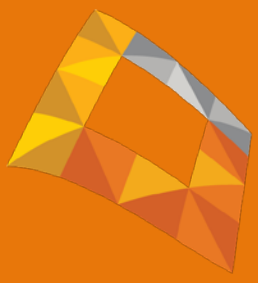
IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT ANNUAL EVALUATION

2017



OPTUM®

The Idaho Behavioral Health Plan (IBHP) Quality Management and Improvement (QMI) 2017 Annual Evaluation summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) for Calendar Year 2017. It provides an overview of outcomes data for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

Table of Contents

Introduction and Overview

This written evaluation of Optum Idaho's Quality Management and Utilization Management (QMUM) Program provides an analysis of the Medicaid outpatient mental health and substance use disorder services managed by the Idaho Behavioral Health Plan (IBHP) in the State of Idaho. The time frame of this evaluation includes activities beginning January 1, 2017 through December 31, 2017 and provides comparative performance from 2014 – 2017.

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

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

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

This mission is actualized in the strategic goals developed by the Optum Idaho Leadership Team and monitored through the *Outcomes Management & Quality Improvement Work Plan* which is a document that is reviewed, revised if necessary, and approved by the Quality Assurance and Performance Improvement (QAPI) Committee each year.

Optum Idaho's comprehensive QMUM program encompasses outcomes, quality assessment, quality management, quality assurance, and performance improvement. The QMUM program is governed by the QAPI committee and includes data driven, focused performance improvement activities designed to meet IDHW and federal requirements. These contractual and regulatory requirements drive Optum's key measures and outcomes for the IBHP.

Optum Idaho's QMUM Program utilizes key measures and outcomes to evaluate and improve the services we provide to IBHP members. The QAPI Committee routinely monitors performance of key measures and outcomes.

Our *Quality Improvement (QI) Plan* document represents our blueprint for utilizing the Plan, Do, Study, Act (PDSA) model for continuous quality improvement (CQI) throughout the entire organization, as well as the provider network and in all our interactions with the community. The *QI Plan* establishes the groundwork that drives improvement for key measures identified in our *Work Plan*. Our 2017 *Work Plan* included the following key measure domains:

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

Measures from the Work Plan are monitored routinely via monthly, quarterly, and annual reports. This Annual Evaluation provides an assessment of the overall effectiveness of the IBHP's programs and services provided. The purpose of this Annual Evaluation is to share with internal and external stakeholders, Optum's performance, outcomes and improvement activities related to services we provide to IBHP members and contracted providers.

2017 Overall Effectiveness and Highlights

The results of Optum Idaho's efforts in 2017 have proven to be positive in achieving the right care, at the right time for our members. Performance targets are based on contractual, regulatory or operational standards.

Based on the overall average for 2017, Optum Idaho met or exceeded performance for 28 (85%) of the 33 total key measures. Four (4) measures fell slightly below the performance goal but were still within 5% of meeting the goal. This high level of operational effectiveness further validates Optum's commitment to IBHP members and families in transforming the behavioral health care system in the State of Idaho.

During 2017, Optum Idaho continued to strive to improve the health of IBHP members through better quality of care and increased access to evidence-based services. In addition to the 33 total performance measures, Optum Idaho provided these opportunities to further increase member access to care:

- Additional community system improvements continued with the launch of the new provider reimbursement for psychotherapy services provided by licensed clinicians in a member's home.
- In partnership with Altarum Institute, a Readiness Assessment was conducted to identify Providers for the first phase of the Intensive Outpatient Program (IOP) implementation. By providing this intermediate level of care, members have an additional option for receiving more intensive therapy to support their individual needs.
- In addition, Optum Idaho continued to focus on collaboration with our partners across the state. During Mental Health Awareness Month (May), the In Touch Community Conversation series included the screening of the documentary, Resilience – The Biology of Stress and the Science of Hope in six locations statewide. The film and panel discussions brought together educators, leaders, counselors, IDHW representatives, providers and students to continue the conversation for maximizing outreach and bringing to light the science behind the effects of toxic stress from a traumatic childhood and the effect it has in adulthood. Additional statewide community outreach activities included face to face discussions, provider trainings, informational media coverage and organized events.
- Optum Idaho partnered with regional peer support specialists in our network on a proactive statewide media outreach campaign to promote the important work these individuals provide as part of the recovery process. Media interviews were conducted in areas where peers were available to speak about their role helping people reach recovery and highlighted specific recovery support programs and services that Optum is helping bring to the communities we serve. Efforts also included the placement of byline articles by local Optum behavioral health experts and a partnership with the Idaho Department of Health and Welfare to create TV and radio Public Service Announcements, in both English and Spanish raising awareness about mental health issues and promoting local recovery support resources. Over 175,000 total impressions through TV, print and radio messages were received across Idaho.
- Additionally, as part of its investment in program and service development, Optum implemented Phase Two of the Intensive Outpatient Program (IOP) during Q4. A partnership with Idaho State University offered two IOP specific trainings to Optum's network in October. Both in-person offerings were well attended and received positive

feedback. An IOP webinar was also created and is posted on Relias, Optum's online learning site that is available to providers across the state.

- Optum's new Education division delivered Youth Empowerment Services (YES) Foundations training in November 2017 providing an overview of the YES project in Idaho including a brief history of YES, and how it will contribute to developing a robust system of care for Idaho's youth and their families. Key topics included YES history, System of Care, Practice Manual, Principles of Care, Access Model, Child and Adolescent Needs and Strengths (CANS), Person Centered Planning, Practice Model, Child and Family Team (CFT), and Wraparound.
- As part of the Youth Empowerment Services (YES) program, Optum contracted with 15 agencies to provide respite to Medicaid-eligible YES Class Members, starting January 2018 which is the first service to be offered under the YES program. Critical to the successful implementation of all YES services, Optum will have an increased focus on Education and Training development with its first YES service training being held for respite workers via a web-based training in April 2018. All respite workers will be required to complete this training to be in-network Respite providers with Optum.
- A statewide information distribution network was also developed which is comprised of community partners and stakeholders. Working with the Idaho Food Bank and libraries across the state, Optum distributed 3,500 flyers with information and tips on handling holiday stress. The material was included in food boxes and shared at library information desks. Optum looks to expand the information distribution network in 2018.
- Optum's community engagement efforts also included media relations activities in Q4 which resulted in more than 620,000 impressions of behavioral health awareness messages. The subjects of the coverage ranged from Substance Use Prevention and Recovery Month activities to Optum's holiday giving activity across the state.
- Optum Idaho continued to maintain its high level of community and stakeholder engagement throughout the year. In Q4, Optum's state and regional staff participated in 72 activities focused on strengthening relationships with stakeholders and community members, educating providers and the public, reaching underserved populations with information about Optum services, and supporting those in need during the Holiday Season.
- The year was completed with generosity, good cheer and community involvement. From Idaho Falls to Twin Falls and Boise to Coeur d' Alene, staff engaged providers, supported crisis and recovery centers, participated in 7Cares Idaho Shares, donated food, and worked tirelessly to support those in need. A provider giving challenge collected donations for Idaho's Crisis Centers and Optum matched those donations up to $3,000 per Crisis Center. Regions 1 & 2 expanded this effort to include recovery centers. Finally, for the fourth year, Optum participated in 7Cares Idaho Shares as a Company that Cares. Donations in Boise and Twin Falls supported ten local charities including the Idaho Food Bank and Salvation Army.

