IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT

January - March, 2016

The Idaho Behavioral Health Plan (IBHP) Quality Management and Improvement (QMI) report summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) for Calendar Year 2016. It provides an overview of outcomes data, through Quarter 1, 2016, for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

Table of Contents

Executive Summary 3

Overall Effectiveness and Highlights 3

Quality Performance Measures and Outcomes 7

Outcomes Analysis 9

ALERT Outcomes 9

Wellness Assessments 10

Inpatient Utilization 15

Emergency Room Utilization Rates 22

Case Management Utilization Rates 23

Prescriber Visit Utilization Rates 25

Individual Therapy Utilization Rates 28

Family Therapy Utilization Rates 29

CBRS Utilization Rates 30

CBRS, Family Therapy, and Individual/Extended Therapy Utilization Rates 31

Services Received Post CBRS Adverse Benefit Determination 32

Appropriateness of Diagnosis-Specific Patterns of Service Utilization 34

Member Satisfaction Survey Results 38

Provider Satisfaction Survey Results 41

Performance Improvement 44

Accessibility & Availability 45

Idaho Behavioral Health Plan Membership 45

Member Services Call Standards 46

Customer Service (Provider Calls) Standards 48

Urgent and Non-Urgent Access Standards 50

Geographic Availability of Providers 51

Member Protections and Safety 52

Notification of Adverse Benefit Determination 52

Grievances 55

Complaint Resolution and Tracking 56

Critical Incidents 59

Response to Written Inquiries 64
Provider Monitoring and Relations 65
Provider Quality Monitoring 65
Coordination of Care 71
Provider Disputes 73
Utilization Management and Care Coordination 75
Service Authorization Requests 75
Field Care Coordination 76
Peer Reviewer Audits 78
Inter-Rater Reliability 79
Population Analysis 81
Language and Culture 81
Results for Language and Culture 82
Claims 82

Executive Summary

The quarterly report of Optum's Quality Management and Utilization Management (QMUM) Program's performance reflects Medicaid members whose benefit coverage is provided through the Idaho Behavioral Health Plan (IBHP) and administered by Optum Idaho.

Optum's comprehensive Quality Assurance and Performance Improvement (QAPI) program encompasses outcomes, quality assessment, quality management, quality assurance, and performance improvement. The QAPI program is governed by the QAPI committee and includes data driven, focused performance improvement activities designed to meet the State of Idaho Department of Administration for the Department of Health and Welfare (IDHW) and federal requirements. These contractual and regulatory requirements drive Optum's key measures and outcomes for the IBHP.

Optum Idaho's QAPI Program utilizes key measures, outcomes and other types of measures to evaluate and improve the services we provide to IBHP members. The QAPI Committee routinely monitors performance of key measures and outcomes as part of Optum Idaho's *Outcomes Management and Quality Improvement Work Plan*.

Key indicator performance and outcomes are reported within each of the following performance domains:

- ALERT outcomes
- Utilization Rates
- Member Satisfaction
- Provider Satisfaction
- Accessibility and Availability of Care and Services
- Geographic Availability of Providers
- Member Protections and Safety
- Provider Monitoring and Relations
- Utilization Management and Care Coordination
- Claims Payment

The purpose of this document 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. Information outlined in this report highlights quarterly performance from Quarter 2, 2015, - Quarter 1 (January 1 – March 31, 2016), unless otherwise noted, and provides comparative performance from each quarter.

Overall Effectiveness and Highlights

Optum Idaho monitors performance measures as part of our Outcomes Management and Quality Improvement Work Plan. An Outcomes Analysis, a new section included in this report, highlights member outcomes. In this report, thirty-five (35) key performance measures were highlighted based on performance targets that are based on contractual, regulatory or operational standards. For this reporting period, Optum met or exceeded performance for 30 (86%) of the 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.

Highlights of Optum's effectiveness in Quarter 1 include the following measures that exceeded their established target for performance during the quarter:

- Member Satisfaction Survey Results
  - Optum Idaho met established performance (≥85.0%) in the following areas for member satisfaction during Quarter 1:
    - Experience with Behavioral Health Provider Network (88.8%)
    - Experience with Counseling or Treatment (90.9%)
    - Overall Experience (86.3%)

- Member Services Call Standards
  - Optum Idaho again exceeded established performance call standards for member service calls during Quarter 1.
    - The percent of calls answered within 30 seconds was met at 94.3% (goal: ≥80% of calls answered in 30 seconds).
    - The average speed of answer was met at 11.2 seconds (goal: ≤30 seconds).
    - Call abandonment rate was met at 1.1% (goal ≤3.5%).

- Customer Service (Provider) Call Standards
  - Optum Idaho again exceeded established performance call standards for customer service (provider) calls during Quarter 1.
    - The percent of calls answered within 30 seconds was met at 98.9% (goal: ≥80% of calls answered in 30 seconds).
    - The average speed of answer was met at 1.7 seconds (goal: ≤30 seconds).
    - Call abandonment rate was met at 0.40% (goal ≤3.5%).

- Urgent and Non-Urgent Access
  - Optum Idaho again exceeded established performance for urgent (within 48 hours) and non-urgent (within 10 days) appointment wait times.
    - Urgent Appointment Wait Time – 16 hours
    - Non-Urgent Appointment Wait Time – 6 days

- Geographic Availability of Providers (100%)
  - Geographic availability of providers met performance standards at 99.9% in Area 1 (requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties) and 99.8% in Area 2 (requires one provider within 45 miles for the remaining 41 counties not included in Area 1 – thirty-seven (37) remaining within the state of Idaho and 4 neighboring state counties)

- Member Grievances (30 days to resolution)
  - Optum continued to exceed the 30 day turnaround time for resolutions. Quarter 1 average resolution turnaround time (goal: ≤30 days) was 21 days.

- Complaint Resolution Timeframes
    - Complaint resolution turnaround time has been met for both quality of service (resolved within 10 days) and quality of care (resolved within 30 days) complaints during 2015 and continued into Q1, 2016.
        - Quality of Service Complaints again met resolution turnaround time at 100% during Quarter 1.
        - Quality of Care complaints again met resolution turnaround time at 100% during Quarter 1.

- Critical Incidents
    - Optum Idaho again exceeded established performance (100%) for Critical Incidents that are reviewed by the Chief Medical Officer within 5 business days from notification.

- Provider Disputes
    - Optum Idaho again exceeded the performance goal (≤30 days) for resolving provider disputes with the average turnaround time during Quarter 1 at 12 days.

- Peer Review Audit Results – MD and PhD (≥88%)
    - Average peer review audit score for MD was 98.0% during Quarter 1.
    - Average peer review audit score for PhD was 97.0% during Quarter 1.

- Claims
    - Optum Idaho again exceeded establish performance for claims paid within 30 (goal: 90.0%) and 90 (goal: 99.0%) calendar days
        - Claims Paid within 30 Calendar Days: 99.9%
        - Claims Paid within 90 Calendar Days: 100.0%
    - Optum Idaho again exceeded establish performance for dollar accuracy (goal: 99.0%) and procedural accuracy (goal: 97.0%)
        - Dollar Accuracy: 100.0%
        - Procedural Accuracy: 99.5%

- Network Monitoring Audits (Overall audit score ≥85%)
    - A total of 84 audits were completed during Quarter 1. Overall audit scores again exceed the goal of ≥ 85.0%.
        - Overall Initial Credentialing audit score was 91.9%
        - Overall Re-credentialing audit score was 96.1%
        - Overall Monitoring audit score was 89.3%
        - Overall Quality of Care audit score was 92.4%

While Optum Idaho met goals in 30 key performance areas, the following 5 areas did not meet performance expectations:

- Initial verbal notification of Adverse Benefit Determination (100% notified on same day)

- Performance for this measure reached 98.7%, slightly below the goal of 100% being notified on the same day.

- Written notification of Adverse Benefit Determination (100% sent within 1 business day)
  - Performance for this measure reached 98.1%, slightly below the goal of 100% sent within 1 business day.

- Service Authorization Requests are reviewed and a determination is made by Peer Reviewer (MD) within 14 days (100%)
  - Further validation of this data is required.

- Member experience with Optum Idaho Staff and Referral Process
  - Performance for this measure was at 77.4%, falling below the goal of ≥85.0%.

- Overall Provider Satisfaction (≥85.0%)
  - Overall provider satisfaction reached 75.0% which was an increase from 65.0% in Quarter 4 but still below the goal of ≥85.0%. Optum Idaho will continue to monitor and address the barriers to provider satisfaction and promote initiatives to improve the provider network experience.

In addition to the performance highlights above, Optum Idaho is dedicated to working in partnership with all community stakeholders to implement an accountable, outcome-driven, recovery-centered system that focuses on improving member care. In Quarter 1, Optum promoted the following initiatives.

- Developing the Family Support Partner program.
- Partnering with provider agencies across the state in their efforts to enhance member care with the focus on recovery and resiliency.
- Utilizing a team approach that includes, field care coordinators, provider quality specialists, network managers and community liaisons. This team approach provides a collaborative process for meeting a member's health needs.
- Investing in Idaho's communities through programs and services with a focus on improving the behavioral health system in Idaho to help people reach recovery.
- Introducing the Community Health Initiatives 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.
- Continue 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.

One person, one family, one community at a time. Recovery-oriented programs and services help people achieve improved mental and physical health, stronger relationships and a sense of self-worth. With the right support, people can and do recover to live full lives.

Quality Performance Measures and Outcomes

Measure	Goal	April - June 2015	July - September 2015	October - December 2015	January - March 2016
Member Satisfaction Survey Results					
Experience with Optum Idaho Staff and Referral Process	≥85.0%	**85.8%**	**77.4%**	Based on the Member Satisfaction Survey sampling methodology, Q4, 2015 & Q1, 2016 data is not yet available.	
Experience with the Behavioral Health Provider Network	≥85.0%	**91.6%**	**88.8%**		
Experience with Counseling or Treatment	≥85.0%	**96.7%**	**90.9%**		
Overall Experience	≥85.0%	**94.2%**	**86.3%**		
Provider Satisfaction Survey Results					
Overall Provider Satisfaction	≥85.0%	**67.0%**	**64.0%**	**65.0%**	**75.0%**
Accessibility & Availability					
Idaho Behavioral Healthplan Membership					
Membership Numbers	NA	**286,394**	**287,120**	**289,033**	Due to claims lag, data is reported one
Member Services Call Standards					
Total Number of Calls	NA	**1,122**	**1,094**	**1,416**	**1,373**
Percent Answered within 30 seconds	≥80.0%	**90.6%**	**88.5%**	**92.4%**	**94.3%**
Average Speed of Answer (seconds)	≤30 Seconds	**12.0**	**14.1**	**12.2**	**11.2**
Abandonment Rate	≤3.5%	**2.2%**	**2.2%**	**1.3%**	**1.1%**
Customer Service (Provider Calls) Standards					
Total Number of Calls	NA	**4,138**	**3,315**	**3,175**	**3,284**
Percent Answered within 30 seconds	≥80.0%	**94.6%**	**97.3%**	**98.9%**	**98.9%**
Average Speed of Answer (seconds)	≤30 Seconds	**10**	**5.5**	**1.4**	**1.7**
Abandonment Rate	≤3.5%	**1.11%**	**0.71%**	**0.31%**	**0.40%**
Urgent and Non-Urgent Access Standards					
Urgent Appointment Wait Time (hours)	48 hours	**35.5**	**23.1**	**20.9**	**15.6**
Non-Urgent Appointment Wait Time (days)	10 days	**5.4**	**3.1**	**4.3**	**5.7**
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%	**99.7%**	**99.8%**	**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)	100.0%	**99.9%**	**99.8%**	**99.8%**	**99.8%**
Member Protections and Safety					
Notification of Adverse Benefit Determinations					
Number of Adverse Benefit Determinations	NA	**523**	**462**	**477**	**621**
Initial Verbal Notification on Same Day	100.0%	**100.0%**	**100.0%**	**100.0%**	**98.7%**
Written Notification Sent within 1 Business Day	100.0%	**98.6%**	**99.6%**	**97.9%**	**98.1%**

Measure	Goal	April - June 2015	July - September 2015	October - December 2015	January - March 2016
Grievances (appeal of adverse determination)					
Number of Grievances	NA	29	21	16	21
Member Grievance Turnaround time	≤30 days	10	17	10	21
Complaint Resolution and					
Total Number of Complaints	NA	42	26	28	14
Percent of Complaints Acknowleged within Turnaround time	5 days	100.0%	100.0%	100.0%	100.0%
Number of Quality of Service Complaints	NA	40	21	26	13
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints	NA	2	5	2	1
Percent Quality of Care Resolved within Turnaround time	≤30 days	100.0%	100.0%	100.0%	100.0%
Critical Incidents					
Number of Critical Incidents Received	NA	16	15	23	17
Percent Ad Hoc Reviews Completed within 5 business days from	100.0%	100.0%	100.0%	100.0%	100.0%
Response to Written Inquiries					
Percent Acknowledged ≤2 business	100.0%	100.0%	100.0%	100.0%	100.0%
Provider Monitoring and Relations					
Provider Quality Monitoring					
Number of Audits	NA	69	76	76	84
Initial Audit (Percent overall score)	≥ 85.0%	97.3%	97.0%	95.1%	91.9%
Recredentialing Audit (Percent overall	≥ 85.0%	95.3%	95.2%	98.4%	96.1%
Monitoring (Percent overall score)	≥ 85.0%	89.9%	91.0%	88.5%	89.3%
Quality (Percent overall score)	≥ 85.0%	90.5%	94.5%	94.7%	92.4%
Percent of Audits that Required a Corrective Action Plan	NA	13.0%	22.4%	22.4%	14.3%
Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)					
Percent PCP is documented in	NA	86.5%	91.7%	97.0%	95.9%
Percent documentation in member record that communication/ collaboration occurred betweem behavioral health provider and primary	NA	74.2%	82.4%	78.7%	78.5%
Provider Disputes					
Number of Provider Disputes	NA	18	1	14	4
Average Number of Days to Resolve Provider Disputes	≤30 days	2	8	7	12
Utilization Management and Care Coordination					
Service Authorization Requests					
Percentage Determination Completed within 14 days	100%	99.0%	99.3%	99.2%	98.9%
Field Care Coordination					
Total Referrals to FCCs	NA	175	211	200	236
Average Number of Days Case Open	NA	61.6	38.9	72.6	119.1

Measure	Goal	April - June 2015	July - September 2015	October - December 2015	January - March 2016
Discharge Coordination: Post Discharge Follow-Up					
Number of Inpatient Discharges	NA	**921**	**852**	**868**	No data due to reporting lag
Percent of Members with Follow-Up Apptointment within 7 Days	NA	**52.9%**	**52.3%**	**48.3%**	
Percent of Members with Follow-Up Apptointment within 30 Days	NA	**70.2%**	**70.6%**	**68.9%**	
Readmissions					
Number of Members Disharged	NA	**921**	**852**	**868**	**933**
Percent of Members Readmitted within 30 days	NA	**11.6%**	**10.0%**	**10.8%**	**8.0%**
Inter-Rater Reliability					
Inter-Rater Reliabililty testing has been deferred until Q1 2016 due to role out of Clinical Model 2.1 in August, 2015.	NA	Results included in Q1 Report			
Peer-Review Audits					
PhD Peer Review Audit Results	≥ 88.0%	**100.0%**	**100.0%**	**95.6%**	**97.0%**
MD Peer Review Audit Results	≥ 88.0%	**98.0%**	**100.0%**	**100.0%**	**98.0%**
Claims					
Claims Paid within 30 Calendar Days	90.0%	**99.9%**	**99.9%**	**99.9%**	**99.9%**
Claims Paid within 90 Calendar Days	99.0%	**99.9%**	**100.0%**	**100.0%**	**100.0%**
Dollar Accuracy	99.0%	**99.8%**	**100.0%**	**99.9%**	**100.0%**
Procedural Accuracy	97.0%	**99.7%**	**100.0%**	**99.7%**	**99.5%**

performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)

Color 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 of population profiling when engaging in population health is to monitor the severity of symptoms and functional problems among those being treated. Over time, members become utilizers and others leave treatment. One concept for understanding population health as an outcome is to see 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 at 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. There can be scores included for initial values that do not have corresponding follow-up scores. These are comparisons of average severity values for the population submitting Wellness Assessments during the first 2 weeks of service and those members who submit them at subsequent visits that occur during the specified quarter.

Fig 1. Analysis: For adults, initial assessments display a flat curve over the 4 quarters from Q2 2015 through Q1 2016. That is, as a whole the level of Global Distress among IBHP utilizers remains approximately the same over time. Of note, there is a consistent reduction in follow-up adult Global Distress scores compared to initial scores for the population in treatment, with scores remains within the Moderate severity range.

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.

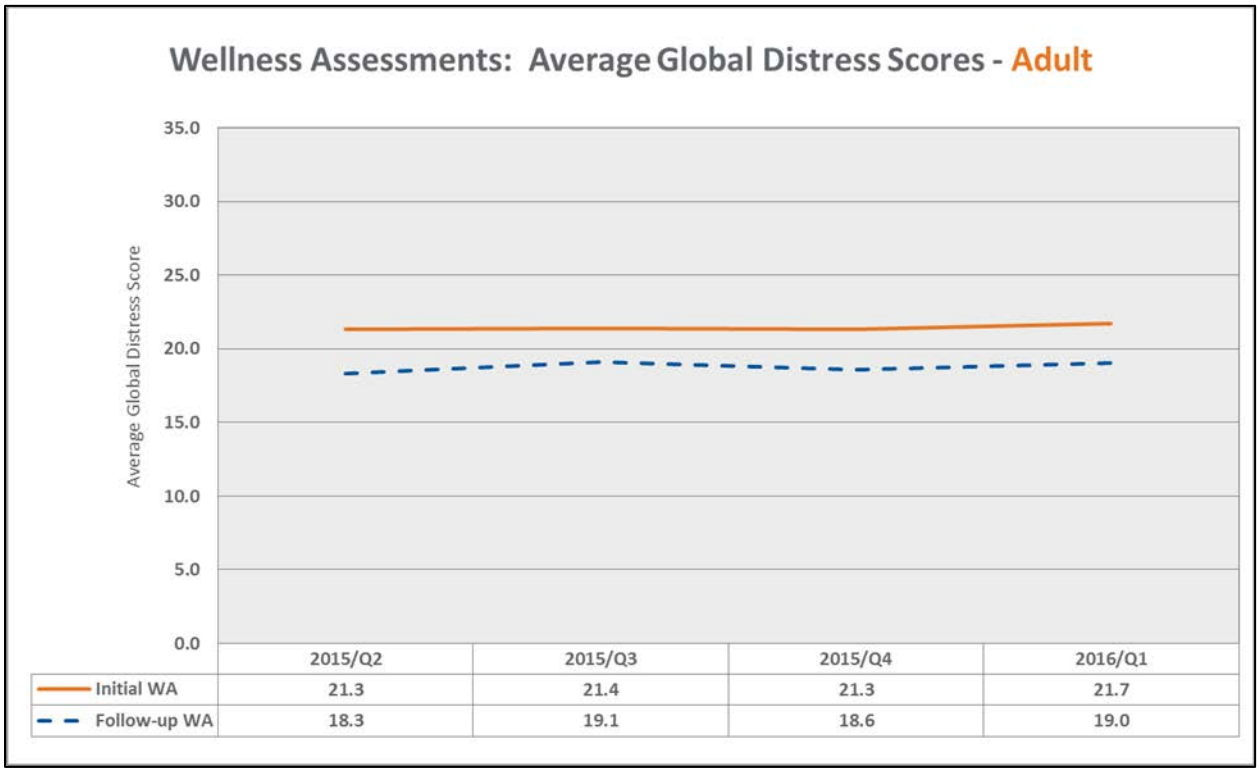


Fig. 1.

Fig. 2 Analysis: For children and youth, between Q2 2015 and Q1 2016, Global Distress scores have remained flat across time. When follow-up scores in the population are compared to initial scores, there is a greater reduction in strain scores on follow-up in Q1 2016 (1.2%) than in Q2 2015 (0.7%).

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.

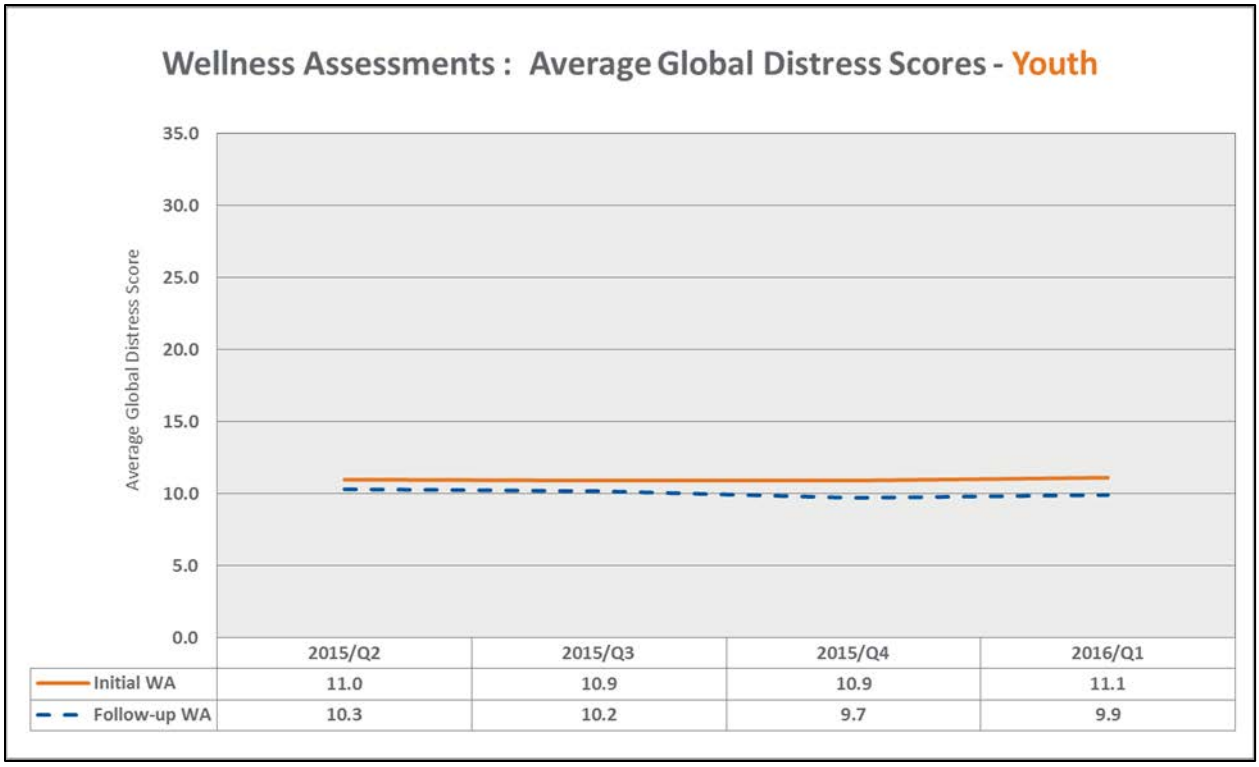


Fig. 2

Fig. 3 Analysis: For children and youth, between Q2 2015 and Q1 2016 average initial Caregiver Strain scores have decreased 4.2% over time. When follow-up scores in the population are compared to initial scores, over time the difference between initial and follow-up scores increased from 0.59 to 0.67, in favor of reduced severity but a very small change compared to scores in Q2 2015. Overall severity levels remained in the moderate range through the study period.

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.

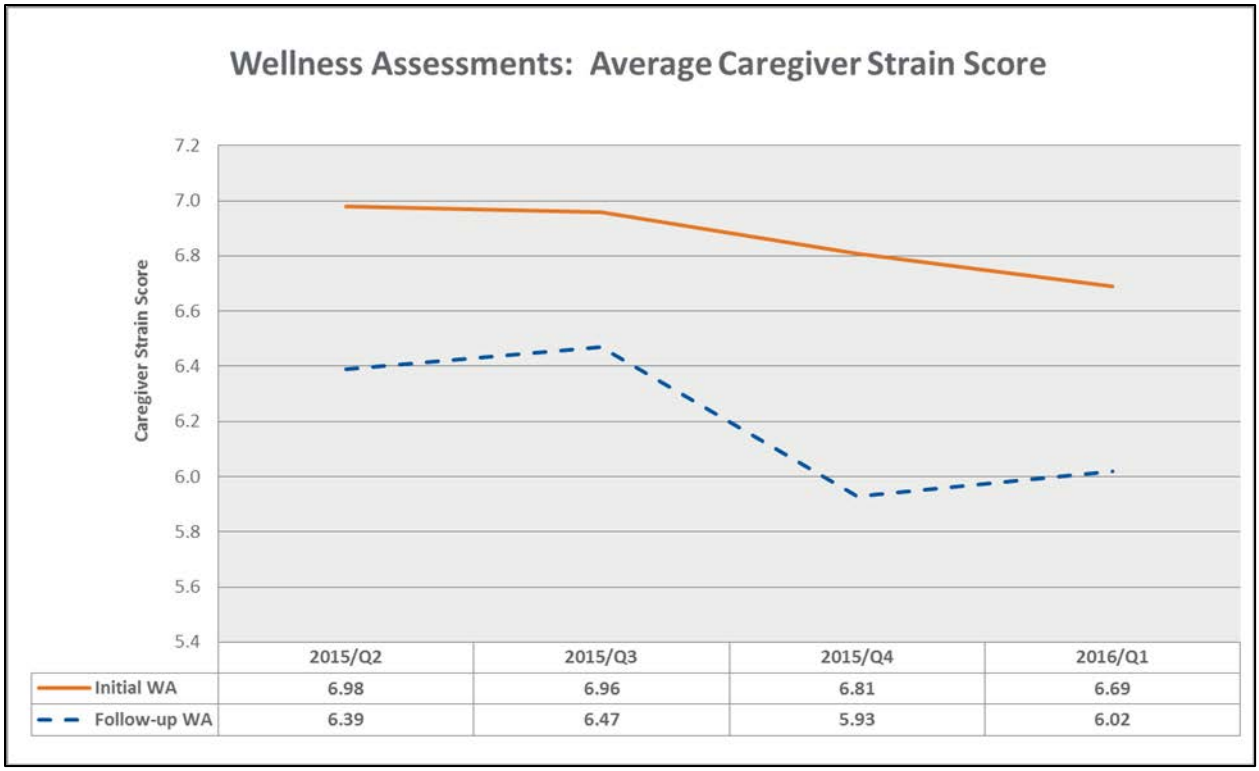


Fig. 3

Fig. 4 Analysis: 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. Outcomes for persons at higher risk due to coexisting physical health issues along with behavioral health problems tend to be worse. Between Q2 2015 and Q1 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.

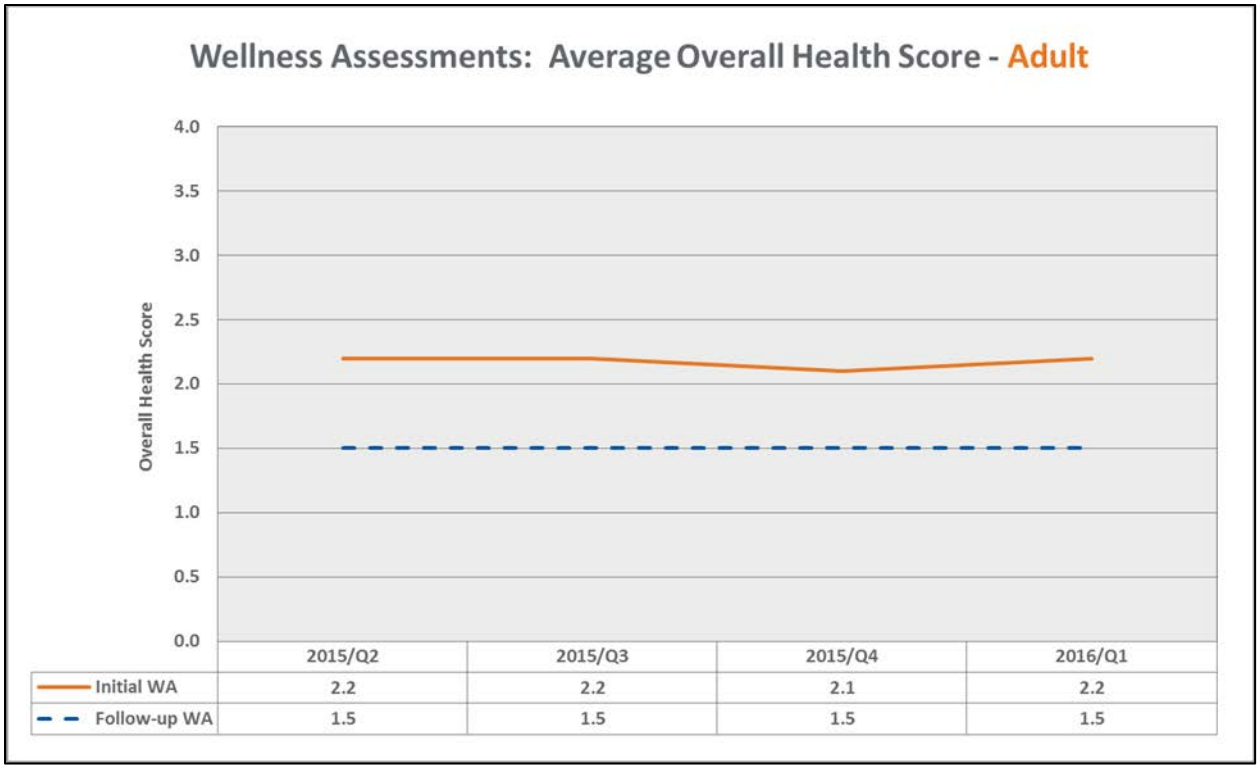


Fig. 4

Fig. 5 Analysis: Child and Youth Physical Health score values are as follows:

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

Between Q2 2015 and Q1 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.

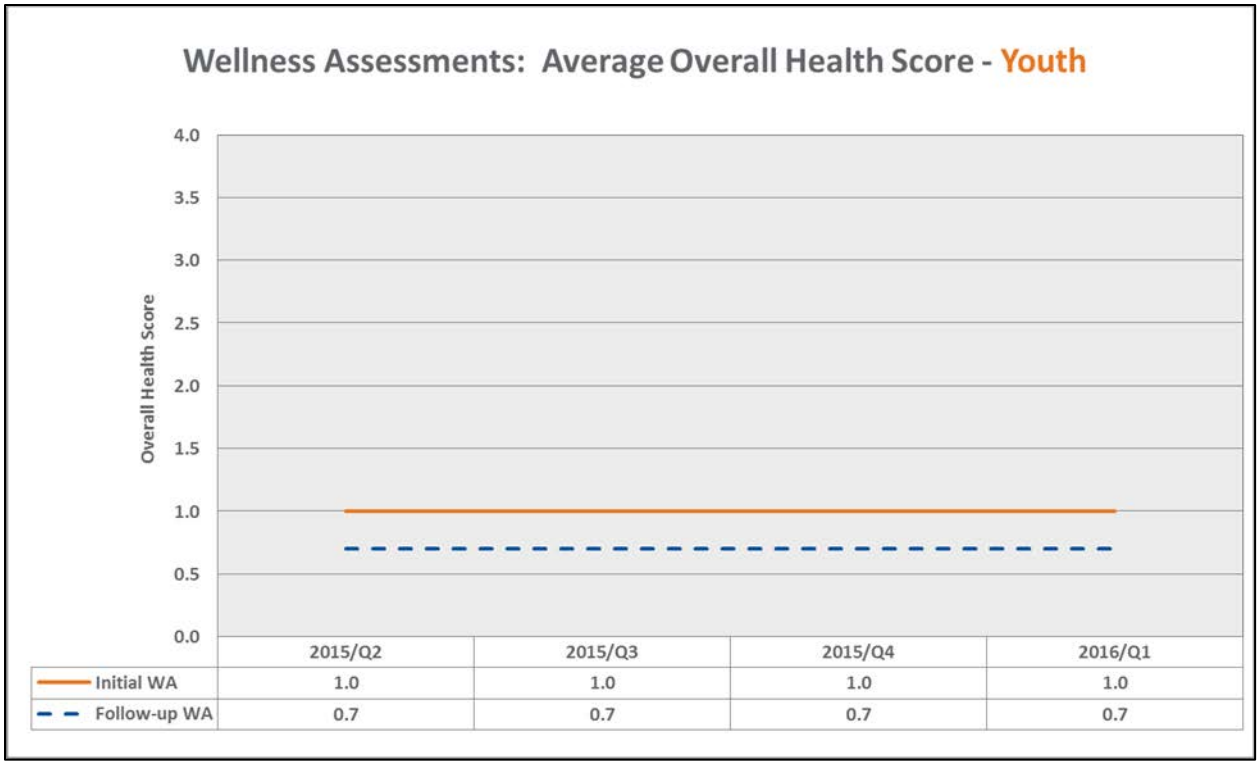
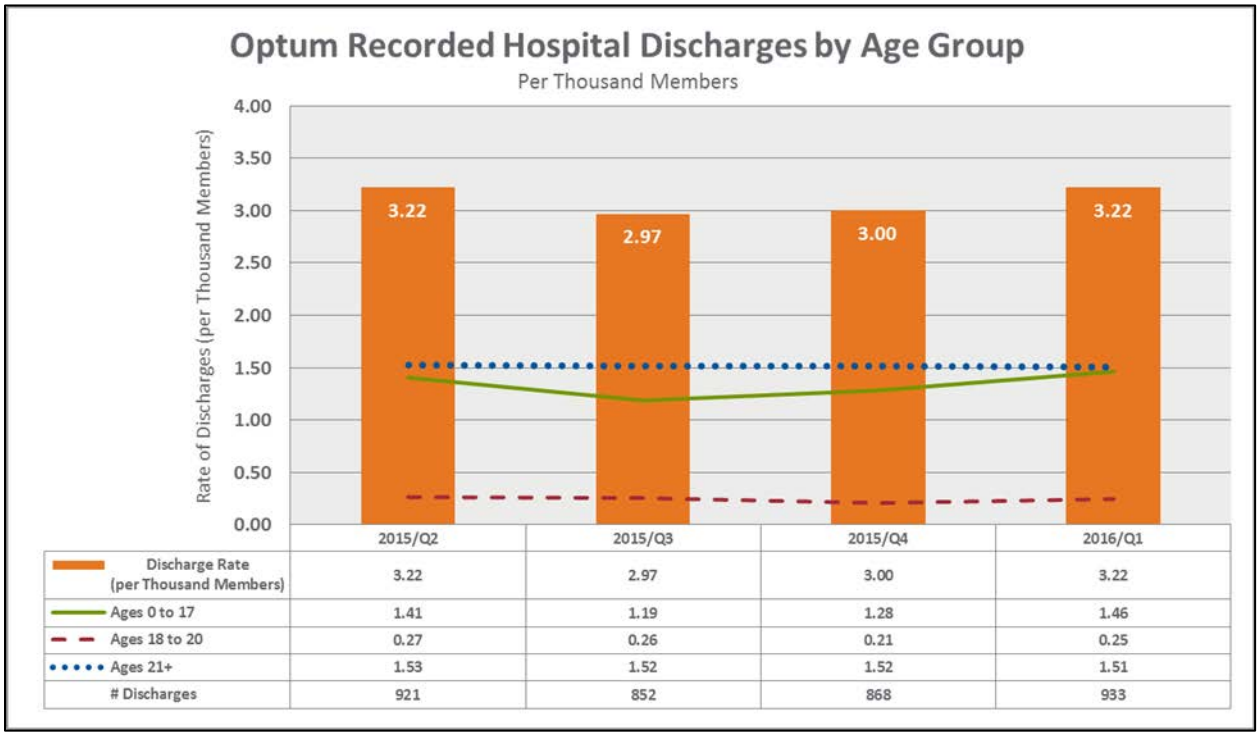


Fig. 5

Inpatient Utilization

Methodology: Data 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 from any otherhospital stay. This 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. This allows the rates in each quarter to be meaningfully compared.

