Optum

2022

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

The Quality Management and Utilization Management (QMUM) 2022 Annual Evaluation summarizes Optum Idaho's performance in accordance with the contract between the Idaho Department of Health and Welfare (IDHW), Division of Medicaid and Optum. This report highlights the outpatient behavioral health services covered by the State of Idaho and provided on behalf of Medicaid members, also known as the Idaho Behavioral Health Plan (IBHP). This QMUM report provides a year-over-year annual view of performance and outcomes data.

Table of Contents

Introduction and Overview 4
Our Mission 4
Optum Idaho QAPI Committee Role/Purpose 6
Summary and Highlights 7
Quality Performance Measures and Outcomes 11
Outcomes Analysis 17
Utilization Rates 17
Family Therapy 18
Peer-Based Services 18
Case Management 19
Prescriber Visits 19
Skills-Building/Community-Based Rehabilitation Services (CBRS) 20
Crisis Intervention & Response by Year by Age 20
Psychiatric Inpatient Utilization 21
Algorithms for Effective Reporting and Treatment (ALERT) 25
Average Overall Health Scores 28
Member Satisfaction Survey Results 29
Provider Satisfaction 31
Performance Improvement Projects 32
Care Coordination Performance Improvement Project (PIP) 32
1915(i) Performance Improvement Project (PIP) 32
Accessibility & Availability 33
Idaho Behavioral Health Plan Membership 33
Member Services Call Standards 33
Customer Service (Provider Calls) Standards 35
Urgent, Non-Urgent, and Critical Appointment Access Standards 37
Geographic Availability of Providers 38
Member Protections and Safety 39
Notification of Adverse Benefit Determination (ABD) 39
Member Appeals 40
Complaint Resolution and Tracking 42
Critical Incidents 44

Table of Contents *(continued)*

Response to Written Inquiries 45
Provider Monitoring and Relations 46
Provider Quality Monitoring 46
Coordination of Care 47
Provider Disputes 48
Utilization Management and Care Coordination 49
Service Authorization Requests 49
Person-Centered Service Plan (PCSP) 50
Field Care Coordination 51
Inter-Rater Reliability 52
Population Analysis 53
Language and Culture 53
Claims 54

Introduction and Overview

The Quality Management Utilization Management (QMUM) Annual Evaluation provides an analysis of the Medicaid outpatient mental health and substance use disorder services managed by the Idaho Behavioral Health Plan (IBHP) in the State of Idaho. The time frame of this evaluation includes activities beginning Jan. 1, 2022, through Dec. 31, 2022, and provides comparative performance from 2019–2022.

Our Mission

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

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

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

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

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

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

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

Leadership and Staffing

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

Support/Corporate Resources

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

Governing Body

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

Designated Behavioral Healthcare Practitioner

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

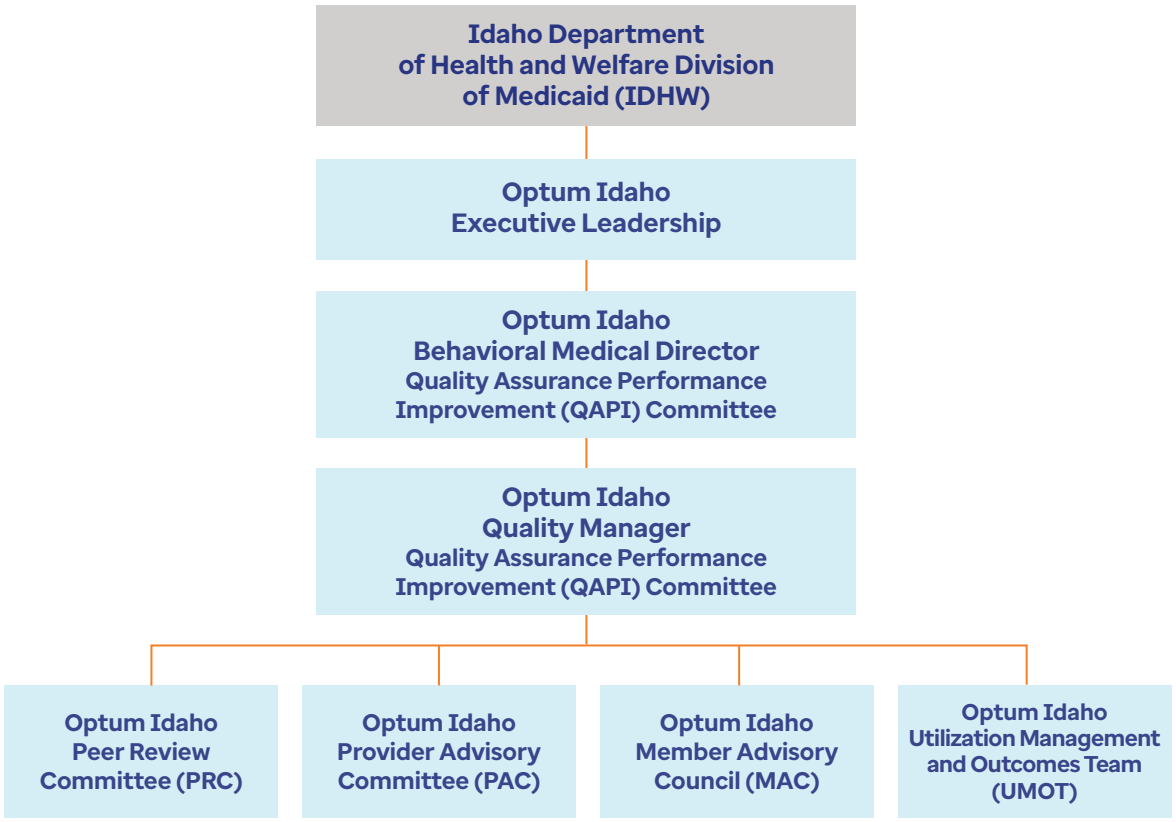
Quality Improvement Program

The QI Program covers all QI processes. Functional area leaders, network practitioners, and cross-functional teams that represent various areas within the organization, have substantial involvement in the QI Program.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Quality Committees

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



Optum Idaho QAPI Committee Role/Purpose

The QAPI Committee's purpose is to oversee, organize, and evaluate all quality improvement activity. It is responsible for the implementation of the Outcomes Management & Quality Improvement Work Plan with the mission to improve the behavioral health and well-being of the membership it serves, promote high quality behavioral care, and focus on recovery and resiliency for members and their families. The QAPI Committee is also responsible for reviewing measurements, outcomes, and reports that show progress toward system transformation. Areas that do not show progress toward desired outcomes are targeted for improvement efforts through the establishment of cross-functional teams to address systems issues on a periodic and time-limited basis.

Structure/Relation to Organization

The QAPI Committee reports to executive leadership and has authority to implement all actions related to the QI program. The following sub-committees provide summary reports to the QAPI Committee:

- Member Advisory Council
- Peer Review Committee
- Provider Advisory Committee

CLICK HERE TO RETURN TO TABLE OF CONTENTS

- Utilization Management and Outcomes Team
- Cross Function Teams (convened as necessary)

Optum Idaho provides a detailed overview of the roles and responsibilities, membership and meeting schedule for the above QAPI sub-committees in the policy titled, "QAPI Committee Structure."

Key Roles (functional areas) and Responsibilities

The quality director is responsible for providing leadership to the QI Program and ensuring organization-wide implementation of the program structure. The quality manager reports to the quality director. The quality director directs the QI Program structure at various levels of implementation and manages the quality team responsible for its daily operations.

Annually, a review of utilization management is conducted and revisions made as identified. Components of the review include the utilization management program structure, scope, processes, information sources used to determine benefit coverage and medical necessity, and the level of involvement of the chief medical officer and designated behavioral health practitioner who oversees the Utilization Management Program.

Preparation for Independent Reviews

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

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

- Achievement of performance targets.
- Identification of opportunities for improvement.
- Development action plans based on root cause analysis for unmet targets.
- Implementation of appropriate and timely actions.
- Monitoring of the effectiveness of implemented interventions.
- Development of additional targets and/or activities when indicated.

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

This *Quality Management Utilization Management Annual Evaluation* demonstrates to internal and external stakeholders the outcomes and improvement activities, as well as an assessment of the overall effectiveness of the IBHP's programs and services. The results of the ongoing quality monitoring and the annual review are used to restructure quality improvement activities for the upcoming year.

Summary and Highlights

Optum Idaho has remained committed to IBHP members and families in transforming the behavioral health care system in Idaho. Each quarter of 2022, Optum Idaho monitored performance measures to ensure the needs of IBHP members and providers were being met. Performance targets are based on contractual, regulatory and/or operational standards. Included in this report is an analysis of Optum Idaho's operational functions which include: outcomes analysis, member satisfaction surveys, provider feedback, performance improvement projects, access and availability, member protections and safety, provider monitoring and safety, utilization management and care coordination, population analysis and claims data.

Based on the overall 2022 annual data, Optum Idaho met or exceeded performance metrics for 88 percent of the total key measures (29 out of 33). Four (4) measures fell below the performance goal:

1. *Written notification within fourteen days for Notice of Adverse Benefit Determinations (ABDS) at 98.7 percent*

2. *Percent of complaints acknowledged within five business days at 98.8 percent,*

3. *Percent of quality-of-service complaints acknowledged within five business days at 97.5 percent, and*

4. *Critical incidents response to written inquiries at 96.2 percent.*

Monitoring member satisfaction with behavioral health services is vital to understanding the voice of the member's experience. In 2022, Optum Idaho exceeded the overall member satisfaction goal at 94 percent. The following member satisfaction goals were also met:

1. Counseling and Treatment at 94 percent,

2. Optum Support for Obtaining Referrals or Authorization at 90 percent, and

3. Accessibility, Availability and Acceptability of the Clinician Network at 89 percent. Members also indicated that they were consistently satisfied with the time it took to get an appointment and with the ability to find care that was respectful of their language, culture and ethnic needs.

Monitoring provider satisfaction with Optum Idaho is necessary to understand provider perspective. In 2022, the Provider Satisfaction Survey was not conducted. Alternatively, a greater emphasis and focus was placed on the relationship the Provider Relations Advocates (PRA's) create with providers. This includes one-on-one conversations focused on discovering root causes around barriers, which include network capacity and administrative burdens.

Additionally, the monthly Provider Advisory Committee (PAC) meeting serves as a forum for network representatives to share input and prioritization of initiatives or issues impacting the provider community. This meeting offers the opportunity for partnership with the network community, IDHW and Optum Idaho. The PAC is also a forum for providers to present their recommendations for changes to procedures, enhancements to systems or to discuss and plan key initiatives.

Optum Conference 2022

The Optum Conference, which offered both virtual and in-person options, took place on October 18th and 19th, 2022. The free conference was open to Optum network providers, non-network providers and other interested community stakeholders, and CEU credit was offered for most sessions. The keynote speaker was Tom Koulopoulos the founder of the Delphi Group think tank, founding partner of Acrovantage Ventures, and author of 13 books, including *Reimagining Healthcare*. Other session topics included:

- Documentation for the Treatment Process
- Engaging Parents & Families in Your Practice
- Comprehensive Care for Newly Arrived Americans
- Hot Legal Issues/Ethics
- Non-surgical Transgender Treatment for Youth
- Suicide Assessment & Tools

This was Optum Idaho's second annual conference with 777 people in attendance. A post-conference survey was completed by 199 attendees, with an average score of 9.2 out of 10 for the question: "How likely are you to recommend the Optum Conference to a friend or colleague?"

SSI/SSDI, Outreach, Access, and Recovery (SOAR) Case Management

Optum Idaho partnered with IDHW in a joint effort to implement SOAR Case Management as a billable service. SOAR Case Management provides SSI/SSDI application assistance to both adults and children, experiencing homelessness or are at risk of homelessness and who have severe and persistent mental illness.

Intensive Home and Community Based Services (IHCBS) – Implementation of New Modality

Optum Idaho partnered with IDHW and the Division of Behavioral Health to increase the availability and expand services for Intensive Home and Community Based Services (IHCBS) to members across the state. Providers were offered the opportunity to receive compensation for training on a new IHCBS modality called "Therapeutic Behavioral Services" which is now available under IHCBS.

Mental Health in Schools – Phase 3

In the United States, over 40% of students will have experienced a mental health problem, such as anxiety or depression, by the time they reach seventh grade. Suicide is the second leading cause of death for ages 10-34, and, according to the 2016 National Survey of Children's Health, 46% of children have experienced at least one Adverse Childhood Experience (ACE).

Idaho's child and adolescent populations are no exception to the risk for behavioral health difficulties. The identified number of suicide attempts in all populations for 2021 has exceeded those of 2020. The Interconnected System Framework (ISF) is an emerging approach for building a single system of Serious Emotional Behavioral (SEB) support in schools.

In 2019, Optum Idaho created a specific training around the ISF targeted to the provider network titled, "Mental Health in Schools." The purpose of this training is to align the languages between the mental health and education communities, train to best practice models and evidence-based national models, and offer a coaching component after training to assist with the facilitation of a collaborative relationship between Optum providers and the school districts they support. This training includes a virtual live session, with an additional three virtual live sessions offered at different times during 2022.

Partial Hospitalization Review

The Partial Hospitalization Review Project Committee examined utilization trends and obtained provider feedback to help guide changes to the Provider Manual. A chart was also developed and added to the Provider Manual that visually displays the similarities and differences between Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP). A Readiness Assessment was rolled out to assist new providers with onboarding a new PHP/IOP service prior to receiving approval. To further support providers, Optum Idaho created a new E-learning course, including a pre-test and post-test, to measure comprehension. This course has been well received and proven to show an increase in provider understanding.

Crisis Centers Review

Focused efforts for reviewing crisis centers included discussions with the centers, in collaboration with Idaho Division of Behavioral Health. Quarterly calls were held to help address some quality improvement areas as noted in audits performed by the Optum Idaho Provider Performance team. From these discussions, a need was identified to adjust unclear language in the audit tool around "detox" to better reflect the purpose of the crisis centers. This change was made to the audit tool and was presented to the centers during one of the quarterly calls. Optum Idaho continues to monitor metrics on crisis centers since the initial 2021 quality improvement discussions and improvements continue to trend upward.

Peer Services Phase 2

Increased family engagement was identified as a need during a Youth Support listening session. Optum Idaho created a series of articles for the Provider Press and Member Matters on the importance of families being engaged in the treatment of their children. In addition, the Optum Conference offered two sessions on this topic, one delivered by a solo presenter and the other a panel discussion, both of which were well received.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

National Committee for Quality Assurance (NCQA) Accreditation

The National Committee for Quality Assurance (NCQA) exists to improve the quality of health care. It is a rigorous and comprehensive framework for essential quality improvement and measurement. During 2022, Optum Idaho closely examined practices and fully aligned with NCQA accreditation which was recognized effective January 01, 2023. This was achieved through collaboration with executive leadership, quality, compliance, clinical, provider relations, communications, and national teams working towards this goal.

External Quality Review

An External Quality Review (EQR) is the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries. Annually, the IDHW oversees the EQR process via the use of a contractor who conducts an audit of Optum Idaho to assure acceptable standards of care are being delivered. This requirement originates with the Centers for Medicare & Medicaid (CMS). On March 3, 2022, a virtual EQR site visit was conducted. The scope of the review was for July 1, 2020 through June 30, 2021. The following areas were reviewed:

- Validation of Performance Improvement Projects – Received a Developing Rating
- Validation of Performance Measures – Received a Fully Compliant Rating
- Review of Compliance with Medicaid Managed Care Regulations – Received a Developing Rating
- Validation of Network Adequacy – Not a Rated Category
- Information Systems Capabilities Assessment (ISCA) – Received a Met Score

The feedback obtained as part of the EQR has helped Optum Idaho improve quality processes. The areas of opportunity were primarily identified within the existing Performance Improvement Projects (PIP). In response, Optum Idaho established another PIP that aligns with the CMS Protocol 3, Validation of Performance Improvement Projects, and has used this as an opportunity to evaluate our processes and bolster staff education.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

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 the yearly outcomes from 2014-2022. The results highlighted in green met or exceeded overall performance goals, those highlighted in yellow fell within 5% of the performance goal. andthose highlighted in red fell below the performance goal.