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

Quality Performance Measures and Outcomes

Below is a grid used to track the Quality Performance Measures and Outcomes. It identifies the performance goal for each measure along with yearly outcomes from 2014 - 2017. Those highlighted in green met or exceeded overall performance. Those highlighted in yellow fell within 5% of the performance goal. Those highlighted in red fell below the performance goal.

Measure	Goal	2014 Overall Performance	2015 Overall Performance	2016 Overall Performance	2017 Overall Performance	Comments
Member Satisfaction Survey Results						
Experience with Optum Idaho Staff and Referral Process	≥85.0%	**84.2%**	**85.0%**	**91.6%**	**NA**	New Survey Implemented, results below
Experience with the Behavioral Health Provider Network	≥85.0%	**90.9%**	**91.1%**	**93.6%**	**NA**	New Survey Implemented, results below
Experience with Counseling or Treatment	≥85.0%	**92.9%**	**94.0%**	**94.8%**	**NA**	New Survey Implemented, results below
Overall Experience	≥85.0%	**90.2%**	**92.0%**	**93.8%**	**NA**	New Survey Implemented, results below
NEW (2017) Member Satisfaction Survey Results						
Optum Support for Obtaining Referrals or Authorizations	≥85.0%				**80.0%**	
Counseling and Treatment	≥85.0%				**95.0%**	
Accessibility, Availability, and Acceptability of the Clinician Network	≥85.0%				**89.0%**	
Overall Satisfaction	≥85.0%				**80.3%**	
Provider Satisfaction Survey Results						
Overall Provider Satisfaction	≥85.0%	**69.3%**	**64.5%**	**75.0%**	**77.0%**	Additional information regarding performance improvement efforts are located in this report.
Accessibility & Availability						
Idaho Behavioral Healthplan Membership						
Membership Numbers	NA	**314,538**	**330,474**	**336,394**	**342,357**	2014 - 2016 numbers were reported in error. They have been revised.
Member Services Call Standards						
Total Number of Calls	NA	**6,483**	**4,838**	**5,153**	**5,292**	
Percent Answered within 30 seconds	≥80.0%	**91.4%**	**91.0%**	**87.8%**	**84.1%**	
Average Speed of Answer (seconds)	≤30 Seconds	**13.0**	**12.6**	**14.9**	**9.5**	
Abandonment Rate	≤3.5% internal ≤7.0% contractual	**1.5%**	**1.9%**	**2.2%**	**2.3%**	

Measure	Goal	2014 Overall Performance	2015 Overall Performance	2016 Overall Performance	2017 Overall Performance	Comments
Customer Service (Provider Calls) Standards						
Total Number of Calls	NA	**16,323**	**14,205**	**12,220**	**13,016**	
Percent Answered within 30 seconds	≥80.0%	**84.0%**	**97.0%**	**97.0%**	**98.3%**	
Average Speed of Answer (seconds)	≤30 Seconds	**NA***	**5.5**	**1.3**	**3.3**	*began tracking in 2015
Abandonment Rate	≤3.5% internal ≤7.0% contractual	**2.9%**	**0.62%**	**0.29%**	**0.40%**	
Urgent and Non-Urgent Access Standards						
Urgent Appointment Wait Time (hours)	48 hours	**18.5**	**22.8**	**24.2**	**23.1**	
Non-Urgent Appointment Wait Time (days)	10 days	**3.8**	**4.7**	**6**	**6**	
Geographic Availability of Providers						
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100.0%	**99.9%***	**99.8%***	**99.8%***	**99.9%***	*performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)
Area 2 - requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	100.0%	**99.8%***	**99.9%***	**99.8%***	**99.8%***	*performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)
Member Protections and Safety						
Notification of Adverse Benefit Determinations						
Number of Adverse Benefit Determinations	NA	**2,266**	**2,038**	**2,139**	**2,164**	
Clinical ABD's	NA	**NA**	**NA**	**NA**	**930**	began tracking Q3, 2017
Administrative ABD's	NA	**NA**	**NA**	**NA**	**318**	began tracking Q3, 2017
Written Notification	14 calendar days from request for services	**NA**	**NA**	**NA**	**99.9%***	14 business days from request for services - implemented 7/1/17 *performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number)
Written Notification Sent within 1 Business Day	100.0%	**77.3%**	**98.4%**	**97.0%**	**NA**	New 14-day requirement tracked above
Member Appeals (formerly grievances)						
Number of Appeals	NA	**278**	**92**	**73**	**113**	
Member Appeals Turnaround time	≤30 days	**9.8**	**11.5**	**15.5**	**7.9**	
Complaint Resolution and Tracking						
Total Number of Complaints	NA	**569**	**133**	61	63	
Percent of Complaints Acknowleged within Turnaround time	100% within 5 days	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Number of Quality of Service Complaints	NA	**560**	**122**	55	56	
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	**100.0%**	**99.3%**	**100.0%**	**96.4%**	
Number of Quality of Care Complaints	NA	**9**	**11**	6	7	
Percent Quality of Care Resolved within Turnaround time	100% within ≤30 days	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Critical Incidents						
Number of Critical Incidents Received	NA	**60**	**66**	67	61	
Percent Ad Hoc Reviews Completed within 5 business days from notification of incident	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	

