notification of ABD	Performance Goal	Target	2014	2015	2016
Total # of ABD's	NA	NA	2,266	2,038	2,139
Written Notification	Written notice is sent within 1 business day following verbal notification	100.0%	77.3%	98.4%	97.0%

Analysis: During 2016, there were 2,139 ABD's. Written notification performance fell below the target of 100% at 97.0%.

Total # of Adverse Benefit Determinations

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**Written Notification Compliance
(TAT = w/in 1 bus. Day)**

Year	Compliance
2014	77.3%
2015	98.4%
2016	97.0%

Barriers: Optum started processing all written ABD notification in Linx starting January 1, 2016. With the shift from the old system, ARTT, to Linx, there were process changes that caused some ABD notification to be out of compliance. The issues were addressed and fixed.

Opportunities and Interventions: Optum Idaho updated and educated all necessary staff on the transition from ARTT to Linx. Auditing was completed to ensure compliance.

Grievances

Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an adverse action that resulted in member financial liability or denied service, which is referred to within Optum as filing a grievance. All grievances are required to be reviewed and resolved within 30 days. Grievances are upheld, overturned, or partially overturned.

2014 – 2016 Overall Performance Results

Grievances	Performance Goal	2014	2015	2016
Number of Member Grievances	NA	278	92	73
Average Number of Days to Resolution	30 Days	10	12	16

Analysis: During 2016, there were 73 Member Grievances – a decrease from 278 grievances during 2014 and 92 grievances during 2015. Optum Idaho continued to exceed the 30-day-turnaround time for resolutions.
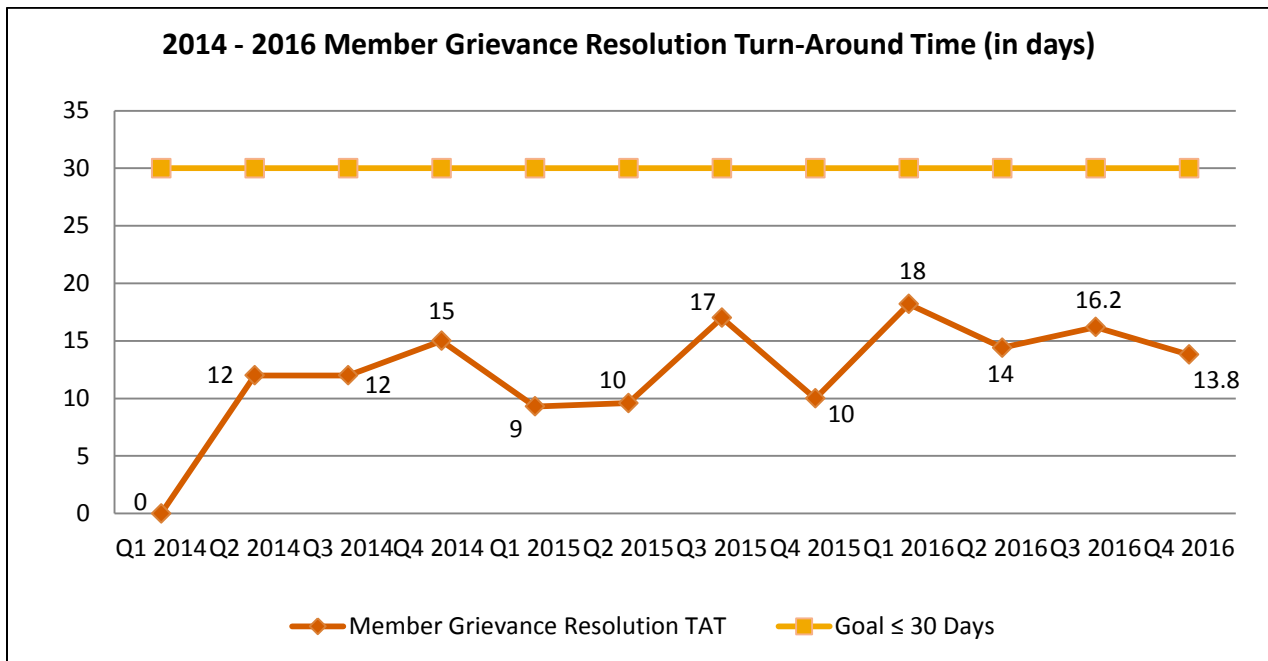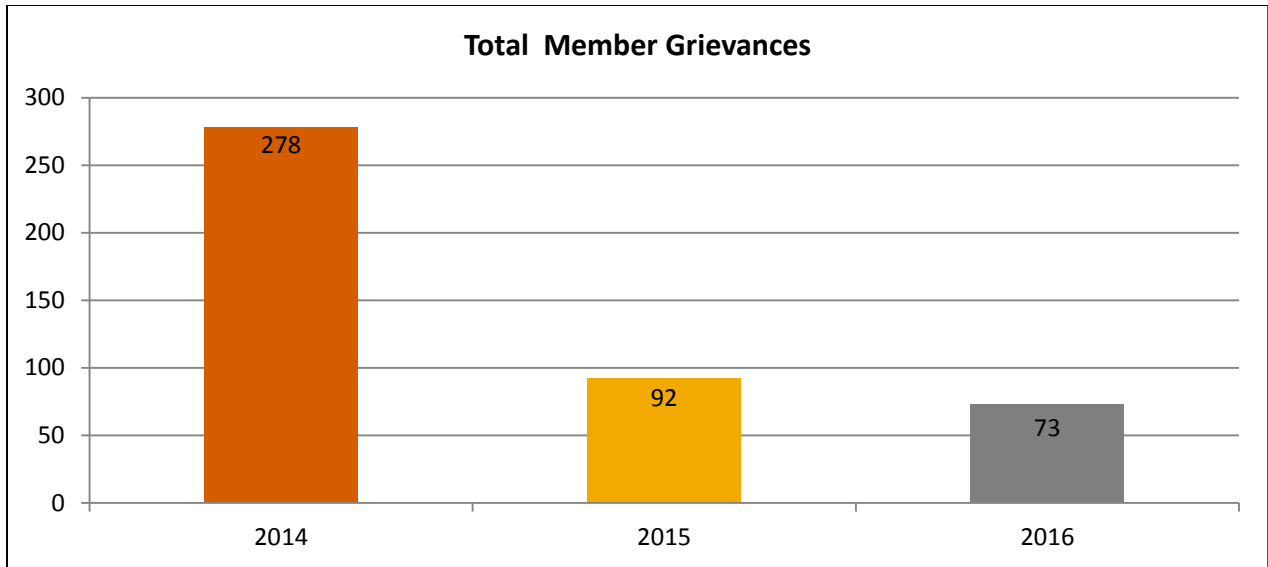
Total Member Grievances

2014 - 2016 Member Grievance Resolution Turn-Around Time (in days)

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

Complaint Resolution and Tracking

Methodology: A complaint is an expression of dissatisfaction logged by a member, a member's authorized representative or a provider concerning the administration of the plan and services received. This is also known as a Quality of Service (QOS) complaint. A concern that relates to

the quality of clinical treatment services provided by an individual provider or agency in the Optum Idaho network is a Quality of Care (QOC) concern.

Complaints are collected and grouped into the following broad categories: Benefit, Service (and Attitude), Access (and Availability), Billing & Financial, Quality of Care, Privacy Incident, and Quality of Practitioner Office Site.
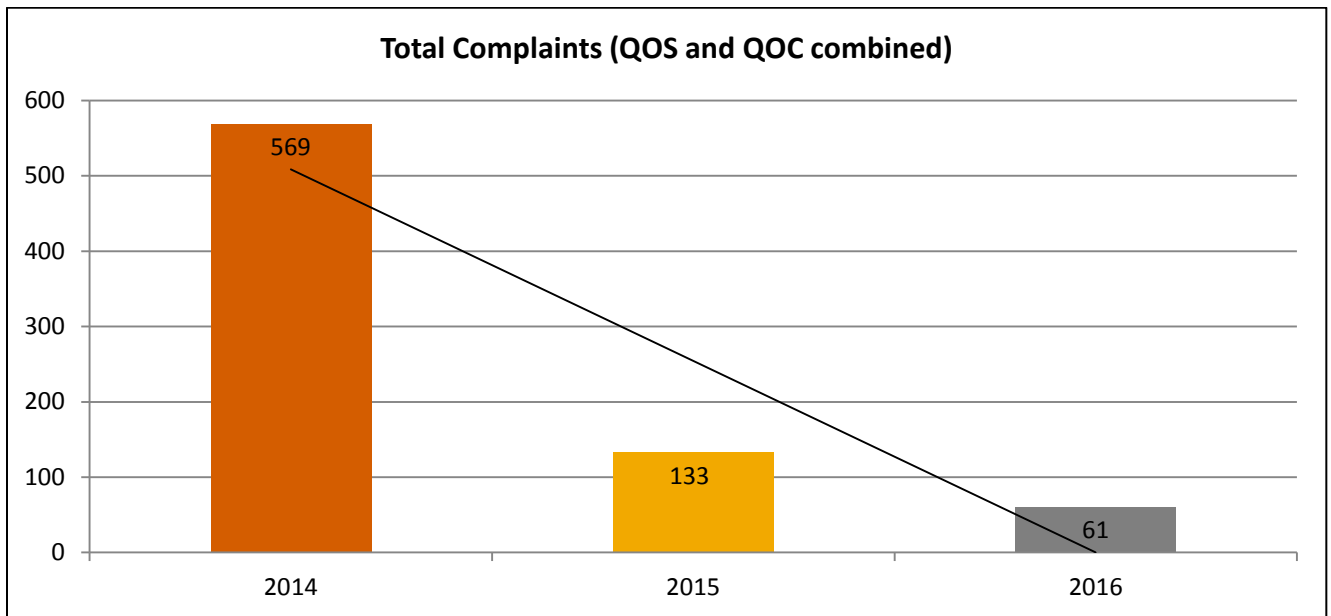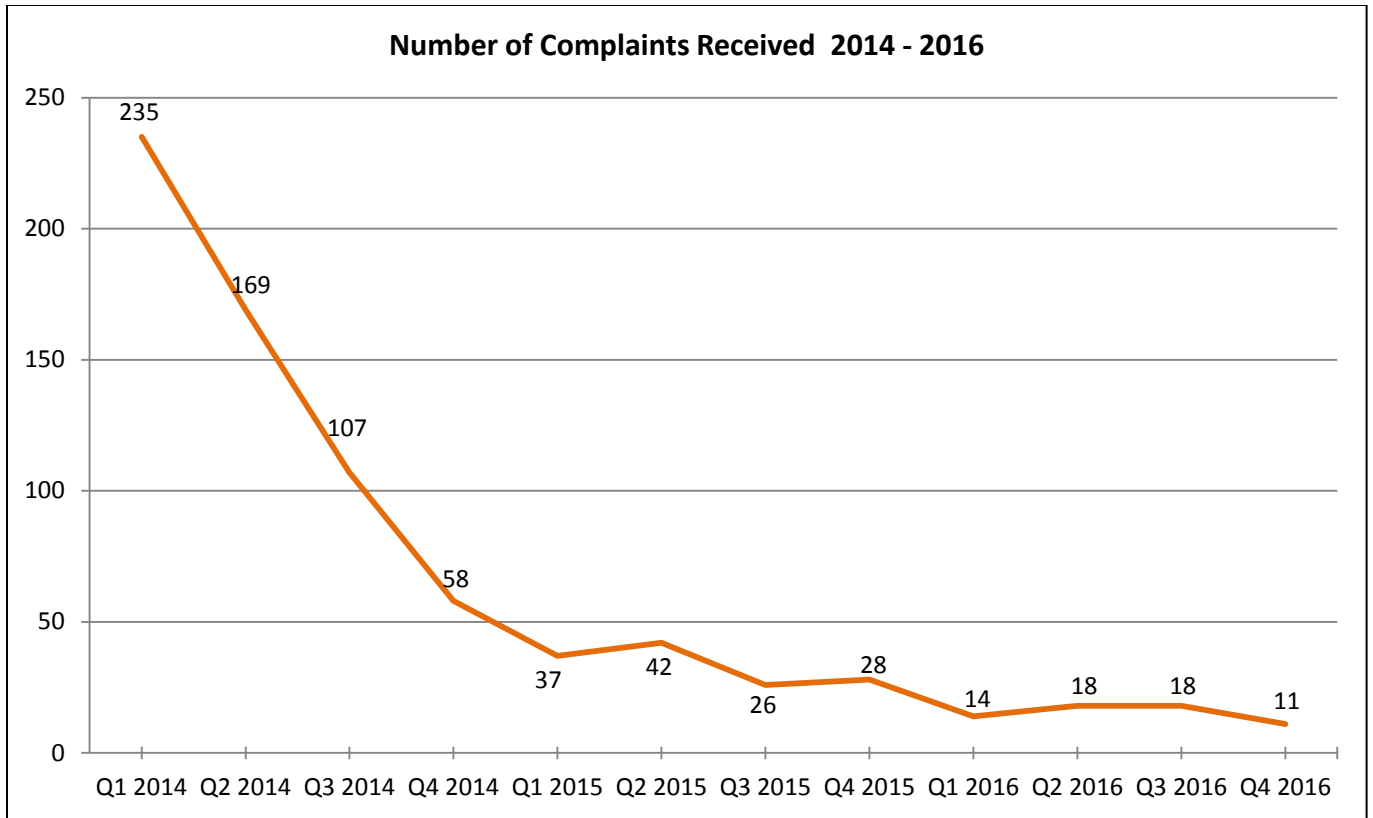
Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for complaints are as follows:

Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Calendar Days

2014 – 2016 Overall Performance Results

Complaints	Performance Goal	2014	2015	2016
Number of Quality of Service (QOS) Complaints Received	NA	560	122	55
Percent QOS Complaints Resolved w/in TAT	10 Days	100.0%	99.3%	100.0%
Number of Quality of Care Complaints (QOC) Received	NA	9	11	6
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%

Analysis: There were 61 total complaints (QOS and QOC combined) received during 2016. This is a decrease from 133 during 2015. Of the total complaints received during 2016, 55 were identified as Quality of Service and 6 were identified as Quality of Care. Optum met the goal of 100% for resolution timeframes for QOS (10 days) and QOC complaints (30 days).