Measure	Goal	2019	2020	2021	2022
2019 – 2022 New Survey: Member Satisfaction Survey Results					
Optum Support for Obtaining Referrals or Authorizations	**≥85%**	94%	91%	90%	90%
Counseling and Treatment	**≥85%**	95%	94%	93%	94%
Accessibility, Availability, and Acceptability of the Clinician Network	**≥85%**	93%	93%	90%	89%
Overall Satisfaction	**≥85%**	94%	90%	90%	94%
Provider Satisfaction Survey Results					
Overall Provider Satisfaction	**≥85%**	76%	88%	72%	N/A*
**Survey conducted via another method*					
Accessibility & Availability – Idaho Behavioral Health Plan Membership					
Membership Numbers	**NA**	318,331	383,601	419,467	420,707
Accessibility & Availability – Member Service Call Standards					
Total Number of Calls	**NA**	4,641	6,999	5,544	6,209
Percent Answered Within 30 Seconds	**≥80%**	76%	84%	68%	81%
Average Daily Hold Time	**≤120 Seconds**	25	20	44	35
Abandonment Rate	**≤3.5% internal, ≤7% contractual**	3.0%	1.5%	4.1%	3.4%

Measure	Goal	2019	2020	2021	2022
Accessibility & Availability – Customer Service (Provider) Call Standards					
Total Number of Calls	**NA**	12,332	13,597	11,778	14,775
Percent Answered within 30 seconds	**≥80%**	98%	98%	98%	95%
Average Daily Hold Time	**≤120 seconds**	3	4	5	11
Abandonment Rate	**≤3.5% internal, ≤7% contractual**	0.3%	0.4%	0.4%	0.9%
Accessibility & Availability – Appointment Access Standards					
Urgent Appointment Wait Time	**48 hours**	19.0	15.0	10.5	9.7
Non-Urgent Appointment Wait Time	**10 days**	4.0	3.5	2.8	3.2
Critical Appointment Wait Time*	**6 hours**	3	3	2	1.7
**Began tracking in 2017.*					
Geographic Availability of Providers					
Area 1 – Requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties	**100%**	99.8%*	99.9%*	99.9%*	99.9%*
Area 2 – Requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	**100%**	99.8%*	99.7%*	99.8%*	99.7%*
**Performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number).*					

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Measure	Goal	2019	2020	2021	2022
Member Protections and Safety – Notification of Adverse Benefit Determinations (ABDs)					
Number of ABDs	NA	475	78	136	280
Clinical ABDs*	NA	381	22	22	169
Administrative ABDs*	NA	94	56	114	111
Written Notification	**100% w/in 14 calendar days from request for services**	98.7%	98.5%	100%	98.7%
Written Notification Sent within 1 Business Day	**100.0%**	NA	NA	NA	NA
**Began tracking in 2017.*					
Member Protections and Safety – Member Appeals					
Number of Appeals	**NA**	14	3	4	11
Member Appeals Turnaround Time	**≤30 days**	NA	NA	NA	NA
Non-Urgent Appeal Resolution Turnaround Time	**≤30 days**	4	16	14	4
Urgent Appeal Resolution Turnaround Time	**72 hours**	19	18	49	0*
**No urgent appeals.*					

Met the goal.

Within 5 percentage points of the goal.

Did not meet the goal.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Measure	Goal	2019	2020	2021	2022
Member Protections and Safety – Complaint Resolution and Tracking					
Total Number of Complaints	**NA**	67	45	29	60
Percent of Complaints Acknowledged within Turnaround time	**100% w/in 5 business days**	100.0%	100.0%	100.0%	98.8%
Number of Quality of Service Complaints	**NA**	55	34	23	27
Percent Quality of Service Resolved within Turnaround Time	**100% w/in ≤10 business days**	96.0%	100.0%	100.0%	97.5%
Number of Quality of Care Complaints	**NA**	12	11	6	33
Percent Quality of Care Resolved within Turnaround Time	**100% w/in ≤30 calendar days**	100.0%	100.0%	100.0%	100.0%
Member Protections and Safety – Critical Incidents					
Number of Critical Incidents Received	**NA**	42	60	51	59
Percent Ad Hoc Reviews Completed within 5 Business Days from Notification of Incident	**100.0%**	100.0%	100.0%	100.0%	100.0%
Member Protections and Safety – Response to Written Inquiries					
Percent Acknowledged ≤2 Business Days	**100.0%**	98.0%	99.0%	100.0%	96.2%
Provider Monitoring and Relations – Provider Quality Monitoring					
Number of Audits	**NA**	439	458	593	388
Percent of Audits that Received Passing Score of ≥85%	**≥85%**	80%	84%	77%	88%
Percent of Audits that Required a Corrective Action Plan	**NA**	20%	16%	33%	12%

Measure	Goal	2019	2020	2021	2022
Provider Monitoring and Relations – Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)					
Percent PCP is Documented in Member Record	**NA**	97%	98%	100%	96%
Percent Documentation in Member Record that Communication/ Collaboration Occurred Between Behavioral Health Provider and PCP	**NA**	78%	76%	80%	83%
Provider Monitoring and Relations – Provider Disputes					
Number of Provider Disputes	**NA**	138	579	375	204
Average Number of Days to Resolve Provider Disputes	**≤30 days**	8.0	9.0	15.0	17.8
Utilization Management and Care Coordination – Service Authorization Requests					
Percentage Determination Completed within 14 Days	**100%**	100.0%	100.0%	100.0%	100.0%
Utilization Management and Care Coordination – Person-Centered Service Plan (PCSP)					
Number of PCSPs Received	**NA**	925	863	619	563
Average Number of Business Days to Review	**≤5 days**	0.16	0.11	0.49	0.40
**Began tracking in 2018 but not a full year's worth of data until 2019.*					
Utilization Management and Care Coordination – Field Care Coordination (FCC)					
Total Referrals to FCCs	**NA**	960	1604	629	1701
Average Number of Days Case Open to FCC	**NA**	48.0	43.0	37.0	41.7
**Began tracking in 2015.*					

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Measure	Goal	2019	2020	2021	2022
Inter-Rater Reliability Testing					
Care Advocate Audit Results	**≥88.0%**	99.0%	100.0%	97.0%	95.0%
MD Peer Review Audit Results	**≥88.0%**	95.0%	*	95.0%	100%
**Data unavailable.*					
Claims					
Claims Paid within 30 Calendar Days	**90.0%**	99.9%	99.0%	99.0%	99.8%
Claims Paid within 90 Calendar Days	**99.0%**	100.0%	99.0%	99.0%	99.9%
Dollar Accuracy	**99.0%**	99.0%	99.0%	99.0%	99.4%
Procedural Accuracy	**97.0%**	99.0%	99.0%	99.0%	99.3%

Met the goal.

Within 5 percentage points of the goal.

Did not meet the goal.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Outcomes Analysis

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

Utilization Rates

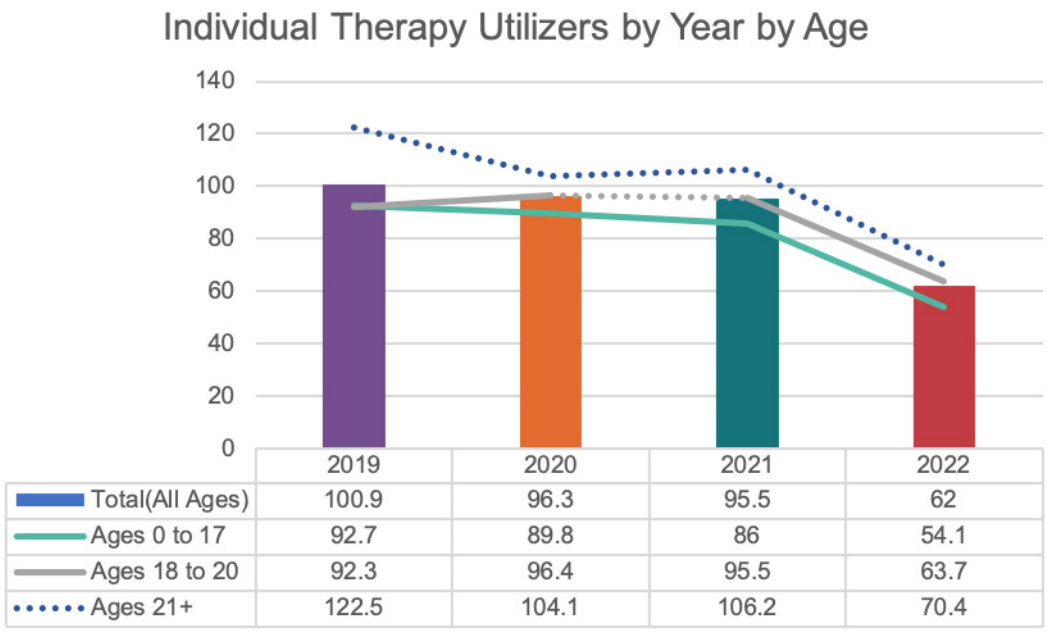
Methodology – Utilization rates are based on claims data. Reliable data requires waiting the 90-day allowable period for providers to file claims. The rate of utilization is calculated with the numerator being the number of unique utilizers of service visits. and thedenominator being the total number of IBHP members, in thousands.

Analysis – Overall, all areas either had a slight decrease or remained consistent.

Barriers – No identified barriers.

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 1

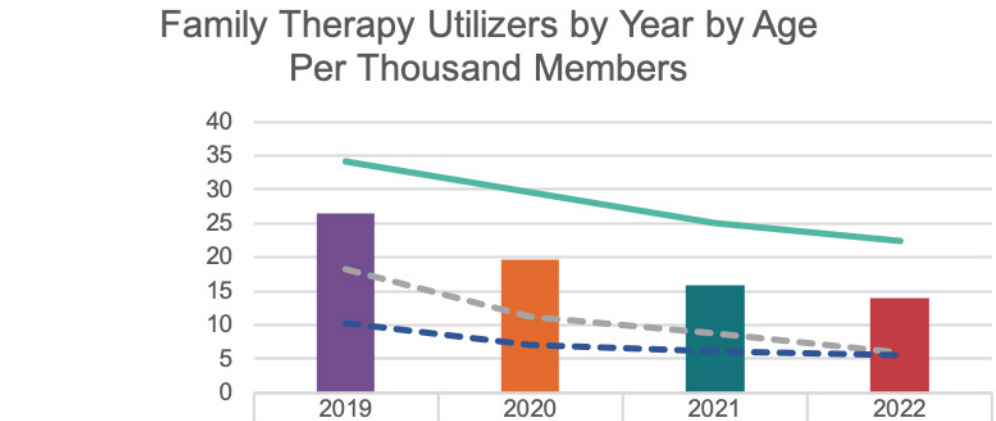


	2019	2020	2021	2022
Total(All Ages)	100.9	96.3	95.5	62
Ages 0 to 17	92.7	89.8	86	54.1
Ages 18 to 20	92.3	96.4	95.5	63.7
Ages 21+	122.5	104.1	106.2	70.4

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Family Therapy

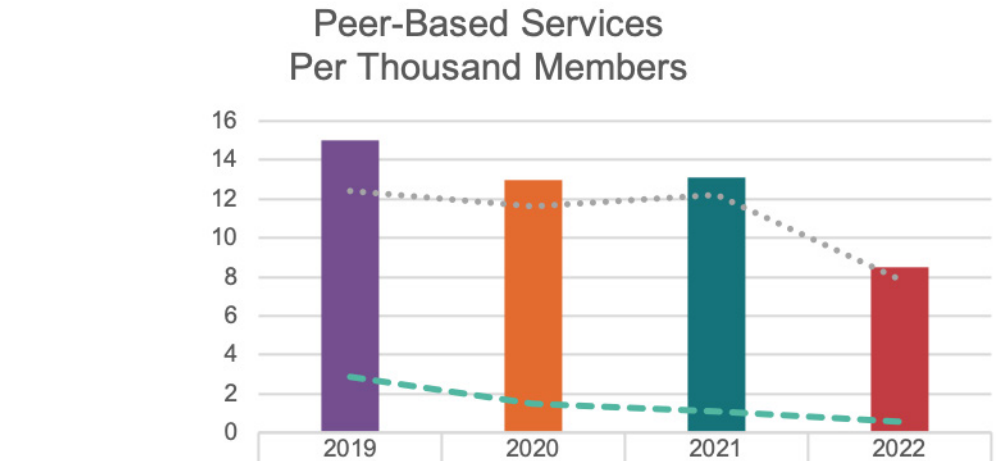
Figure 2



	2019	2020	2021	2022
Total(All Ages)	26.5	19.6	15.9	13.9
Ages 0 to 17	34.2	29.6	25.1	22.4
Ages 18 to 20	18.3	11.2	8.8	6
Ages +21	10.3	7	6.2	5.6

Peer-Based Services

Figure 3

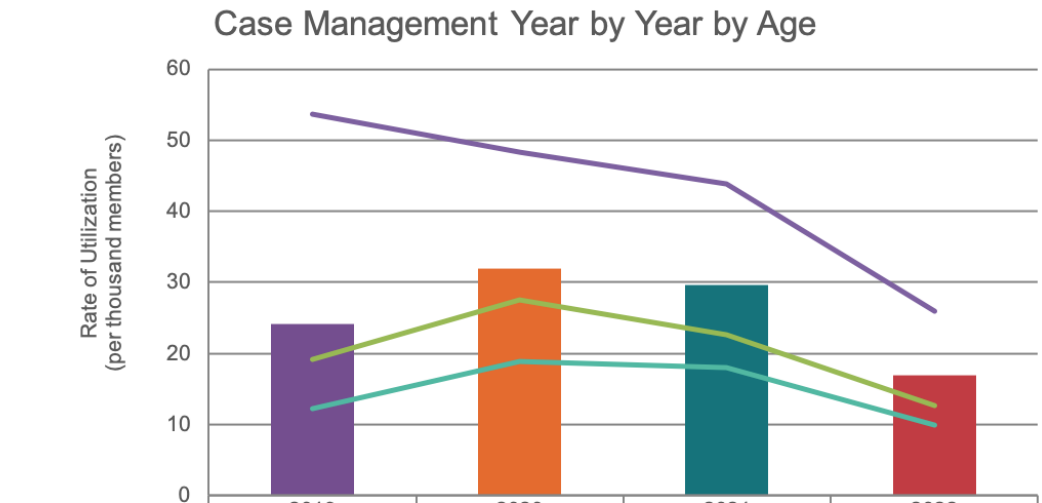


	2019	2020	2021	2022
Total Utilization	15	13	13.1	8.5
Family Support	2.9	1.5	1.1	0.6
Peer Support	12.4	11.6	12.2	7.9

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Case Management

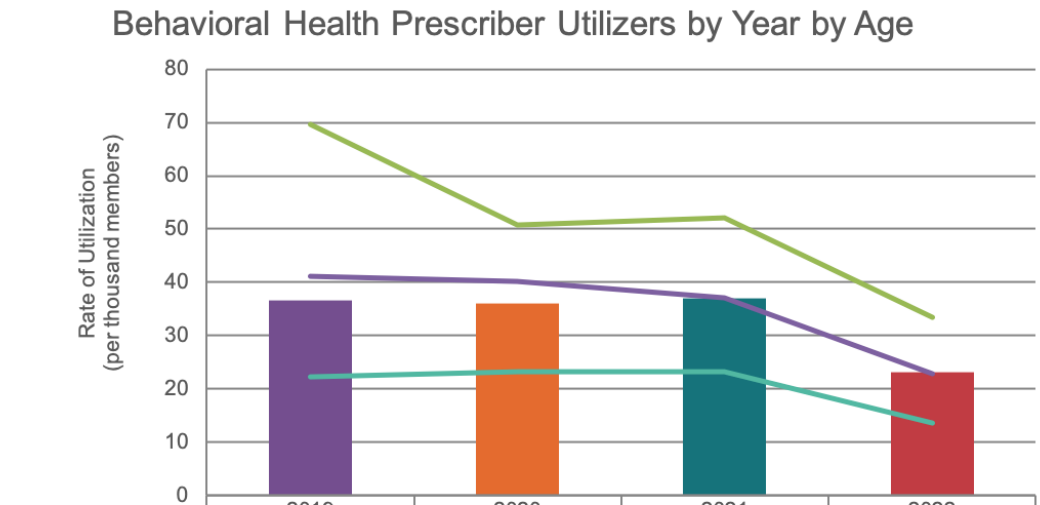
Figure 4



	2019	2020	2021	2022
Total (All Ages)	24.2	31.9	29.7	16.9
Ages 0 to 17	12.3	18.9	18	10
Ages 18 to 20	19.2	27.6	22.6	12.7
Ages 21+	53.6	48.3	43.9	25.9

Prescriber Visits

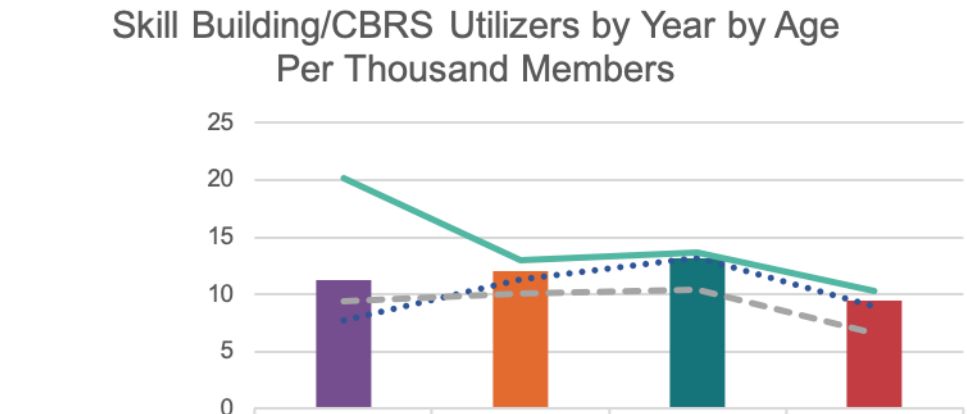
Figure 5



	2019	2020	2021	2022
Total (All Ages)	36.6	36	37	23.2
Ages 0 to 17	22.3	23.2	23.2	13.7
Ages 18 to 20	69.7	50.8	52.2	33.5
Ages 21+	41.2	40.1	37.2	22.8

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

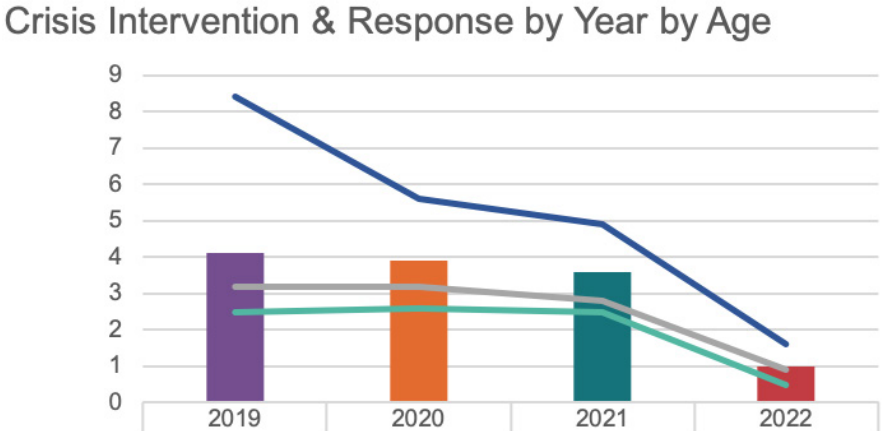
Figure 6



	2019	2020	2021	2022
Total(All Ages)	11.3	12	13.2	9.4
Ages 0 to 17	7.7	11.3	13.2	8.9
Ages 18 to 20	9.4	10.1	10.4	6.6
Ages 21+	20.2	13	13.7	10.3

Crisis Intervention & Response by Year by Age

Figure 7



	2019	2020	2021	2022
Total(All Ages)	4.1	3.9	3.6	1
Ages 0 to 17	2.5	2.6	2.5	0.5
Ages 18 to 20	3.2	3.2	2.8	0.9
Ages 21+	8.4	5.6	4.9	1.6

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 account for an increase in IBHP members over this time frame, the data has been standardized by displaying the numbers per thousand members.