Measure	Goal	2014 Overall Performance	2015 Overall Performance	2016 Overall Performance	2017 Overall Performance	Comments
Response to Written Inquiries						
Percent Acknowledged ≤2 business days	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	
Provider Monitoring and Relations						
Provider Quality Monitoring						
Number of Audits	NA	**210**	**287**	**368**	**519**	
Initial Audit (Percent overall score)	≥ 85.0%	**92.0%**	**97.0%**	**96.0%**	**94.0%**	
Recredentialing Audit (Percent overall score)	≥ 85.0%	**96.0%**	**97.0%**	**94.0%**	**92.0%**	
Monitoring (Percent overall score)	≥ 85.0%	**89.4%**	**90.1%**	**76.0%***	**94.4%**	*Only 9 monitoring audits were conducted in 2016, one of which scored at 58.3%, significantly impacting the overall score. All other audits met the performance goal.
Quality (Percent overall score)	≥ 85.0%	**86.0%**	**94.0%**	**95.4%**	**85.0%**	
Percent of Audits that Required a Corrective Action Plan	NA	**18.7%**	**17.8%**	**9.5%**	**11.0%**	
Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)						
Percent PCP is documented in member record	NA	**90.6%**	**93.0%**	**94.7%**	**95.7%**	
Percent documentation in member record that communication/ collaboration occurred betweem behavioral health provider and primary care provider	NA	**83.4%**	**80.3%**	**85.1%**	**78.0%**	
Provider Disputes						
Number of Provider Disputes	NA	**156**	**57**	**52**	**88**	
Average Number of Days to Resolve Provider Disputes	≤30 days	**11.2**	**8.3**	**13.4**	**7.2**	
Utilization Management and Care Coordination						
Service Authorization Requests						
Percentage Determination Completed within 14 days	100%	**No data available**	**98.8%**	**99.1%**	**99.2%**	
Field Care Coordination						
Total Referrals to FCCs	NA	**NA***	**774**	**722**	**800**	*began tracking in 2015
Average Number of Days Case Open to FCC	NA	**NA***	**63.2**	**79.0**	**48.0**	*began tracking in 2015
Peer-Review Audits						
PhD Peer Review Audit Results	≥ 88.0%	**91.0%**	**97.1%**	**99.9%**	**NA**	During 2017, there were no PhD denial decisions that required a Peer Review Audit.
MD Peer Review Audit Results	≥ 88.0%	**91.7%**	**99.5%**	**98.0%**	**98.3%**	
Inter-Rater Reliability						
Inter-Rater Reliabililty Testing	NA	**NA**	**NA**	**93.8%**	**62.2%**	

Measure	Goal	2014 Overall Performance	2015 Overall Performance	2016 Overall Performance	2017 Overall Performance	Comments
Claims						
Claims Paid within 30 Calendar Days	90.0%	**99.7%**	**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%	**99.8%**	**99.9%**	**99.9%**	**99.7%**	
Procedural Accuracy	97.0%	**100.0%**	**99.7%**	**99.9%**	**99.8%**	
KEY:		**met goal**	**within 5% of goal**	**did not meet goal**		

Outcomes Analysis

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

ALERT Outcomes

Methodology: Optum's proprietary Algorithms for Effective Reporting and Treatment (ALERT®) outpatient management program quantifiably measures the effectiveness of services provided to individual patients, to identify potential clinical risk and "alert" practitioners to that risk, track utilization patterns for psychotherapeutic services, and measure improvement of Member well-being. ALERT Online is an interactive dashboard that is available to network providers.

Information from the Idaho Standardized Assessments completed by the provider's patients is available in ALERT Online both as a provider group summary and also individual Member detail. The Idaho Standardized Assessment is a key component of the Idaho ALERT program and for that reason providers are required to ask Members to complete the Assessment at the initiation of treatment and to monitor treatment progress whenever the provider requests authorization to continue treatment.

Wellness Assessments

Methodology: An important part assessment when engaging in population health is to monitor the severity of symptoms and functional problems among those being treated. One concept for understanding population health as an outcome is to monitor whether utilizers as a group are getting healthier or sicker.

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

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

ADULT global distress scores are described as follows:

Total Score	Severity Level	Description
0-11	Low	Low level of distress (*below clinical cut-off score of 12*).
12-24	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
25-38	Severe	Approximately one in four clients has scores in this elevated range of distress.
39+	Very Severe	This level represents extremely high distress. Only 2% of clients typically present with scores in this range.

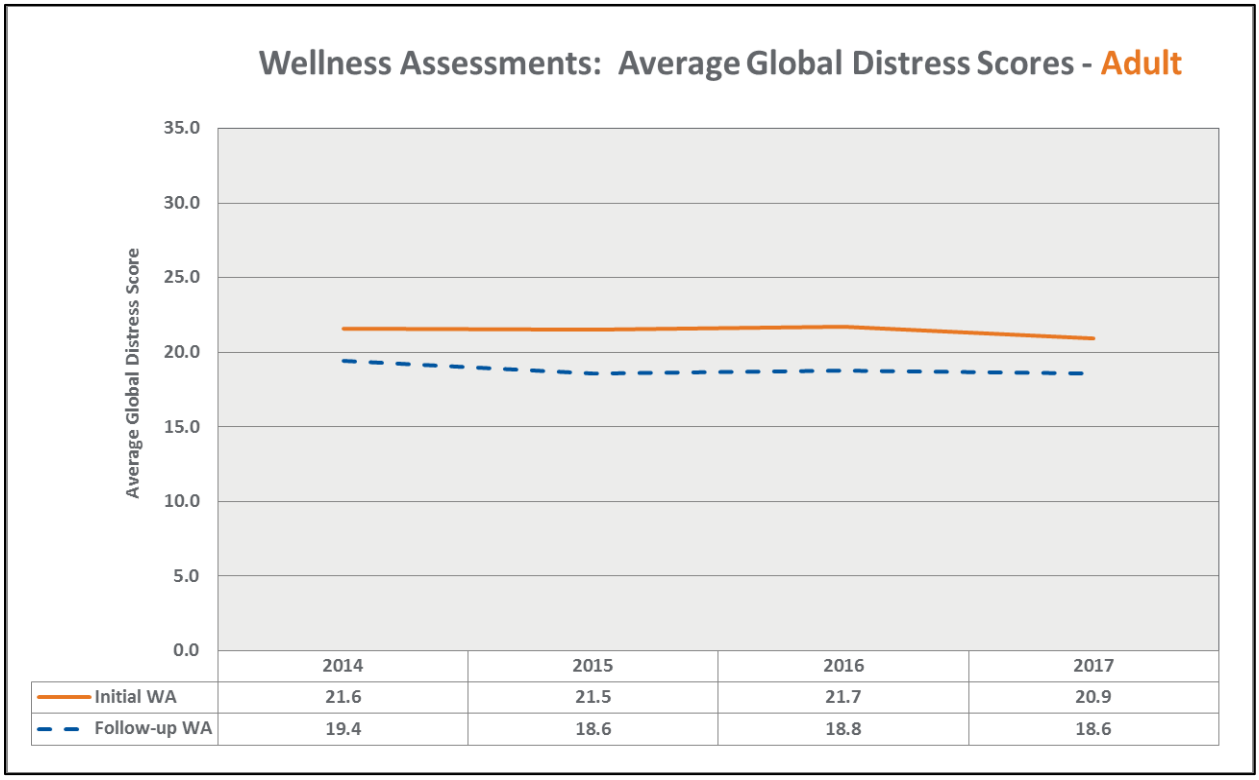


Figure 1: Adult initial and follow-up assessments display a consistently flat trend curve across the four years from 2014 to 2017.