Number of Complaints Received 2014 - 2016

235	169	107	58	37	42	26	28	14	18	18	11

Q1 2014, Q2 2014, Q3 2014, Q4 2014, Q1 2015, Q2 2015, Q3 2015, Q4 2015, Q1 2016, Q2 2016, Q3 2016, Q4 2016

Total Complaints (QOS and QOC combined)

2014	2015	2016
569	133	61

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Total Quality of Service & Quality of Care Complaints

Year	Quality of Service	Quality of Care
2014	560	9
2015	122	11
2016	55	6

Quality of Service Resolution TAT Compliance (≤10 Days)

Year	Compliance
2014	100.0%
2015	99.3%
2016	100%

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2015 Quality of Care Resoluation TAT Complaince (≤30 Days)

Year	Compliance
2014	100.0%
2015	100.0%
2016	100.0%

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

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

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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 potential Critical Incidents (CI). Providers are required to report potential Critical Incidents to Optum Idaho within 24 hours of being made aware of the occurrence. A Critical Incident 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 Idaho classifies a Critical Incident as being any of the following events:

- A completed suicide by a member who was engaged in treatment at any level of care at the time of the death, or within the previous 60 calendar days.
- A serious suicide attempt by a member, requiring an overnight admission to a hospital medical unit that occurred while the member was receiving treatment services.
- An unexpected death of a member that occurred while the member was receiving agency based treatment or within 12 months of a member having received MH/SA treatment.
- A serious injury requiring an overnight admission to a hospital medical unit of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of a serious physical assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a sexual assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a serious physical assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of sexual assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A homicide that is attributed to a member who was engaged in treatment at any level of care at the time of the homicide, or within the previous 60 calendar days.
- A report of an abduction of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- An instance of care ordered or provided for a member by someone impersonating a physician, nurse or other health care professional.
- High profile incidents identified by the IDHW as warranting investigation.

Within Optum ID, 3 of the above Critical Incidents are classified as Sentinel Events:
- A completed suicide by a member who has engaged in treatment at any level of care at the time of death, or within the previous 60 calendar days.
- A homicide that is attributed to a member who was engaged in treatment at any level of care at the time of the homicide, or within the previous 60 calendar days.
- An instance of care ordered or provided for a member by someone impersonating a physician, nurse or other health care professional.
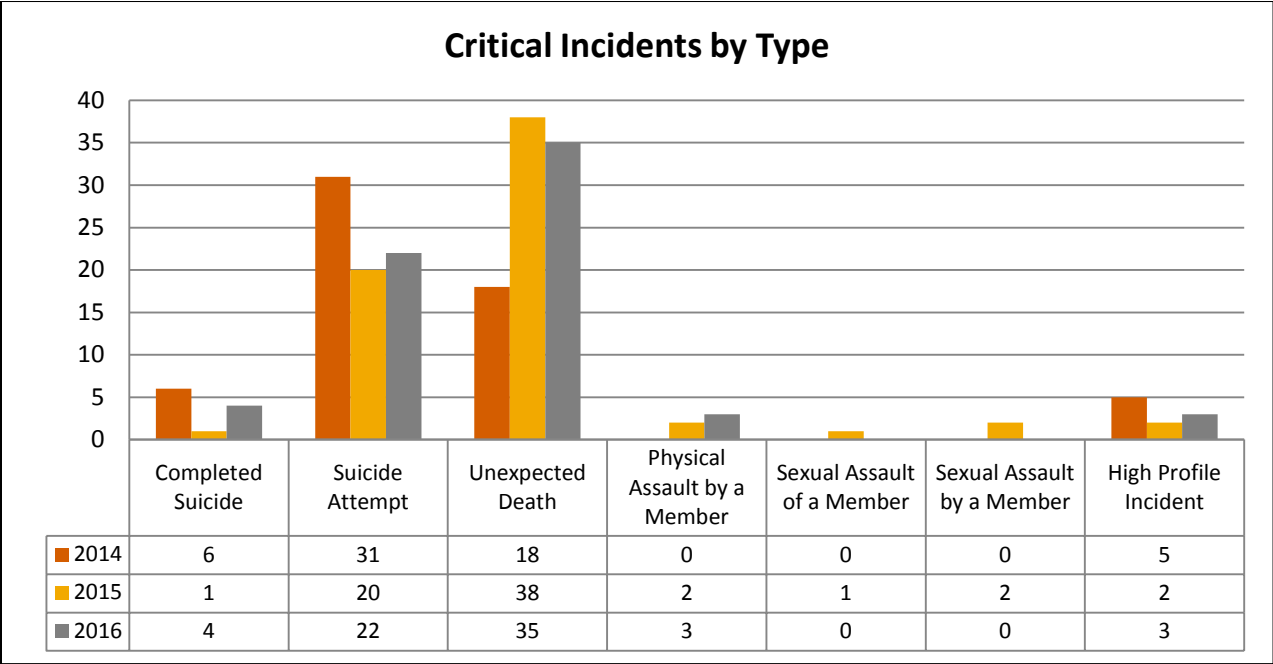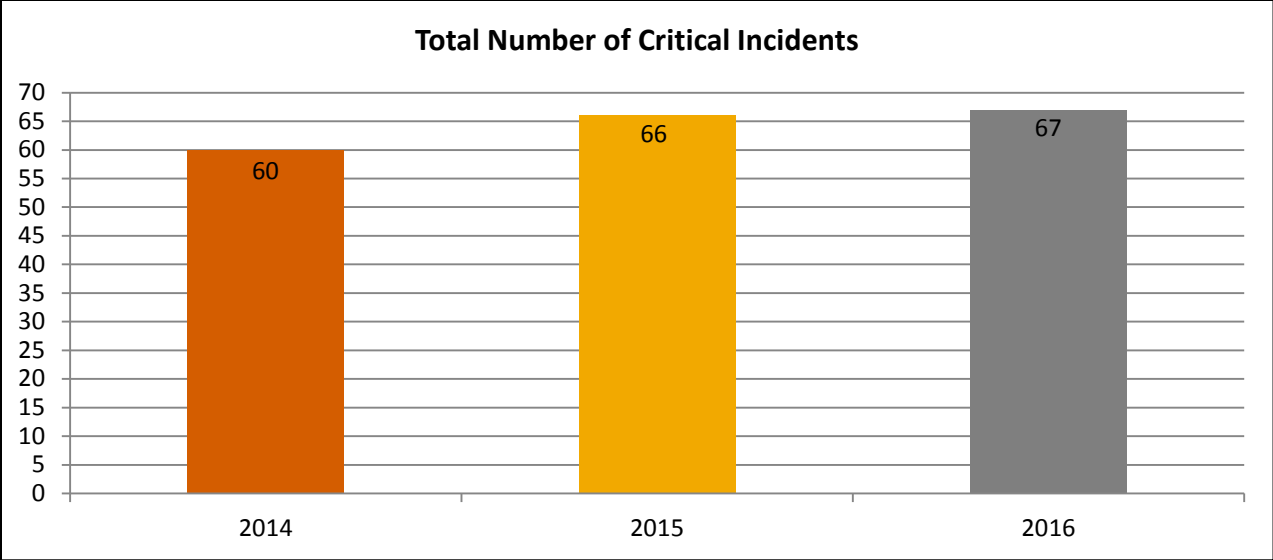
Optum has a Sentinel Events Committee (SEC) to review Critical Incidents that meet Optum's definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review Critical Incidents that do not meet Optum's definition of sentinel event. The SEC and PRC make recommendations for improving patient care and safety, including recommendations that the Optum Provider Quality Specialists conduct site audits and/or record reviews of providers in the Optum network as well as providers working under an accommodation agreement with Optum 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 Critical Incident. Critical Incident Ad-hoc review is completed within 5 days from notification of incident.
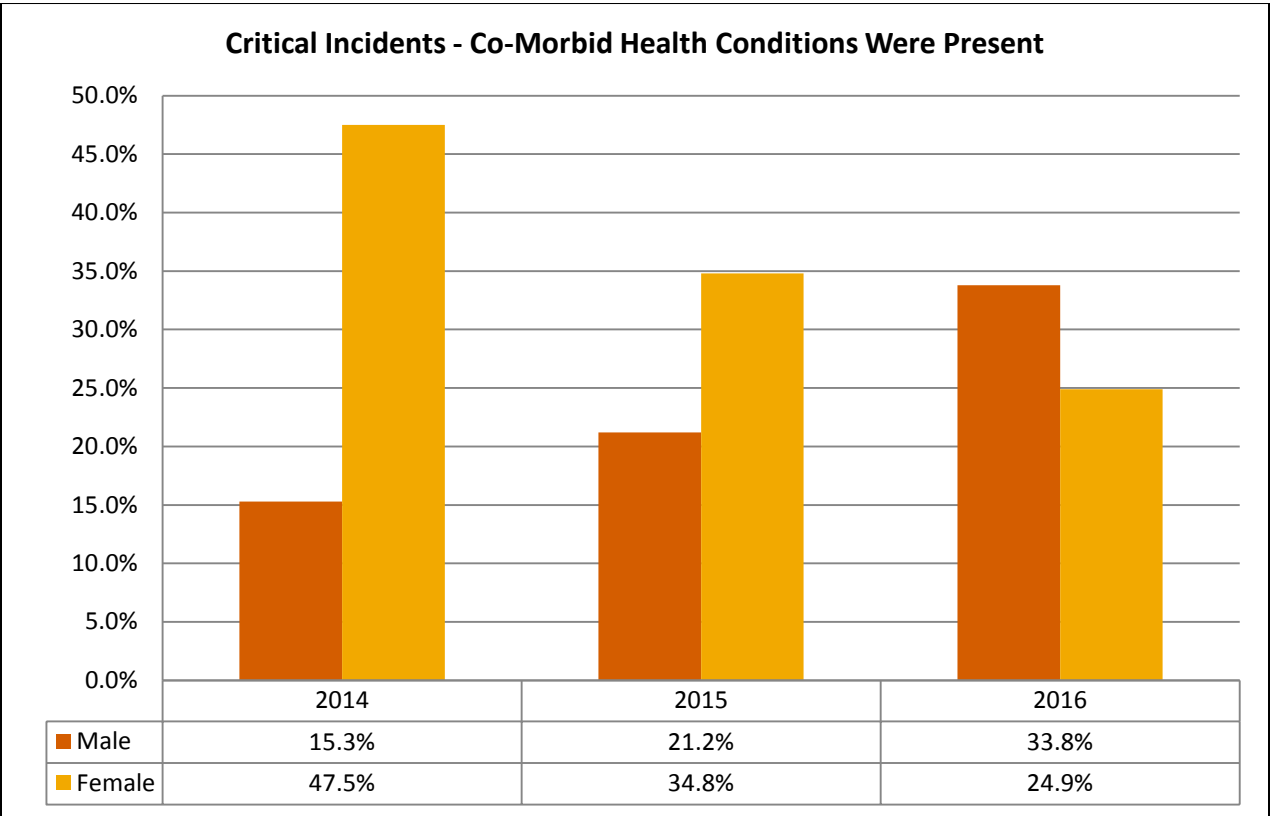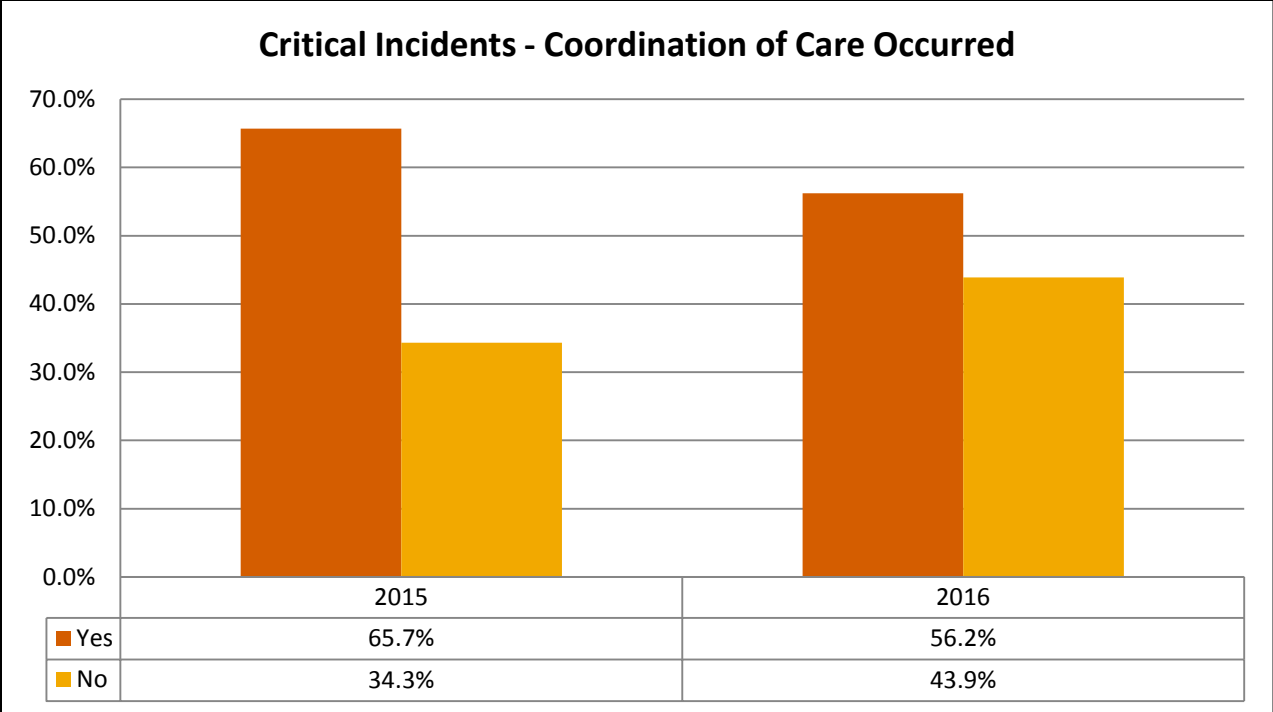
2014 – 2016 Overall Performance Results

Critical Incidents	Performance Goal	2014	2015	2016
Number of CI's Received	NA	60	66	67
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100.0%	100.0%	100.0%

Analysis: There were 67 Critical Incidents reported during 2016. 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 2016 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 56.2% of cases. Of the 67 reported Critical Incidents in 2016, 33.8% of males and 24.9% of females showed that member had a co-morbid health condition. Of the cases reported in 2016, 93.9% of the cases were adults (18+) and 6.1% were children/adolescents (17 and below). Further analysis showed that the average age for males was 41 and females 42.