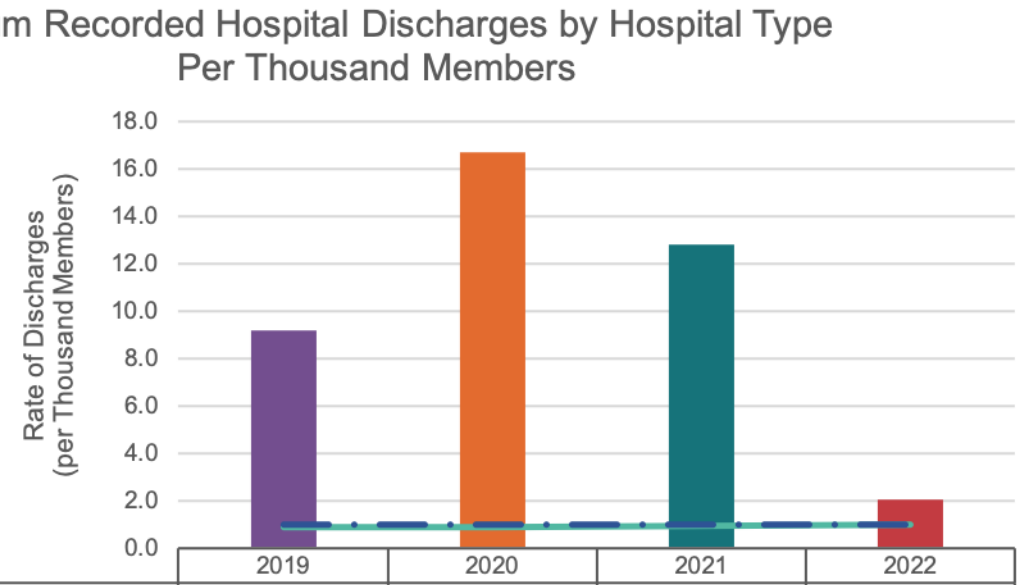
Analysis – A well-performing outpatient behavioral health system is generally expected to provide members with appropriate services in the least restrictive setting. The following data tracks the actual rates of psychiatric hospitalization, as a type of outcome measure for the plan's performance as a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

Barriers – Hospital discharge planners are responsible for arranging post-discharge outpatient appointments for behavioral health services Optum Idaho has an outpatient-only contract and, as a result, hospitals and their staff responsible for discharge planning fall outside of Optum's management. However, Optum Idaho relies on member discharge notification from the hospitals, even though they are not obligated to provide this information. Upon notification of a discharge, the Optum Idaho wellness coordinators attempt to verify that appointments are scheduled and attended.

Opportunities and Interventions – Optum Idaho continues to establish and build relationships with the hospitals to better serve members and will continue to monitor.

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

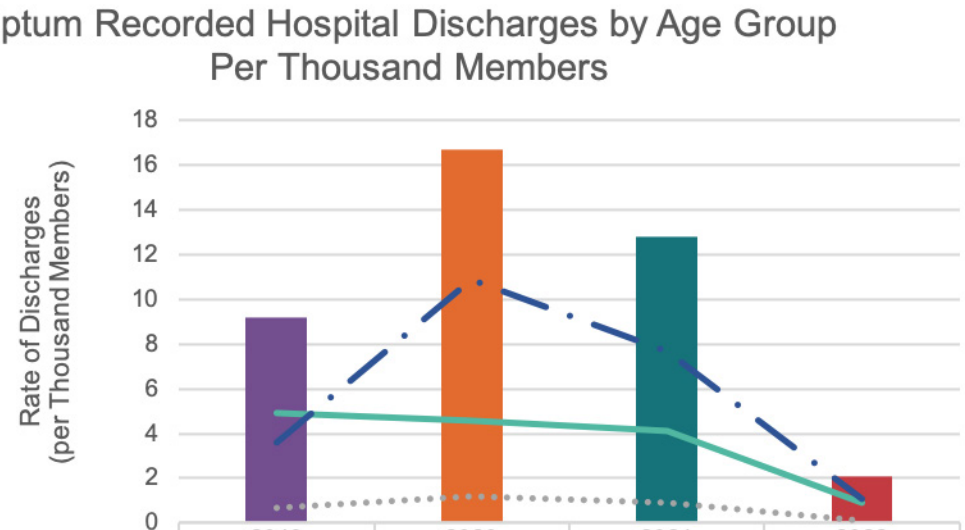
Figure 8



	2019	2020	2021	2022
Discharge Rate (Per Thousand Member)	9.2	16.7	12.8	2.1
State Hospital	0.8	1	0.3	0
Community Hospital	8.4	15.7	12.5	2.1

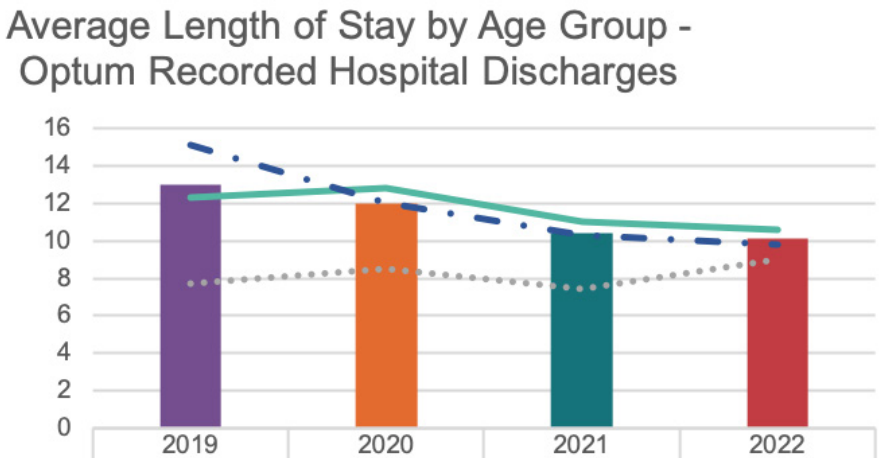
CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 9



	2019	2020	2021	2022
Discharge Rate (per Thousand Members)	9.2	16.7	12.8	2.1
Ages 0 to 17	4.9	4.6	4.1	0.9
Ages 18 to 20	0.7	1.2	0.9	0.1
Ages 21+	3.6	10.9	7.7	1.1

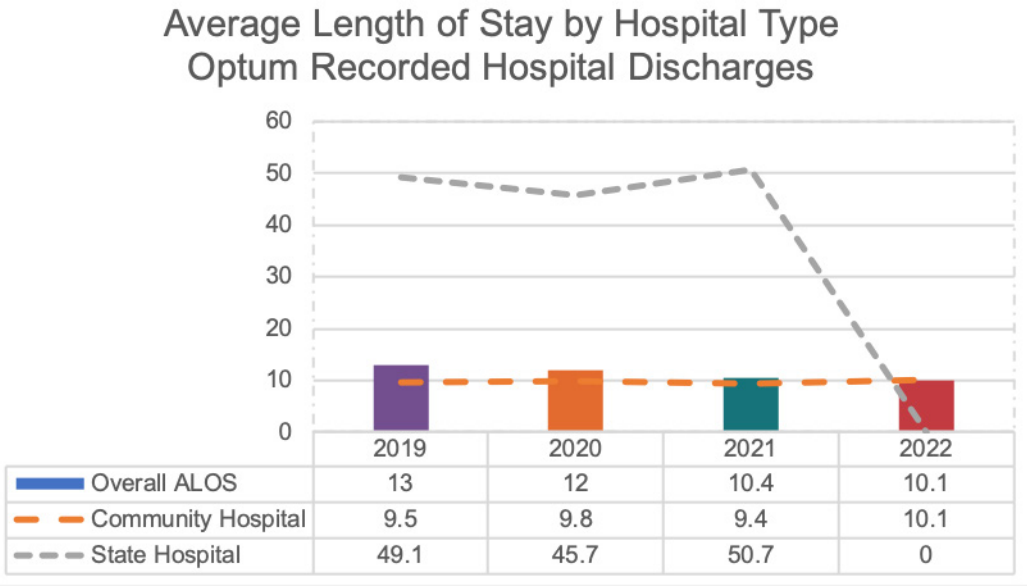
Figure 10 indicates that the average length of stay by age decreased overall.



	2019	2020	2021	2022
Overall ALOS	13	12	10.4	10.1
Ages 0 to 17	12.3	12.8	11	10.6
Ages 18 to 20	7.7	8.5	7.4	9
Ages 21+	15.1	12	10.3	9.8

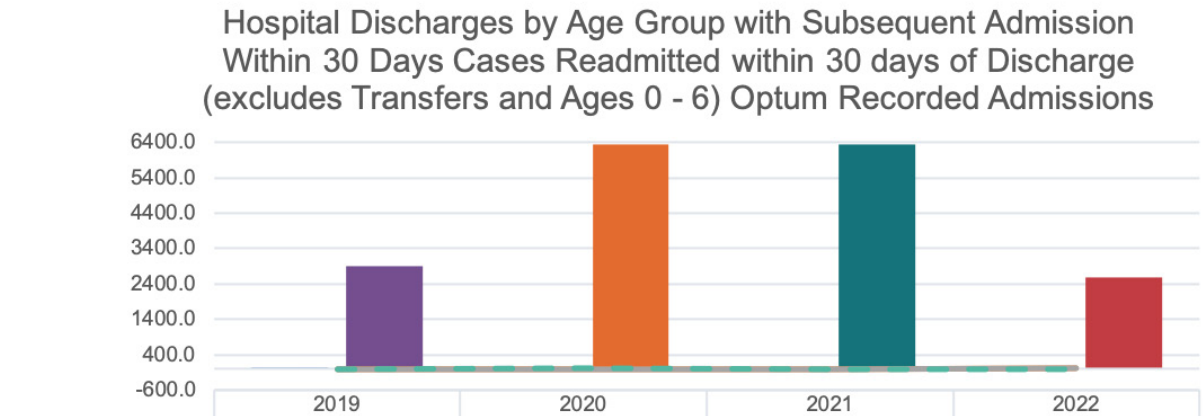
CLICK HERE TO RETURN TO TABLE OF CONTENTS

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



	2019	2020	2021	2022
Overall ALOS	13	12	10.4	10.1
Community Hospital	9.5	9.8	9.4	10.1
State Hospital	49.1	45.7	50.7	0

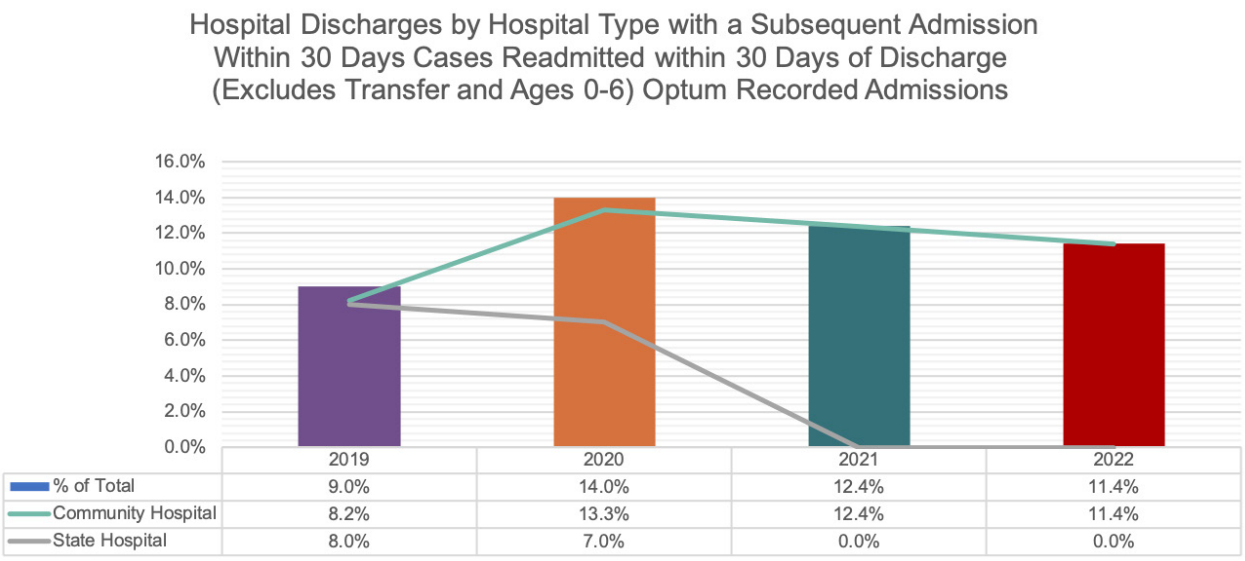
Figure 12 shows the readmission percentages by age group. According to the Healthcare Effectiveness Data and Information Set's (HEDIS) definition, a readmission to a hospital occurs within 30 days of discharge and is counted for all people ages six years and over, excluding transfers between hospitals. Overall, total readmissions within 30 days of discharge decreased in 2022.



	2019	2020	2021	2022
% OF Total	9.0	14.0	12.4	10.10
# Discharges	2,907	6,356	6,357	2601
Ages 7 to 17	3.8	3.2	0.0	11.40
Ages 18 to 20	0.8	0.8	0.0	11.40
Ages 21+	4.6	10.0	0.1	0.0

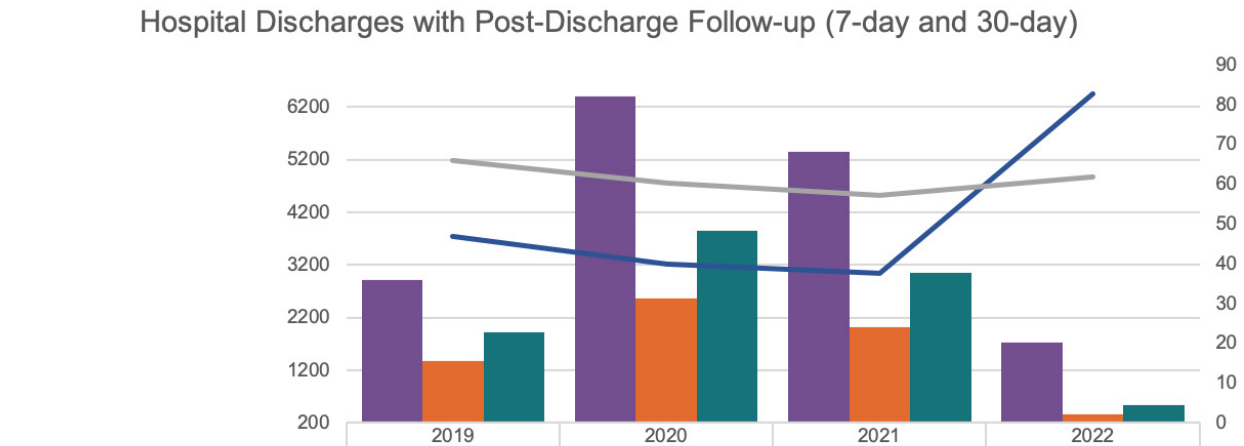
CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 13 shows readmissions percentages by hospital type decreased.



	2019	2020	2021	2022
% of Total	9.0%	14.0%	12.4%	11.4%
Community Hospital	8.2%	13.3%	12.4%	11.4%
State Hospital	8.0%	7.0%	0.0%	0.0%

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



	2019	2020	2021	2022
Number of DC Cases	2924	6391	5351	1734
DC Cases with Visit w/in 7 Days	1374	2555	2011	357
DC Cases with Visit w/in 30 Days	1930	3850	3055	535
% 7 Day Follow-up	47	40	37.6	82.6
% 30 Day Follow-up	66	60.2	57.1	61.8

CLICK HERE TO RETURN TO TABLE OF CONTENTS

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

Opportunities and Interventions – Optum Idaho will continue to monitor.

Algorithms for Effective Reporting and Treatment (ALERT)

Optum's proprietary Algorithms for Effective Reporting and Treatment (ALERT®) outpatient management program quantifiably measures the effectiveness of services provided to individual patients. The purpose is 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.

Methodology – The Idaho Standardized Assessment is a key component of the Idaho ALERT program. Providers are required to ask members to complete the Wellness Assessment at the initiation of treatment and to monitor treatment progress whenever the provider requests authorization to continue treatment. This information is captured in the ALERT Online dashboard, When engaging in population health, an important part of the assessment is to monitor the severity of symptoms and functional problems among those being treated, and whether the symptoms are improving or worsening.