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.

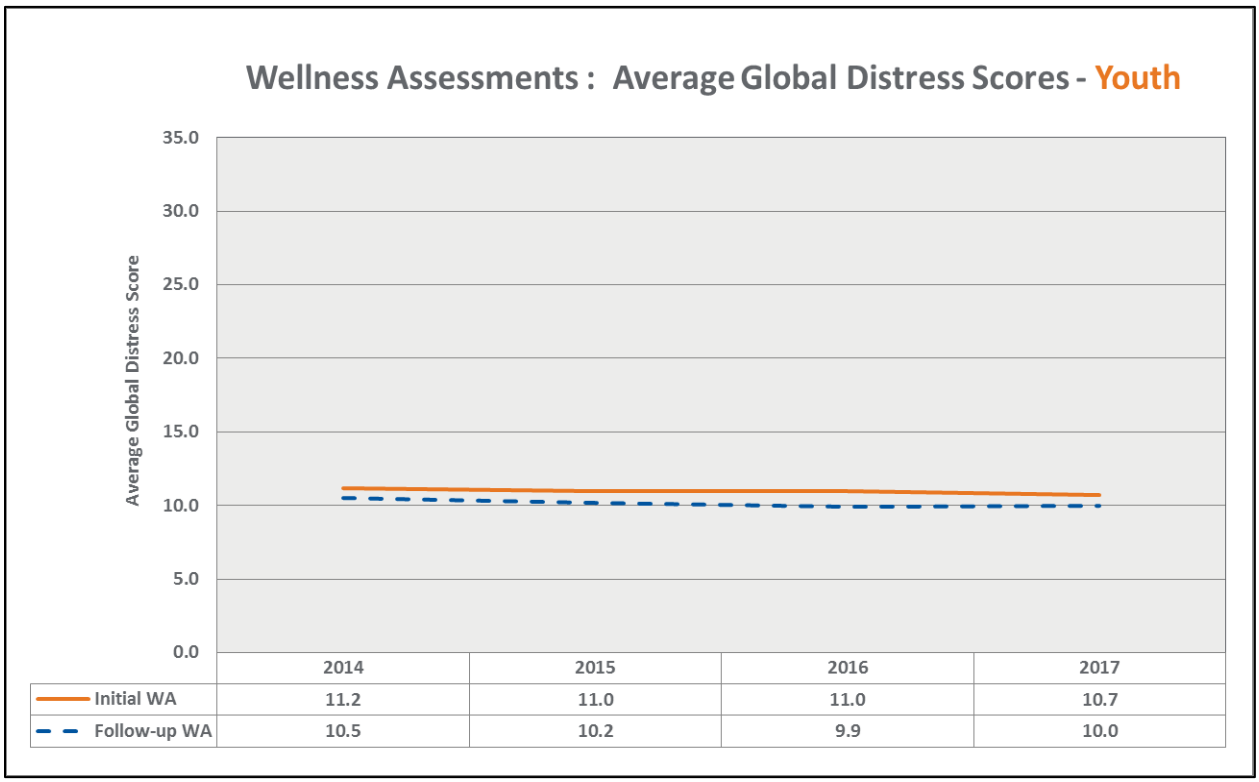


Figure 2: Youth initial and follow-up assessments display a consistently flat trend curve across the four years from 2014 to 2017.

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.

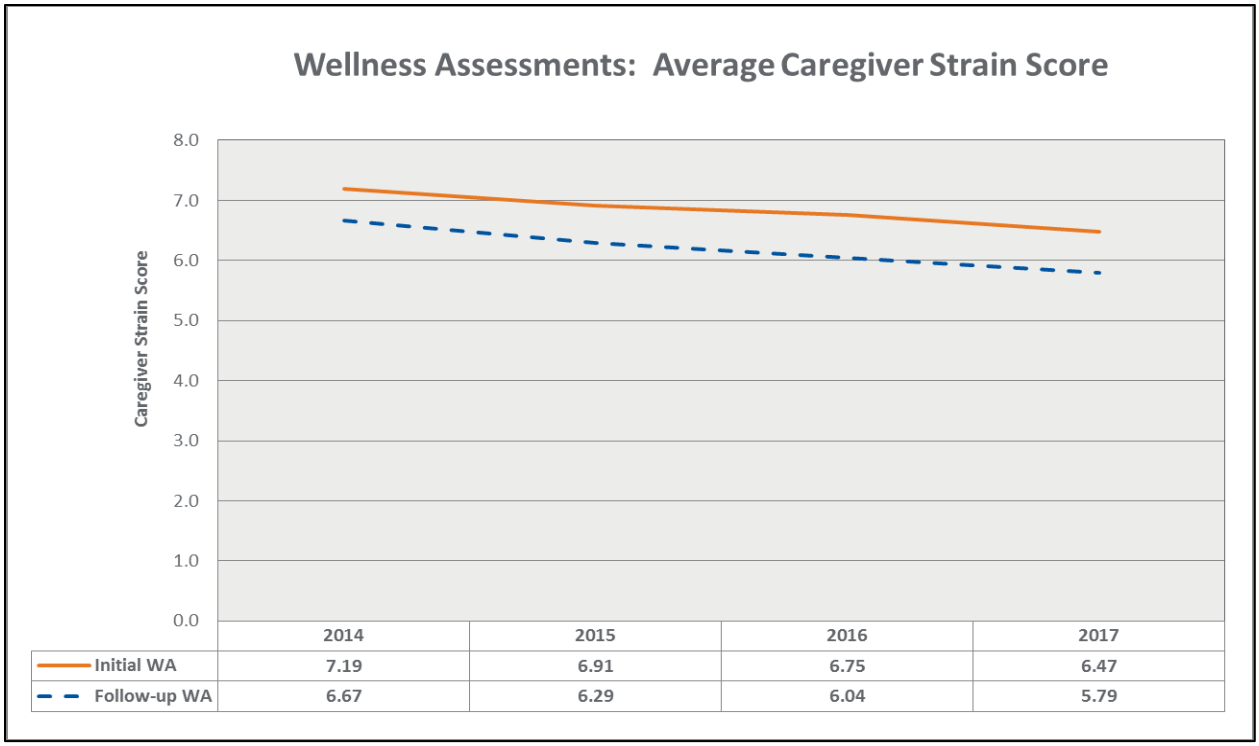


Figure 3: For children and youth, average initial Caregiver Strain scores have improved over the four year study period, improving 10% from 2014 to 2017. When follow-up scores in the population are reviewed, these have had the same improvement trend as the initial assessments. Overall severity levels have remained at the lower end of the moderate range.

