IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT

July - September, 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 3, 2016, for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

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Executive Summary

The quarterly report of Optum Idaho'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 Idaho'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 Idaho'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 3, 2016, (July 1 – September 30, 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. In this report, thirty-three (33) key performance measures were highlighted based on performance targets that are based on contractual, regulatory or operational standards. For this reporting period, Optum Idaho met or exceeded performance for 32 (97.0%) of the total key measures. This high level of operational effectiveness further validates Optum Idaho's commitment to IBHP members and families in transforming the behavioral health care system in the State of Idaho.

Highlights of Optum Idaho's effectiveness in Q3 include the following measures that met or exceeded the established target for performance during the quarter:

- Member Satisfaction Survey Results
  - Optum Idaho exceeded established performance (≥85.0%) in the following areas for member satisfaction:
    - Experience with Optum Idaho Staff and Referral Process (94.0%)
    - Experience with Behavioral Health Provider Network (94.0%)
    - Experience with Counseling or Treatment (93.6%)
    - Overall Experience (91.5%)

- Member Services Call Standards
  - Optum Idaho exceeded established performance call standards for member service calls:
    - The percent of calls answered within 30 seconds was met at 82.0% (goal: ≥80% of calls answered in 30 seconds).
    - The average speed of answer was met at 18.0 seconds (goal: ≤30 seconds).
    - Call abandonment rate was met at 3.4% (goal ≤3.5%).

- Customer Service (Provider) Call Standards
  - Optum Idaho again exceeded established performance call standards for customer service (provider) calls:
    - 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 0.16% (goal ≤3.5%).

- Urgent and Non-Urgent Access to Services
  - Optum Idaho again exceeded established performance for urgent (within 48 hours) and non-urgent (within 10 days) appointment wait times.
    - Urgent Appointment Wait Time – 22.0 hours
    - Non-Urgent Appointment Wait Time – 5.5 days

- Geographic Availability of Providers
  - Geographic availability of providers has a goal of 100%. Optum Idaho met performance standards at 99.8% 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)

- Initial Verbal Notification of Adverse Benefit Determination
  - The established goal is 100% of verbal notifications are given the same day following an adverse determination of notified on the same day. Performance for this measure reached 99.6%.

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

- Member Grievances
  - Optum Idaho continued to exceed the 30 day turnaround time for resolutions. Quarter 3 average resolution turnaround time was 16.2 days.

- Complaint Timeframes
  - Optum Idaho met the goal of 100% for complaint acknowledgement (within 5 business days).
  - Complaint resolution turnaround time was met at 100% for both quality of service (resolved within 10 days) and quality of care (resolved within 30 days) complaints during Q3, 2016.

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

- Customer Response to Written Inquiries
  - Optum Idaho again met established performance (100%) for response to written inquiries within 2 business days.

- Network Monitoring Audits
  - A total of 82 audits were completed during Quarter 3. Overall audit scores exceeded the goal of ≥ 85.0%.
    - Overall Initial Credentialing audit score was 98.3%
    - Overall Re-credentialing audit score was 92.2%
    - Overall Quality of Care audit score was 96.5%

- Provider Disputes
  - Optum Idaho again exceeded the performance goal (≤30 days) for resolving provider disputes with the average turnaround time during Quarter 3 at 9.9 days.

- Service Authorization Requests
  - Optum Idaho met established performance (100%) for review of authorization requests within 14 days.
    - Performance for this measure reached 99.5%. (performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)

- Peer Review Audit Results – MD and PhD (≥88%)
  - Average peer review audit score for MD was 98.1%.
  - Average peer review audit score for PhD was 100.0%.

- 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: 100.0%

While Optum Idaho met performance goals in 32 or 33 key performance areas, the following area did not meet performance expectations:

- Written notification of Adverse Benefit Determination (100% sent within 1 business day)
    - Performance for this measure reached 96.3%, slightly below the goal of 100% sent within 1 business day.

In addition to the performance highlights above, Optum continues its efforts to partner with community stakeholders to further engage in meaningful ways within our communities where we live and work. We are dedicated to working in partnership with all community stakeholders to implement an accountable, outcomes-driven, recovery-centered system focused on improving member care.

We have been working in collaboration with the Idaho Department of Health and Welfare to improve the health status of Idahoans through behavioral health system enhancements. We are excited to announce that on October 20, 2016 we awarded the first Community Health Initiatives Grant (CHI) to St.Luke's Health System and the REACH Institute. The goal of the $420,000 grant is to improve behavioral health outcomes for child and adolescent Medicaid participants with Severe Emotional Disturbances (SED). We will 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 stakeholders and the members we serve.

In collaboration with The Speedy Foundation, Idaho Federation of Families and the Idaho Children's Trust Fund, we held four InTouch Community Conversations across the state during the third quarter. The screening of the documentary, *Paper Tigers*, followed by a panel discussion with local community experts, brought together leaders, counselors, IDHW representatives, teachers, Corrections Department, students, providers and members to begin a conversation about the positive approaches of discipline, education and engagement for children and adolescents affected by trauma.

Along with investment partners and new residents, we celebrated the completion of The Springs II, the second phase of an apartment community in McCall that brings an additional 36 homes to the region, helping address a need for more affordable housing. The Springs II integrates three additional 2-story garden apartment buildings with a mix of studio, one-, two- and three-bedroom apartments into the now 72-unit apartment community. Optum employees presented "welcome baskets" with household items, cleaning supplies and other amenities donated by the company to all the residents of The Springs community.

Additional community outreach efforts during the third quarter included:

• Working with targeted media outlets across the state to educate and inform audiences about our collaborative efforts to move to a member-centric system of care.
• Working with the Regional Behavioral Health Boards to identify region specific community outreach opportunities.
• Participating in statewide Recovery Month resource fairs and presentations. Staff members shared information and insight the benefits we provide to members as well as tips for recognizing when someone you care about may be struggling with a mental health issue.

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

Below is a grid used to track the Quality Performance Measures and Outcomes. It identifies the performance goal for each measure along with quarterly. Those highlighted in green met or exceeded overall performance. Those highlighted in yellow fell within 5% of the performance goal. Those highlighted in red fell below the performance goal.

Measure	Goal	October - December 2015	January - March 2016	April - June 2016	July - September 2016
Member Satisfaction Survey Results					
Experience with Optum Idaho Staff and Referral Process	≥85.0%	**90.1%**	**94.0%**	Based on the Member Satisfaction Survey sampling methodology, Q1, 2016, is the most recent data available.	
Experience with the Behavioral Health Provider Network	≥85.0%	**93.1%**	**94.0%**		
Experience with Counseling or Treatment	≥85.0%	**95.3%**	**93.6%**		
Overall Experience	≥85.0%	**94.8%**	**91.5%**		
Provider Satisfaction Survey Results					
Overall Provider Satisfaction	≥85.0%	**65.0%**	**75.0%**	**74.0%**	Moved to Annual Survey. (Results expected January 2017)
Accessibility & Availability					
Idaho Behavioral Healthplan Membership					
Membership Numbers	NA	**289,033**	**289,814**	**293,793**	Due to claims lag, data is reported one quarter in arrears
Member Services Call Standards					
Total Number of Calls	NA	**1,416**	**1,373**	**1,193**	**1,175**
Percent Answered within 30 seconds	≥80.0%	**92.4%**	**94.3%**	**93.0%**	**82.0%**
Average Speed of Answer (seconds)	≤30 Seconds	**12.2**	**11.2**	**12.0**	**18.0**
Abandonment Rate	≤3.5%	**1.3%**	**1.1%**	**0.8%**	**3.4%**
Customer Service (Provider Calls) Standards					
Total Number of Calls	NA	**3,175**	**3,284**	**3,032**	**2,818**
Percent Answered within 30 seconds	≥80.0%	**98.9%**	**98.9%**	**91.1%**	**98.9%**
Average Speed of Answer (seconds)	≤30 Seconds	**1.4**	**1.7**	**0.8**	**1.7**
Abandonment Rate	≤3.5%	**0.31%**	**0.40%**	**0.20%**	**0.16%**

Measure	Goal	October - December 2015	January - March 2016	April - June 2016	July - September 2016
Urgent and Non-Urgent Access Standards					
Urgent Appointment Wait Time (hours)	48 hours	**20.9**	**15.6**	**27.5**	**22.0**
Non-Urgent Appointment Wait Time (days)	10 days	**4.3**	**5.7**	**5.6**	**5.5**
Geographic Availability of Providers					
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100.0%	**99.9%***	**99.9%***	**99.9%***	**99.8%***
Area 2 - requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	100.0%	**99.8%***	**99.8%***	**99.8%***	**99.8%***
Member Protections and Safety					
Notification of Adverse Benefit Determinations					
Number of Adverse Benefit Determinations	NA	**477**	**621**	**508**	**540**
Initial Verbal Notification on Same Day	100.0%	**100.0%**	**98.7%**	**99.6%***	**99.6%***
Written Notification Sent within 1 Business Day	100.0%	**97.9%**	**98.1%**	**99.0%**	**96.3%**
Grievances (appeal of adverse determination)					
Number of Grievances	NA	**16**	**21**	**9**	**26**
Member Grievance Turnaround time	≤30 days	**10**	**18.2**	**14.4**	**16.2**
Complaint Resolution and Tracking					
Total Number of Complaints	NA	**28**	**14**	**18**	**18**
Percent of Complaints Acknowleged within Turnaround time	5 days	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Number of Quality of Service Complaints	NA	**26**	**13**	**15**	**17**
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**	**1**	**3**	**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	**23**	**17**	**17**	**16**
Percent Ad Hoc Reviews Completed within 5 business days from notification of incident	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Response to Written Inquiries					
Percent Acknowledged ≤2 business days	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Measure	Goal	October - December 2015	January - March 2016	April - June 2016	July - September 2016
Provider Monitoring and Relations					
Provider Quality Monitoring					
Number of Audits	NA	**76**	**84**	**163**	**82**
Initial Audit (Percent overall score)	≥ 85.0%	**95.1%**	**91.9%**	**96.3%**	**98.3%**
Recredentialing Audit (Percent overall score)	≥ 85.0%	**98.4%**	**96.1%**	**93.4%**	**92.2%**
Monitoring (Percent overall score)	≥ 85.0%	**88.5%**	**89.3%**	**58.3%****	**NA*****
Quality (Percent overall score)	≥ 85.0%	**94.7%**	**92.4%**	**97.4%**	**96.5%**
Percent of Audits that Required a Corrective Action Plan	NA	**22.4%**	**14.3%**	**8.6%**	**7.3%**
Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)					
Percent PCP is documented in member record	NA	**97.0%**	**95.9%**	**93.8%**	**97.1%**
Percent documentation in member record that communication/ collaboration occurred betweem behavioral health provider and primary care provider	NA	**78.7%**	**78.5%**	**87.0%**	**86.5%**
Provider Disputes					
Number of Provider Disputes	NA	**14**	**4**	**19**	**14**
Average Number of Days to Resolve Provider Disputes	≤30 days	**7**	**13.5**	**17.4**	**9.9**
Utilization Management and Care Coordination					
Service Authorization Requests					
Percentage Determination Completed within 14 days	100%	**99.2%**	**98.9%**	**99.2%**	**99.5%***
Field Care Coordination					
Total Referrals to FCCs	NA	**200**	**236**	**162**	**175**
Average Number of Days Case Open to FCC	NA	**72.6**	**119.1**	**53.0**	**97.0**
Discharge Coordination: Post Discharge Follow-Up					
Number of Inpatient Discharges	NA	**868**	**943**	**888**	No data due to reporting lag
Percent of Members with Follow-Up Appointment within 7 Days	NA	**48.8%**	**52.5%**	**50.3%**	
Percent of Members with Follow-Up Apptointment within 30 Days	NA	**69.7%**	**72.3%**	**69.1%**	
Readmissions					
Number of Members Disharged	NA	**868**	**943**	**888**	**846**
Percent of Members Readmitted within 30 days	NA	**10.8%**	**9.1%**	**9.8%**	**10.4%**
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			

Measure	Goal	October - December 2015	January - March 2016	April - June 2016	July - September 2016
Peer-Review Audits					
PhD Peer Review Audit Results	≥ 88.0%	**95.6%**	**97.0%**	**100.0%**	**100.0%**
MD Peer Review Audit Results	≥ 88.0%	**100.0%**	**98.0%**	**96.4%**	**98.1%**
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%	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Dollar Accuracy	99.0%	**99.9%**	**100.0%**	**100.0%**	**100.0%**
Procedural Accuracy	97.0%	**99.7%**	**99.5%**	**100.0%**	**100.0%**

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

*** there was only 1 monitoring audit during Q2*

****there were 0 monitoring audits during Q3*

met goal **within 5% of goal** **did not meet goal**

Outcomes Analysis

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

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.

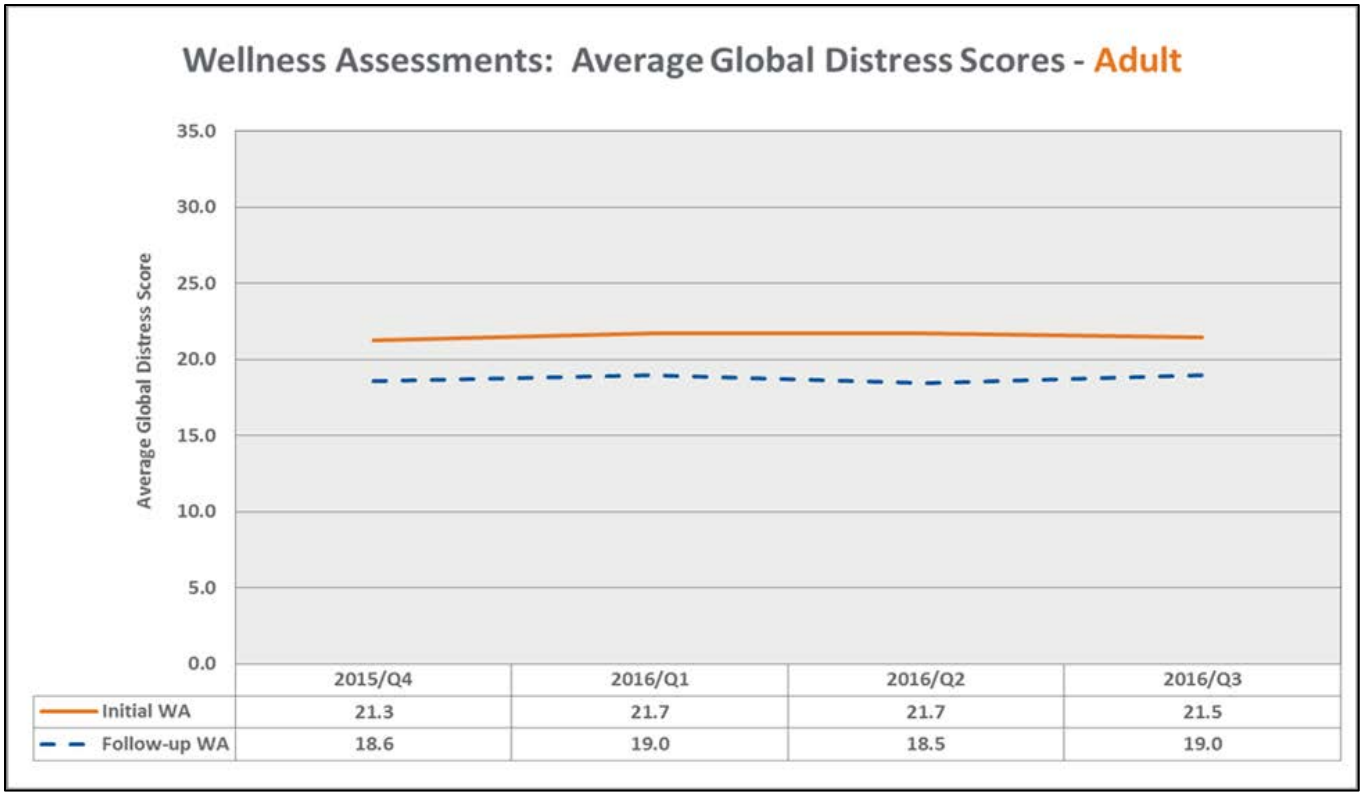


Fig. 1

Analysis: For adults, initial assessments display a flat curve over the 4 quarters from Q4 2015 through Q3 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 before-and-after scores remaining within the Moderate severity range.

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.

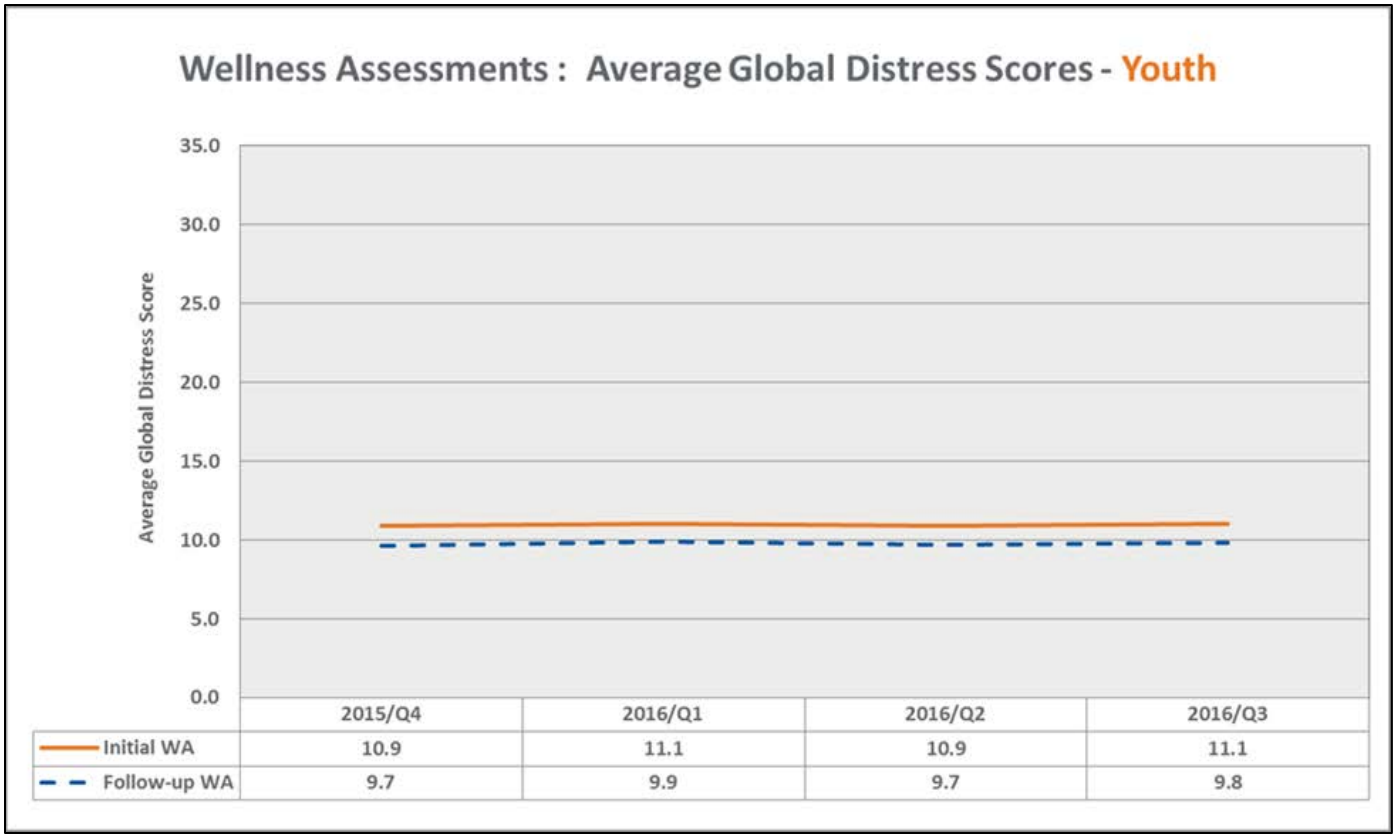


Fig. 2

Analysis: For children and youth, between Q4 2015 and Q3 2016, Global Distress scores have remained flat across time. When follow-up scores in the population are compared to initial scores, there is a similar reduction in strain scores on follow-up in Q3 2016 (1.3%) as in Q4 2015 (1.2%). Scores begin and remain in the moderate range.

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.

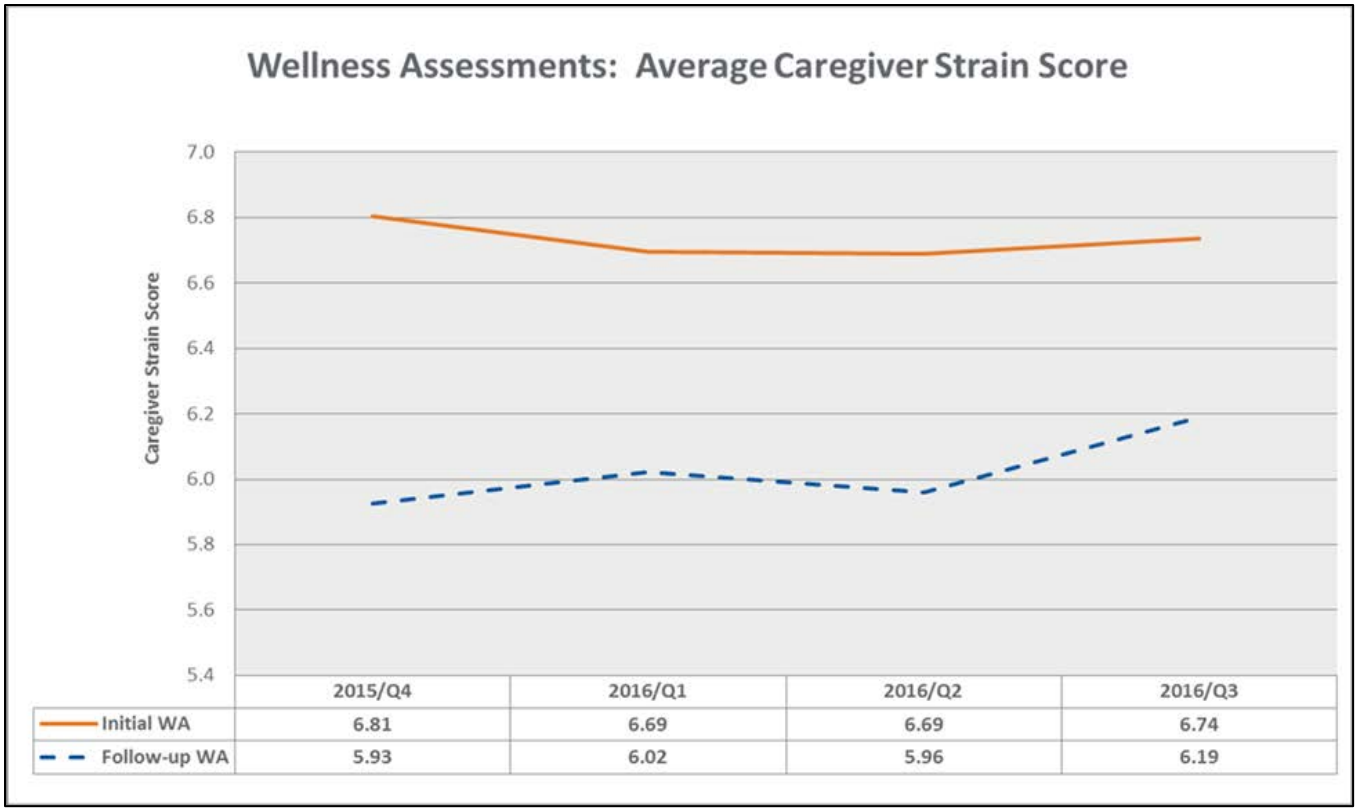


Fig. 3

Analysis: For children and youth, between Q4 2015 and Q3 2016 average initial Caregiver Strain scores have decreased 1.3% over time. When follow-up scores in the population are compared to initial scores, over time the difference between initial and follow-up scores decreased from 0.88 to 0.55, a slight increase in severity compared to scores in Q4 2015. Overall severity levels remained in the moderate range through the study period.

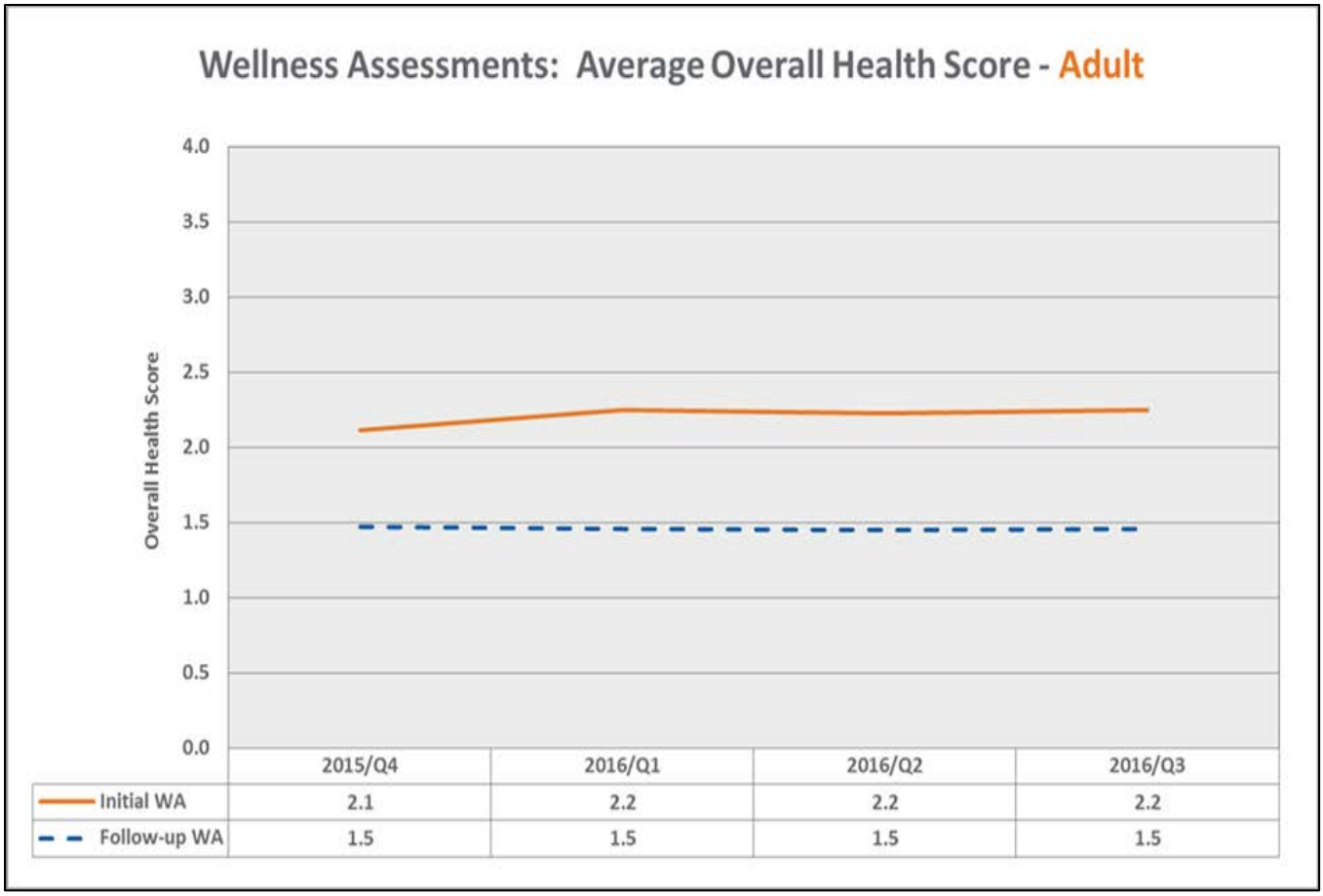


Fig. 4

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 Q4 2015 and Q3 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

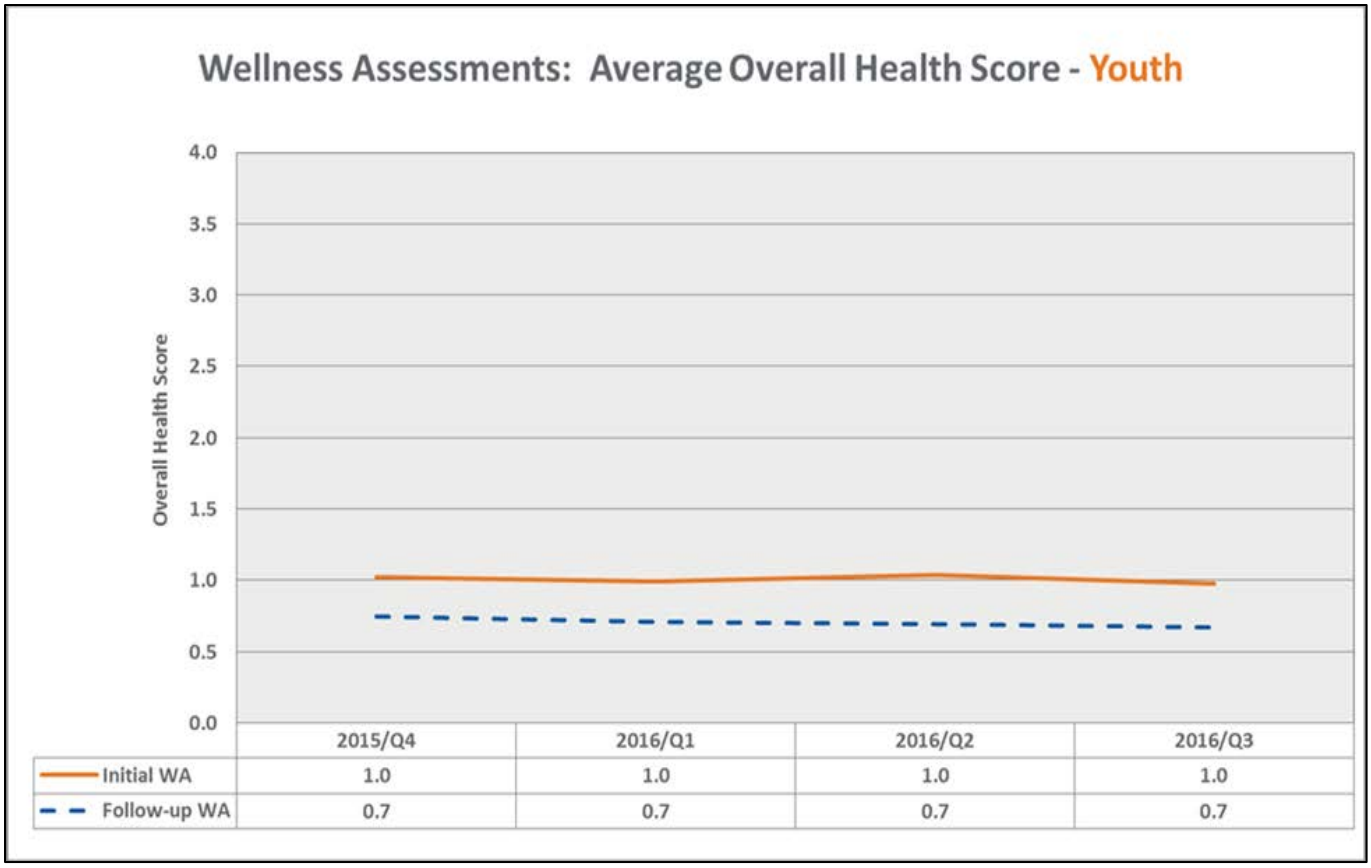


Fig. 5

Analysis: Child/Youth Physical Health score values are as follows:

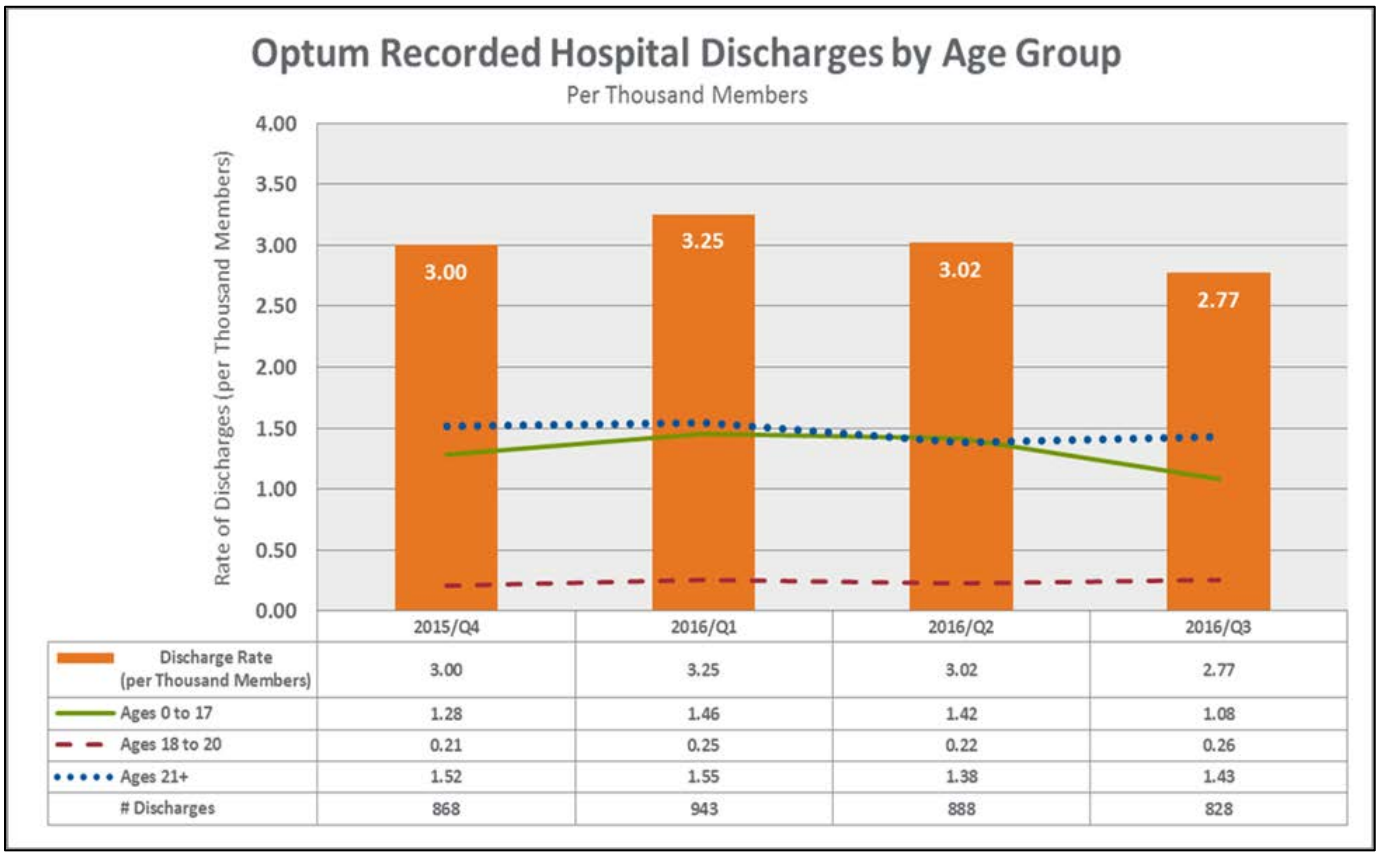
0 = Excellent 1 = Very Good 2 = Good 3 = Fair 4 = Poor

Between Q4 2015 and Q3 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.

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 other hospital 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.

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/Q4	2016/Q1	2016/Q2	2016/Q3
Discharge Rate (per Thousand Members)	3.00	3.25	3.02	2.77
Ages 0 to 17	1.28	1.46	1.42	1.08
Ages 18 to 20	0.21	0.25	0.22	0.26
Ages 21+	1.52	1.55	1.38	1.43
# Discharges	868	943	888	828

Fig.6

Analysis: The overall rate of discharges (and correspondingly admissions, since without an admission there is no discharge), varied from 3.00 to 3.25 and then returned to 2.77 per 1,000 members. This change represents overall no significant change in hospitalizations.
Within age groups, for adults 21+, there has been a 5.3% decrease in hospital discharges from Q4 2015 to Q3 2016. For children and youth 0-17 years, hospitalization rates have decreased 18.5% between Q4 2015 and Q3 2016. For transitioning youth 18-20 years, hospital discharges have increased 23.8% between the start and the end of the study's period. In summary, hospital discharge rates changed little during the study period.