Analysis: In general, a well performing outpatient behavioral health system is expected to keep members out of facility-based care such as psychiatric hospitals. Furthermore, when managing a health population, managed care organizations need to monitor for possible negative unintended consequences. The need to monitor unintended consequences leads to knowing whether managed care initiatives result in increases in hospital admissions, readmissions, and emergency room visits. Worsening could theoretically be attributable to decreased authorization of CBRS, a service that has been popular despite lacking medical necessity (appropriateness) for childhood disorders. The following data tracks the actual rates of these events, as a type of outcome measure for the plan's operation as a whole.



	2015/Q2	2015/Q3	2015/Q4	2016/Q1
Discharge Rate (per Thousand Members)	3.22	2.97	3.00	3.22
Ages 0 to 17	1.41	1.19	1.28	1.46
Ages 18 to 20	0.27	0.26	0.21	0.25
Ages 21+	1.53	1.52	1.52	1.51
# Discharges	921	852	868	933

Fig. 1 The overall rate of discharges (and correspondingly admissions, since without an admission there is no discharge), remained stable at 3.22 per 1,000 members. This change represents overall no change in hospitalizations.

Within age groups, for adults 21+, there has been a 1.3% increase in hospital discharges. For children and youth 0-17 years, hospitalization rates have fluctuated, with a transient decrease in Q3 2015 and a progressive return to baseline since. Between Q2 2015 and Q1 2016, there has been an 3.5% increase in discharges for children and youth. For transitioning youth 18-20 years, hospital discharges have decreased 7.4% between the start and the end of the study's period. In summary, hospital discharge rates changed little during the study period.

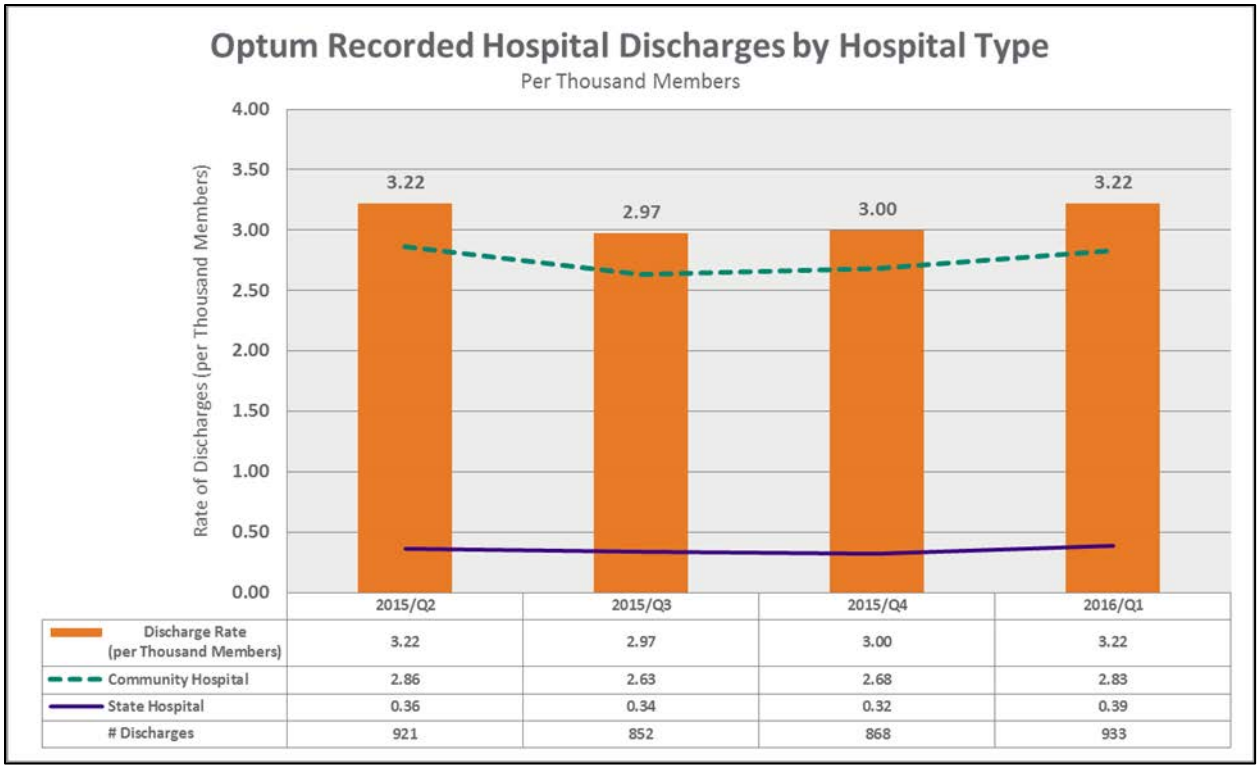


Fig. 2 During the study period from Q2 2015 through Q1 2016, discharges from the state hospitals community hospitals remained stable.

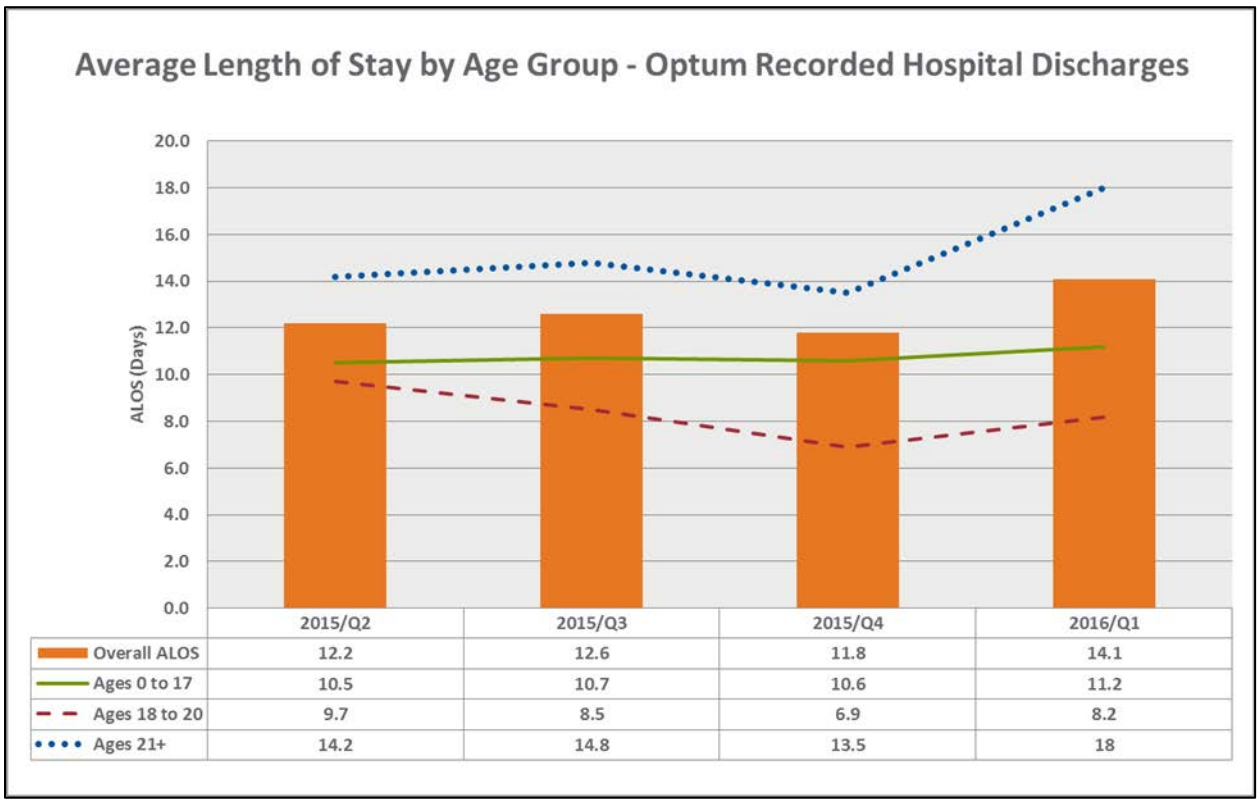
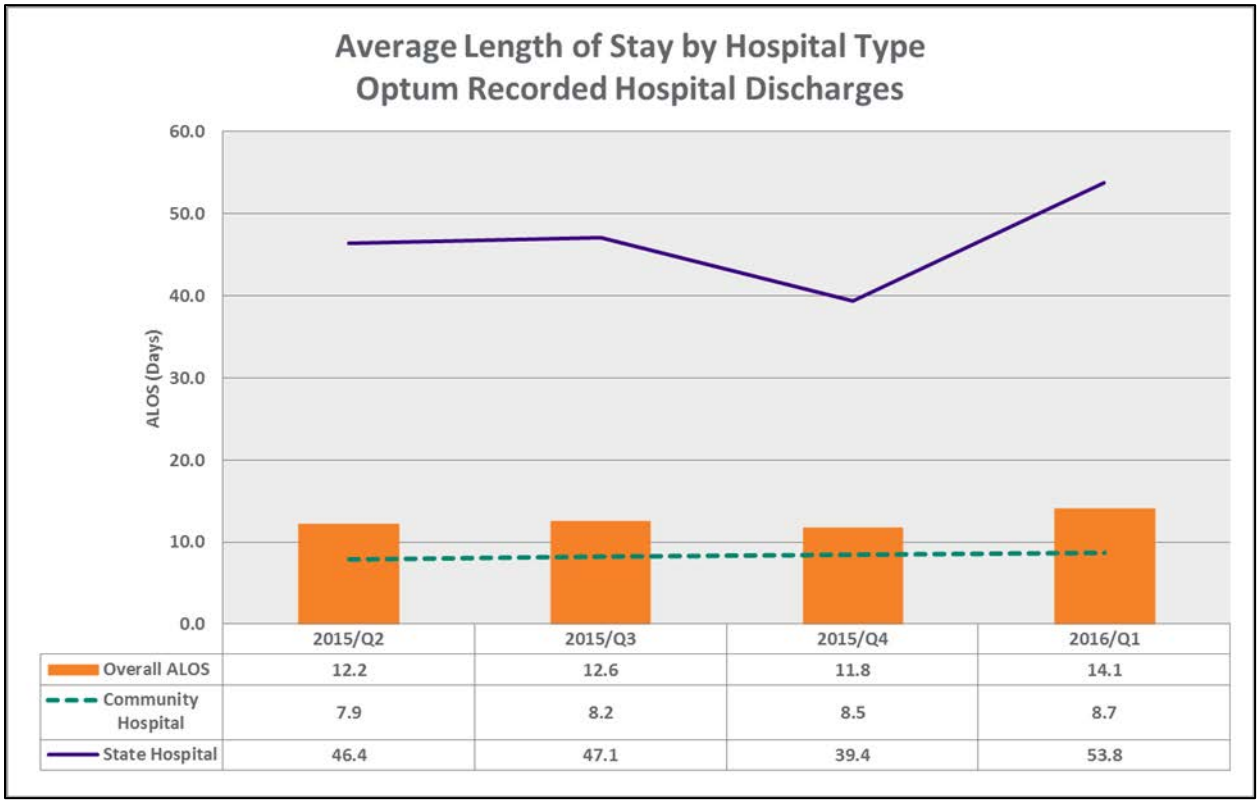
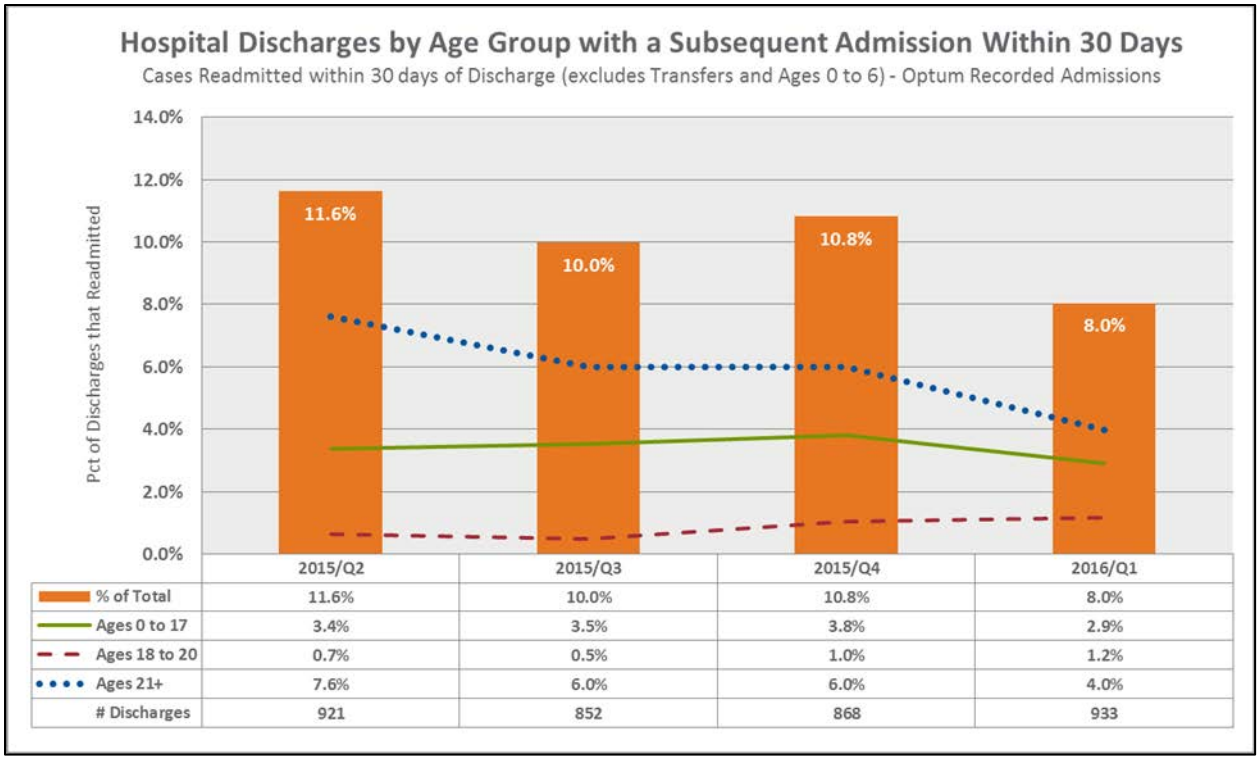


Fig. 3: From Q2 2015 to Q1 2016, based on information reported to Optum Idaho from hospitals, the overall average length of stay increased from 12.2 to 14.1 days, a 15.6% increase. When examined by age group, average lengths of stay for both children and youth and for adults 21+ increased 6.7% and 7.0%, respectively, while the length of stay for transitioning youth decreased 15.5%.



	2015/Q2	2015/Q3	2015/Q4	2016/Q1
Overall ALOS	12.2	12.6	11.8	14.1
Community Hospital	7.9	8.2	8.5	8.7
State Hospital	46.4	47.1	39.4	53.8

Fig. 4: When average length of stay was examined by hospital type, state hospitals increased 15.9%, predominantly between Q4 2015 and Q1 2016. Community hospitals showed a 10.1% increase during the study period.



	2015/Q2	2015/Q3	2015/Q4	2016/Q1
% of Total	11.6%	10.0%	10.8%	8.0%
Ages 0 to 17	3.4%	3.5%	3.8%	2.9%
Ages 18 to 20	0.7%	0.5%	1.0%	1.2%
Ages 21+	7.6%	6.0%	6.0%	4.0%
# Discharges	921	852	868	933

Fig. 5: According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals. Overall psychiatric hospital readmissions within 30 days of discharge fluctuated by quarter. Starting at 11.6% in Q2 2015, the rate decreased to 8.0% in Q1 2016. For overall readmissions during the study period, readmissions reduced 31% between Q2 2015 and Q1 2016.

Because of possible seasonal fluctuations in hospital readmissions, the year-over-year changes between Q3 2014 and 2015, Q4 2014 and 2015, and Q1 2015 and 2016 were examined. For Q3, readmission rates decreased 13.8% between 2014 and 2015. For Q4, readmission rates decreased 13.9% respectively. For Q1 2016, year-over-year hospital readmission rates decreased nearly 39% compared to the prior year's rate.

During the study period of Q2 2015 to Q1 2016, within age groups, readmission rates for 0-17 reduced 14.7%, 21+ reduced 47.4% while 18-20 members increased 71.4%. The large percentage increase for transitioning youth is due to the numbers being very small, so a small absolute increase appears as a very large percentage increase.

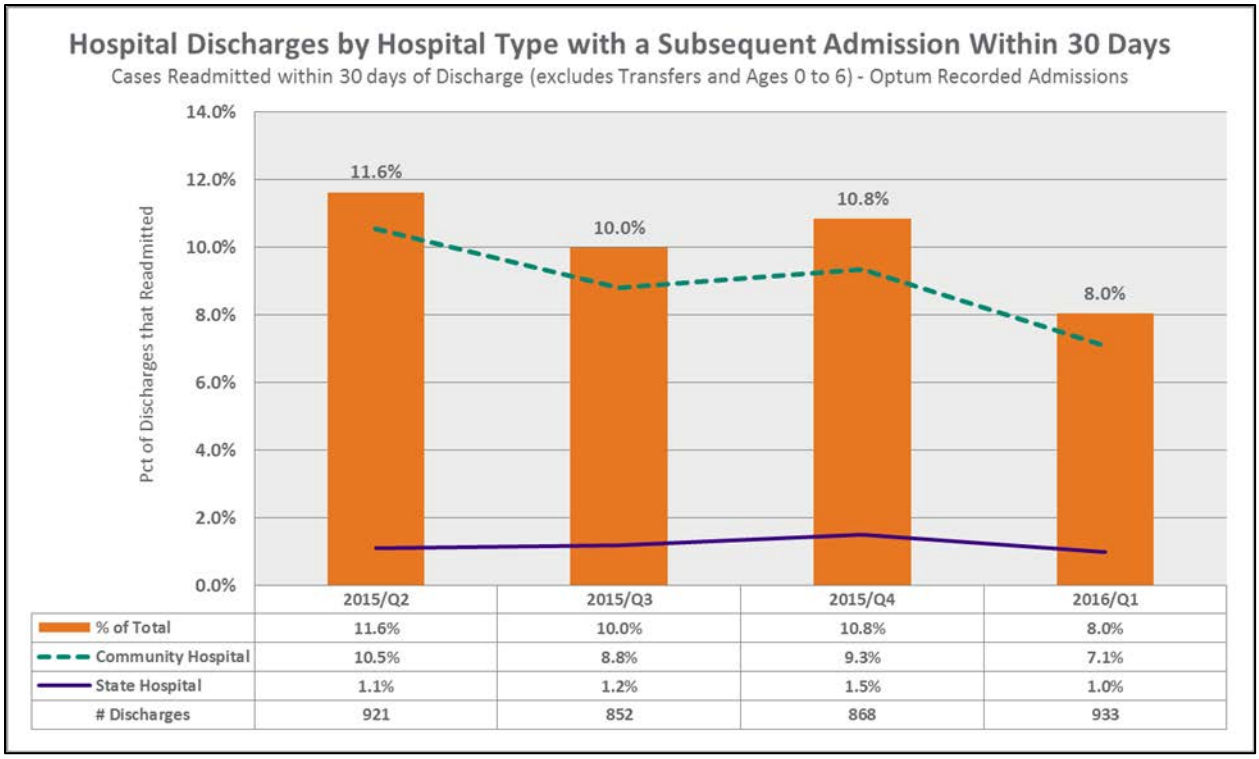


Fig. 6: When broken out by hospital type, the fluctuations in readmission rates per quarter can be accounted for by activity by the community hospitals. The mean readmission rate for the state hospitals amounted to 1.1% (range 1.0 to 1.1%) for the study period. The mean readmission rate for community hospitals was 8.8% (range 7.1 to 10.5%). Between Q2 2015 and Q1 2016, there was a reduction of 32.4% in community hospital readmission rates compared to 9.1% for state hospitals.

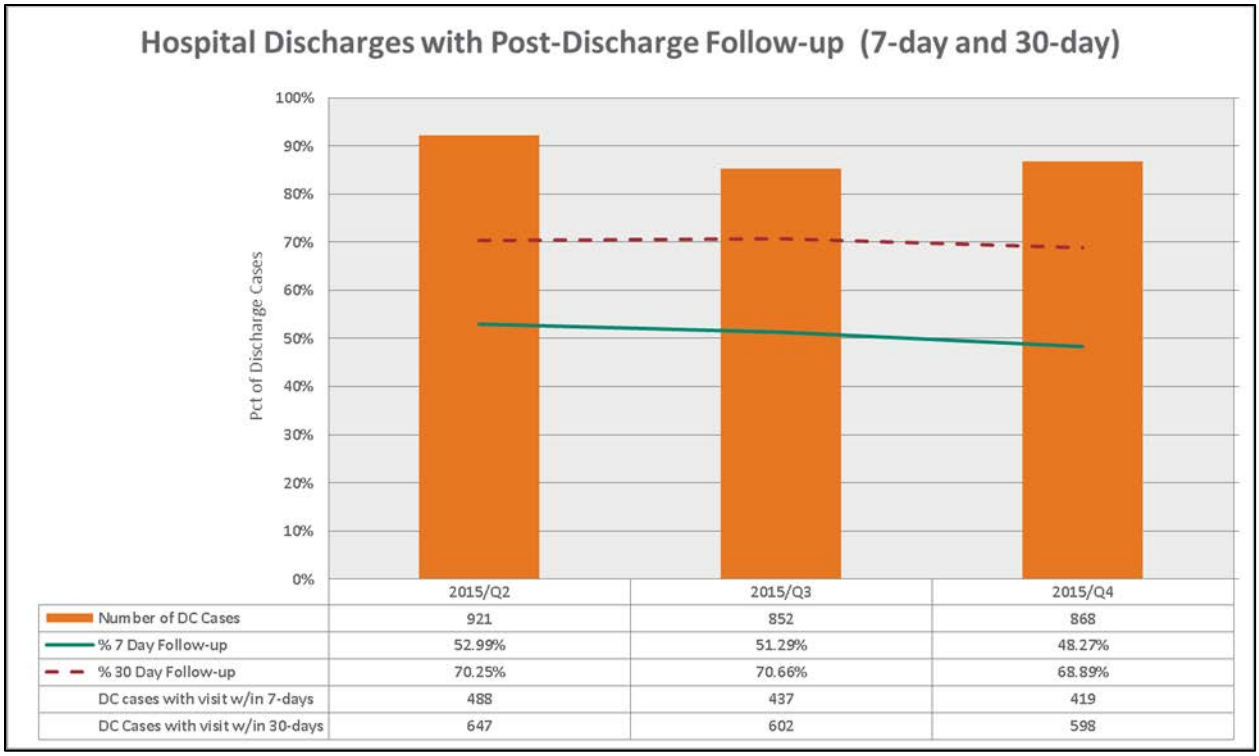


Fig. 7: One of the goals for care coordination that Optum Idaho promotes is improvement in the transition of members from inpatient to outpatient care, to support improved continuity of care. One of the measures for this is a HEDIS measure that examines the percentage of discharged members who are seen for an outpatient behavioral health visit within 7 days. Examination of 30 day outpatient visit attendance rates is also common. Examining attendance rates as percentages instead of raw numbers of appointments helps control for fluctuations in discharge rates from quarter to quarter. Between Q2 2015 and Q4 2015, the most recent quarter for which there is outpatient claims data before the 90-day claims lag allowed for claims to be filed, there was an 8.9% reduction in visits occurring within 7 days of discharge. There was a 1.9% reduction in visits occurring within the first 30 days after discharge. During the interim, no 7-day or 30-day visit rate exceeded that seen in Q2 2015. Notwithstanding the addition in July 2014 of Field Care Coordinators and Community Transition Support Services to assist with the members at highest risk, no consistent positive impact has appeared for post-stabilization visit rates.

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. Hospital practices such as having the follow-up appointment "to be arranged by parent" or releasing patients after a very brief stay without an appointment set the stage for failed transfers of care.

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.

Very few members have accepted Community Transition Support Services when offered. The practice of asking members whether they want a Peer Support Specialist to work with their Provider and themselves has not been fruitful. The target population for Community Transition Support Services is those members who have demonstrated difficulty following up with outpatient services when discharged from hospitals in the past. This target population is particularly difficult to serve due to the symptoms of the members' behavioral health disorders often interfering with willingness to receive services.

Opportunities and Interventions: Overall, there were favorable outcomes for hospital discharge rates and readmission rates for all age groups. Average lengths of stay decreased at the state hospitals but increased for community hospitals. Optum Idaho does not manage inpatient care, so the ability of outpatient services to better serve members and allow them to leave the hospital earlier is the only path available for reducing duration of inpatient stays. As outpatient services improve, the severity of illness of those who enter the hospital might worsen, making longer stays necessary. Desired improvement was not consistently seen in timeliness of post-stabilization visits rates for either 7-day or 30-day visits.

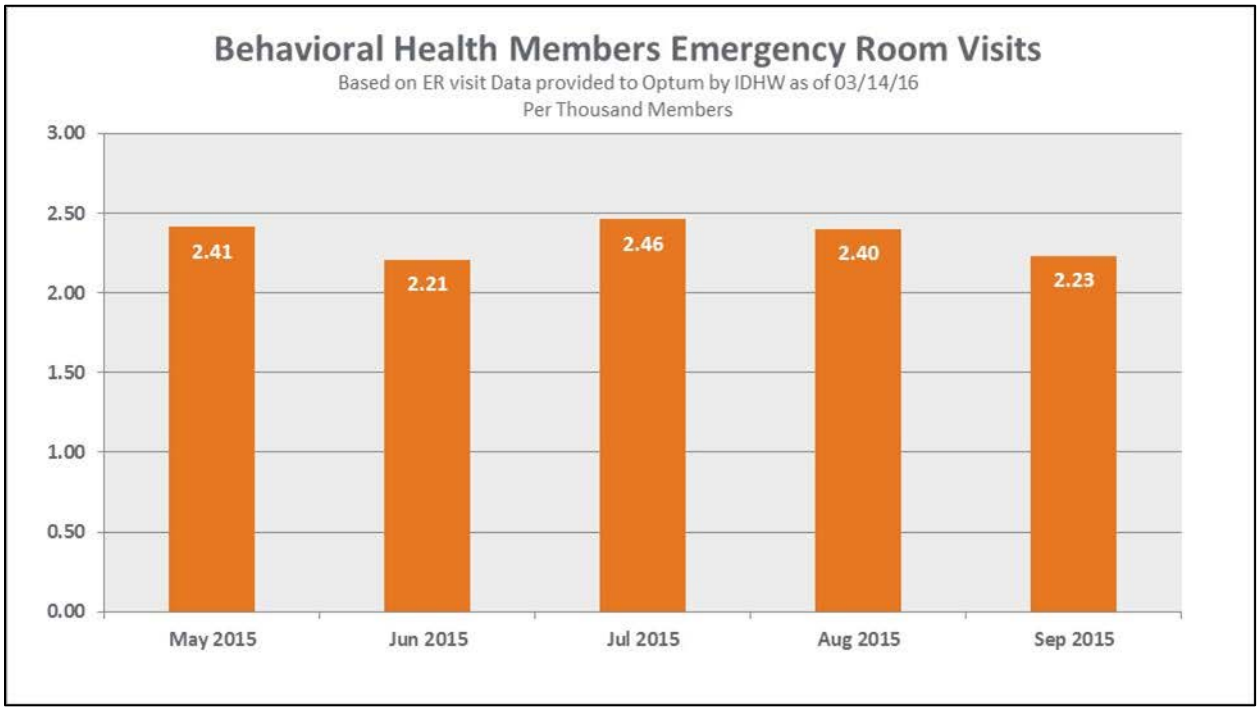
There are two main opportunities for further change remains to strengthen the capacity of outpatient services to keep members in community-based care. The first is an on-going pilot program first with the state hospitals and then community hospitals to use an Appointment Reminder Program based on information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

Emergency Room Utilization Rates

Methodology: Data is provided to us by IDHW. Data from IDHW is incomplete: Data for April 2015 has not been delivered, so data from May 2015 to Sep 2015 is displayed. As of today, we have not received data for visits after September 2015. Utilization is given as visits per 1,000 members in the IBHP for each month.

Analysis: This graph displays the available findings about utilizer rates for Idaho Emergency Room visits for psychiatric care. It covers five consecutive months during 2015, from May 2015 to September 2015.

The underlying concern was the possibility that changes in outpatient services instituted during the IDHP's management of the benefit could have increased visits to Emergency Rooms. It is also of interest to see the extent to which there is diversion of visits to emergency rooms for crises. Although there is no independent measure of the extent to which visits were for crises, for analytic purposes, the purpose of the visits will be assumed to be emergencies. Over the 5 month period, utilization rates per 1,000 members fluctuated between a low of 2.21 and a high of 2.46 with no distinct evident trend in utilization. For the period for which data is available, no clear increase in emergency room utilization appears.

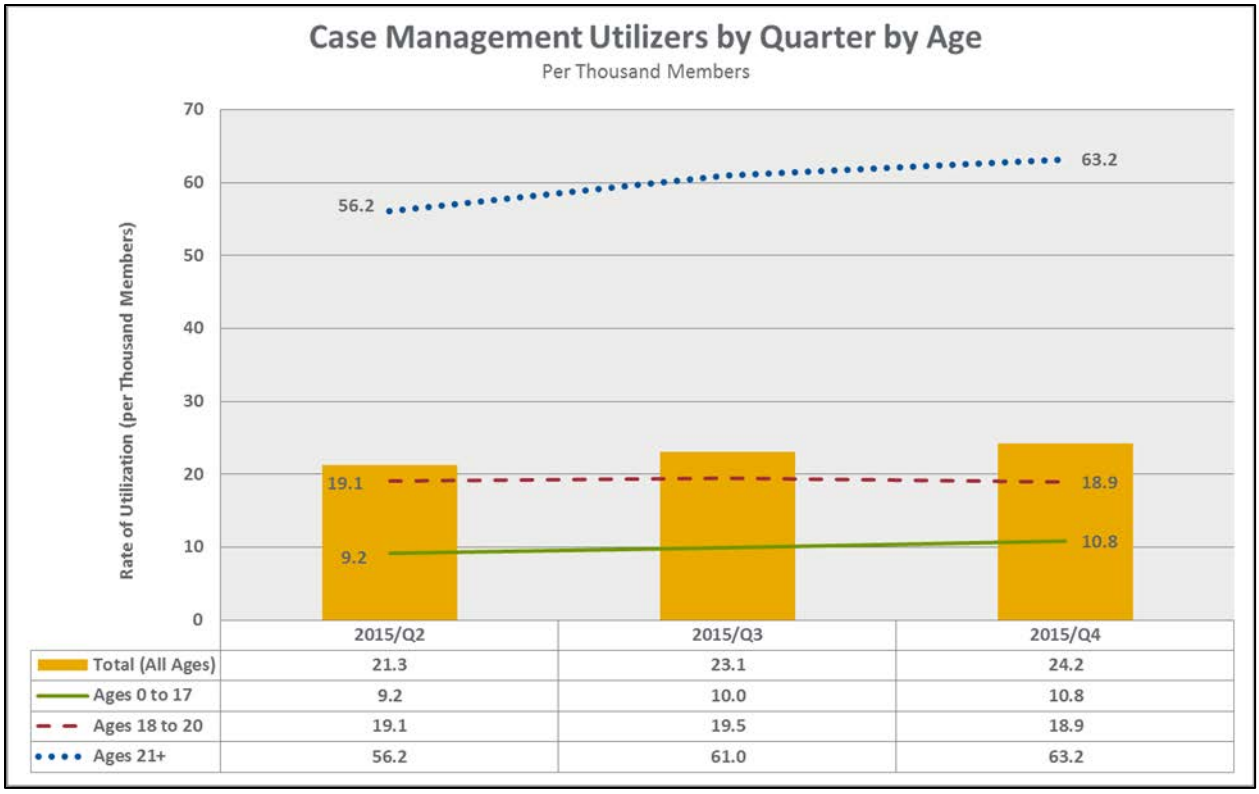


Case Management Utilization Rates

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 case management services for a specific quarter. Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: Between Q2 2015 and Q4 2015, the last quarter for which reliable claims data is available, utilization rate of Case Management Services increased 13.6%. When broken out by age groups, the 0-17, 18-20, and 21+ year groups showed an increase of 17.4% and 12.5% for 0-17 and 21+ groups, respective, and a slight decrease of 1.0% for the 18-20 year group. Overall and almost independent of age, case management service utilization increased during the study period.