No providers were put on unavailable status due to a Critical Incident.

Total Number of Critical Incidents

Year	Count
2014	60
2015	66
2016	67

Critical Incidents by Type

	Completed Suicide	Suicide Attempt	Unexpected Death	Physical Assault by a Member	Sexual Assault of a Member	Sexual Assault by a Member	High Profile Incident
2014	6	31	18	0	0	0	5
2015	1	20	38	2	1	2	2
2016	4	22	35	3	0	0	3

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Critical Incidents - Coordination of Care Occurred

	2015	2016
Yes	65.7%	56.2%
No	34.3%	43.9%

Critical Incidents - Co-Morbid Health Conditions Were Present

	2014	2015	2016
Male	15.3%	21.2%	33.8%
Female	47.5%	34.8%	24.9%

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Critical Incidents by Age (Adults vs. Children/Adolescents)

	2014	2015	2016
■ Adult (18+)	84.7%	84.8%	93.9%
■ Child/Adolescent (17 and under)	15.3%	15.2%	6.1%
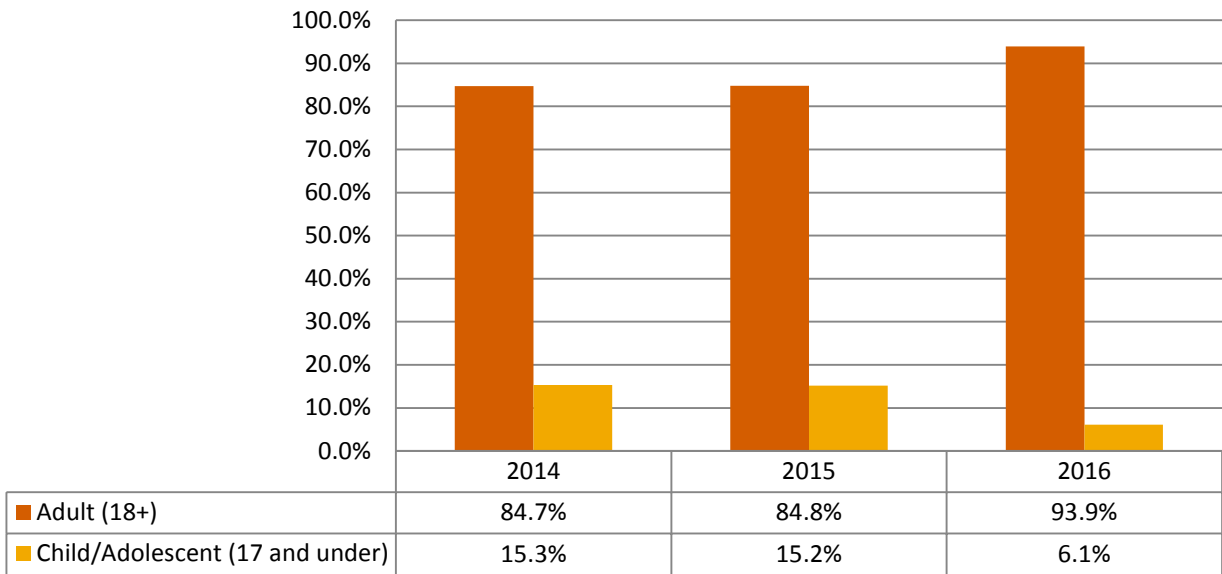
Critical Incidents by Average Age
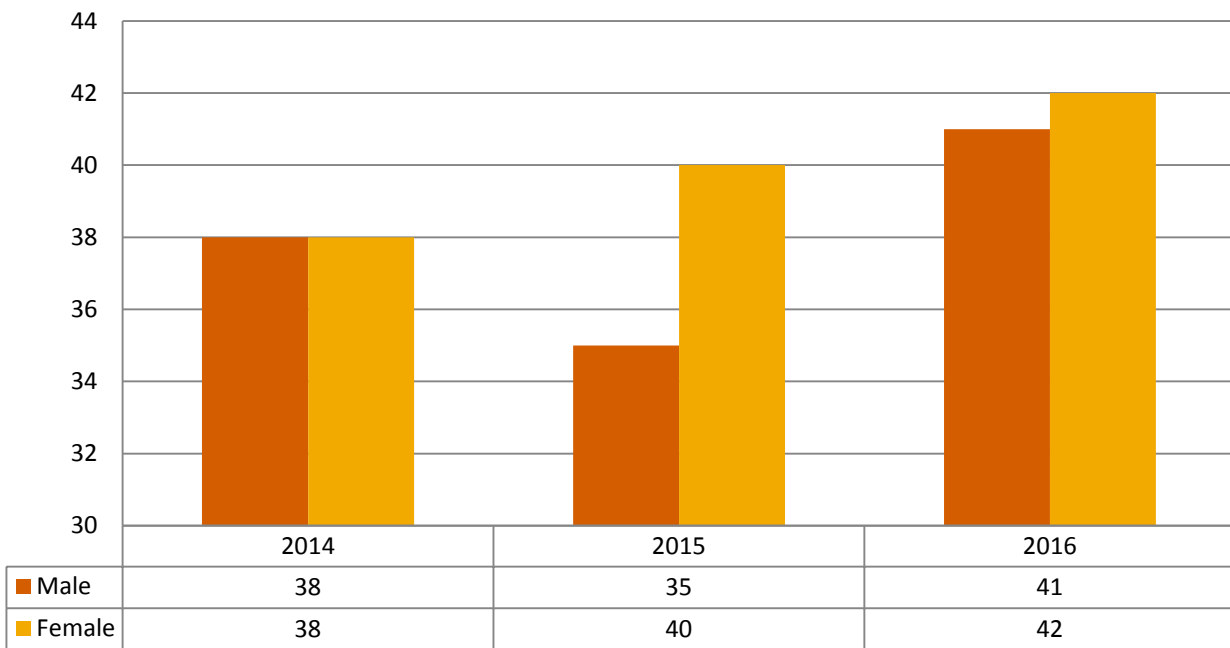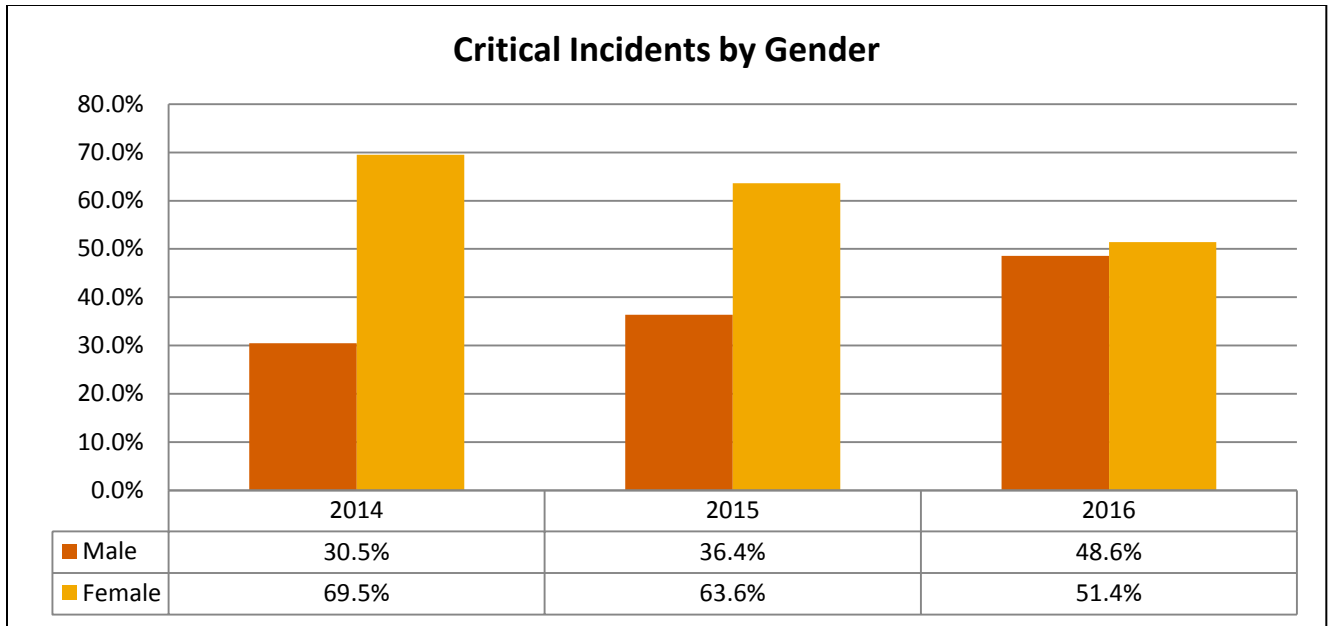
	2014	2015	2016
■ Male	38	35	41
■ Female	38	40	42

Critical Incidents by Gender

	2014	2015	2016
■ Male	30.5%	36.4%	48.6%
■ Female	69.5%	63.6%	51.4%

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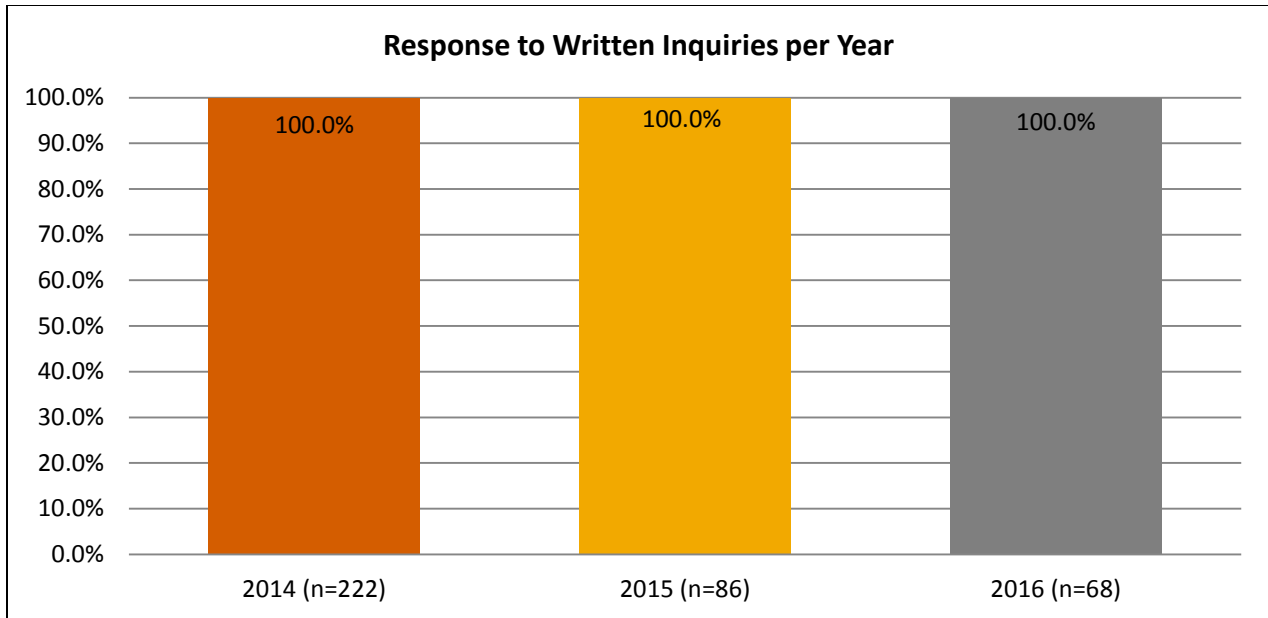**Opportunities and Interventions:** No opportunities for improvement were identified.

Response to Written Inquiries

Methodology: Optum Idaho's policy is to respond to all phone calls, voice mail 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.