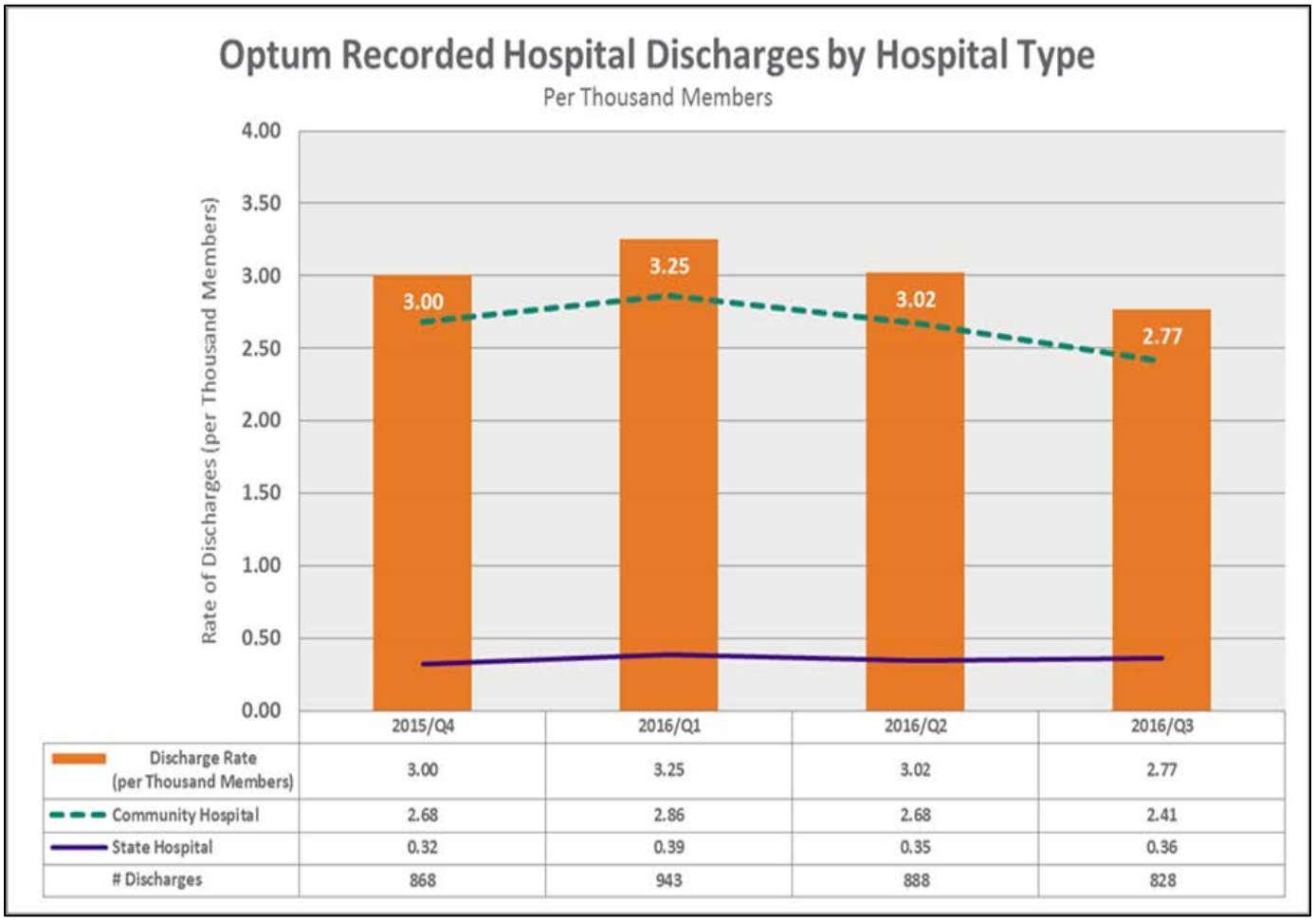


Fig. 7

Analysis: During the study period from Q4 2015 through Q3 2016, discharges from the state remained stable and decreased in 2016 for community hospitals.

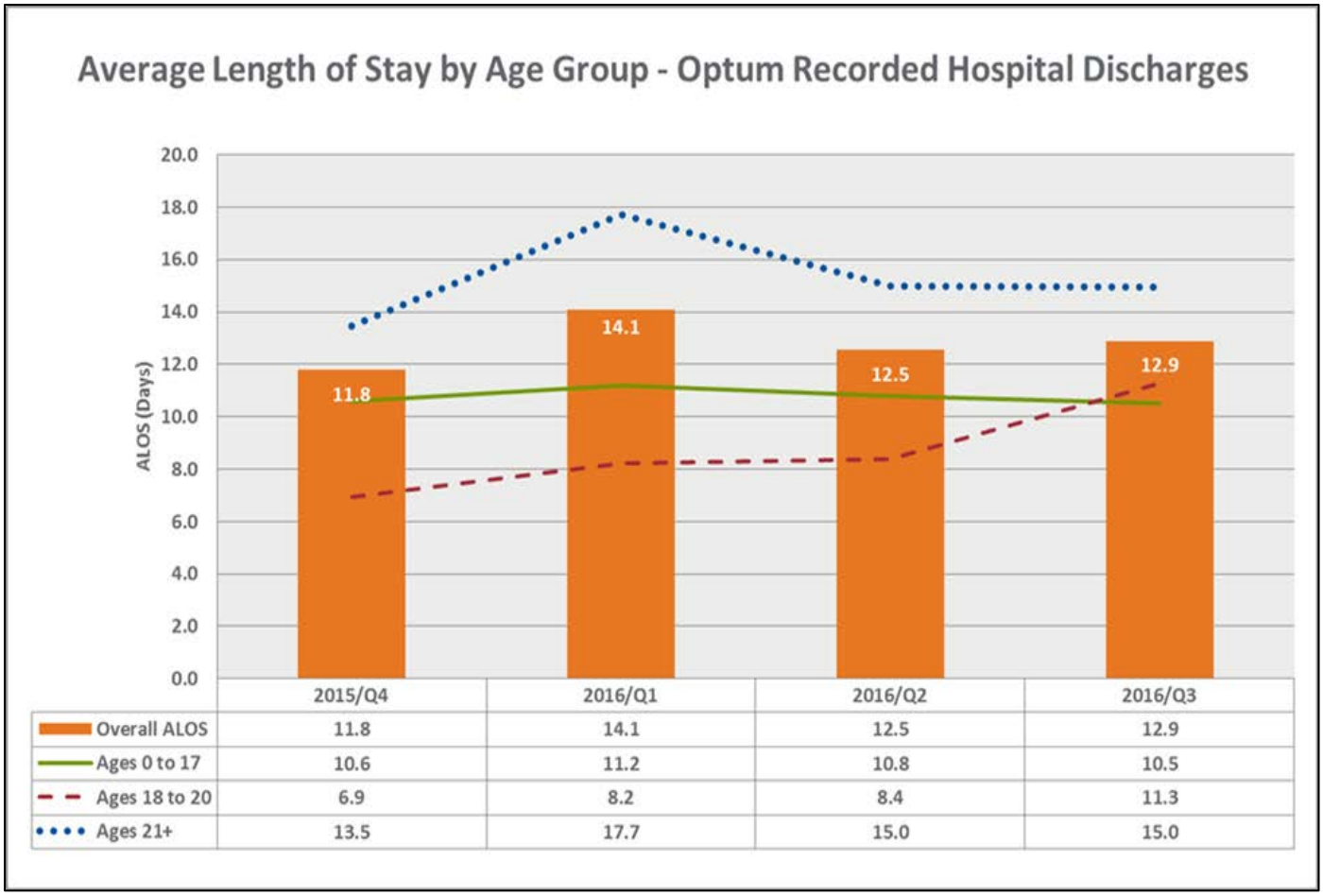


Fig. 8

Analysis: From Q4 2015 to Q3 2016, based on information reported to Optum Idaho from hospitals, the overall average length of stay increased by 1.1 days. When examined by age group, an average length of stay for all 21+ is predominantly driving the increase in average length of stay.

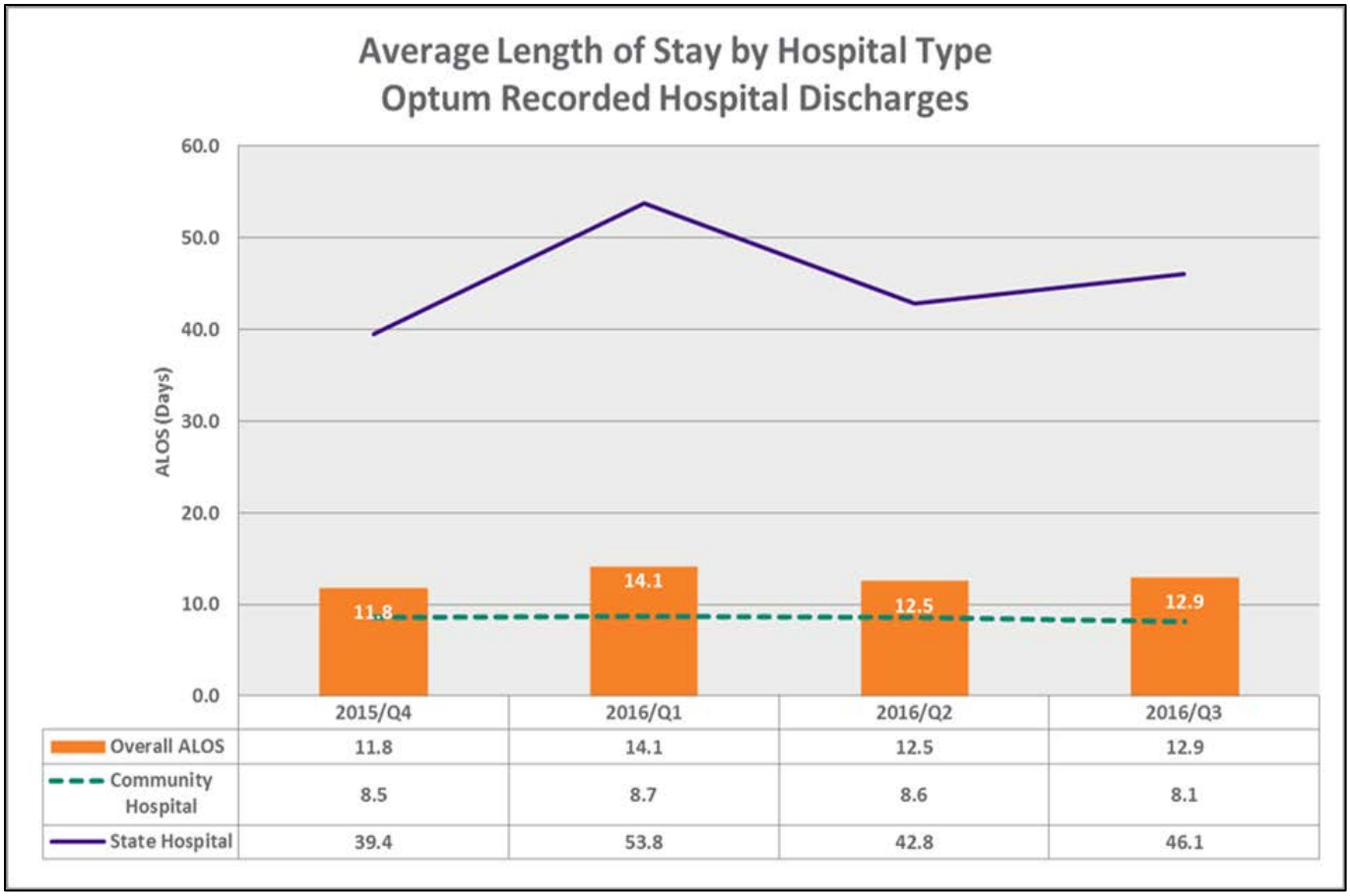
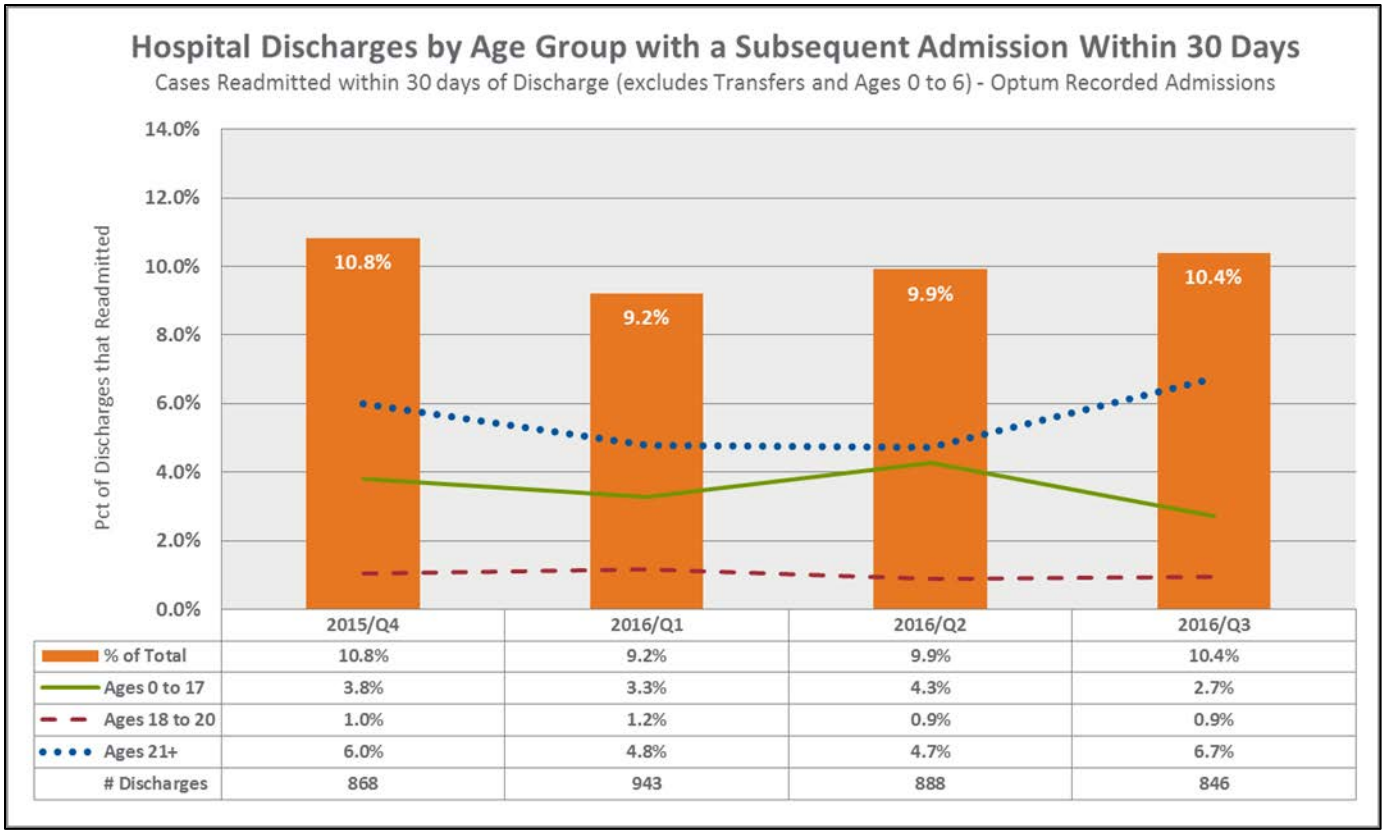


Fig. 9

Analysis: When average length of stay was examined by hospital type, state hospitals increased 17%, from Q4 2015 to Q3 2016. Community hospitals showed a 4.9% decrease during the study period, a relative decrease but a small absolute change of 0.4 days.



	2015/Q4	2016/Q1	2016/Q2	2016/Q3
% of Total	10.8%	9.2%	9.9%	10.4%
Ages 0 to 17	3.8%	3.3%	4.3%	2.7%
Ages 18 to 20	1.0%	1.2%	0.9%	0.9%
Ages 21+	6.0%	4.8%	4.7%	6.7%
# Discharges	868	943	888	846

Fig. 10

Analysis: 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 10.8% in Q4 2015, the rate decreased to 10.4% in Q3 2016. For overall readmissions during the study period, readmissions reduced 3.7% between Q4 2015 and Q3 2016.

Because of possible seasonal fluctuations in hospital readmissions, the year-over-year changes between Q3 2015 and Q3 2016 were examined. For Q3 2015, readmission rates were 10%. In comparison with Q3 2016, readmission rates increased 4.0% year over year.

During the study period of Q4 2015 to Q3 2016, within age groups, readmission rates for 0-17 decreased 23.7%, 21+ increased 11.7% while 18-20 members decreased 10.0%. The large percentage changes for youth and transitioning youth are due to the numbers being very small, so a small absolute change appears as a very large percentage change.

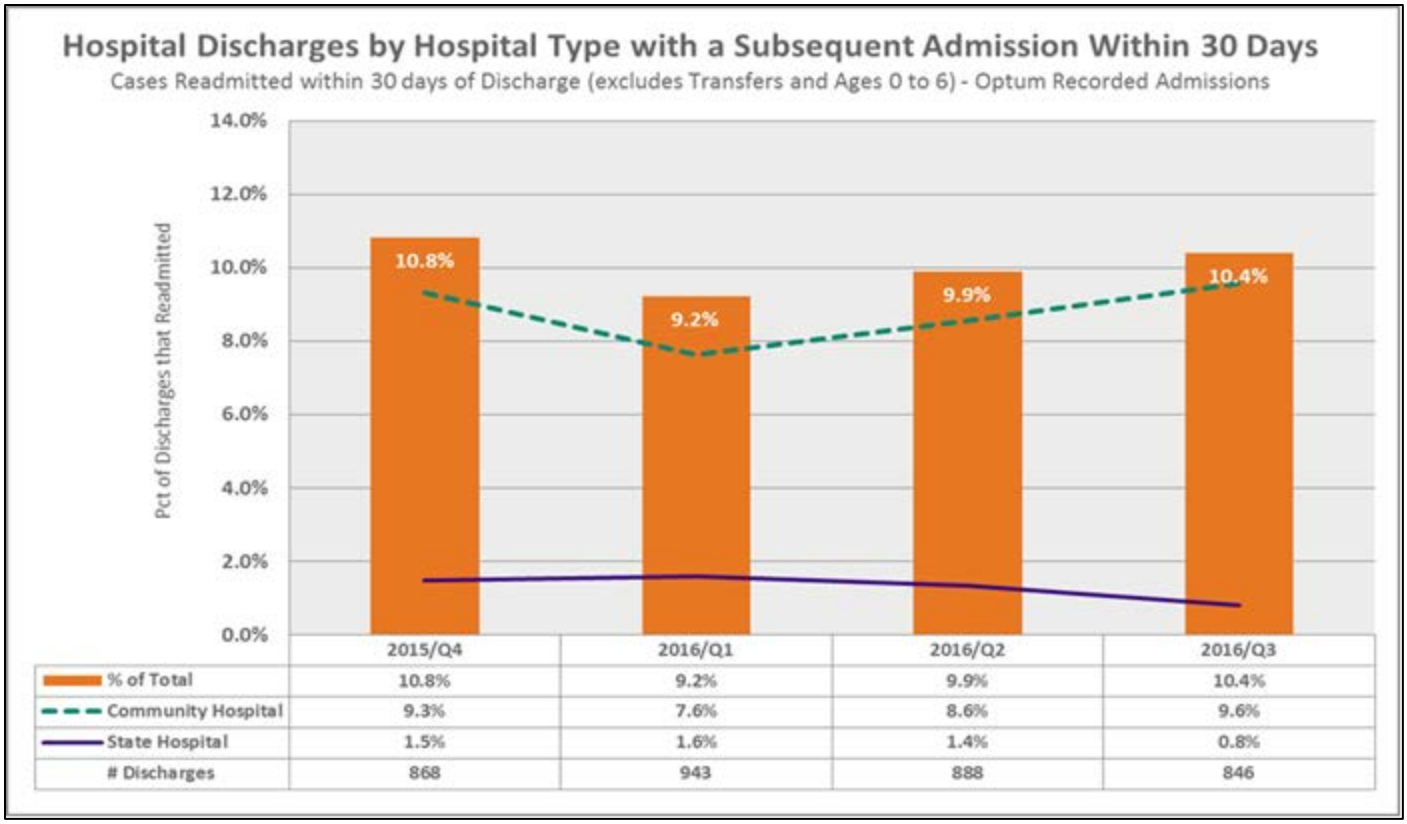


Fig. 11

Analysis: When broken out by hospital type, the fluctuations in readmission rates per quarter can be accounted for by tracking the activity of the community hospitals. The mean readmission rate for the state hospitals amounted to 1.3% (range 0.8% to 1.5% for the study period. The mean readmission rate for community hospitals was 8.8% (range 7.6% to 9.6%). Between Q4 2015 and Q3 2016, there was an increase of 3.1% in community hospital readmission rates compared to 47% for state hospitals. The large percentage changes for state hospital are due to the numbers being very small, so a small absolute change appears as a very large percentage change.

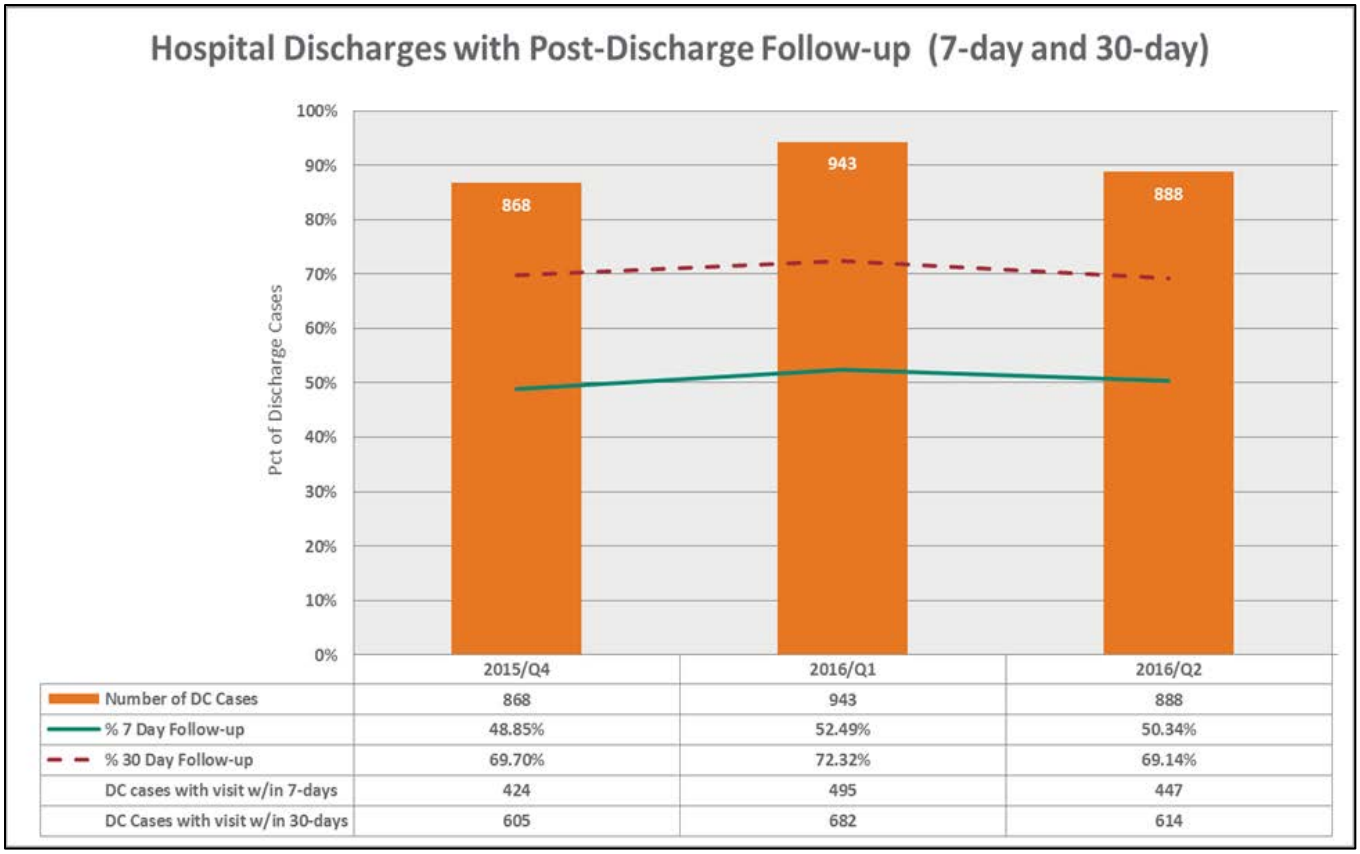


Fig. 12
Note: DC is an abbreviation for discharge.

Analysis: 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 Q4 2015 and Q2 2016, 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 a 1.5% improvement in visits occurring within 7 days of discharge. There was a 0.5% reduction in visits occurring within the first 30 days after discharge. 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.

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 can 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, 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, average lengths of stay decreased at the state hospitals but very slightly increased for community hospitals. Optum Idaho does not manage inpatient care. As outpatient services improve, however, the severity of illness of those who enter the hospital might worsen, making longer stays necessary. Desired improvement in timeliness of post-stabilization visits rates for either 7-day or 30-day visits has not been observed.

There are two opportunities 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 Idaho 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 Optum Idaho by IDHW. Data from December 2015 to April 2016 is displayed. Utilization is given as visits per 1,000 members in the IBHP for each month.

Analysis: This graph displays the available findings about utilization of Idaho Emergency Room visits for psychiatric care. 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 emergency room visits will be assumed to be emergencies. Over the 5 month period, for the period for which data is available, emergency room utilization remains consistent, with January 2016 being a notable exception.

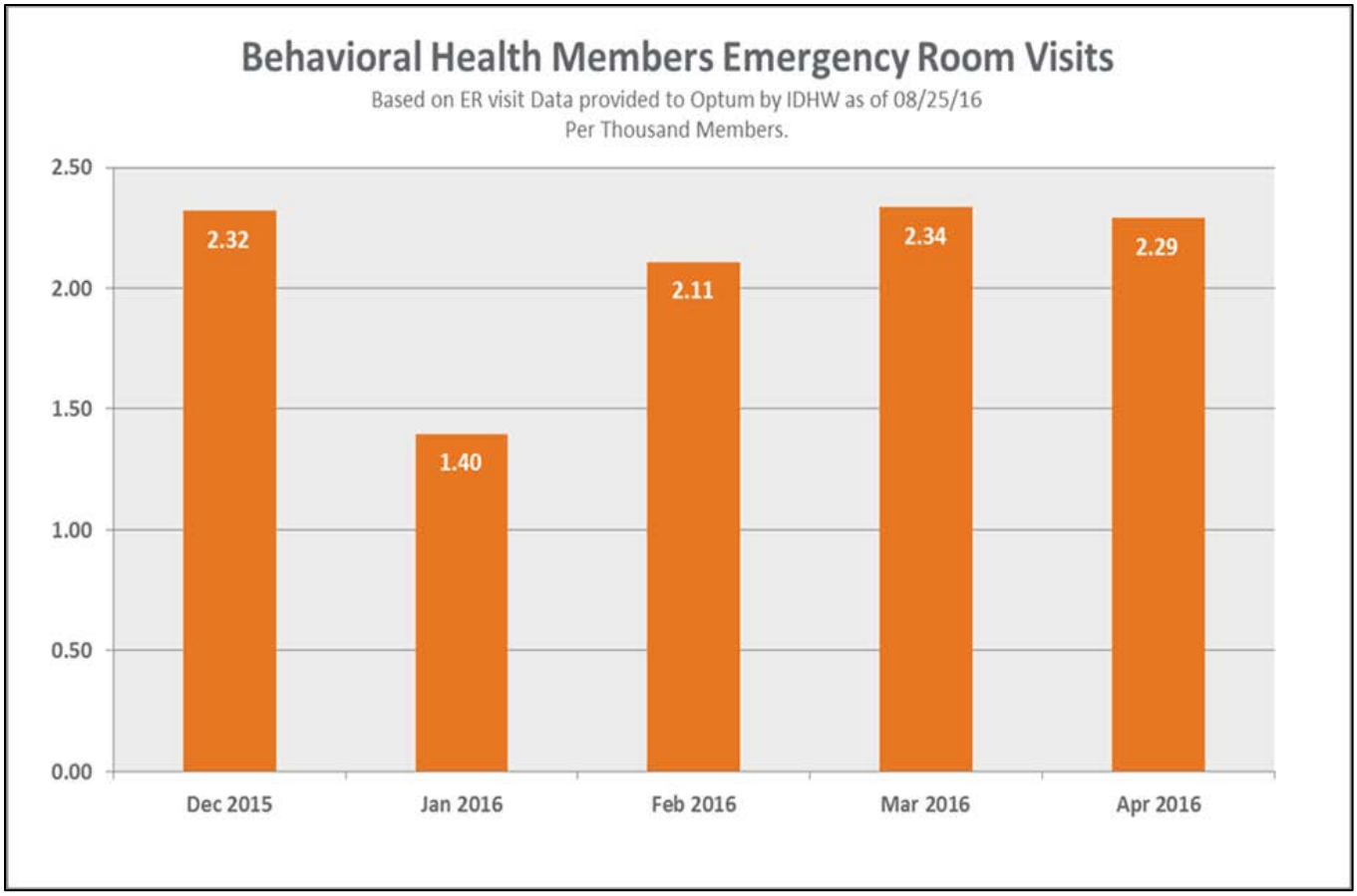


Fig. 13

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 Q4 2015 and Q2 2016, the last quarter for which reliable claims data is available, utilization rate of Case Management Services increased 6.6%. When broken out by age groups, the 0-17, 18-20, and 21+ year groups showed an increase of 9.2% and 4.9% for 0-17 and 21+ groups, respectively, and a larger increase of 14.8% for the 18-20 year group. Overall and for all age groups, case management service utilization increased during the study period.

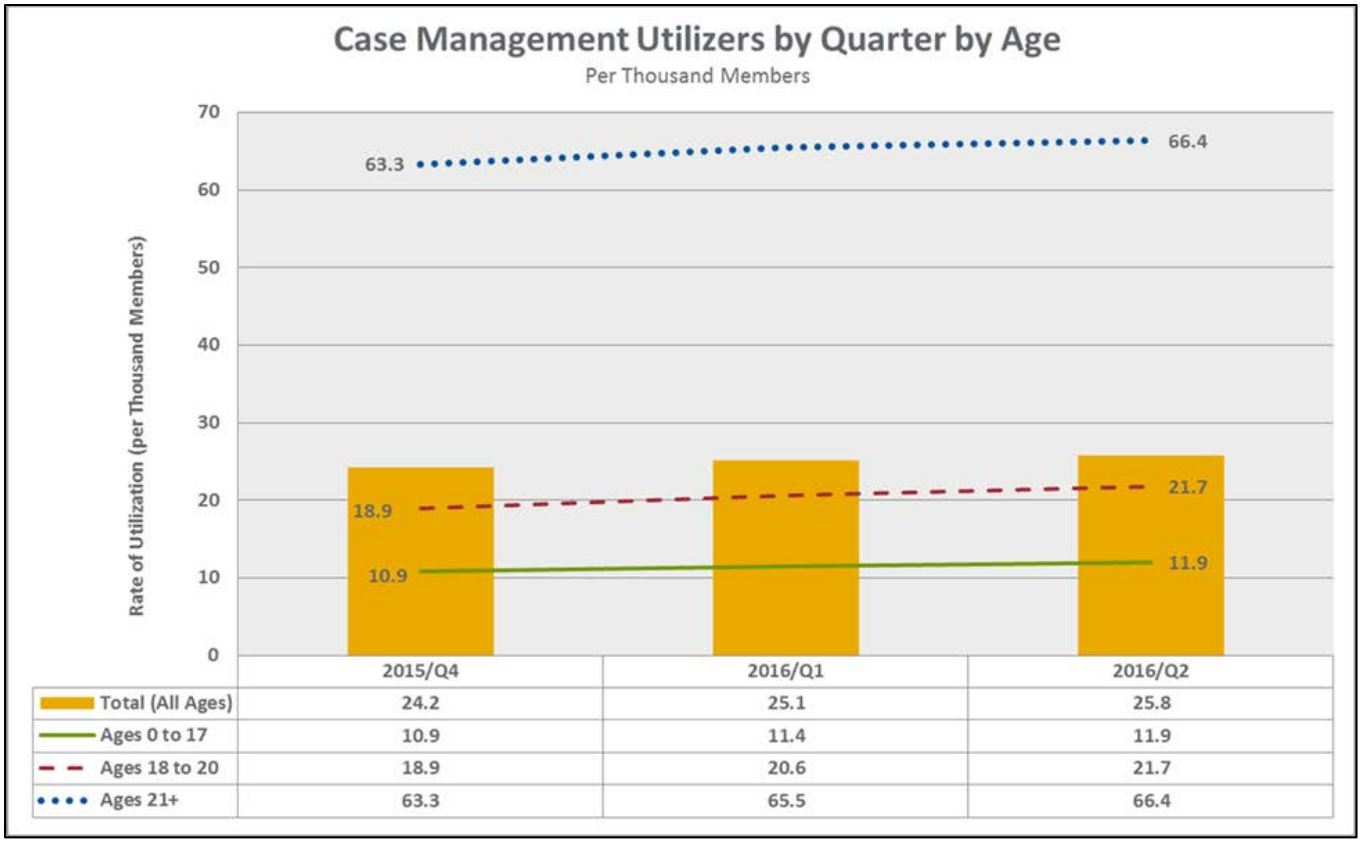


Fig. 14

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. 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

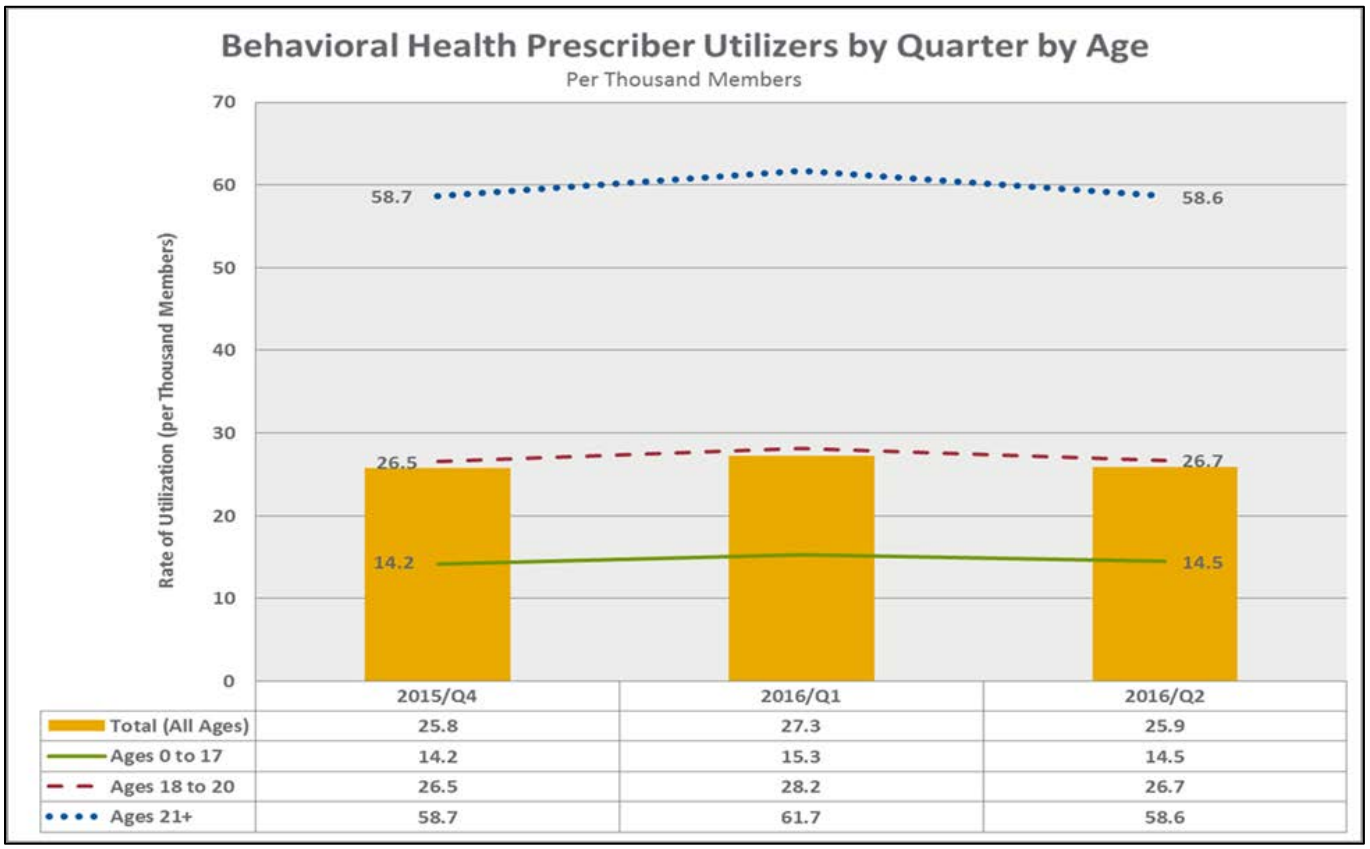
Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed, since reliable data requires waiting for the 90-day claims lag allowed providers to file claims.