	2015/Q2	2015/Q3	2015/Q4
Total (All Ages)	21.3	23.1	24.2
Ages 0 to 17	9.2	10.0	10.8
Ages 18 to 20	19.1	19.5	18.9
Ages 21+	56.2	61.0	63.2

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

Opportunities and Interventions: Although 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, an increase in utilization of case management occurred prior to that change. Unexpectedly, case management utilization increased least for transitioning youth, despite their frequently needing more assistance making arrangements for care and social services as their service needs increase approaching adulthood. Transitioning youth also need more education in how to locate and access services, as they approach adulthood. Children, despite often having parents to make arrangements for medical and social services, unexpectedly showed the greatest increase in case management utilization. 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.

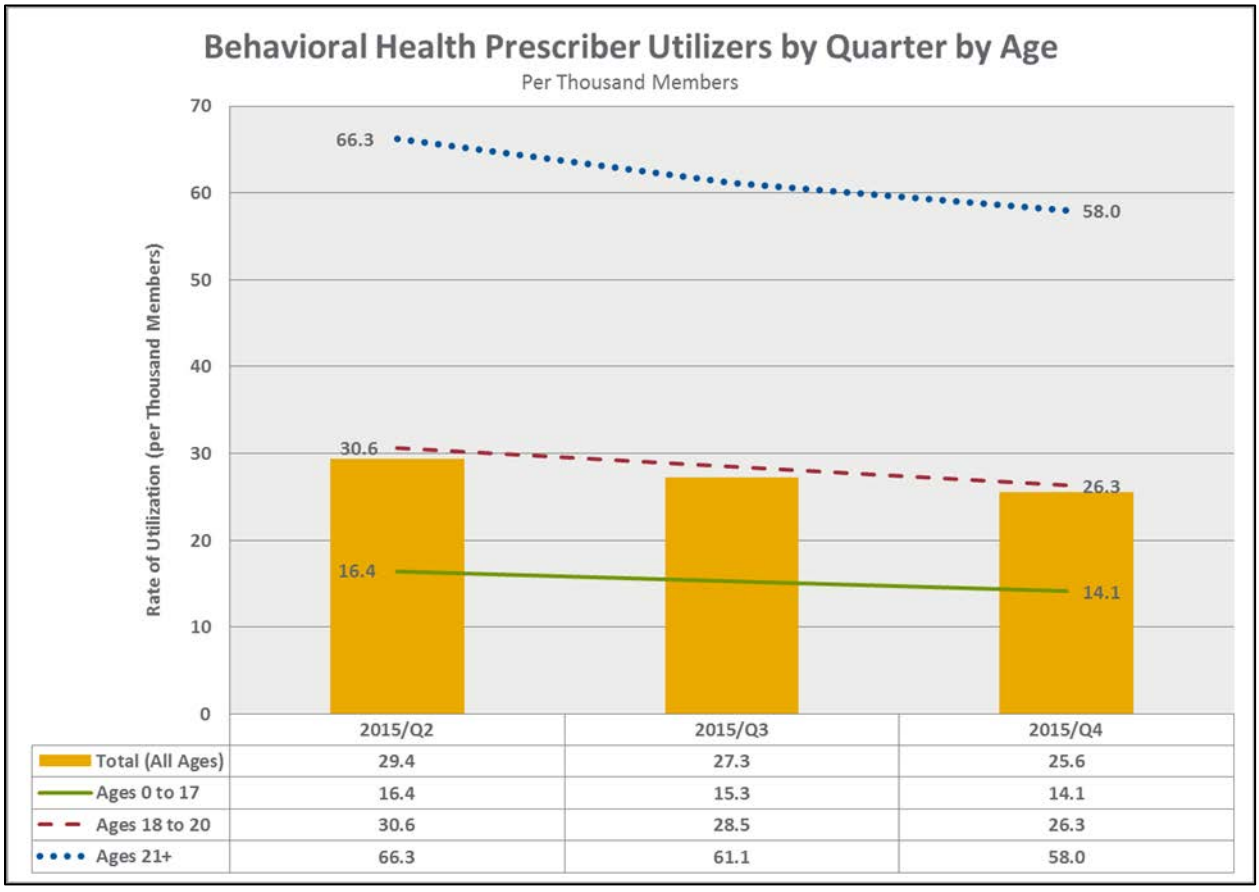
Prescriber Visit Utilization Rates

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. The rate is derived by dividing the numerator by the denominator.

Analysis: Overall, the utilization rate for behavioral health prescription visits reduced by 5% between Q2 2014 and Q4 2015. Within age groups, 0-17, 18-20, and 21+ years, prescription visit rates decreased 14% for 0-17 year olds, 14% for 18-20 year olds, and 12.5% for 21+ years and over. From a high level perspective, the use of behavioral health prescribers reduced 13% overall when all age groups are combined.

Utilization of prescriber visits is much greater for adults than for children. This pattern is appropriate in view of disability being a common eligibility requirement for adults to receive Medicaid in Idaho. The severity of adult behavioral health conditions often requires medication management. Child and youth disorders are often caused or heavily shaped by family issues, making medication management often less necessary



	2015/Q2	2015/Q3	2015/Q4
Total (All Ages)	29.4	27.3	25.6
Ages 0 to 17	16.4	15.3	14.1
Ages 18 to 20	30.6	28.5	26.3
Ages 21+	66.3	61.1	58.0

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 for analysis. The actual number of members receiving prescriptions from non-network providers may be substantial.

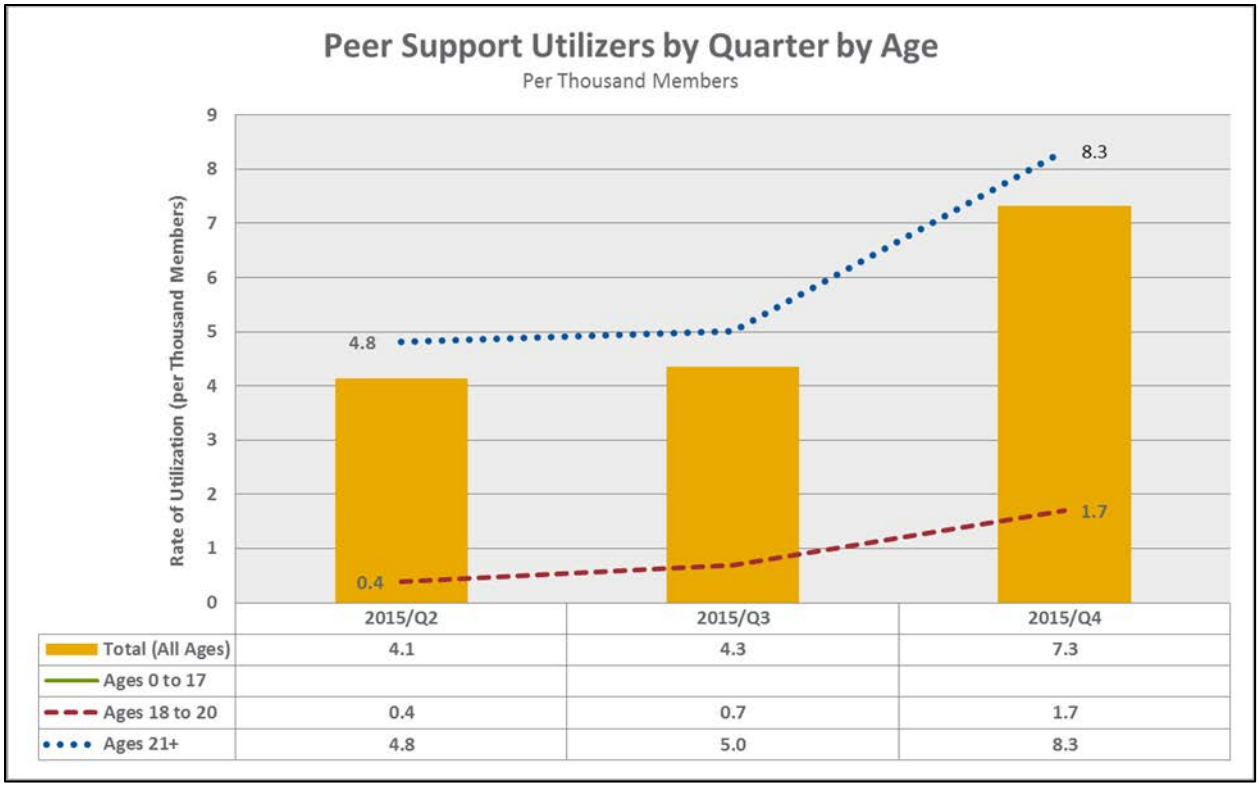
Opportunities and Interventions: Further analysis is needed to clarify the penetration of prescription services for the utilizer population, including non-network prescribers with data from non-Optum sources. The issue of appropriateness of utilization would need further analysis by diagnostic groupings to see if those members with diagnoses that national guidelines for clinical practice indicate medication management is appropriate are receiving medication and prescriber visits. Planning further system interventions will require more information.

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-day claims lag allowed providers to file claims.

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

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 78% between Q2 2015 and Q4 2015. This increase can be attributed to both the 18-20 and the 21+ year groups, since a 325% increase has occurred for the 18-20 years group and 73% for the 21+ group. Use of Peer Support services in the 21+ group is 4.9 times larger than in the 18-20 group. The numerically very large increase in Peer Support use in the 18-20 group is due to the high multiplicative effect of an absolutely small increase in use of Peer Support from 0.4 to 1.7 per 1,000 members.



	2015/Q2	2015/Q3	2015/Q4
Total (All Ages)	4.1	4.3	7.3
Ages 0 to 17			
Ages 18 to 20	0.4	0.7	1.7
Ages 21+	4.8	5.0	8.3

Barriers: The chief barrier to utilization of peer support specialists has been the limited number certified by the State of Idaho. A separate barrier has been variation of provider agencies across the state in willingness to offer this service. There is also a very limited supply of Peer Support Specialists. From Q2 2015 through Q4 2015, claims for 35 unique provider agencies have been filed. The lack of extensive historical experience with Peer Support for providers in the State of Idaho is also a likely interfering factor, since 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 underutilization outpatient services.

Optum Idaho does not control the number of Peer Support Specialists who are trained and certified. Our span of control is limited to advising provider agencies how to use those certified specialists.

Optum Idaho has already made changes in the utilization management program to make authorization of Peer Support Services easier for providers. The reimbursement rate structure has, since go-live, been more attractive for providers than is case management and CBRS. Providers have received training about Peer Support Services and Recovery and Resiliency benefits through use of Peer Support. Continued efforts in these directions are being pursued.

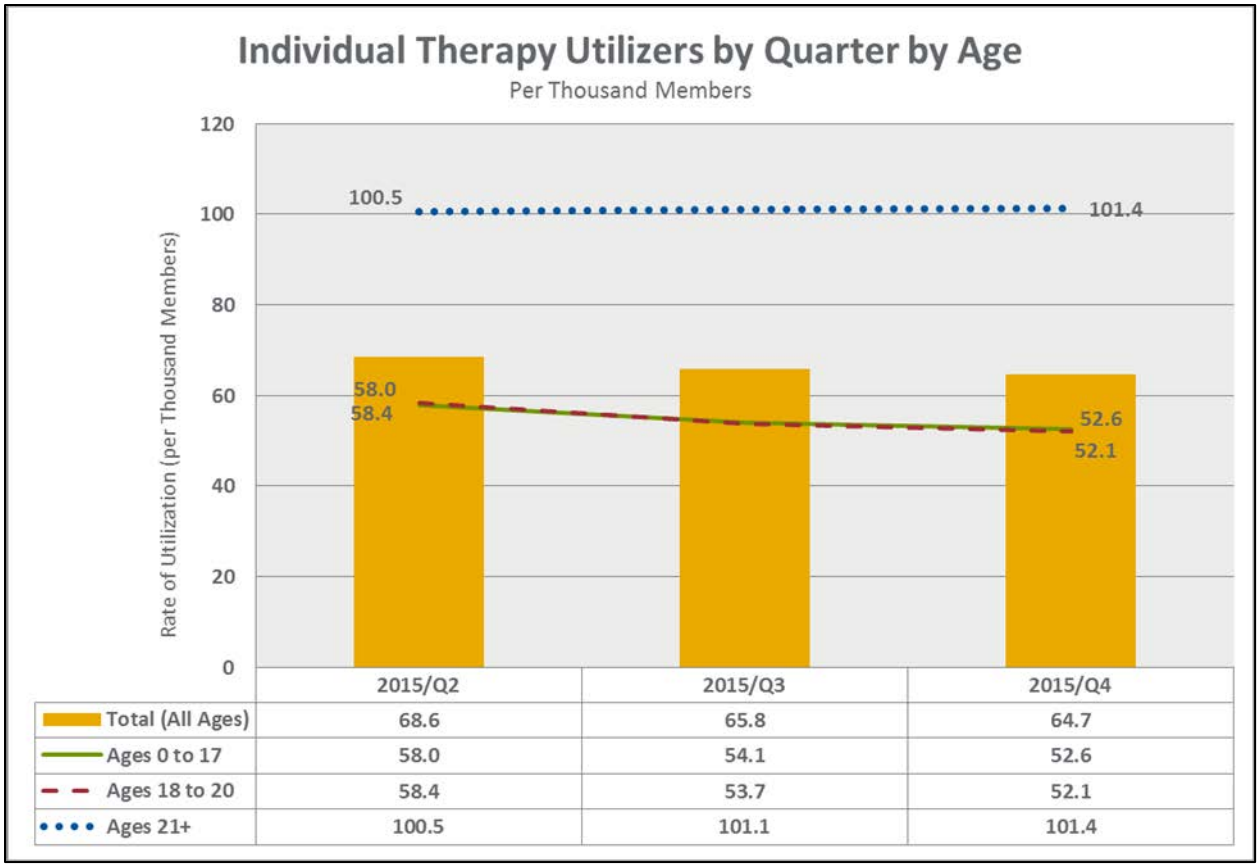
Individual Therapy Utilization Rates

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 Individual and Extended Therapy visits for a specific quarter. Individual and Extended Therapy are combined due to both being one-to-one therapies of different duration.
Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: Individual Therapy is important for many behavioral health disorders. Its appropriateness, however, can vary depending on the developmental age of a member. 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. As youth mature, their developmental capacity to use services comes to resemble the capacities of adults. It is expected, therefore, that there should be more adult utilizers of Individual Therapy than what would be seen with children, and that youth especially in the transitioning group aged 18-20 years should be intermediate.

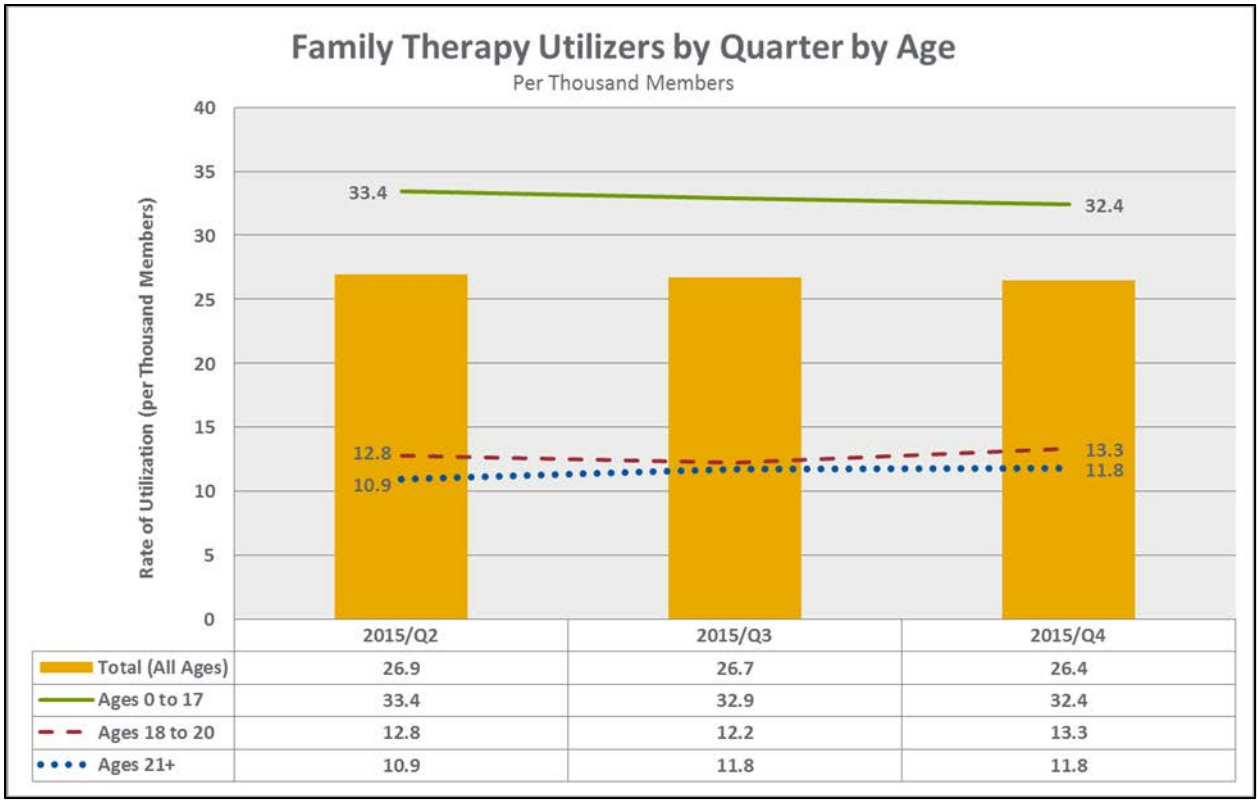
Examination of the data for the age groups 0-17 years, 18-20 years, and 21+ years, shows a clear predominance of utilizers of Individual Therapy in the adult group and many fewer for children and transitioning youth. In contrast to the expectation of more Individual Therapy for the transitioning youth group, it was found to nearly overlap child rates. In terms of utilizer rates, transitioning youth seem to be treated as though they are still children, at least with respect to use of Individual Therapy. Over the study period, there was very little change in utilizer rates for all age groups.



Family Therapy 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 Family Therapy visits for a specific quarter.
Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: Over the past 3 quarters beginning Q2 2015 for which there are reliable claims data, there is overall a small decrease of 2% in the utilizer rates for Family Therapy for all age groups studies. The 0-17 year group decreased 3%, the 18-20 year group increased 4%, and the adult 21+ year group increased 8%..



	2015/Q2	2015/Q3	2015/Q4
Total (All Ages)	26.9	26.7	26.4
Ages 0 to 17	33.4	32.9	32.4
Ages 18 to 20	12.8	12.2	13.3
Ages 21+	10.9	11.8	11.8

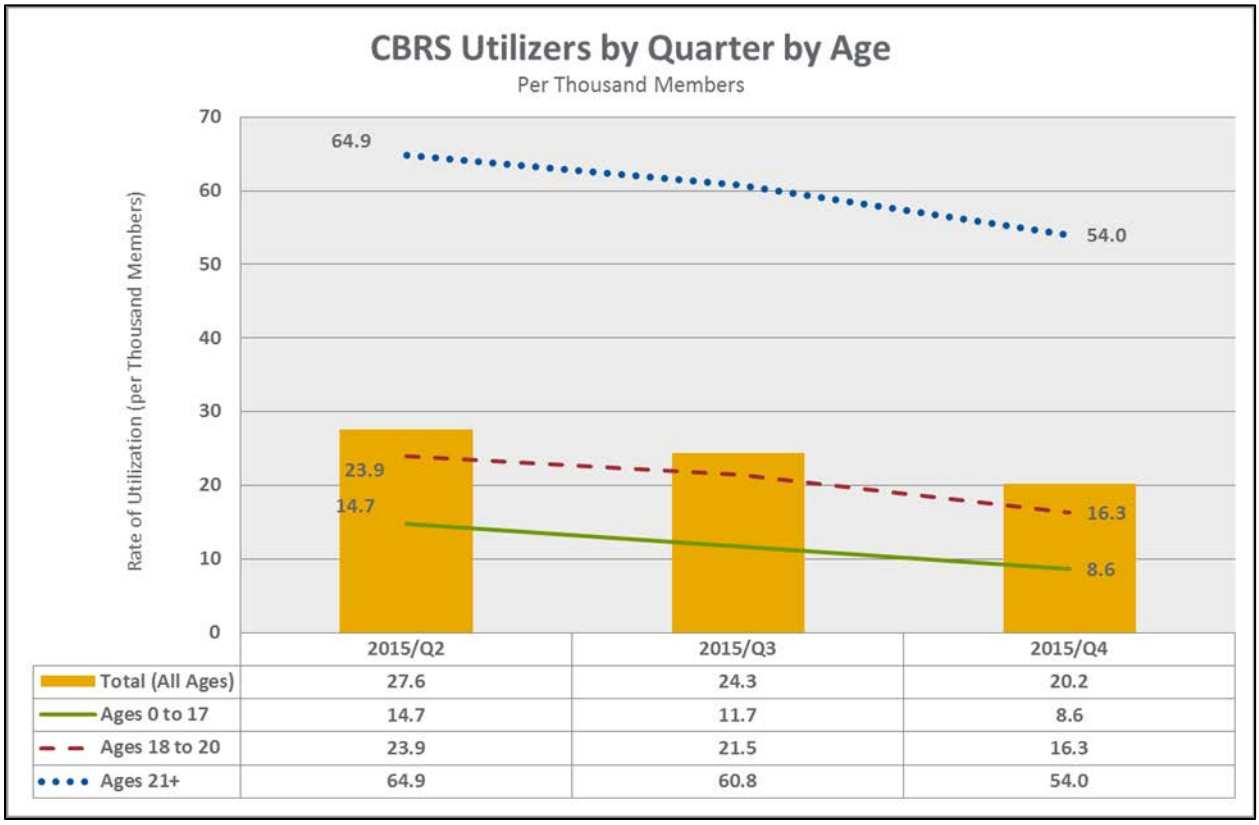
CBRS Utilization Rates

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. The rate is derived by dividing the numerator by the denominator.

Analysis: CBRS, the IBHP's name for psychosocial rehabilitation services, is a set of rehabilitation services originally developed to better meet the functional needs of adults with schizophrenia and severe and persistent bipolar disorder. The only two diagnostic groupings that the Treatment Guidelines of the American Psychiatric Association recognize psychosocial rehabilitation as appropriate are those two diagnoses. The extension of use of techniques developed for adults with usually psychotic chronic conditions to children with very different conditions historically appeared in Idaho to the extent that CBRS was being used more with children/youth than with adults. Because the age of onset of schizophrenia and bipolar disorder has a modal distribution around the 18-20 year group, the use of more CBRS for transitioning youth would be expected than for children 0-17.

Between Q2 2014 and Q4 2015, three month's duration, the reduction in CBRS for all age groups combined was 39%. 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 42%,

32%, and 17% respectively within the study period of Q2 2015 to Q4 2015. The study period began with a predominance of adult over transitioning youth and children and youth utilizers of CBRS, by the end of study period, adult utilizers predominated 6.3 times over child utilizers, and transitioning child and youth utilizers predominating 1.9 times over child utilizers. These changes have sustained a more clinically appropriate use of CBRS for different age groups.

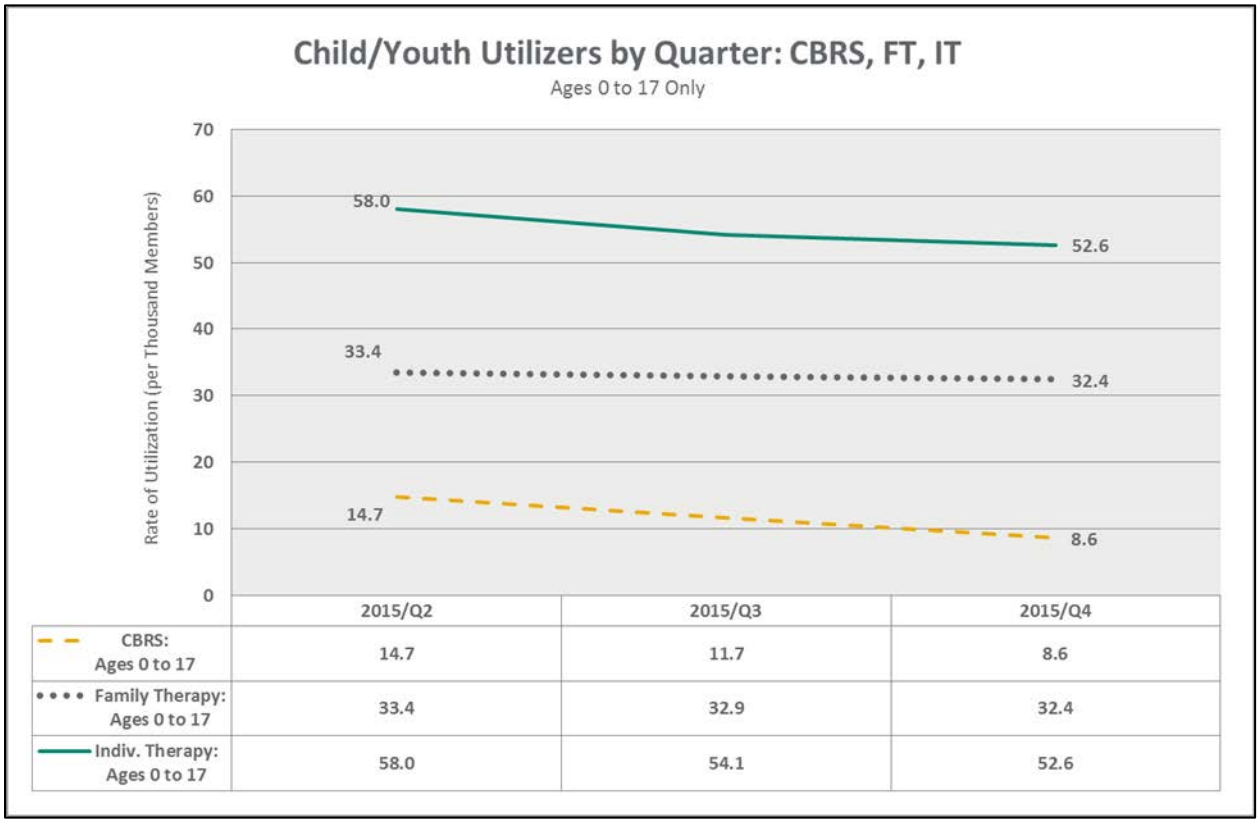


CBRS, Family Therapy, and Individual/Extended Therapy Utilization Rates

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, Family Therapy, or Individual/Extended Therapy for a specific quarter. For simplification, the utilizers of Individual and Extended Therapy, both 1-to-1 therapies, are combined under the name "IT" (Individual Therapies).
Denominator is the total number of IBHP members for the same quarter, in thousands. The rate is derived by dividing the numerator by the denominator.

Analysis: This graph combines the findings about utilizer rates for CBRS, Family Therapy, and the Individual Therapies in one graph for the child group 0-17 years. It begins in the first quarter in which Optum Idaho initiated utilization review, Q2 2015 and runs through Q4 2015, the most recent quarter in which reliable claims data is available. For the child group 0-17 years, there is a reduction in utilizers of Individual Therapies of 9.3%, CBRS utilizer rates have reduced 41.5%, and Family Therapy utilizer rates have decreased 3.0%.

Appropriate treatment planning for childhood disorders should display a greater use of Family Therapy than Individual Therapies, since Individual Therapy is expected to be an add-on treatment for most disorders, and Family Therapy the core treatment modality. The current pattern does not conform with this expected rate. The use of Individual Therapies still far exceeds the use of Family Therapy. There has been improvement over time. The ratio of Individual Therapies to Family Therapy (IT/FT) for Q2 2015 had been 1.7. For Q4 2015 the ratio was 1.6, a 6.5% reduction.



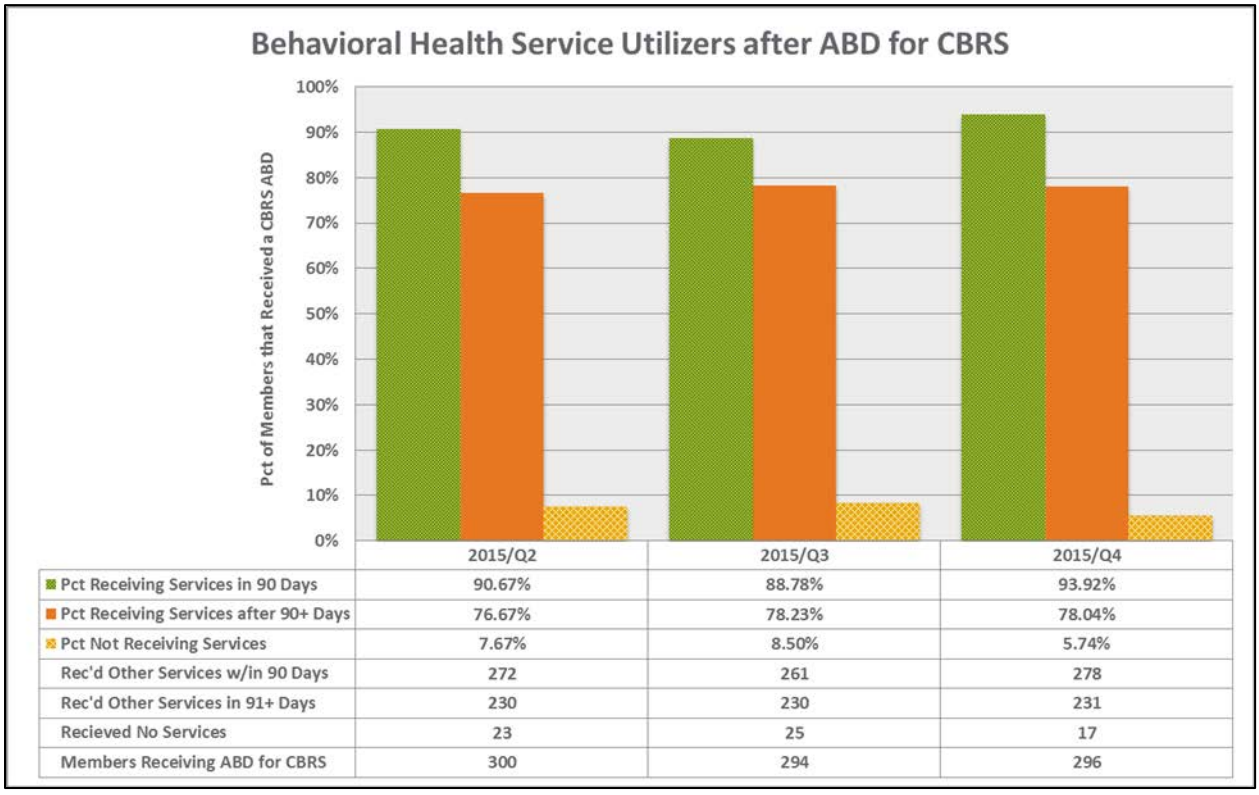
	2015/Q2	2015/Q3	2015/Q4
CBRS: Ages 0 to 17	14.7	11.7	8.6
Family Therapy: Ages 0 to 17	33.4	32.9	32.4
Indiv. Therapy: Ages 0 to 17	58.0	54.1	52.6

Services Received Post CBRS Adverse Benefit Determination

Methodology: Based on Adverse Benefit Determination and Claims data. The design was to identify the final (or last) ABDs entered for requests for CBRS issued within a quarter between Q3 2014 and Q3 2015, the last quarter for which reliable claims data is available. Claims paid for treatment services (that is, medication management or psychotherapy) were then recorded as positive for both the period within 90 days of the ABD and then any following the 90-day period, to allow time for providers and members/families to shift into medically necessary care.

Analysis: Between Q2 2015 and Q4 2015, use of medically necessary services has increased following denials of authorization for CBRS. In Q2 2015, 7.7% of members who had had CBRS authorization denied did not follow up with therapeutic services. Since Q4 2015, 5.7% of members have not included therapeutic services in place of CBRS, a 25% reduction in under-utilizers. Over the three quarters of this study, in the first 90 days following the ABD,

approximately 89-94% of members have received therapeutic services. Treatment continuation has been present in approximately 77-78% of members who have received ABDs. The overall pattern has been one of openness to acceptance of alternative services to CBRS, with an increasing acceptance over the study period. An unknown percentage of these members receiving "no services" may in fact be receiving medication from non-network prescribers that would not be reportable from Optum's claims database.



	2015/Q2	2015/Q3	2015/Q4
Pct Receiving Services in 90 Days	90.67%	88.78%	93.92%
Pct Receiving Services after 90+ Days	76.67%	78.23%	78.04%
Pct Not Receiving Services	7.67%	8.50%	5.74%
Rec'd Other Services w/in 90 Days	272	261	278
Rec'd Other Services in 91+ Days	230	230	231
Recieved No Services	23	25	17
Members Receiving ABD for CBRS	300	294	296

Barriers: Historically, the Idaho Medicaid benefit, before Optum, limited access to all psychotherapies. Consequently, patterns of practice evolved that adapted to the benefit structure by favoring psychosocial rehabilitation over psychotherapy. And within the psychotherapies, Individual Therapy became favored, even though it was not the most important psychotherapy for most childhood disorders. Although progressively changing, limited provider familiarity with evidence-based therapies for children has 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 repeated work with providers to encourage trying new practices. Provider trainings on medical necessity, promotion of use of national guidelines form the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry, care management contacts by Care Advocates, Field Care Coordinators, and Medical Directors, and the Utilization Management program that informs providers when a requested service is not consistent with national guidelines and makes recommendations for more appropriate care 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 Idaho continues to look at rectification of the service mix delivered to children and youth in the State. Over time, as utilization of medically appropriate services for these age groups matures, we look for further reduction in CBRS and enhancement of Family Therapy with eventual use of more Family Therapy for children than Individual Therapies. We also look to increased utilization of Individual Therapies in the transitioning youth group, 18-20 years. We also desire a continued increase in Peer Support Services in adults and transitioning youth. With Family Support Services becoming available in May 2016, we also look towards use of those value-added, Recovery and Resiliency services being used for the benefit of children and their families.

In addition to provider education improving utilization of appropriate services through recommendations on the supply side, we plan to continue member and family education to promote knowledge of medically necessary treatment in order to improve utilization from the demand side.