2014 – 2016 Overall Performance Results

Customer Service Response to Written Inquiries	Performance Goal	2014	2015	2016
Percent Acknowledged ≤ 2 business days	100.0%	100.0%	100.0%	100.0%

Analysis: The data summarizes Optum Idaho Customer Service responsiveness to written inquiries to both members and providers. The data indicated that the standard of 100% acknowledged within 2 business days was again consistently met during 2016.

Response to Written Inquiries per Year

100.0%	100.0%	100.0%
2014 (n=222)	2015 (n=86)	2016 (n=68)

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 and ongoing review of quality of care concerns, complaints/grievances, significant events and sanctions/limitations on licensure. In coordination with the Optum Idaho QI Department, Optum Idaho staff conducts site visits for:

- Facilities not accredited by an acceptable accrediting agency
- All providers are subject to network monitoring site visits
- Quality of Care (QOC) concerns and significant events, as needed

Methodology: The Optum 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.

Monitoring audits occur through site visits and treatment record reviews. The main objectives are: determine the clinical proficiency of the Optum Idaho network by conducting site audits and

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implementing performance measurement; provide quality oversight of the Optum Idaho network; and educate providers on the clinical "best practice" and effective treatment planning.
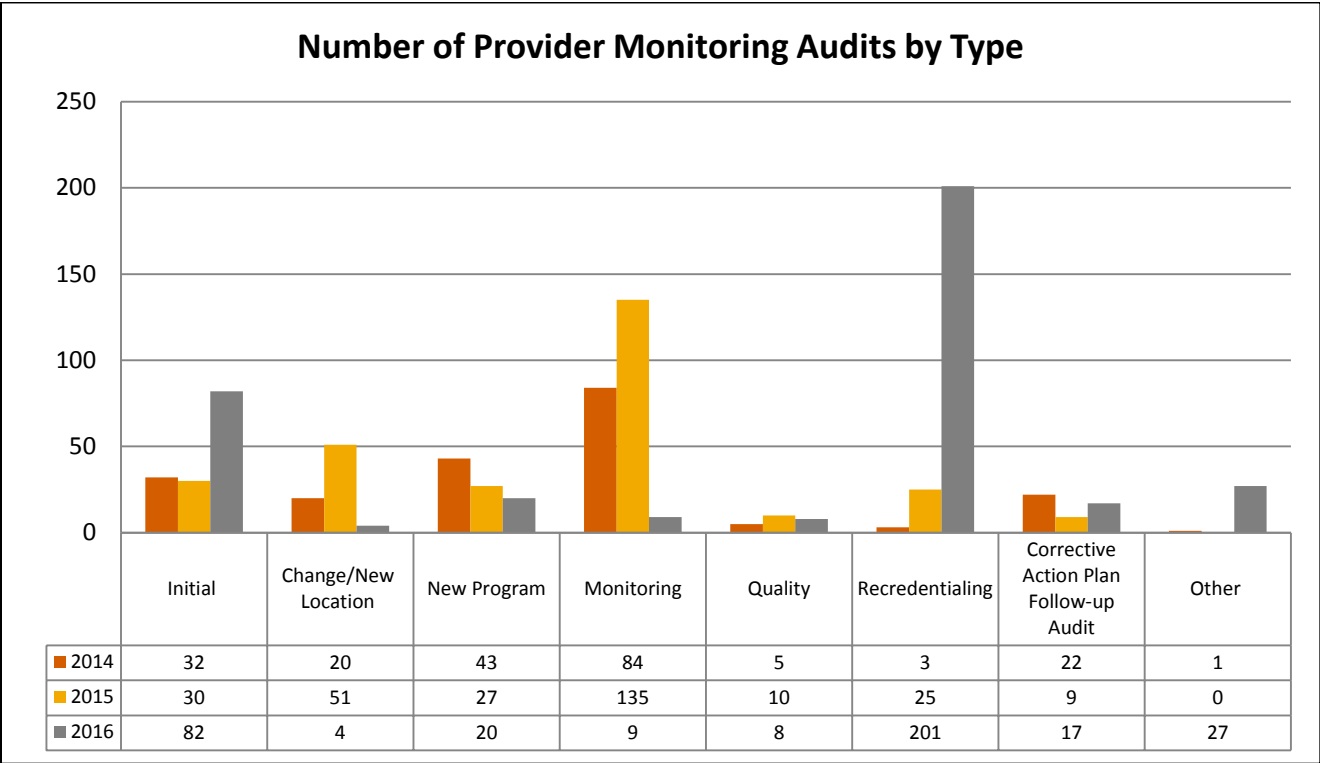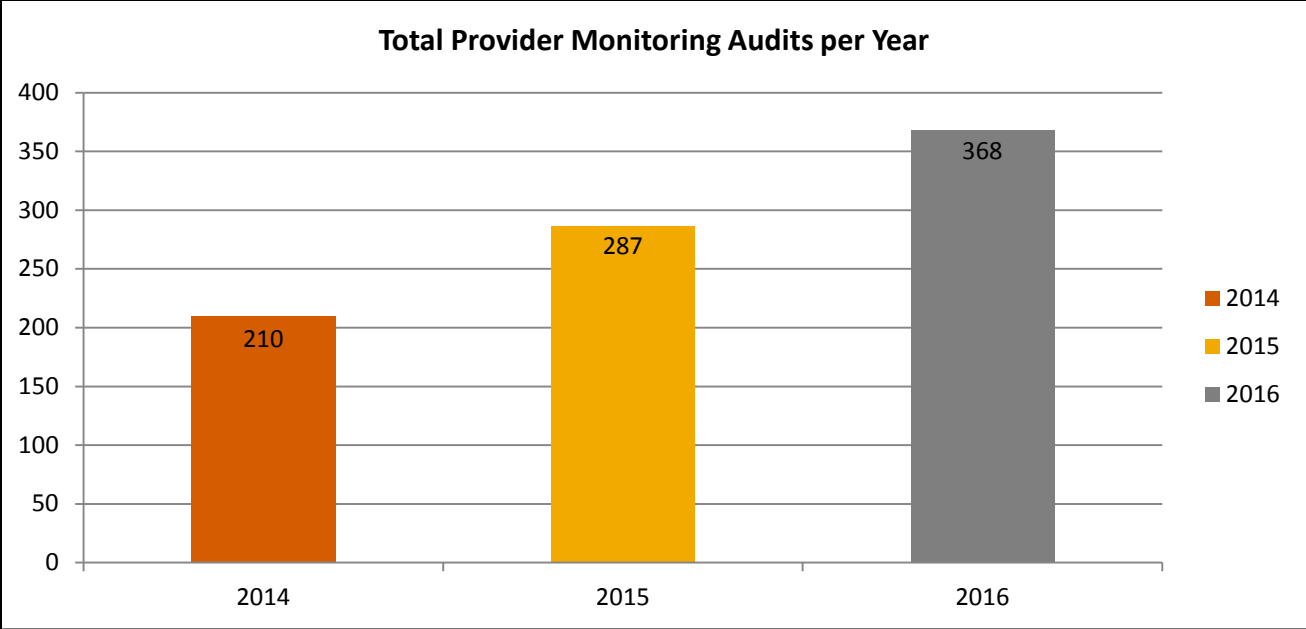
The provider will receive verbal feedback at the conclusion of the site visit and written feedback within 30 days of the site visit. Scores above 85% are considered passing. A score between 80-84% requires submission of a corrective action plan. A score of 79% or below requires submission of a corrective action plan and participation in a re-audit within 4 – 6 months. Audit types and scores are tracked in an internal Excel tracking spreadsheet.
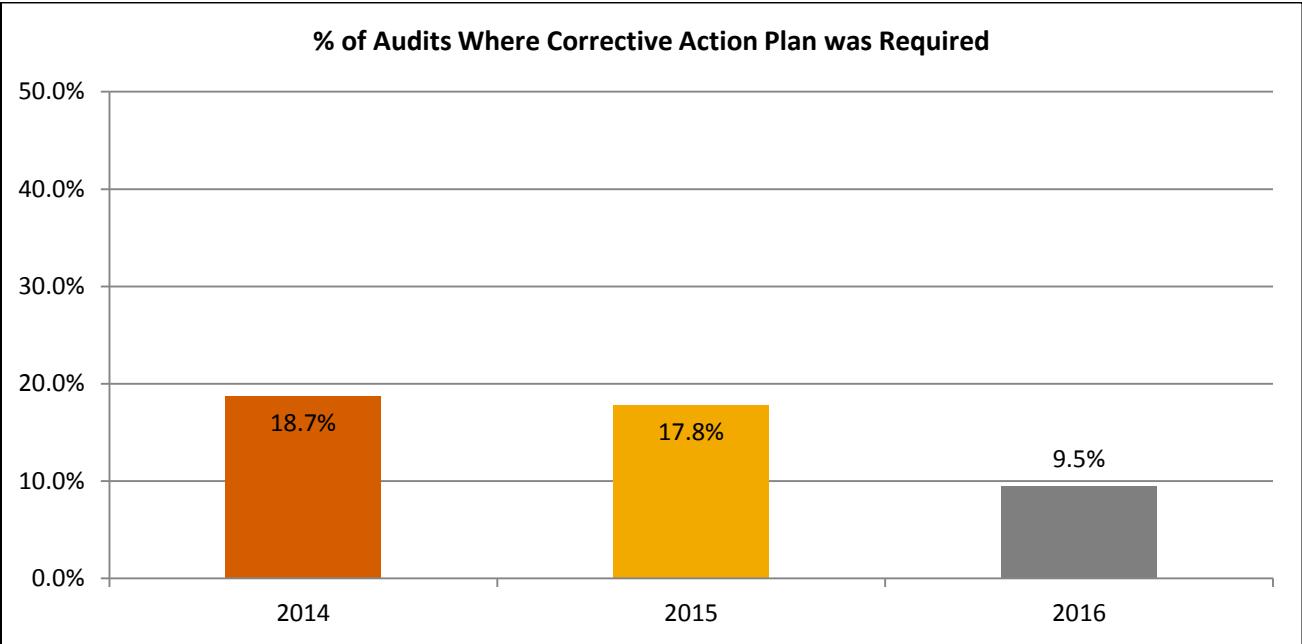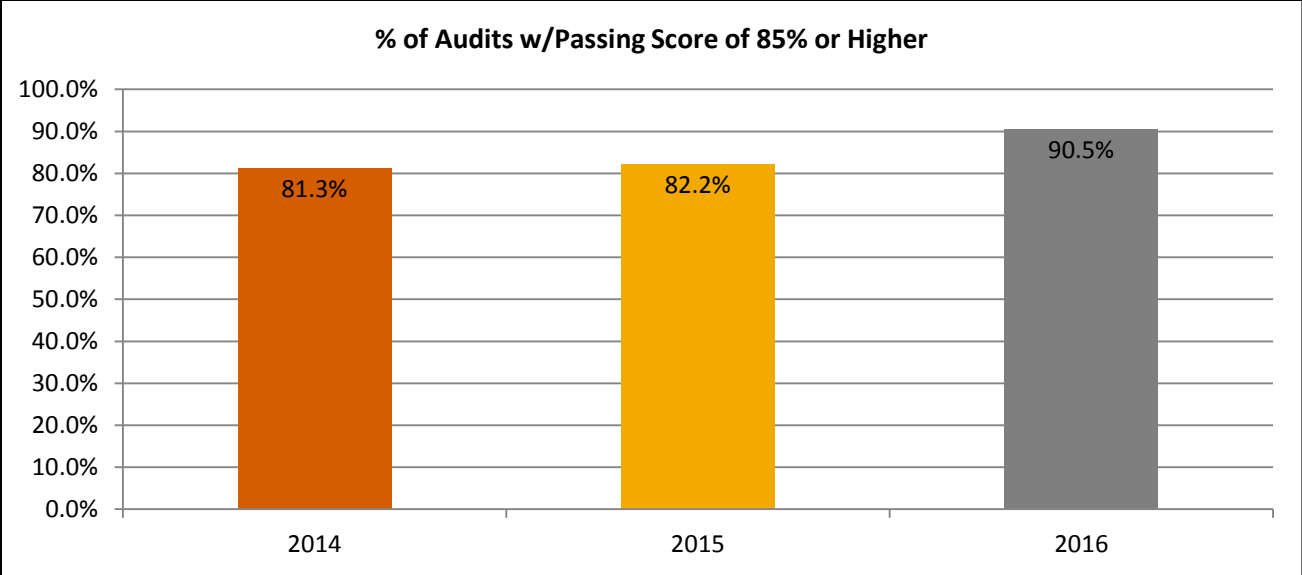
2014 – 2016 Overall Performance Results

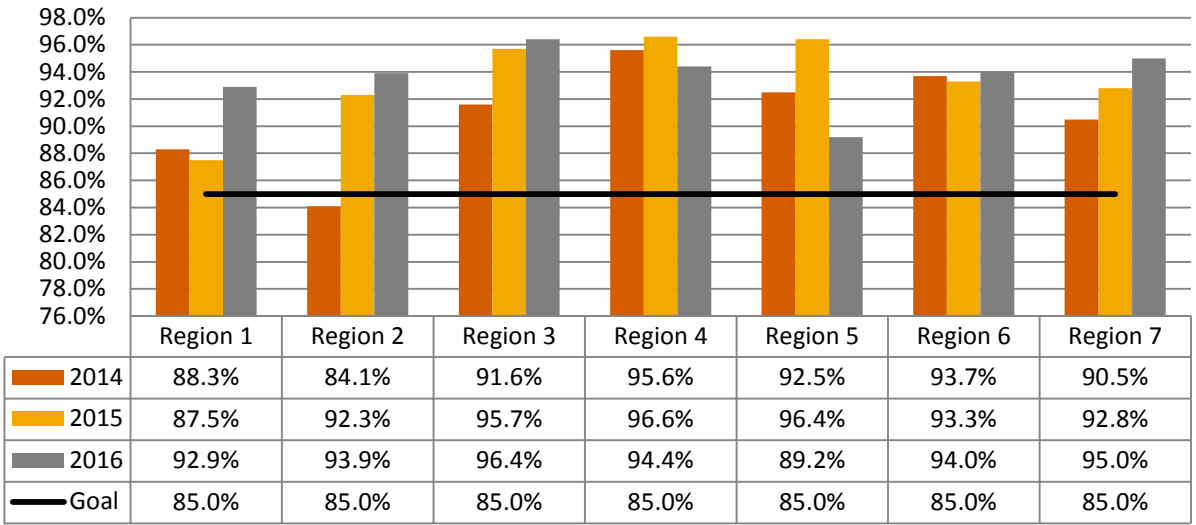| Treatment Record Audit	Performance Goal	2014	2015	2016
Number of Audits Conducted	NA	210	287	368
Initial Audit (Average overall score)	85.0%	92.0%	97.0%	96.0%
Re-credentialing Audit (Average overall score)	85.0%	96.0%	97.0%	94.0%
Monitoring (Average overall score)	85.0%	89.4%	90.1%	76.0%
Quality (Average overall score)	85.0%	86.0%	94.0%	95.4%
Percent of Audits Not Requiring a Corrective Action Plan	NA	81.3%	82.2%	90.5%
Percent of Audits Requiring a Corrective Action Plan	NA	18.7%	17.8%	9.5%

Analysis: A total of 368 audits were conducted during 2016, which is an increase from 287 audits completed during 2015.   During 2016, 90.5% (or 333) of audits received a passing score (≥85%) and did not require a Corrective Action Plan. Corrective Action Plans were implemented for 9.5%   (or 35) of the audits that were completed during 2016.