The 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 remained stable between Q4 2015 and Q2 2016.

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, often making medication management less necessary.



	2015/Q4	2016/Q1	2016/Q2
Total (All Ages)	25.8	27.3	25.9
Ages 0 to 17	14.2	15.3	14.5
Ages 18 to 20	26.5	28.2	26.7
Ages 21+	58.7	61.7	58.6

Fig. 15

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

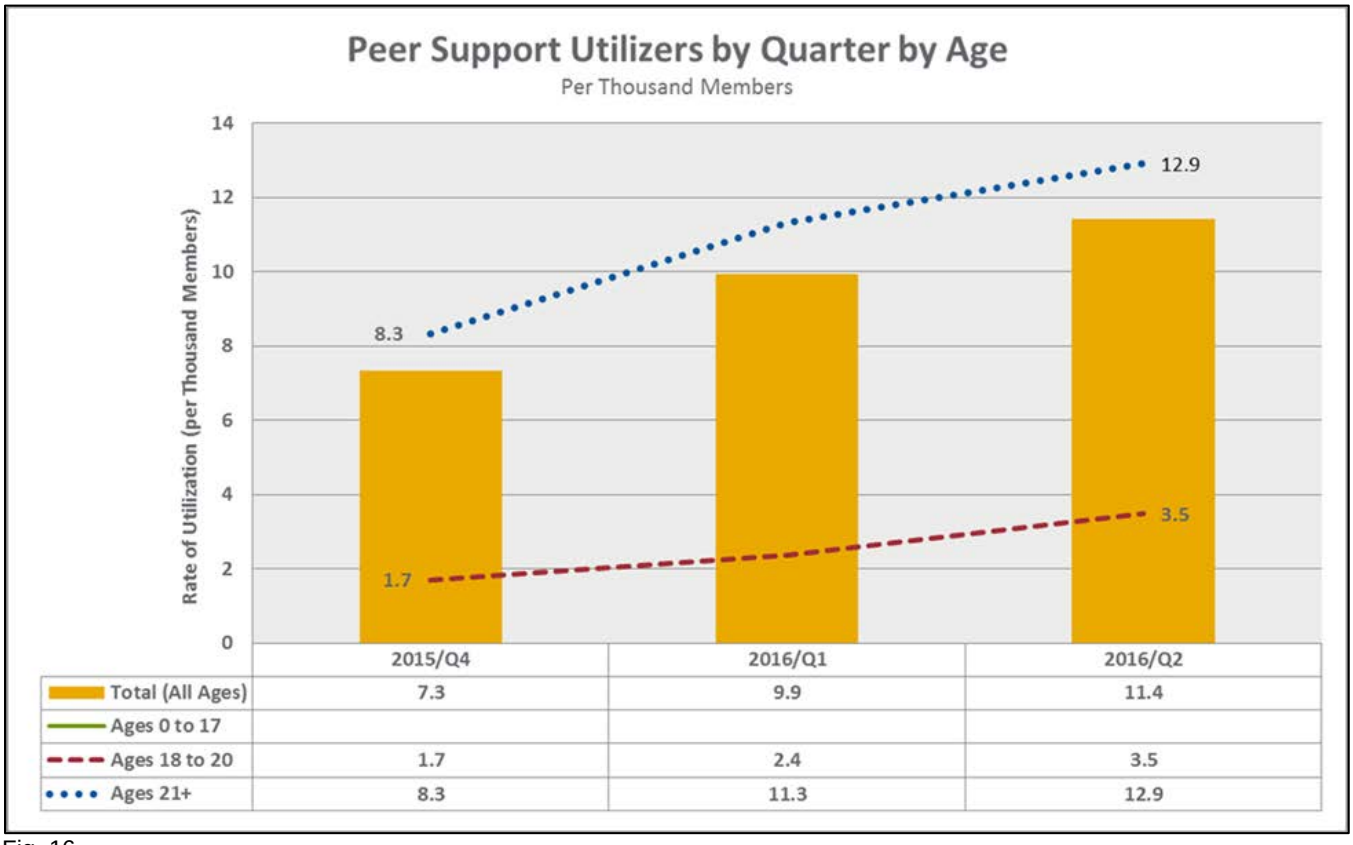
non-Optum sources. The issue of appropriateness of utilization would need further analysis by diagnostic groupings to see if those members with diagnoses that national guidelines for clinical practice indicate medication management is appropriate are receiving medication and prescriber visits. Planning 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 56% between Q4 2015 and Q2 2016. This increase can be attributed to both the 18-20 and the 21+ year groups, since a 106% increase has occurred for the 18-20 years group and 55% for the 21+ group. Use of Peer Support services in the 21+ group is 3.7 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 1.7 to 3.5 per 1,000 members.



	2015/Q4	2016/Q1	2016/Q2
Total (All Ages)	7.3	9.9	11.4
Ages 0 to 17			
Ages 18 to 20	1.7	2.4	3.5
Ages 21+	8.3	11.3	12.9

Fig. 16

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 remains a limited supply of Peer Support Specialists. 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 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. The trend data suggest increasing use of Peer Support as these changes make their way through the utilization management system. Year-over-year, there has been a 166% increase in the use of Peer Support Services in Q3 2014 to Q2 2015 compared to Q3 2015 to Q2 2016.

Individual Therapy Utilization Rates

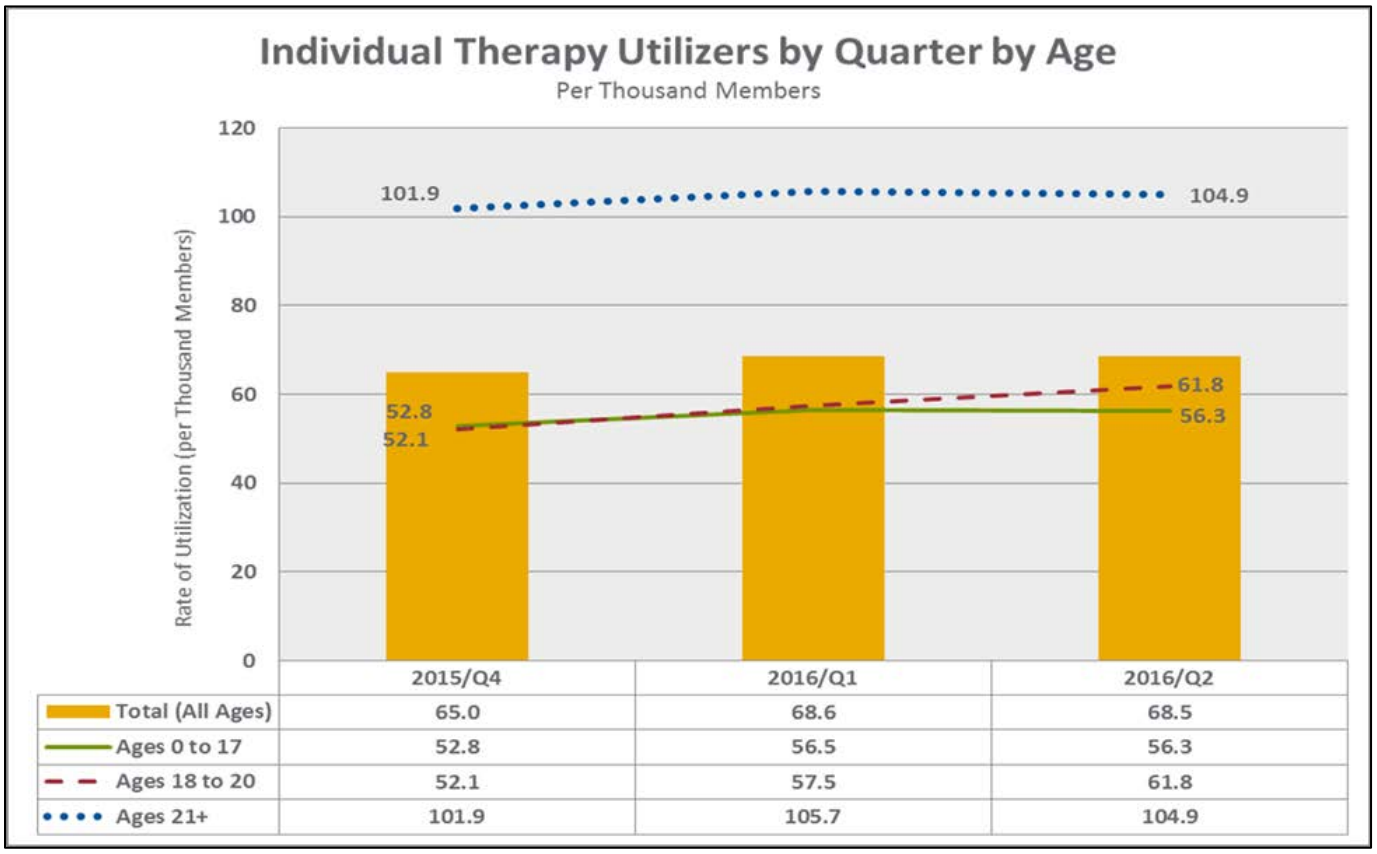
Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.

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. The situation is improving however, with a near 19% over the study period for transitioning youth. Otherwise, there were nominal improvements in utilizer rates for all 0-17 years and 21+ years group. Overall utilization of Individual Therapies increased 5.4% between Q4 2015 and Q2 2016.



	2015/Q4	2016/Q1	2016/Q2
Total (All Ages)	65.0	68.6	68.5
Ages 0 to 17	52.8	56.5	56.3
Ages 18 to 20	52.1	57.5	61.8
Ages 21+	101.9	105.7	104.9

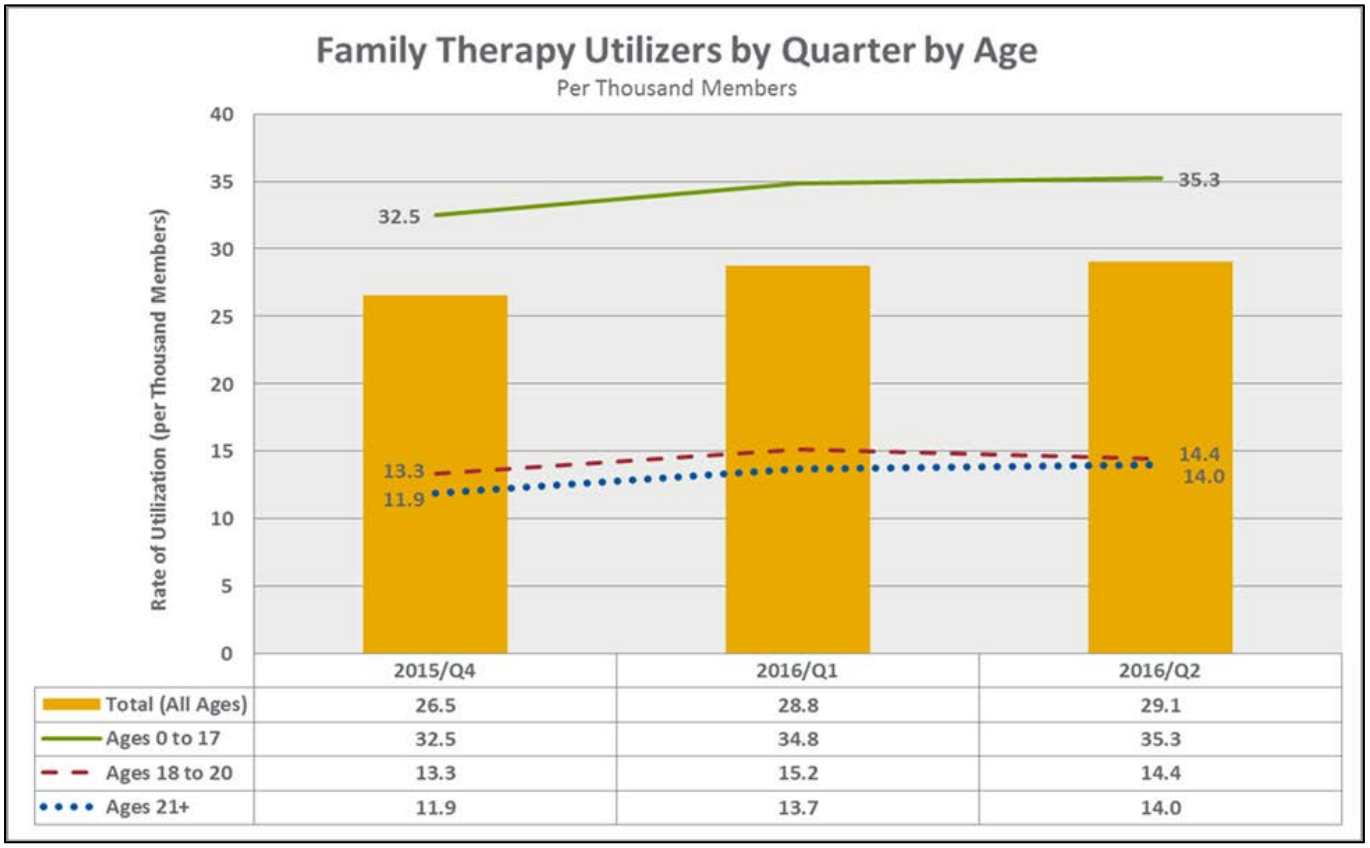
Fig. 17

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 Q4 2015 for which there are reliable claims data, there is overall an increase of 9.8% in the utilizer rates for Family Therapy for all age groups combined. The 0-17 year group increased 8.6%, the 18-20 year group increased 8.3%, and the adult 21+ year group increased 17.6%.



	2015/Q4	2016/Q1	2016/Q2
Total (All Ages)	26.5	28.8	29.1
Ages 0 to 17	32.5	34.8	35.3
Ages 18 to 20	13.3	15.2	14.4
Ages 21+	11.9	13.7	14.0

Fig. 18

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, Community-Based Rehabilitative Services, formerly called "psychosocial rehabilitation services," is a set of rehabilitation services originally developed to better meet the functional needs of adults in the stable phase of Schizophrenia and severe and persistent Bipolar Disorder. Those two diagnoses are the only two diagnostic groupings for which the Treatment Guidelines of the American Psychiatric Association recognize psychosocial rehabilitation as appropriate. The extension of use of techniques developed for adults with usually psychotic chronic conditions to children with very different non-psychotic conditions historically appeared in Idaho to such an extent that CBRS was being used more with children/youth than 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. An appropriate higher rate of CBRS utilization among transitioning youth than children was in fact seen this quarter.

Between Q4 2015 and Q2 2016, three month's duration, the reduction in CBRS for all age groups combined was 25.7%. 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 37.2%, 19.6%, and 20.1% respectively within the study period of Q4 2015 to Q2 2016. 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 8 times over child utilizers, with transitioning child and youth utilizers predominating 2.4 times over child utilizers. These changes have sustained a more clinically appropriate use of CBRS for different age groups.

The year-over-year change in utilization of CBRS for all groups was a decrease of 39% between Q4 2014 and Q4 2015. For children 0-17 years, utilization decreased 60% between Q4 2014 and Q4 2015.

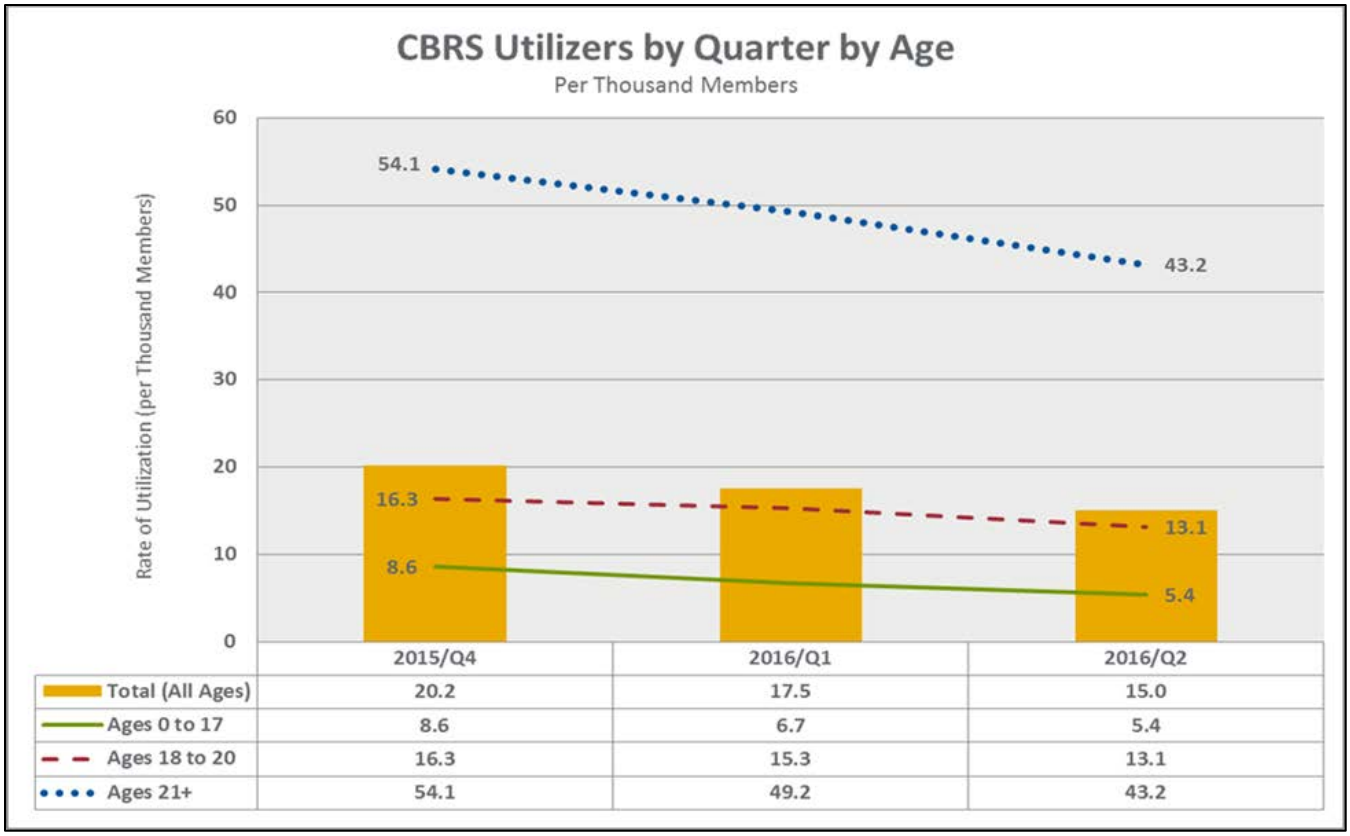


Fig. 19

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 Q4 2015 and runs through Q2 2016, the most recent quarter for which reliable claims data is available. For the child group 0-17 years, there is an increase in utilizers of Individual Therapies of 6.6%, CBRS utilizer rates have reduced 37.2%, and Family Therapy utilizer rates have increased 8.6%.

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 not been improvement over time. The ratio of Individual Therapies to Family Therapy (IT/FT) for Q4 2015 had been 1.6 and for Q2 2016 it remains 1.6.

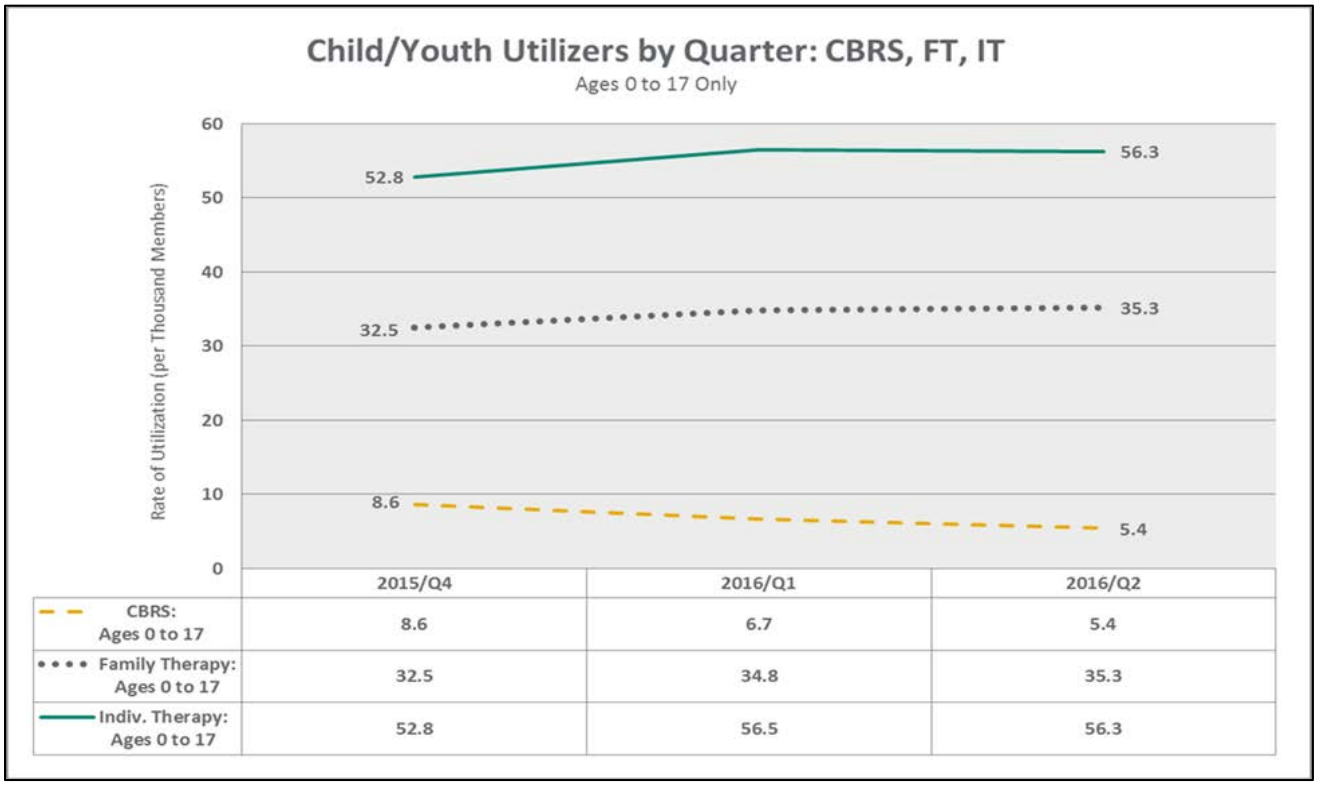


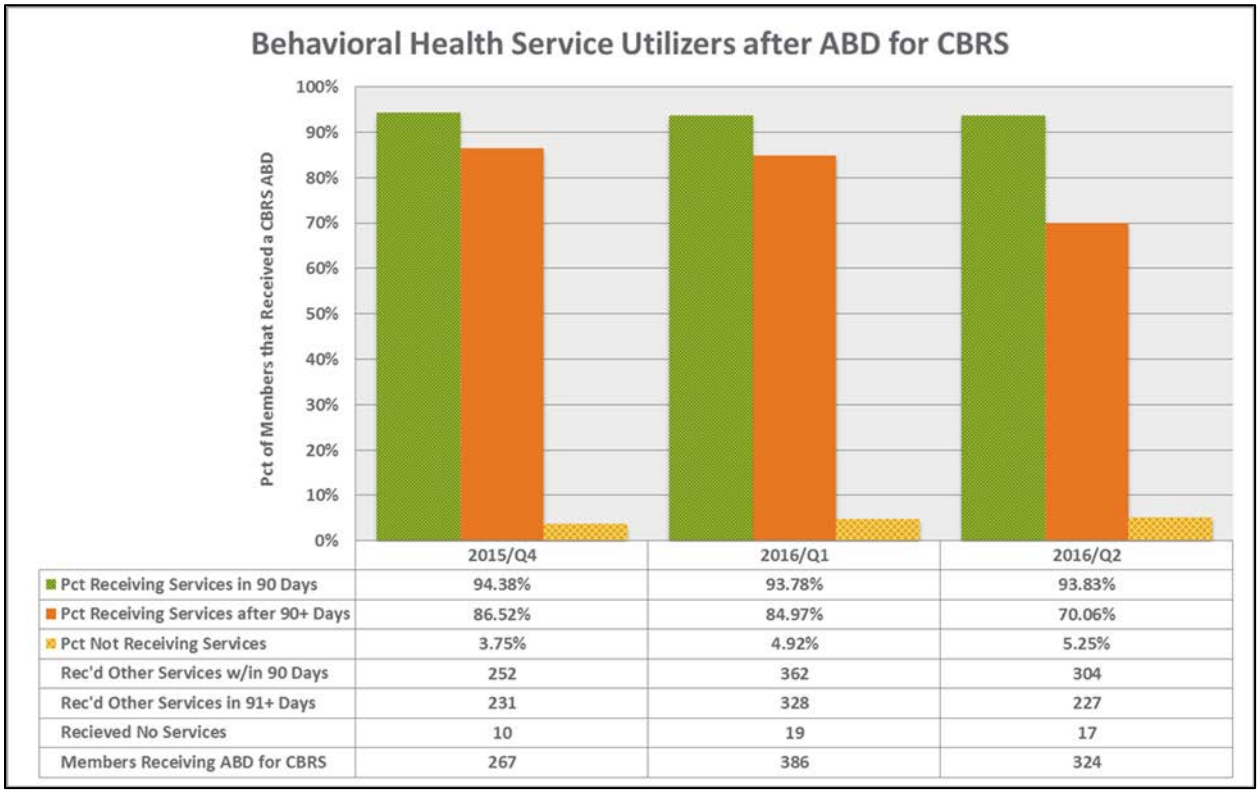
Fig. 20

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 Q4 2014 and Q4 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 Q4 2015 and Q2 2016, use of medically necessary services has increased following denials of authorization for CBRS. In Q4 2015, 3.8% of members who had had CBRS authorization denied did not follow up with therapeutic services. As of Q2 2016, 5.3% of members have not included therapeutic services in place of CBRS. Over the three quarters of this study, in the first 90 days following the ABD, approximately 93-94% of members have received therapeutic services. Treatment continuation has been present in approximately 70-86% of members who have received ABDs. The overall pattern has been one of sustained openness to acceptance of alternative services to CBRS over the study period. An unknown percentage of these members receiving “no services” may in fact be receiving medication

services from non-network prescribers that would not be reportable from Optum's claims database.



	2015/Q4	2016/Q1	2016/Q2
Pct Receiving Services in 90 Days	94.38%	93.78%	93.83%
Pct Receiving Services after 90+ Days	86.52%	84.97%	70.06%
Pct Not Receiving Services	3.75%	4.92%	5.25%
Rec'd Other Services w/in 90 Days	252	362	304
Rec'd Other Services in 91+ Days	231	328	227
Recieved No Services	10	19	17
Members Receiving ABD for CBRS	267	386	324

Fig. 21

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 the core psychotherapy recommended in national professional treatment guidelines for most childhood disorders. Although progressively changing, limited provider familiarity with evidence-based therapies for children as well has historically underdeveloped Family Therapy workforce have constrained patterns of clinical practice consistent with national guidelines.

Opportunities and Interventions: The key to provider adoption of clinical practices consistent with national guidelines has been education and 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 Idaho 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. For example, Eating Disorders were updated earlier in 2015.

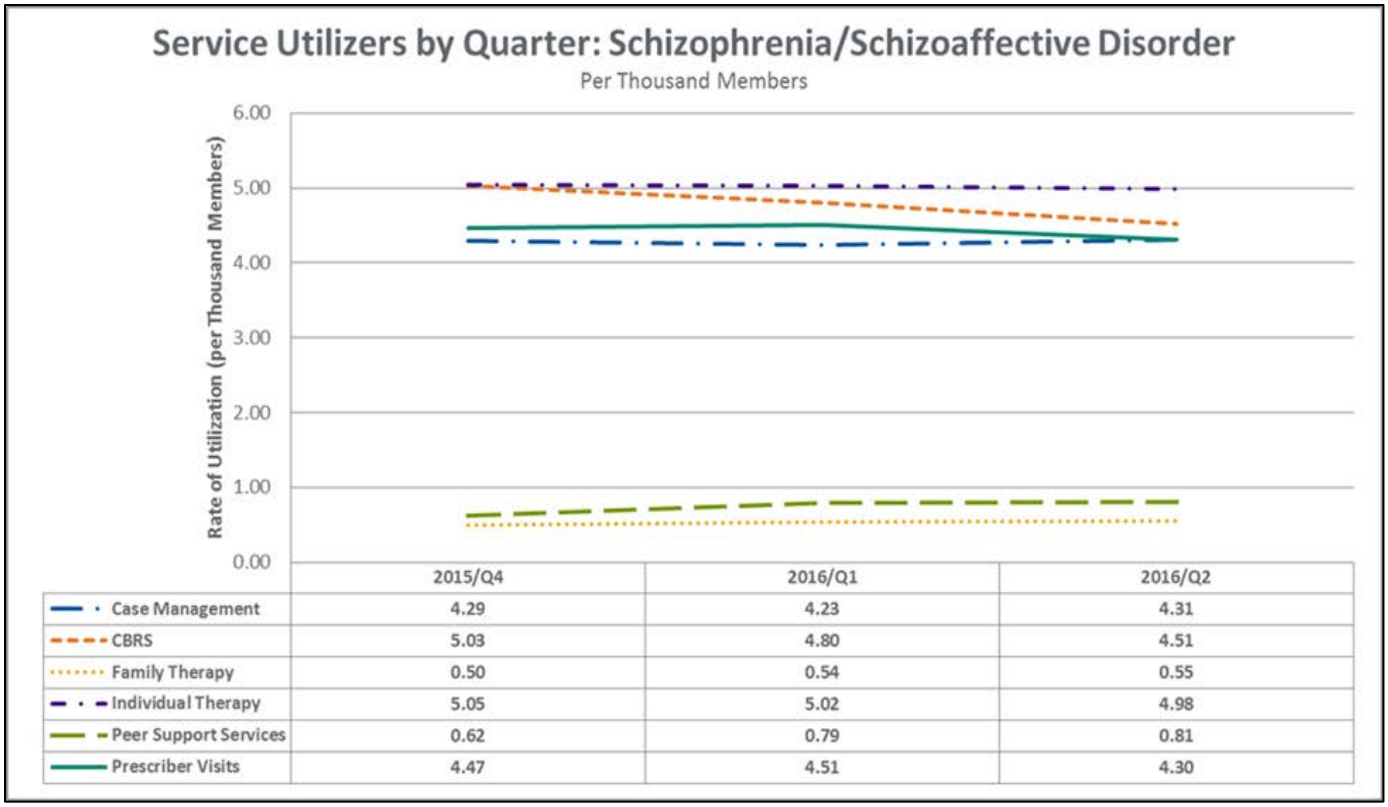
These guidelines are used for making medical necessity determinations in accordance with a quality that meets professionally-recognized standards of health care, in keeping with the IDAPA definition of medical necessity.

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 difficulty clinically distinguishing Schizophrenia from 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 now for Individual Therapy, followed by CBRS, and then by Behavioral Health prescriber visits. An unknown number of IBHP members receive their medication from non-network prescribers who accept Medicaid reimbursement, so the 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 Q4 2015, there has been a consistent rate of use of Individual Therapy, 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, as recommended adjunctive services.



	2015/Q4	2016/Q1	2016/Q2
Case Management	4.29	4.23	4.31
CBRS	5.03	4.80	4.51
Family Therapy	0.50	0.54	0.55
Individual Therapy	5.05	5.02	4.98
Peer Support Services	0.62	0.79	0.81
Prescriber Visits	4.47	4.51	4.30

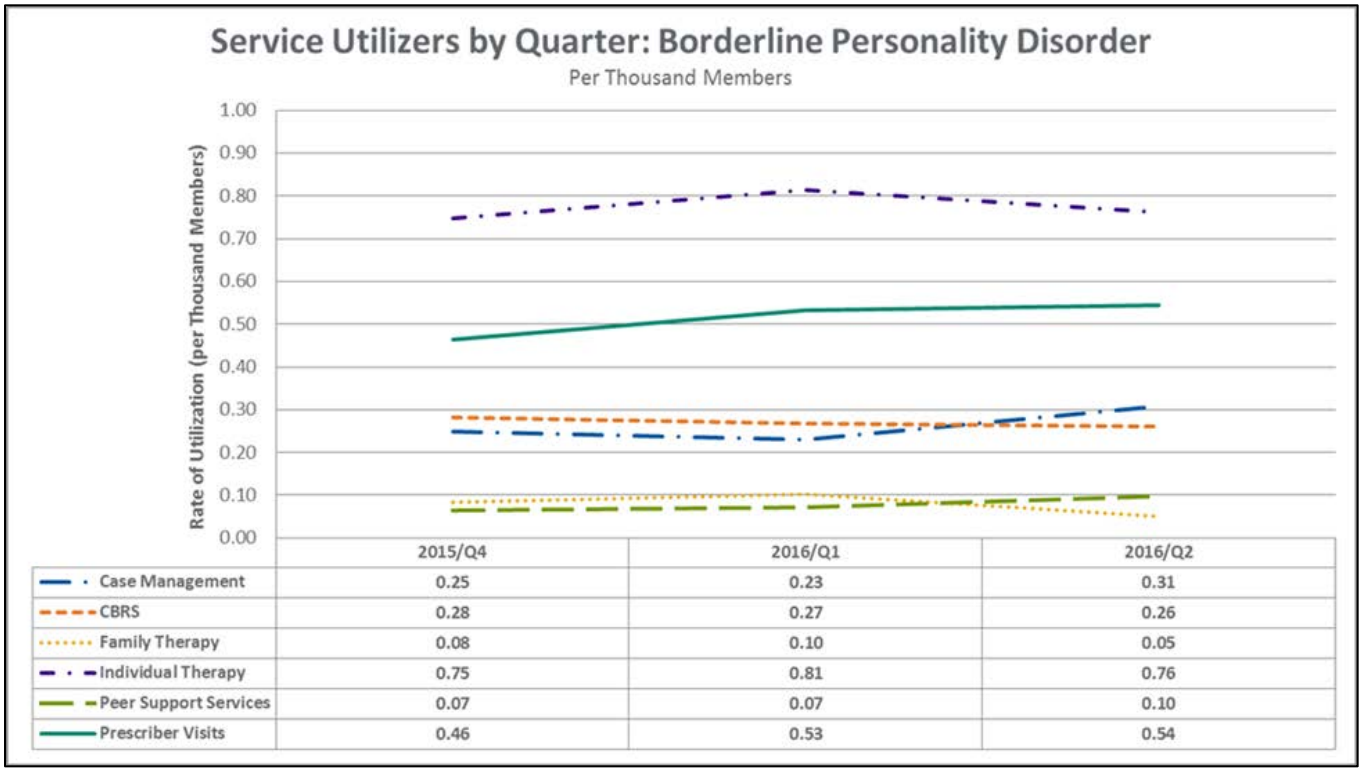
Fig. 22

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 for adults. Recommendations include primarily specialized Individual Therapy for a protracted period, but not 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 Q4 2015 and Q2 2016, shows that the most commonly used treatment is Individual Therapy, in keeping with recommendations from national professional treatment guidelines that the primary intervention be Individual Therapy. The 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, switching in order in Q2 2016. 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 Q2 2016 towards more billings for Individual Therapy and Behavioral Health medication management, the nationally recommended services. There is slightly more use of Case Management Services, which some authorities in Borderline Personality Disorder regard as the most helpful intervention for most persons with that disorder but which is not mentioned explicitly as a major intervention for Borderline Personality Disorder in the national treatment guidelines. Optum Idaho looks forward to an increase in all these services other than CBRS, which is not indicated for Borderline Personality Disorder.