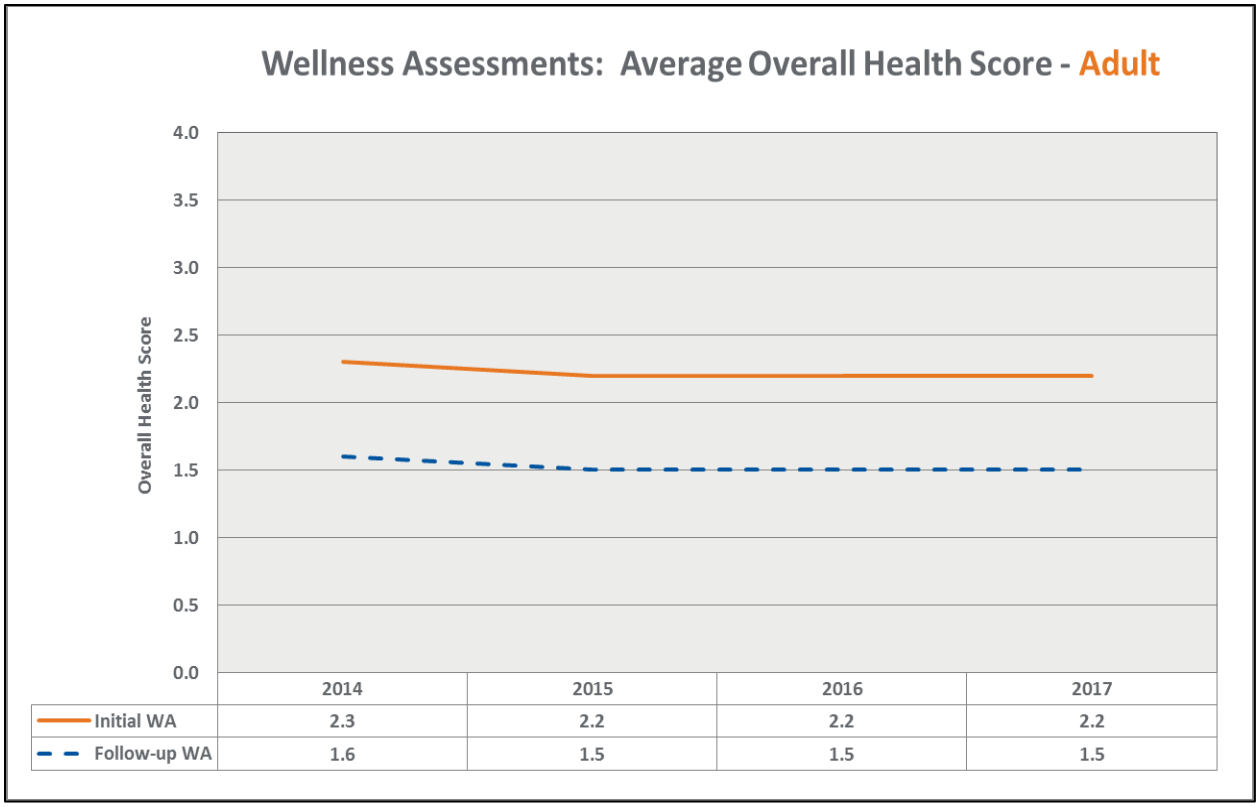


Figure 4: Adult Physical Health score values are as follows:

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

Overall physical health status is an important predictor of risk. Persons with coexisting physical health issues and behavioral health problems tend to do worse. From 2015 through 2017, 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 of "good." These lower scores for the population remained in the same approximate range throughout the study period.

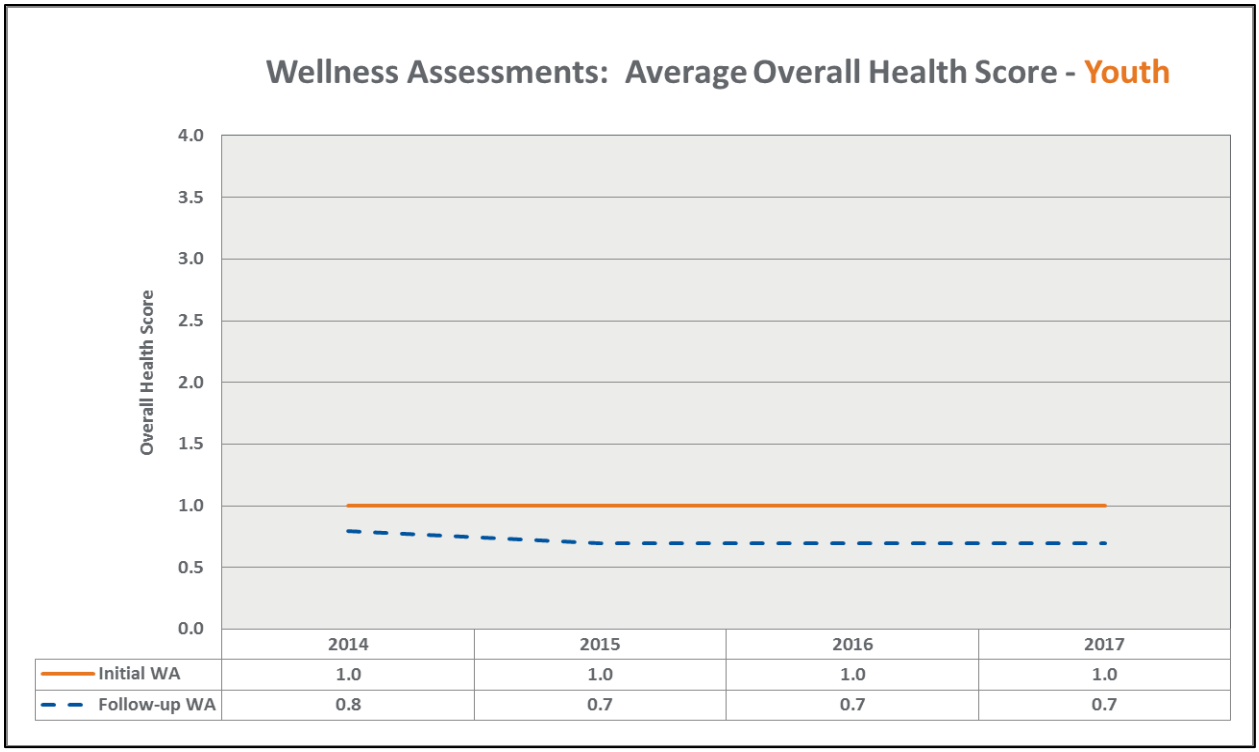


Figure 5: Child and Youth Physical Health score values are as follows:

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

From 2014 to 2017, 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 improved scores in the range between "very good" and "excellent." These lower scores for the population remained in the same approximate range throughout the study period.