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

Analysis – Average Global Distress Scores for adults and youth (Figure 15) for initial and follow-up assessments remained consistent. Average Caregiver Strain Scores (Figure 16) measured within moderate levels during the same period.

For the Average Overall Health Score (Figure 17), adults scored on average between fair and good on the initial assessments. On follow-up assessments conducted over the same period, adults scored on average between good and very good. These scores have remained consistent. The scores for children and youth at baseline on the initial assessment consistently averaged very good. On follow-up assessments over the same period, children and youth showed improved scores in the range between very good and excellent, and remained consistent throughout the study period.

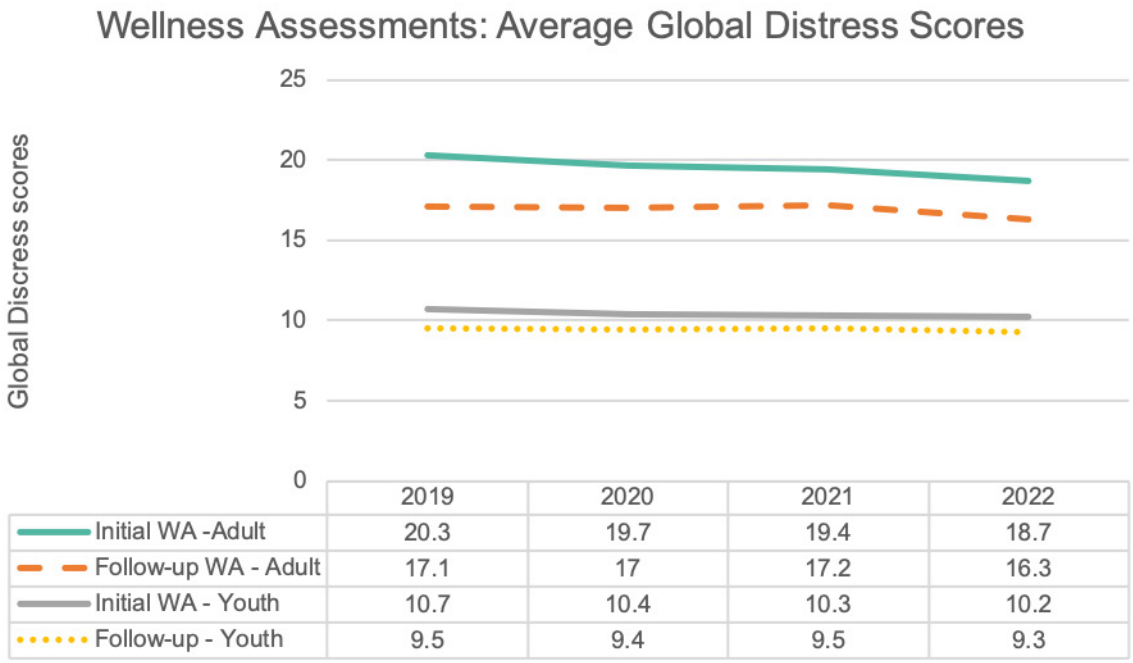
Barriers – No identified barriers.

Opportunities and Interventions – No opportunities for improvement were identified.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

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

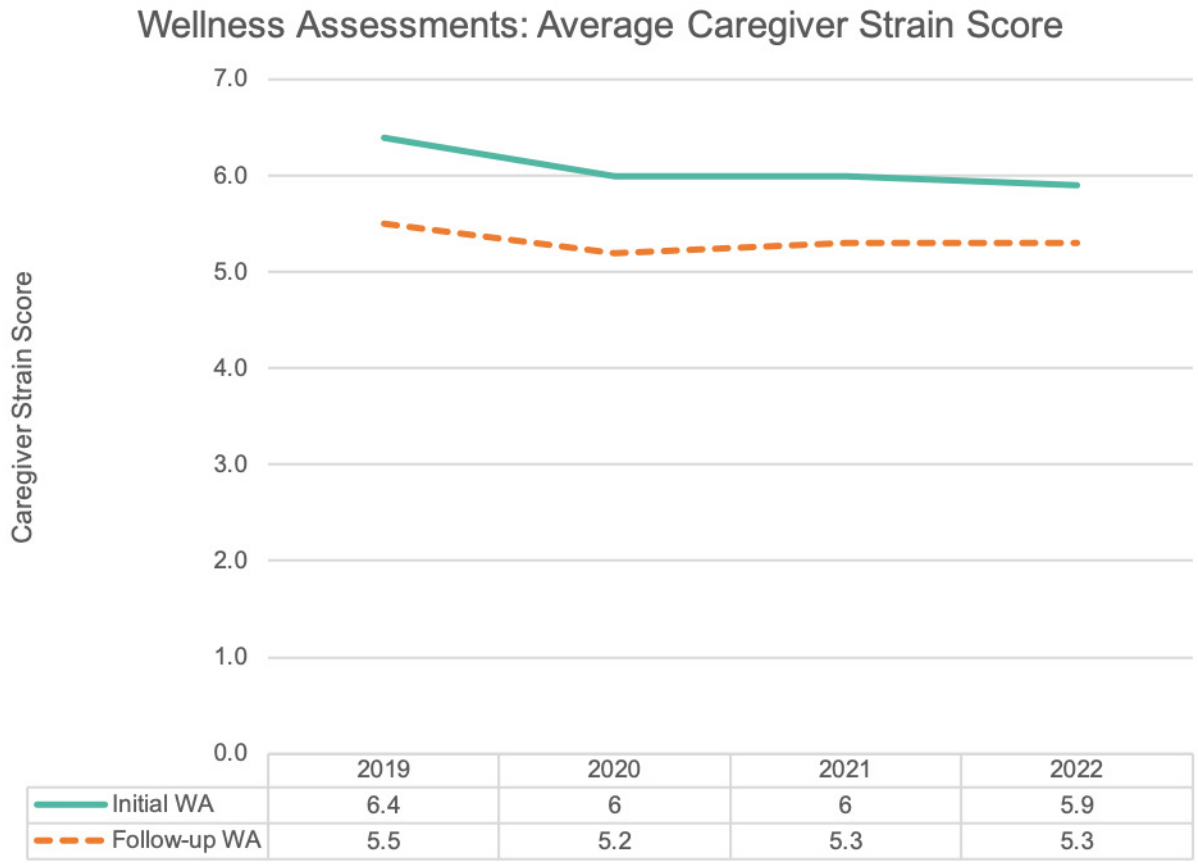
Figure 15



CLICK HERE TO RETURN TO TABLE OF CONTENTS

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

Figure 16



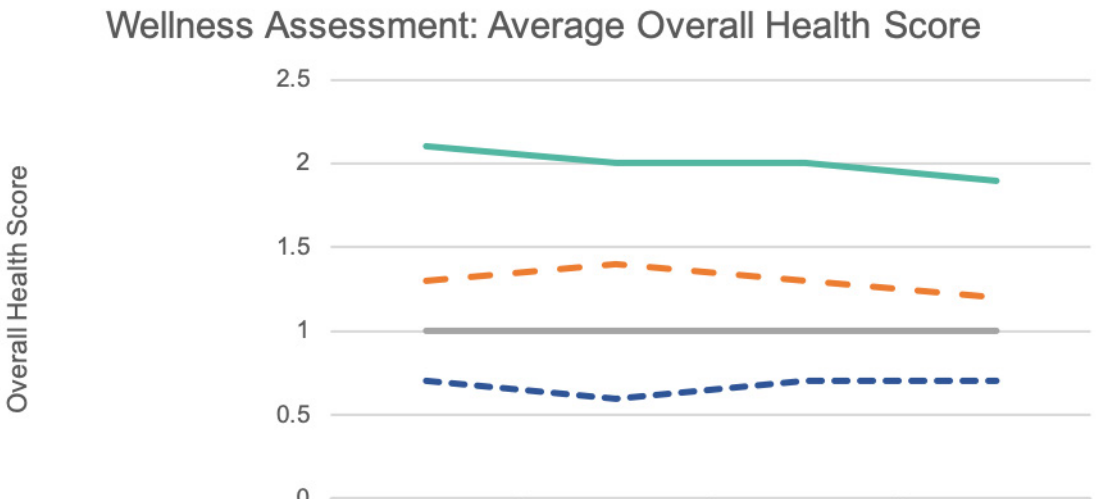
CLICK HERE TO RETURN TO TABLE OF CONTENTS

Average Overall Health Scores

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

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

Figure 17



	2019	2020	2021	2022
Initial WA -Adult	2.1	2	2	1.9
Follow-up WA - Adult	1.3	1.4	1.3	1.2
Initial WA - Youth	1	1	1	1
Follow-up - Youth	0.7	0.6	0.7	0.7

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Member Satisfaction Survey Results

Optum Idaho monitors member satisfaction with its behavioral health services, and surveys IBHP adults 18 years of age and older and parents of children ages 11 years and younger. The survey is administered through a live telephone interview with translation services available to members upon request. Due to various privacy regulations, members between the ages of 12 and 17 are not surveyed.

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

Analysis – Member satisfaction performance goals were met in 2022 for all survey domains.

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

Opportunities and Interventions – No opportunities for improvement were identified.

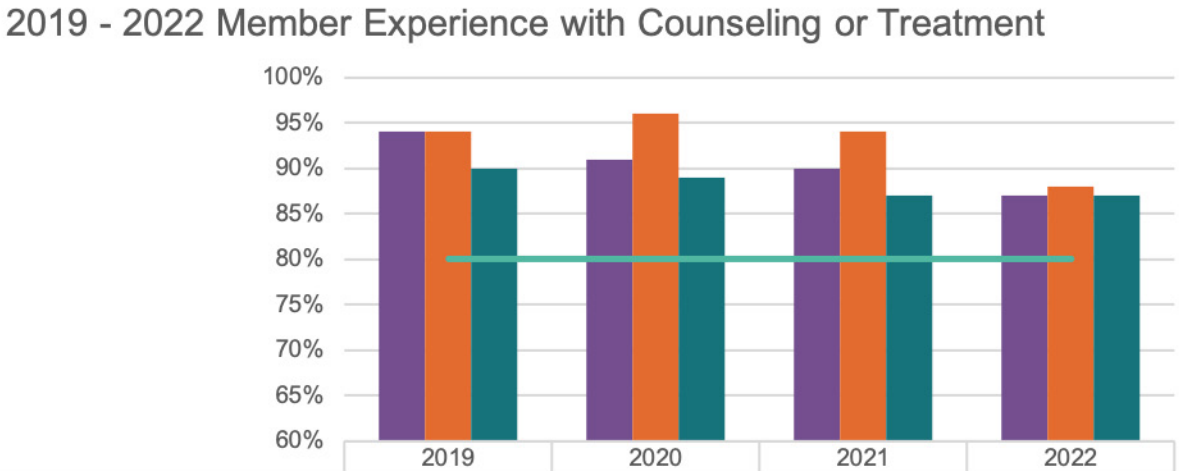
Member Satisfaction Survey	Performance Goal	2019	2020	2021	2022
2019 – 2022 Overall Performance Results					
Overall Satisfaction (Goal: ≥85.0%)	≥85%	94%	90%	90%	94%
Optum Support for Obtaining Referrals or Authorizations	≥85%	94%	91%	90%	90%
Accessibility, Availability, and Acceptability of the Clinician Network	≥85%	93%	93%	90%	89%
Counseling and Treatment	≥85%	95%	94%	93%	93%

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 18

	2019	2020	2021	2022
Optum Support for Obtaining Referrals or Authorizations	94%	91%	90%	90%
Counseling and Treatment	95%	94%	93%	87%
Accessibility, Availability, and Acceptability of the Clinician Network	93%	93%	90%	91%
Overall Satisfaction	94%	90%	91%	93%
Goal	80%	80%	80%	80%

Figure 19



	2019	2020	2021	2022
Satisfied With The Time It took to get an appointment	94%	91%	90%	87%
Ability to Find Care That was Respectful of my Language, Culture and Ethnic Needs	94%	96%	94%	88%
Satisfaction with Experience of Finding an Available Clinician	90%	89%	87%	87%
Goal	80%	80%	80%	80%

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Satisfaction

The goal of obtaining provider satisfaction information is to improve the provider's experiences with, and suggestions for, Optum Idaho. That information is utilized to improve the provider's experience.

Provider Relations Advocates (PRA's) are regularly engaged in recruiting and information gathering efforts with providers. These include one-on-one conversations with providers focused on getting to root causes around some barriers in provider capacity and administrative burdens, which Optum and the State have been asked to address. For 2022, the Provider Relations team and members of ELT consolidated this feedback and worked closely with IDHW on answers and remedies. The summary of findings and potential solutions will be presented to ELT and QAPI at a date to be determined.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Performance Improvement Projects

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

Care Coordination Performance Improvement Project (PIP)

The purpose of the Optum Idaho's Care Coordination PIP was to assist with coordination of care transitions and improve member and family engagement in alignment with the national quality standards defined by the Agency for Healthcare Research and Quality (AHRQ) and the National Committee for Quality Assurance (NCQA).

During phase 1, an algorithm was created that categorized high-risk members using the following data points: utilization, crisis/emergent, complexity, social determinants, and interactions unique to all members in the IBHP. The algorithm automatically referred high-risk members into the Care Coordination Program, which allowed Optum Idaho to capture more at-risk members versus relying on referrals alone. The implementation algorithm resulted in the identification of additional high-risk members, which also correlated to an increase in daily average Field Care Coordination (FCC) referrals from 2019 to 2020 suggesting that the implementation of the high-risk algorithm had a statistically significant impact on the number of FCC referrals. In 2021, Optum Idaho identified additional opportunities for a second phase of this PIP that included:

1. Development of a clinical portal to improve clinical operations, documentation, and activities for more effective data collection and analysis.
2. Identification of member segmentation opportunities that would allow for improved care coordination outreach to specific sub-populations.
3. Use of data to monitor and evaluate outcomes of the Care Coordination Program to predict rehospitalization, service utilization and appropriate services based on member acuity.
4. Increase member utilization in the FCC Program.

In 2022, the Care Coordination PIP workgroup decided to focus the PIP on increasing member utilization of the FCC program. Optum Idaho measured outcomes to determine if increased referrals to the FCC Program would increase member engagement in outpatient services, while decreasing re-admission to inpatient services. The first intervention was the creation of an educational presentation shared with providers on the FCC referral process. The second intervention was the publication of the "Express Access Provider List" which included providers that had committed to scheduling appointments within five business days. Opportunities to identify and implement additional interventions will continue as this PIP moves forward into the next measurement year.

1915(i) Performance Improvement Project (PIP)

The purpose of the 1915(I) PIP was to determine if implementing communication and education efforts to Youth Empowerment Services (YES) Program participants, families, and providers, while increasing Targeted Care Coordinator (TCC) workforce development efforts to increase the percentage of individuals completing their initial or renewal Person Centered Service Plans (PCSPs), year-over-year to the target of 86%, thereby, maintaining member eligibility and engagement in community-based services. The PIP was initiated in late 2021 at the request of IDHW.

Four interventions were identified, developed and implemented.

In 2022 Optum Idaho focused on increasing individuals completing their PCSP prior to their expiration date and increasing the number of providers who were able to complete the PCSP.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Accessibility & Availability

Idaho Behavioral Health Plan Membership

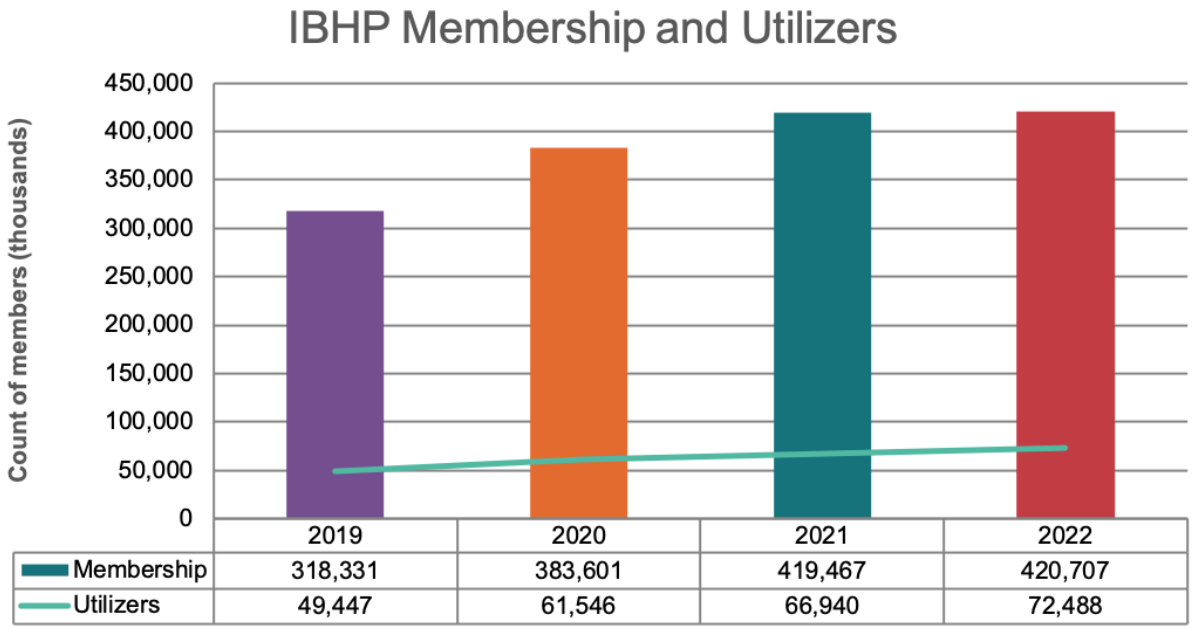
Methodology – The IDHW sends IBHP membership data to Optum Idaho monthly. "Membership" refers to IBHP members with the Medicaid benefit. "Utilizers" refers to the number of Medicaid members who use IBHP services.