Network providers are given the opportunity to rate the Provider Quality Monitoring Audit process in a Satisfaction Survey. Beginning in Q1, 2016, Optum Idaho began using a new Satisfaction Survey for providers to complete once a monitoring audit is completed. The survey used to gather this information is through the Qualtrics Survey Application. The survey is sent to providers by email.   If an email address is not on file, the provider will not receive the survey. Surveys are emailed every other week to providers who were audited within the previous 2 weeks. Providers have 4 weeks to complete and return the survey. Results were tabulated beginning in Q2. The results at the end of 2016 showed that 89 responses were received. Of those responses, 90.0% of providers stated that the overall value of the audit process was excellent/very good/good, followed by 10.0% who stated it was fair/poor. Ninety-four percent (94.0%) indicated that the Overall Rating of the Auditor was excellent/very good/good, while 6.0% indicated the Overall Rating of the Auditor was fair/poor.

Total Provider Monitoring Audits per Year

Number of Provider Monitoring Audits by Type

	Initial	Change/New Location	New Program	Monitoring	Quality	Recredentialing	Corrective Action Plan Follow-up Audit	Other
2014	32	20	43	84	5	3	22	1
2015	30	51	27	135	10	25	9	0
2016	82	4	20	9	8	201	17	27

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

Year	Value
2014	81.3%
2015	82.2%
2016	90.5%

% of Audits Where Corrective Action Plan was Required

Year	Value
2014	18.7%
2015	17.8%
2016	9.5%

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Overall Average Audit Score per Region

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
2014	88.3%	84.1%	91.6%	95.6%	92.5%	93.7%	90.5%
2015	87.5%	92.3%	95.7%	96.6%	96.4%	93.3%	92.8%
2016	92.9%	93.9%	96.4%	94.4%	89.2%	94.0%	95.0%
Goal	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Number of Provider Monitoring Audits per Region

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
2014	32	29	28	44	15	33	29
2015	45	30	37	59	25	35	56
2016	56	29	51	68	29	48	87

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Rating of Overall Value of Audit Process

	Excellent	Very Good	Good	Fair	Poor
Q2 2016 (Responses: 50)	64.0%	16.0%	16.0%	2.0%	2.0%
Q3 2016 (Responses: 30)	50.0%	33.3%	3.3%	6.7%	6.7%
Q4 2016 (Responses: 9)	62.5%	25.0%	0.0%	12.5%	0.0%

Overall Rating of Auditor

	Excellent	Very Good	Good	Fair	Poor
Q2 2016 (Responses: 50)	74.0%	18.0%	2.0%	4.0%	2.0%
Q3 2016 (Responses: 30)	57.0%	23.0%	7.0%	3.0%	10.0%
Q4 2016 (Responses: 8)	75.0%	25.0%	0.0%	0.0%	0.0%

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

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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. Coordination of services improves the quality of care to members in several ways:

- It allows behavioral health and medical providers to create a comprehensive care plan
- It allows a primary care physician to know that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for members who are being treated with psychotropic and non-psychotropic medication
- It allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders
- It promotes a safe and effective transition from one level of care to another
- It can reduce the risk of relapse

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 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.
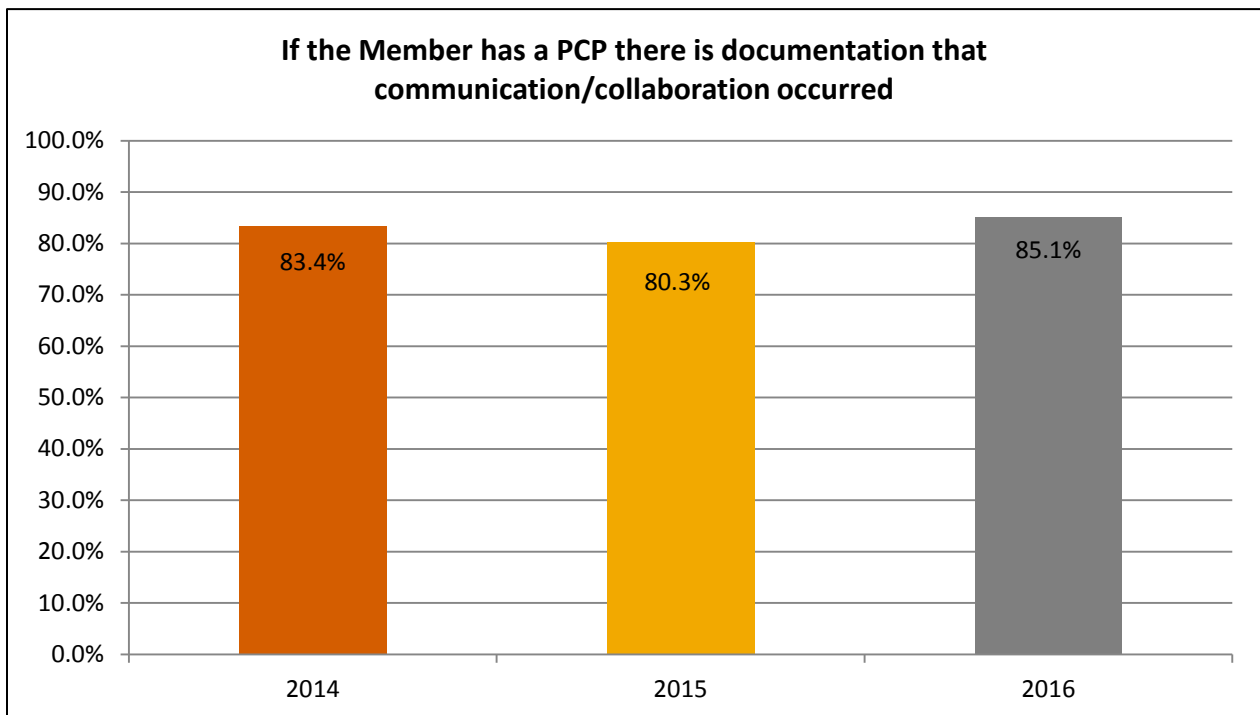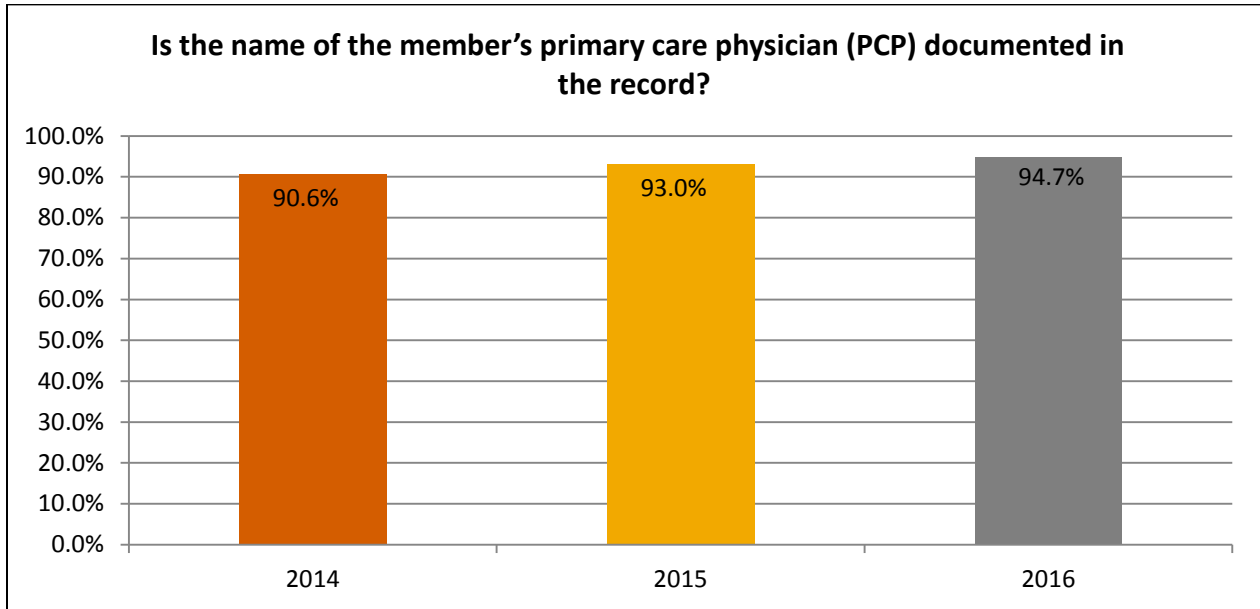
The Optum Idaho Provider Quality Specialist staff use a Treatment Record Review Audit Tool to ensure Coordination of Care between providers is taking place. Below are the questions and results from the audit tool.
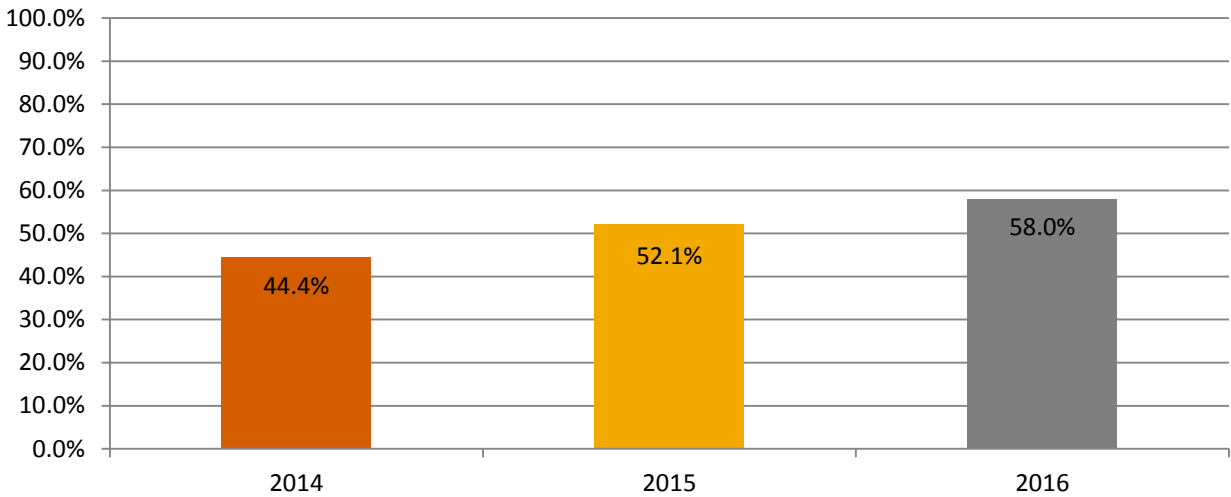
2014 – 2016 Overall Performance Results