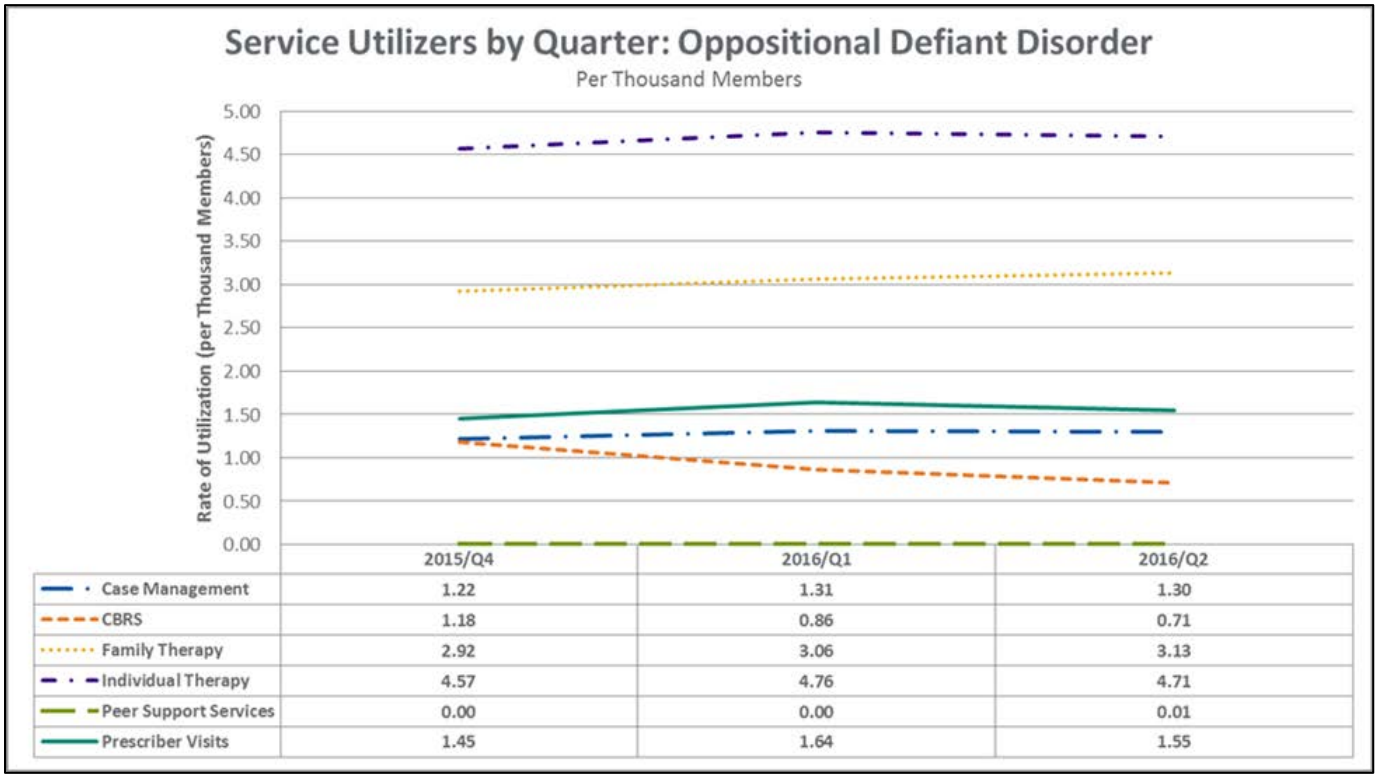
	2015/Q4	2016/Q1	2016/Q2
Case Management	0.25	0.23	0.31
CBRS	0.28	0.27	0.26
Family Therapy	0.08	0.10	0.05
Individual Therapy	0.75	0.81	0.76
Peer Support Services	0.07	0.07	0.10
Prescriber Visits	0.46	0.53	0.54

Fig. 23

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 its treatment: 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. Prescriber visits is the 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 time 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 minimal due to their being suitable only for adults 18 years of age and over. Trend analysis shows further decrease in use of CBRS, but an increase in both Individual Therapy and Family Therapy during this period. Increasing the use of Family Therapy for children with this disorder remains an opportunity for growth for the Health Plan.



	2015/Q4	2016/Q1	2016/Q2
Case Management	1.22	1.31	1.30
CBRS	1.18	0.86	0.71
Family Therapy	2.92	3.06	3.13
Individual Therapy	4.57	4.76	4.71
Peer Support Services	0.00	0.00	0.01
Prescriber Visits	1.45	1.64	1.55

Fig. 24

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	Q2 2015 (n=105)	Q3 2015 (n=83)	Q4 2015 (n=120)	Q1 2016* (n=121)
Experience w/Optum ID Staff and Referral Process	≥85.0%	85.8%	77.4%	90.1%	94.0%
Experience with the Behavioral Health Provider Network	≥85.0%	91.6%	88.8%	93.1%	94.0%
Experience with Counseling or Treatment	≥85.0%	96.7%	90.9%	95.3%	93.6%
Overall Experience	≥85.0%	94.2%	86.3%	94.8%	91.5%

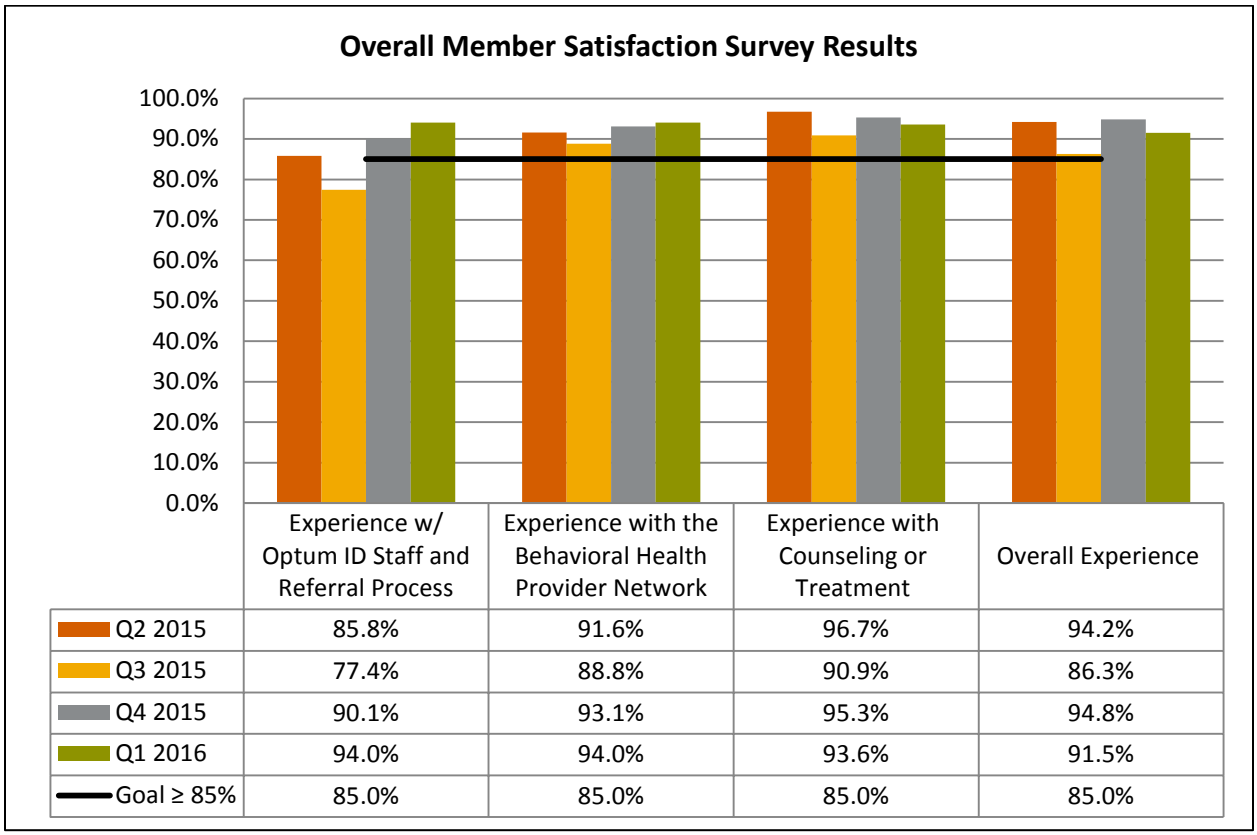
*Based on the Member Satisfaction Survey sampling methodology, Q1, 2016 data is the most recent set of results available.

Analysis: The survey was offered in English and Spanish. The survey was initially mailed on April 29, 2016 to 992 enrollees. Non-respondents were sent a second request and survey on June 10, 2016. The results presented in this report represent responses received before July 25, 2016. All mailings included a cover letter, survey, and postage-paid business reply envelope. Of the surveys mailed, 133 surveys (13.4%) were returned to Optum Idaho as undeliverable; and 10 surveys (1.0%) were returned as refused. Of the surveys mailed, 121 responses were received from the 849 surveys that were delivered, resulting in a 14.3% response rate.

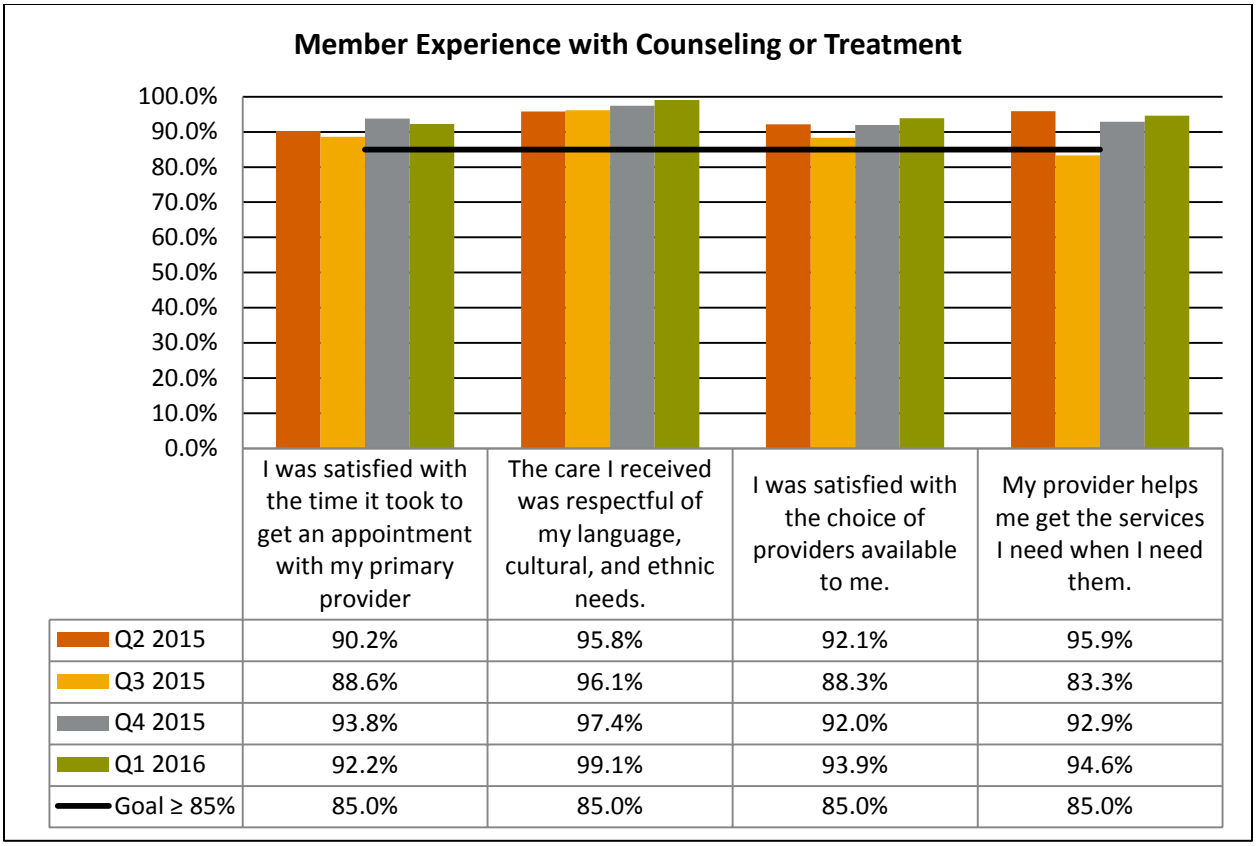
The rate of member's Experience with Optum Idaho Staff and Referral Process increased from 90.1% to 94.0%. The rate of member's Experience with the Behavioral Health Provider Network increased from 93.1% to 94.0%. The rate of member's Experience with Counseling or Treatment and the rate of member's Overall Experience decreased during Q1, however, both remained above the goal of 85.0%

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." Q1 result was 92.2% which was a decrease from 93.8% during Q4.
- "The care I received was respectful of my language, cultural, and ethnic needs." Q1 result was 99.1% which was an increase from 97.4% during Q4.
- "I was satisfied with the choice of providers available to me." Q1 result was 93.9% which was an increase from 92.0% during Q4.
- "My provider helps me get the services I need when I need them." Q1 result was 94.6% which was an increase from 92.9% during Q4.



	Experience w/ Optum ID Staff and Referral Process	Experience with the Behavioral Health Provider Network	Experience with Counseling or Treatment	Overall Experience
Q2 2015	85.8%	91.6%	96.7%	94.2%
Q3 2015	77.4%	88.8%	90.9%	86.3%
Q4 2015	90.1%	93.1%	95.3%	94.8%
Q1 2016	94.0%	94.0%	93.6%	91.5%
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.
Q2 2015	90.2%	95.8%	92.1%	95.9%
Q3 2015	88.6%	96.1%	88.3%	83.3%
Q4 2015	93.8%	97.4%	92.0%	92.9%
Q1 2016	92.2%	99.1%	93.9%	94.6%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%

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

Provider Satisfaction Survey Results

Optum Idaho has moved to a provider satisfaction surveying method that includes a Net Promoter Score (NPS) function. The NPS is a standard measurement approach that allows Optum Idaho to identify key factors that are most impactful on a provider's level of satisfaction in our network so we are better able to take the necessary steps to improve.

What is changing?

- **The questionnaire will take less time to complete.** Optum Idaho values our provider's input and wants to make sure a provider's participation in the survey is not adversely impacting their operations.
- **The questions will be more focused** on Optum Idaho processes and related provider experiences with measurable satisfaction rating scales.
- **The survey will be conducted annually.** For those providers who recently participated in the past quarter's survey, this may seem duplicative, however, the provider will notice the questions have changed and we encourage the provider's participation.

What remains the same?

- **Optum's commitment to use provider feedback to improve** our processes and to improve the provider's experience participating in the Optum Idaho Medicaid Network.
- **Multiple options to participate and complete the survey** will remain; on the phone at the time of the call, reschedule a call at a time more convenient, complete an emailed survey or a paper survey.

The new survey is being executed now, through the 4th Quarter with survey results expected in January, 2017.

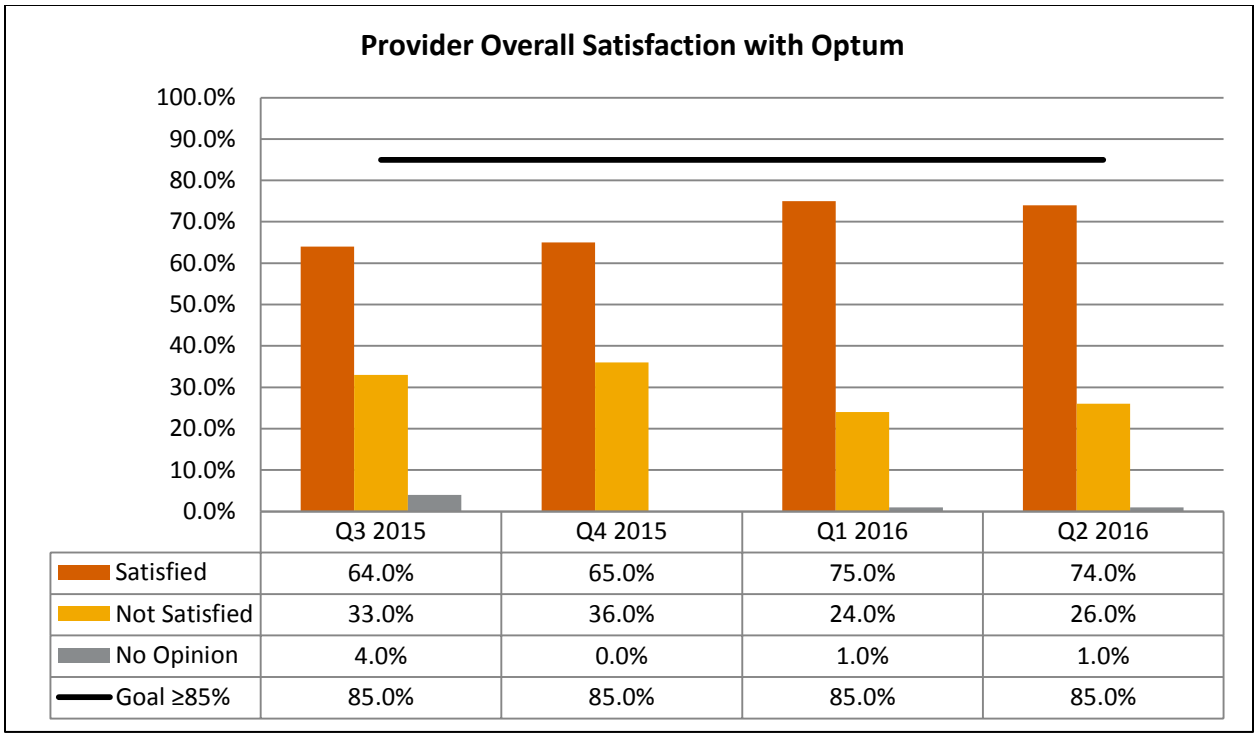
At this time, the results from previous provider satisfaction surveys will be included in this report. The previous survey was completed by Fact Finders, Inc., an independent health research company, that conducted the Provider Satisfaction Survey for Optum Idaho. The questionnaire used to survey Optum providers was developed to measure key indicators of satisfaction with Optum. These included:

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

Quarterly Performance Results:

Provider Satisfaction Survey	Performance Goal	Q3 2015	Q4 2015	Q1 2016	Q2 2016
Satisfied	≥85.0%	64.0%	65.0%	75.0%	74.0%
Not Satisfied	NA	33.0%	36.0%	24.0%	26.0%
No Opinion	NA	4.0%	0.0%	1.0%	1.0%



	Q3 2015	Q4 2015	Q1 2016	Q2 2016
Satisfied	64.0%	65.0%	75.0%	74.0%
Not Satisfied	33.0%	36.0%	24.0%	26.0%
No Opinion	4.0%	0.0%	1.0%	1.0%
Goal ≥85%	85.0%	85.0%	85.0%	85.0%

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 Optum Idaho quality committee structure routinely oversees and monitors improvement initiatives and Improvement Action Plans (IAP) until completion or closure.

In Quarter 3, Optum Idaho managed a total of seven (7) open IAPs that carried over from the previous quarter. There were no "new" IAPs initiated during the quarter. Of the total, two (2) IAPs were closed in Quarter 3, with five (5) remaining open for monitoring in Quarter 4.

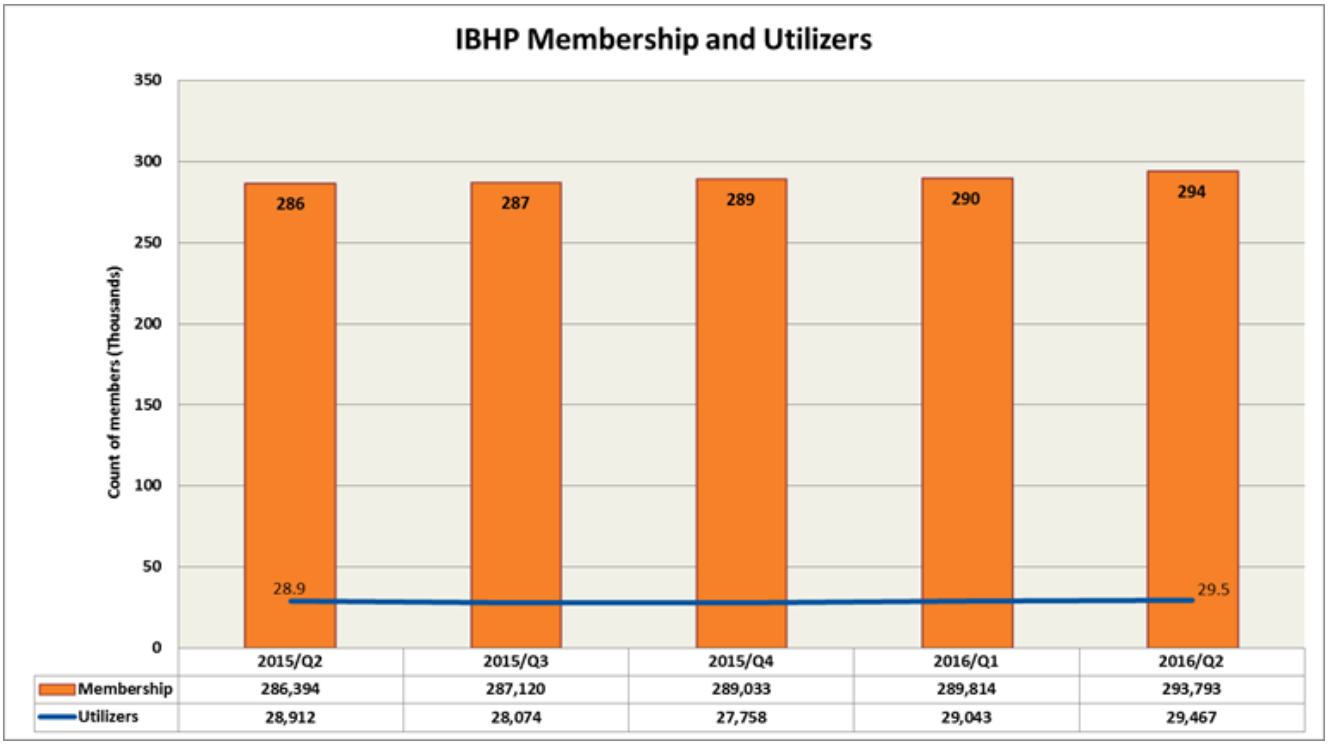
The following is a listing of the improvement action plans, status, and key accomplishments that were achieved during Quarter 3.

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	Closed 9/6/16	•Provider Advisory Committee (PAC) finalized survey tool and made recommendations to the IDHW. •Change request submitted to IDHW. •IDHW approved change. •PAC agreed and approved the new survey tool. •First annual survey will be delivered to IDHW in January 2017. •Survey tool will incorporate net promoter scoring functionality which will help influence improvement actions that are most likely to impact positive scoring.
Provider Satisfaction with Peer Review Process	2/1/2015	Clinical and Services Advisory Committee	Closed 7/5/16	•no new key accomplishments reported during Q3.
ALERT Peer Review	10/2/2015	Quality Assurance Performance Improvement Committee and Clinical and Services Advisory Committee	Open	•Doctor re-training completed on 7/25. •Request report from reporting team to identify members who trigger Youth High Impairment. •Outreach to members. •Pilot being scheduled. •Redefining workflows for provider non-response.
Appointment Reminder	2/23/16	Clinical and Services Advisory Committee	Open	• no new key accomplishments reported during Q3.
FCC Familiarity	3/22/16	Clinical and Services Advisory Committee and Provider Advisory Committee	Open	•Field Care Coordinators (FCC's) are presenting flyers describing their roles and availability during all outreach and events. •FCC's are making additional efforts to identify themselves by their titles and explanation of their roles and availability when communicating to providers, members, and stake holders. •Developing and tele-training for providers educating on FCC services.
Communication Plan for Youth Transition	6/28/16	Clinical and Services Advisory Committee	Open	•Complex reporting requirement for has been clarified. •Letters are close to completion.
Task Force for Youth Transition	6/28/16	Clinical and Services Advisory Committee	Open	• No new key accomplishments reported during Q3.

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.



	2015/Q2	2015/Q3	2015/Q4	2016/Q1	2016/Q2
Membership	286,394	287,120	289,033	289,814	293,793
Utilizers	28,912	28,074	27,758	29,043	29,467

Analysis: Membership numbers and utilizers increased slightly.
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified

Member Services Call Standards

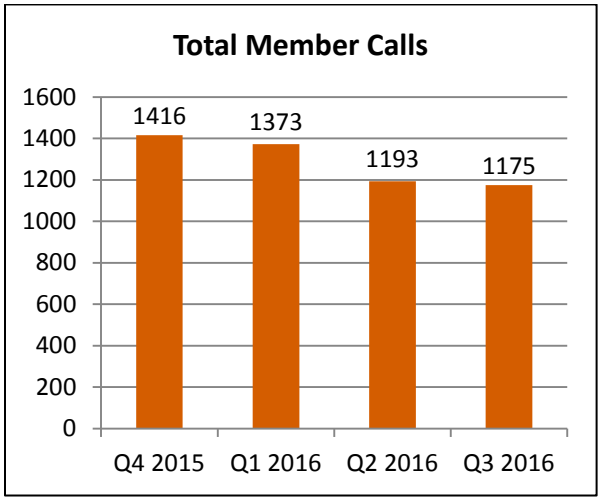
Methodology: Optum Idaho provides access to care 24 hours a day, seven days a week, 365 days per year through our toll-free Member Access and Crisis Line. This line is answered by a team of Masters-level behavioral health clinicians who are trained to assess the member's needs, provide counseling as appropriate, and refer the member to the most appropriate resources based on the member's needs.

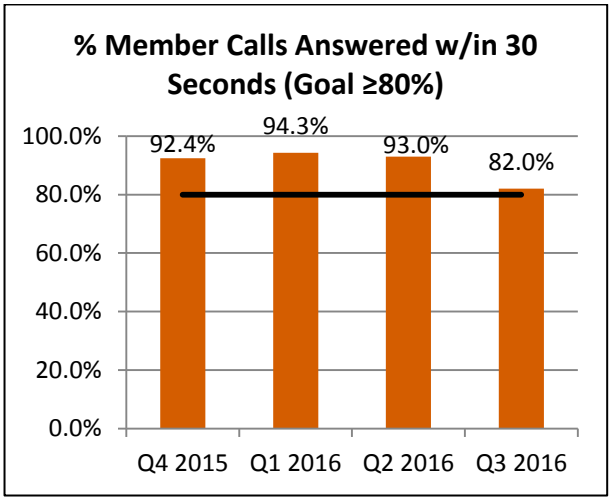
To ensure we meet our member's needs in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate (≤7%). Data source is Avaya's Communication system (ProtoCall).

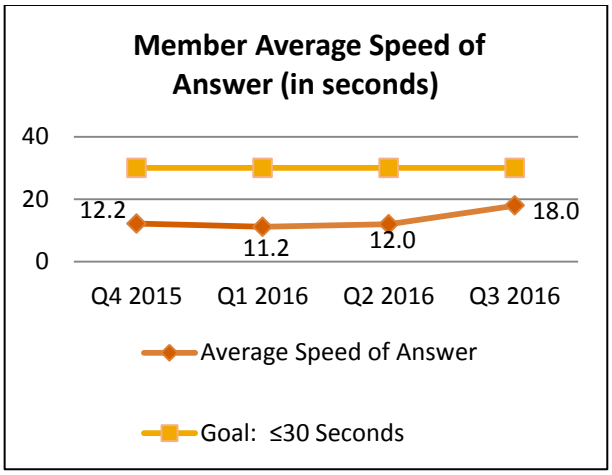
Quarterly Performance Results:

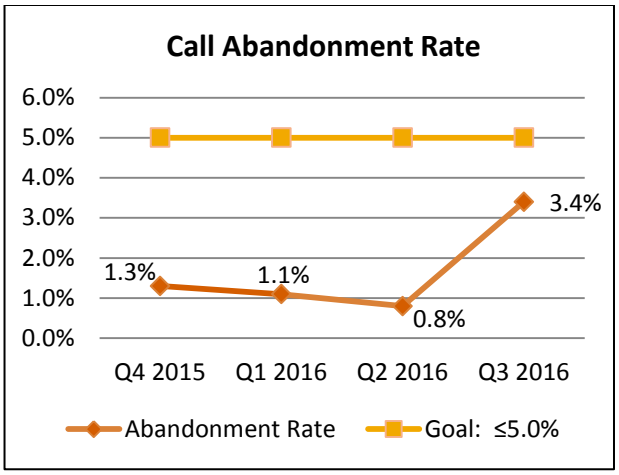
Member Service Line	Optum Idaho Standards	IBHP Contract Standards	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Total Number of Calls	NA	NA	1,416	1,373	1,193	1175
Percent of Calls Answered Within 30 Sec	≥80.0%	None	92.4%	94.3%	93.0%	82.0%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	12.2 sec	11.2 sec	12.0 sec	18.0 sec
Abandonment Rate	≤3.5%	≤7%	1.3%	1.1%	0.8%	3.4%

Analysis: During Q3, the Member Services and Crisis Line received a total of 1,175 calls. During Q3, 82.0% of calls were answered within 30 seconds (goal ≥80%). The average speed to answer was met at 18.0 seconds (goal ≤30 seconds). The call abandoned rate was 3.4% which met both the Optum Idaho Standards goal of ≤3.5% and the IBHP Contractual Standards goal of ≤7.0%. Optum Idaho will continue to monitor the fluctuations in the metrics and identify trends.









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

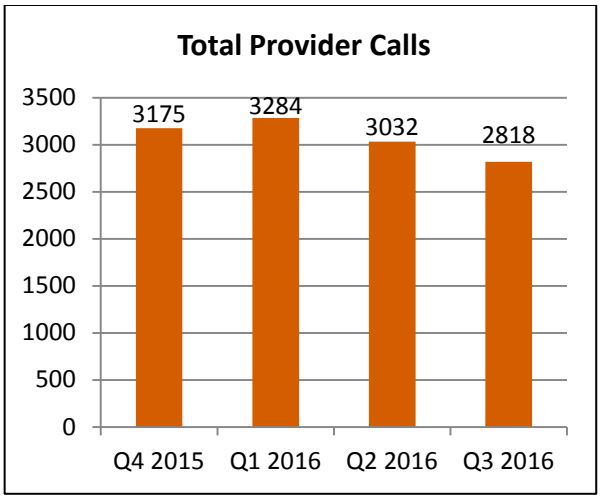
Customer Service (Provider Calls) Standards

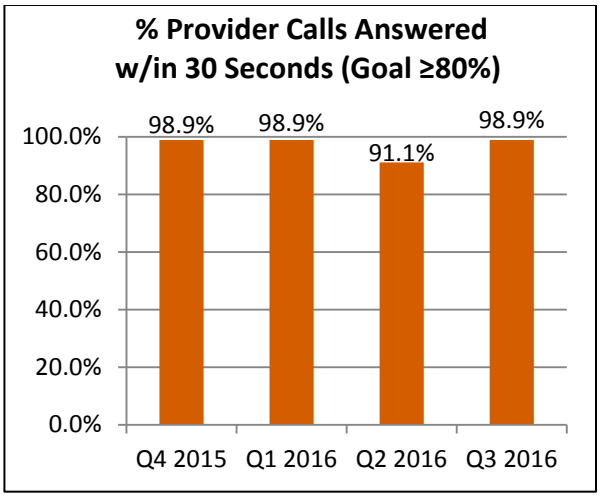
Methodology: The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho. To ensure the needs of our providers and stakeholders are met in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual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

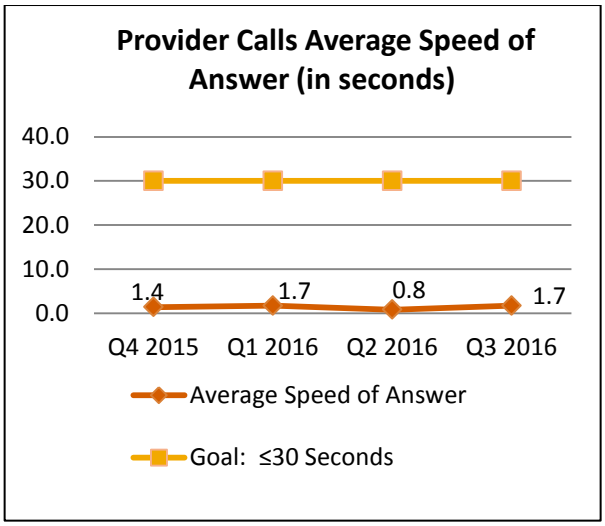
Quarterly Performance Results:

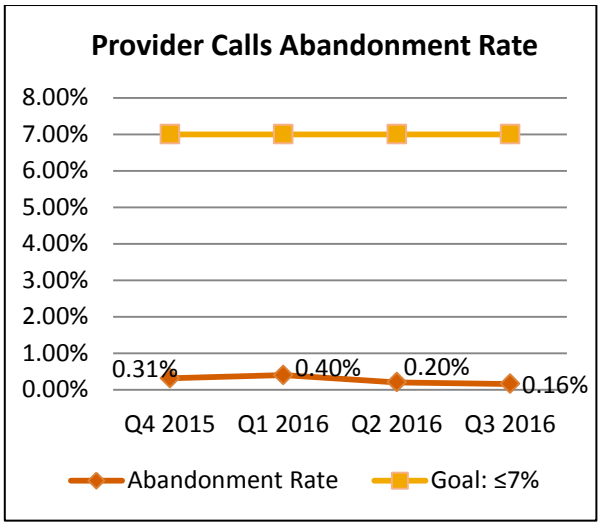
Customer Service Line (Provider Calls)	Optum Idaho Standards	IBHP Contract Standards	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Total Number of Calls	NA	NA	3,175	3,284	3,032	2818
Percent of Calls Answered Within 30 Seconds	≥80.0%	None	98.9%	98.9%	91.1%	98.9%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	1.4 sec	1.7 sec	0.8 sec	1.7 sec
Abandonment Rate	≤3.5%	≤7%	0.31%	0.40%	0.20%	0.16%

Analysis: The total number of Customer Service provider calls during Q3 was 2,818. Customer service call standards met performance goals for all three customer service line measures again during Q3. 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 Q3, again meeting our goal of ≤30 seconds. The call abandonment rate was 0.16% continuing to meet both the Optum Idaho internal goal of ≤3.5% and the IBHP Contract Standard of ≤ 7%.