Analysis – During 2022 membership and utilizer numbers increased.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 20



	2019	2020	2021	2022
Membership	318,331	383,601	419,467	420,707
Utilizers	49,447	61,546	66,940	72,488

Member Services Call Standards

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

Analysis – The Member Services and Crisis Line received a total of 6,209 calls during 2022, and Optum Idaho exceeded all established performance call standards. Even with increased recruitment efforts, the vendor reported to Optum Idaho that staff retention and increased demand on their services from other clients continued to be a challenge in 2022, citing the impact of COVID-19. Optum Idaho clinical and customer service teams collaborated with the vendor and identified that Optum Idaho could support the vendor by transferring select calls to Optum Idaho staff. Optum Idaho also scheduled increased solution-focused sessions with the vendor to monitor progress and adjust interventions accordingly. The efforts were successful overall, as evidenced by meeting the performance measures related to member services calls.

Barriers – Based on the above analysis, the vendor continues to experience a reduction in staff due to COVID-19.

Opportunities and Interventions – Ongoing monitoring efforts with the vendor continue to ensure that members are receiving excellent customer service.

Figure 21

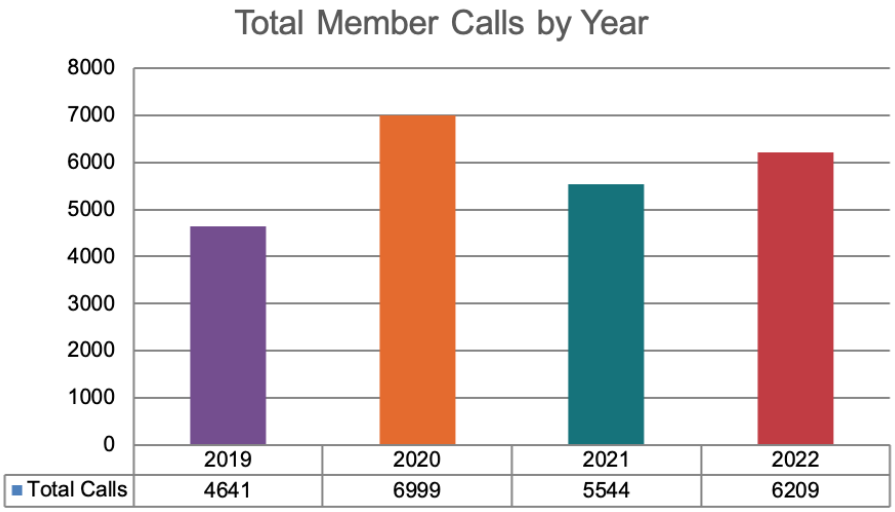


Figure 22

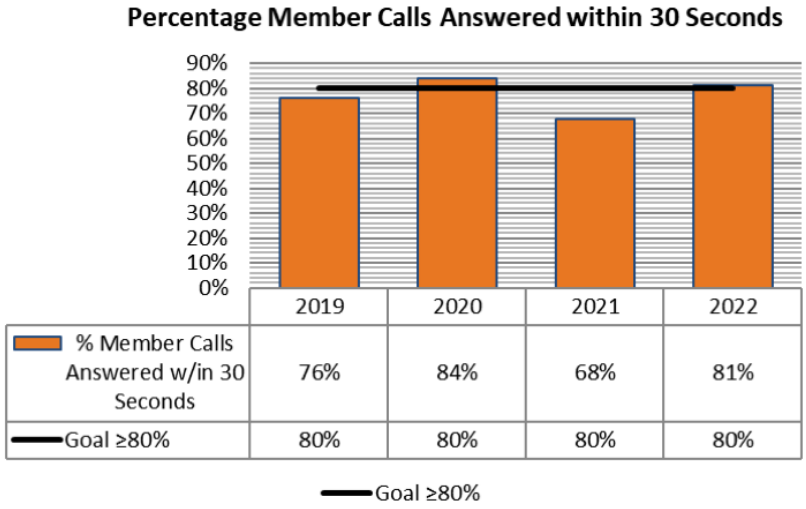
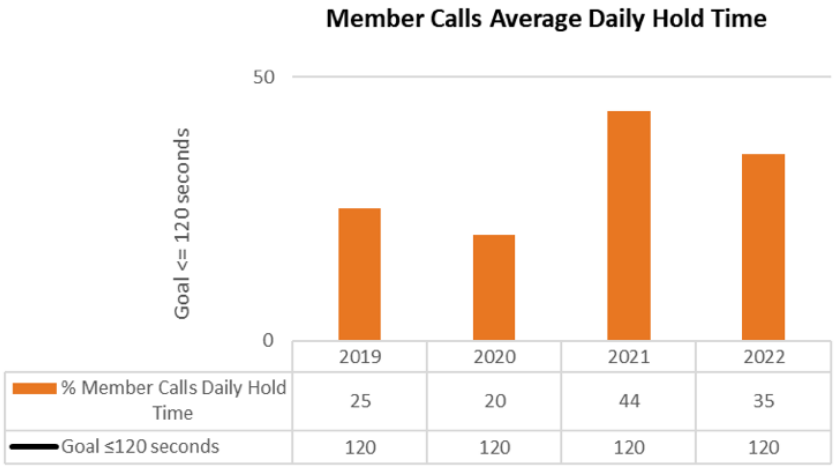
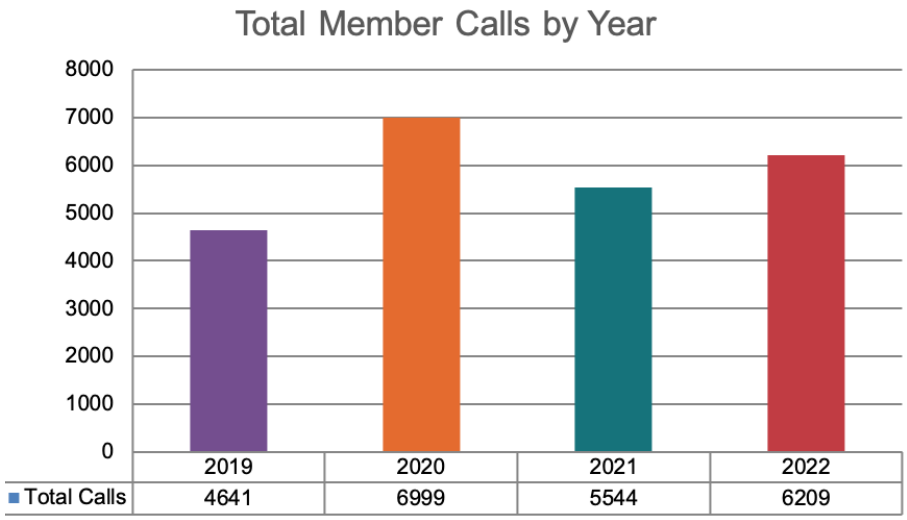


Figure 23



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 24



Customer Service (Provider Calls) Standards

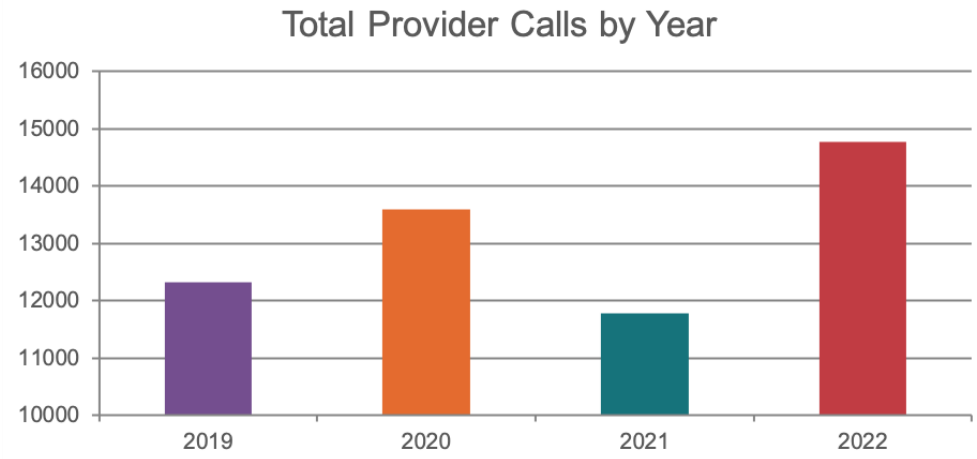
Methodology – Optum Idaho is contractually obligated to track the percent of provider calls answered within 30 seconds, daily average hold time and call abandonment rate. The Customer Service Line is primarily used by providers, the IDHW personnel and any other stakeholders to contact Optum Idaho to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

Analysis – The Customer Service Line received 14,775 calls during 2022 and Optum Idaho exceeded all established performance call standards.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 25



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 26

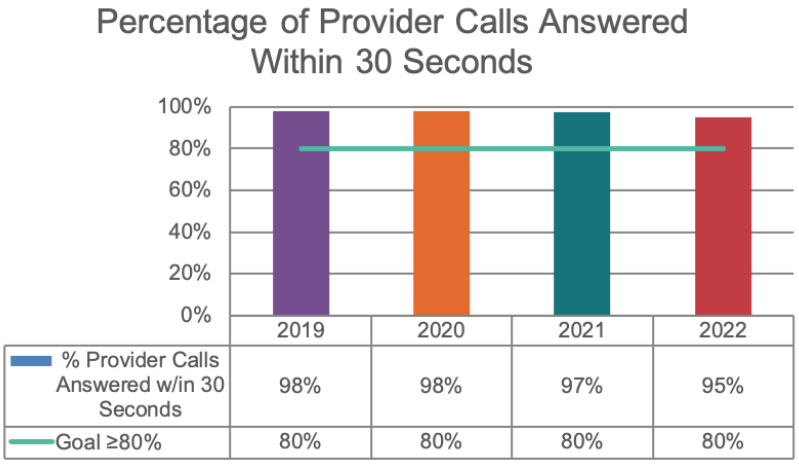


Figure 27

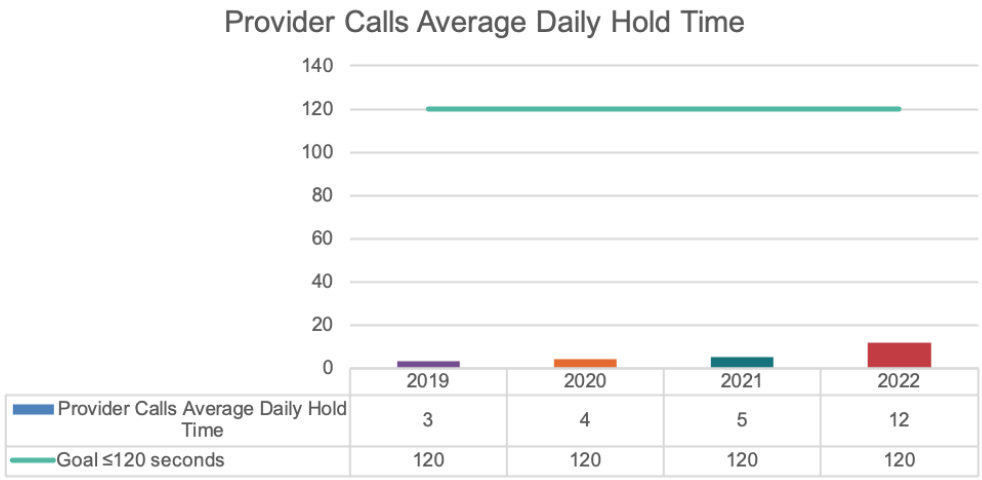
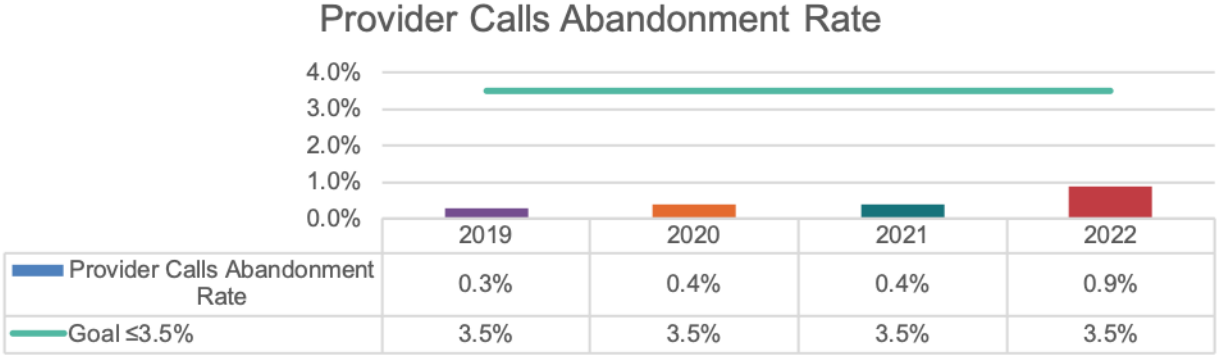


Figure 28



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Urgent, Non-Urgent, and Critical Appointment Access Standards

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

Analysis – Optum Idaho again exceeded the performance goal for Urgent Appointment wait times during 2022, with an average of 9.7 hours (goal within 48 hours). The overall performance goal for Non-Urgent Appointment wait times was also met with an average of 3.2 days (goal within 10 days). Optum Idaho initially began tracking data for Critical Appointment wait times in July 2017. Critical Appointment wait times met the goal of being offered within six hours in 2022, with an average of two hours (goal within six hours).

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 29

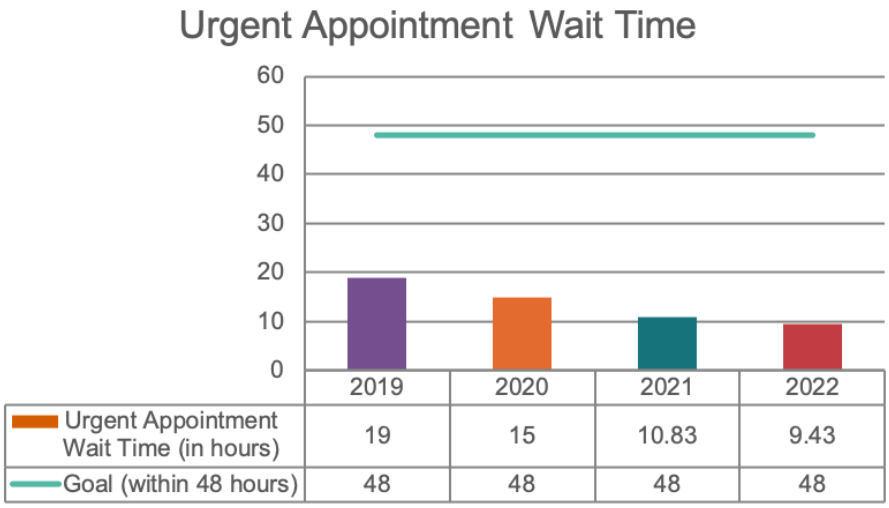
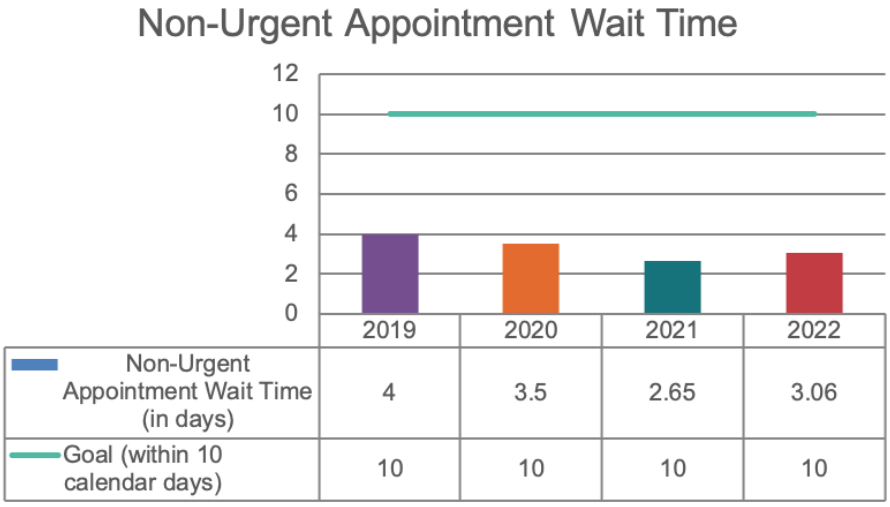
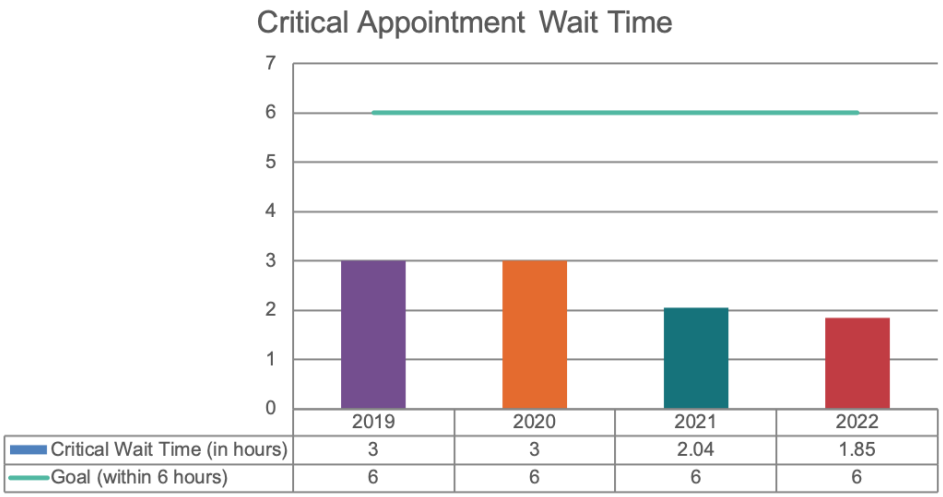


Figure 30



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 31



Geographic Availability of Providers

Methodology – Optum Idaho's software enables the accessibility of health care networks to be accurately measured based on the geographic locations of health care providers relative to the locations of the members being served. On a quarterly basis, Optum Idaho uses the software to calculate estimated driving distance based on zip codes of unique members and network providers.