Appropriateness of Diagnosis-Specific Patterns of Service Utilization

Methodology: Optum by contract conducts utilization management in accordance with national professional standards of clinical practice. Optum has adopted the use of recommendations of practice from SAMSHA, the American Psychiatric Association's (APA) Treatment Guidelines, and the American Academy of Child and Adolescent Psychiatry's (AACAP) Practice Parameters as a best approximation of national professional standards. The reasons for selecting the APA and AACAP recommendations include:

1. Both organizations are well respected national organizations representing providers who treat both adults and children.
2. Both maintain robust, standardized processes incorporating reviews of the literature plus expert consensus.
3. Both are recognized by a federal agency, the AHRQ (Agency for Healthcare Research and Quality), including a national guideline clearinghouse that maintains guidelines in accordance with AHRQ standards.
4. Both periodically update their guidelines. APA maintains guideline watches. AACAP periodically catches up by updating practice parameters. Eating Disorders was updated earlier in 2015.

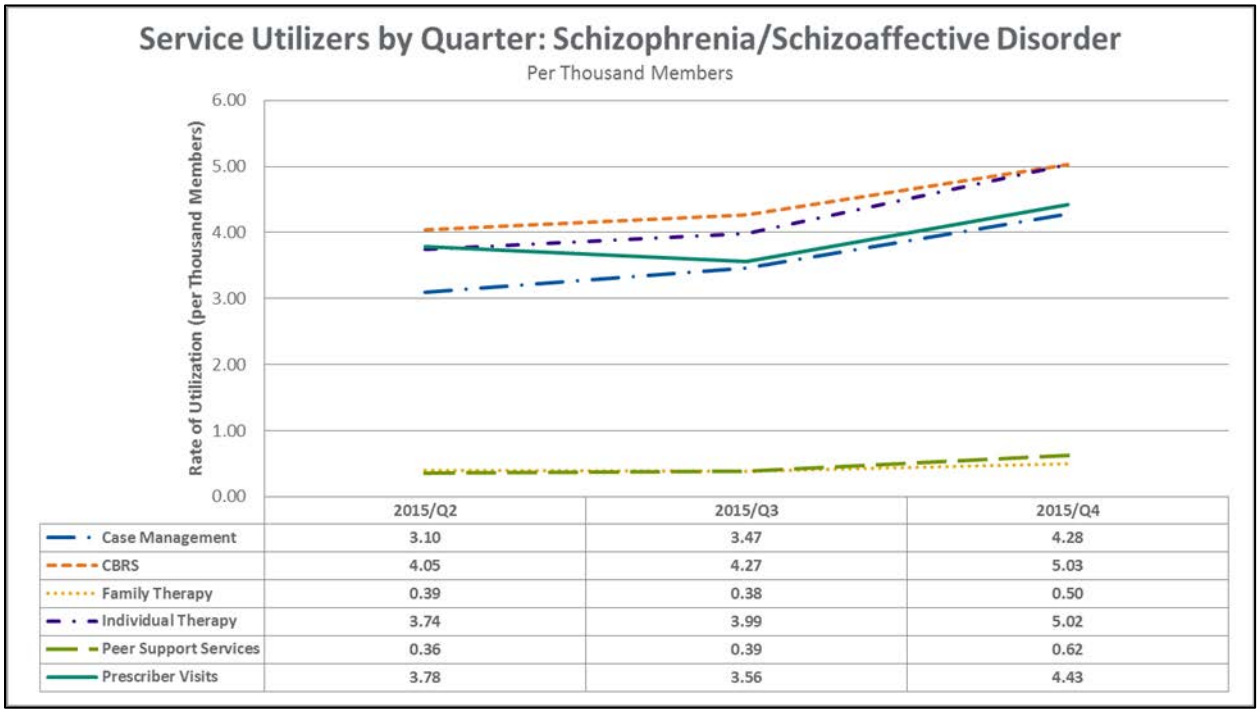
These guidelines are used for making medical necessity determinations that are of a quality that meets professionally-recognized standards of health care, in keeping with the IDAPA definition of medical necessity.

The following section compares claims data for service visits to the diagnosis-specific recommendations from the APA and AACAP treatment guidelines as well as from SAMHSA's recommendations for care. Because of the 90-day claims lag allow for providers to submit claims, only the last 3 quarters that are past the 90-day claims lag are presented, so that the data can be reliable.

Service utilization rates are displayed as visits per 1,000 IBHP members for each calendar year quarter during the past 4 quarters for which reliable data is available.

Analysis: Schizophrenia: APA Treatment Guidelines recommend the use of medication management, and then in the stable phase of Schizophrenia adjunctive use of specific psychosocial interventions that include Family Interventions, Supported Employment (not covered under the Idaho State Plan), Assertive Community Treatment (not covered under the Idaho State Plan), Skills Training (covered under CBRS), and Cognitive Behavioral Psychotherapy (covered under the Individual Therapy benefit). For purposes of analyses, due to a common practice in Idaho of coding persons with Schizophrenia as having Schizoaffective Disorder, data is presented that combines claims data for both Schizophrenia and Schizoaffective Disorder.

The most commonly used service billed to the IBHP is for CBRS, followed by Individual Therapy and then Behavioral Health prescriber visits. An unknown number of IBHP members receive their medication from non-network prescribers who accept Medicaid reimbursement, so that number provided should not be construed as representative of the actual medication service visits that are delivered. Case Management Services are also being received and appear as the fourth most commonly billed service. Peer Support Services, a SAMSHA-recommended service covered as a Value-Added Service under Optum Idaho, appears with low frequency, as does Family Therapy. As time has passed since Q2 2015, there has been a distinct increase in the rate of use of Individual Therapy, CBRS, Behavioral Health prescriber visits, and Case Management, suggesting that members with Schizophrenia or Schizoaffective Disorder are receiving more recommended principal treatments for this disorder. There is also a small increase in the use of Peer Support Services and Family Therapy, despite these services being nationally professionally recommended interventions.

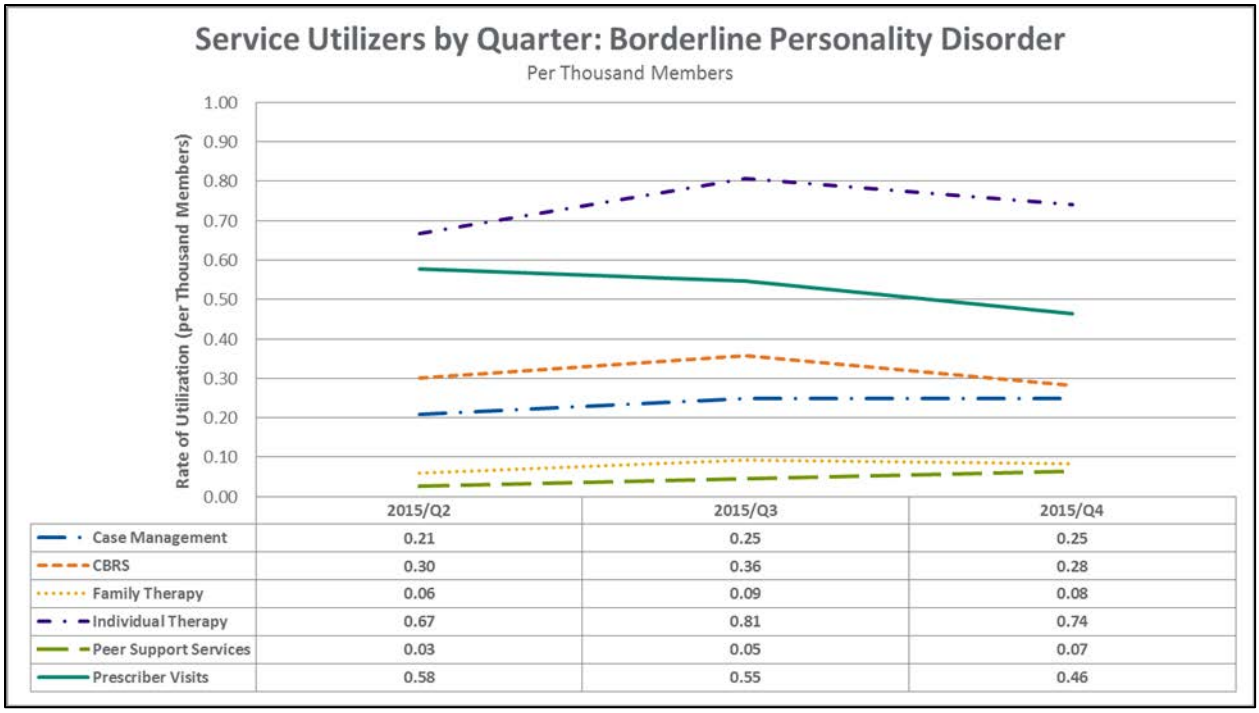


	2015/Q2	2015/Q3	2015/Q4
Case Management	3.10	3.47	4.28
CBRS	4.05	4.27	5.03
Family Therapy	0.39	0.38	0.50
Individual Therapy	3.74	3.99	5.02
Peer Support Services	0.36	0.39	0.62
Prescriber Visits	3.78	3.56	4.43

Borderline Personality Disorder: Even though Borderline Personality Disorder can occur in adolescents, national professional guidelines for its treatment come from the APA's Treatment Guidelines. Recommendations include primarily specialized Individual Therapy for a protracted period other than Cognitive Behavioral Therapy, which has not been found to be of benefit. Individual Therapy is said to be the primary therapy. In specific situations, adjunctive Family Therapy, Group Therapy, and Couples Therapy are also recommended. Although there are no FDA approved medications specifically for Borderline Personality Disorder, the use of medication off-label is recommended to help with symptom control, especially in the area of cognitive distortions, emotional storms, anger, depression, and anxiety.

The observation during peer reviews that some IBHP members with a diagnosis of Borderline Personality Disorder receive CBRS without the use of Individual Therapy or medication management led to a concern that persons with that diagnosis might not be receiving appropriate treatment.

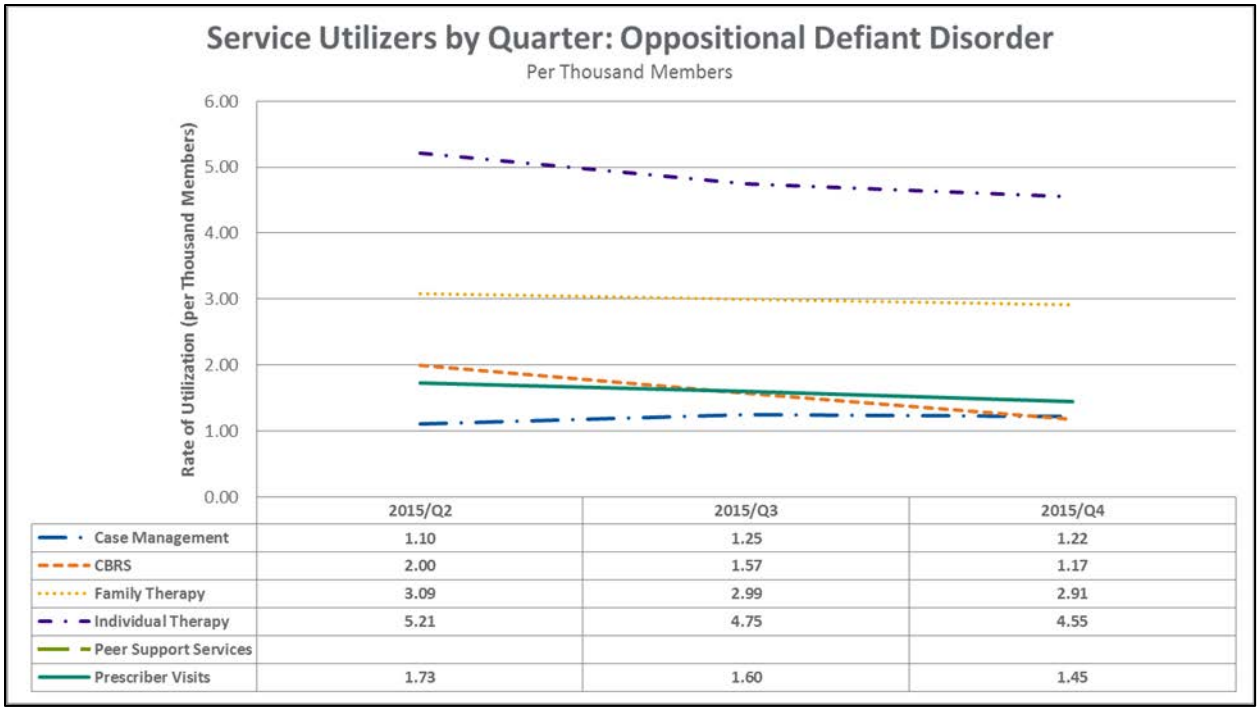
Review of the quarters between Q2 2015 and Q4 2015, the interval for which reliable claims data exist, shows that the most commonly used treatment is Individual Therapy, in keeping with recommendations from national professional treatment guidelines. Next most common service billed for was Behavioral Health medication management. The third most common is CBRS, and the fourth most common Case Management Services. Both Peer Support Services and Family Therapy, despite being recommended in national professional guidance and SAMHSA, are the least frequently used among the services examined. It should be mentioned that CBRS continues to be extensively used, even though it is not recommended in the APA professional guidelines. Over time, there is less common use of CBRS for this diagnosis. Unlike with Schizophrenia and Schizoaffective Disorder, there is a trend in Q4 2015 towards fewer billings for Individual Therapy and Behavioral Health medication management, the nationally recommended services. There is increasing use of Case Management Services, which some authorities in Borderline Personality Disorder regard as the most helpful intervention for persons with that disorder but which is not mentioned in the national treatment guidelines. It is premature to judge if the decrease in Individual Therapy and Behavioral Health prescriber visits is part of a trend or a transient fluctuation.



	2015/Q2	2015/Q3	2015/Q4
Case Management	0.21	0.25	0.25
CBRS	0.30	0.36	0.28
Family Therapy	0.06	0.09	0.08
Individual Therapy	0.67	0.81	0.74
Peer Support Services	0.03	0.05	0.07
Prescriber Visits	0.58	0.55	0.46

Oppositional Defiant Disorder: This childhood disorder is one of the five most prevalent diagnoses given for IBHP members. The AACAP Practice Parameters identify only two evidence-based practices for it: Family-based behavioral intervention by parents to reshape child disruptive behavior and, for school-aged children, Individual Therapy that uses Problem-Solving Skills Training. At all ages, the principal known effective intervention is a form of Parenting Skills Training that Optum Idaho allows to be billed under the Family Therapy benefit.

The graph for the study period displays that the procedure most commonly billed for is Individual Therapy, not the expected service of Family Therapy. Family Therapy appears as the second most common service. The study period began with CBRS as the third most common service, but by Q4 2015 it had moved to fourth most service. Prescriber visits have moved from fourth most common to third most common, even though medication management is usually not a solution for Oppositional Defiant Disorder except in those instances in which Oppositional Defiant Disorder is secondary to a medication-responsive disorder such as ADHD or a Depressive Disorder. Over times there has been a small increase in the use of Case Management Services, which are support services but not a therapeutic service for this diagnosis. Peer Support Services are not displayed due to their being suitable only for adults 18 years of age and over. Trend analysis shows decrease in use of both Individual Therapy and CBRS and consistent use of Family Therapy during this period. It would have been expected that as service patterns moved away from CBRS, which is not indicated for Oppositional Defiant Disorder, and from Individual Therapy, a service that is not expected to be used as much as Parenting Skills Training, that the use of Family Therapy would have increased. The fact that Family Therapy is not being used less is consistent with appropriate service utilization; the absence of an increase in its used is not consistent.



	2015/Q2	2015/Q3	2015/Q4
Case Management	1.10	1.25	1.22
CBRS	2.00	1.57	1.17
Family Therapy	3.09	2.99	2.91
Individual Therapy	5.21	4.75	4.55
Peer Support Services			
Prescriber Visits	1.73	1.60	1.45

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 medication services within the Optum network in the last 90 days are eligible to participate. As of the survey mail date, 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 for the survey only once every 12 months.

A random sample of individuals eligible for the survey is then selected. 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* (composite score of qsts 2-7)
- *Experience with provider network* (composite score of qsts 10-14)
- *Experience with counseling and treatment* (composite score of qsts 15-23)
- *Overall experience* (qst 25, % respondents selected 'Excellent', 'Very Good', or 'Good')

Quarterly Performance Results:

Member Overall Satisfaction Survey	Performance Goal	Q4 2014	Q1 2015	Q2 2015	Q3 2015*
Experience w/Optum ID Staff and Referral Process	≥85.0%	84.7%	85.5%	85.8%	77.4%
Experience with the Behavioral Health Provider Network	≥85.0%	91.5%	91.0%	91.6%	88.8%
Experience with Counseling or Treatment	≥85.0%	92.6%	91.9%	96.7%	90.9%
Overall Experience	≥85.0%	88.6%	92.2%	94.2%	86.3%

*Based on the Member Satisfaction Survey sampling methodology, Q3, 2015 data is the most recent results available.

Analysis: The rate of member's Overall Experience with Behavioral Health services decreased from 94.2% during Q2, 2015, to 86.3% during Q3, 2015. The Member's experience with the Behavioral Health Provider Network decreased from 91.6% during Q2 to 88.8% during Q3. Member's experience with counseling and treatment decreased from 96.7% during Q2 to 90.9% during Q3.

Member's experience with Optum ID Staff and Referral Process decreased from 85.8% during Q2 to 77.4% during Q3. Questions 2 – 7 on the survey comprise the broader category of "Experience with Optum Staff and Referral Process. The questions are:

- The information I received helped me.
- My calls were answered quickly.
- The Optum Idaho staff treated me with courtesy and respect.
- The Optum Idaho staff listened carefully to me.
- The Optum Idaho staff explained things in a way I could understand.
- I was satisfied with the process of getting referrals.

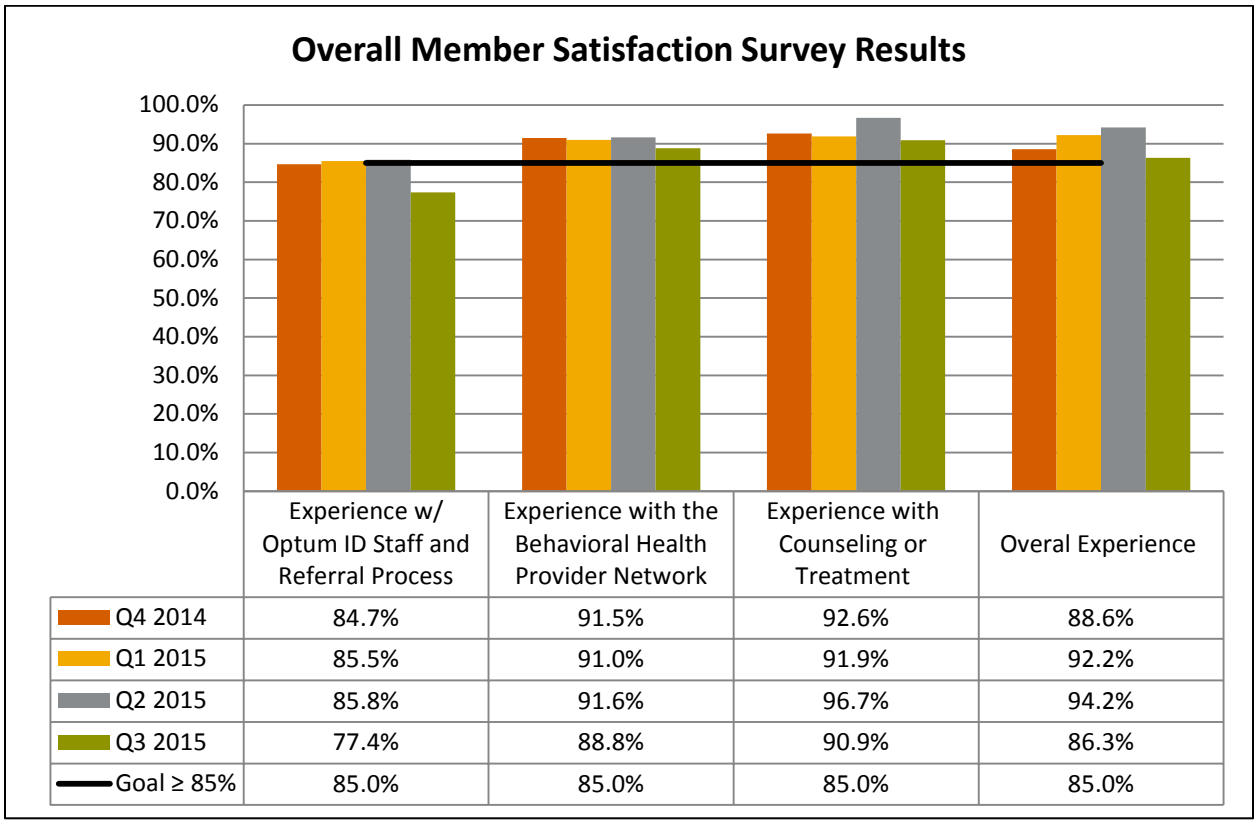
These questions are designed to be answered only by survey respondents who answered "Yes" to question 1: "Did you speak with an Optum Idaho staff member?" The data, however, indicated that respondents, who answered "No" to question 1, did answer questions 2 – 7, which may have impacted the decrease in this category.

In addition, the Member Satisfaction Survey includes specific questions related to the member's experiences with counseling and treatment:

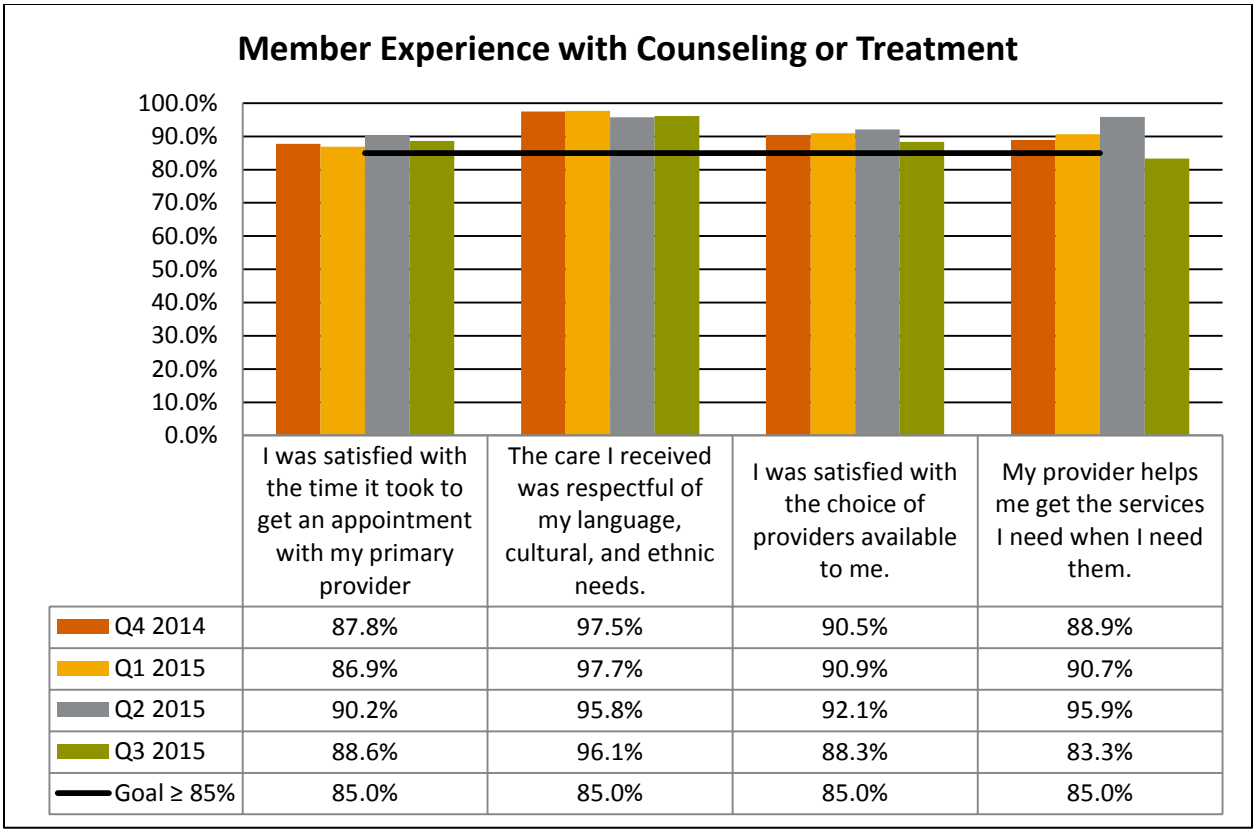
- "I was satisfied with the time it took to get an appointment with my primary provider."

Q3 result was 88.6% which was a decrease from 90.2% during Q2.

- "The care I received was respectful of my language, cultural, and ethnic needs."
  Q3 result was 96.1% which was an increase from 95.8% during Q2.
- "I was satisfied with the choice of providers available to me."
  Q3 result was 88.3% which was a decrease from 92.1% during Q2.
- "My provider helps me get the services I need when I need them."
  Q3 result was 83.3% which was a decrease from 95.9% during Q2.



	Experience w/ Optum ID Staff and Referral Process	Experience with the Behavioral Health Provider Network	Experience with Counseling or Treatment	Overal Experience
Q4 2014	84.7%	91.5%	92.6%	88.6%
Q1 2015	85.5%	91.0%	91.9%	92.2%
Q2 2015	85.8%	91.6%	96.7%	94.2%
Q3 2015	77.4%	88.8%	90.9%	86.3%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%



	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.
Q4 2014	87.8%	97.5%	90.5%	88.9%
Q1 2015	86.9%	97.7%	90.9%	90.7%
Q2 2015	90.2%	95.8%	92.1%	95.9%
Q3 2015	88.6%	96.1%	88.3%	83.3%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%

Barriers: Forty-eight of survey respondents answered "No" to question #1, "Did you speak with an Optum Idaho staff member." However, the data showed that some of the respondents answered the additional questions (questions 2-7) which are designed to only be answered if the respondent answered "Yes" to question 1.
Opportunities and Interventions: Optum Idaho will continue to monitor and identify trends.

Provider Satisfaction Survey Results

Optum Idaho regularly conducts a provider satisfaction survey of providers delivering behavioral health services to IBHP members. This survey addresses provider satisfaction with Optum services including Care Advocacy, Network Services and Claims Administration. The results of the survey are analyzed for tracking and trending. Action plans are developed to address opportunities for improvement. In 2014 Optum Idaho established a target for "Overall Provider Satisfaction" of 85%.

Methodology: Fact Finders, Inc., an independent health research company, conducts the Provider Satisfaction Survey for Optum. The questionnaire used to survey Optum providers has been developed to measure key indicators of satisfaction with Optum. These include:

Overall Satisfaction	*Customer Service Line*
Authorizations	*Peer Review*
Field Care Coordinators	*Alert Care Management*
Claims	*Optum Website*
Training and Education	*Electronic Health Records*
Provider Monitoring Audits	*Complaint Process*
Suggestions for Improvement	

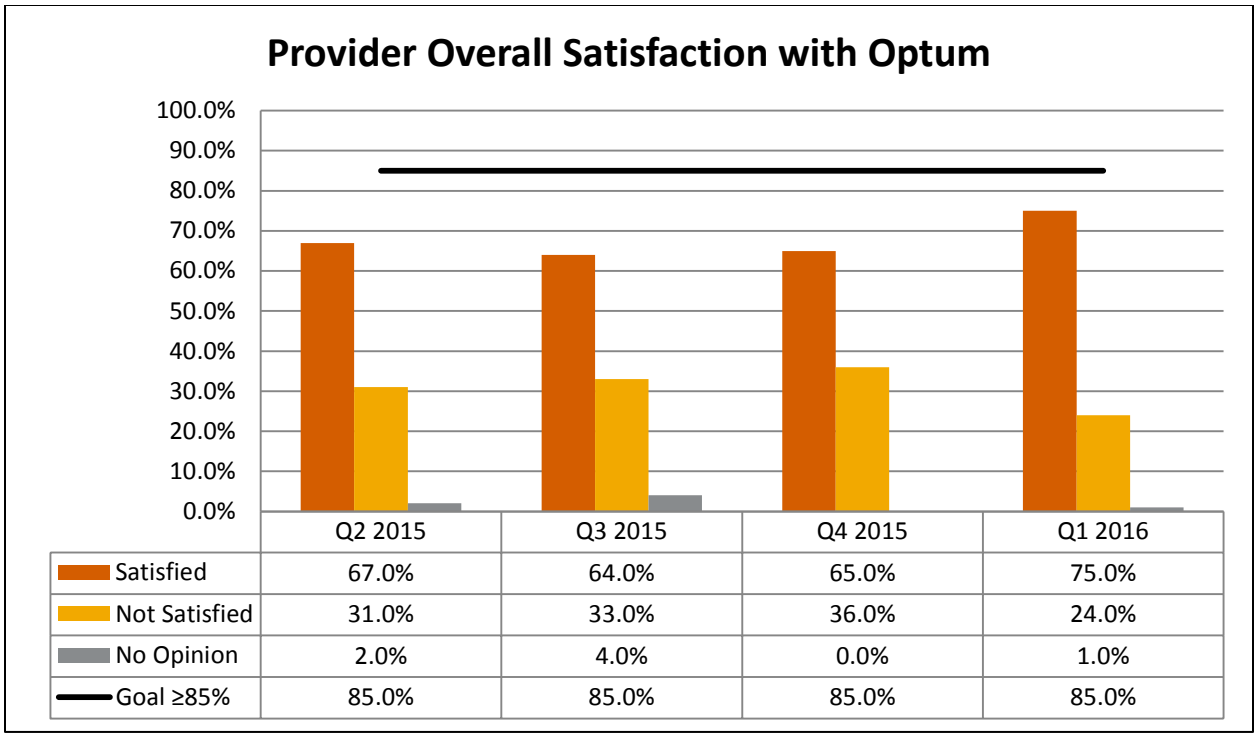
Surveys are conducted over the phone between providers and a representative from Fact Finders, Inc. The representative from Fact Finders, Inc., places an initial call to the provider agency to introduce the research and schedule an appointment to conduct the survey. Provider agencies are then called by an interviewer at the appointed date and time. Providers are given the option of calling Fact Finders' toll-free telephone number to complete the interview at their convenience, as well. Providers may also request to complete the survey via fax.

Quarterly Performance Results:

Provider Satisfaction Survey	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Satisfied	≥85.0%	67.0%	64.0%	65.0%	75.0%
Not Satisfied	NA	31.0%	33.0%	36.0%	24.0%
No Opinion	NA	2.0%	4.0%	0.0%	1.0%

Analysis: Although overall Provider satisfaction continued to fall below the performance goal of ≥85%, the scores increased 13% from the previous quarter. Several Improvement Action Plans were initiated in Q1 and Q2, 2015 to monitor and address Provider Satisfaction. These Improvement Action Plans address:

- Provider Overall Satisfaction with Optum
- Provider Satisfaction with Peer Review Process
- Provider Satisfaction-Customer Service



	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Satisfied	67.0%	64.0%	65.0%	75.0%
Not Satisfied	31.0%	33.0%	36.0%	24.0%
No Opinion	2.0%	4.0%	0.0%	1.0%
Goal ≥85%	85.0%	85.0%	85.0%	85.0%

Barriers: Optum Idaho continues to monitor and address the barriers to provider satisfaction.

Opportunities and Interventions: We will continue to monitor this measure in 2016 and promote initiatives to improve the network experience with Optum. The following project initiatives highlight key accomplishments during Q1:

Improvement Action Plan	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
Provider Overall Satisfaction with Optum (Provider Survey Results)	1/23/2015	Provider Advisory Committee Quality Assurance Performance Improvement	Open	•Provider Advisory Committee (PAC) reviewed the Provider Satisfaction survey and made recommendations for changes. Will present recommendations to QAPI.
Provider Satisfaction-Customer Service	1/30/2015	Quality Assurance Performance Improvement	Open	•Continuing to monitor
Provider Satisfaction with Peer Review Process	2/1/2015	Clinical and Services Advisory Committee	Open	•36% of Peer Reviews were conducted in house 1/11 – 2/5/16. •The Provider Advisory Committee is working to revise Provider Satisfaction Survey questions

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 were initiated and are currently open. 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 Q1.

Improvement Action Plan	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
Special Programming for Pre-Adults Facing Transition to Adulthood	4/26/2014	Clinical and Services Advisory Committee	Open	•Optum involved with juvenile corrections outreach •Trainings on recovery and resiliency ongoing •Looking into closing this IAP and separating it into 2 or 3 different IAP's to reconfigure objectives
Provider Overall Satisfaction with Optum (Provider Survey Results)	1/23/2015	Provider Advisory Committee Quality Assurance Performance Improvement	Open	•Provider Advisory Committee (PAC) reviewed the Provider Satisfaction survey and made recommendations for changes. Will present recommendations to QAPI.
Provider Satisfaction with Peer Review Process	2/1/2015	Clinical and Services Advisory Committee	Open	•36% of Peer Reviews were conducted in house 1/11 – 2/5/16. •The Provider Advisory Committee is working to revise Provider Satisfaction Survey questions.
Provider Satisfaction-Customer Service	1/30/2015	Quality Assurance Performance Improvement	Open	•Continuing to monitor
Complaint Acknowledgement	1/27/2015	Quality Assurance Performance Improvement	Open	•Provider Satisfaction Survey results indicated that 67% of providers received written acknowledgement of complaint. Internal Audit results indicated that 93% of complaints had acknowledgement letter sent. The plan is to role this IAP over to the overall Provider Satisfaction IAP as PAC is reviewing the Provider Satisfaction Survey questions and making recommendations for change.