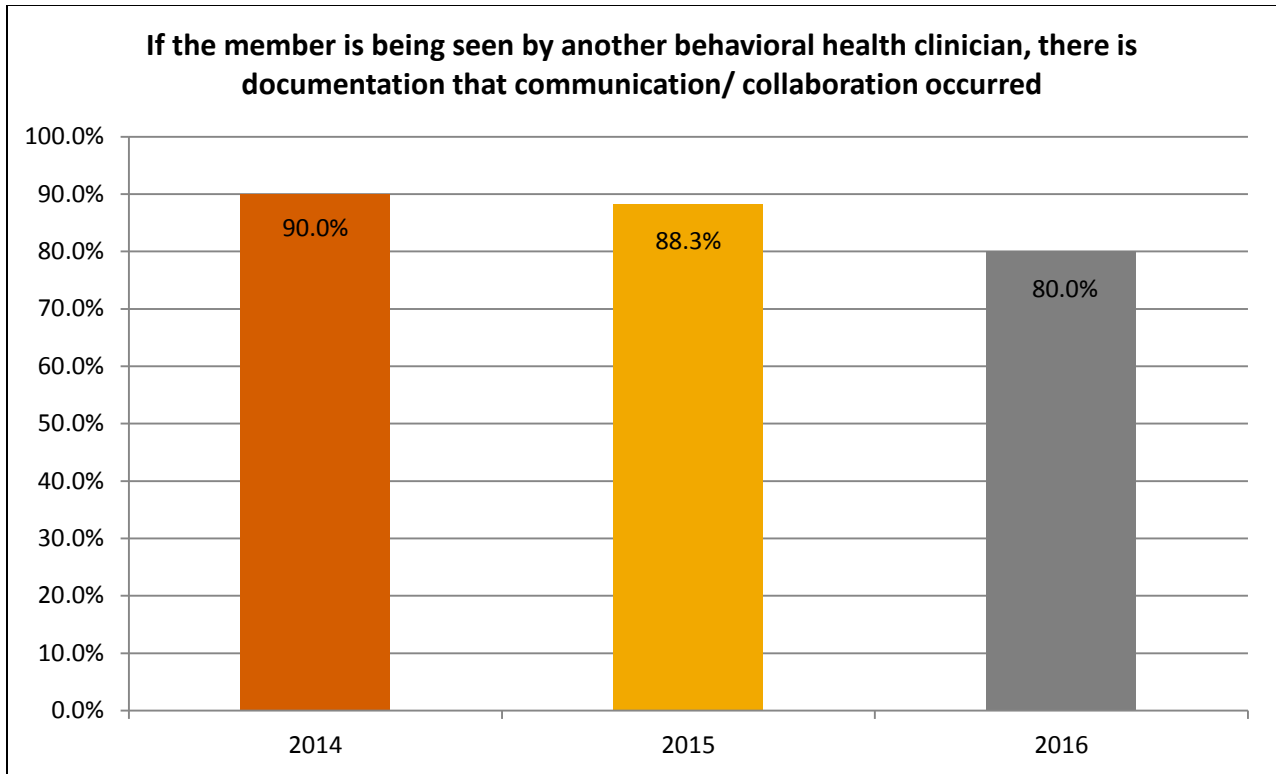| Coordination of Care (% answered in the affirmative)	Performance Goal	2014	2015	2016
Is the name of the member's primary care physician (PCP) documented in the record?	NA	90.6 %	93.0%	94.7%
If the Member has a PCP there is documentation that communication/collaboration occurred	NA	83.4%	80.3%	85.1%
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? This is a non-scored question.	NA	44.4%	52.1%	58.0%
If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred.	NA	90.0%	88.3%	80.0%

Analysis: Coordination of Care audits completed during 2016 revealed that 94.7% of member records reviewed had documentation of the name of the member's PCP. Of those, 85.1%

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indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. The results also revealed that that 58.0% 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, 80.0% indicated that communication/collaboration had occurred.

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

	2014	2015	2016
	90.6%	93.0%	94.7%

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

	2014	2015	2016
	83.4%	80.3%	85.1%

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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? This is a non-scored question.

	2014	2015	2016
	44.4%	52.1%	58.0%

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

Chart showing percentages by year:
- 2014: 90.0%
- 2015: 88.3%
- 2016: 80.0%

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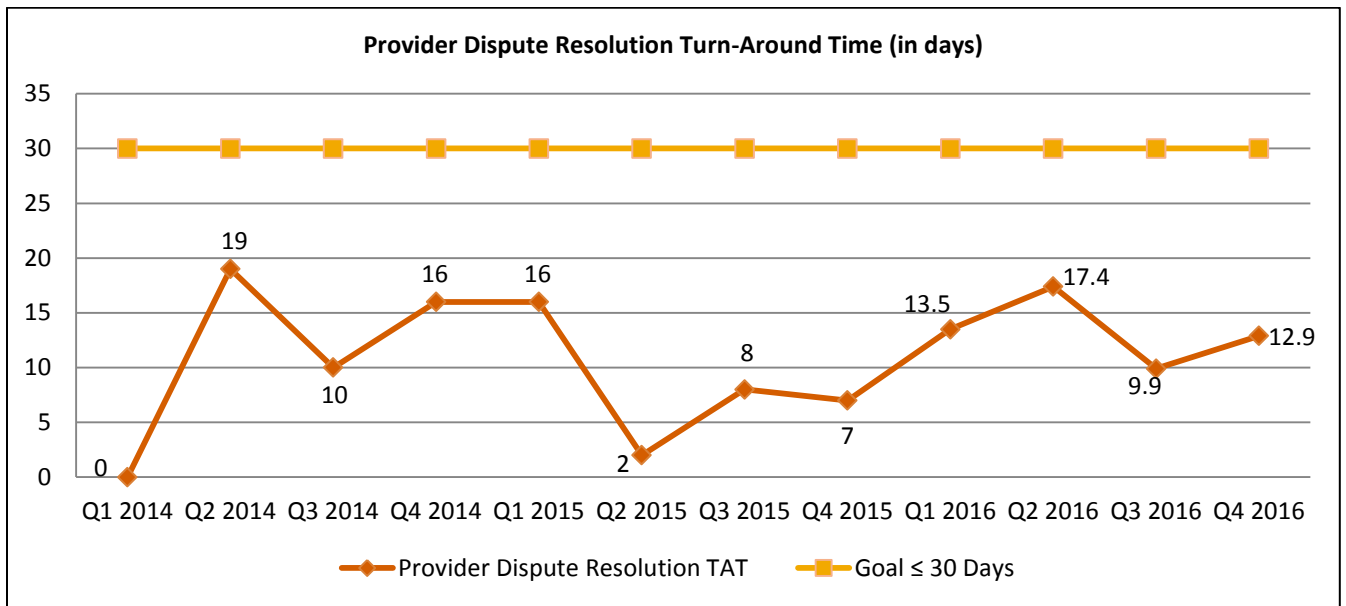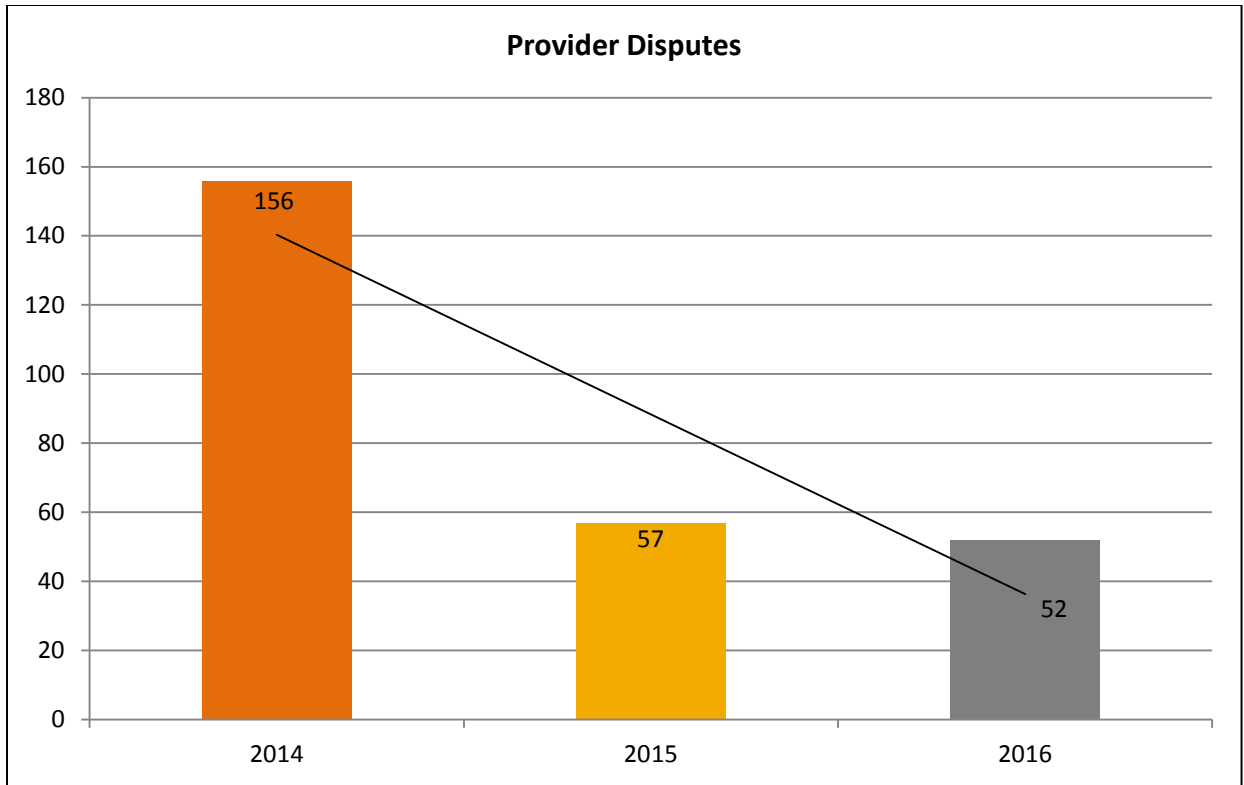*Opportunities and Interventions:* No opportunities for improvement were identified.

Provider Disputes

Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination (claims-based denials) 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. Provider disputes require that a written notice be sent within 30 days following the request for consideration.

2014 – 2016 Overall Performance Results

Provider Disputes	Performance Goal	2014	2015	2016
Number of Provider Disputes	NA	156	57	52
Average # of Days Provider Disputes Resolved	30 Days	11.2 days	8.3 days	13.4 days

Analysis: During 2016, there were 52 provider disputes a decrease from 57 in 2015 and 156 in 2014. All were resolved within the goal of ≤30 days.

Provider Disputes

Year	Value
2014	156
2015	57
2016	52

Provider Dispute Resolution Turn-Around Time (in days)

Quarter	Provider Dispute Resolution TAT	Goal ≤ 30 Days
Q1 2014	0	30
Q2 2014	19	30
Q3 2014	10	30
Q4 2014	16	30
Q1 2015	16	30
Q2 2015	2	30
Q3 2015	8	30
Q4 2015	7	30
Q1 2016	13.5	30
Q2 2016	17.4	30
Q3 2016	9.9	30
Q4 2016	12.9	30

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 service requests for the outpatient behavioral health services offered under the IBHP. Optum adheres to a 14 day turnaround time for processing requests for those non urgent requests of services that require prior authorization. Services are offered in Categories of Services: Category 1, Category 2, Category 3 and Category 4 services.   Category 2 and Category 3 services require that a provider submit a service request form in advance of the provision of the service in order to obtain a prior authorization required for reimbursement. Category 4 services have an annual allotment of units associated with them that providers use at their discretion. Prior authorization of the Category 4 services are not required unless the allotment has been exhausted.
2015 - 2016 Performance Results

Service Authorization Requests	Performance Goal	2015	2016
Number of Service Authorization Requests	NA	43,285	21,667
Percent Determinations Completed within 14 days	100.0%	98.8%	99.1%

Analysis: Data reflects that in 2015 the monthly number of UM authorizations was reduced by approximately 50%.

Since CBRS continues to require a prior authorization and continues to be carefully reviewed, the number of authorizations has steadily decreased since Optum' s implementation. It is important to point out that the more significant decline in CBRS authorizations beginning in 2015, was accompanied by an increase in utilization of Case Management and Peer Support and Family Support services. Coincidently, Case Management, Peer Support and Family Support were moved from a Category 3 (eliminating the requirement for prior authorization) to a Category 4 level of service also in 2015.

Determinations Completed withing 14 Days (Excludes Open Authorizations)
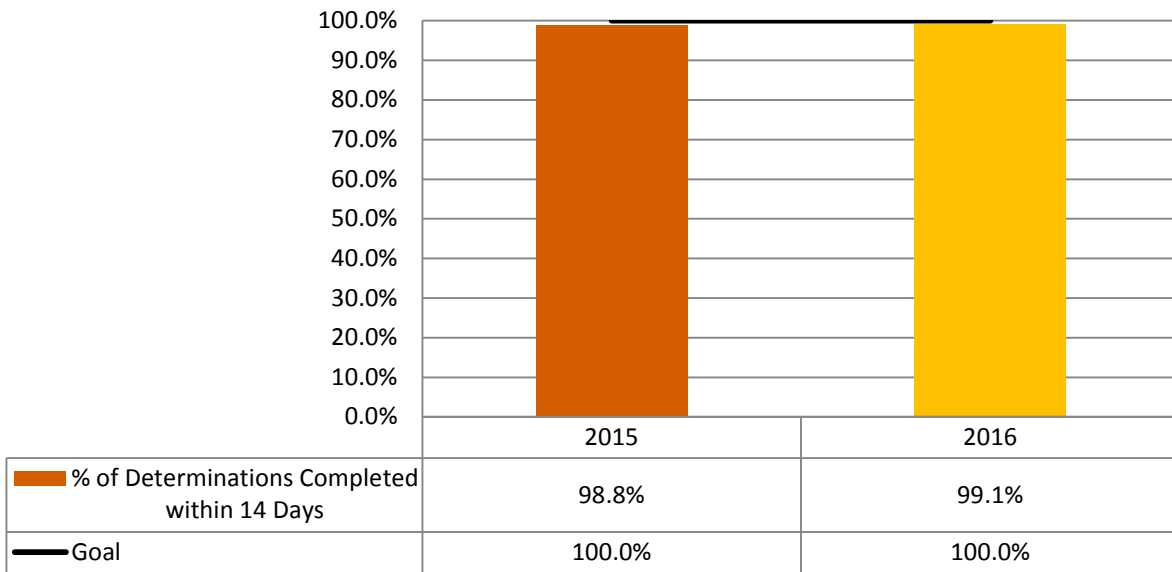
	2015	2016
% of Determinations Completed within 14 Days	98.8%	99.1%
Goal	100.0%	100.0%

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

Opportunities and Interventions: We continue to monitor these utilization patterns as they relate to appropriate member care and provider usage.