Individual Therapy Utilization Rates

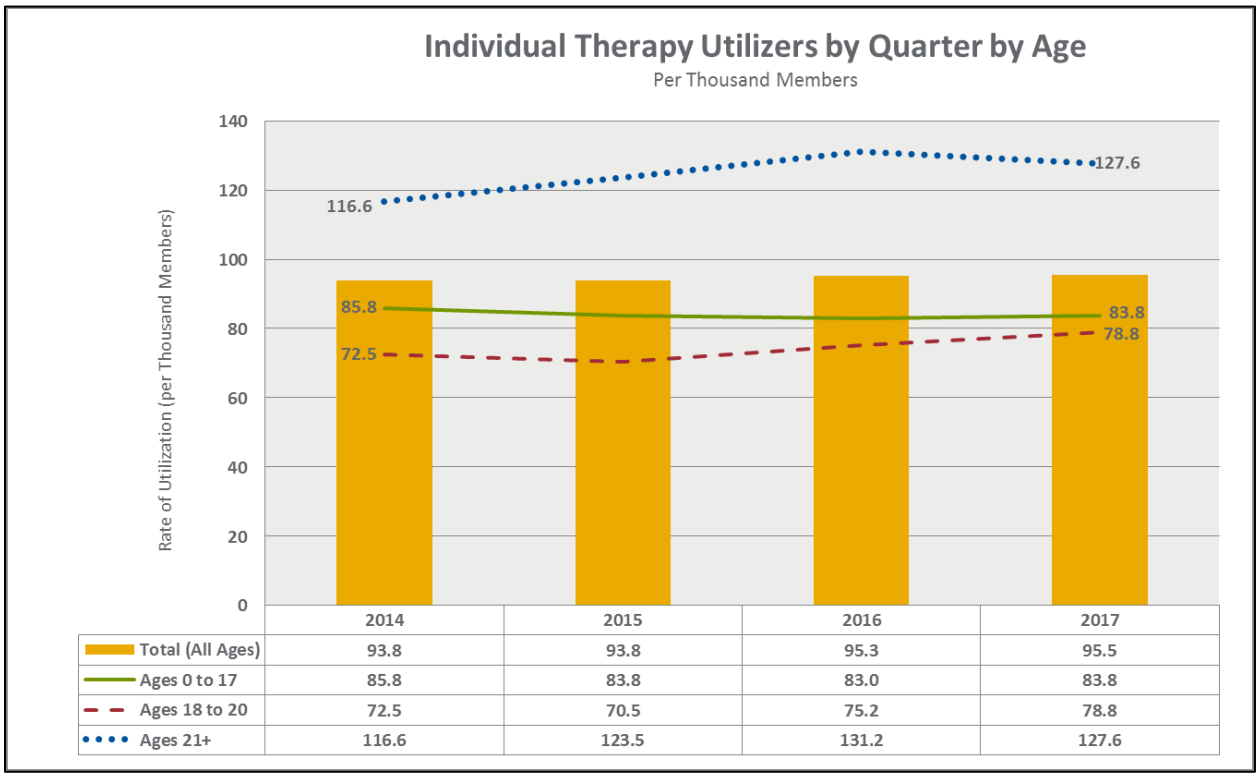
Methodology: Utilization rates are based on claims data. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.

The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of Individual and Extended Therapy visits for a specific year.
Denominator is the total number of IBHP members for the same year, in thousands.

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

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

Examination of the data for the age groups 0-17 years, 18-20 years, and 21+ years, shows a predominance of utilizers of Individual Therapy in the adult group and fewer for children and transitioning youth. Overall utilization of Individual Therapies increased 2% between 2014 and 2017.



	2014	2015	2016	2017
Total (All Ages)	93.8	93.8	95.3	95.5
Ages 0 to 17	85.8	83.8	83.0	83.8
Ages 18 to 20	72.5	70.5	75.2	78.8
Ages 21+	116.6	123.5	131.2	127.6

Figure 6

Barriers: No identified barriers

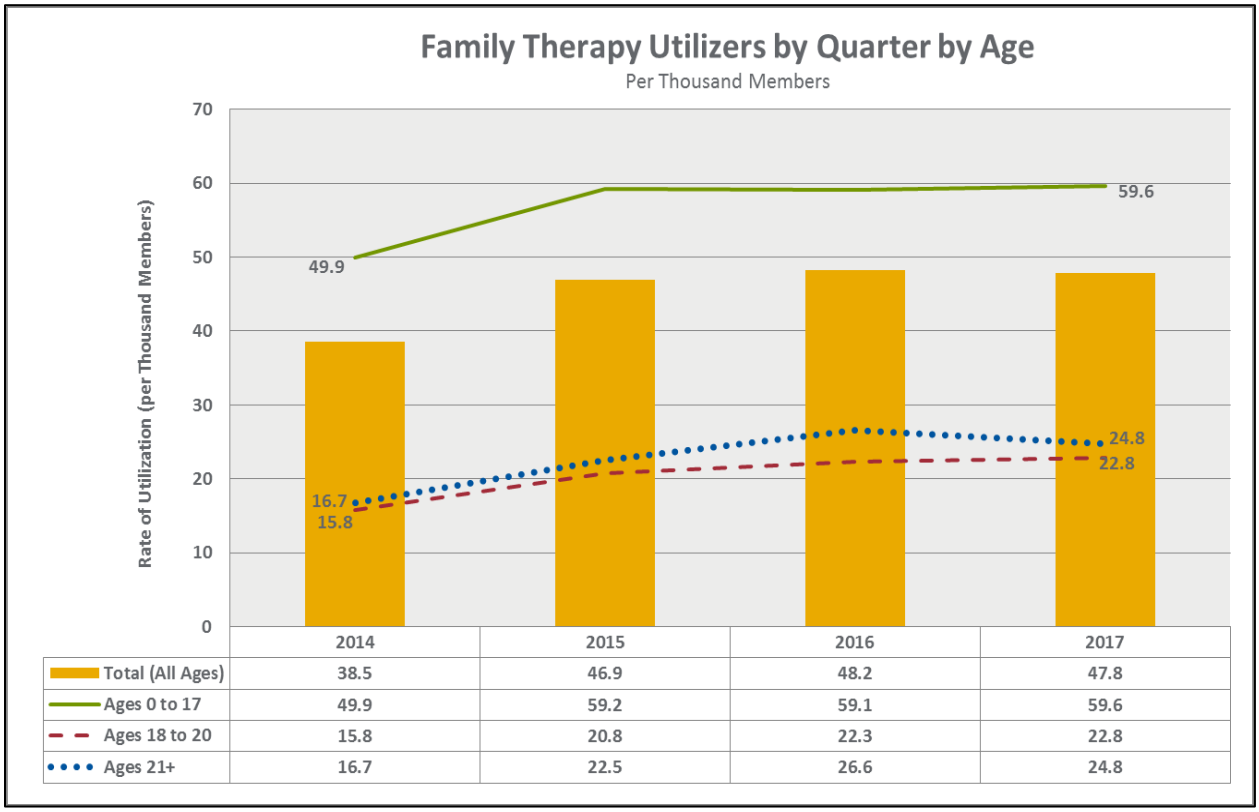
Opportunities and Interventions: Continued recommendation for evidence based individual psychotherapy for appropriate diagnostic categories.