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

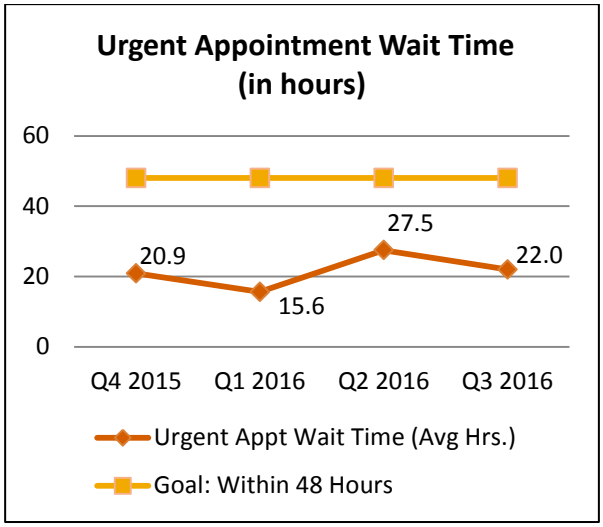
Urgent and Non-Urgent Access Standards

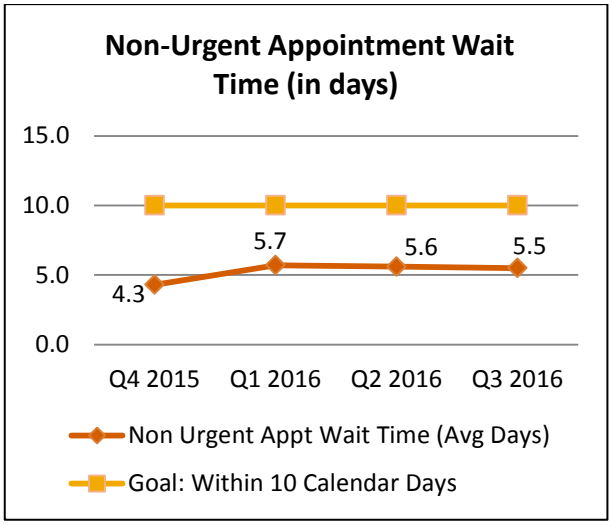
Methodology: As part of our Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, we develop, maintain, and monitor a network with adequate numbers and types of clinicians and outpatient programs. We require that the network providers adhere to specific 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	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Urgent Appointment Wait Time	Within 48 hours from request	20.9 hours	15.6 hours	27.5 hours	22.0 hours
Non-Urgent Appointment Wait Time	Within 10 days from request	4.3 days	5.7 days	5.6 days	5.5 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. During Q3, the Urgent Appointment Wait time decreased from 27.5 hours in Q2 to 22.0 hours. The performance goal for non-urgent appointment wait time is an appointment within 10 days. This goal was again met during Q3 at 5.5 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	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Area 1 (within 30 miles)	100.0%	99.9%	99.9%	99.9%	99.8%
Area 2 (within 45 miles)	100.0%	99.8%	99.8%	99.8%	99.8%

Analysis: Optum Idaho continued to meet contract availability standards. During Q3, Area 1 availability standards were met at 99.8% 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).

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

Member Protections and Safety

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

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

As part of Optum's ongoing assessment of the overall network, Optum Idaho evaluates, audits, and reviews the performance of existing contracted providers, programs, and facilities.

Notification of Adverse Benefit Determination

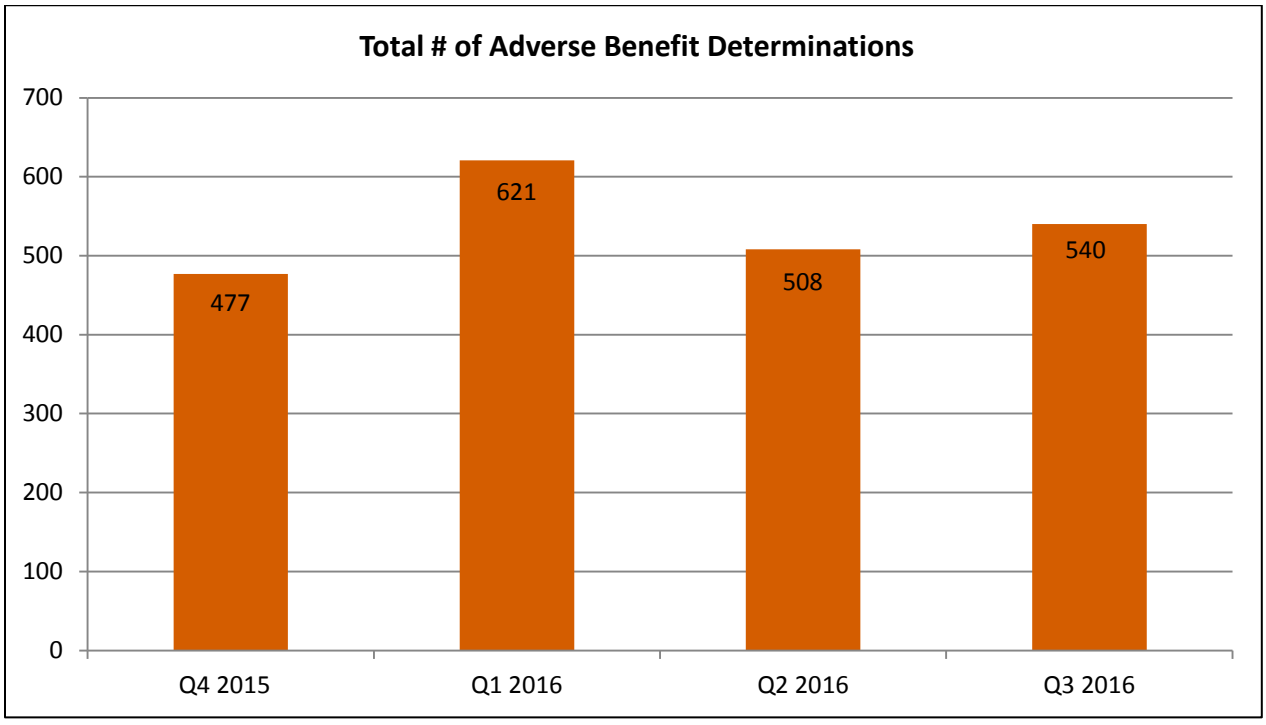
Methodology: Adverse Benefit Determinations (ABD's) are maintained in the Linx database. When a request for services is received, Optum has 14 days to review the case and

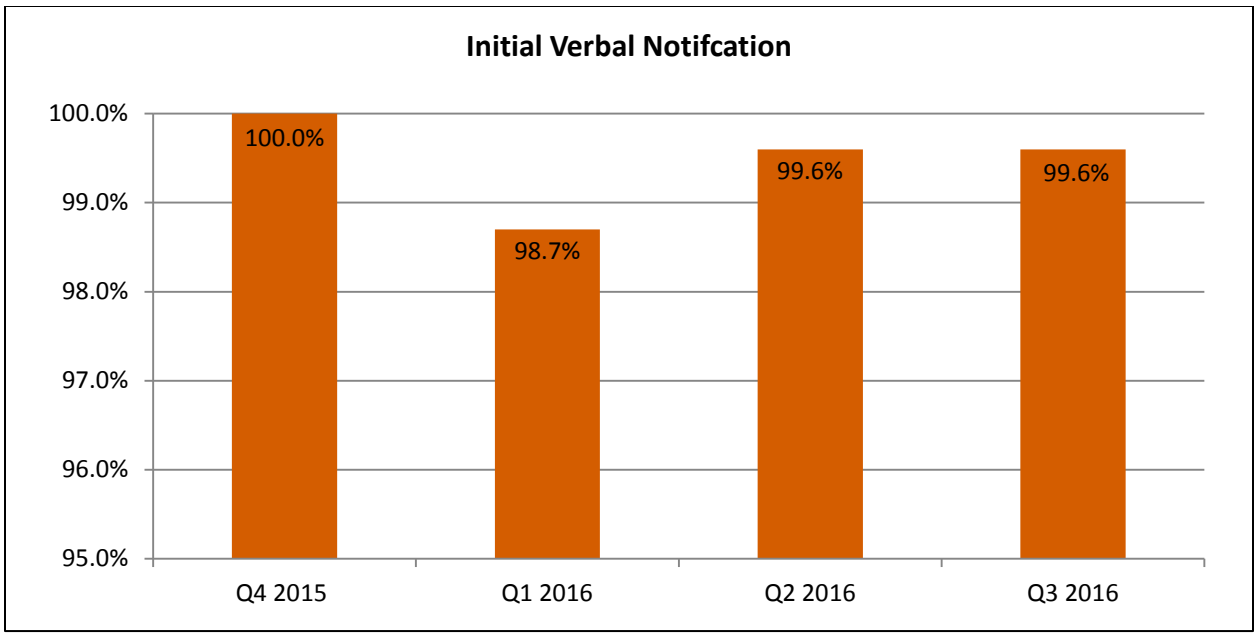
make a determination to authorize services or deny services in total or in part. Once a determination is made to deny or reduce services, Optum has one (1) day following the verbal notification of the decision to mail a written notice informing the member and provider of the denial.

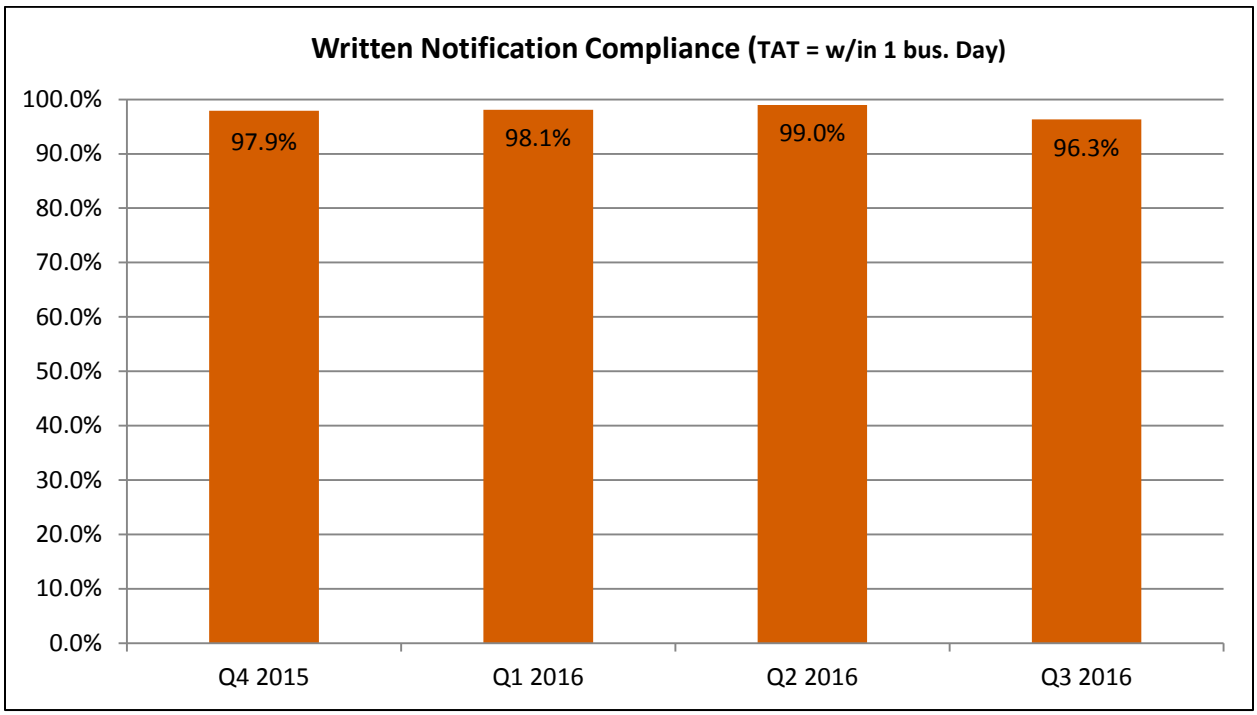
Quarterly Performance Results:

Notification of ABD	Performance Goal	Target	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Total # ABD's	NA	NA	477	621	508	540
Initial Verbal Notification to Provider	1 business day from determination date	100.0%	100.0%	98.7%	99.6%	99.6%
Written Notification	1 business day from verbal notification	100.0%	97.9% (467/477)	98.1% (609/621)	99.0% (503/508)	96.3% (520/540)

Analysis: During Q3, there were 540 ABDs. Verbal notification compliance was 99.6%. There were only 2 verbal notifications out of compliance. Written notification compliance dropped from 99.0% in Q2 to 96.3% in Q3. There were 20 written notifications out of compliance. The noncompliant written notifications were late by an average of 1.5 business days. Thirteen (13) of the noncompliant written notifications were late by one (1) day.




Initial Verbal Notifcation
100.0%
99.0%
98.0%
97.0%
96.0%
95.0%
100.0%
98.7%
99.6%
99.6%
Q4 2015
Q1 2016
Q2 2016
Q3 2016


Written Notification Compliance (TAT = w/in 1 bus. Day)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
97.9%
98.1%
99.0%
96.3%
Q4 2015
Q1 2016
Q2 2016
Q3 2016

Barriers: The ABD process is divided between three different teams- the Optum Idaho Medical Directors conducting the peer reviews, the Clinical team processing those reviews and completing the verbal notifications, and the Quality team processing the written notifications. The multiple handoffs between departments creates more opportunities for ABDs to fall out of compliance. At the beginning of Q3, the Optum Idaho Medical Directors started doing their own verbal notifications during the peer review. This was an attempt to streamline the process. In September, the Quality team took over the processing of the reviews from the Clinical team in another effort to limit the number of handoffs. While having the Optum Idaho Medical Directors conduct and document the verbal ABD notification streamlined the process, it created another barrier for the written notification turn-around times. Medical Directors were sending in their review a day or two after it was completed. When the Quality team received these late reviews, the written notifications were already out of compliance.

Opportunities and Interventions: The Quality team is closely monitoring the ABD process and working with the Optum Idaho Medical Directors to have them send in their peer reviews the day the peer review was conducted. Optum Idaho is looking at more ways to improve the ABD notification process. Education will continue to be provided on Optum Idaho ABD compliance measures.

Grievances

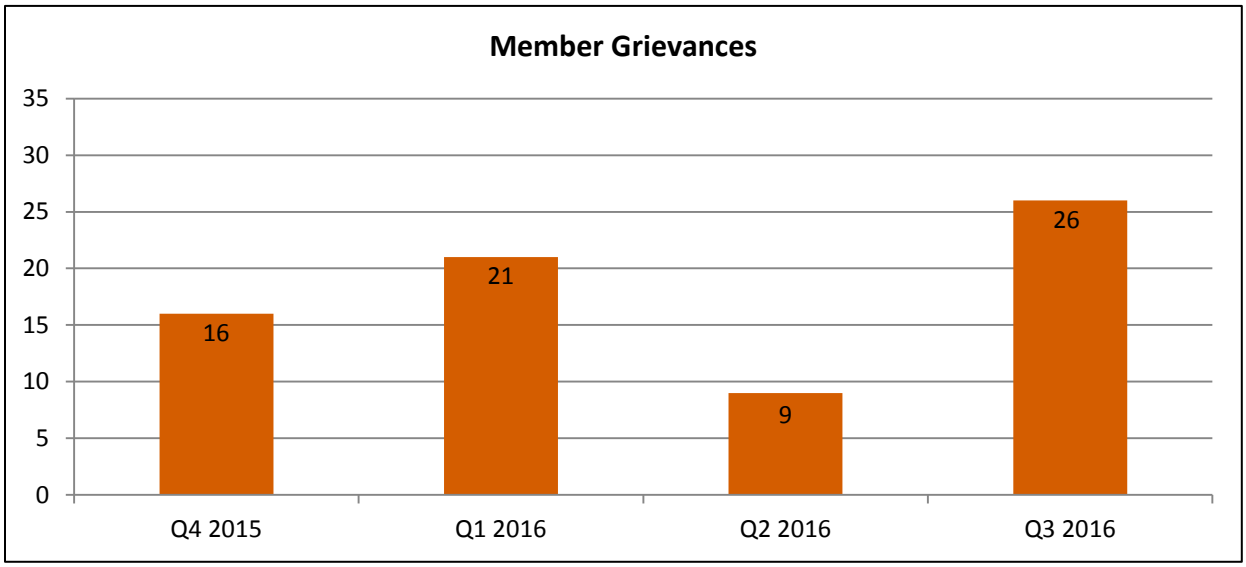
Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an adverse action that resulted in member financial liability or denied service, which is referred to within Optum as filing a grievance. All grievances are required to be reviewed and resolved within 30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

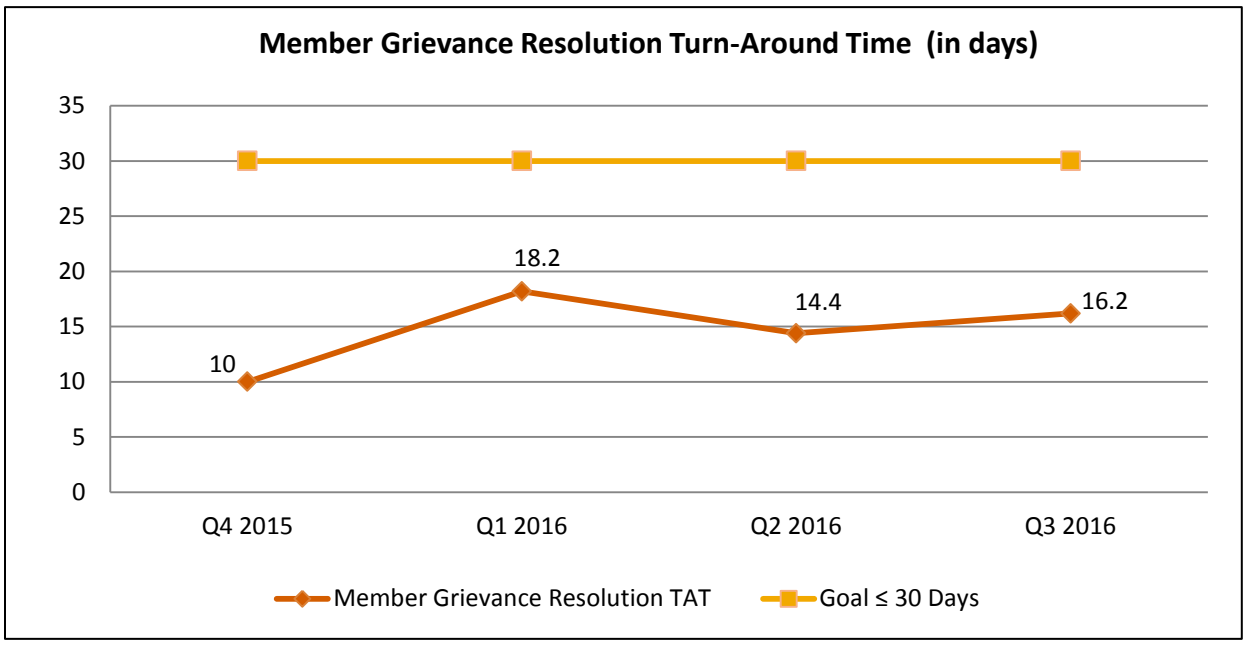
Quarterly Performance Results:

Grievances	Performance Goal	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Number of Member Grievances	NA	16	21	9	26
Average Number of Days to Resolution	30 Days	10	18.2*	14.4	16.2
Number of Overturned Grievances	NA	2	1	0	4
Number of Partially Overturned Grievances	NA	0	0	2	0
% of Grievances Overturned or Partially Overturned	NA	12.5%	4.8%	22.2%	15.4%

**due to error in reporting, this was changed from 21 to 18.2.*

Analysis: During Q3, 2016, there were 26 Grievances. Four (4) grievances were completely overturned. There were no partially overturned Grievances. Optum Idaho continued to exceed the 30-day turnaround time for resolutions with a 16.2 day average.





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.

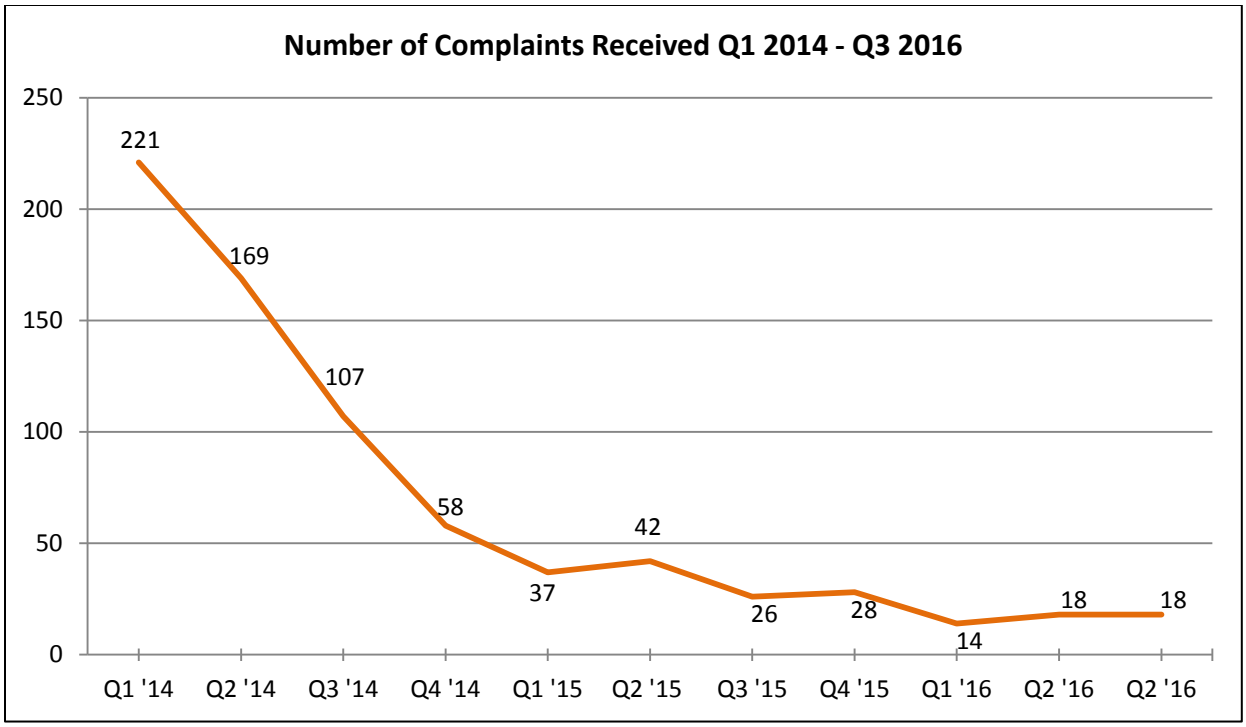
Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for complaints are as follows:

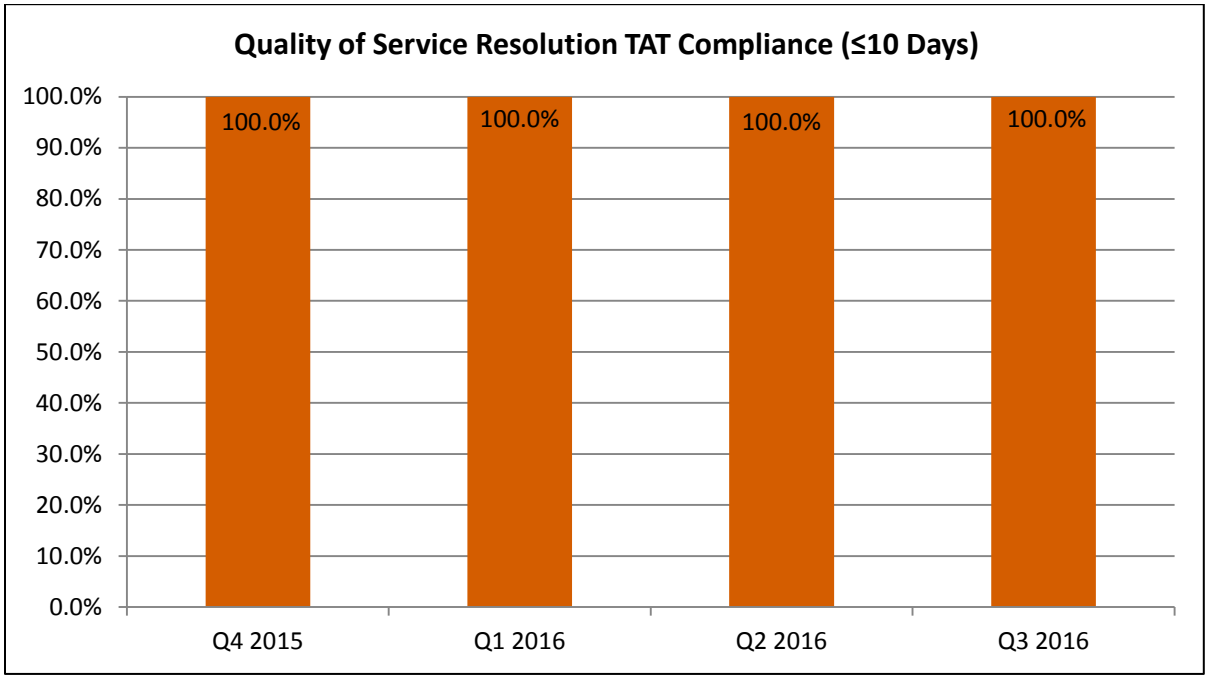
Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Calendar Days

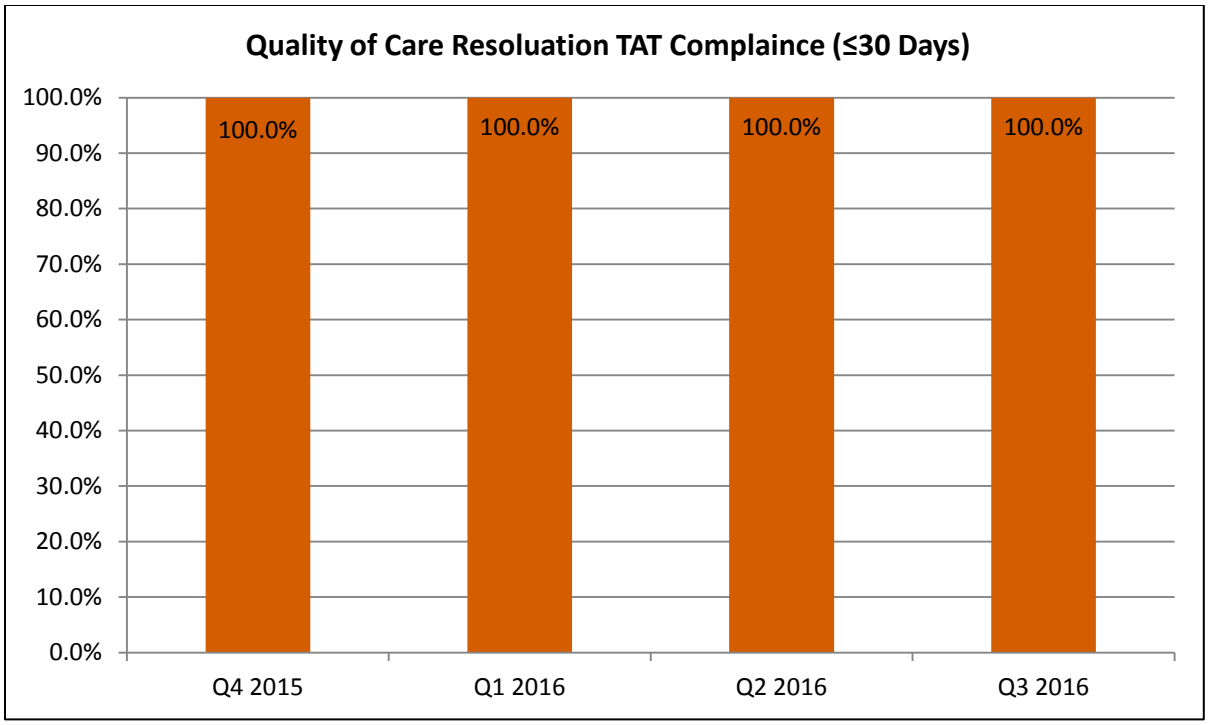
Quarterly Performance Results:

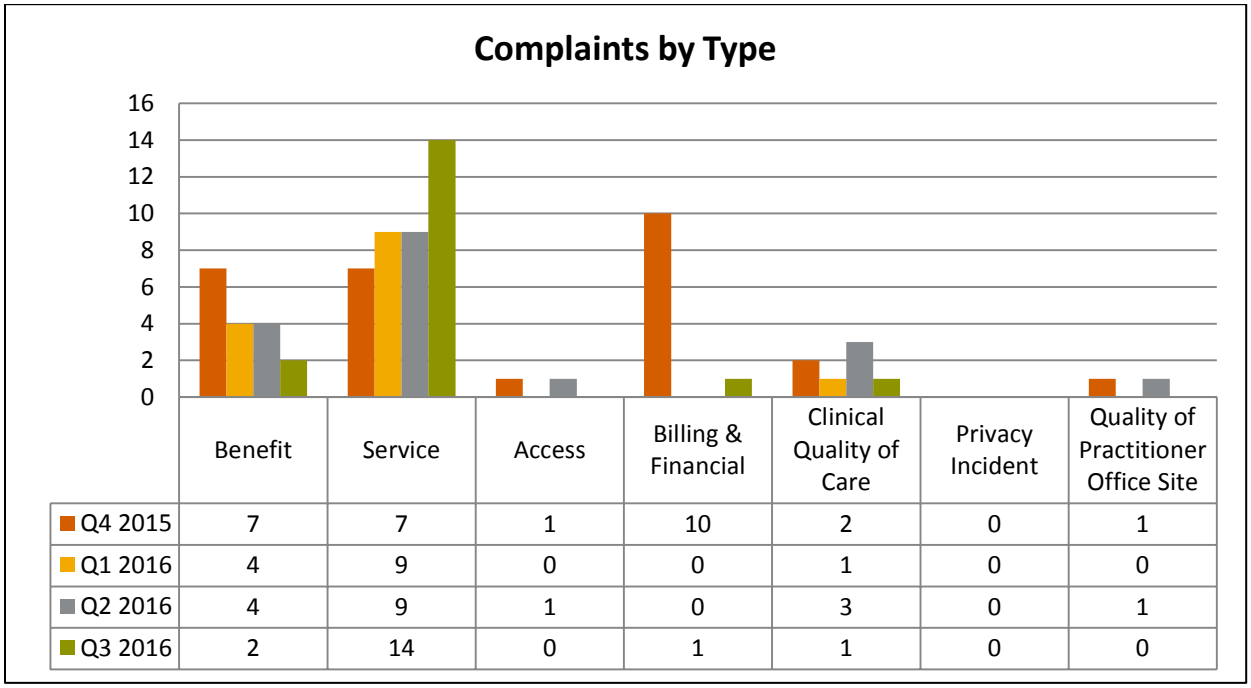
Complaints	Performance Goal	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Number of Quality of Service (QOS) Complaints Received	NA	26	13	15	17
Percent QOS Complaints Resolved w/in TAT	10 Days	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints (QOC) Received	NA	2	1	3	1
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%	100.0%

Analysis: During Q3, there were 18 total complaints. Seventeen (17) were identified as Quality of Service and 1 was identified as Quality of Care. Optum Idaho met the resolution turnaround time at 100% for both QOS complaints (10 business days) and QOC concerns (30 days).


Number of Complaints Received Q1 2014 - Q3 2016
250
200
150
100
50
0
221
169
107
58
37
42
26
28
14
18
18
Q1 '14
Q2 '14
Q3 '14
Q4 '14
Q1 '15
Q2 '15
Q3 '15
Q4 '15
Q1 '16
Q2 '16
Q2 '16


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%
100.0%
100.0%
100.0%
100.0%
Q4 2015
Q1 2016
Q2 2016
Q3 2016





	Benefit	Service	Access	Billing & Financial	Clinical Quality of Care	Privacy Incident	Quality of Practitioner Office Site
Q4 2015	7	7	1	10	2	0	1
Q1 2016	4	9	0	0	1	0	0
Q2 2016	4	9	1	0	3	0	1
Q3 2016	2	14	0	1	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 Idaho network as well as providers working under an accommodation agreement with Optum Idaho to provide services to members. The SEC and PRC may provide providers with written

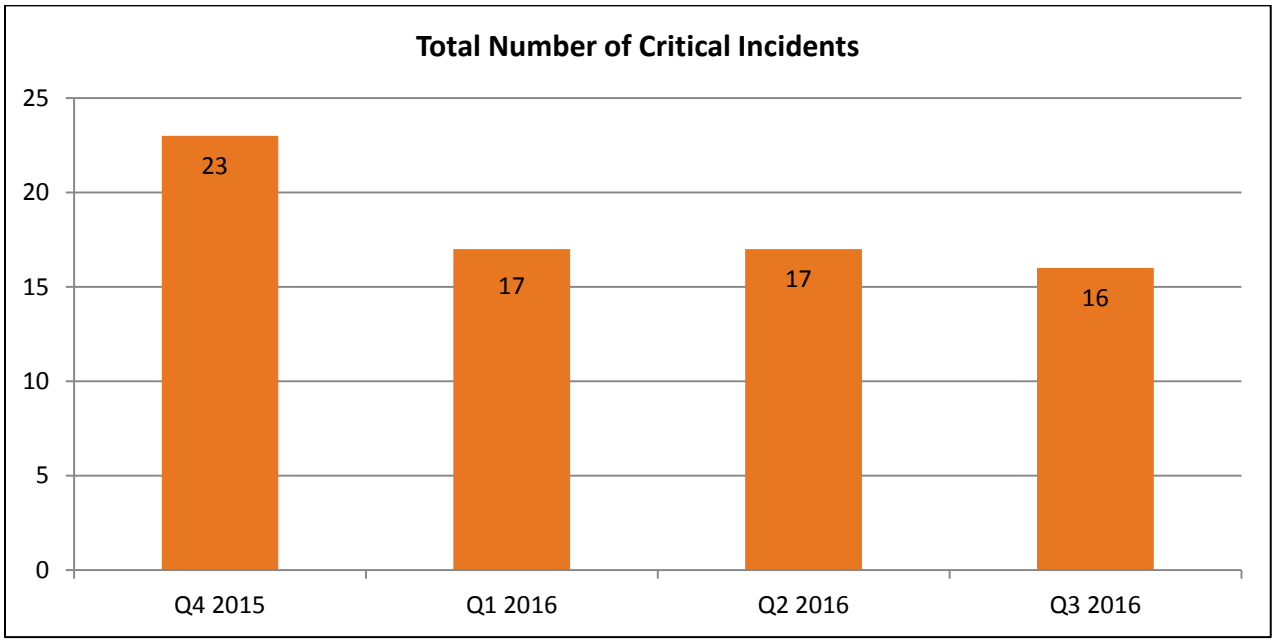
feedback related to observations made as a result of the review of the Critical Incident. Critical Incident Ad-hoc review is completed within 5 days from notification of incident.