7 Day Post-Discharge Monitoring	4/8/2015	Clinical and Services Advisory Committee	Open	•SR26 report modified to track post-hospital outpatient follow-up appointments for members for 7 days vs. 10 days. This change is in line with NCQA/ HEDIS standards. •Reporting needs to be determined.
ALERT Peer Review	10/2/2015	Quality Assurance Performance Improvement Committee and Clinical and Services Advisory Committee	Open	•Project charter completed. •Draft of ABD letter completed. •Overall workflow completed. •Planning for pilot project initiated.
Appointment Reminder	2/23/16	Clinical and Services Advisory Committee	Open	•IAP initiated. •Network providers engaged in initial set up. •Training of providers initiated.
FCC Familiarity	3/22/16	Clinical and Services Advisory Committee and Provider Advisory Committee	Open	•IAP initiated. •Draft of FCC flyer completed and submitted to communications

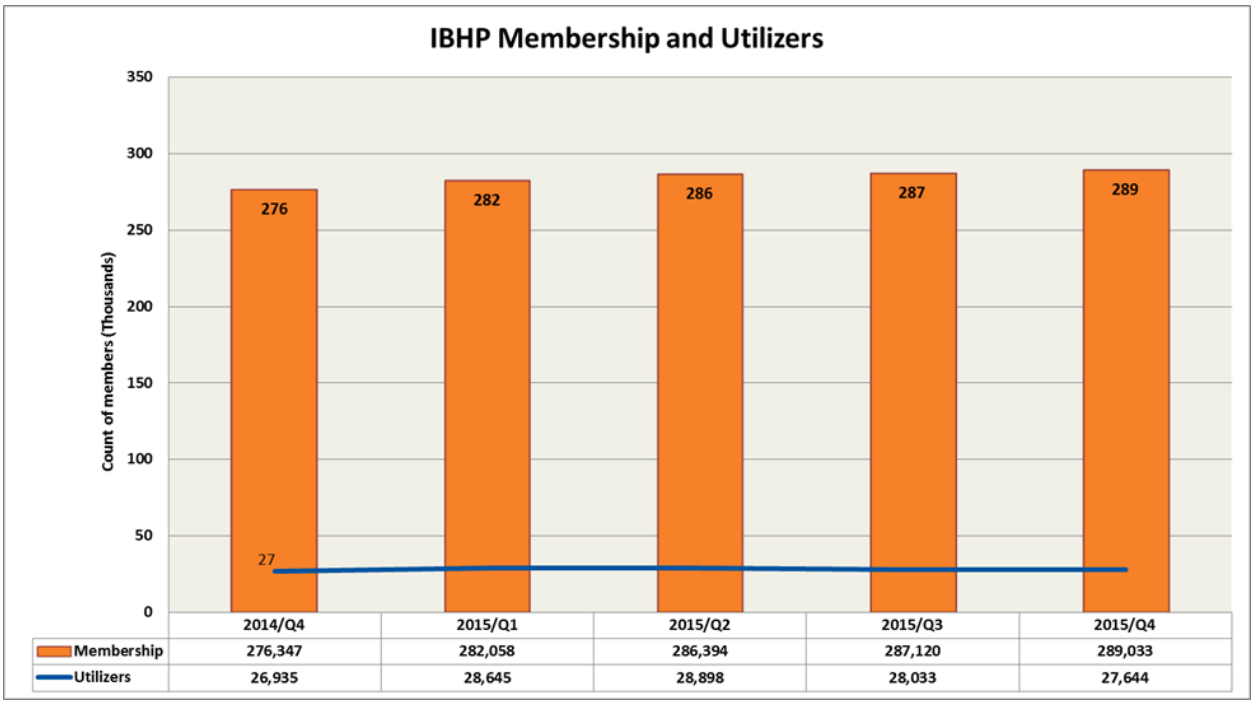
The following is a list of Improvement Action Plans Closed during Q1, 2016:

Improvement Action Plan	Date Closed
Provider Website	1/19/16
Clinical Model 2.1	2/5/16
Authorizations: Provider Service Line-Ease of Getting Through	3/1/16
Authorizations: Resolution of Questions	3/1/16

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. Due to claims lag, data is reported one quarter in arrears.



Analysis: While membership numbers increased slightly, 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 (120 seconds) and call abandoned rate (≤7%). Data source is Avaya's Communication system (ProtoCall).

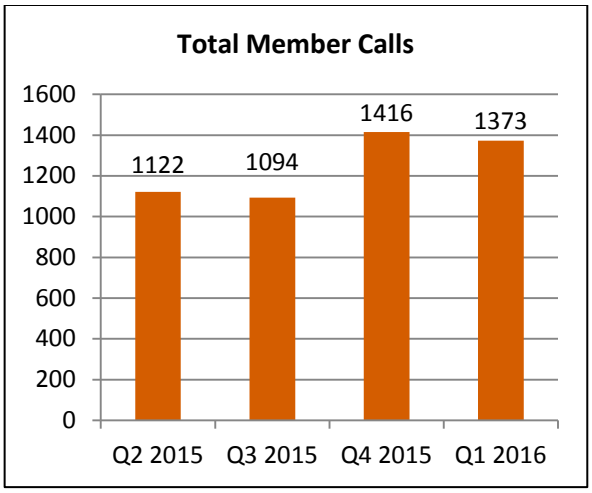
Quarterly Performance Results:

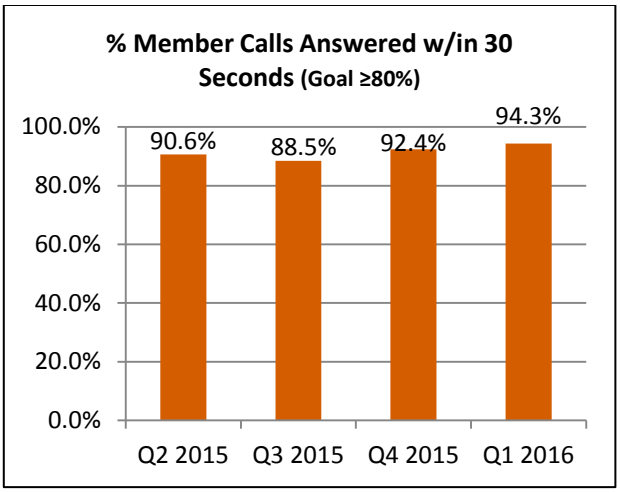
Member Service Line	Optum Idaho Standards	IBHP Contract Standards	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Total Number of Calls	NA	NA	1,122	1,094	1,416	1,373
Percent of Calls Answered Within 30 Sec	≥80.0%	None	90.6%	88.5%	92.4%	94.3%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	12.0 sec	14.1 sec	12.2 sec	11.2 sec
Abandonment Rate	≤3.5%	≤7%	2.2%	2.2%	1.3%	1.1%

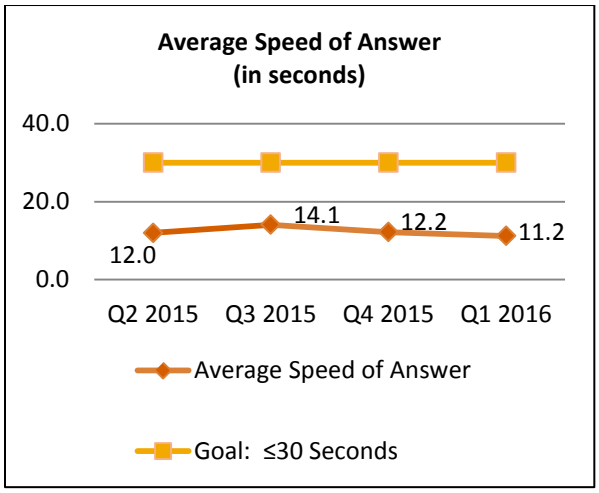
In addition, Optum Idaho generates a Member Access and Crisis Line Bi-annual Report to analyze additional measures related to the types and outcomes of calls received. The table below represents the bi-annual performance for the top-five primary issues identified in clinical calls made to the Member Access Line. This information along with call access standards are reviewed routinely to by our Member Advisory Committee to monitor trends and service gaps. The top 5 Clinical Call Types are identified in the table below.

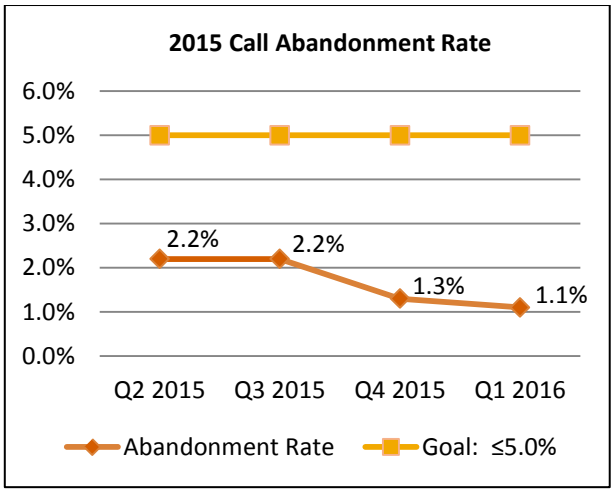
January – June 2014	July – December 2014	January – June 2015	July – December 2015
33% Alcohol/Drugs	29% Alcohol/Drugs	38% Alcohol Drugs	41% Alcohol/Drugs
14% Child	15% Anxiety	16% Child	13% Child
11% Depression	13% Child	10% Depression	11% Anxiety
8% Anxiety	9% Depression	9% Anxiety	8% Depression
4% Medication	4% Medication	4% Medication	3% Medication

Analysis: During Q1, the Member Services and Crisis Line received a total of 1,373 calls. Optum Idaho exceeded established performance call standards in each quarter of the 2015 calendar year and continued to exceed these goals in Q1 of 2016. In Q1, 94.3% of calls were answered within 30 seconds (goal ≥80%), which was an increase from 92.4% in Q4. The average speed to answer was met at 11.2 seconds (goal ≤30 seconds). The abandoned rate of 1.1% during Q1 met both the Optum Idaho Standards goal of ≤3.5% and the IBHP Contractual Standards goal of ≤7.0%.









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

Opportunities and Interventions: No opportunities for improvement were identified

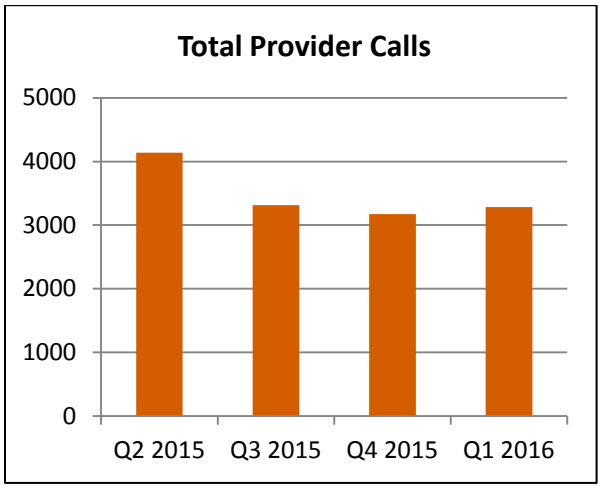
Customer Service (Provider Calls) Standards

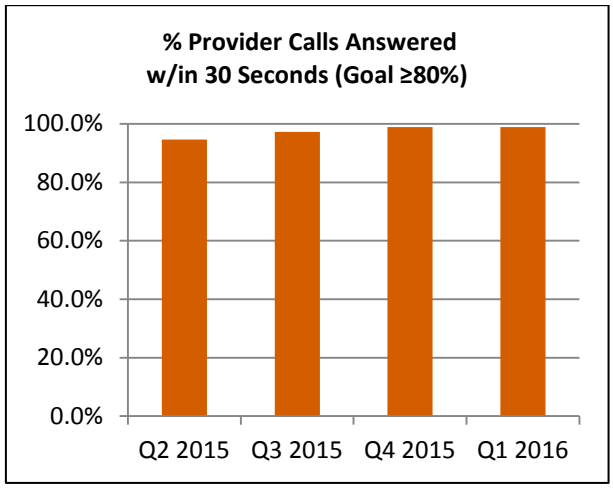
Methodology: The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho. To ensure the needs of our providers and stakeholders are met in a timely and efficient manner, Optum established performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate (≤7%) as shown in the grid below.

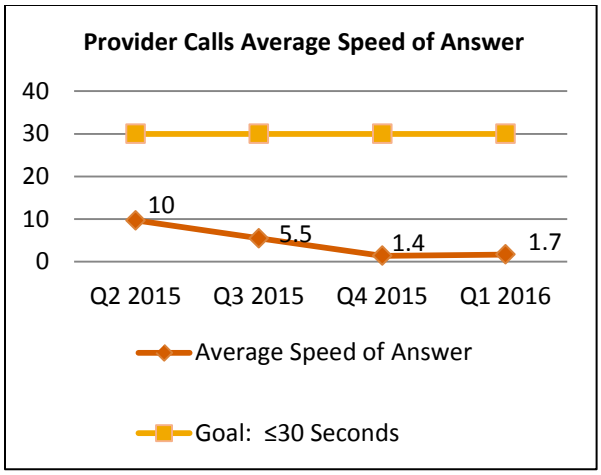
Quarterly Performance Results:

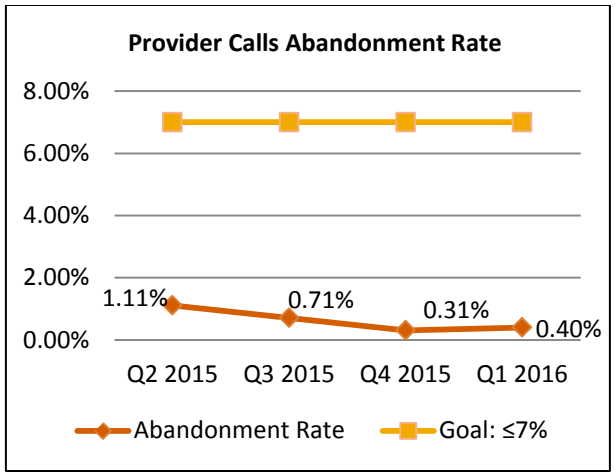
Customer Service Line	Optum Idaho Standards	IBHP Contract Standards	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Total Number of Calls	NA	NA	4,138	3,315	3,175	3,284
Percent of Calls Answered Within 30 Sec	≥80.0%	None	94.6%	97.3%	98.9%	98.9%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	10 sec	5.5 sec	1.4 sec	1.7 sec
Abandonment Rate	≤3.5%	≤7%	1.11%	0.71%	0.31%	0.40%

Analysis: Customer service call standards met performance goals for all three customer service line measures again during Q1. The percent of calls answered within 30 seconds was at 98.9%, remaining above our goal of ≥80%. The average speed of answer was at 1.7 seconds during Q1, again meeting our goal of ≤30 seconds. The call abandonment rate was 0.40% continuing to meet both the Optum Idaho internal goal of ≤3.5% and the IBHP Contract Standard of ≤ 7%. The total number of provider calls during Q1 was 3,284. This was an increase from 3,175 calls during Q4.









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

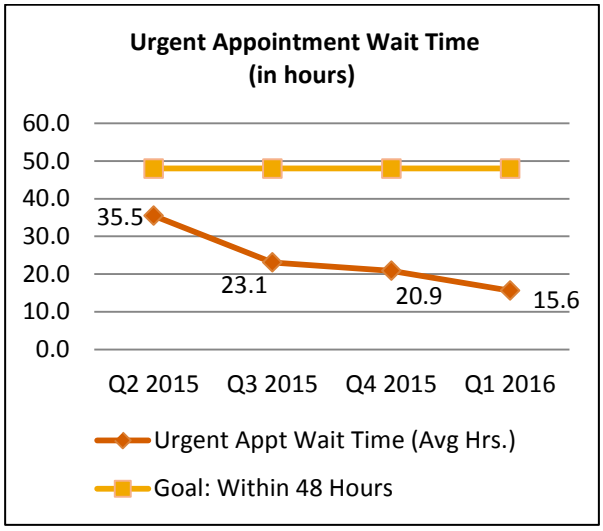
Urgent and Non-Urgent Access Standards

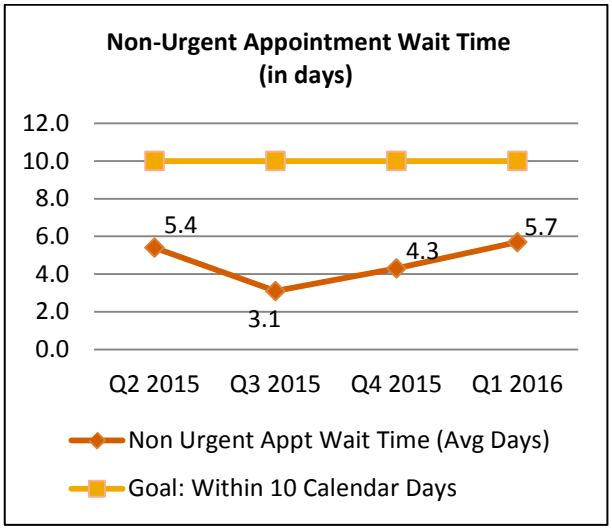
Methodology: As part of our Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network providers adhere to specific access standards for *Urgent Appointments* being offered within 48 hours and *Non-urgent Appointments* being offered within 10 business days of request. Urgent and non-urgent access to care is monitored via monthly provider telephone polling by the Network team.

Quarterly Performance Results:

Urgent/Non-Urgent Appointment Wait Time	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Urgent Appointment Wait Time	Within 48 hours from request	35.5 hours	23.1 hours	20.9 hours	15.6 hours
Non-Urgent Appointment Wait Time	Within 10 days from request	5.4 days	3.1 days	4.3 days	5.7 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. During Q1, the Urgent Appointment Wait time decreased from 20.9 hours in Q4 to 15.6 hours, again meeting the performance goal. The performance goal for non-urgent appointment wait time is an appointment within 10 days. This goal was again met during Q1 at 5.7 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 against standards will be 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.

Quarterly Performance Results:

Geographic Availability of Providers		Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Area 1	(within 30 miles)	100.0%	99.7%	99.8%	99.9%	99.9%
Area 2	(within 45 miles)	100.0%	99.9%	99.8%	99.8%	99.8%

Analysis: Optum Idaho continues to meet contract availability standards. During Q1, Area 1 availability standards were met at 99.9% and Area 2 availability standards were met at 99.8%. Our performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number). Along with continued recruitment of new providers to

the network, the network manager staff continued to encourage existing providers to expand service offerings including TeleHealth services.

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 informed by national standards such as NCQA (National Committee for Quality Assurance) and URAC (Utilization Review Accreditation Commission).

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

As part of Optum's ongoing assessment of the overall network, Optum 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.

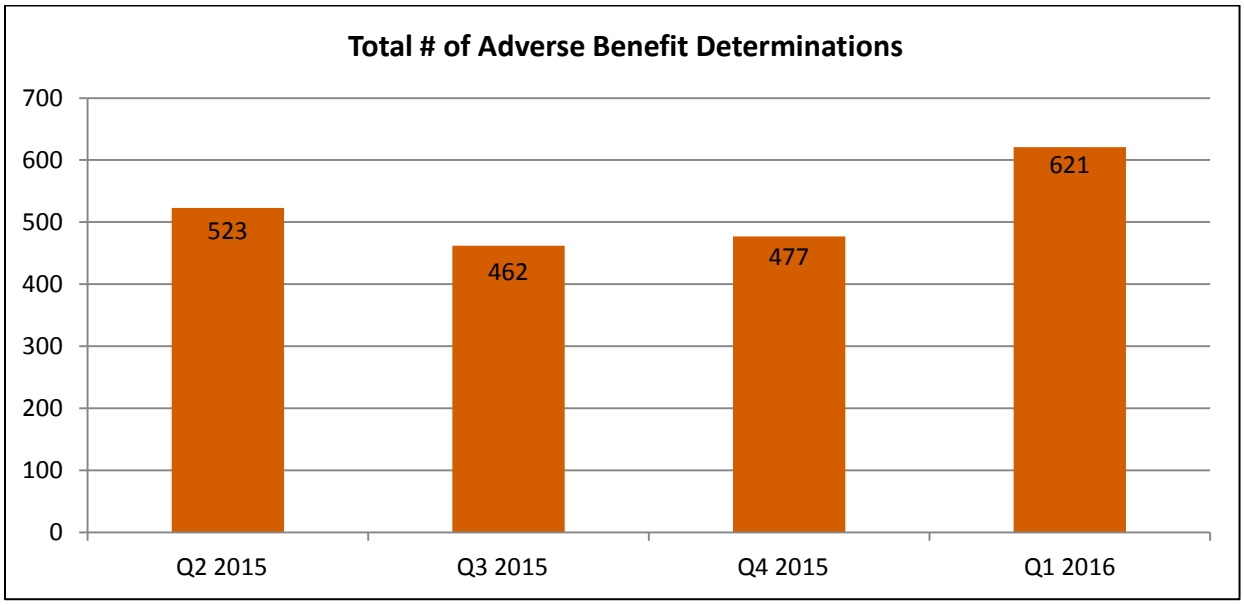
Quarterly Performance Results:

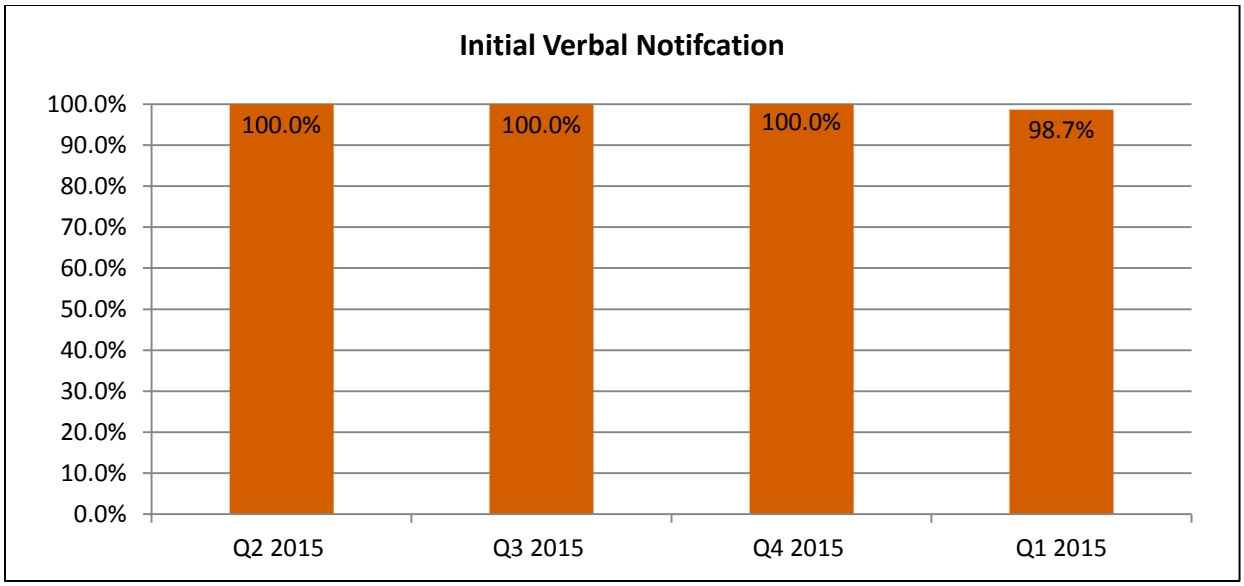
Notification of ABD	Performance Goal	Target	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Total # ABD's	NA	NA	523	462	477	621
Initial Verbal Notification to Provider	1 business day from determination date	100.0%	100.0%	100.0%	100.0%	98.7%
Written Notification	1 business day from verbal notification	100.0%	98.6%* (516/523)	99.6% (460/462)	97.9% (467/477)	98.1% (609/621)

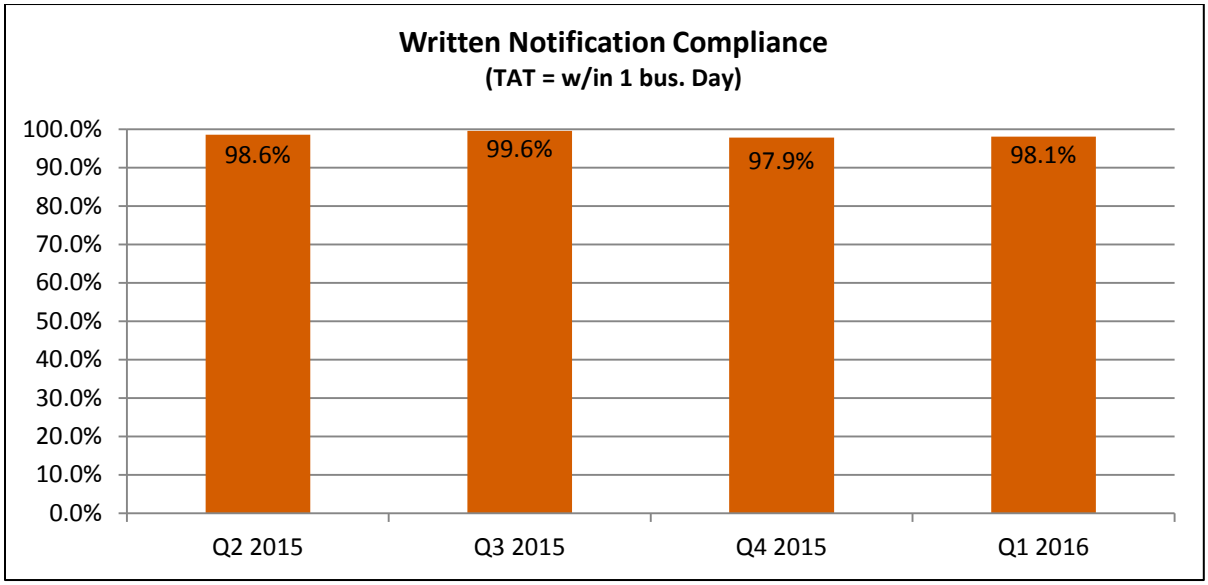
*****percentages were modified from the original quarterly report (approved by QAPI 08/18/2105) to correct timeframes not met due to "holidays", in which the Optum offices were closed.

Analysis: During Q1 2016, there were 621 total ABDs. This is a 30% increase from the previous quarter which had 477 ABDs. There was an increase in Q1 CBRS requests which directly correlates to the increase in ABDs. The Optum Idaho Care Advocates have also become more stringent and consistent in applying the Level Of Care Guidelines, thus resulting in more ABDs.

Verbal notification compliance for Q1 was 98.7%. There were 8 verbal notifications that were out of compliance. Sevent (7) of the 8 were out of compliance by 1 business day. One (1) of the 8 was out of compliance by 2 business days. Written notification compliance was 98.1%. There were 12 written notifications that were out of compliance. Of the 12, 11 were late by 1 business day and 1 was late by 2 business days. The notifications which fell outside the turnaround time were late because they were processed late by Optum staff involved with the decision making process.







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 notifications to be out of compliance. Those issues have been fixed and the amount of noncompliant ABDs has decreased since January, 2016. The shift from ARTT to Linx has also allowed for more accurate verbal notification tracking. It is believed that the old system did not properly track verbal notification compliance.

The performance goal for the verbal notifications turned into a barrier as well because some determinations were being completed outside of business operational hours, thus not allowing us to reach our goal of same day verbal notification as the determination date. The performance goal was revised from same day to 1 business day so determinations could be made after hours and the verbal notifications could be provided the next business day.

Opportunities and Interventions: Optum has updated and educated all necessary staff on the shift from ARTT to Linx. Auditing is done weekly to ensure no notifications are outstanding. The verbal notification process has been streamlined to increase efficiencies and decrease noncompliance. Other methods to streamline the process are being explored for implementation in 2016 Q3.

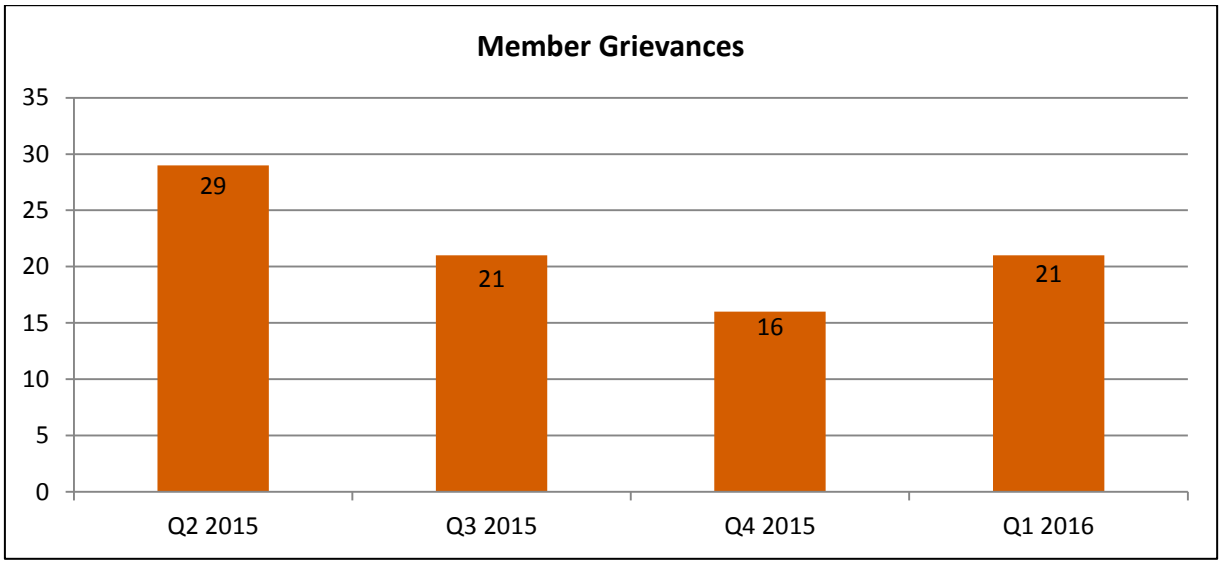
Grievances

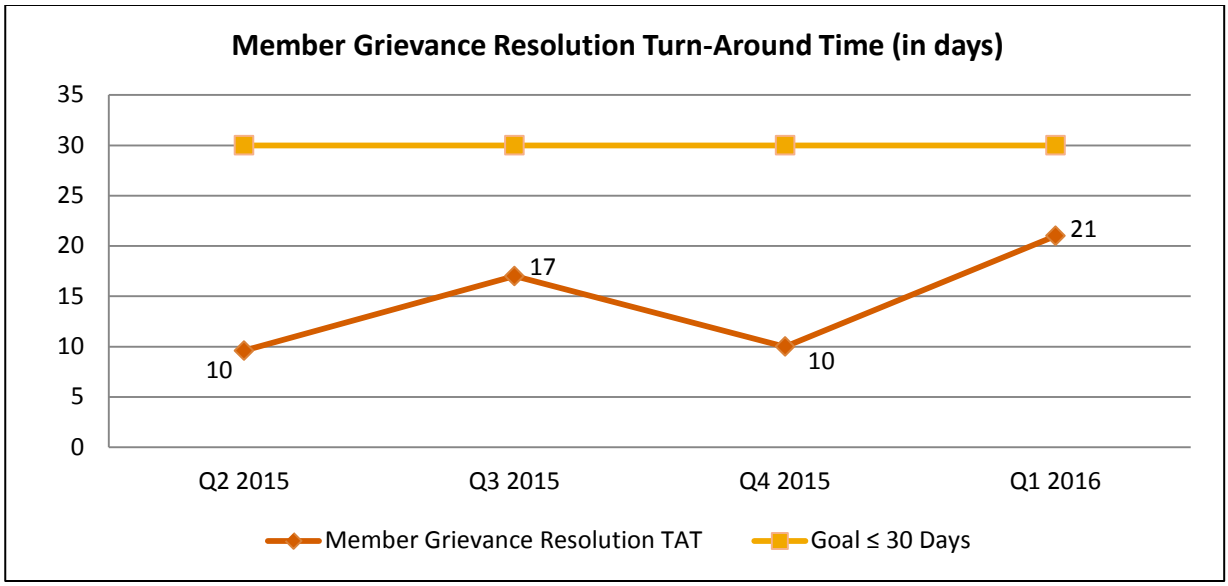
Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an adverse action that resulted in member financial liability or denied service, which is referred to within Optum as filing a grievance. All grievances are required to be reviewed and resolved within 30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

Quarterly Performance Results:

Grievances	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Number of Member Grievances	NA	29	21	16	21
Average Number of Days to Resolution	30 Days	10	17	10	21
Number of Overturned Grievances	NA	1	1	2	1
Number of Partially Overturned Grievances	NA	1	2	0	0
% of Grievances Overturned or Partially Overturned	NA	6.9%	14.3%	12.5%	4.8%

Analysis: During Q1, Optum ID 21 member grievances. Optum continued to exceed the 30 day turnaround time for resolutions.