1. The Clinical team provided Network training in August of 2016 regarding the trending analysis for Category 4 services and how utilization had transitioned based upon no front end authorization requirements.
2. In Q1 of 2017, Practice Management was implemented with the addition of an FTE to complete clinical audits of those providers with unusual practice patterns.
3. The Clinical Team makes PNI referrals when utilization is reviewed as part of the prior authorization process, and there appear to be the presence of outliers for utilization.

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.

The Field Care Coordinators receive referrals from different sources. The below table identifies the referral sources and the number of referrals made to FCC staff during Q1 through Q4, 2016.

Referral Sources	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Discharge Coordinator	191	136	151	112
Utilization Reviewers	11	10	12	8
Providers	22	6	6	5
Department of Behavioral Health	7	3	2	6
Juvenile Justice	0	0	0	0
Provider Quality Specialist	1	2	2	3
Peer Review Committee	3	4	1	2
Hospitals	0	0	0	0
EPSDT	1	1	0	0
Family	0	0	0	0
Member Services/Crisis Line	0	0	1	0
Education	NA	NA	NA	6
FCC Manager Referral	NA	NA	NA	4
Outpatient Disposition	NA	NA	NA	3
Total	236	162	175	149

Analysis: During 2016, Field Care Coordinators received 722 referrals. The majority of referrals are made by Optum Idaho Discharge Coordinators. The number of days that a Field Care Coordinator keeps a case open varies by case.
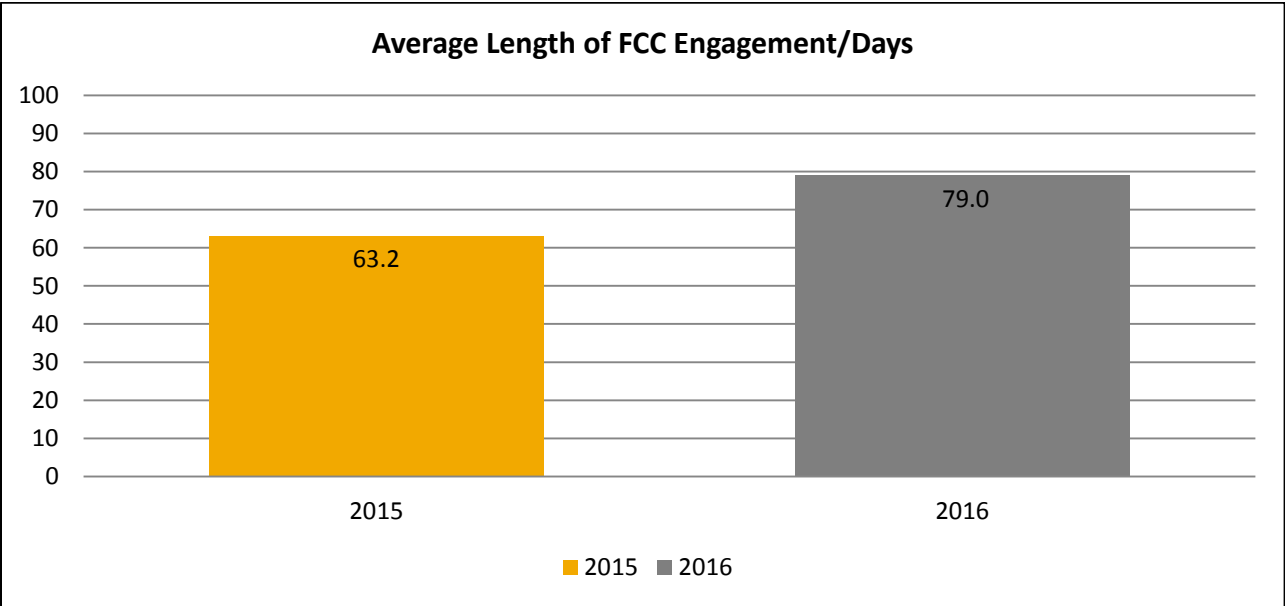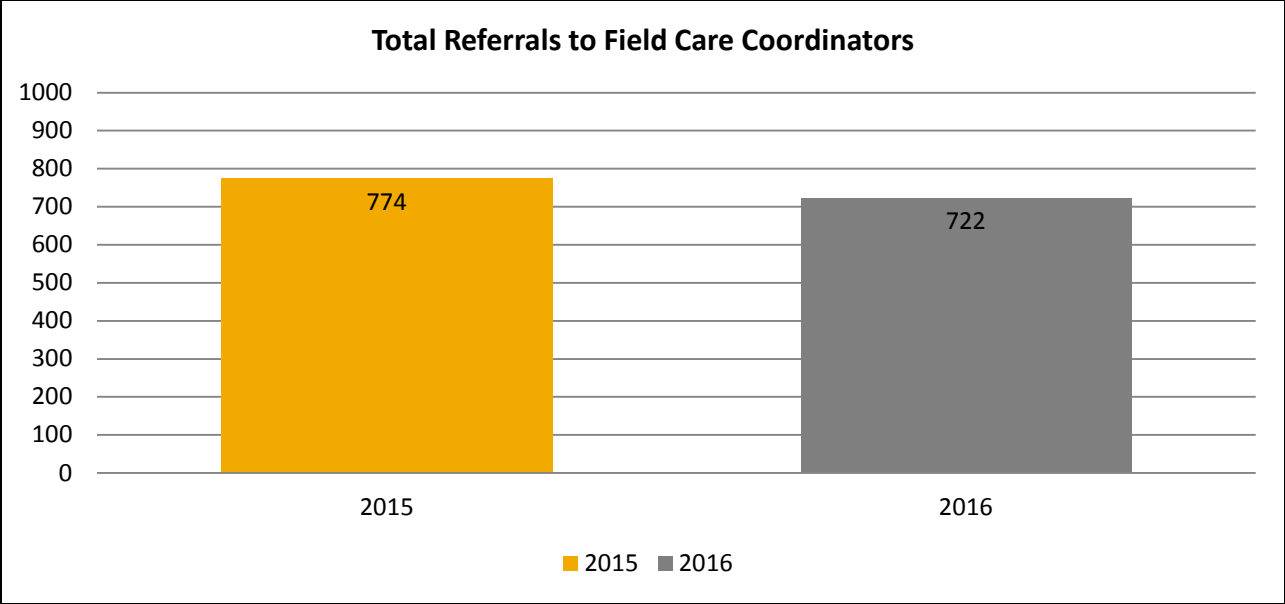
Total Referrals to Field Care Coordinators

Average Length of FCC Engagement/Days

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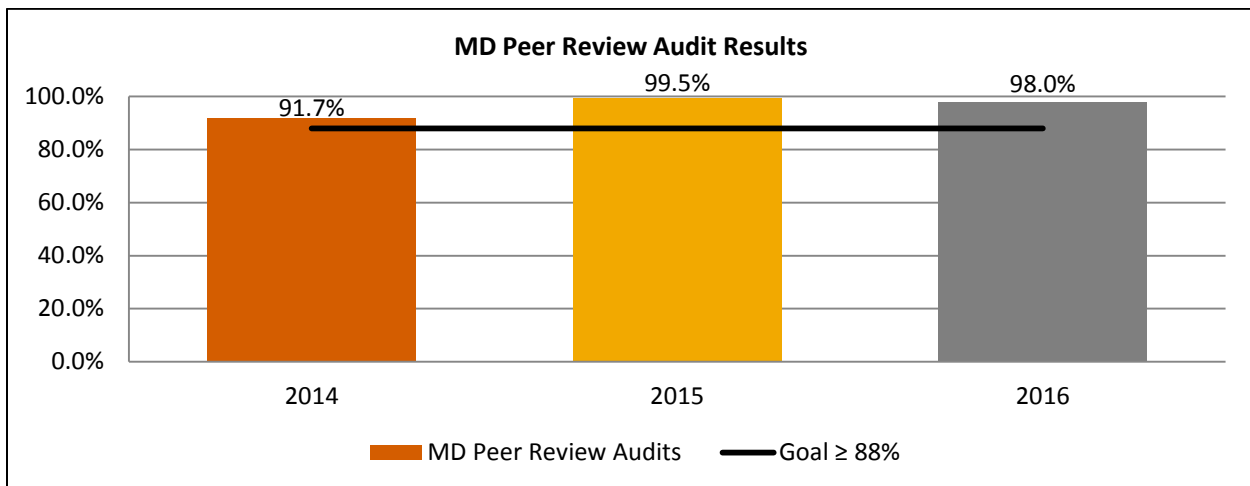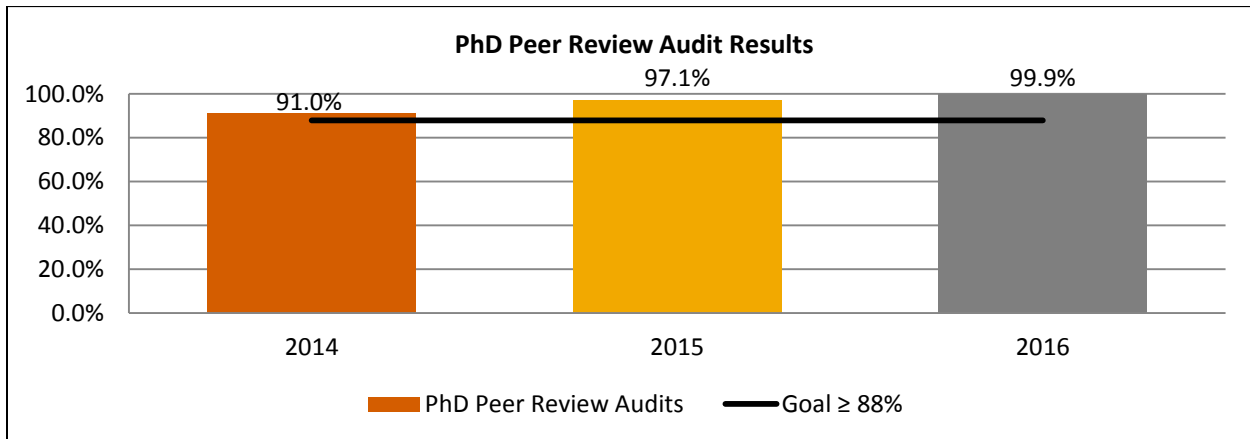**Opportunities and Interventions:** No opportunities for improvement were identified.

Peer Reviewer Audits

Methodology: Optum Idaho promotes a process for review and evaluation of the clinical documentation of non-coverage determinations and appeal reviews by Optum physicians and doctoral-level psychologists 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. Any pattern of deficiency incurred by an individual Peer Reviewer may result in clinical supervision, as needed. Optum Idaho's established target score for Peer Reviewer audits is ≥ 88%.

Analysis: Based on the performance goal of ≥ 88%, audit results indicate that PhD and MD Peer Review Audits received passing scores during 2016.

PhD Peer Review Audit Results

MD Peer Review Audit Results

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

Inter-Rater Reliability

Optum 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 annual assessment of inter-rater reliability. Inter-rater Reliability testing is completed annually.

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Methodology: Each respondent completed an instrument based on the *Level of Care Guidelines* and the *ASAM Criteria*. The instrument was administered confidentially either in person or after having been transmitted via a secure intranet site. Respondents were given 1 business day to complete the instrument. The interim Clinical Program Manager at Optum Idaho was designated to encourage participation and identify administration or instrument issues.

An internally-developed inter-rater reliability tool was used to measure the consistency with which clinical staff makes level of care decisions and case determinations in the process of care advocacy.   A set of 23 multiple choice questions derived from the content of 4 separate requests for service authorization were responded to by the entire Care Advocate team consisting of 10 clinicians.   Within the content of the four different authorizations considerations involving both child and adult treatment options were reviewed.

QUESTIONS	CLINICIANS											
	3	3	2	3	3	3	3	3	3	3		90%
	1	1	1	1	1	1	1	1	1	1		100%
	2	2	2	2	2	2	2	2	2	2		100%
	2	2	2	2	1	1	2	2	2	2		80%
	1	1	1	1	1	1	1	1	1	1		100%
	2	2	2	2	2	2	2	2	2	2		100%
	4	4	4	3	4	4	4	4	4	4		90%
	1	1	1	1	1	1	1	1	1	1		100%
	2	2	2	1	2	2	2	1	2	1		70%
	1	1	1	1	1	1	1	1	1	1		100%
	3	3	3	3	3	3	3	3	3	3		100%
	2	2	2	2	2	2	2	2	2	2		100%
	2	2	2	2	2	2	2	2	2	2		100%
	1	1	1	1	1	1	1	1	1	1		100%
	3	3	3	3	3	3	3	3	3	3		100%
	2	2	2	2	2	2	2	2	2	2		100%
	2	2	2	2	2	2	2	2	2	2		100%
	2	2	2	2	2	2	2	2	2	2		100%
	1	1	1	1	1	1	1	1	1	1		100%
	1	1	1	1	1	1	1	1	1	1		100%
	1	1	1	2	1	1	1	1	1	1		100%
	2	2	2	2	2	2	2	2	2	2		100%
%	100%	100%	96%	87%	96%	96%	100%	96%	100%	96%		

Analysis: A total of 230 item responses were analyzed in this review, matching the responses for each clinician in each of the four service request forms. One question fell below criteria (#9), but the balance of the questions was within acceptable ranges for clinician accuracy. A Fleiss' Kappa analysis was completed using the entire data set from the review. This type of analysis evaluates the level of consistency evidenced between multiple raters in the review. Acceptable levels of reliability in the clinician's decisions across a data set of this proportion would begin at .85 in the review. The current review for clinician consistency and reliability in responding was determined to fall at .902 for the Fleiss' value, with an observed average pairwise agreement comparison percentage value that was slightly stronger at 93.8%.

Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: The improved performance of the Care Advocate team with routine review of the LOCGs is evident and will be continued.
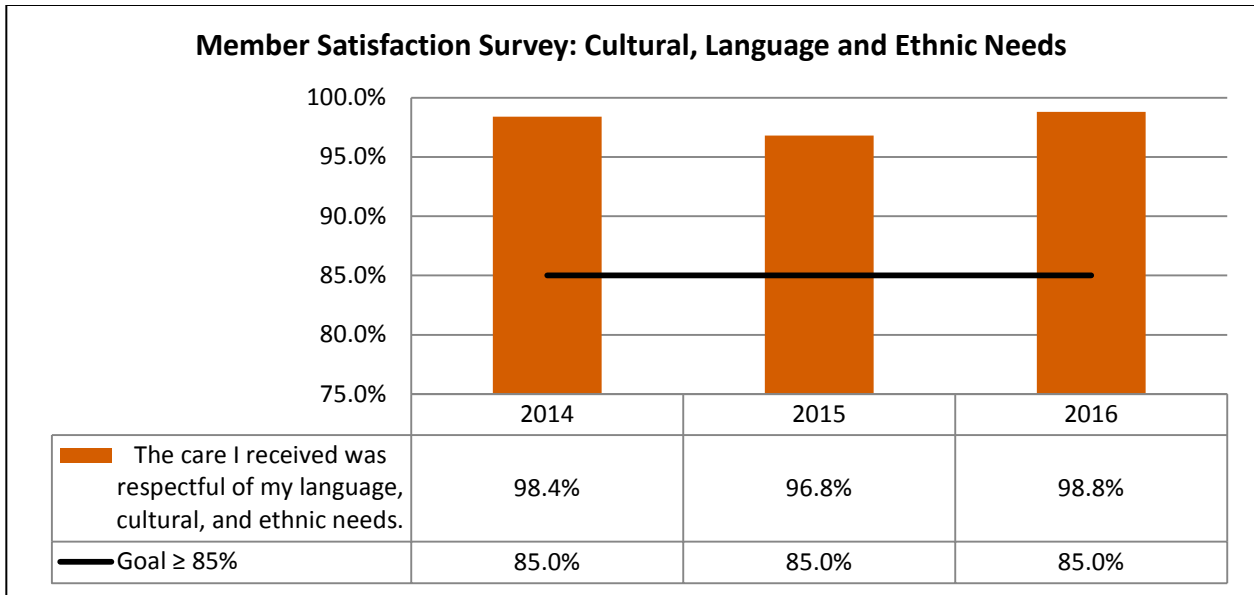
Population Analysis

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 2016, 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
The care I received was respectful of my language, cultural, and ethnic needs.	98.4%	96.8%	98.8%
Goal ≥ 85%	85.0%	85.0%	85.0%

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

Results for Language and Culture

Methodology: Optum 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.

Analysis: During 2016, Optum responded to a variety of requests for language assistance including:

- Member written communication translated to Spanish (Annual Member Mailing)
- Member written communication formatted to large print (Annual Member Mailing)
- Mental Health First Aid (MHFA) training materials translated to Spanish.
- Interpreter Services – Language Service Associates (verbal translations by phone)

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

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from the received date to the paid date (check), plus two days for mail time. Company holidays are included.
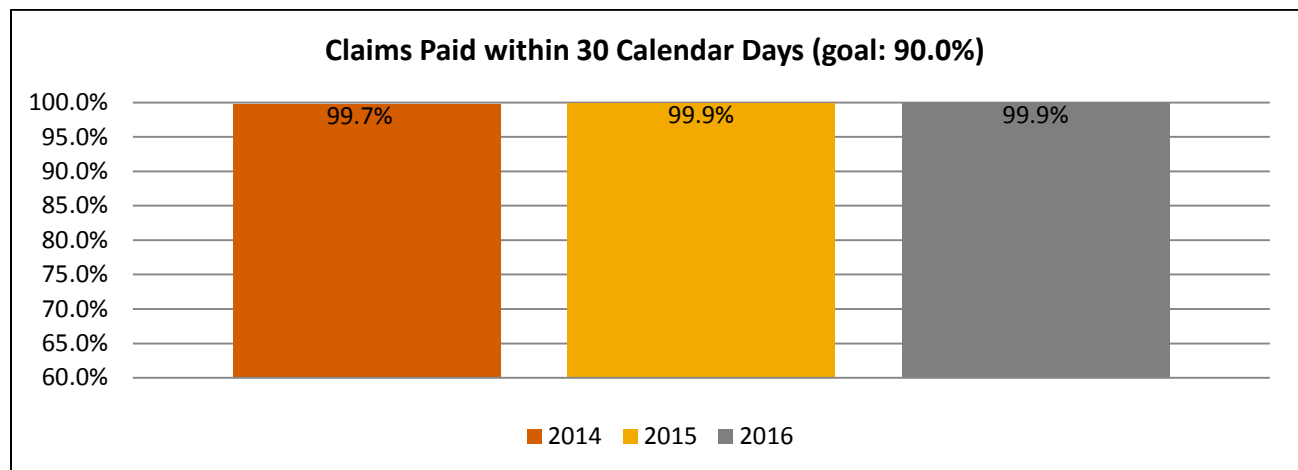
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid dollars minus overpayments and underpayments divided by the total paid dollars).
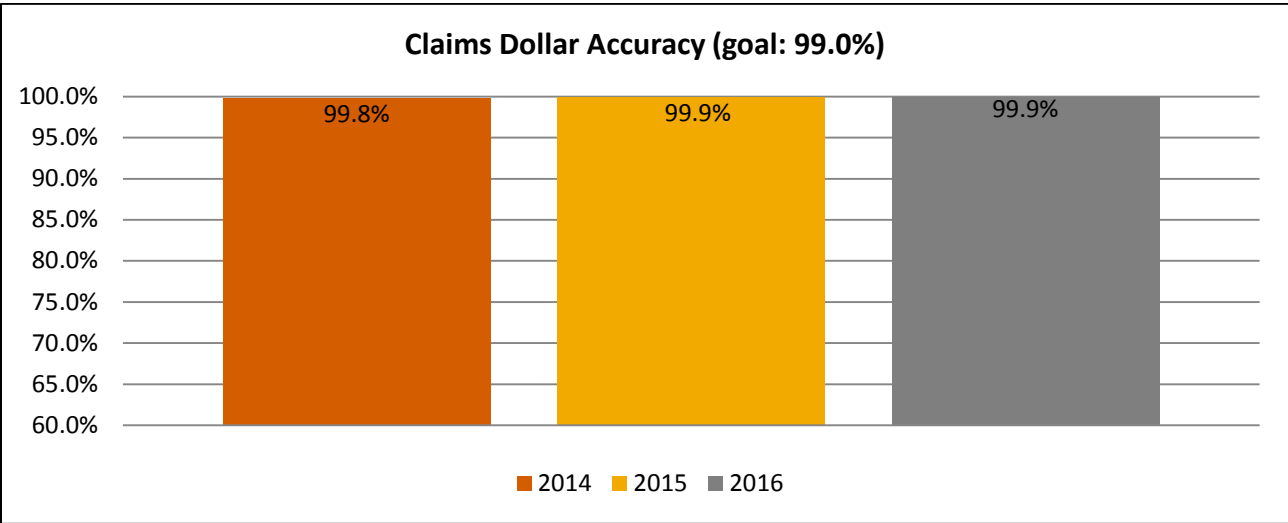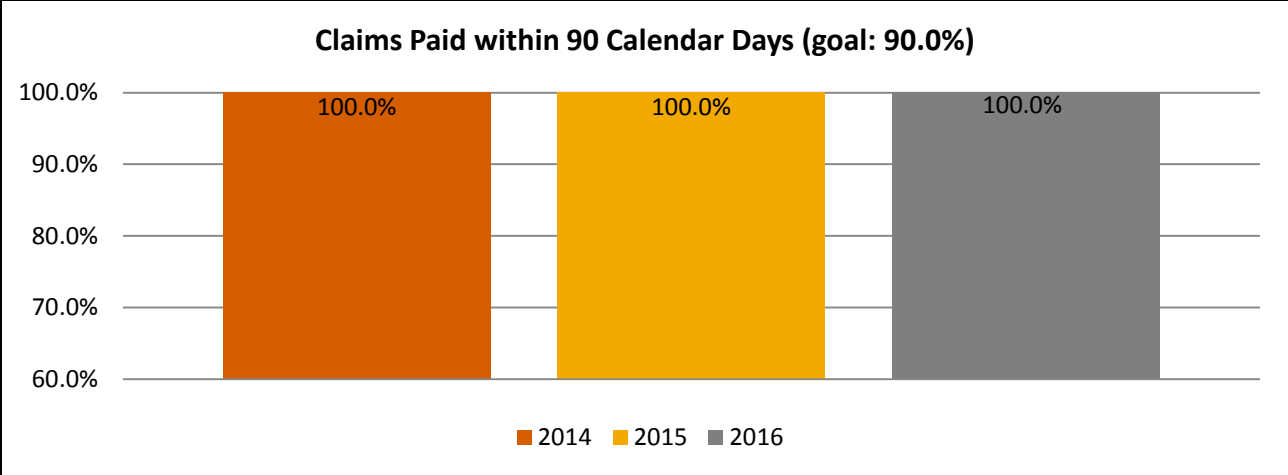
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial errors (total number of claims audited minus the number of claims with non-financial errors divided by the total claims audited).
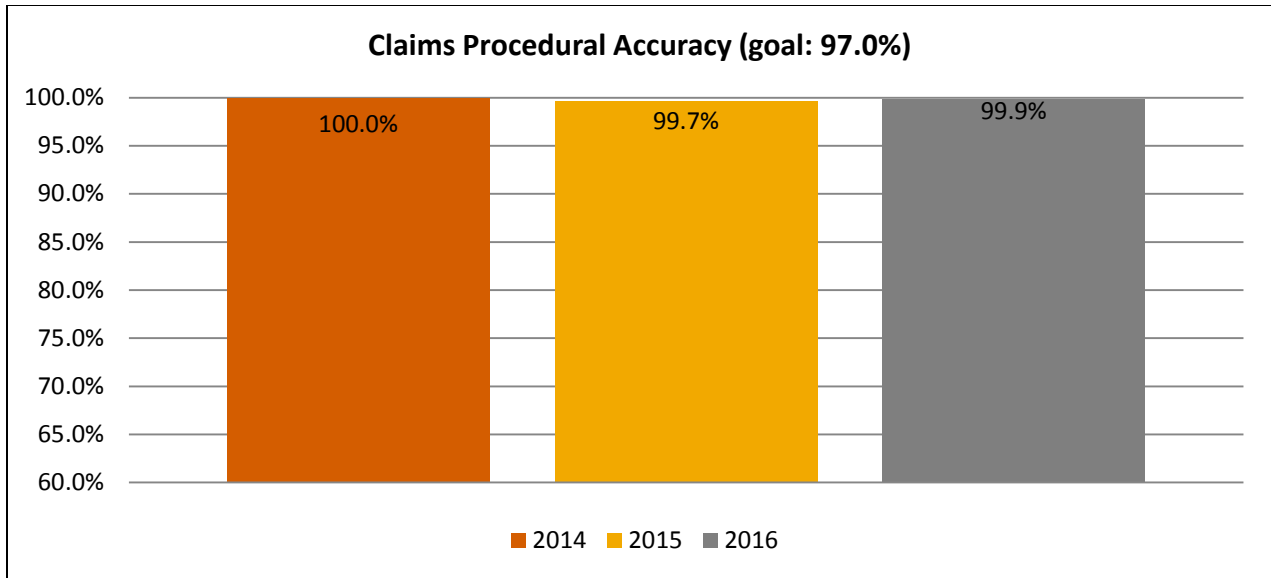
2014 – 2016 Overall Performance Results

Claims	Performance Goal	2014	2015	2016
Paid within 30 days	90%	99.7%	99.9%	99.9%
Paid within 90 days	99%	100.0%	100.0%	100.0%
Dollar Accuracy	99%	99.8%	99.9%	99.9%
Procedural Accuracy	97%	100.0%	99.7%	99.9%

Analysis: The data shows that all performance goals continued to be met during 2016.

Claims Paid within 30 Calendar Days (goal: 90.0%)

	2014	2015	2016
	99.7%	99.9%	99.9%

■ 2014 ■ 2015 ■ 2016

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Claims Paid within 90 Calendar Days (goal: 90.0%)

	2014	2015	2016
Claims Paid within 90 Calendar Days	100.0%	100.0%	100.0%

Claims Dollar Accuracy (goal: 99.0%)

	2014	2015	2016
Claims Dollar Accuracy	99.8%	99.9%	99.9%

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Claims Procedural Accuracy (goal: 97.0%)

2014 100.0% **2015** 99.7% **2016** 99.9%

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