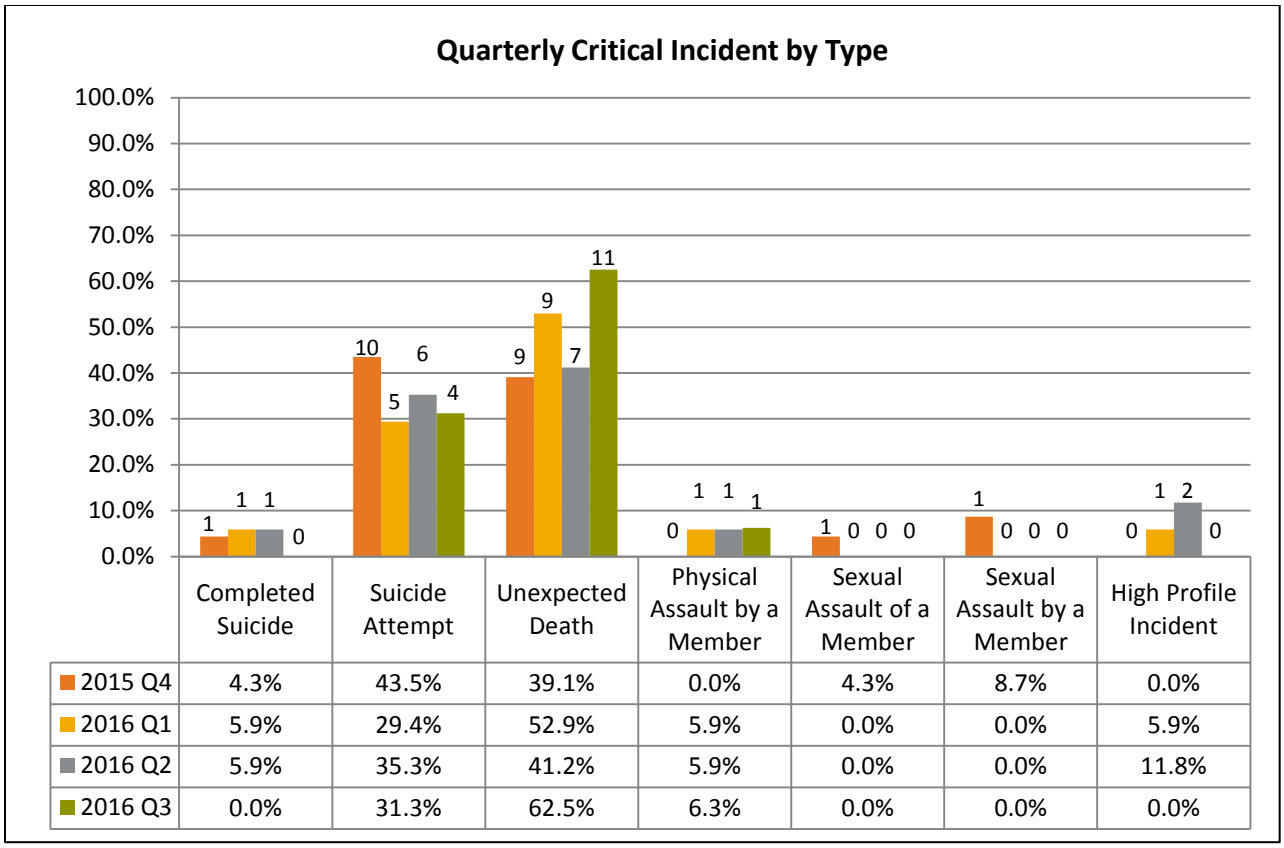
Quarterly Performance Results:

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

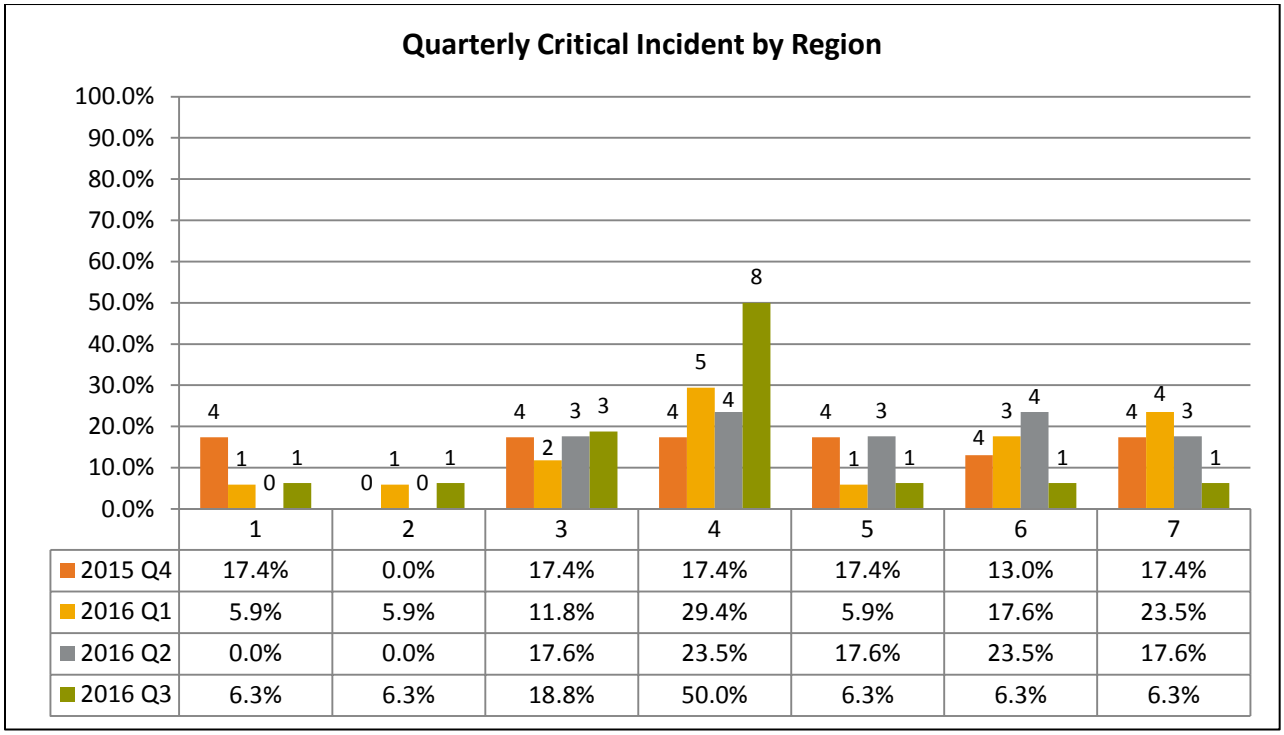
Analysis: There were 16 Critical Incidents reported during Q3. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. Of the 16 Critical Incidents reported, 11 (62.5%) were from unexpected deaths, 4 (31.3%) were from suicide attempts, 1 (6.3%) was from a physical assault by a member.

During Q3, 50.0% of the Critical Incidents reported occurred in Region 4. Coordination of Care between the behavioral health provider and the Primary Care Provider (PCP) occurred in 56.3% of the cases. Of the 16 reported Critical Incidents, 37.5% of males and 43.8% of females showed that member had a co-morbid health condition. Of the cases reported during Q3, 87.5% were adults (18+) and 12.5% were children/adolescents (17 and below). Further analysis showed that the average age for males was 29 and females 47. Of Critical Incidents reported during Q3, 50.0% were males and 50.0% were females. No providers were put on unavailable status due to a Critical Incident.

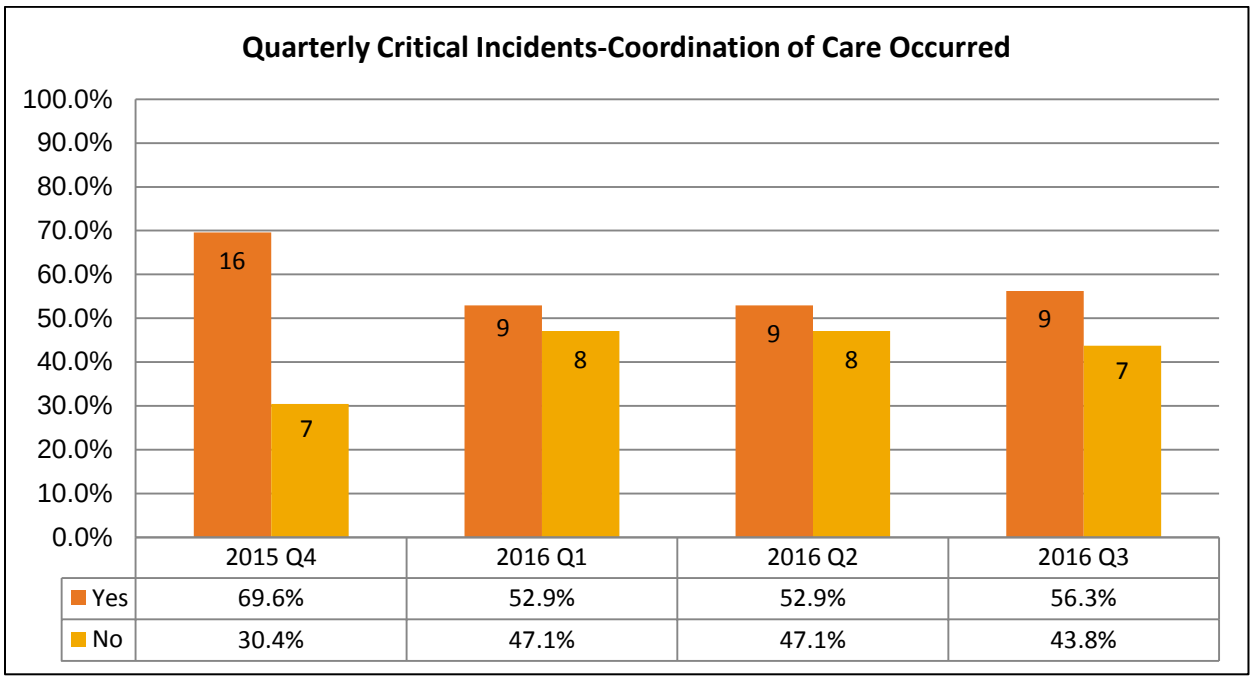




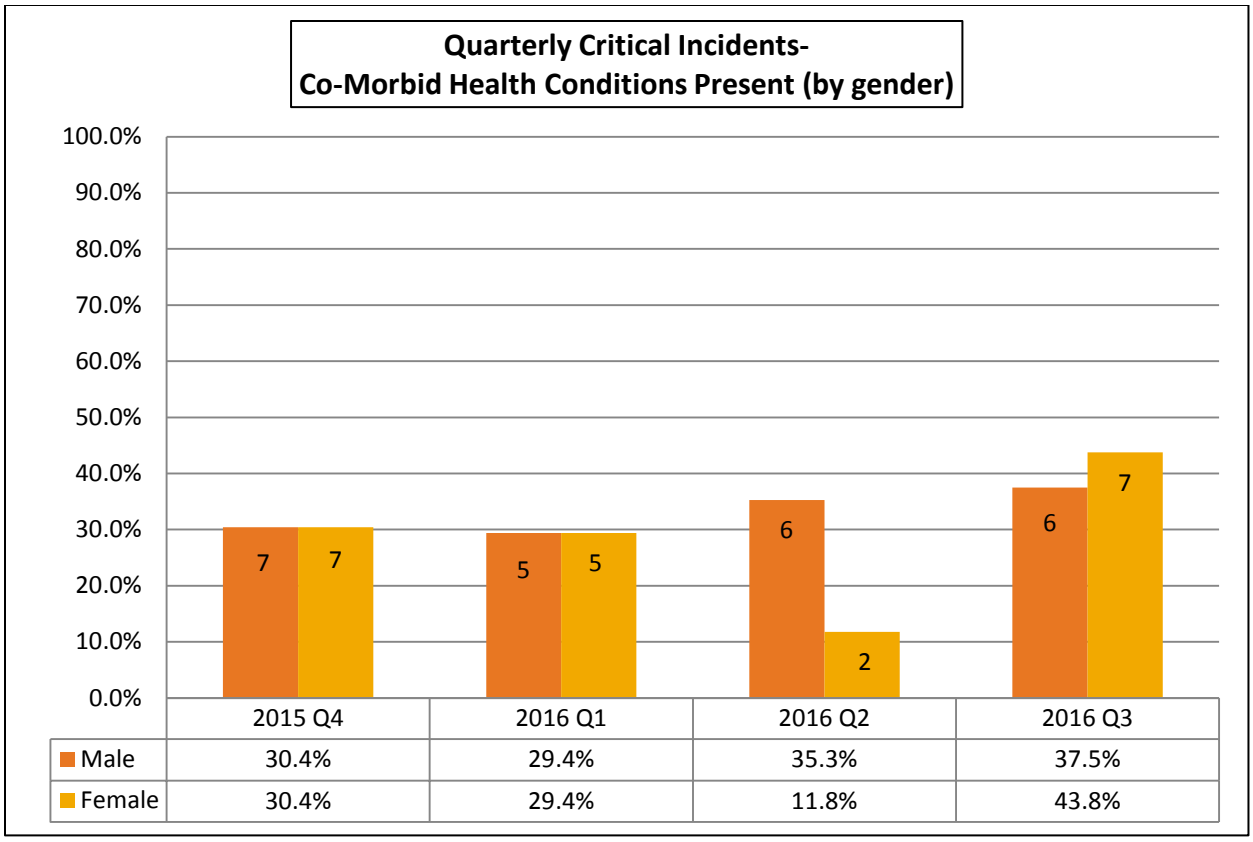
	Completed Suicide	Suicide Attempt	Unexpected Death	Physical Assault by a Member	Sexual Assault of a Member	Sexual Assault by a Member	High Profile Incident
2015 Q4	4.3%	43.5%	39.1%	0.0%	4.3%	8.7%	0.0%
2016 Q1	5.9%	29.4%	52.9%	5.9%	0.0%	0.0%	5.9%
2016 Q2	5.9%	35.3%	41.2%	5.9%	0.0%	0.0%	11.8%
2016 Q3	0.0%	31.3%	62.5%	6.3%	0.0%	0.0%	0.0%



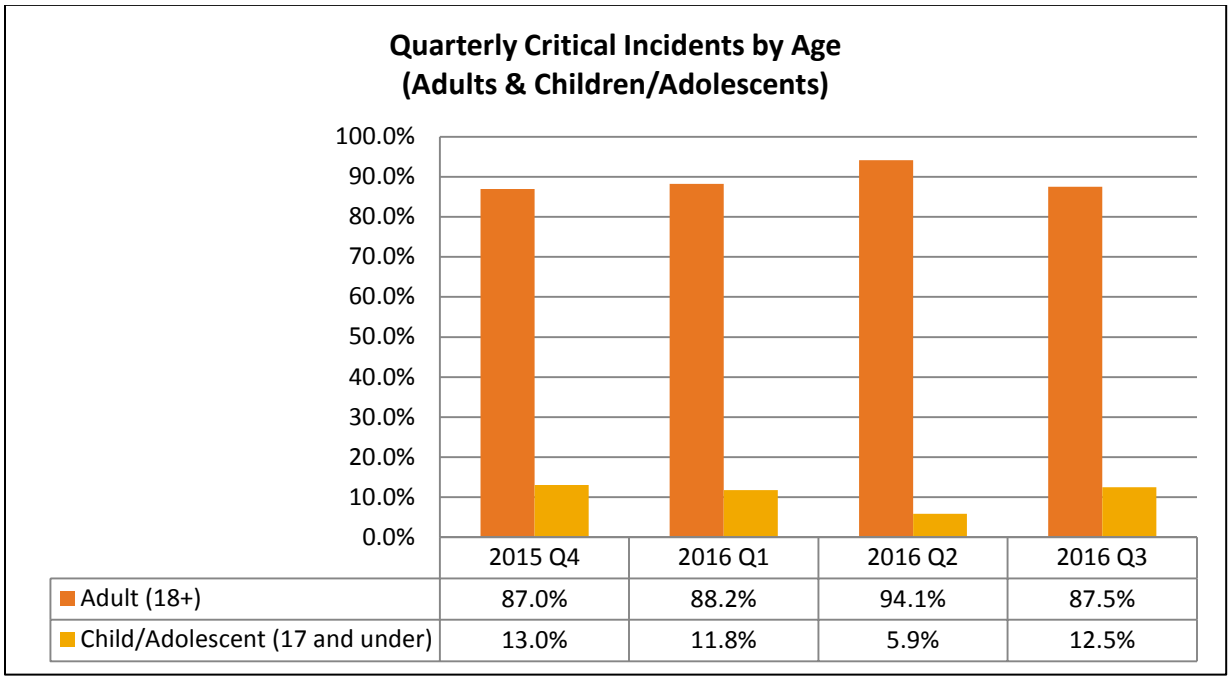
	1	2	3	4	5	6	7
2015 Q4	17.4%	0.0%	17.4%	17.4%	17.4%	13.0%	17.4%
2016 Q1	5.9%	5.9%	11.8%	29.4%	5.9%	17.6%	23.5%
2016 Q2	0.0%	0.0%	17.6%	23.5%	17.6%	23.5%	17.6%
2016 Q3	6.3%	6.3%	18.8%	50.0%	6.3%	6.3%	6.3%



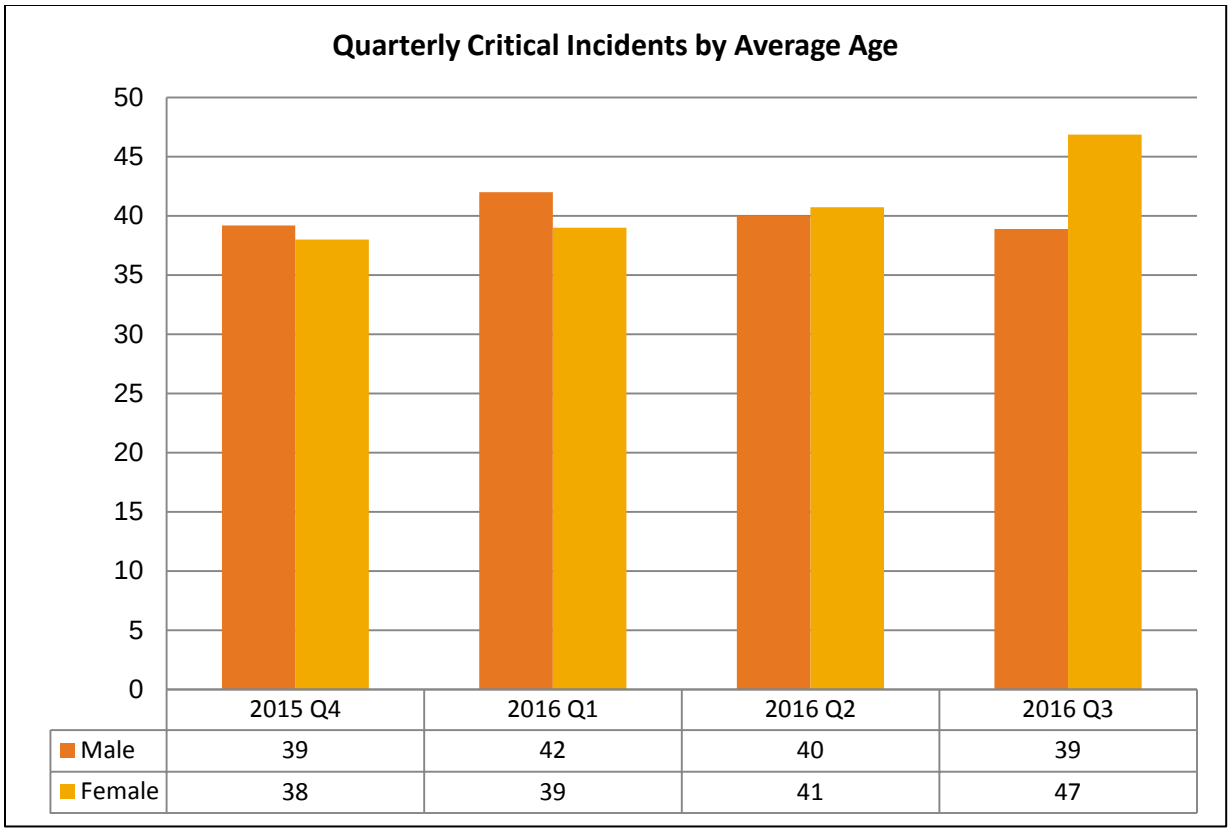
	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Yes	69.6%	52.9%	52.9%	56.3%
No	30.4%	47.1%	47.1%	43.8%

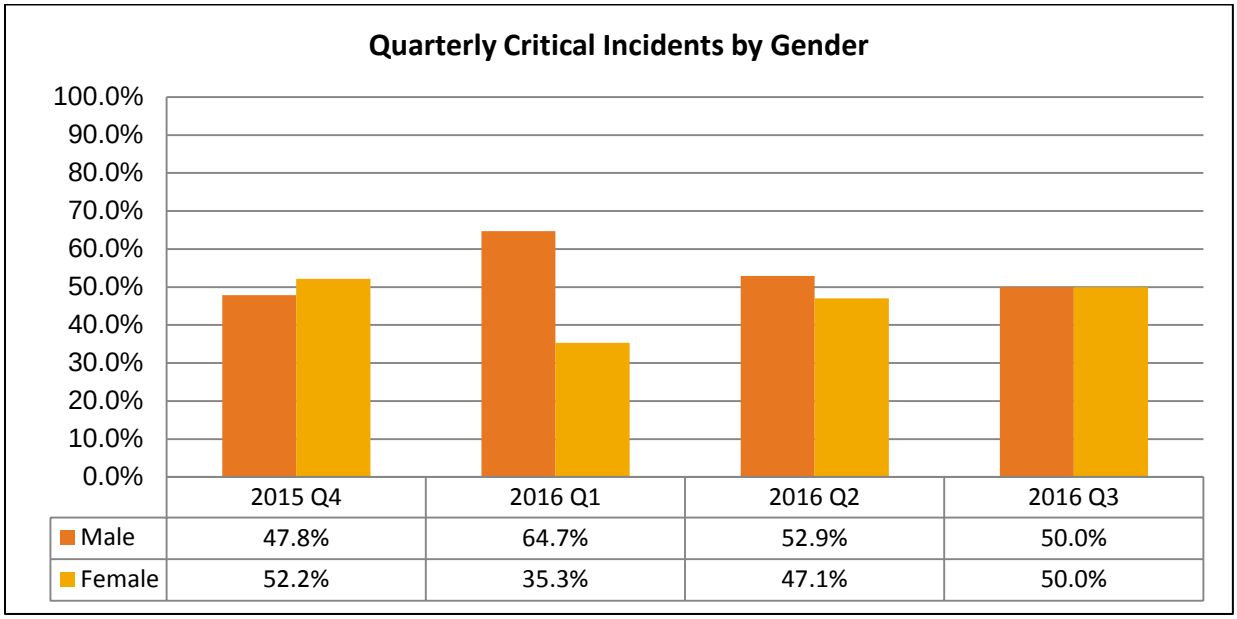


	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Male	30.4%	29.4%	35.3%	37.5%
Female	30.4%	29.4%	11.8%	43.8%



	2015 Q4	2016 Q1	2016 Q2	2016 Q3
Adult (18+)	87.0%	88.2%	94.1%	87.5%
Child/Adolescent (17 and under)	13.0%	11.8%	5.9%	12.5%





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

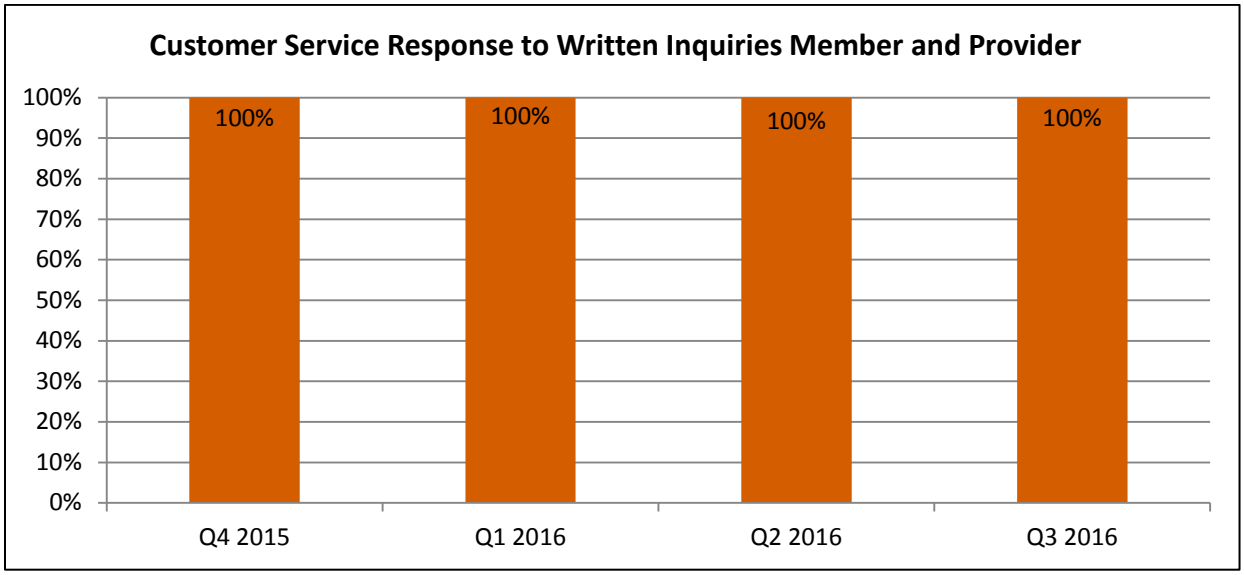
Response to Written Inquiries

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 Idaho's Customer Service Department.

Quarterly Performance Results:

Customer Service Response to Written Inquiries	Performance Goal	Q4 2015	Q1 2016	Q2 2016	Q3 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 Q3.



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 Idaho 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:

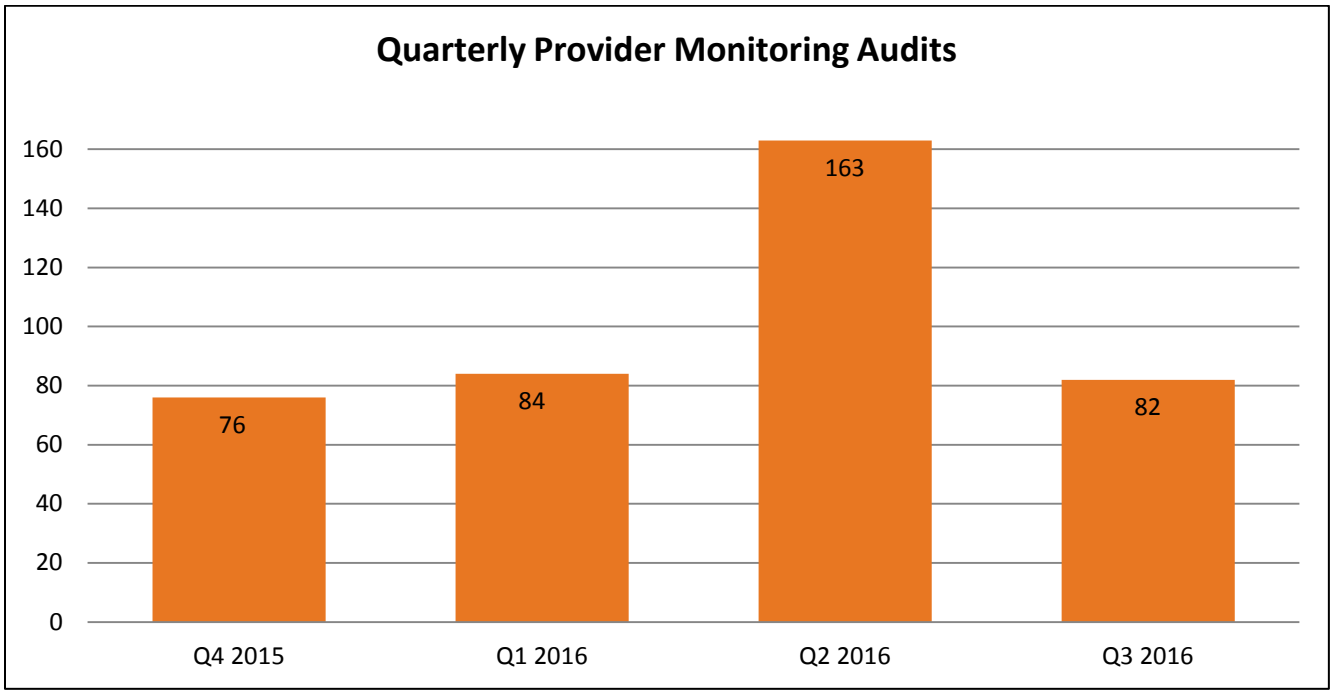
Treatment Record Audit	Performance Goal	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Number of Audits Conducted	NA	76	84	163	82
Initial Audit (Average overall score)	85.0%	95.1%	92.4%	96.3%	98.3%
Recredentialing Audit (Average overall score)	85.0%	98.4%	96.0%	93.4%	92.2%
Monitoring (Average overall score)	85.0%	88.5%	89.3%	58.3%*	NA**
Quality (Average overall score)	85.0%	94.7%	92.4%	97.4%	96.5%
Percent of Audits Requiring a Corrective Action Plan	NA	22.4%	14.3%	8.6%	7.3%

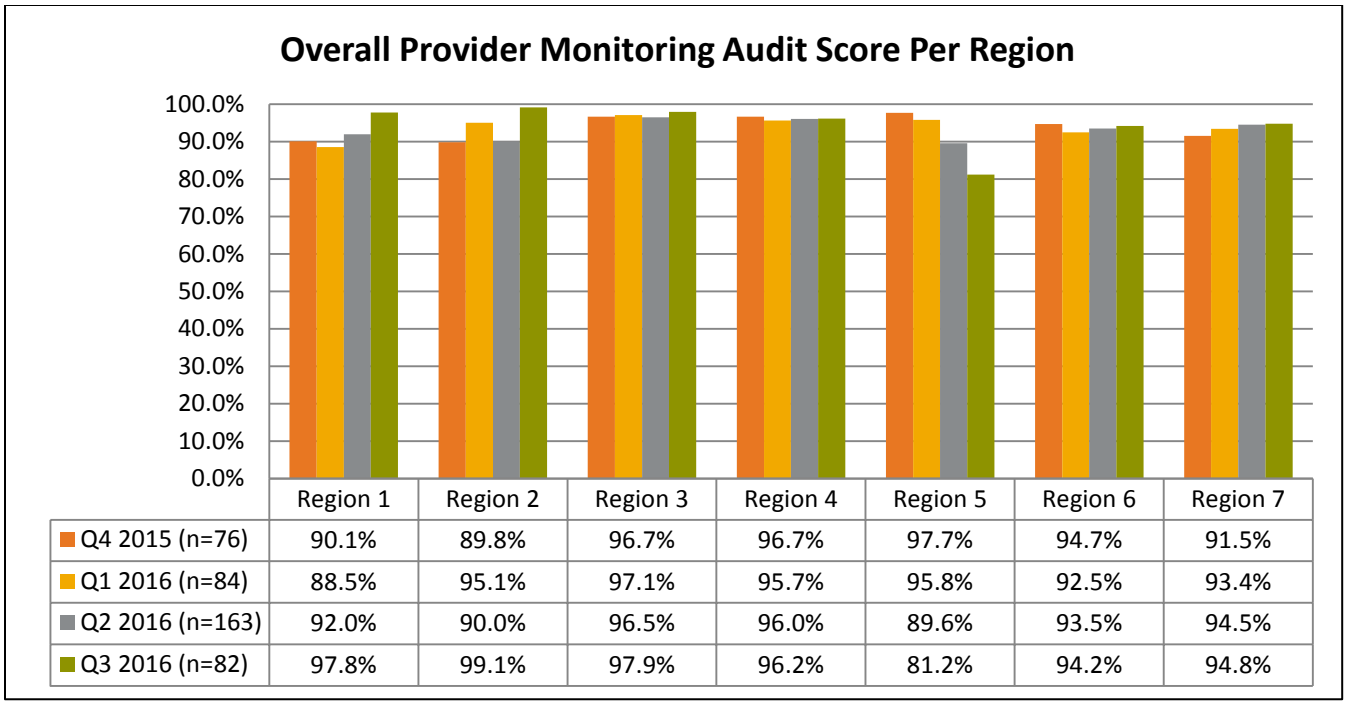
*there was only 1 monitoring audit during Q2. **there were no monitoring audits during Q3.

Analysis: During Q3, eight-two (82) Provider Monitoring Audits were completed. Of the 82 audits completed, 92.7% received a passing score. Corrective action plans were implemented for 7.3% of the audits. Overall audit scores per region and per audit type are reflected in graphs below.

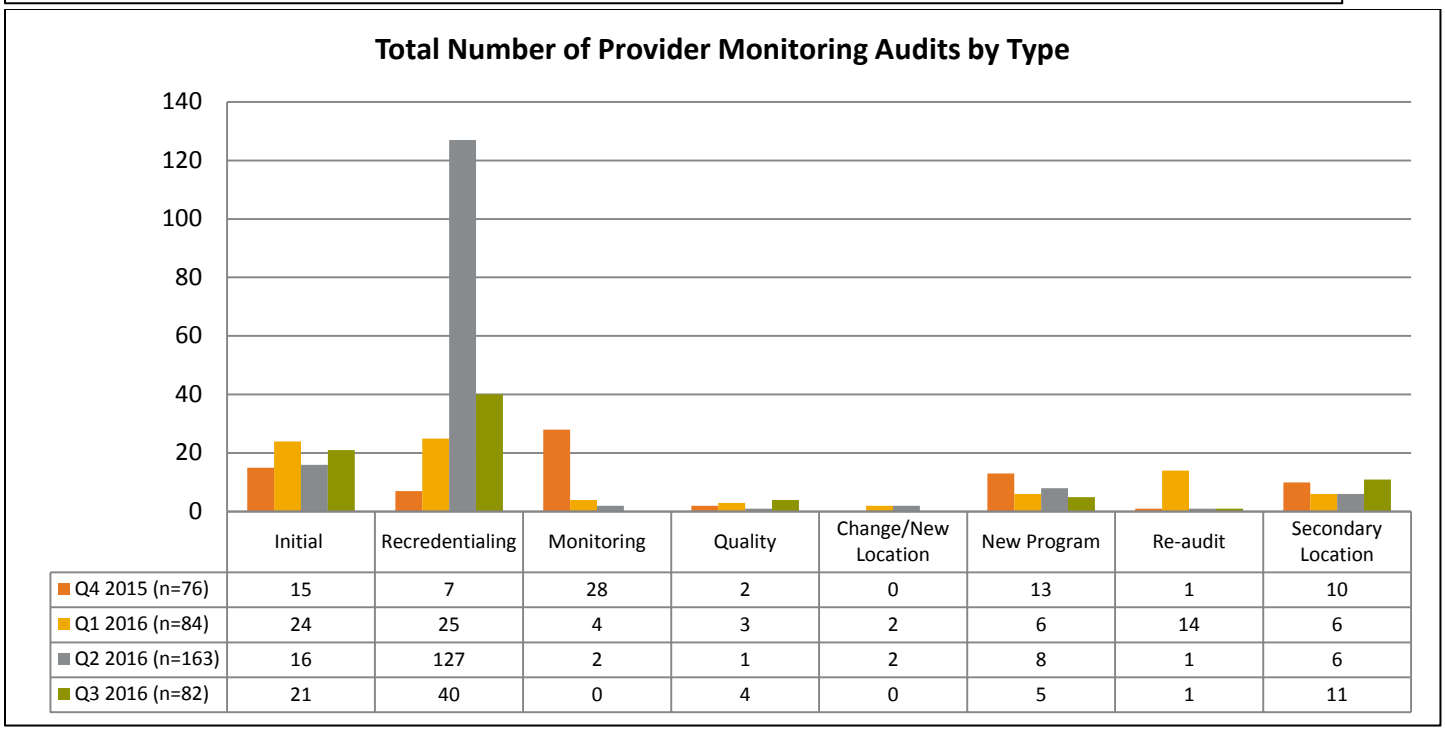
Network providers are given the opportunity to rate the Provider Quality Monitoring Audit process in a Satisfaction Survey. Beginning in Q1, 2016, Optum Idaho began using a new

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. The results at the end of Q3 showed that 50.0% of providers who returned the survey stated that the overall value of the audit process was excellent, followed by 36.6% who stated it was very good and good (combined). There were 6.7% of respondents that stated that the process was fair and another 6.7% that stated that the process was poor. Fifty-seven percent (57.0%) indicated that the Auditor was excellent. Fifty percent (50.0%) of respondents indicated that their overall experience with the audit was excellent.