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:

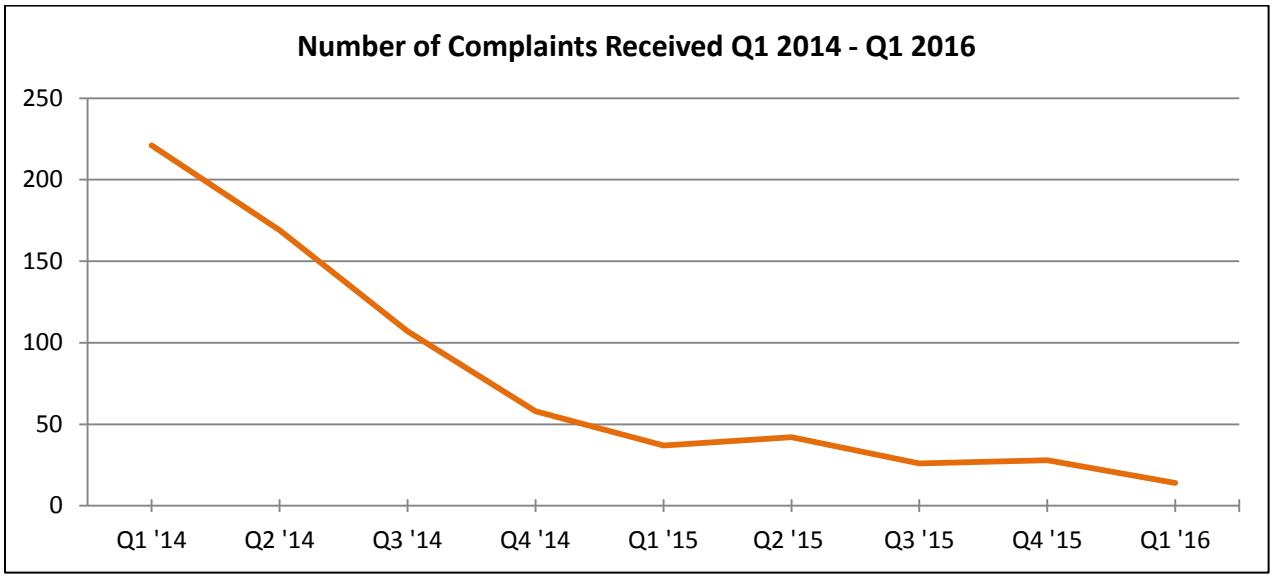
Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Calendar Days

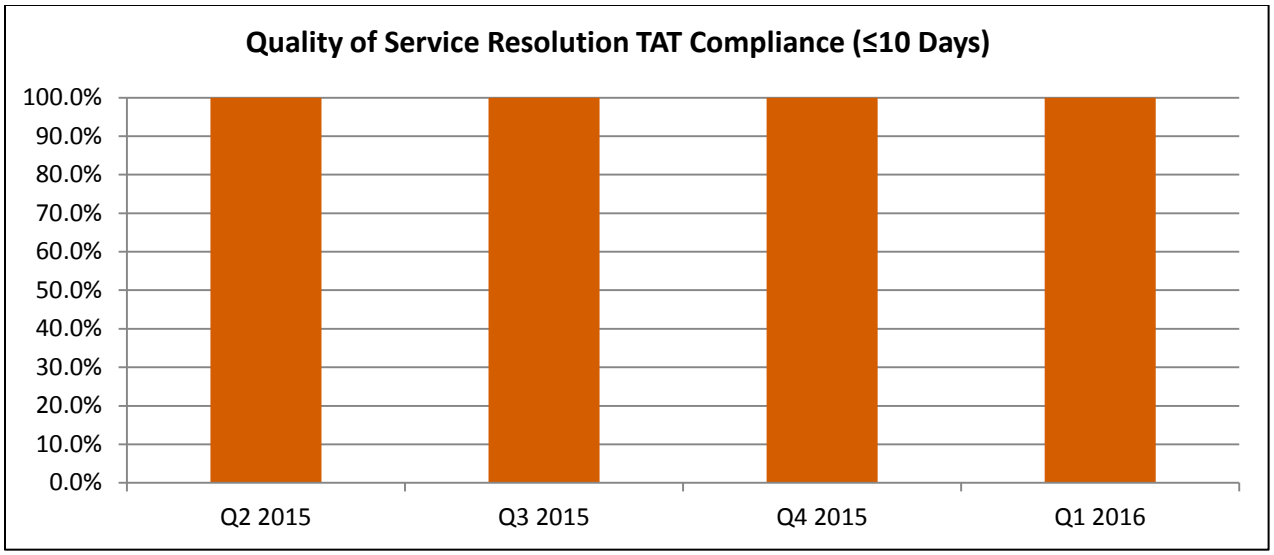
Quarterly Performance Results:

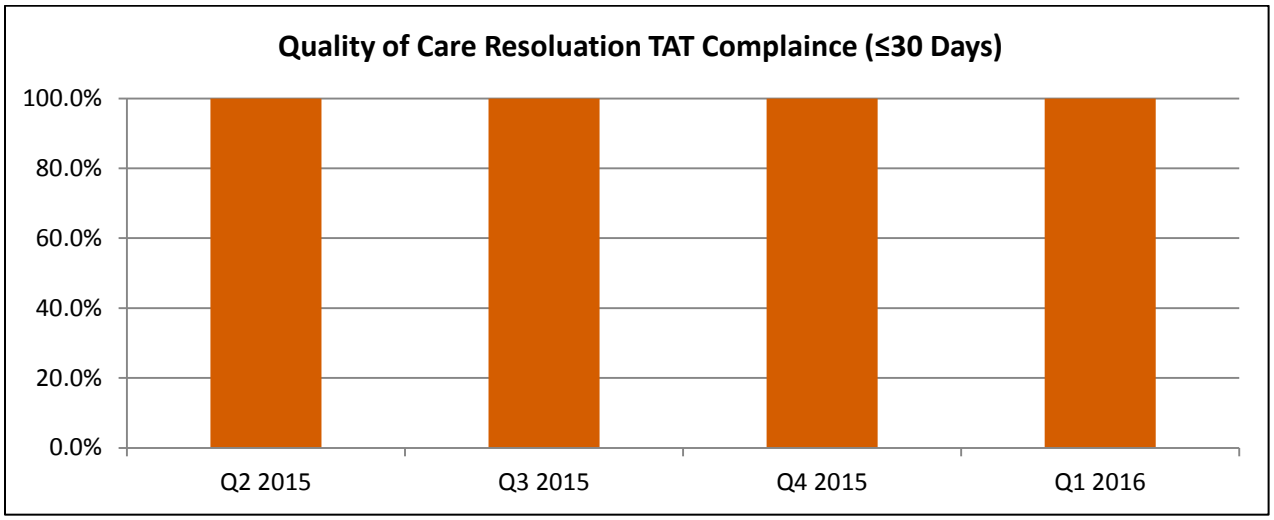
Complaints	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Number of Quality of Service (QOS) Complaints Received	NA	40	21	26	13
Percent QOS Complaints Resolved w/in TAT	10 Days	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints (QOC) Received	NA	2	5	2	1
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%	100.0%

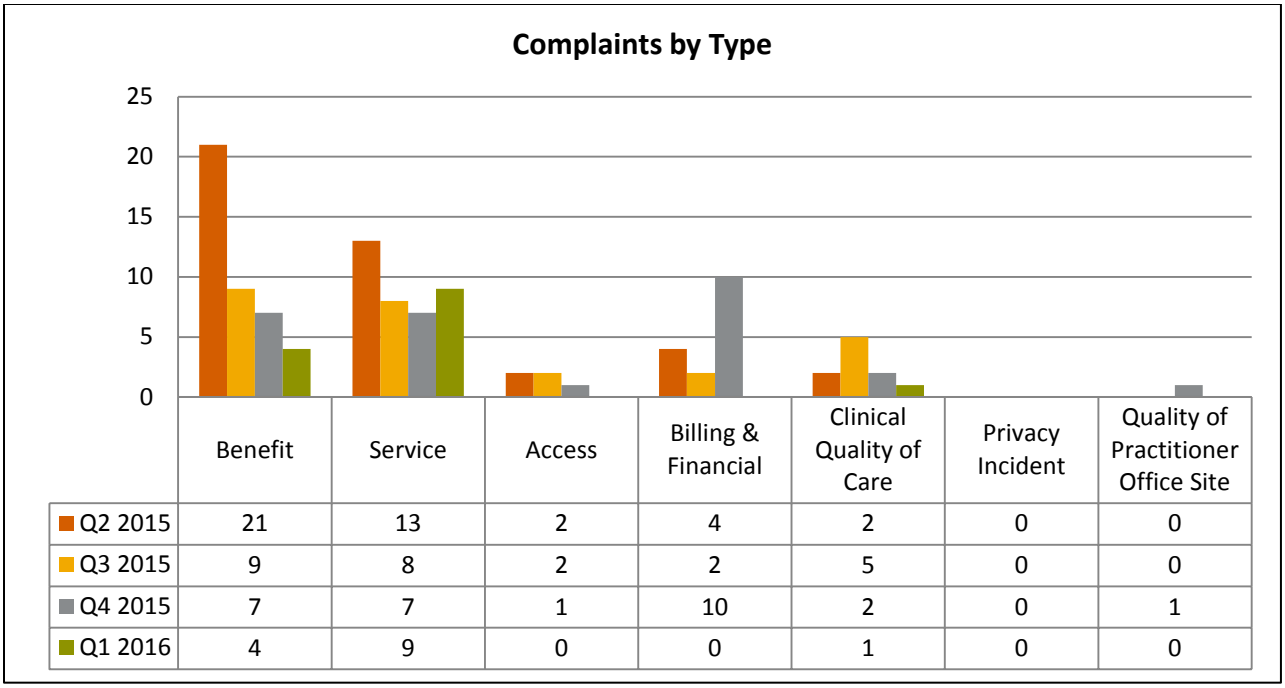
Analysis: Of the total complaints logged in Q1, thirteen (13) were identified as Quality of Service and 1 was a Quality of Care. Optum met the goal of 100% for resolution timeframes for both QOS complaints (10 business days) and QOC concerns (30 days).

The total number of complaints decreased from 28 during Q4 to 14 during Q1 which is the lowest number of complaints Optum Idaho has ever received. During Q4, 2015, we reported that the data showed a noticeable increase in the number of complaints in the category of Billing & Financial, although no trends were identified in the nature of these complaints. During Q1, complaints in the Billing & Financial category were at 0. There were 4 in the category of Benefit, 9 in the category of Service, and 1 Quality of Care.




Quality of Service Resolution TAT Compliance (≤10 Days)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Q2 2015
Q3 2015
Q4 2015
Q1 2016


Quality of Care Resoluation TAT Complaince (≤30 Days)
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Q2 2015
Q3 2015
Q4 2015
Q1 2016



	Benefit	Service	Access	Billing & Financial	Clinical Quality of Care	Privacy Incident	Quality of Practitioner Office Site
Q2 2015	21	13	2	4	2	0	0
Q3 2015	9	8	2	2	5	0	0
Q4 2015	7	7	1	10	2	0	1
Q1 2016	4	9	0	0	1	0	0

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

Critical Incidents

Methodology: To improve the overall quality of care provided to our members, Optum Idaho employs peer reviews for occurrences related to members that have been identified as 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 (also defined as a sentinel event).
- 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 (also defined as a sentinel event).
- 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 (also defined as a sentinel event).
- High profile incidents identified by the IDHW as warranting investigation.

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 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.

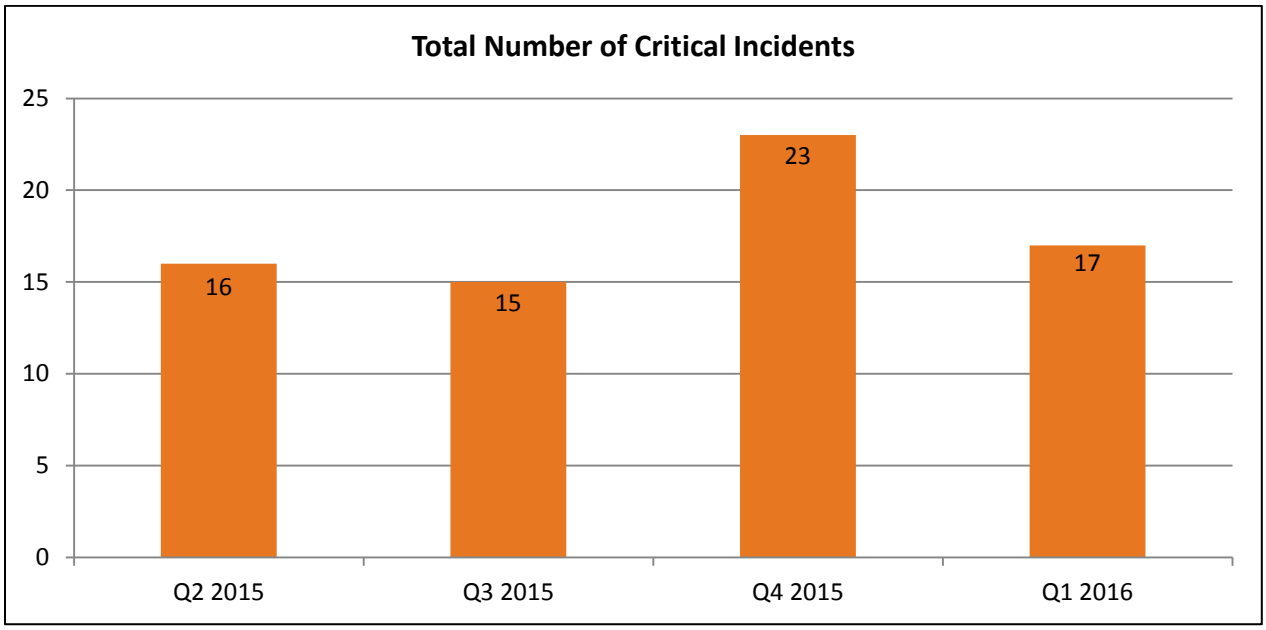
Quarterly Performance Results:

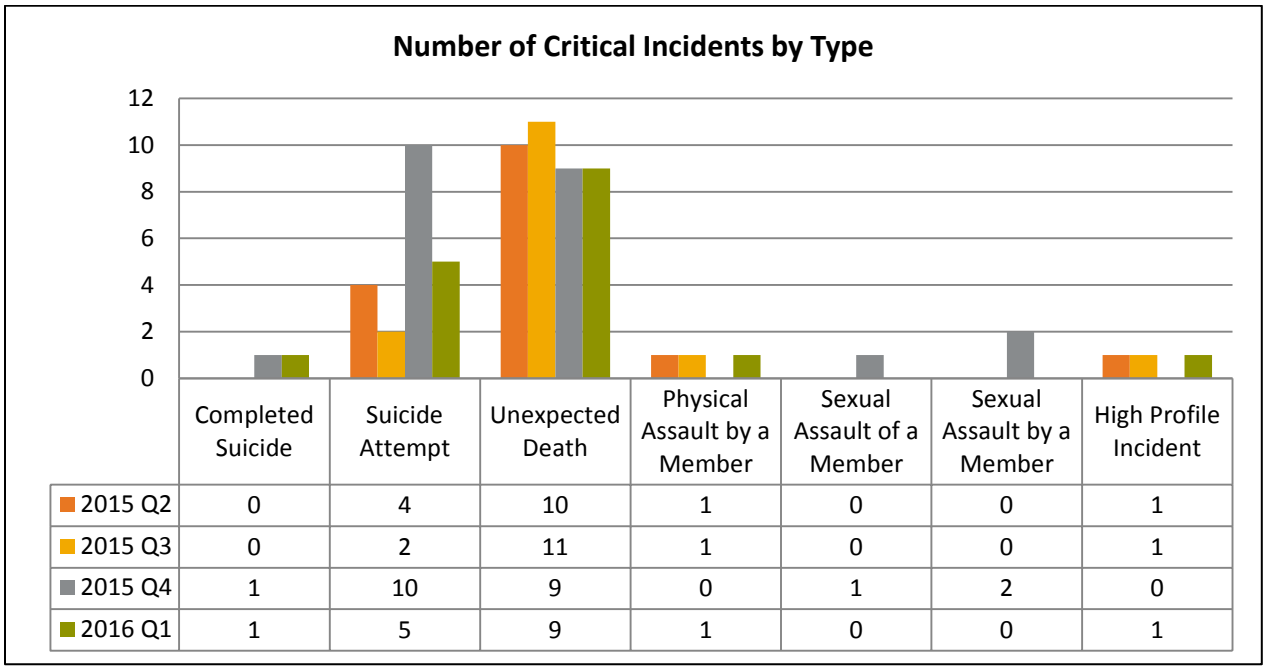
Critical Incidents	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Number of CI's Received	NA	16	15	23	17
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100.0%	100.0%	100.0%	100.0%

Analysis: There were 17 Critical Incidents reported during Q1. This is a decrease from 23 during Q4, 2015. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. Of the 17 Critical Incidents reported, 9 (52.9%) were from unexpected deaths, 1 (5.9%) was from a completed suicide, 5 (29.4%) were from suicide attempts, 1 (5.9%) was from a physical assault by a member, and 1 (5.9%) was from a high profile incident. Of note, during Q4, it was reported that 8 Critical Incidents were from unexpected deaths and 11 were from suicide attempts. After further review, the Peer Review Committee determined that one of the suicide attempts should have been characterized as an unexpected death. The graph below is an accurate reflection of this change.

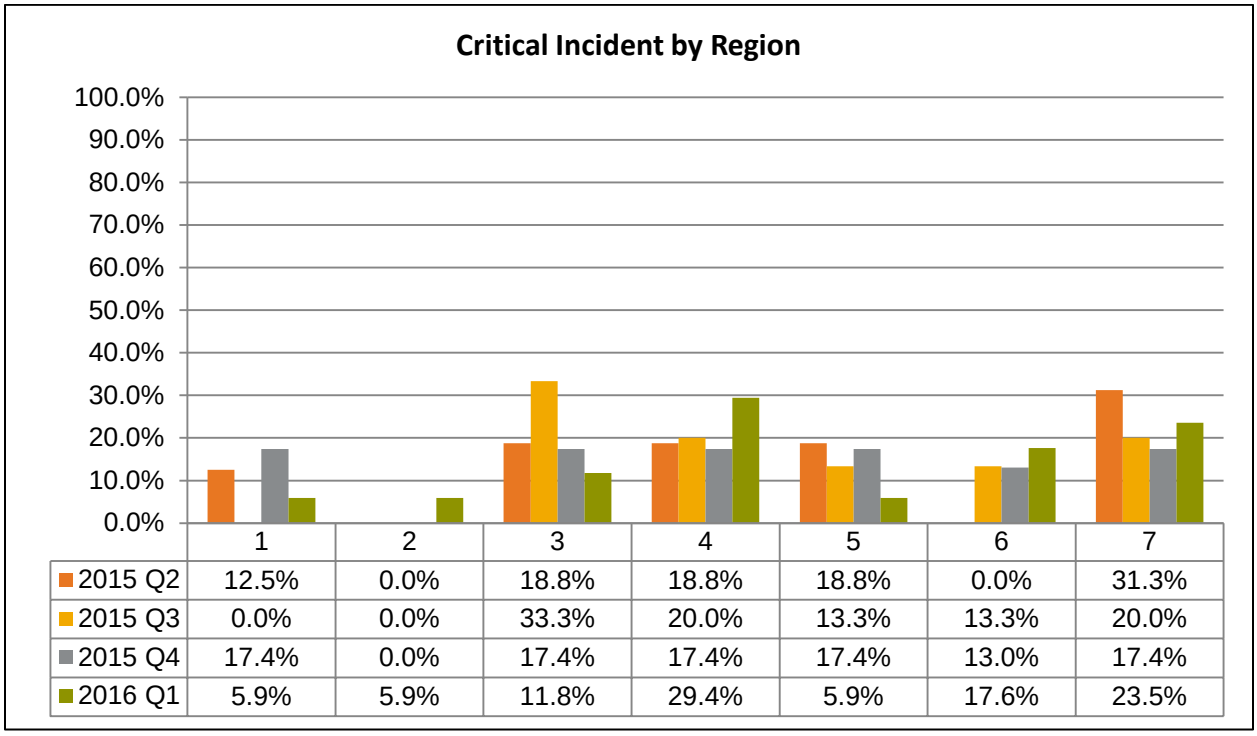
Regionally, 29.4% of Critical Incidents occurred in Region 4 followed by 23.5% in Region 7. During Q1, 52.9% of the Critical Incidents that were reported showed there was coordination of

care between the behavioral health provider and the Primary Care Provider (PCP). Of the cases reported during Q1, 88.2% were adults (18+) and 11.8% children/adolescents (17 and below). Further analysis shows that the average age for males was 42 and females 39. Of Critical Incidents reported during Q1, 64.7% were males and 35.3% were females. 29.4% of males and 29.4% of females involved in a Critical Incident showed a co-morbid health condition. No providers were put on unavailable status due to a Critical Incident.

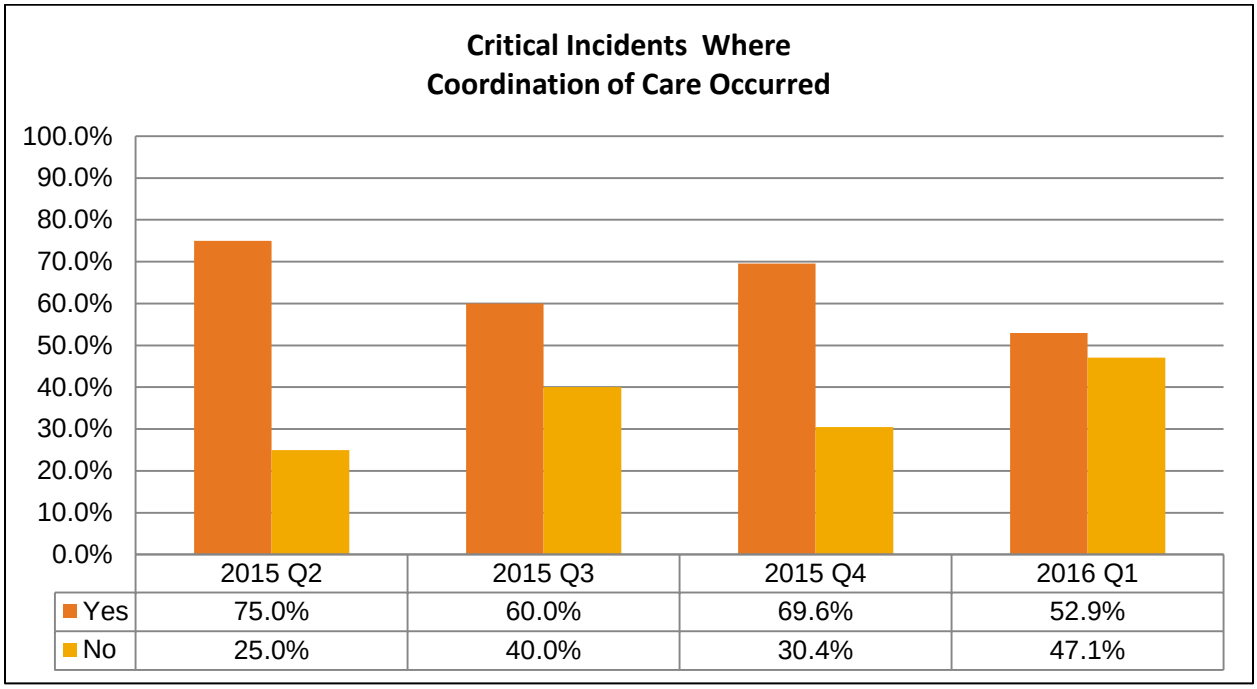




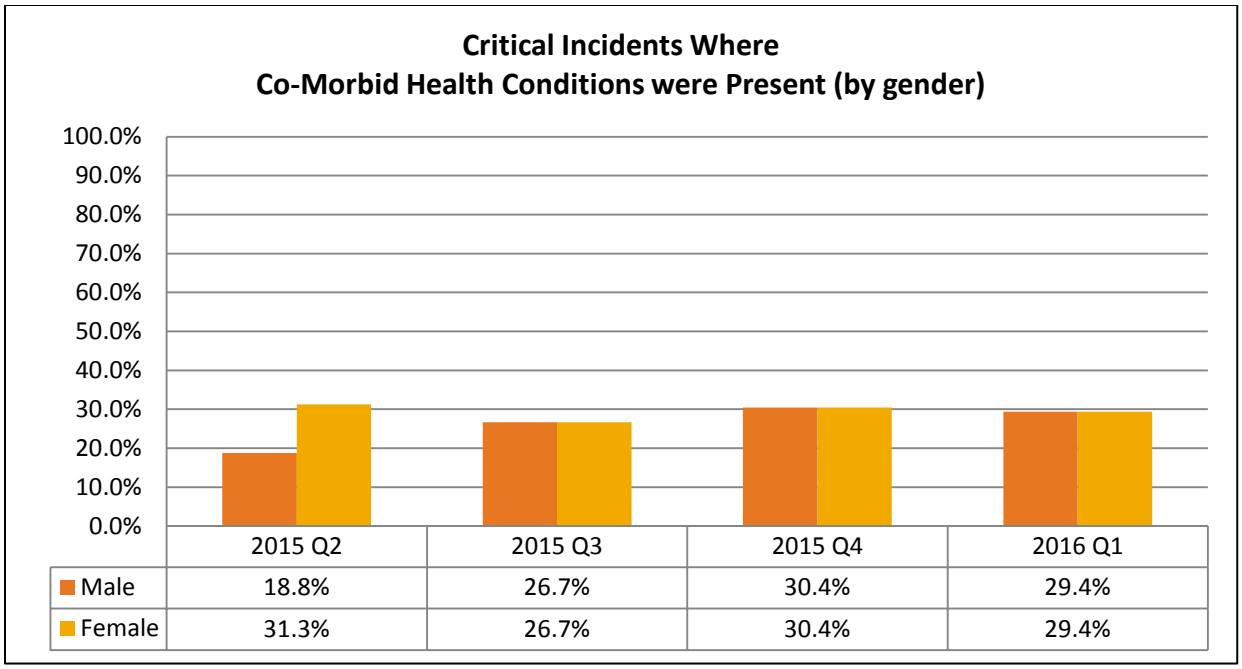
	Completed Suicide	Suicide Attempt	Unexpected Death	Physical Assault by a Member	Sexual Assault of a Member	Sexual Assault by a Member	High Profile Incident
2015 Q2	0	4	10	1	0	0	1
2015 Q3	0	2	11	1	0	0	1
2015 Q4	1	10	9	0	1	2	0
2016 Q1	1	5	9	1	0	0	1

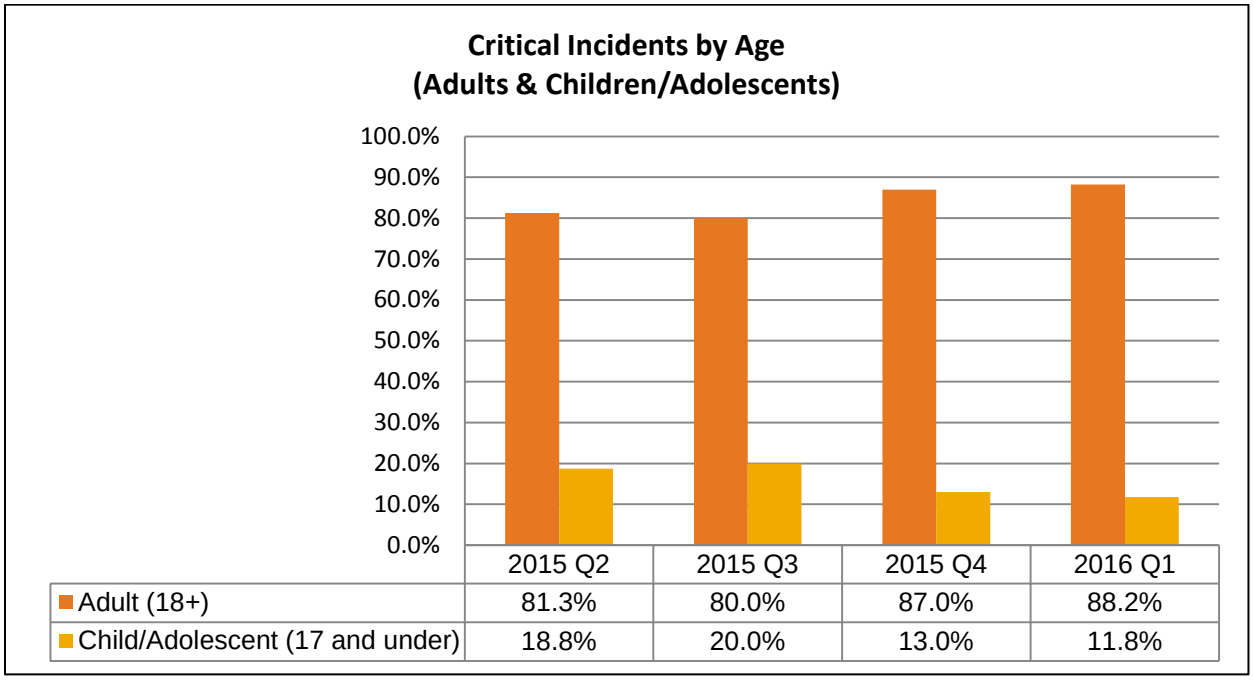


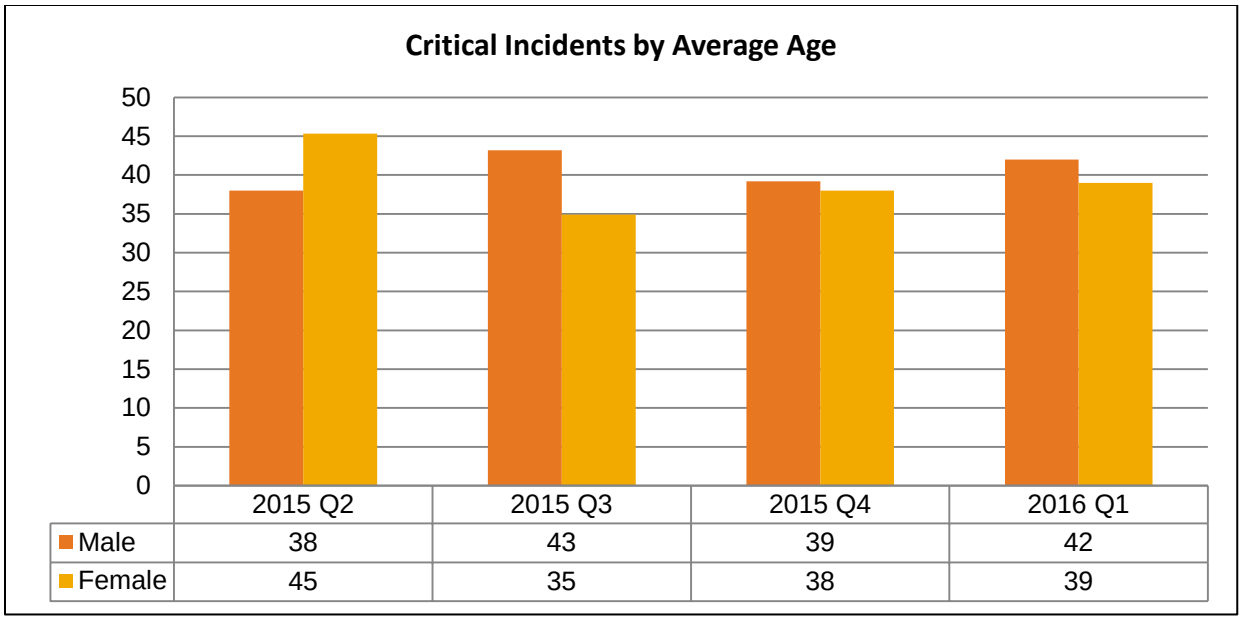
	1	2	3	4	5	6	7
2015 Q2	12.5%	0.0%	18.8%	18.8%	18.8%	0.0%	31.3%
2015 Q3	0.0%	0.0%	33.3%	20.0%	13.3%	13.3%	20.0%
2015 Q4	17.4%	0.0%	17.4%	17.4%	17.4%	13.0%	17.4%
2016 Q1	5.9%	5.9%	11.8%	29.4%	5.9%	17.6%	23.5%



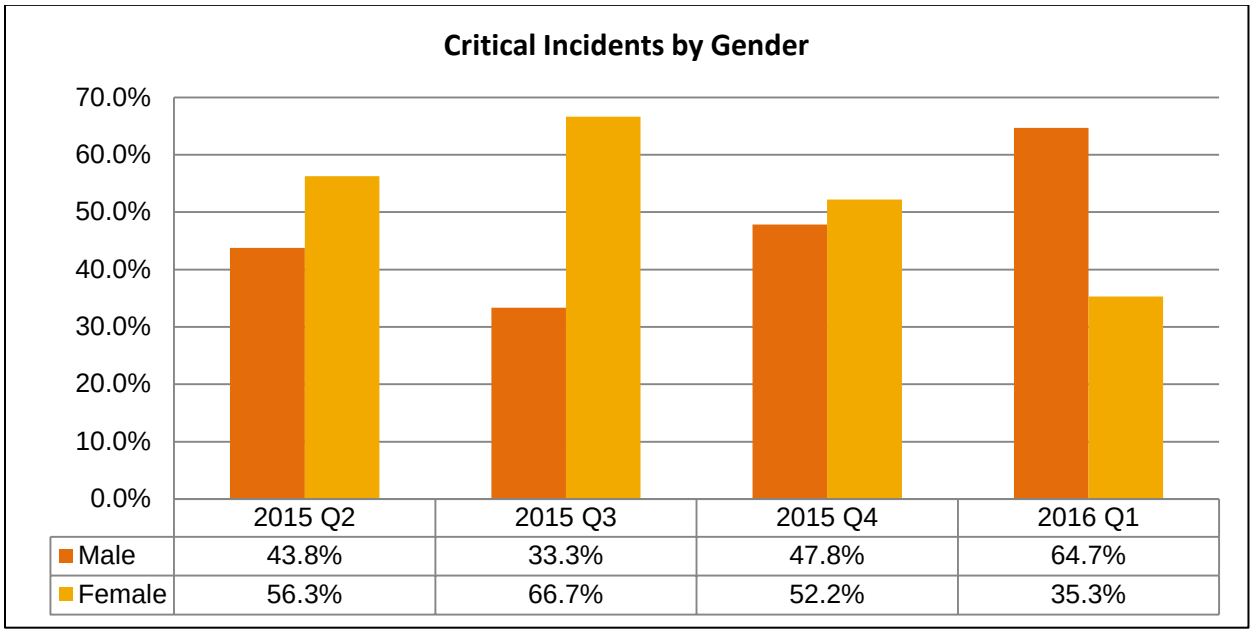
	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Yes	75.0%	60.0%	69.6%	52.9%
No	25.0%	40.0%	30.4%	47.1%


Critical Incidents Where
Co-Morbid Health Conditions were Present (by gender)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2015 Q2
2015 Q3
2015 Q4
2016 Q1
Male
18.8%
26.7%
30.4%
29.4%
Female
31.3%
26.7%
30.4%
29.4%


Critical Incidents by Age
(Adults & Children/Adolescents)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2015 Q2
2015 Q3
2015 Q4
2016 Q1
Adult (18+)
81.3%
80.0%
87.0%
88.2%
Child/Adolescent (17 and under)
18.8%
20.0%
13.0%
11.8%



	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Male	38	43	39	42
Female	45	35	38	39



	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Male	43.8%	33.3%	47.8%	64.7%
Female	56.3%	66.7%	52.2%	35.3%

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

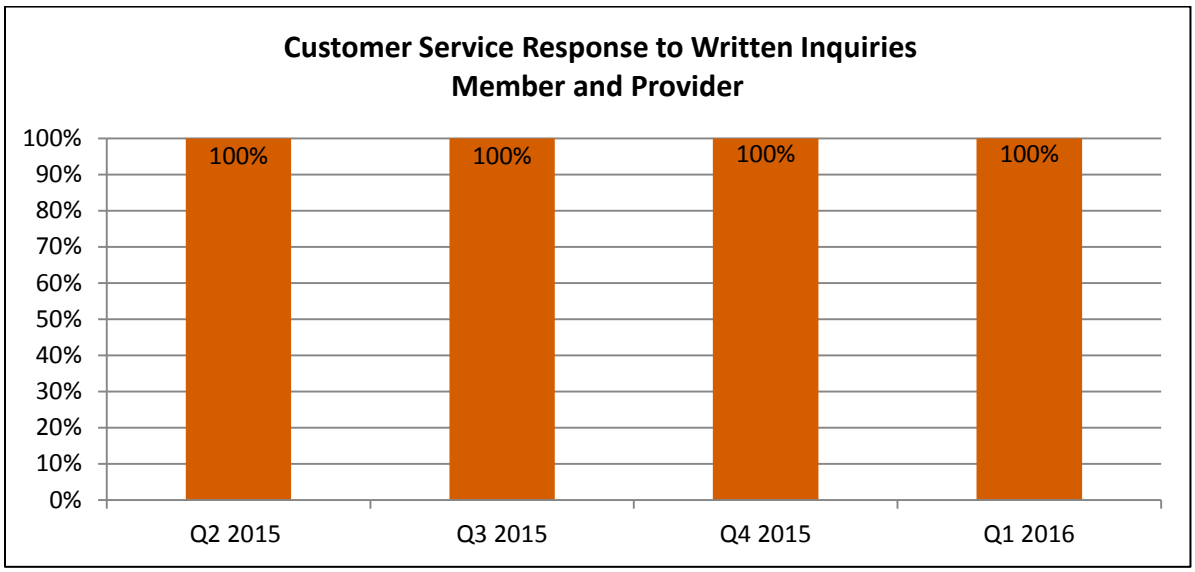
Response to Written Inquiries

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.