Family Therapy Utilization Rates

Methodology: Utilization rates are based on claims data. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.
The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of Family Therapy visits for a specific year.
Denominator is the total number of IBHP members for the same year, in thousands.

Analysis: Over the four-year study period beginning 2014 there was a 25% increase in the overall utilizer rates for Family Therapy, for all age groups combined, with most of that increase

coming from youth ages 0-17 in 2015. Adults and transitioning youth increased utilization steadily throughout the study period, though Adults +21 declined slightly from 2016 to 2017.



	2014	2015	2016	2017
Total (All Ages)	38.5	46.9	48.2	47.8
Ages 0 to 17	49.9	59.2	59.1	59.6
Ages 18 to 20	15.8	20.8	22.3	22.8
Ages 21+	16.7	22.5	26.6	24.8

Figure 7

Barriers: No identified barriers

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

Peer Support Utilization Rates

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

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

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 over five-fold from 2014 to 2017.

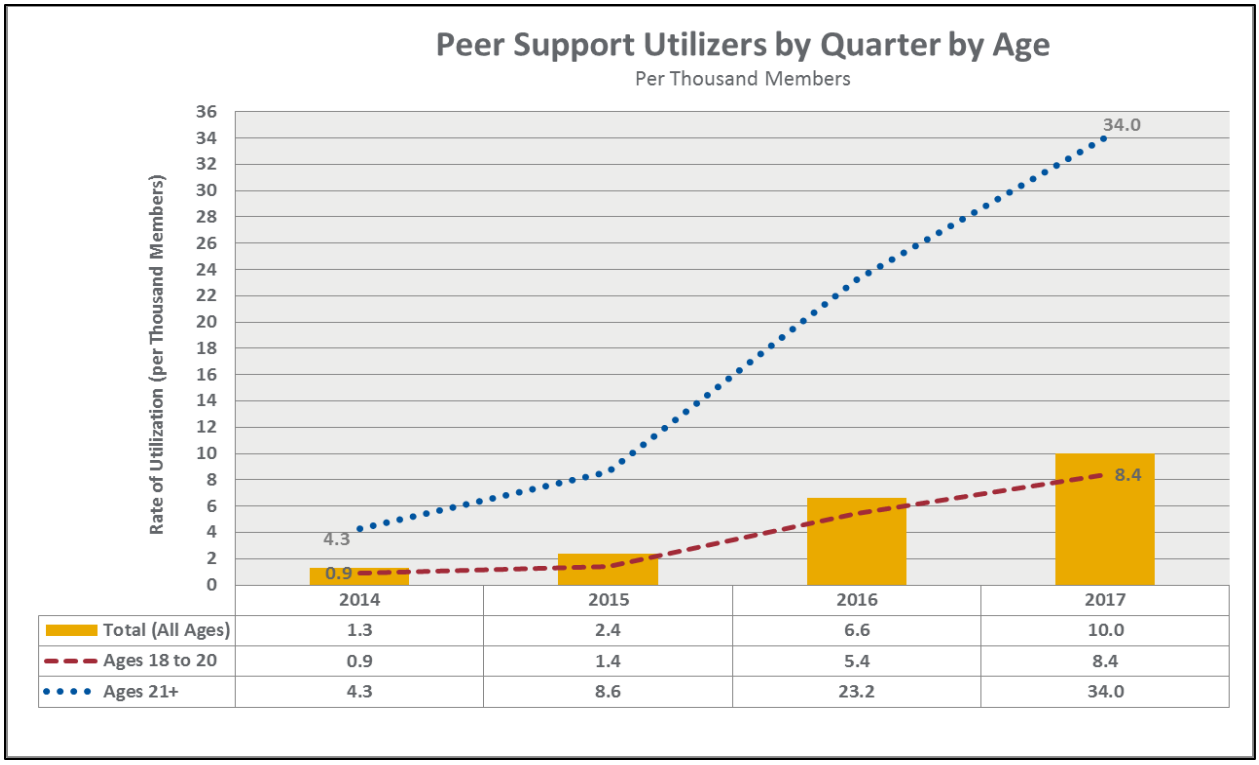


Figure 8

Barriers: In the past, the chief barrier to utilization of Peer Support Services had been the limited number of certified specialists. This is less the case today as additional specialists have received training and certifications.