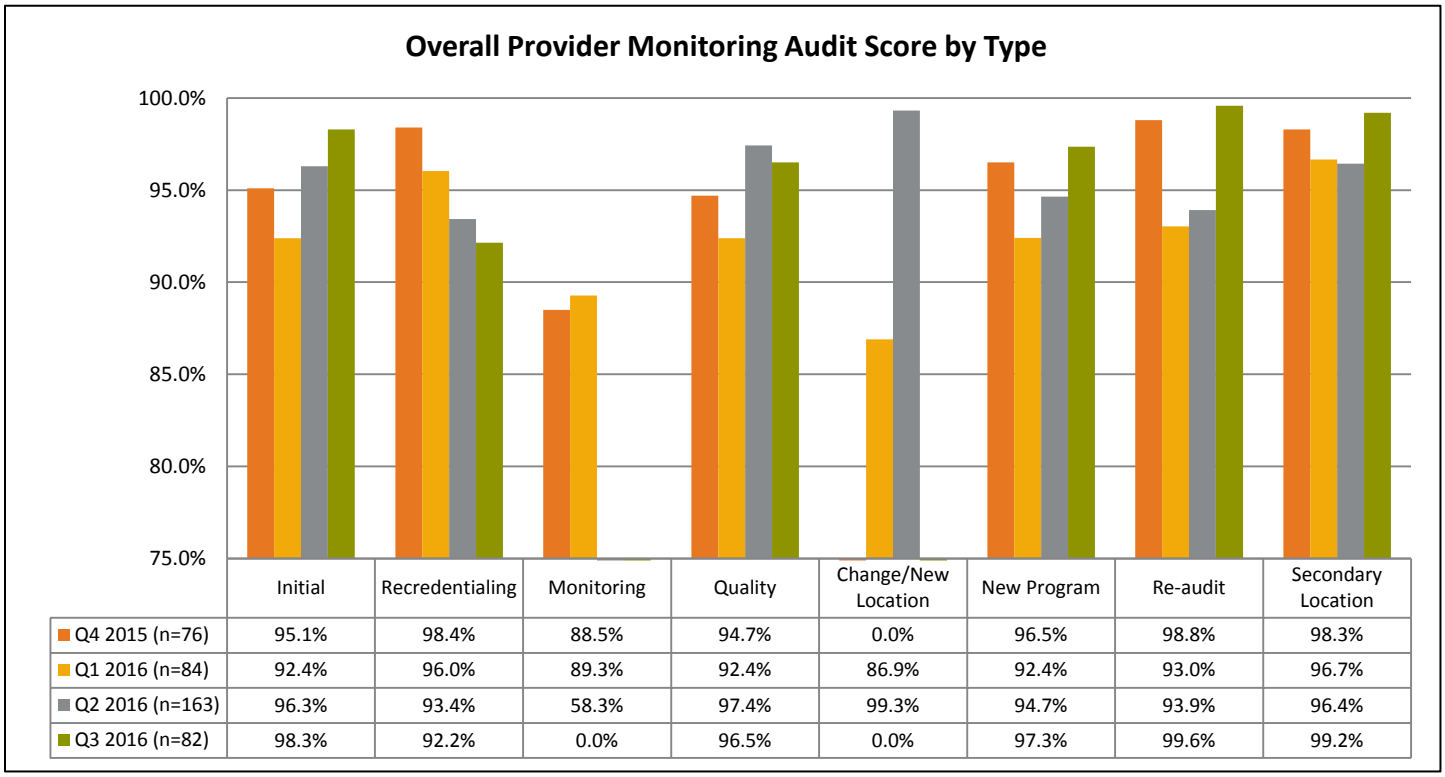




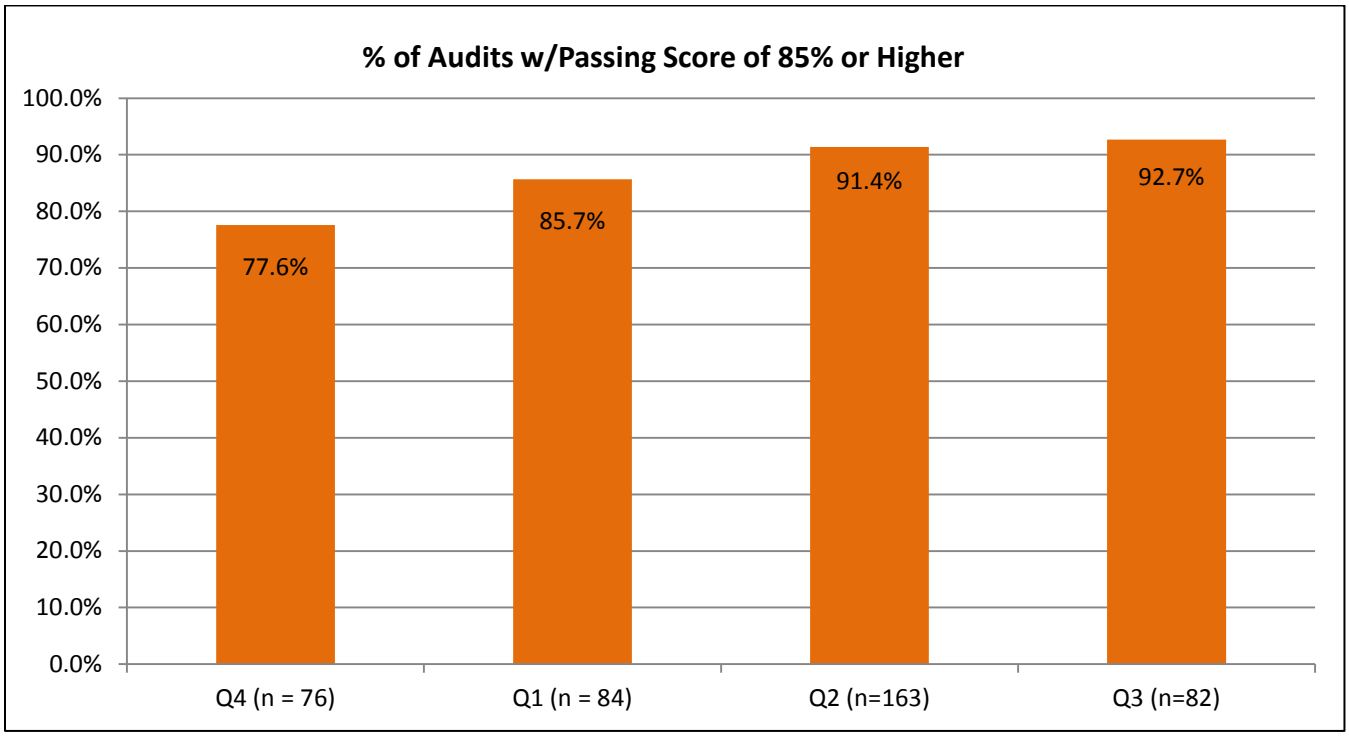
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Q4 2015 (n=76)	90.1%	89.8%	96.7%	96.7%	97.7%	94.7%	91.5%
Q1 2016 (n=84)	88.5%	95.1%	97.1%	95.7%	95.8%	92.5%	93.4%
Q2 2016 (n=163)	92.0%	90.0%	96.5%	96.0%	89.6%	93.5%	94.5%
Q3 2016 (n=82)	97.8%	99.1%	97.9%	96.2%	81.2%	94.2%	94.8%

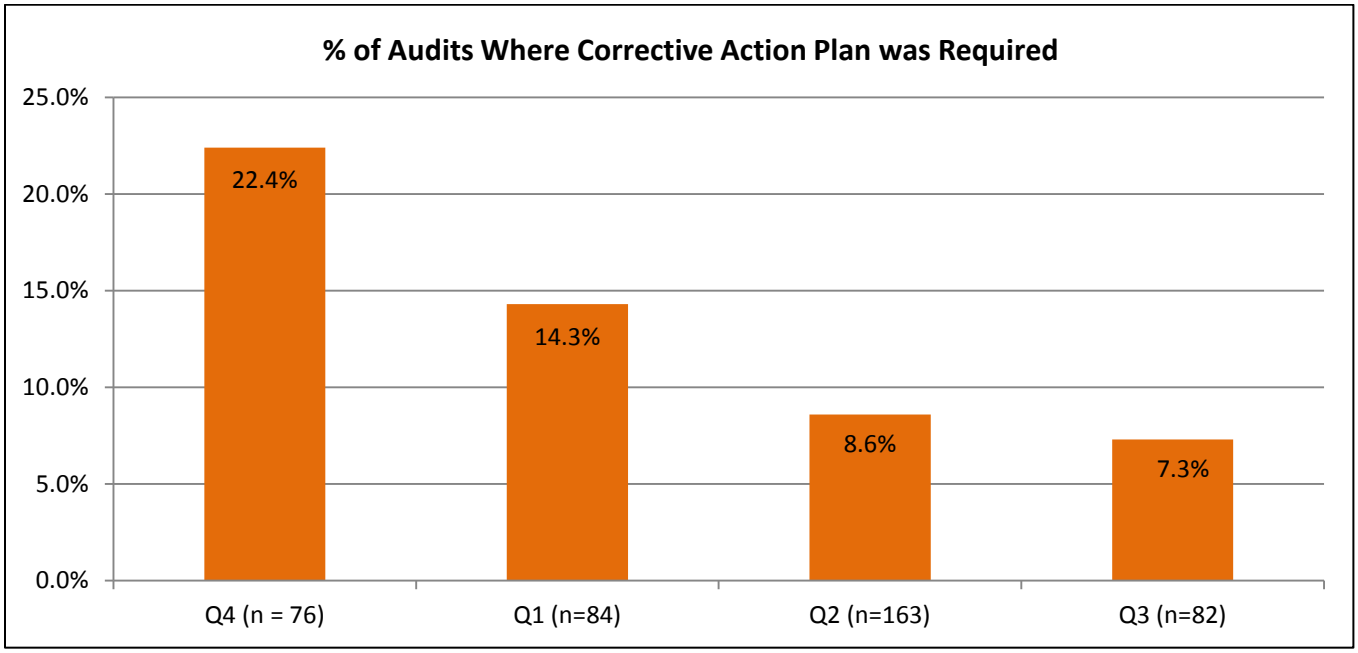


	Initial	Recredentialing	Monitoring	Quality	Change/New Location	New Program	Re-audit	Secondary Location
Q4 2015 (n=76)	15	7	28	2	0	13	1	10
Q1 2016 (n=84)	24	25	4	3	2	6	14	6
Q2 2016 (n=163)	16	127	2	1	2	8	1	6
Q3 2016 (n=82)	21	40	0	4	0	5	1	11

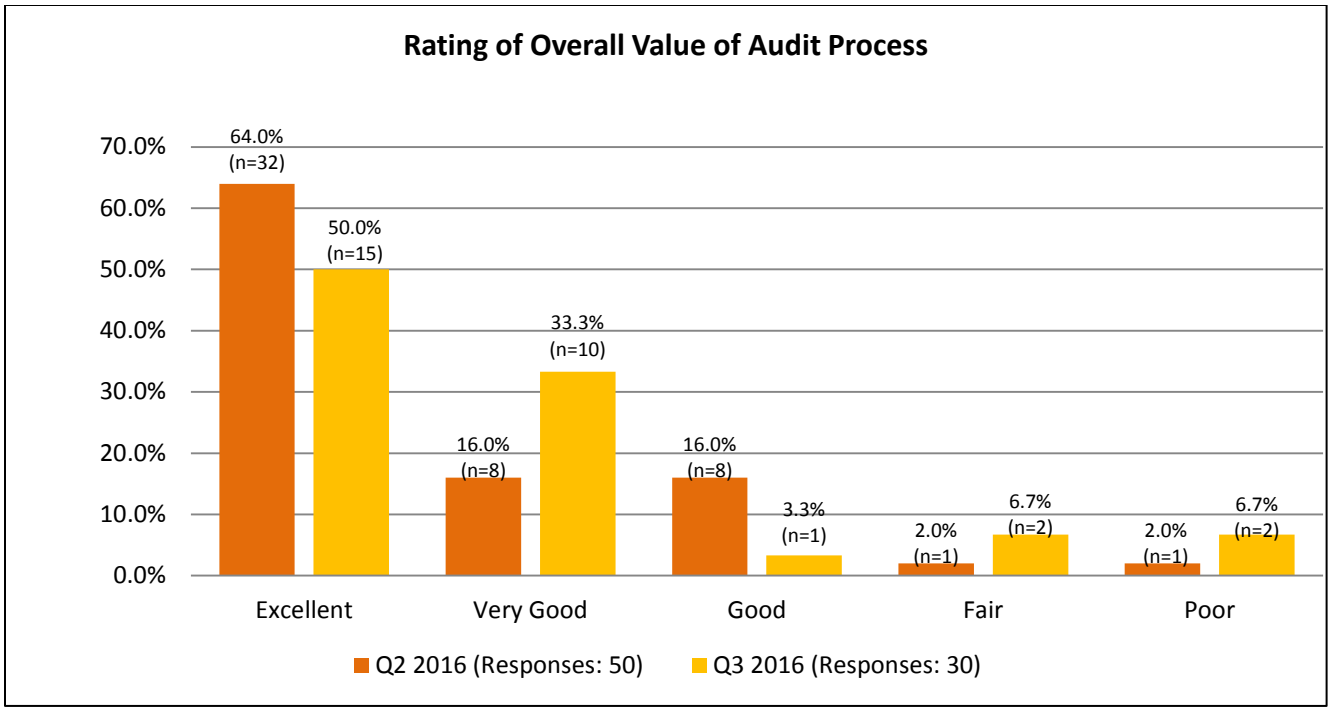


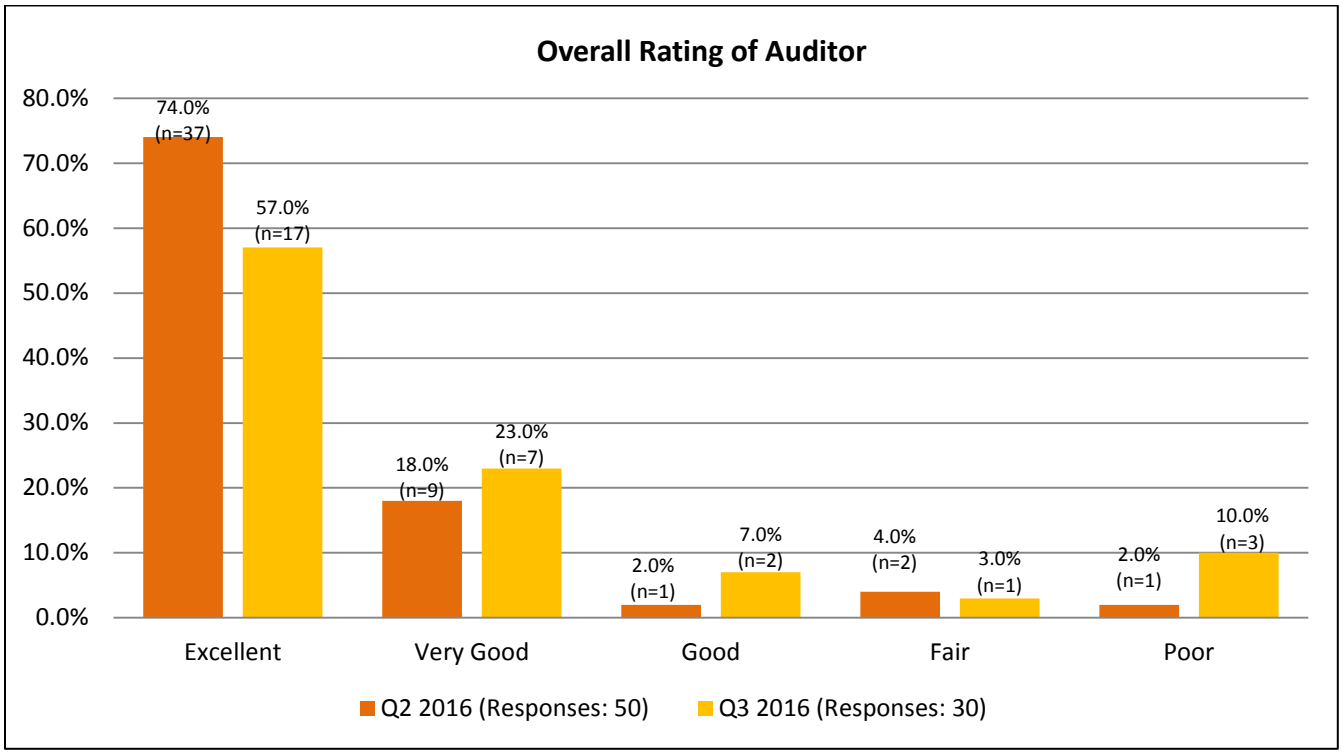
	Initial	Recredentialing	Monitoring	Quality	Change/New Location	New Program	Re-audit	Secondary Location
Q4 2015 (n=76)	95.1%	98.4%	88.5%	94.7%	0.0%	96.5%	98.8%	98.3%
Q1 2016 (n=84)	92.4%	96.0%	89.3%	92.4%	86.9%	92.4%	93.0%	96.7%
Q2 2016 (n=163)	96.3%	93.4%	58.3%	97.4%	99.3%	94.7%	93.9%	96.4%
Q3 2016 (n=82)	98.3%	92.2%	0.0%	96.5%	0.0%	97.3%	99.6%	99.2%

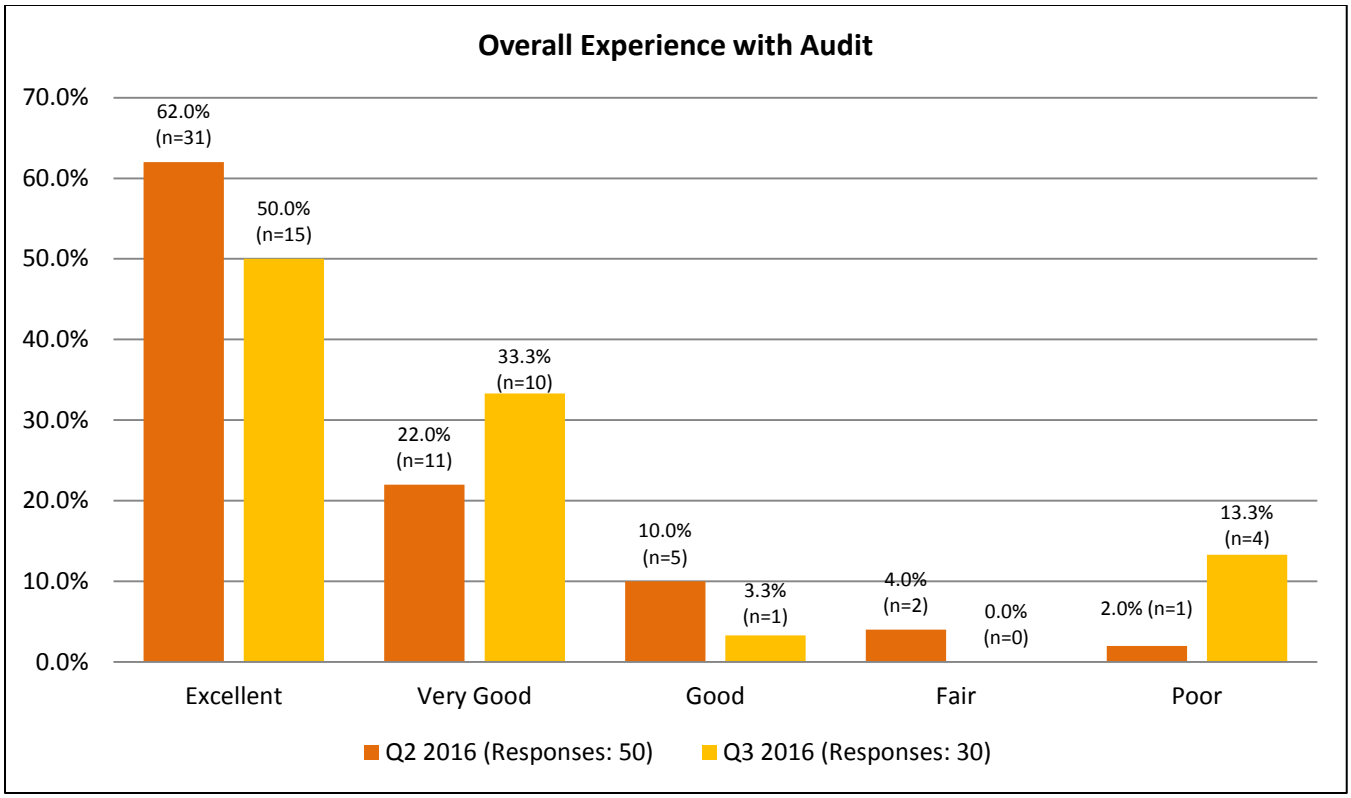




Below are the results of the surveys received back by the end of Q3 that were sent to providers regarding their rating of the Monitoring Audit Process.


Rating of Overall Value of Audit Process
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
64.0% (n=32)
50.0% (n=15)
16.0% (n=8)
33.3% (n=10)
16.0% (n=8)
3.3% (n=1)
2.0% (n=1)
6.7% (n=2)
2.0% (n=1)
6.7% (n=2)
Excellent
Very Good
Good
Fair
Poor
Q2 2016 (Responses: 50)
Q3 2016 (Responses: 30)


Overall Rating of Auditor
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
74.0% (n=37)
57.0% (n=17)
18.0% (n=9)
23.0% (n=7)
2.0% (n=1)
7.0% (n=2)
4.0% (n=2)
3.0% (n=1)
2.0% (n=1)
10.0% (n=3)
Excellent
Very Good
Good
Fair
Poor
Q2 2016 (Responses: 50)
Q3 2016 (Responses: 30)



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

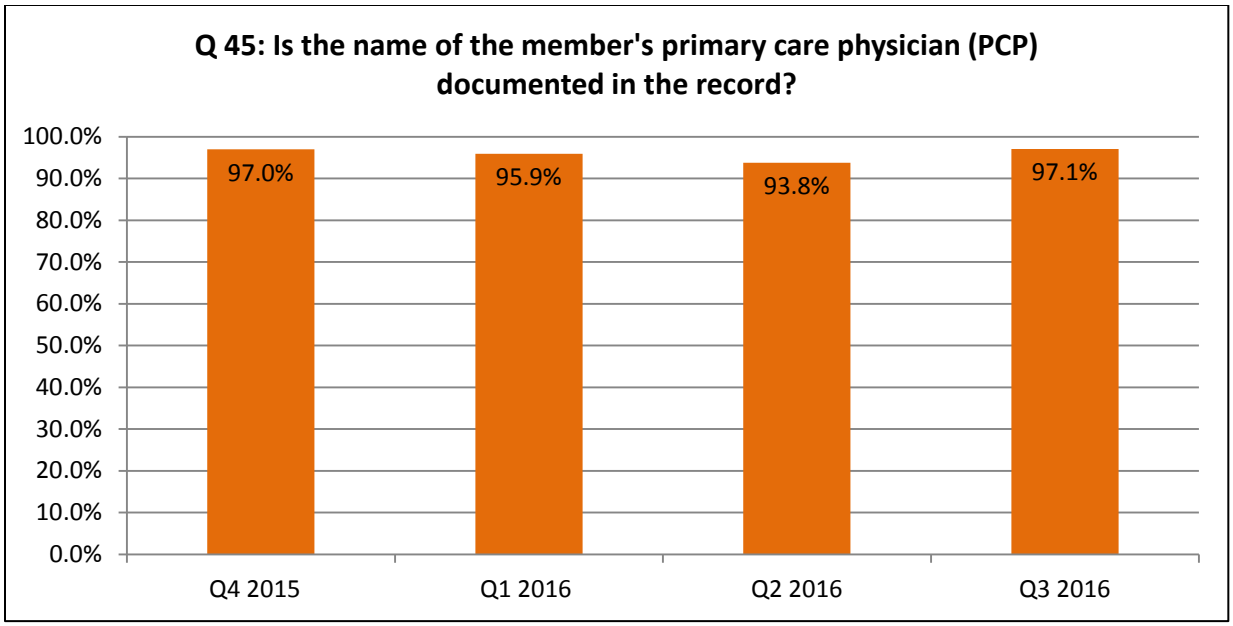
Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expect providers to make a "good faith" effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the member as part of an overall approach to coordinating care.

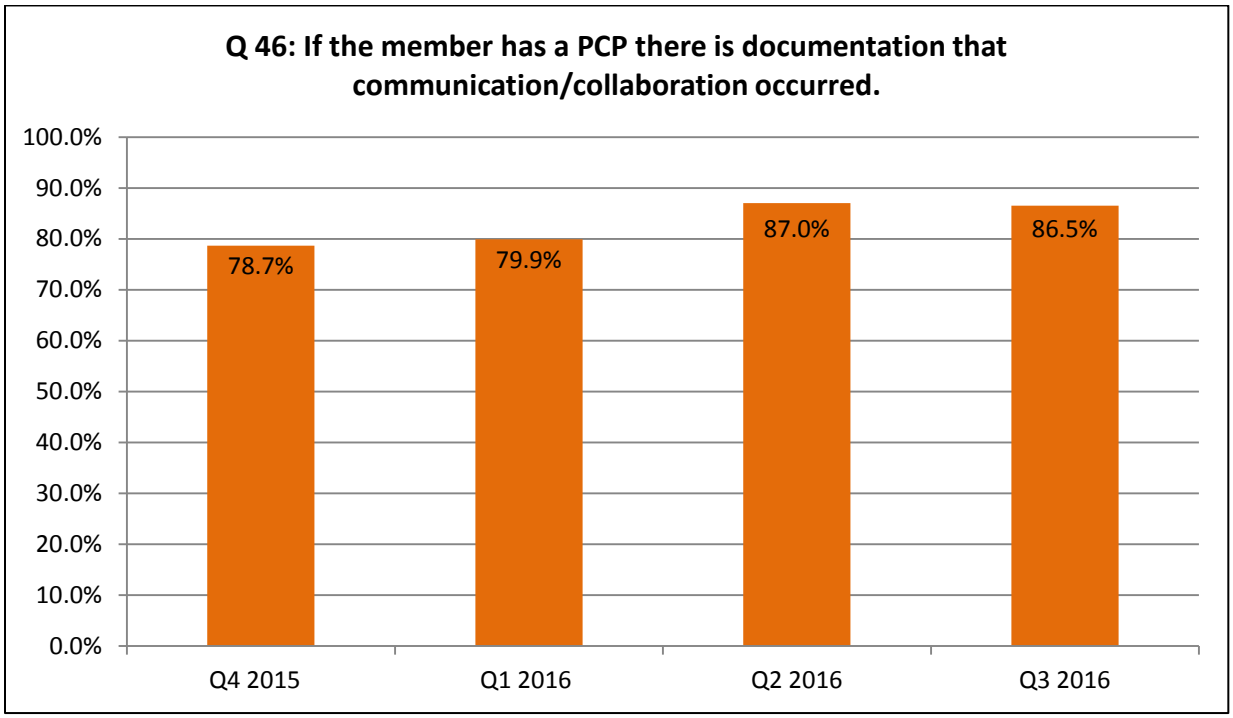
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff. The results are tabulated in an internal Excel spreadsheet.

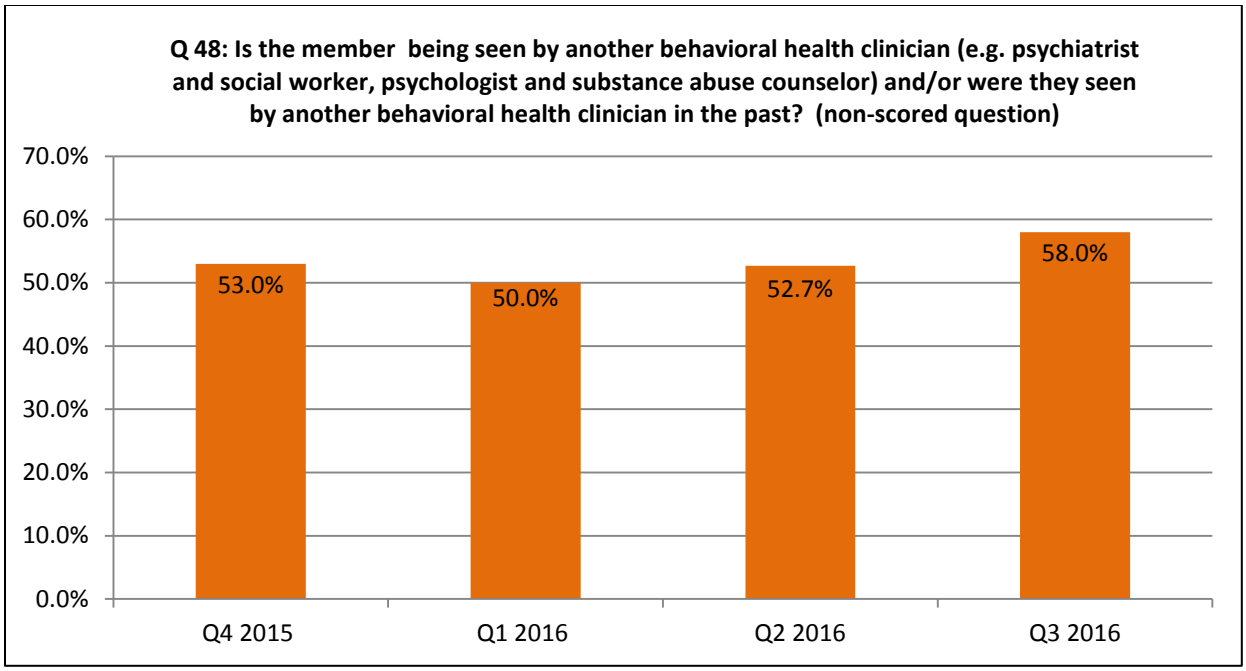
Quarterly Performance Results:

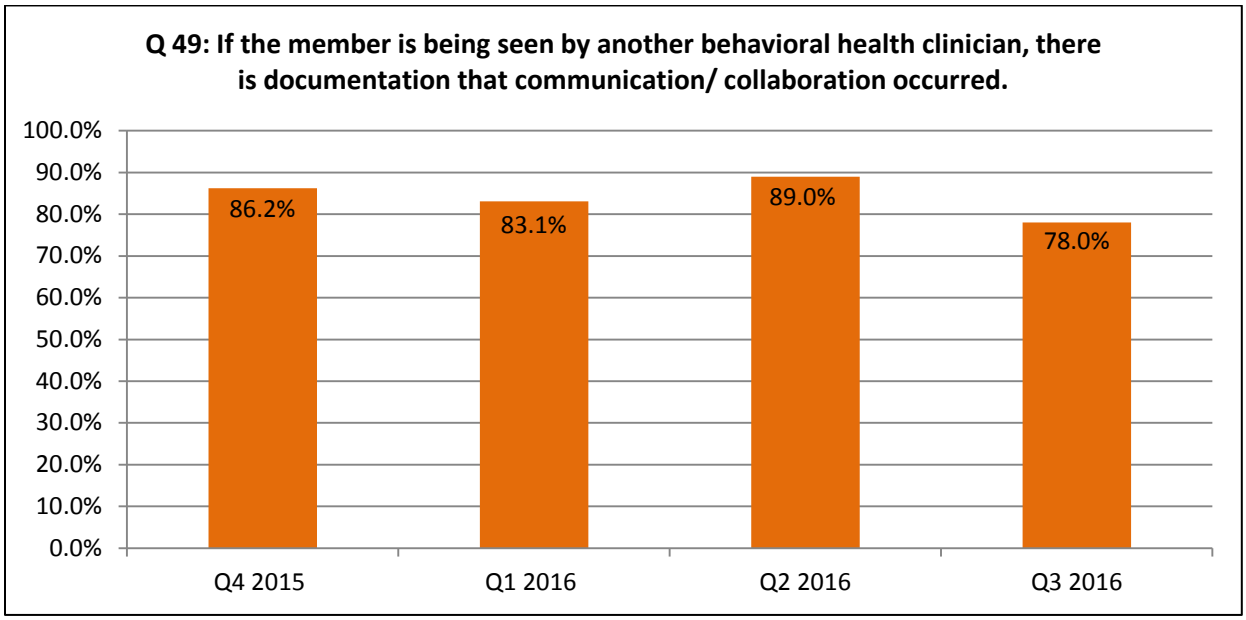
Coordination of Care (% answered in the affirmative)	Performance Goal	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Q45: Is the name of the member's primary care physician (PCP) documented in the record?	NA	97.0%	95.8%	93.8%	97.1%
Q 46: If the Member has a PCP there is documentation that communication/collaboration occurred	NA	78.7%	79.9%	87.0%	86.5%
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	53.0%	50.0%	52.7%	58.0%
Q49 If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred.	NA	86.2%	83.1%	89.0%	78.0%

Analysis: Coordination of Care audits completed during Q3 revealed that 97.1% of member records (134/138) reviewed had documentation of the name of the member's PCP. Of those, 86.5% (116/134) indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. The results also indicated that that 58.0% (80/138) 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, 79.0% (62/80 indicated that communication/collaboration had occurred.


Q 45: Is the name of the member's primary care physician (PCP) documented in the record?
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
97.0%
95.9%
93.8%
97.1%
Q4 2015
Q1 2016
Q2 2016
Q3 2016


Q 46: If the member has a PCP there is documentation that communication/collaboration occurred.
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
78.7%
79.9%
87.0%
86.5%
Q4 2015
Q1 2016
Q2 2016
Q3 2016





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

Provider Disputes

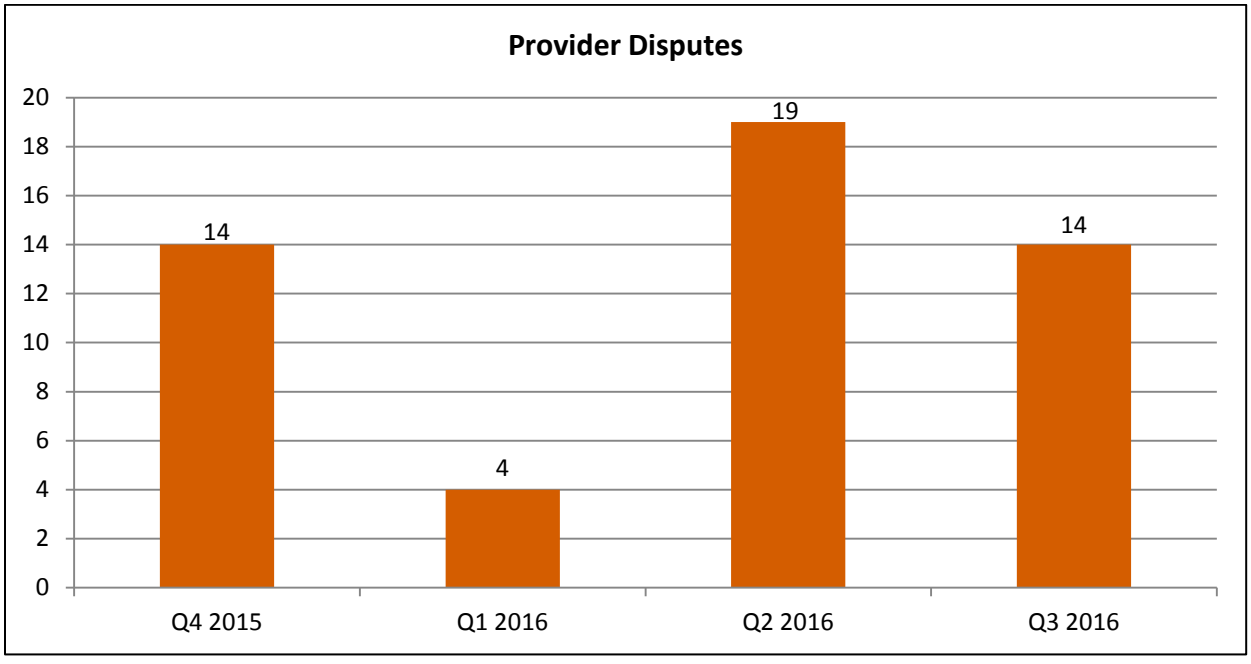
Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination (claims-based denials) when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is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

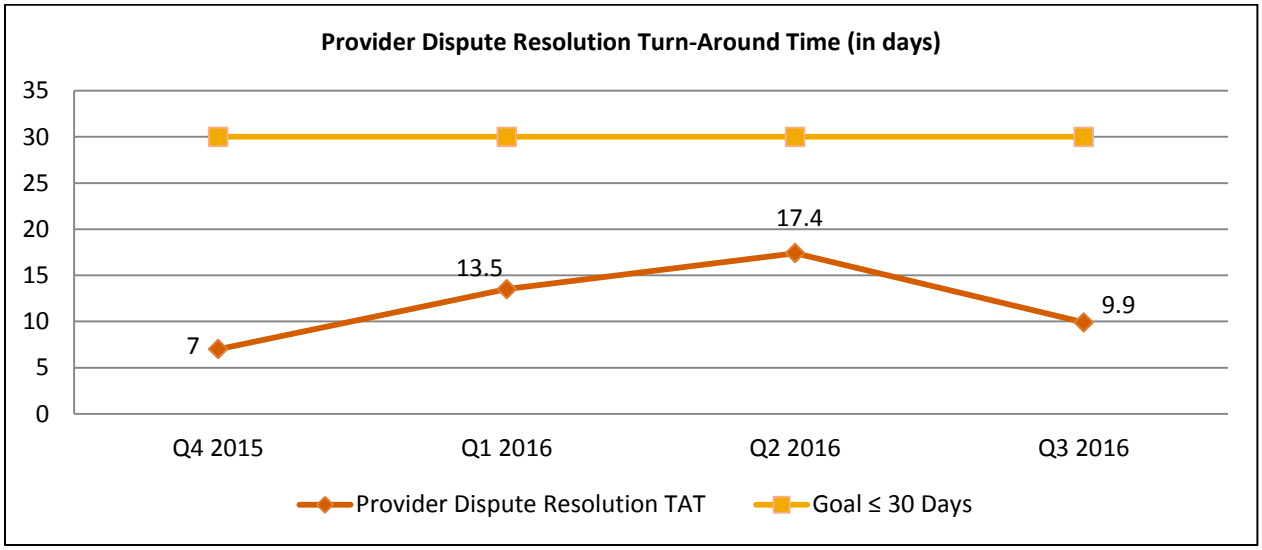
Quarterly Performance Results:

Provider Disputes	Performance Goal	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Number of Provider Disputes	NA	14	4	19	14
Average # of Days Provider Disputes Resolved	≤30 Days	7	13.5*	17.4	9.9
Number of Disputes Overturned	NA	14	4	16	6
% of Disputes Overturned	NA	100.0%	100.0%	84.2%	42.9%

**due to error in reporting, this was changed from 12 to 13.5.*

Analysis: During Q3, there were 14 Provider Disputes. Six (6) disputes were overturned, the rest were upheld. All were resolved within the goal of ≤30 days, with an average resolution time of 9.9 days.