Quarterly Performance Results:

Customer Service Response to Written Inquiries	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Percent Acknowledged ≤ 2 business days	100.0%	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 met during Q1.



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 completes 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 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.

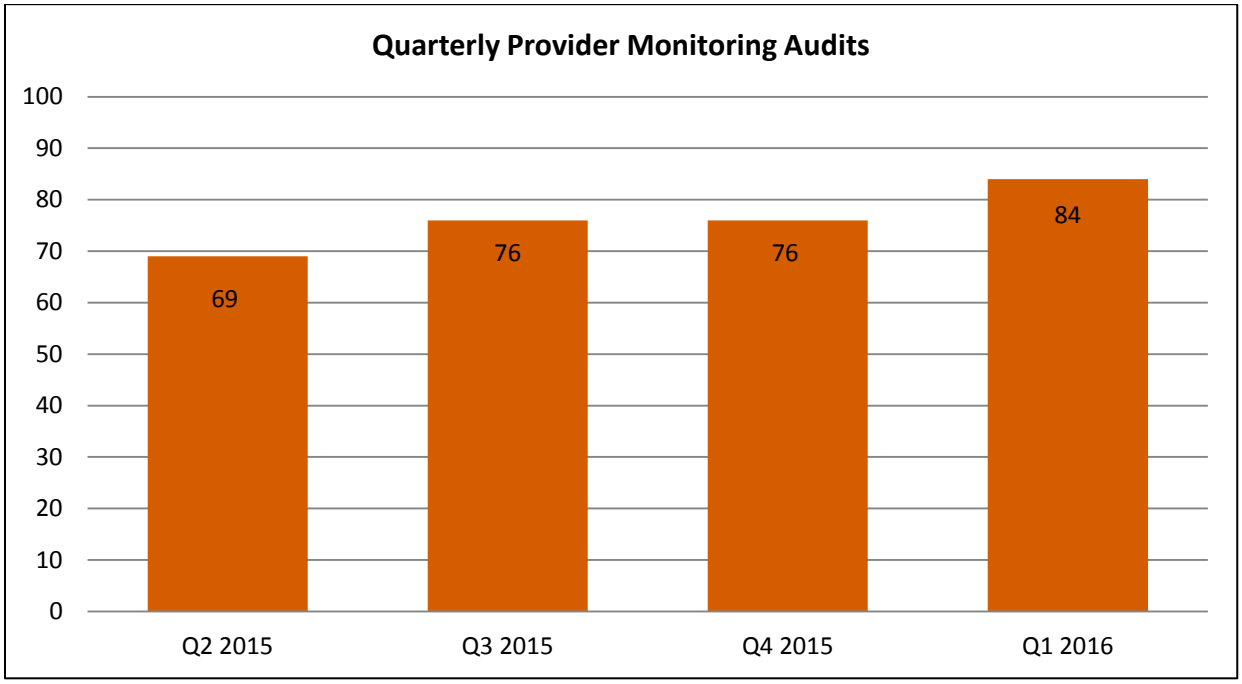
Quarterly Performance Results:

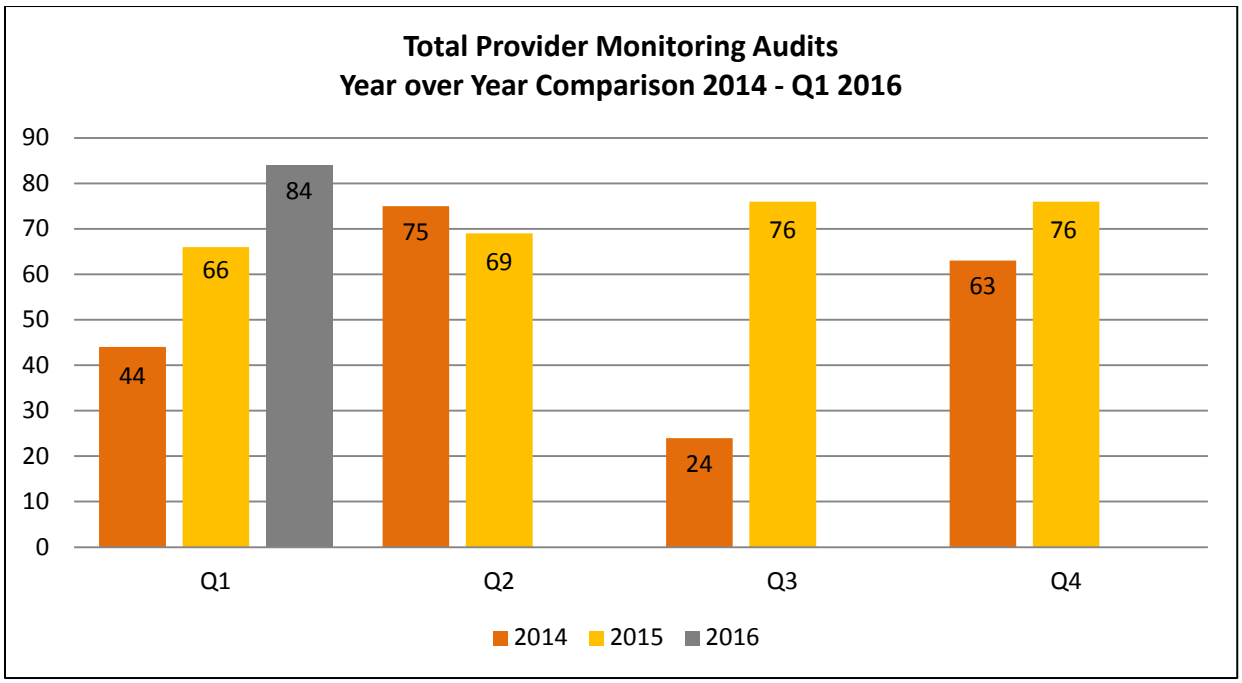
Treatment Record Audit	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Number of Audits Conducted	NA	69	76	76	84
Initial Audit (Average overall score)	85.0%	97.3%	97.0%	95.1%	91.9%
Recredentialing Audit (Average overall score)	85.0%	95.3%	95.2%	98.4%	96.1%
Monitoring (Average overall score)	85.0%	89.9%	91.0%	88.5%	89.3%
Quality (Average overall score)	85.0%	90.5%	94.5%	94.7%	92.4%
Percent of Audits Requiring a Corrective Action Plan	NA	13.0%	22.4%	22.4%	14.3%

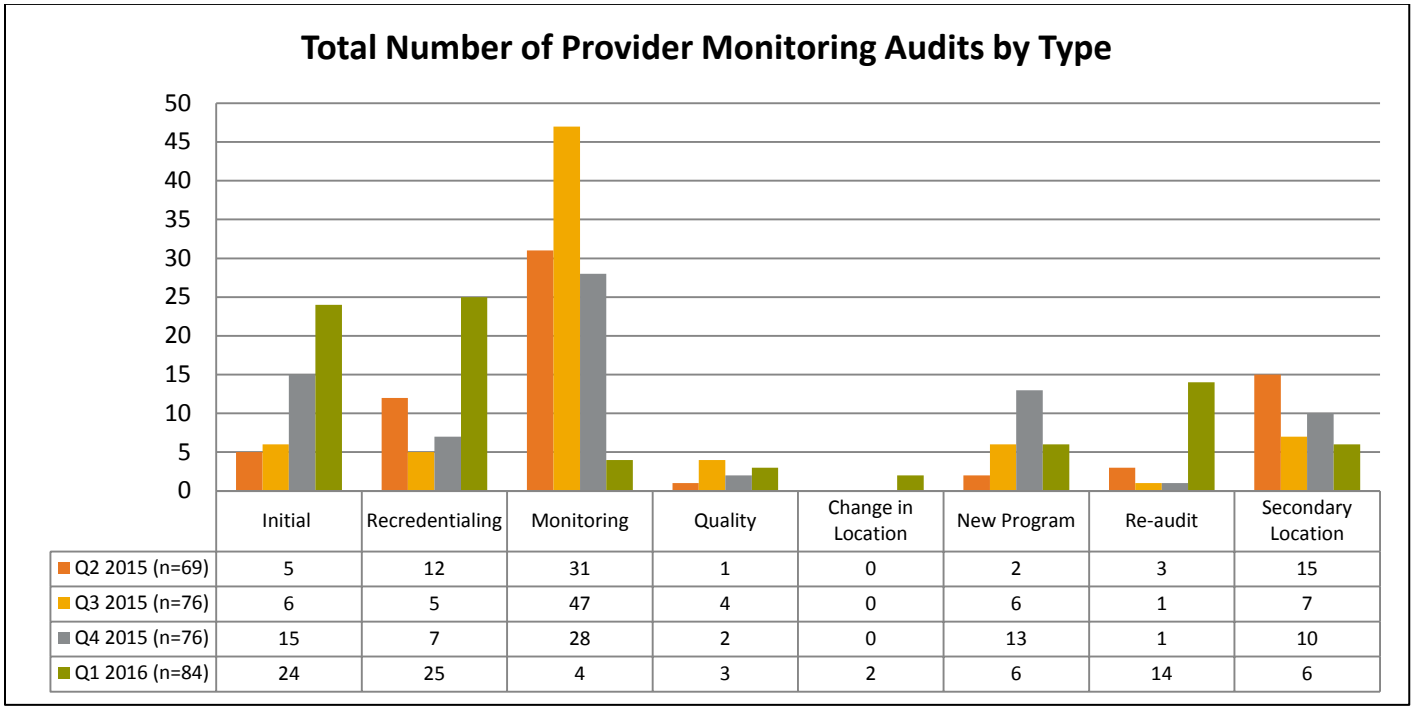
Analysis: During Q1, 2016, 84 Provider Monitoring Audits were completed. Of the audits completed during Q1, 85.7% received a passing score. Corrective action plans were implemented for 14.3% of the audits that were completed. Overall audit scores per region and per audit type are reflected in graphs below.

Also, 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 which was approved by United Health Group. 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

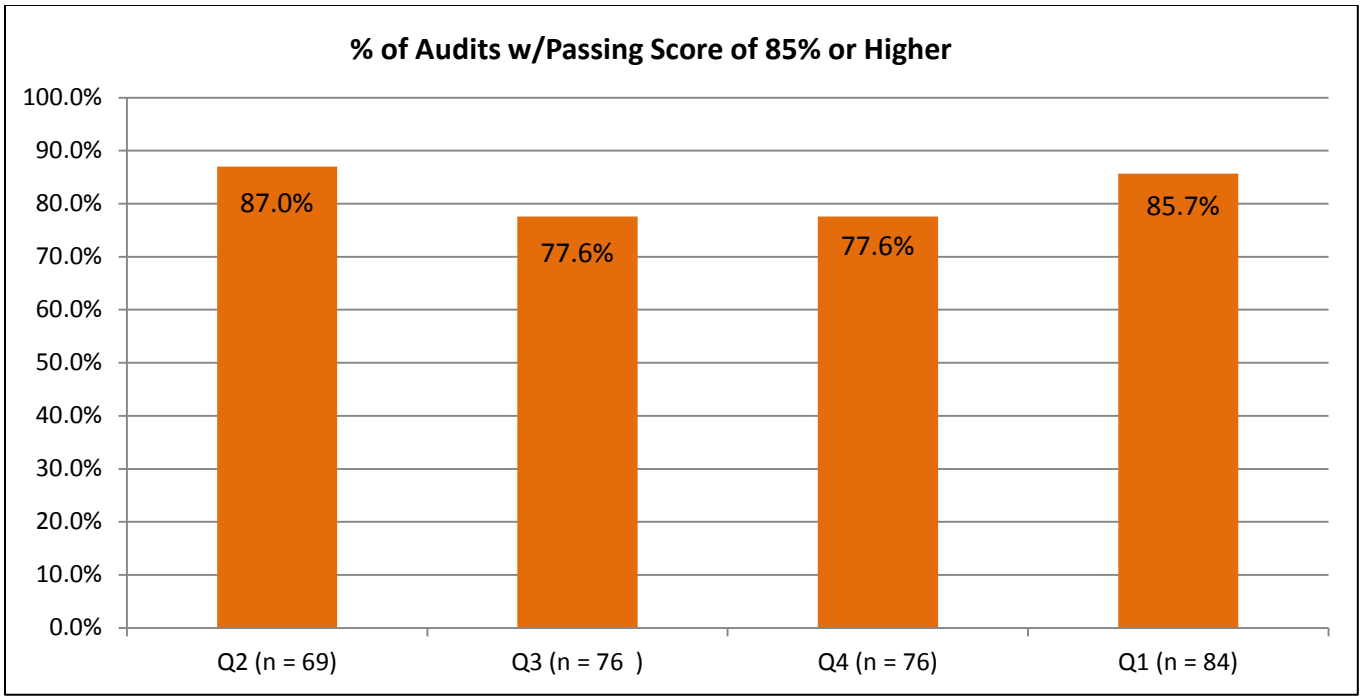
the survey. In order to capture all survey data and allow for accurate reporting, results for Q1 will be presented in the Q2 report.

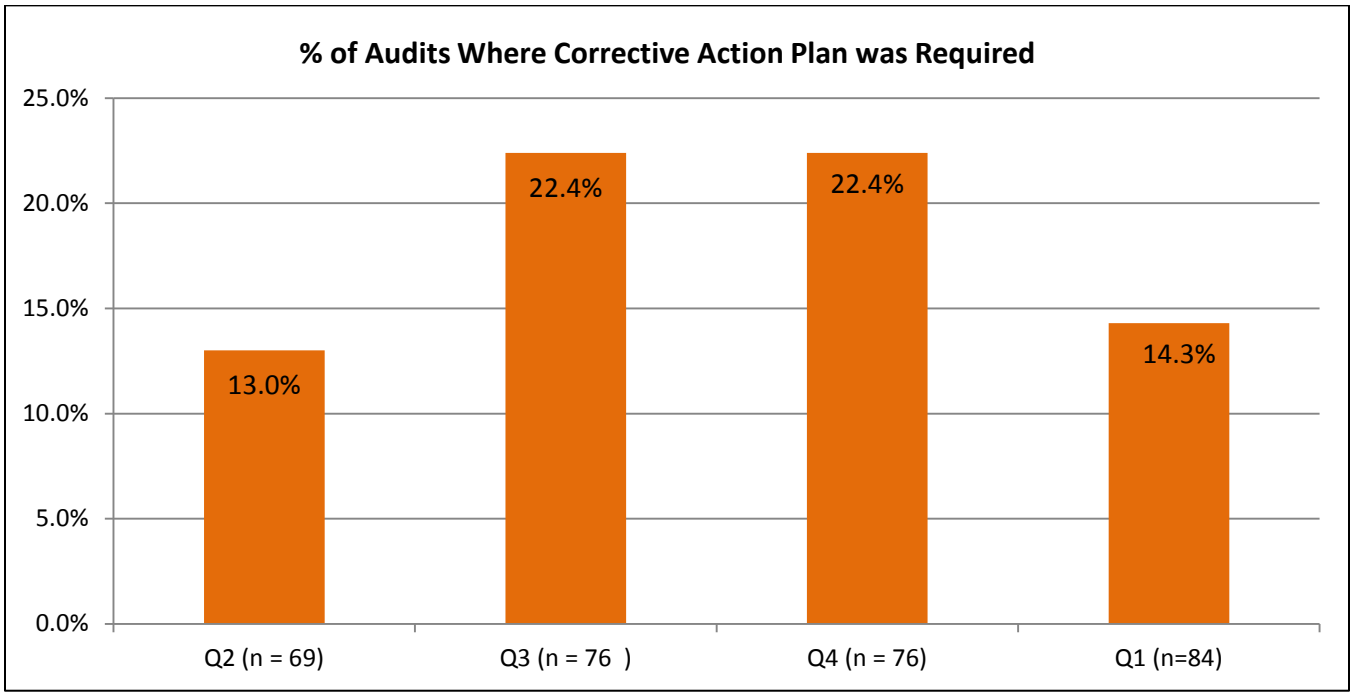


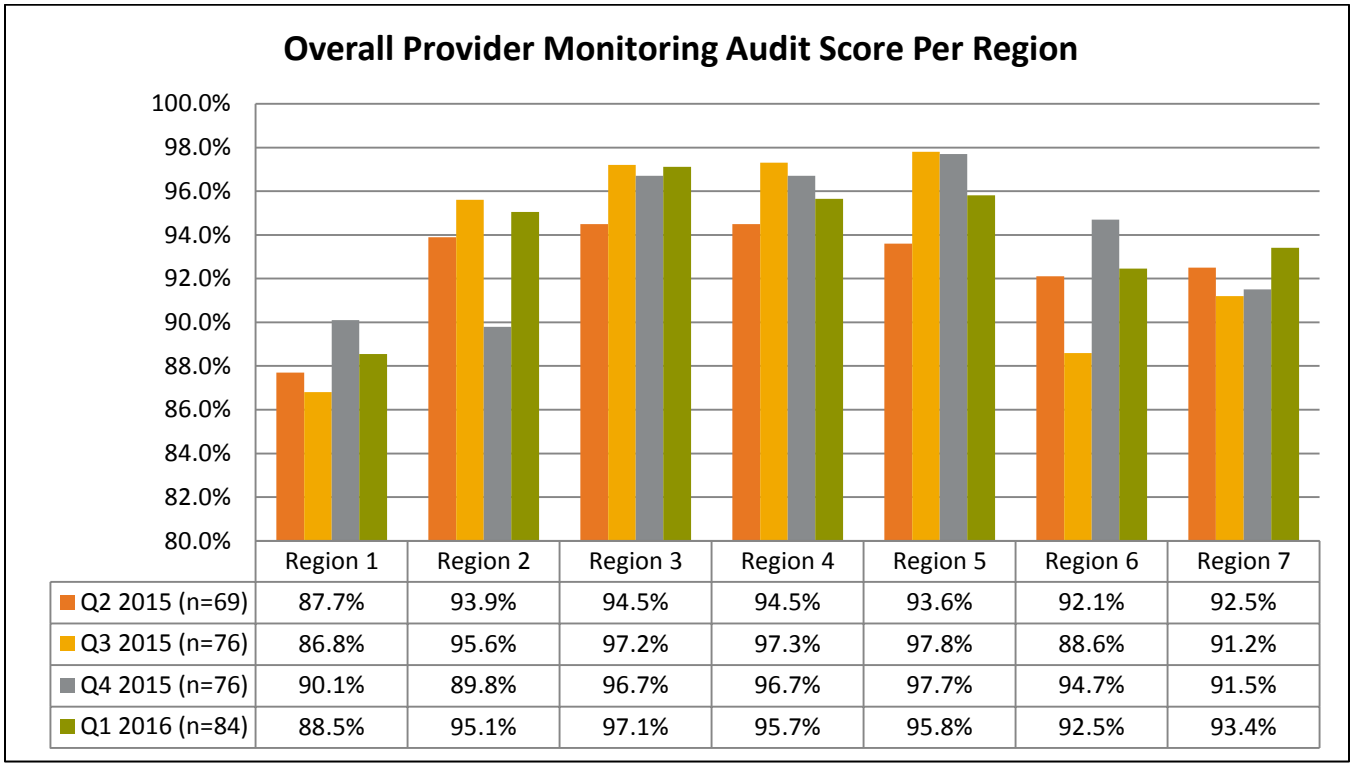




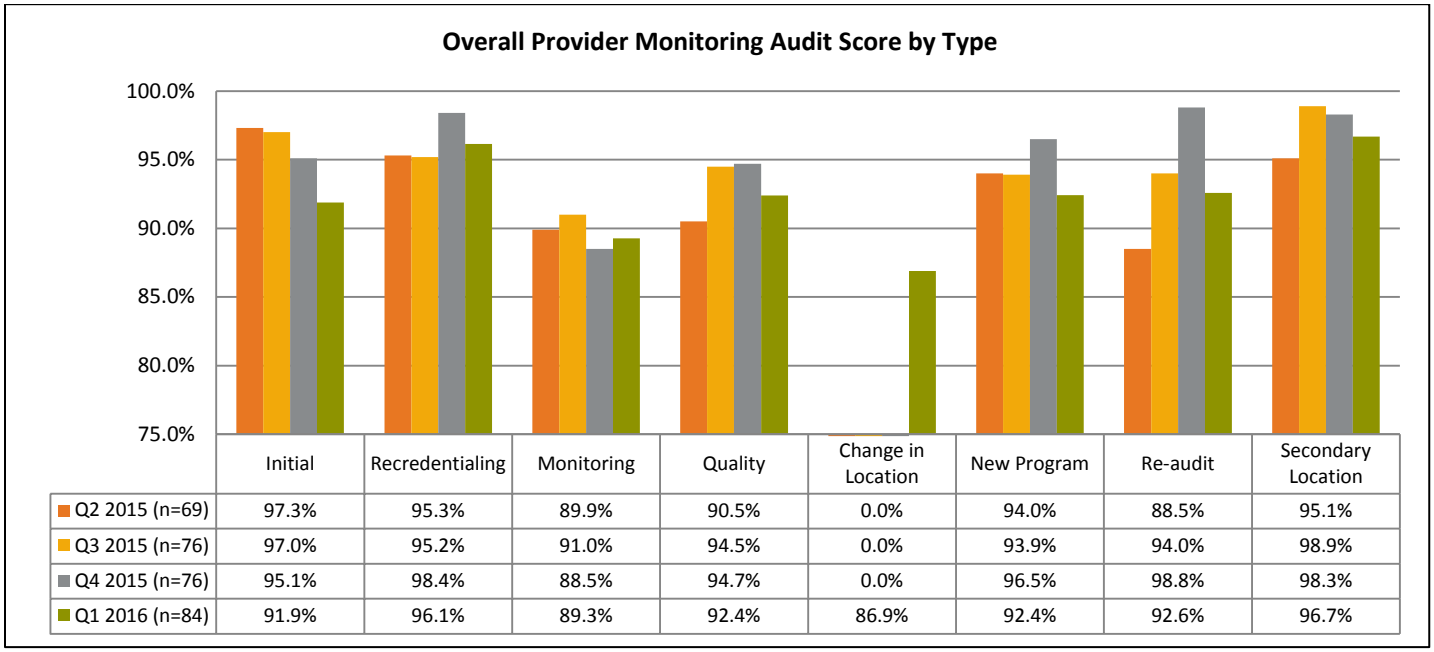
	Initial	Recredentialing	Monitoring	Quality	Change in Location	New Program	Re-audit	Secondary Location
Q2 2015 (n=69)	5	12	31	1	0	2	3	15
Q3 2015 (n=76)	6	5	47	4	0	6	1	7
Q4 2015 (n=76)	15	7	28	2	0	13	1	10
Q1 2016 (n=84)	24	25	4	3	2	6	14	6


% of Audits w/Passing Score of 85% or Higher
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
87.0%
77.6%
77.6%
85.7%
Q2 (n = 69)
Q3 (n = 76)
Q4 (n = 76)
Q1 (n = 84)


% of Audits Where Corrective Action Plan was Required
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
13.0%
22.4%
22.4%
14.3%
Q2 (n = 69)
Q3 (n = 76)
Q4 (n = 76)
Q1 (n=84)



	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Q2 2015 (n=69)	87.7%	93.9%	94.5%	94.5%	93.6%	92.1%	92.5%
Q3 2015 (n=76)	86.8%	95.6%	97.2%	97.3%	97.8%	88.6%	91.2%
Q4 2015 (n=76)	90.1%	89.8%	96.7%	96.7%	97.7%	94.7%	91.5%
Q1 2016 (n=84)	88.5%	95.1%	97.1%	95.7%	95.8%	92.5%	93.4%



	Initial	Recredentialing	Monitoring	Quality	Change in Location	New Program	Re-audit	Secondary Location
Q2 2015 (n=69)	97.3%	95.3%	89.9%	90.5%	0.0%	94.0%	88.5%	95.1%
Q3 2015 (n=76)	97.0%	95.2%	91.0%	94.5%	0.0%	93.9%	94.0%	98.9%
Q4 2015 (n=76)	95.1%	98.4%	88.5%	94.7%	0.0%	96.5%	98.8%	98.3%
Q1 2016 (n=84)	91.9%	96.1%	89.3%	92.4%	86.9%	92.4%	92.6%	96.7%

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

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, as well as accrediting organizations, expect providers to make a "good faith" effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member as part of an overall approach to coordinating care.

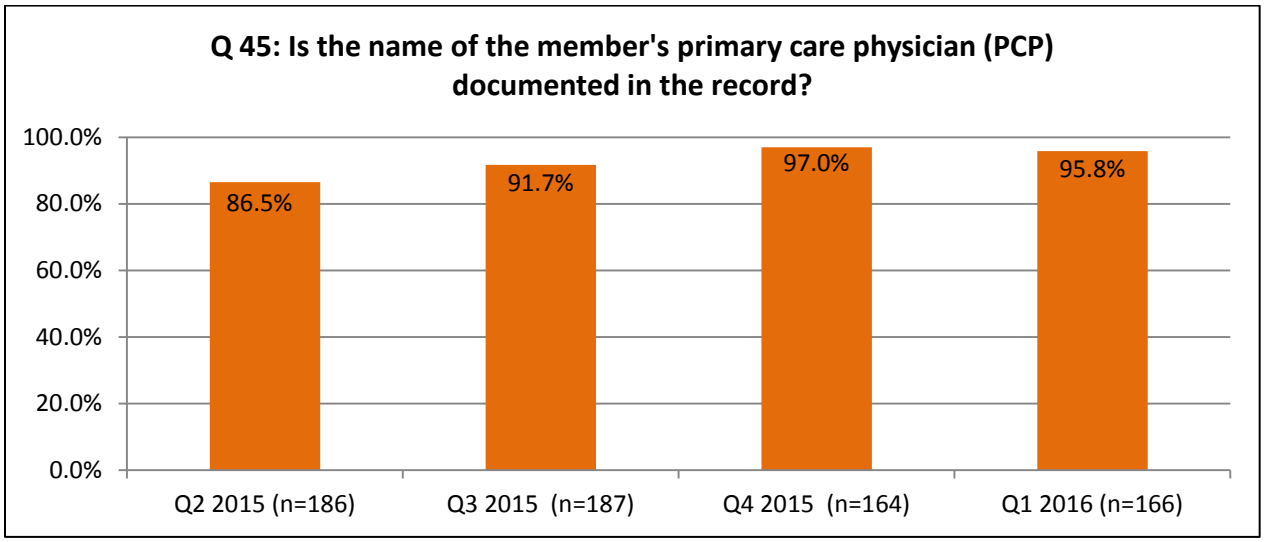
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff. The results are tabulated in an internal Excel spreadsheet.

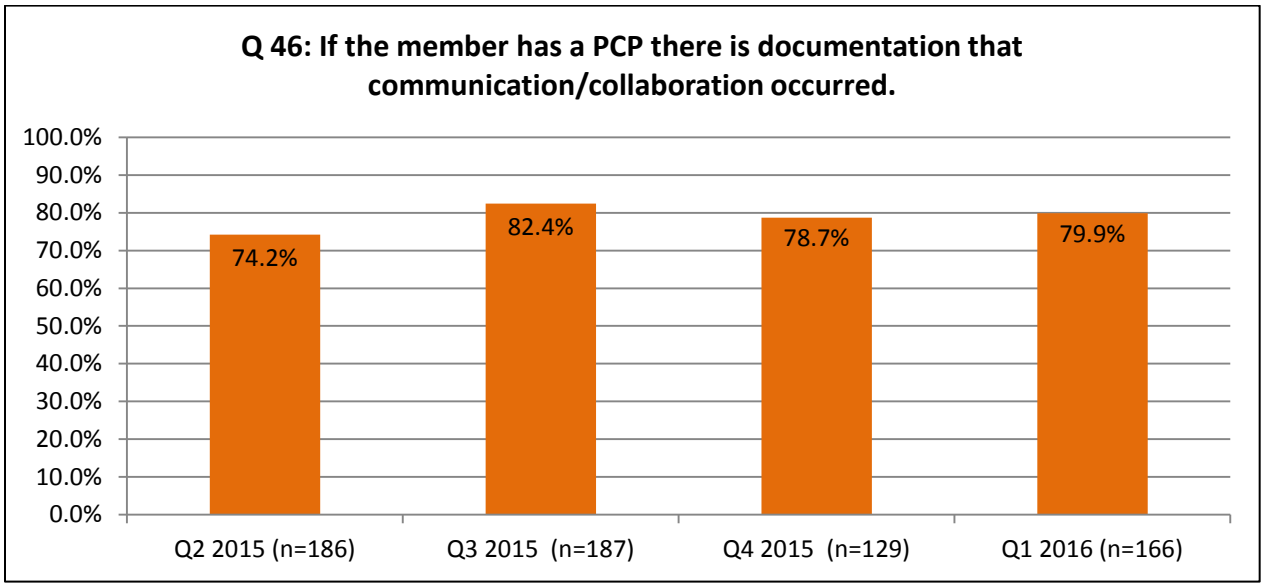
Quarterly Performance Results:

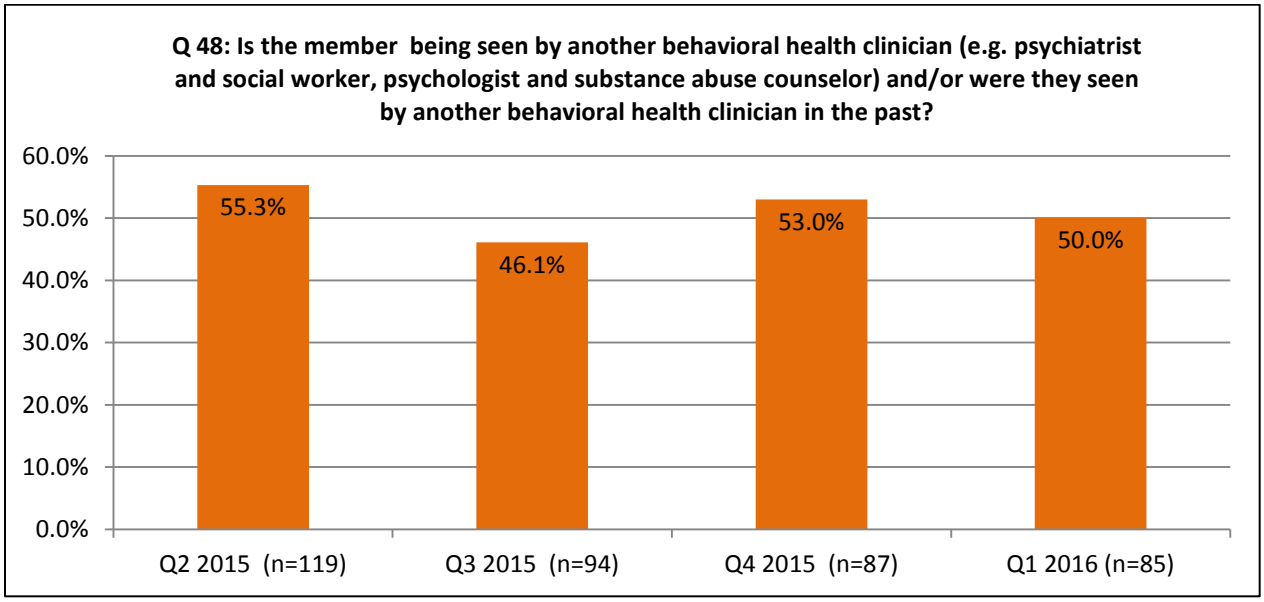
Coordination of Care (% answered in the affirmative)	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Q45: Is the name of the member's primary care physician (PCP) documented in the record?	NA	86.5 %	91.7%	97.0%	95.8%
Q 46: If the Member has a PCP there is documentation that communication/collaboration occurred	NA	74.2%	82.4%	78.7%	79.9%
Q48 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	55.3%	46.1%	53.0%	50.0%

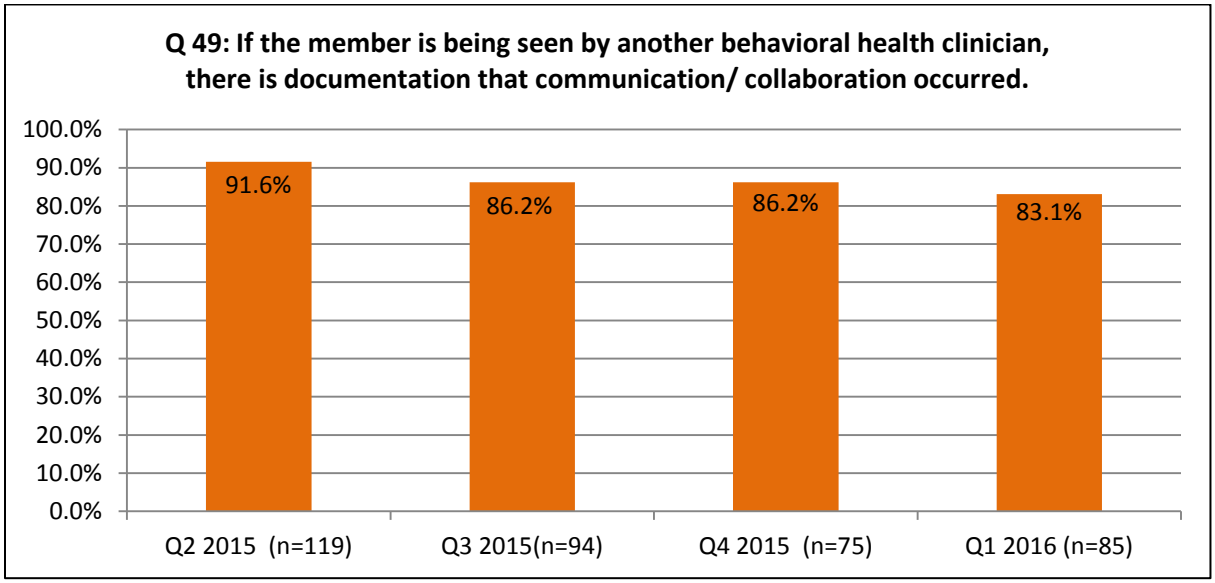
Q49 If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred.	NA	91.6%	86.2%	86.2%	83.1%

Analysis: Coordination of Care audits completed during Q1 revealed that 95.8% of member records reviewed had documentation of the name of the member's PCP. Of those, 79.9% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. The results also indicated that that 50.0% 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, 83.1% indicated that communication/collaboration had occurred.