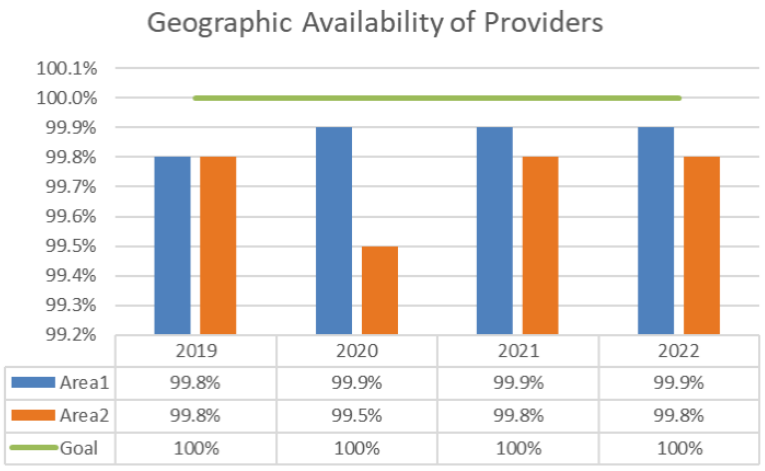
Optum Idaho's contract availability standards for Area 1 requires one provider within 30 miles of Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville Counties. For the remaining 41 counties in Area 2 (37 remaining within the state of Idaho and four neighboring state counties), Optum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

Analysis – During 2022, Optum Idaho continued to meet contract provider availability standards. Area 1 availability standards were met at 99.9 percent, and Area 2 availability standards were met at 99.7 percent. Performance is viewed as meeting the goal due to established rounding methodology which is rounding to the nearest whole number.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 32



Member Protections and Safety

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

Notification of Adverse Benefit Determination (ABD)

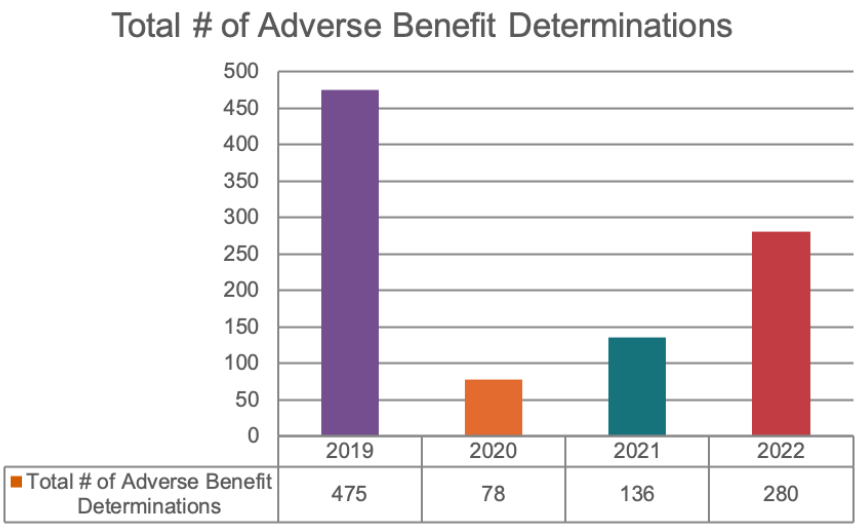
Methodology – An Adverse Benefit Determination (ABD) is defined as the denial or limited authorization of a requested service. When a request for services is received, Optum Idaho has 14 calendar days to review the case based on clinical or administrative guidelines, make a determination to authorize or deny services in total or in part, and mail the ABD notification letter.

Analysis – There were 280 ABDs made in 2022. The goal of 100 percent for written notification sent within 14 calendar days from the date of request was nearly met at 98.8 percent.

Barriers – There was an error discovered while transferring service requests to the national team who processes certain types of ABDs.

Opportunities and Interventions – The Optum Idaho quality team met with the national team to identify best practices. The team also created and began utilizing a notice of extension letter to the member if the determination would not be made within the contractual turnaround time.

Figure 33



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Member Appeals

Methodology – Optum Idaho recognizes the right of a member or authorized representative to appeal an ABD that resulted in member financial liability or denied services. All non-urgent appeals are required to be reviewed and resolved within 30 calendar days. Urgent appeals are required to be reviewed and resolved within 72 hours.

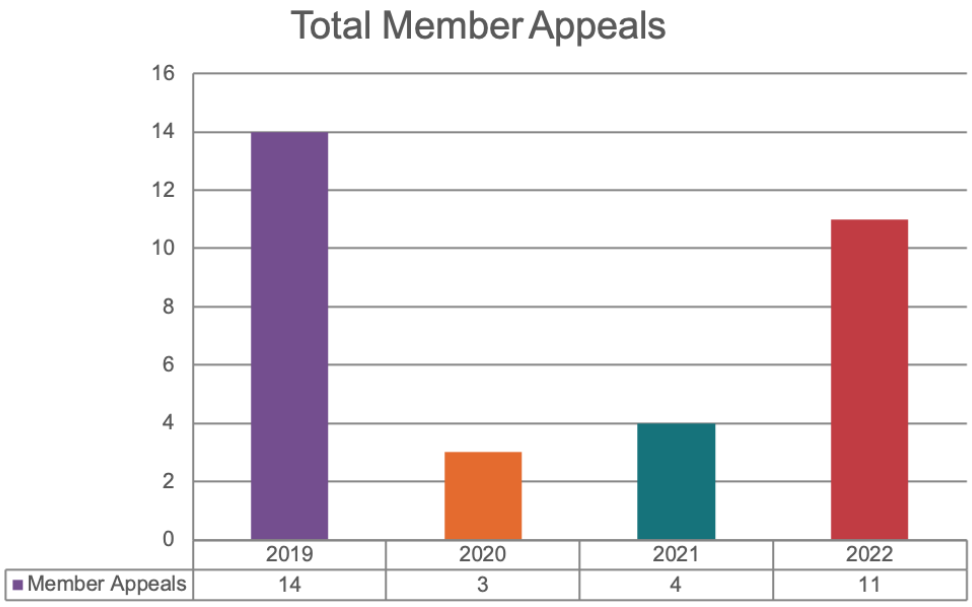
Additionally, all non-urgent appeals are required to be acknowledged in writing within five calendar days from receipt of the appeal request. All appeals are upheld, overturned, or partially overturned.

Analysis – During 2022, there were 11 Member Appeals. The performance goals for acknowledgment and determination of member appeals is 100 percent, and in 2022 Optum Idaho did not meet its goal for acknowledgment (87 percent) or determination (93 percent).

Barriers – There was an error discovered while transferring member appeals to the national team who has staff that peer review certain types of member appeals.

Opportunities and Interventions – The Optum Idaho quality team met with the national team to identify best practices. The team also created and began utilizing a notice of extension letter to the member if the determination would not be made within the contractual turnaround time.

Figure 34



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 35

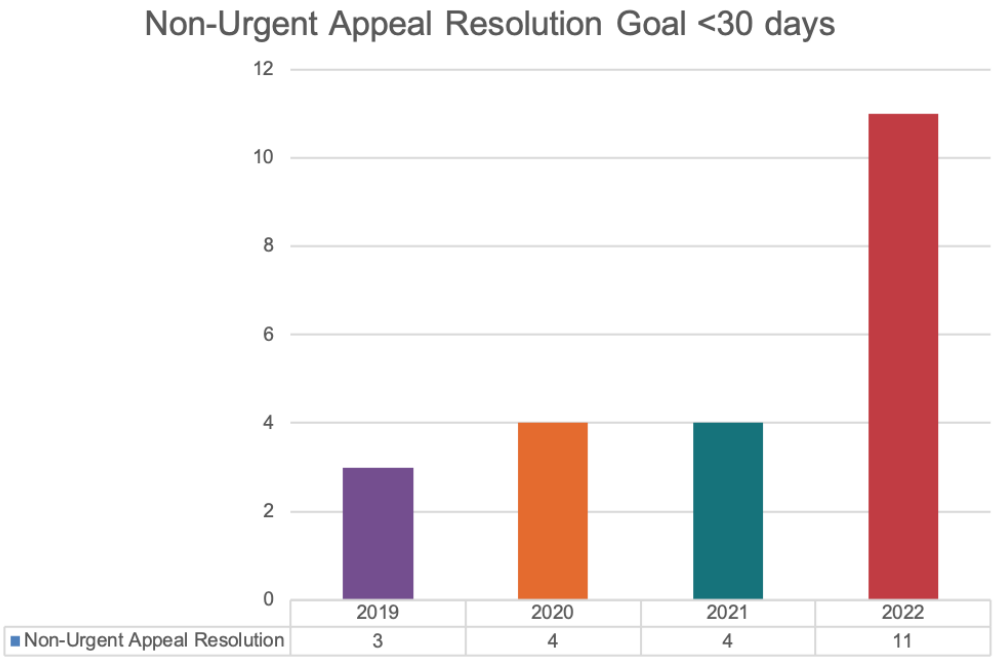
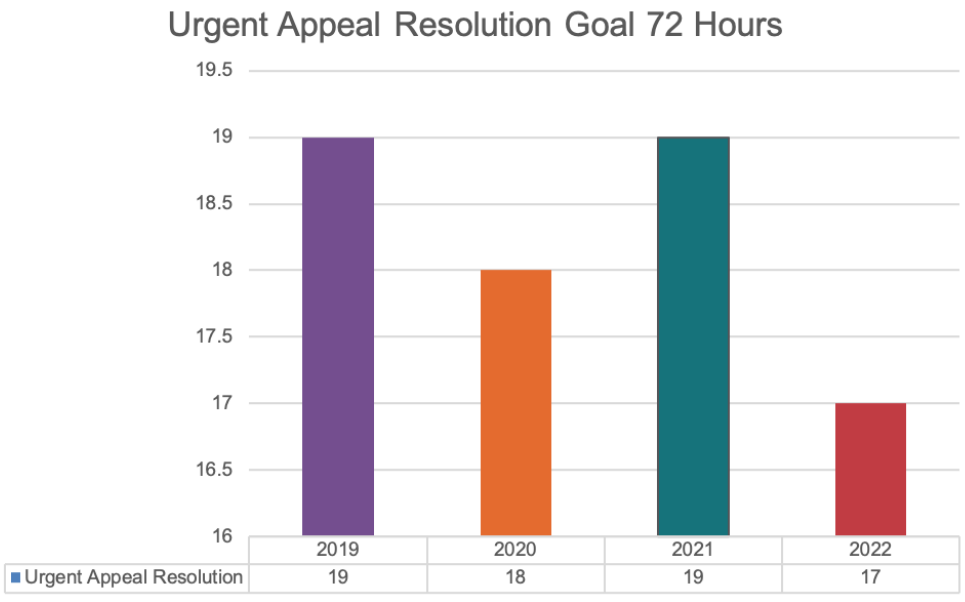


Figure 36



CLICK HERE TO RETURN TO TABLE OF CONTENTS

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: Access, Billing & Financial, Clinical, Service and Quality of Practitioner Office Site.

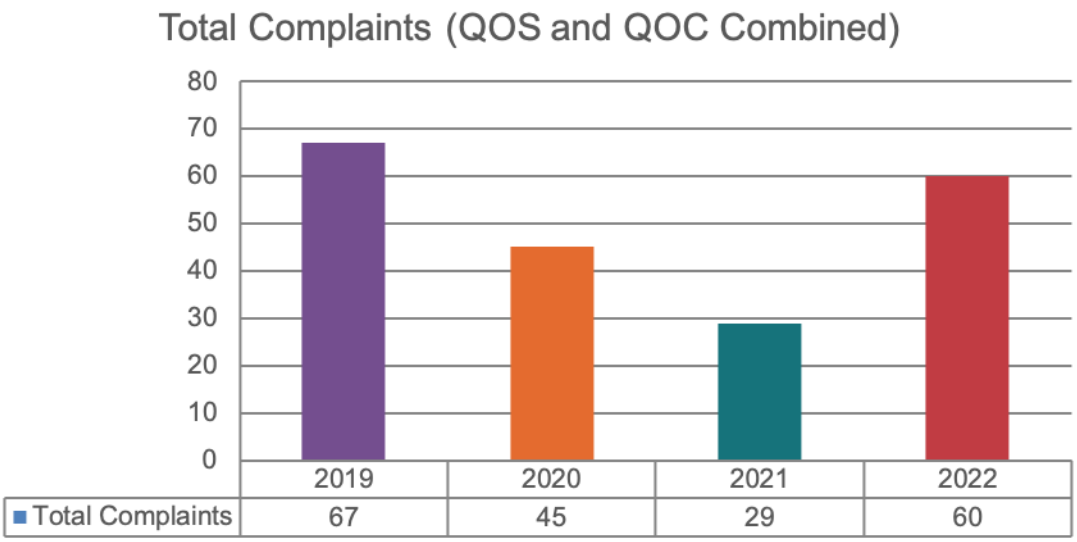
Optum Idaho maintains a process for recording and triaging QOC concerns and QOS complaints to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. Both QOS complaints and QOC concerns are to be acknowledged in writing within 5 business days.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

Analysis – Analysis – There were 60 total complaints received during 2022. Of the total complaints received, 27 were identified as QOS and 33 were identified as QOC. Optum Idaho nearly met resolution compliance for QOS complaints at 97.5 percent and QOC concern's turnaround times were met at 100 percent.

Barriers – There was an identified gap in Optum Idaho staff knowledge surrounding the complaint process and contractual turnaround times.

Opportunities and Interventions – The Optum Idaho quality team created updated trainings on complaints.

Figure 37



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 38

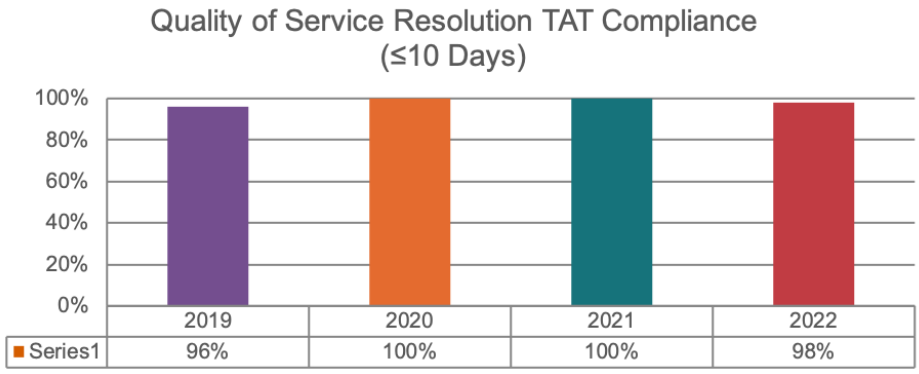


Figure 39

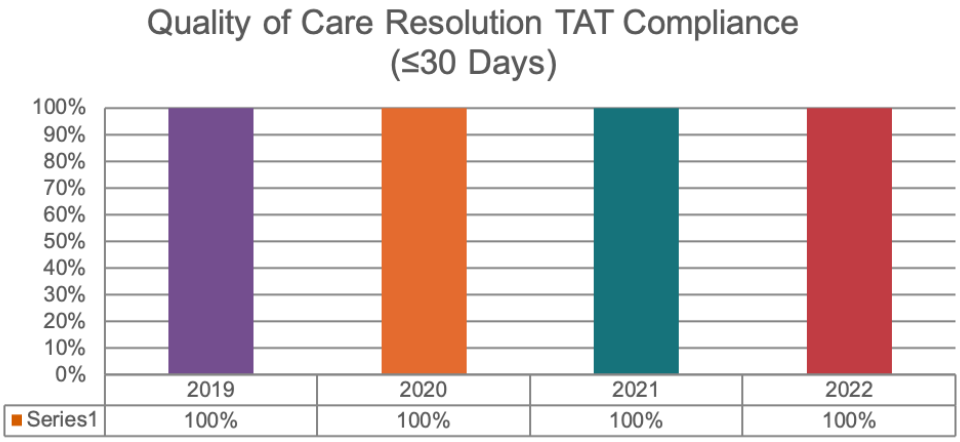
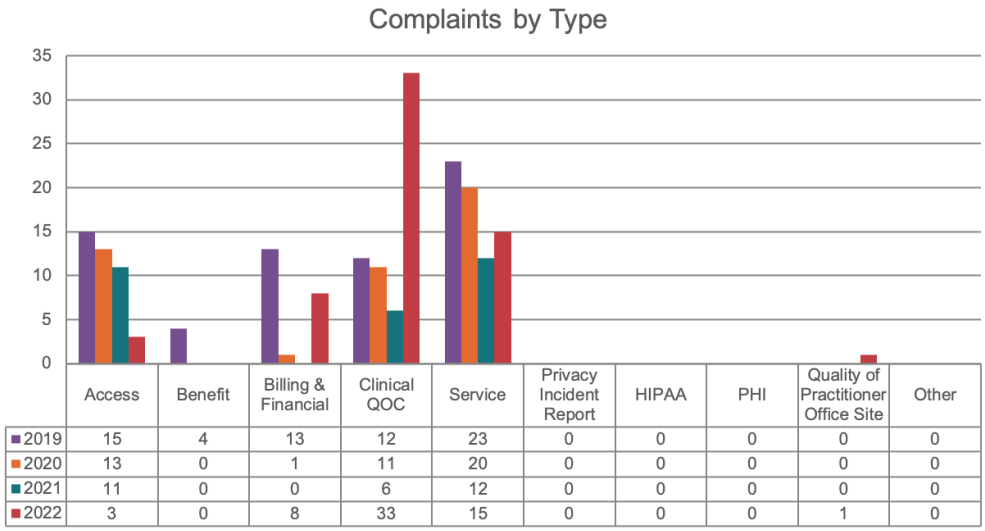