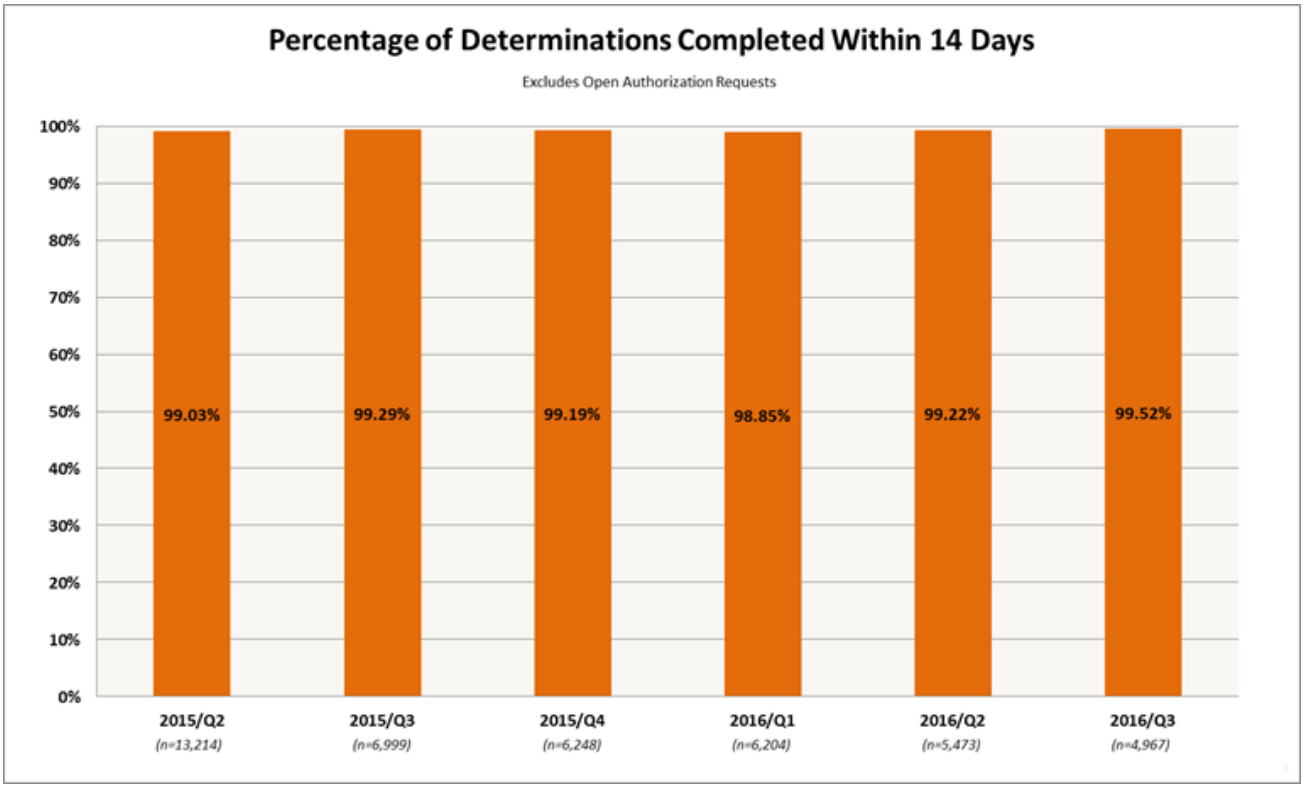
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Utilization Management and Care Coordination

Service Authorization Requests

Methodology: Optum Idaho has formal systems and workflows designed to process pre-service, concurrent and post service requests for benefit coverage of services, for both in-network and out-of- network (OON) providers and agencies. Optum Idaho adheres to a 14-day turnaround time for processing requests for non-urgent pre-service requests.

Service Authorization Requests	Performance Goal	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Number of Service Authorization Requests	NA	6,248	6,204	5,473	4,967
Percent Determinations Completed within 14 days	100.0%	99.2%	98.8%	99.2%	99.5%



Analysis: During Q3, there were 4,967 service authorization requests. Of those, 99.5% of the requests were completed within the 14-day turnaround time.

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

Field Care Coordination

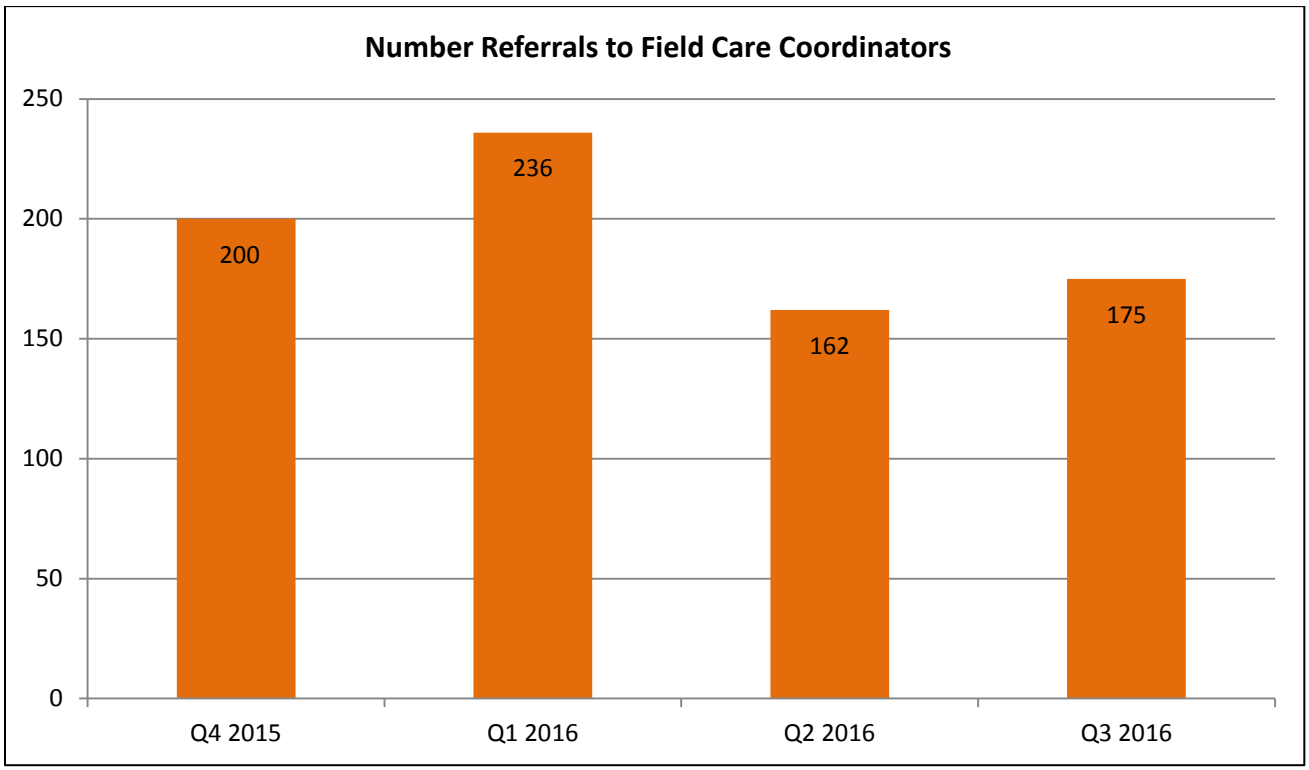
Methodology: The Field Care Coordination (FCC) program includes regionally based clinicians across the state of Idaho. They provide locally based care coordination and discharge planning support. Field Care Coordinators work with the provider to help members. The FCC team focuses on member wellness,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

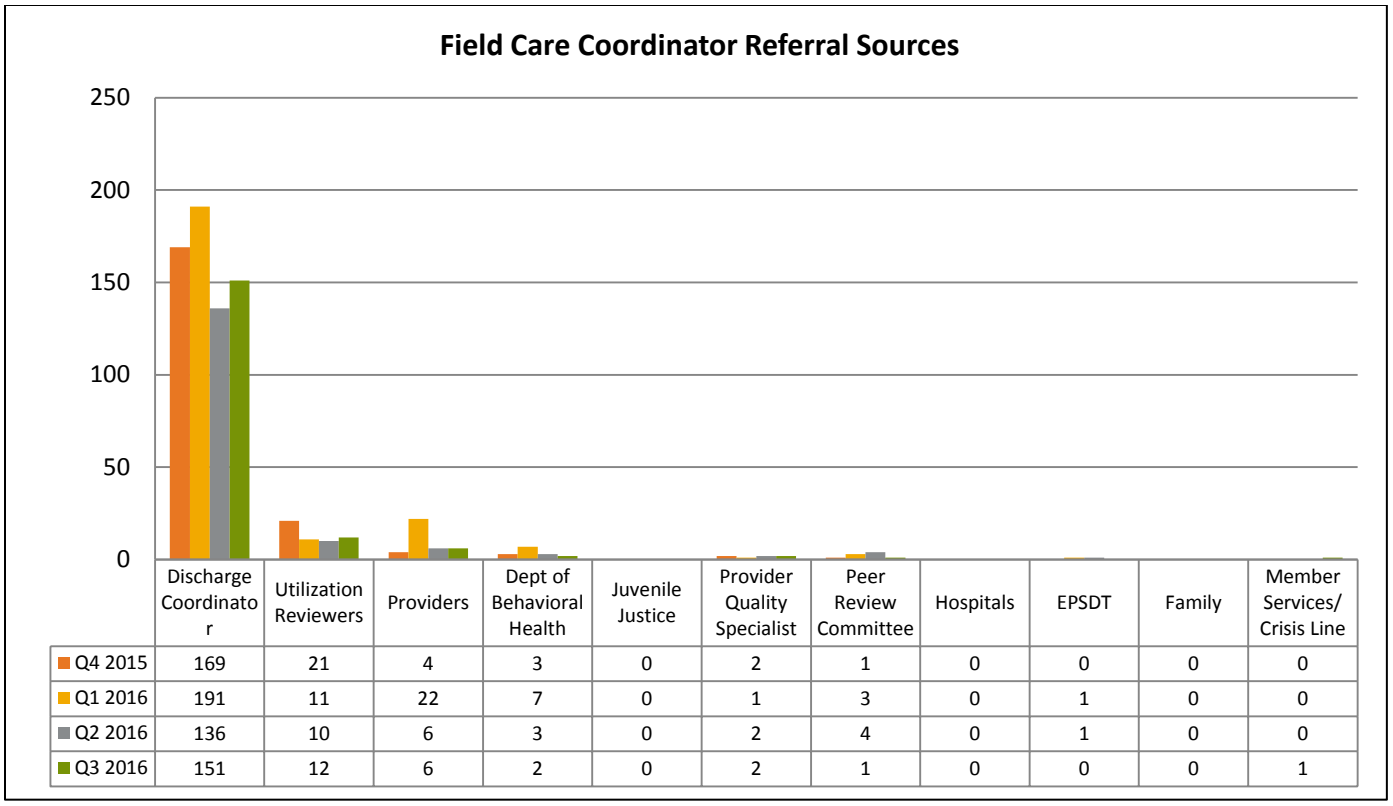
- Focusing on members and member families who are at greatest clinical risk
- Focusing on member's wellness and the member's responsibility for his/her own health and well-being.
- Improved care coordination for members moving between services, especially those being discharged from 24-hour care settings.

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 Q4, 2015 through Q3, 2016.

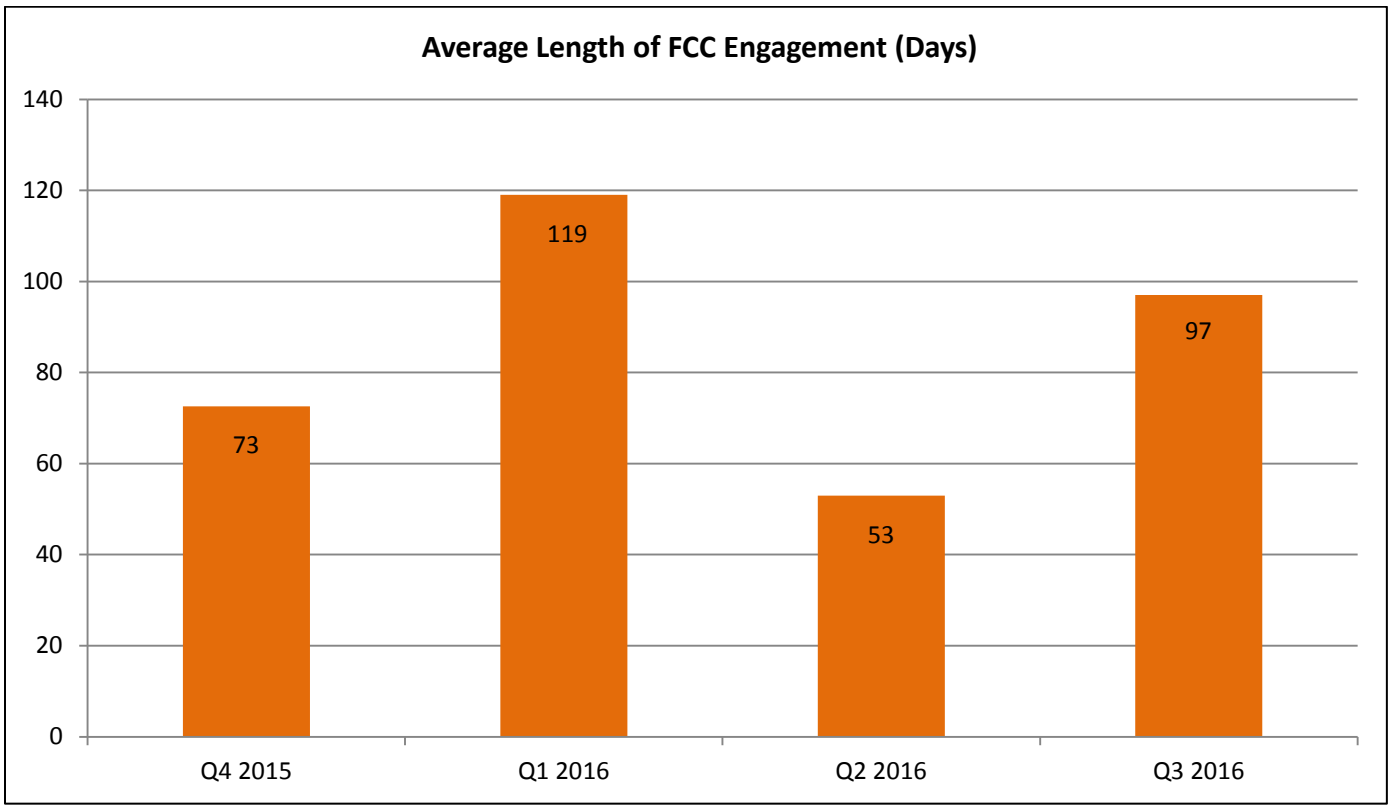
Referral Sources	Q4 2015	Q1 2016	Q2 2016	Q3 2016
Discharge Coordinator	169	191	136	151
Utilization Reviewers	21	11	10	12
Providers	4	22	6	6
Dept of Behavioral Health	3	7	3	2
Juvenile Justice	0	0	0	0
Provider Quality Specialist	2	1	2	2
Peer Review Committee	1	3	4	1
Hospitals	0	0	0	0
EPSDT	0	1	1	0
Family	0	0	0	0
Member Services/Crisis Line	0	0	0	1
Total	200	236	162	175

Analysis: During Q3, Field Care Coordinators received 175 referrals. Of these referrals, 151 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement during Q3 was 97 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
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
Q2 2016	136	10	6	3	0	2	4	0	1	0	0
Q3 2016	151	12	6	2	0	2	1	0	0	0	1

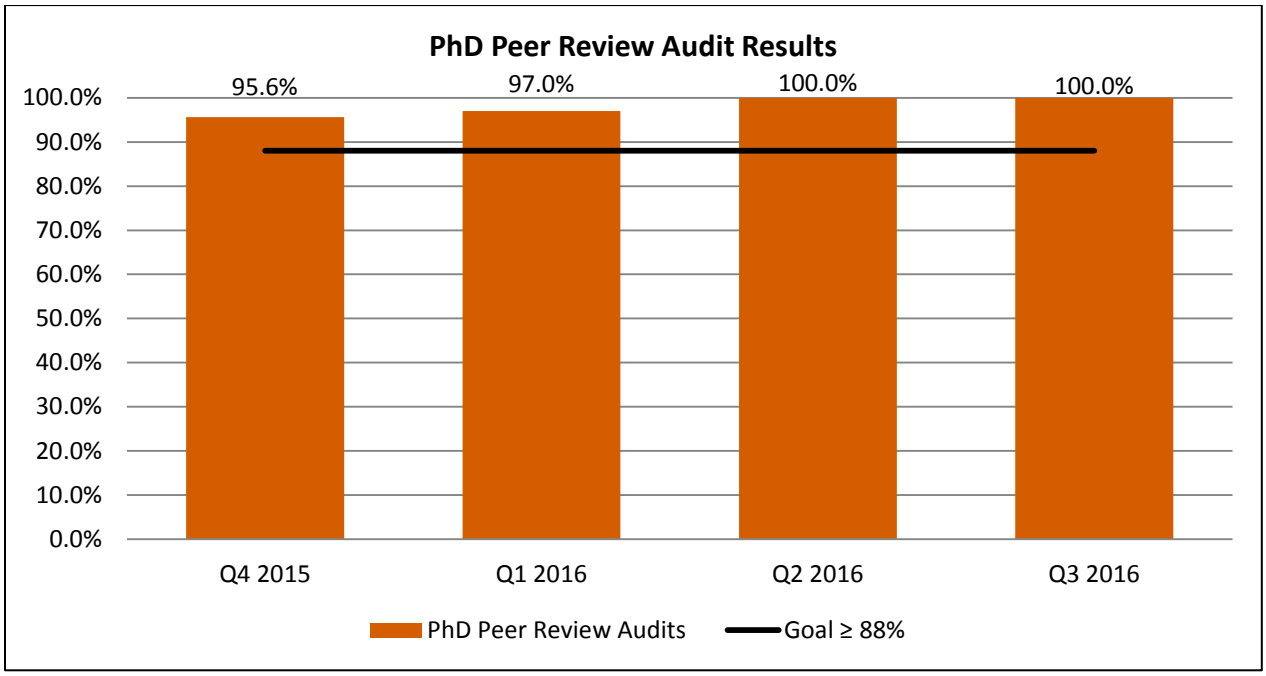


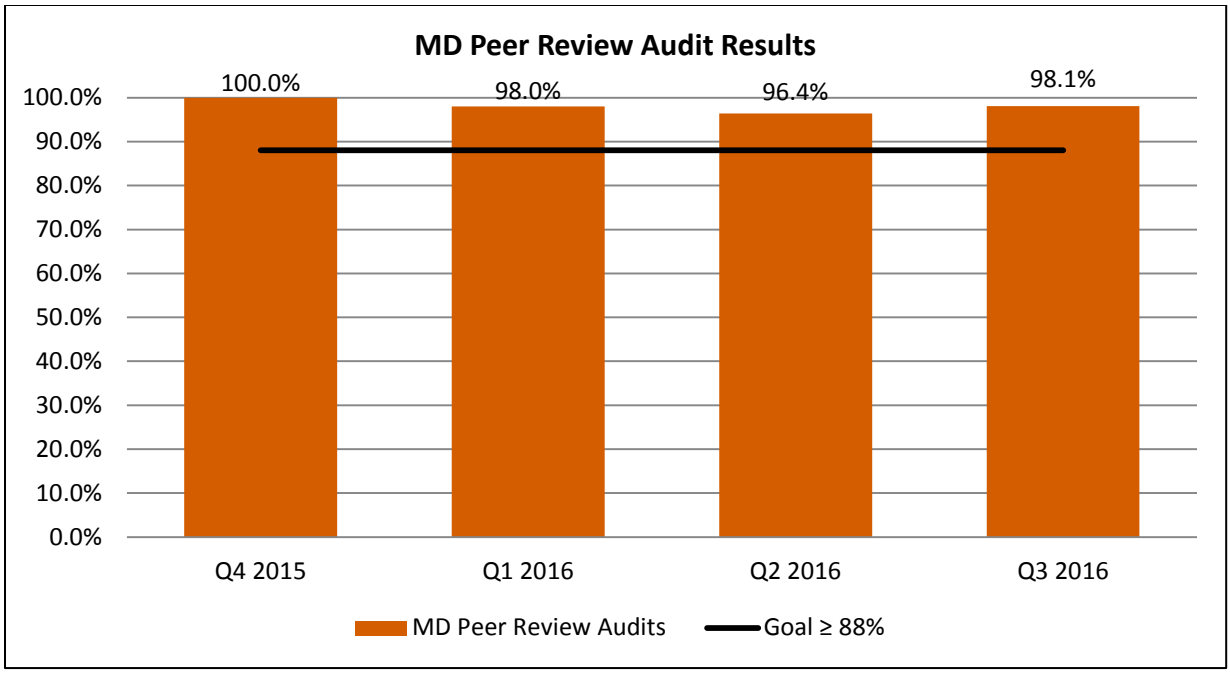
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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 Q3.





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

Inter-Rater Reliability

Optum Idaho evaluates and promotes the consistent application of the Level of Care Guidelines and the Coverage Determination Guidelines by clinical personnel by providing orientation and training, routinely reviewing documentation of clinical transactions in member records, providing ongoing supervision and consultation and administering an annual assessment of inter-rater reliability. The most recent results were included in the Q1 Quarterly report. Inter-rater Reliability testing is completed annually.

Population Analysis

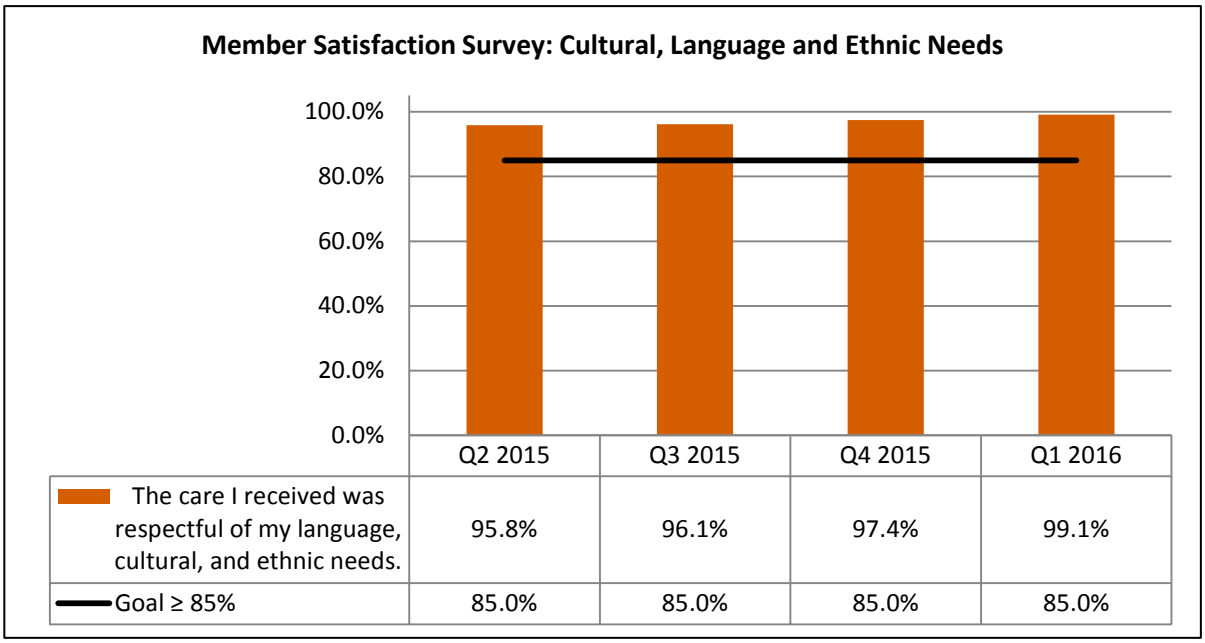
Language and Culture

Methodology: Optum strives to provide culturally competent behavioral health services to its Members. Optum uses U. S. Census results to estimate the ethnic, racial, and cultural distribution of our membership. Below is a table listing the 2015 census results for ethnic, racial and cultural distribution of the Idaho Population. Optum Idaho uses the Member Satisfaction Survey to gage whether the care that the member receives is respectful to their cultural and linguistic needs.

2015* Idaho Census Results for Ethnic, Racial and Cultural Distribution of Population							
Total Population (Estimate)	Hispanic or Latino	White	Black	American Indian & Alaska Native	Asian	Native Hawaiian & Other Pacific Islander	Two or more races
1,634,464	**12.2%**	**93.4%**	**0.8%**	**1.7%**	**1.5%**	**0.2%**	**2.3%**

*most current data available

Analysis: Hispanic or Latino counted for 12.2 % of the Idaho population an increase from 11.2% from the 2010 Census results. This is the second highest population total, with White consisting of 93.4% (an increase from 89.1% from the 2010 Census results). Ethnic and racial backgrounds can overlap which explains for the percentage total > 100%. The Member Satisfaction Survey results show that 99.1% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q1 2016 data is the most recent results available.



	Q2 2015	Q3 2015	Q4 2015	Q1 2016
The care I received was respectful of my language, cultural, and ethnic needs.	95.8%	96.1%	97.4%	99.1%
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)	2
Member Written Communication Formatted to Large Print (Annual Member mailing)	1
Mental Health First Aid (MHFA) Training Materials Translated to Spanish	0
Interpreter Services – Language Service Associates (verbal translations by phone	9

Analysis: During Q3, Optum Idaho responded to 12 requests for language assistance.

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).

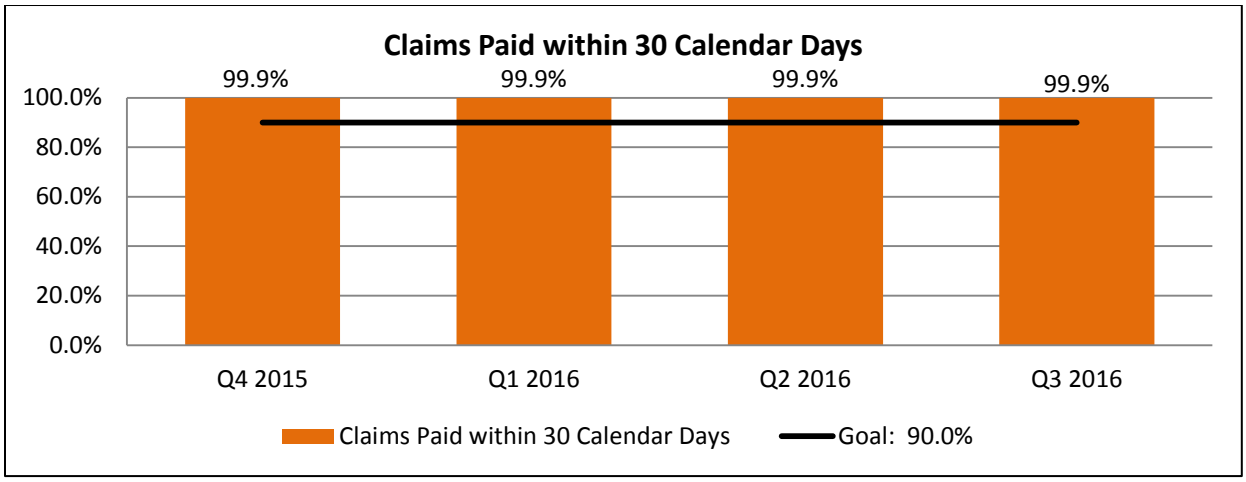
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims

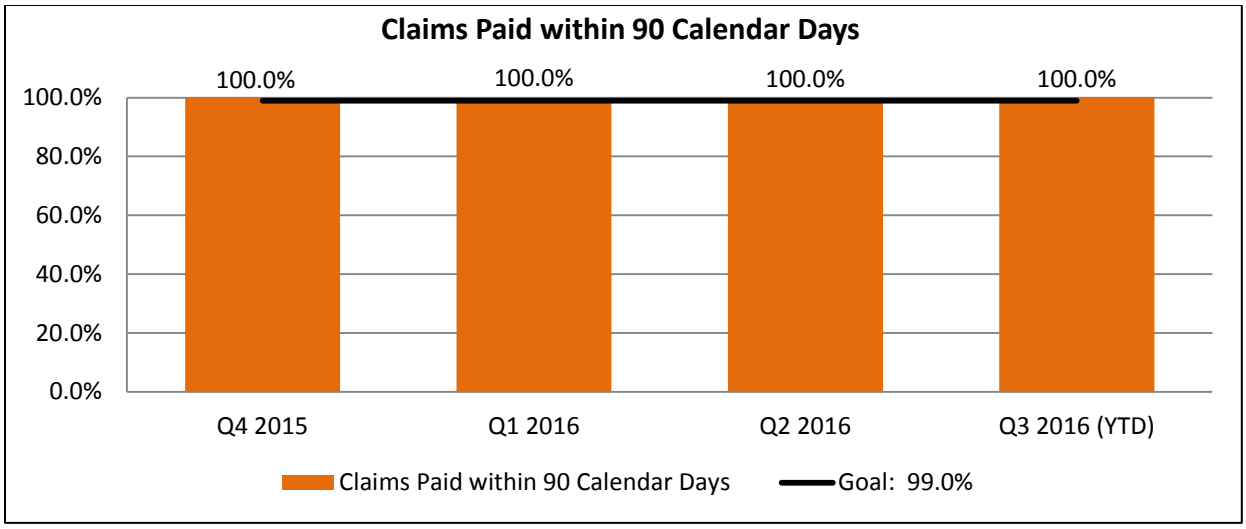
processed without non-financial errors (total number of claims audited minus the number of claims with non-financial errors divided by the total claims audited).

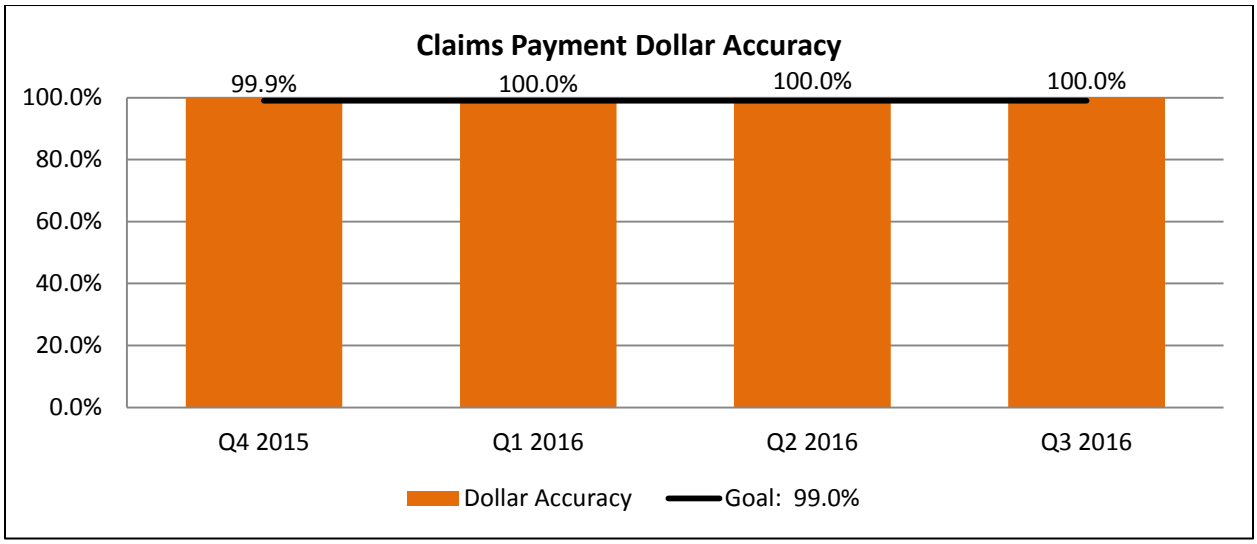
Quarterly Performance Results:

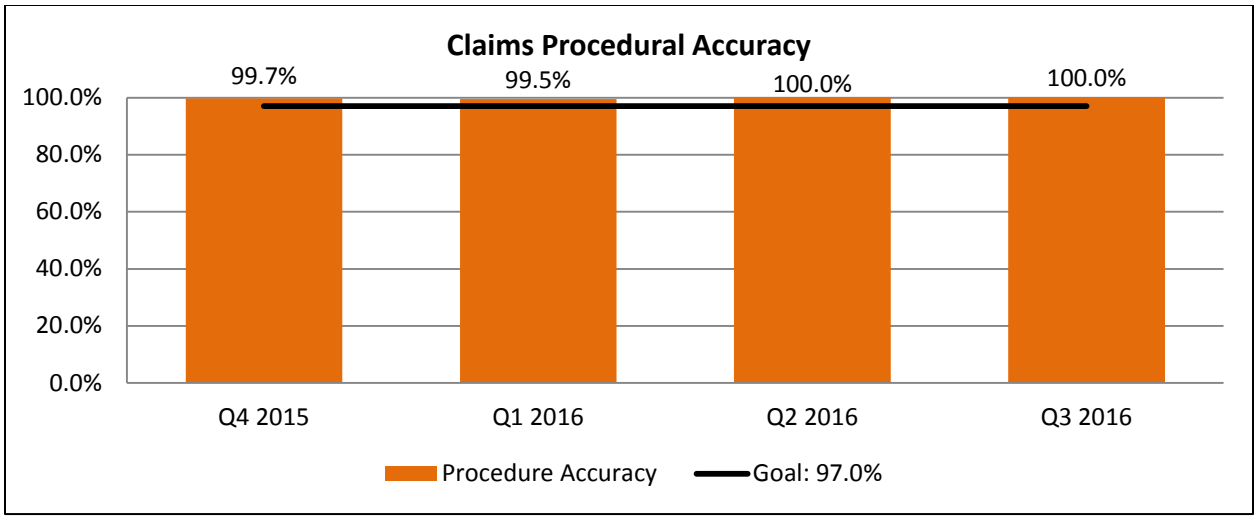
Claims	Performance Goal	Q4 2015	Q1 2016	Q2 2016	Q3 2016 (based on the Sept. OR57 report)
Paid within 30 days	90%	99.9%	99.9%	99.9%	99.9%
Paid within 90 days	99%	100.0%	100.0%	100.0%	100.0%
Dollar Accuracy	99%	99.9%	100.0%	100.0%	100.0%
Procedural Accuracy	97%	99.7%	99.5%	100.0%	100.0%

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




Claims Paid within 90 Calendar Days
100.0%
100.0%
100.0%
100.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Q4 2015
Q1 2016
Q2 2016
Q3 2016 (YTD)
Claims Paid within 90 Calendar Days
Goal: 99.0%


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



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