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

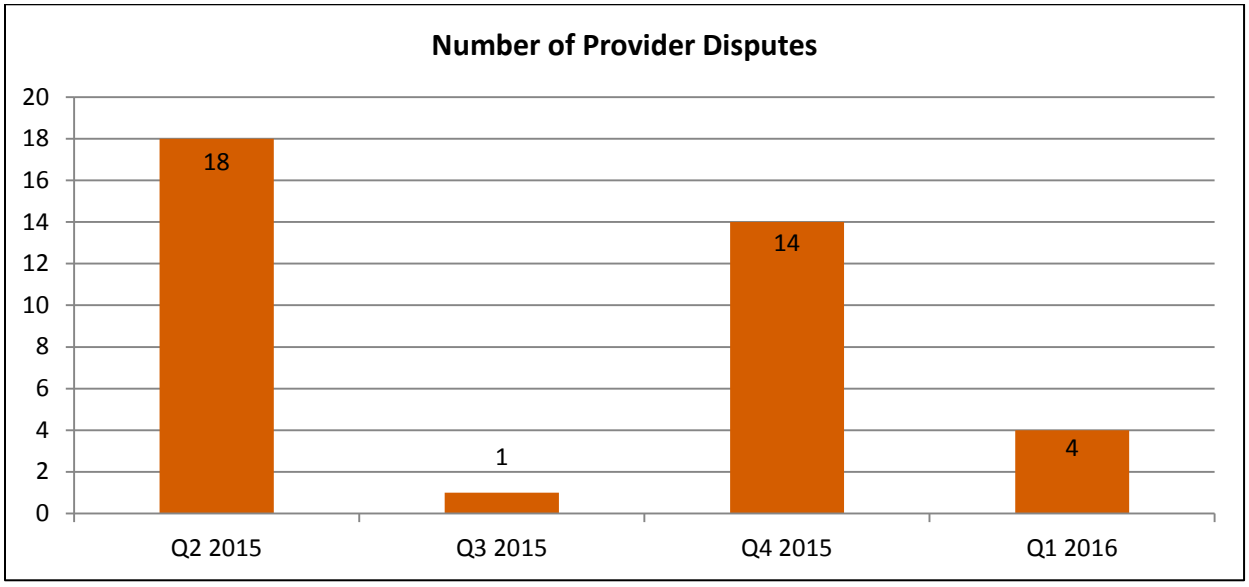
Provider Disputes

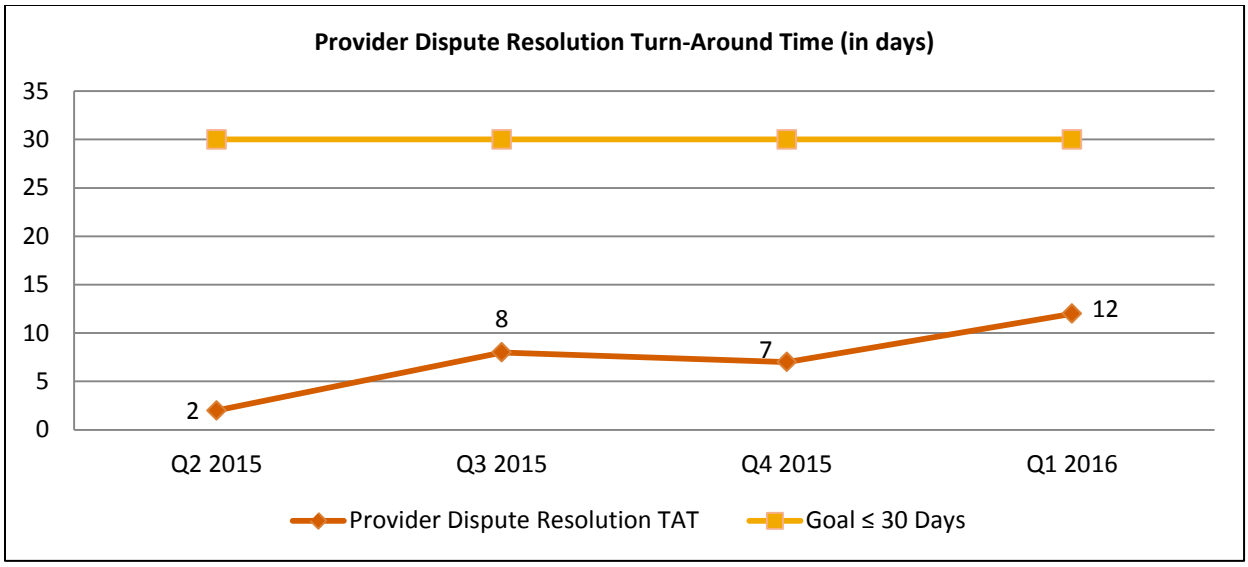
Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination (claims-based denials) when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is believed to have been incorrectly issued. Provider disputes require that a written resolution notice be sent within 30 days following the request for consideration.

Quarterly Performance Results:

Provider Disputes	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Number of Provider Disputes	NA	18	1	14	4
Average # of Days Provider Disputes Resolved	30 Days	2	8	7	12
Number of Disputes Overturned	NA	8	0	14	4
% of Disputes Overturned	NA	44.4%	0.0%	100.0%	100.0%

Analysis: There were 4 provider disputes during Q1; a decrease from 14 during Q4, 2015. All were resolved within the goal of ≤30 days, with an average resolution of 12 days. All provider disputes in Q1 were overturned due to new claims information that was submitted.





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

Utilization Management and Care Coordination

Service Authorization Requests

Methodology: Optum Idaho has formal systems and workflows designed to process pre-service, concurrent and post service requests for benefit coverage of services, for both in-network and out-of- network (OON) providers and agencies. Optum Idaho adheres to a 14-day turnaround time for processing requests for non-urgent pre-service requests that results in a denial or limited authorization of a requested service; termination, suspension, or reduction of a previously authorized service, the denial in whole or in part of a payment for service; or the failure to act upon a request for services in a timely manner.

Service Authorization Requests	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Number of Service Authorization Requests	NA	13,344	7,052	6,299	See below
Percent Determinations Completed within 14 days	100.0%	99.0%	99.3%	99.2%	See below

Analysis: It has been determined that the data for this measure requires further validation.
Barriers: It has been determined that there may be data entry errors. Because of this, the report cannot be validated.

Opportunities and Interventions: Optum Idaho's Clinical Program Manager has requested this report on a monthly basis to complete validation and ensure accuracy. Update will be provided in the Q2 report.

Field Care Coordination

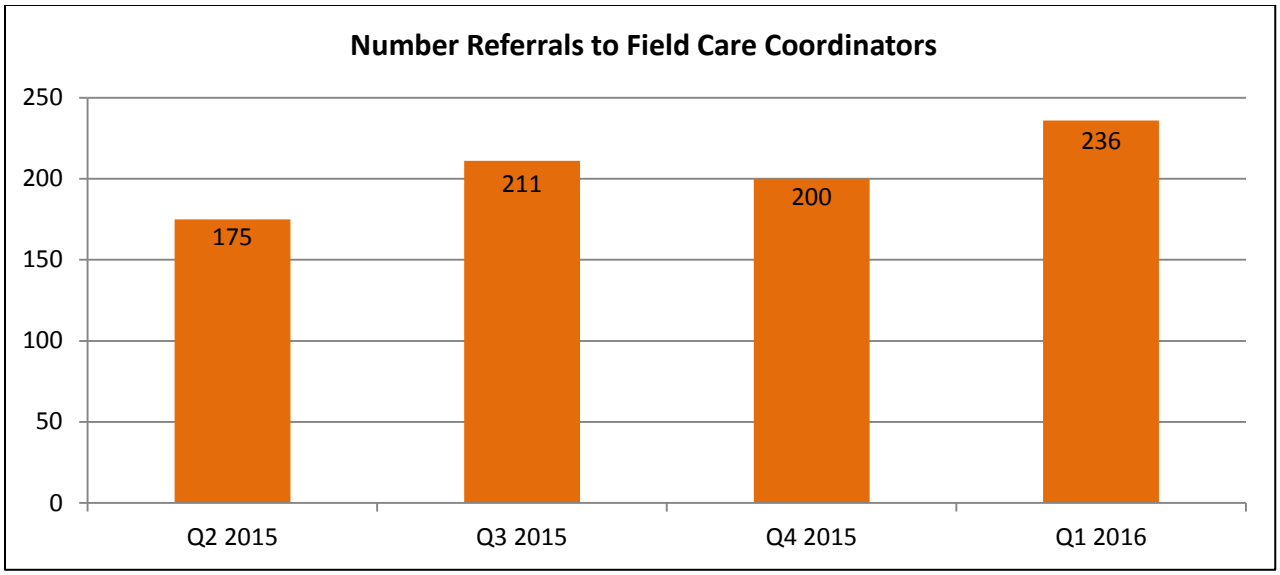
Methodology: The Field Care Coordination (FCC) program includes regionally based clinicians across the state of Idaho. They provide locally based care coordination and discharge planning support. Field Care Coordinators work with the provider to help members. The FCC team focuses on member wellness,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

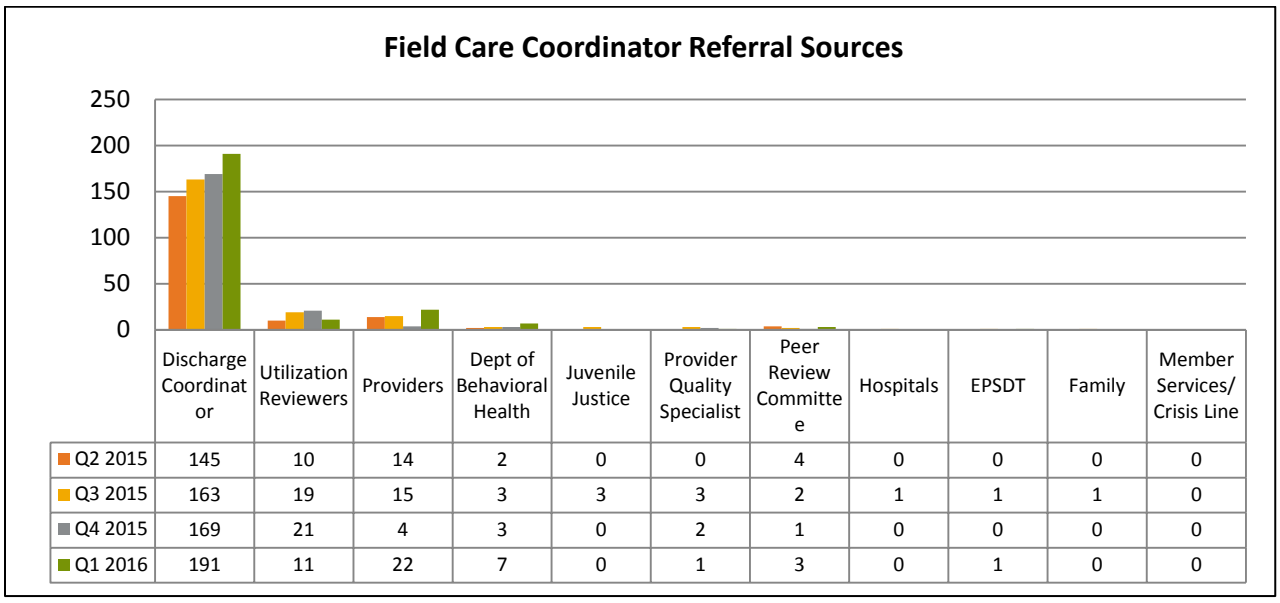
- Focusing on members and member families who are at greatest clinical risk
- Focusing on member's wellness and the member's responsibility for his/her own health and well-being.
- Improved care coordination for members moving between services, especially those being discharged from 24-hour care settings.

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 Q2, 2015 through Q1, 2016.

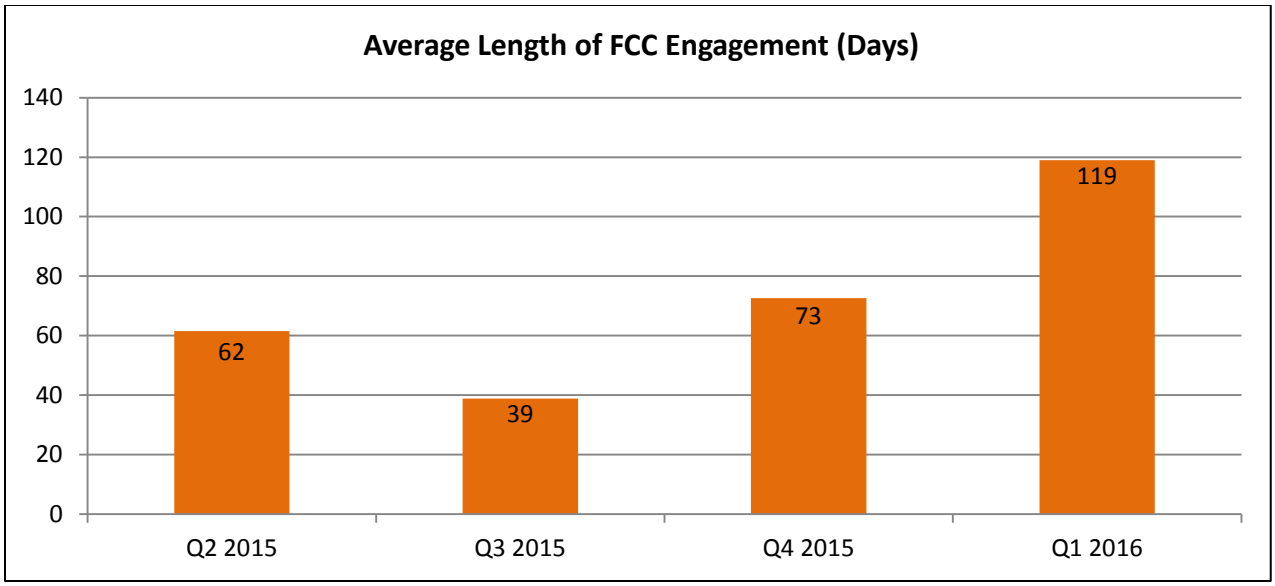
Referral Sources	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Discharge Coordinator	145	163	169	191
Utilization Reviewers	10	19	21	11
Providers	14	15	4	22
Dept of Behavioral Health	2	3	3	7
Juvenile Justice	0	3	0	0
Provider Quality Specialist	0	3	2	1
Peer Review Committee	4	2	1	3
Hospitals	0	1	0	0
EPSDT	0	1	0	1
Family	0	1	0	0
Member Services/Crisis Line	0	0	0	0
Total	175	211	200	236

Analysis: During Q1, Field Care Coordinators received 236 referrals, an increase from 200 during Q4, 2015. Of the 236 referrals, 191 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement was 119.1 days.





	Discharge Coordinator	Utilization Reviewers	Providers	Dept of Behavioral Health	Juvenile Justice	Provider Quality Specialist	Peer Review Committee	Hospitals	EPSDT	Family	Member Services/ Crisis Line
Q2 2015	145	10	14	2	0	0	4	0	0	0	0
Q3 2015	163	19	15	3	3	3	2	1	1	1	0
Q4 2015	169	21	4	3	0	2	1	0	0	0	0
Q1 2016	191	11	22	7	0	1	3	0	1	0	0

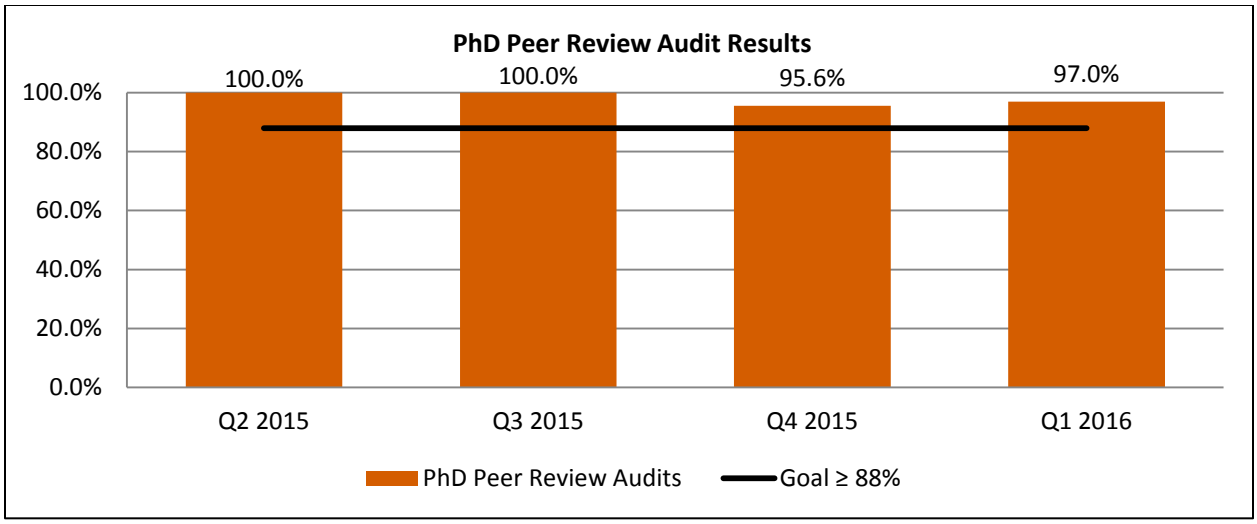


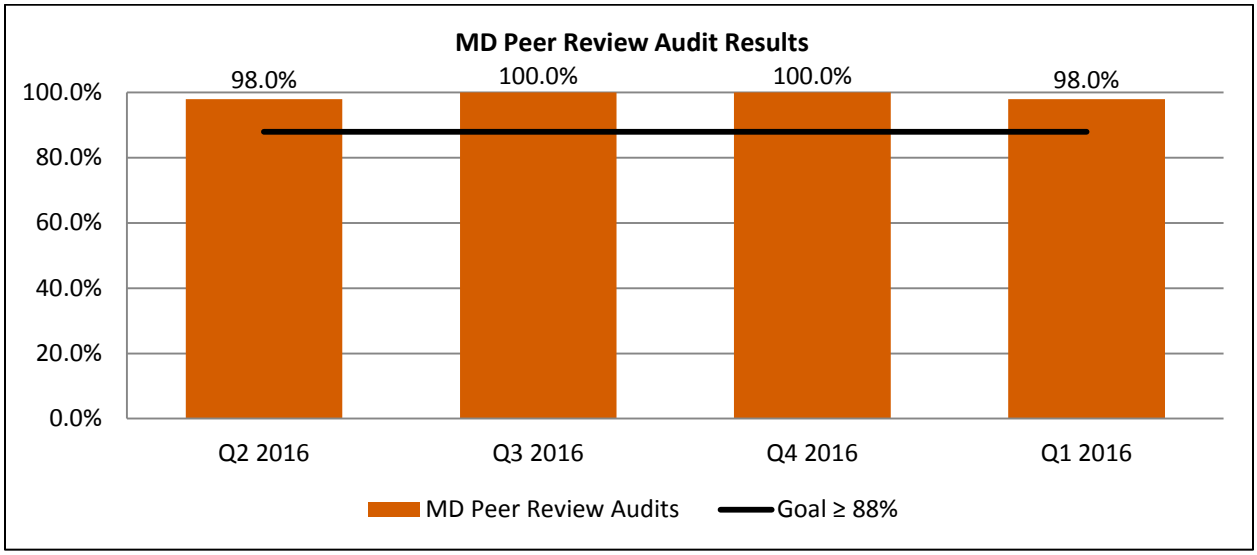
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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 Q1.





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.

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.

	CLINICIANS											
QUESTIONS	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%
	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 through the 2016 calendar year.

Population Analysis

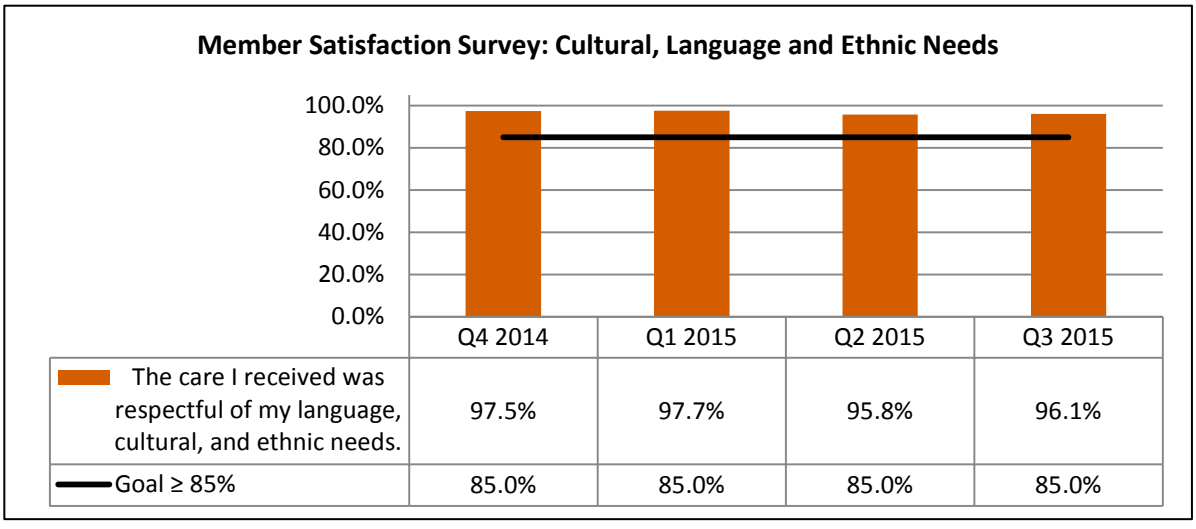
Language and Culture

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 2010 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.

2010* Idaho Census Results for Ethnic, Racial and Cultural Distribution of Population								
Total Population (Estimate)	Hispanic or Latino	White	Black or African American	American Indian & Alaska Native alone	Asian alone	Native Hawaiian & Other Pacific Islander alone	Some other race alone	Two or more races
1,567,582	**11.2%**	**89.1%**	**0.7%**	**1.4%**	**1.2%**	**0.1%**	**5.1%**	**2.5%**

*most current data available

Analysis: Hispanic or Latino counted for 11.2% of the Idaho population. This is the second highest population total, with White consisting of 89.1% (ethnic and racial backgrounds can overlap which explains for the percentage total > 100%). The Member Satisfaction Survey results show that 96.1% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q3 2015 data is the most recent results available.



	Q4 2014	Q1 2015	Q2 2015	Q3 2015
The care I received was respectful of my language, cultural, and ethnic needs.	97.5%	97.7%	95.8%	96.1%
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.

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.

Quarterly Performance Results:

Language Assistance Requests by Type	# of Requests
Member Written Communication Translated to Spanish (Annual Member Mailing)	NA (annual mailing)
Member Written Communication Formatted to Large Print (Annual Member mailing)	NA (annual mailing)
Mental Health First Aid (MHFA) Training Materials Translated to Spanish	0
Interpreter Services – Language Service Associates (verbal translations by phone	12

Analysis: During Q1, Optum responded to 12 requests for language assistance through 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

from the received date to the paid date (check), plus two days for mail time. Company holidays are included.

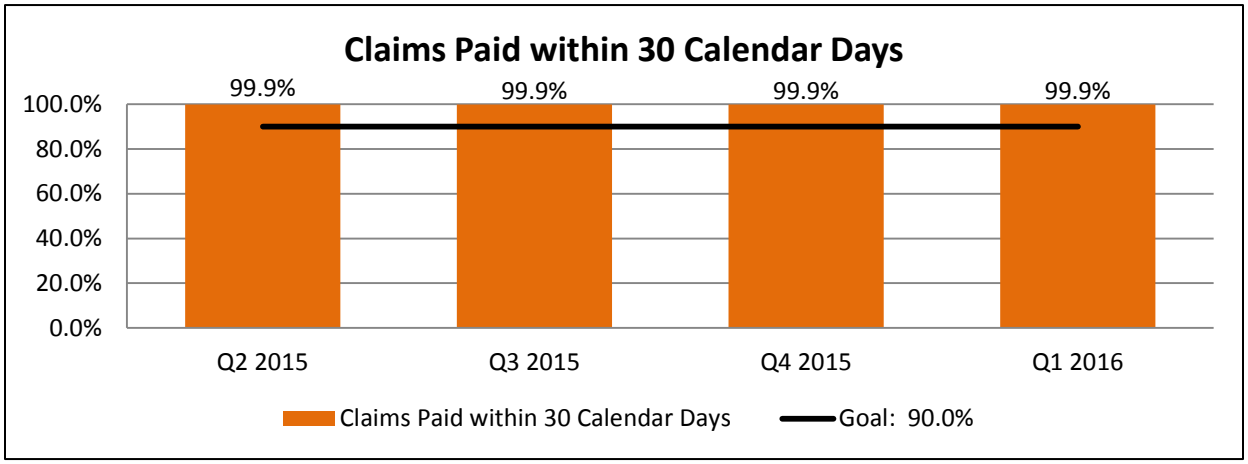
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid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

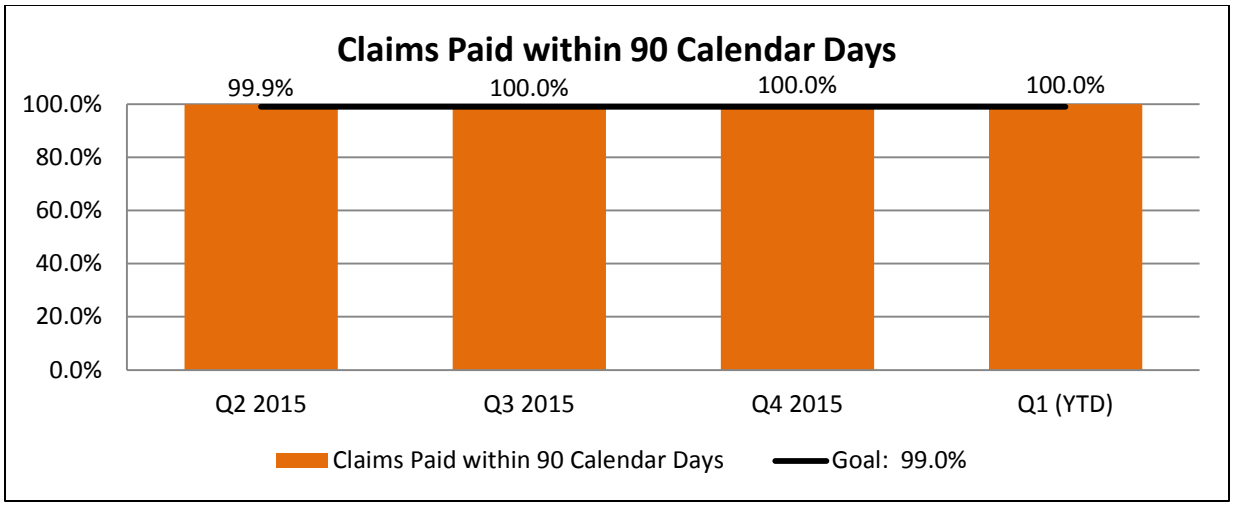
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial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

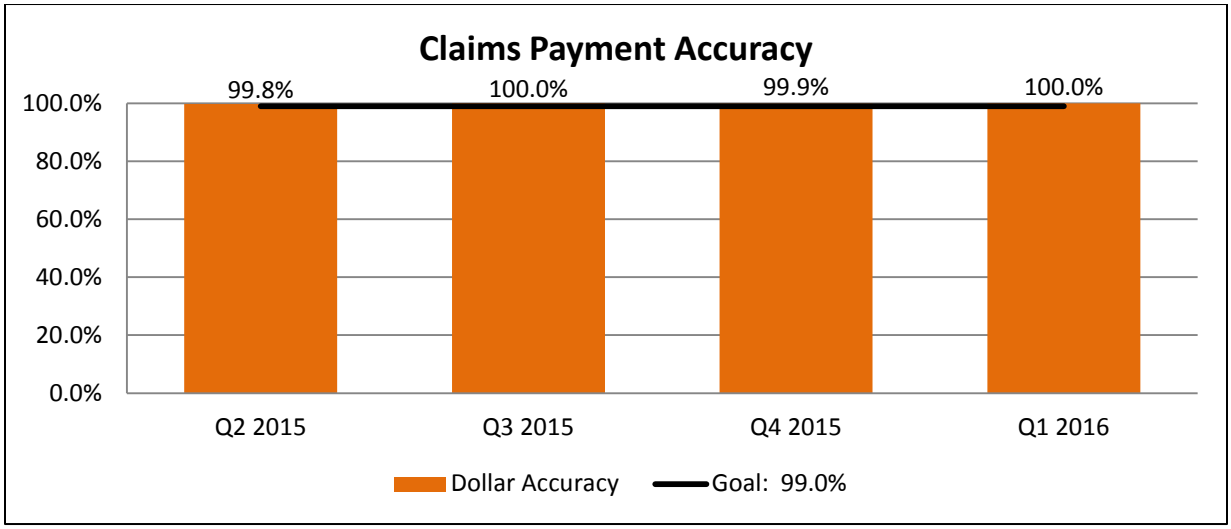
Quarterly Performance Results:

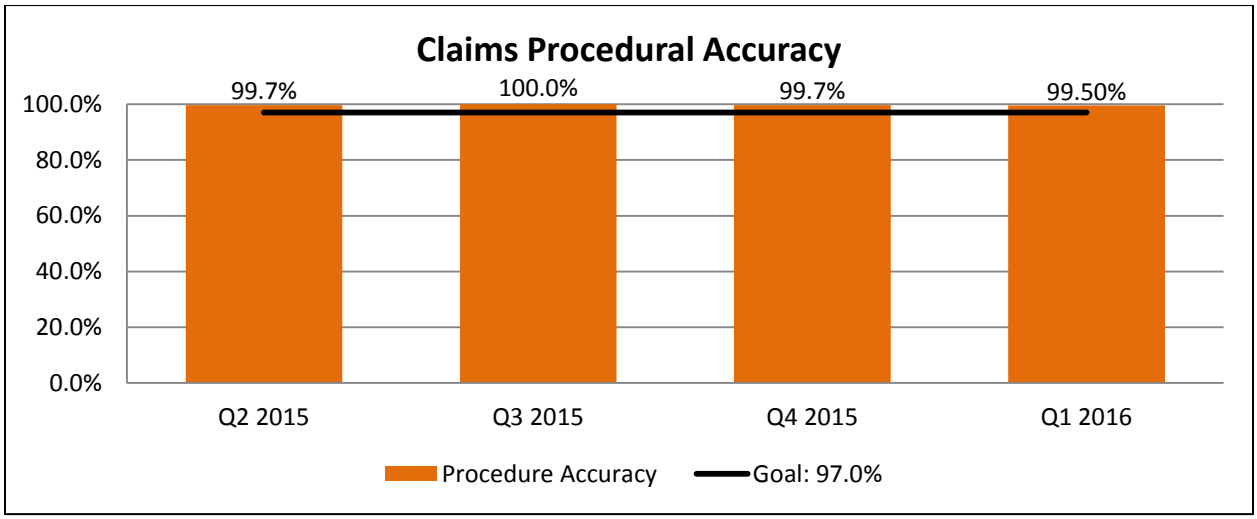
Claims	Performance Goal	Q2 2015	Q3 2015	Q4 2015	Q1 2016 (based on the March. OR57 report)
Paid within 30 days	90%	99.9%	99.9%	99.9%	99.9%
Paid within 90 days	99%	99.9%	100.0%	100.0%	100.0%
Dollar Accuracy	99%	99.8%	100.0%	99.9%	100.0%
Procedural Accuracy	97%	99.7%	100.0%	99.7%	99.5%

Analysis: The data shows that all performance goals have been met calendar year to date.




Claims Paid within 90 Calendar Days
99.9%
100.0%
100.0%
100.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Q2 2015
Q3 2015
Q4 2015
Q1 (YTD)
Claims Paid within 90 Calendar Days
Goal: 99.0%


Claims Payment Accuracy
99.8%
100.0%
99.9%
100.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Q2 2015
Q3 2015
Q4 2015
Q1 2016
Dollar Accuracy
Goal: 99.0%


Claims Procedural Accuracy
99.7%
100.0%
99.7%
99.50%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Q2 2015
Q3 2015
Q4 2015
Q1 2016
Procedure Accuracy
Goal: 97.0%

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