Figure 40



	Access	Benefit	Billing & Financial	Clinical QOC	Service	Privacy Incident Report	HIPAA	PHI	Quality of Practitioner Office Site	Other
2019	15	4	13	12	23	0	0	0	0	0
2020	13	0	1	11	20	0	0	0	0	0
2021	11	0	0	6	12	0	0	0	0	0
2022	3	0	8	33	15	0	0	0	1	0

Critical Incidents

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

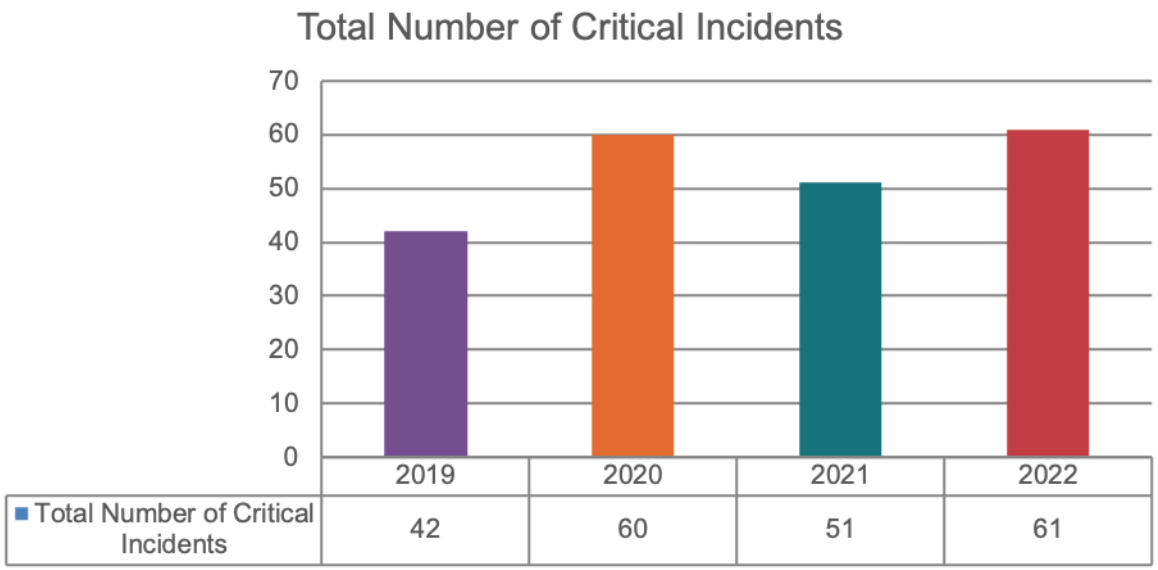
An internal CI Ad-Hoc Committee review is completed within five business days, as per NCQA standards, to identify any QOC concerns that may have led to the incident. If a QOC concern is identified, the matter is taken to Optum Idaho's Peer Review Committee (PRC) to review these CIs. The PRC makes recommendations for improving patient care and safety, including recommendations that the provider performance team conduct site audits and/or record reviews of providers in the Optum Idaho network, as well as out-of-network providers working under an accommodation agreement with Optum Idaho. The PRC may send written feedback to providers related to observations made as a result of the review of the QOC concern.

Analysis – There were 61 CIs reported during 2022. The turnaround time for the Ad-Hoc Committee review within 5 business days from notification of the incident was met at 100 percent. The highest numbers of CIs reported in 2022, 49 percent, were in the category of unexpected deaths. Of all cases reported in 2022, 82 percent of the cases involved adults, ages 18 and over, and 18 percent involved children/adolescents, ages 17 and under. Further analysis showed that the average age for adult males was 39 and adult females was 37 years old.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 41



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Response to Written Inquiries

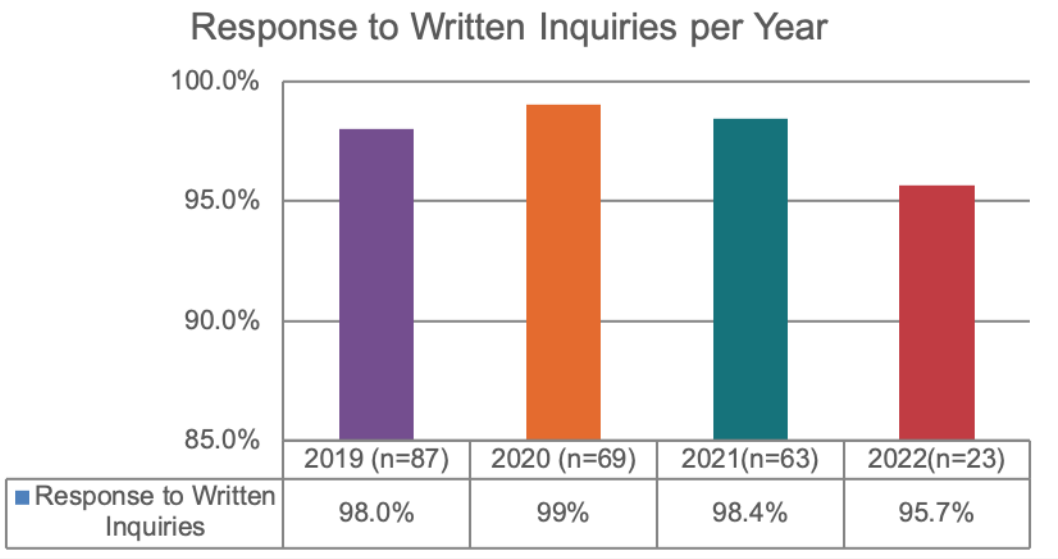
Methodology – Optum Idaho's policy is to respond to all member and provider phone calls and email/ written inquiries within 2 business days. Optum Idaho maintains and tracks this data in an internal database.

Analysis – Optum Idaho had a 96.2 percentage rate of responding to written inquiries within two business days.

Barriers – There was an identified gap in Optum Idaho staff knowledge surrounding contractual turnaround times for responding to written inquiries.

Opportunities and Interventions – The Optum Idaho quality team provided training to select staff regarding contractual turnaround times.

Figure 42



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Monitoring and Relations

Provider Quality Monitoring

Optum Idaho performs site visits to monitor provider adherence to quality standards. The Optum Idaho provider performance team completes treatment record reviews and site audits. They provide a standardized review of providers and facilities covering access, clinical record keeping and quality of their delivery of behavioral health services.

Methodology – Following an audit, the provider will receive initial verbal feedback followed by a written report within 30 days of the site visit. Scores above 85 percent are considered passing, between 80-84 percent require submission of a corrective action plan (CAP), and 79 percent or below require submission of a CAP and participation in a re-audit within four to six months.

Analysis – During 2022, a total of 388 audits were conducted.

- 88 percent (341) of audits received a passing score (≥85%) and did not require a CAP
- 12 percent (47) of the audits did not receive a passing score and CAPs were implemented

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 43

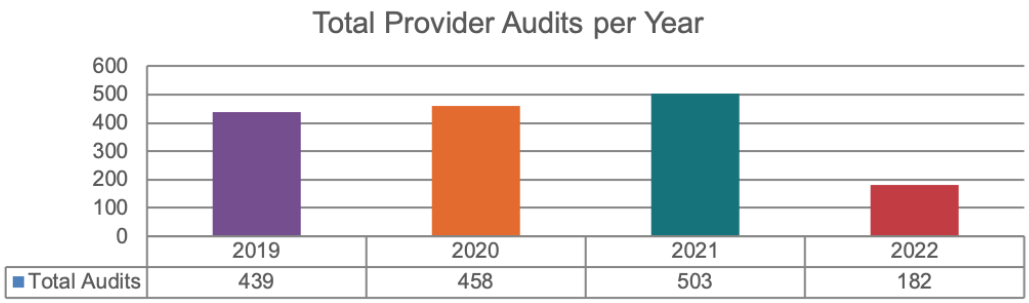
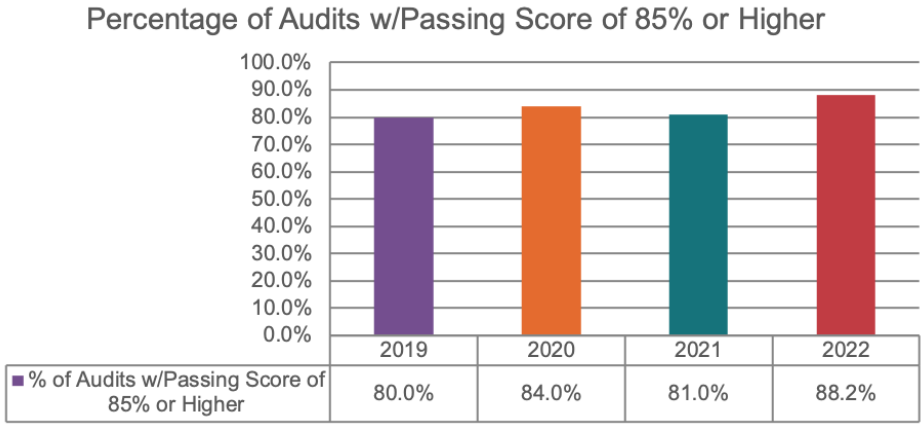


Figure 44



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Coordination of Care

Methodology – To coordinate and manage care between behavioral health and medical professionals, Optum Idaho requires providers to attempt to obtain member consent to exchange appropriate treatment information with other medical care professionals.

Optum Idaho, as well as accrediting organizations, expects providers to make a good faith effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member as part of an overall approach to coordinating care. Providers are audited by the Optum Idaho provider performance team for compliance with coordination of care.

Analysis – Coordination of Care audits completed during 2022 revealed that 86 percent of member records reviewed had documented the name of the member's primary care provider (PCP). Of those, 93.5 percent indicated that collaboration had occurred between the behavioral health provider and the member's PCP.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 45

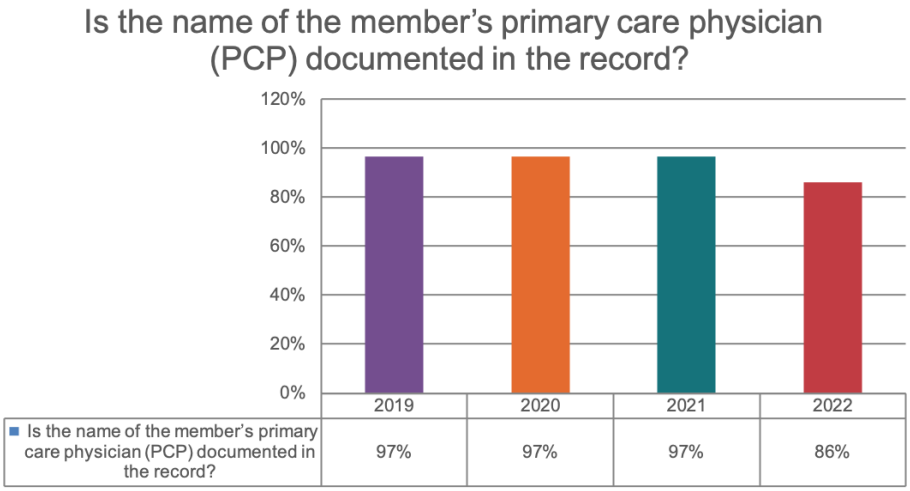
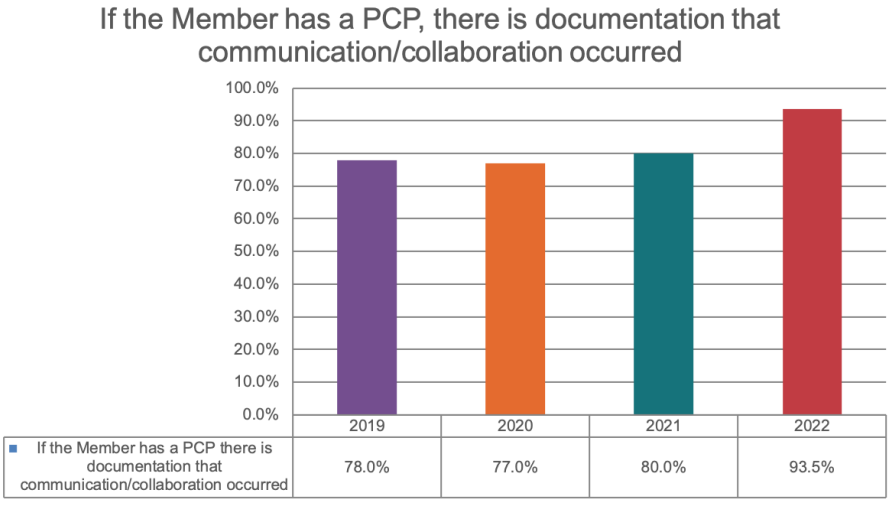


Figure 46



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Provider Disputes

Methodology – Provider disputes are requests for reconsideration by a provider of a claim, or group of claims, for services provided that have been denied, adjusted or contested. Optum Idaho requires that written resolution be sent within 30 calendar days following the receipt of the provider dispute request.

Analysis – In 2022, Optum Idaho received 204 provider disputes. All were resolved within the contractual turnaround time of ≤30 days.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 47

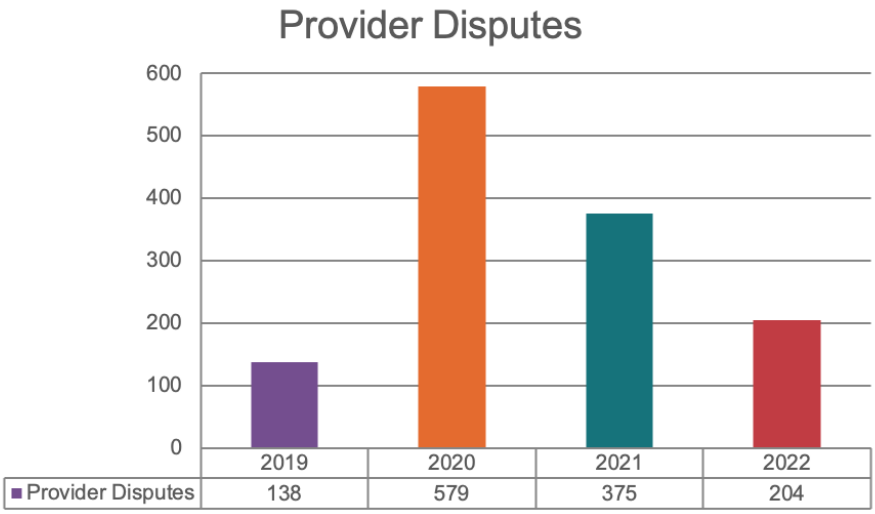
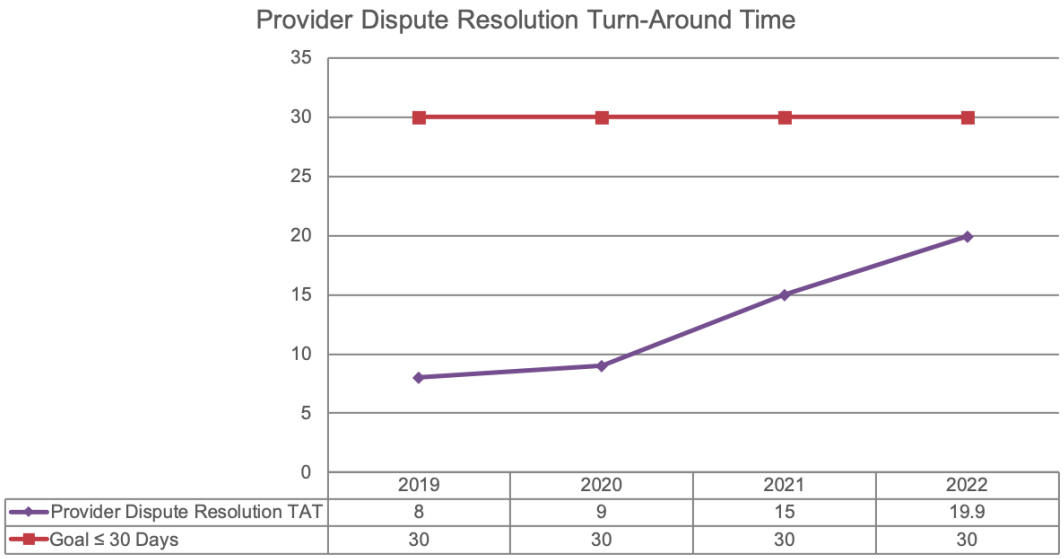


Figure 48



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Utilization Management and Care Coordination

Service Authorization Requests

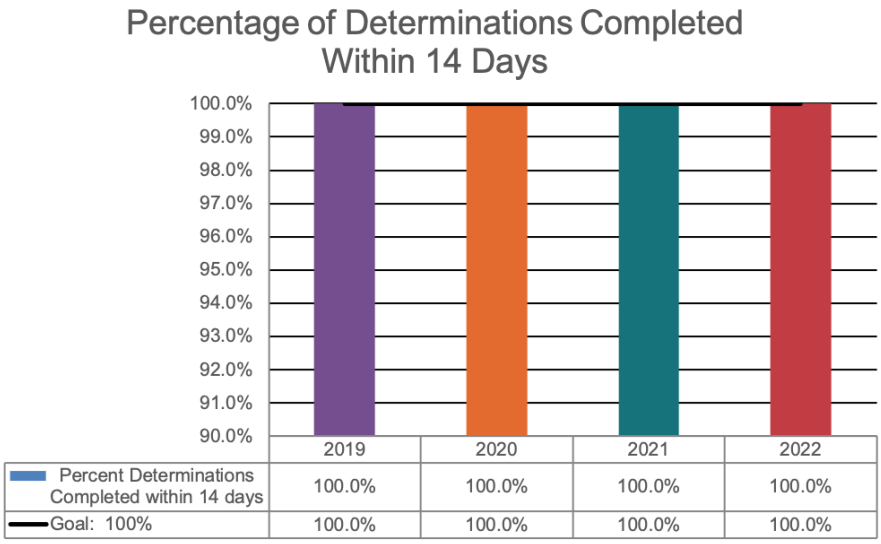
Methodology – Methodology – Optum Idaho has formal systems and workflows in place designed to process requests for benefit coverage of services requiring prior and concurrent authorization. Optum Idaho adheres to a 14-day turnaround time for processing non-urgent pre-service and concurrent requests.

Analysis – During 2022, Optum Idaho received 3,897service authorization requests. The performance goal of 100 percent of determinations completed within 14 days was met.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 49



	2019	2020	2021	2022
Percent Determinations Completed within 14 days	100.0%	100.0%	100.0%	100.0%
Goal: 100%	100.0%	100.0%	100.0%	100.0%

Person-Centered Service Plan (PCSP)

All children and youth members in the YES Program are required to have a PCSP developed in a Child and Family Team. A PCSP is member-directed, ongoing, and focuses on the strengths, interests, and needs of the individual. A PCSP is developed with the member, the member's authorized representative, and the member's treatment providers. It reflects the services and supports that are important to the member and their family to meet the needs identified through a functional needs assessment.

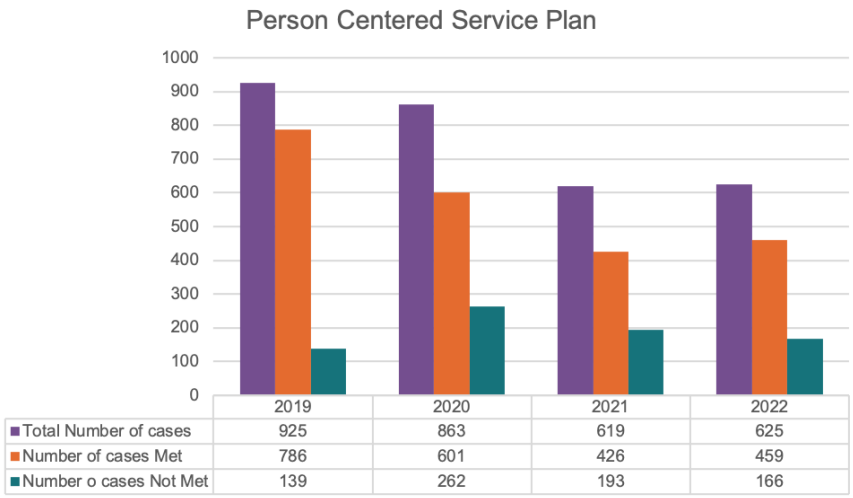
Methodology – Optum Idaho reviews completed PCSPs according to standards established in federal law to ensure the planning process includes people that were chosen by the member and their family. Meetings are scheduled at times and locations that are convenient for the youth and their family. The PCSP includes strategies to address conflicts or disagreements, including clear conflict-of-interest guidelines for all planning participants and methods for the person/family to request updates to the plan.

Analysis – During 2022, Optum Idaho received 625 PCSPs for review. Of those, 459 (73 percent) met federal standards and 166 (27 percent) did not. All were reviewed within the performance goal of five business days, with an average turnaround time of 0.49 days.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 50



	2019	2020	2021	2022
Total Number of cases	925	863	619	625
Number of cases Met	786	601	426	459
Number o cases Not Met	139	262	193	166

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Field Care Coordination

Methodology – The Field Care Coordination (FCC) Program includes regionally based clinicians across the state of Idaho. They provide local support in collaboration with providers to assist members with care coordination and discharge planning. This is achieved by focusing on consumers and families who are at greatest clinical risk, focusing on member wellness and member responsibility for their own health and well-being, and improving care coordination for members moving between services, especially those being discharged from 24-hour care settings.

Analysis – The FCC team received 1,596 referrals in 2022. The number of days that a Field Care Coordinator keeps a case open varies depending on the complexity of the case, with the average case in 2022 being open for 61 days.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 51

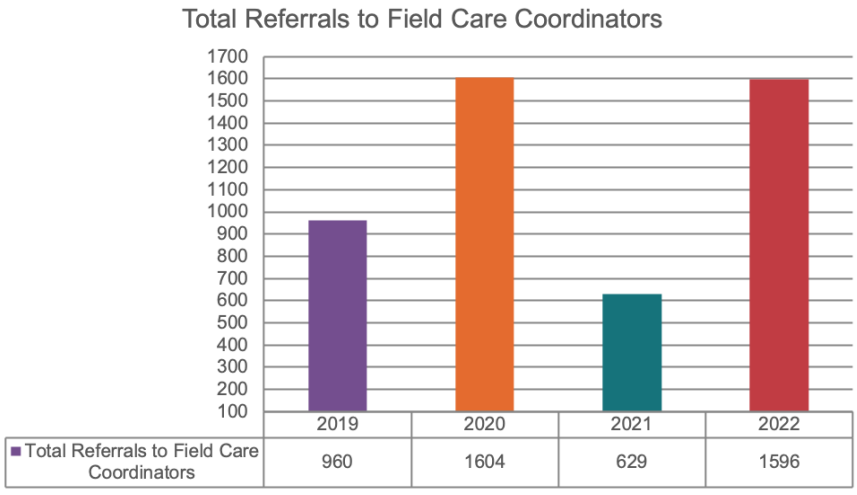
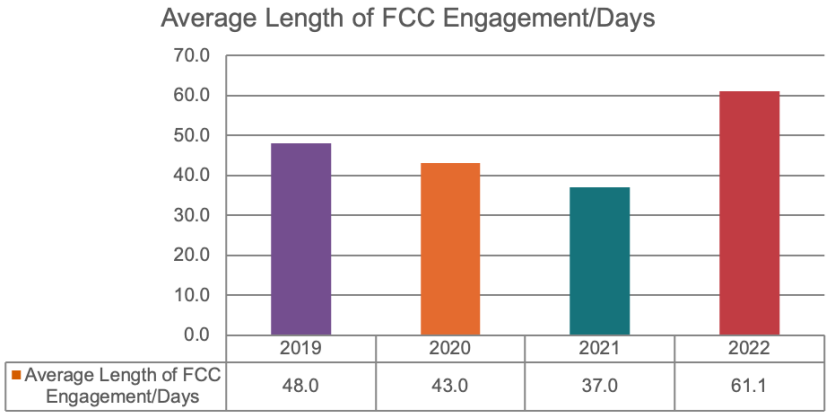


Figure 52



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Inter-Rater Reliability

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

Results are summarized and reviewed for trends.

Analysis – During 2022, Care Advocate audits IRR audit results were 97 percent. MD Peer Review audit results were 100 percent.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 53

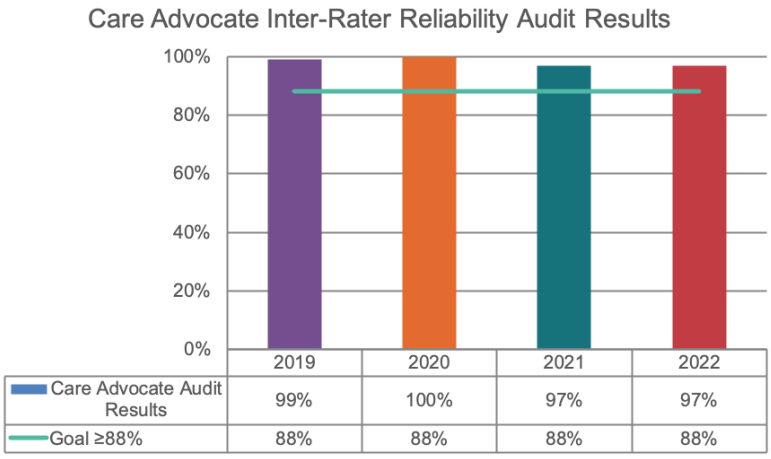
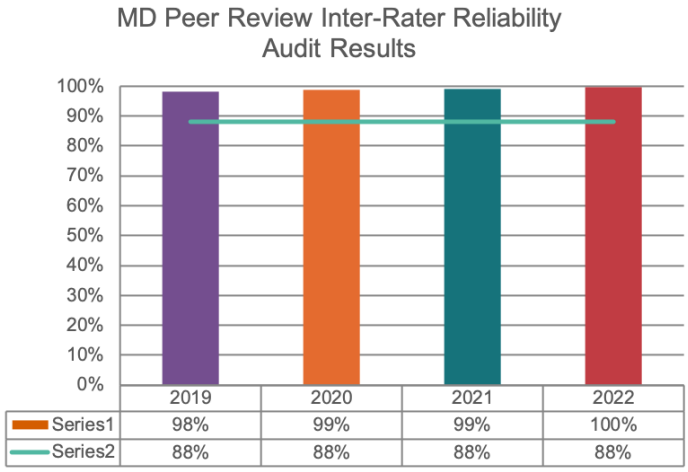


Figure 54



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Population Analysis

Language and Culture

Methodology – Optum Idaho strives to provide culturally competent behavioral health services to its members. The table below lists the U.S. Census 2020* results which estimate the ethnic, racial and cultural distribution of the Idaho population. Optum Idaho uses the Member Satisfaction Survey to gauge whether the care the member receives is respectful to their cultural and linguistic needs.

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

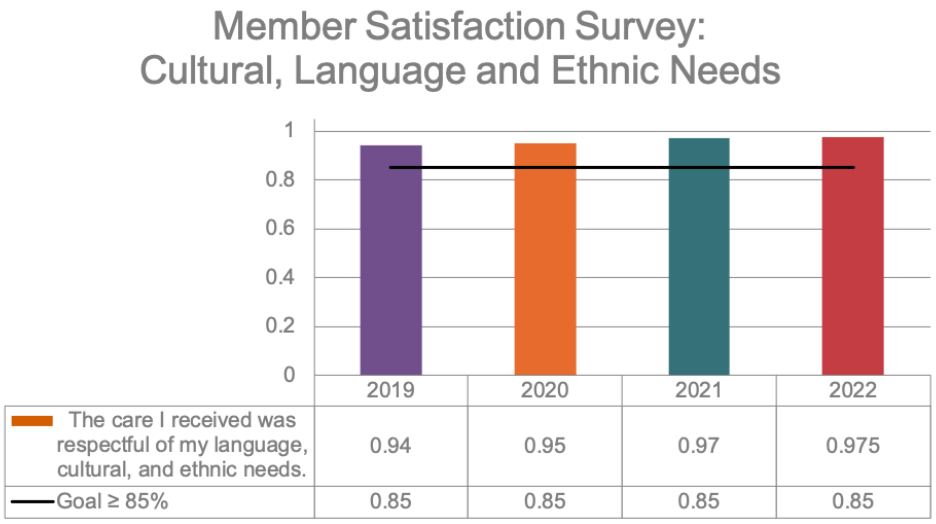
Analysis – People who identify as Hispanic or Latino accounted for 18.7 percent of the Idaho population. This is the second highest population total, with people identifying as White accounting for 61.9 percent. The 2022 Member Satisfaction Survey results consistently show that members feel that the care they received was respectful of their language, cultural and ethnic needs.

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

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 55



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Claims

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

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

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

Analysis – All claims performance goals have consistently been met.

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

Opportunities and Interventions – No opportunities for improvement were identified.

Figure 56

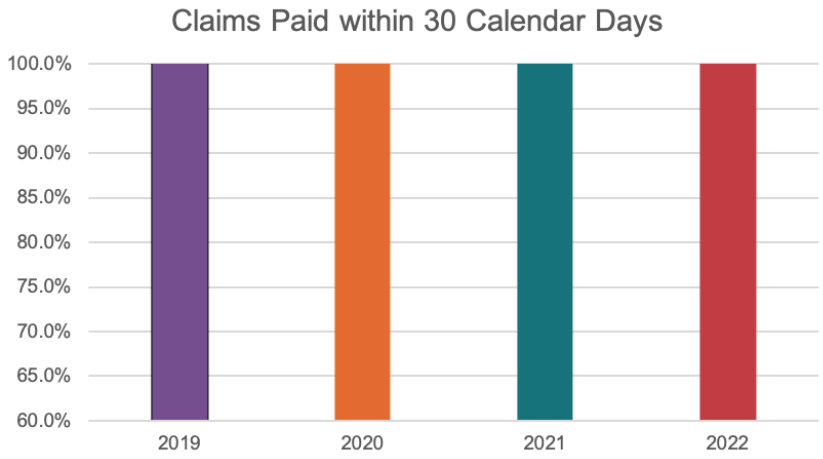
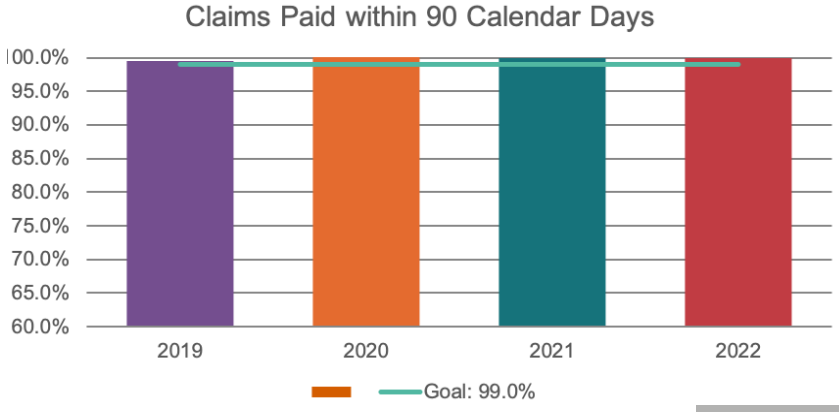


Figure 57



CLICK HERE TO RETURN TO TABLE OF CONTENTS

Figure 58

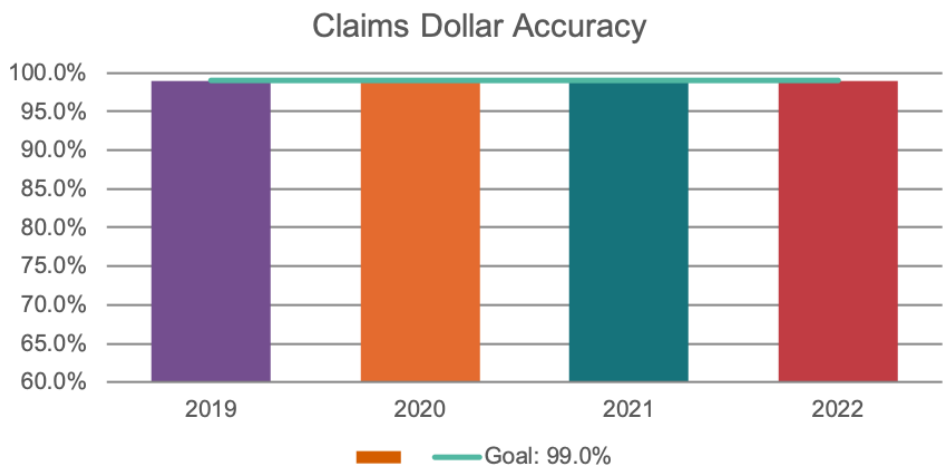
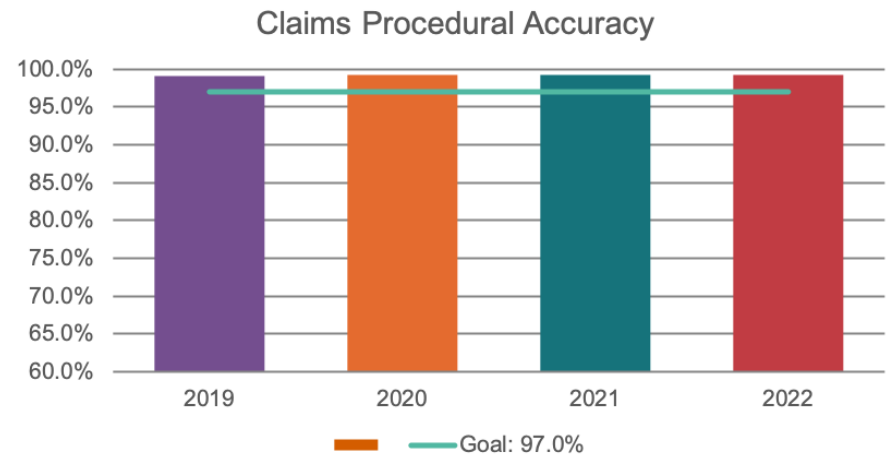


Figure 59



CLICK HERE TO RETURN TO TABLE OF CONTENTS