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

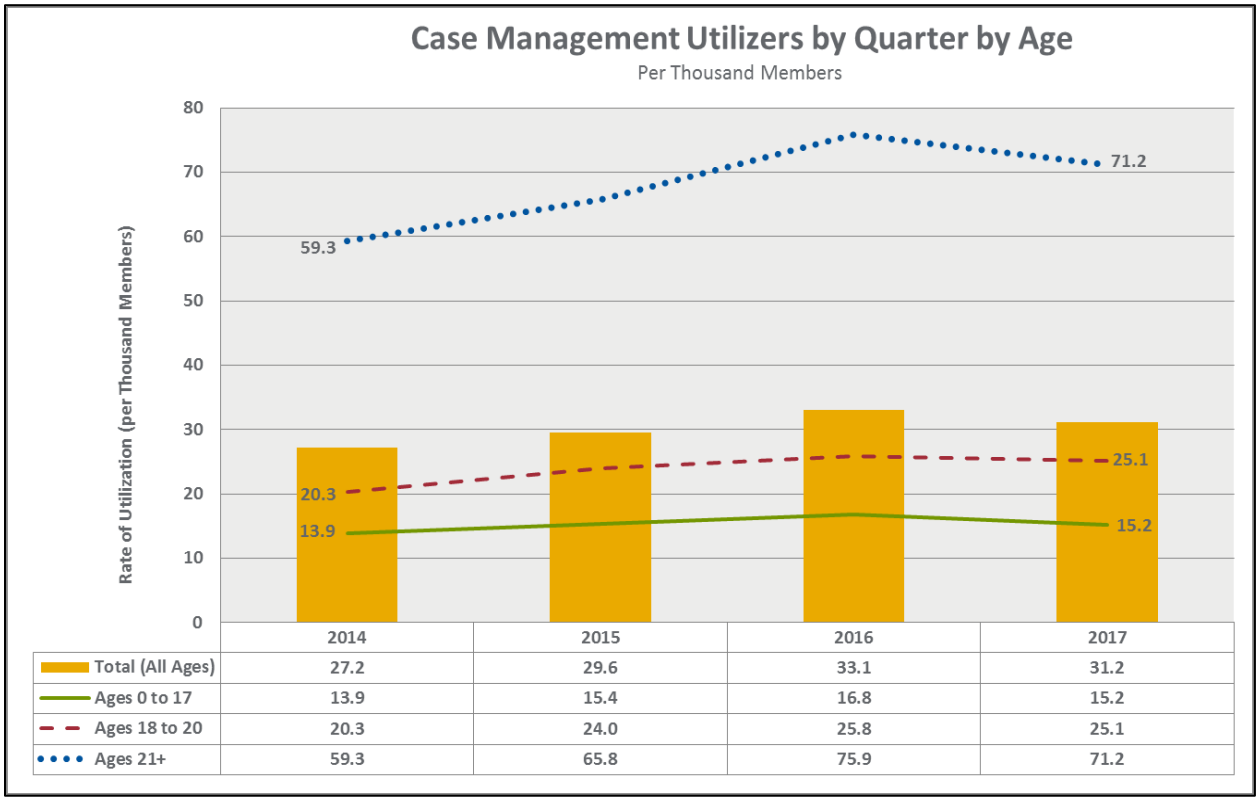
Optum Idaho has made changes in the utilization management program to make authorization of Peer Support Services easier for providers. Providers have received training about Peer Support Services and Recovery and Resiliency benefits through use of Peer Support.

Case Management Utilization Rates

Methodology: Utilization rates are based on claims data. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims.

The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of case management services for a specific year.
Denominator is the total number of IBHP members for the same year, in thousands.

Analysis: Case management service utilization increased 15% from 2014 to 2017, though 2017 utilization was down slightly from 2016, most prominently with the 21+ age group.



	2014	2015	2016	2017
Total (All Ages)	27.2	29.6	33.1	31.2
Ages 0 to 17	13.9	15.4	16.8	15.2
Ages 18 to 20	20.3	24.0	25.8	25.1
Ages 21+	59.3	65.8	75.9	71.2

Figure 9

Barriers: No barriers were identified.

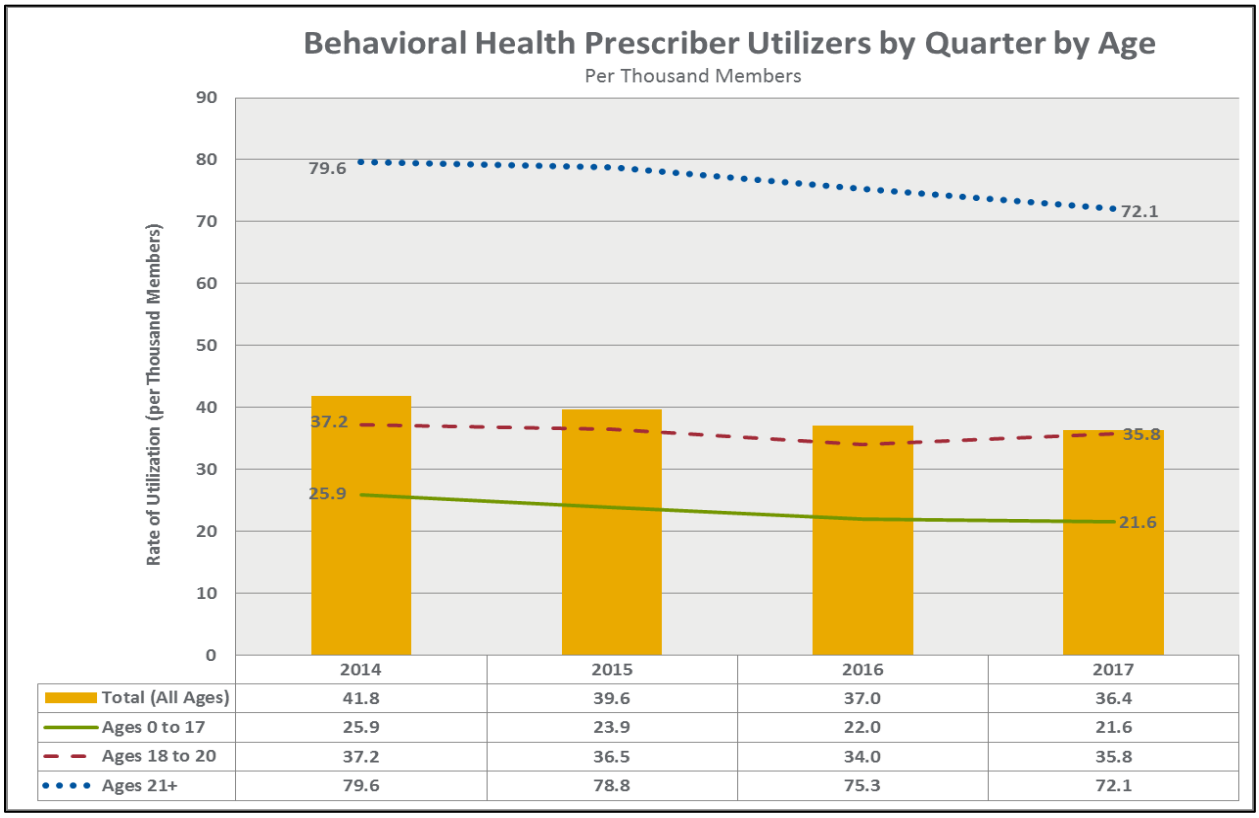
Opportunities and Interventions: Case Management Services were changed in mid-August 2015 to a status that allows a predetermined number of case management hours before requiring clinical review. Further monitoring is needed to see whether Case Management services should be returned to a status that 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. 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 specific years. Denominator is the total number of IBHP members for the same year, in thousands.

Analysis: Overall, the utilization rate for behavioral health prescription visits decreased 12.9% between 2014 and 2017.

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



	2014	2015	2016	2017
Total (All Ages)	41.8	39.6	37.0	36.4
Ages 0 to 17	25.9	23.9	22.0	21.6
Ages 18 to 20	37.2	36.5	34.0	35.8
Ages 21+	79.6	78.8	75.3	72.1

Figure 10

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

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

CBRS Utilization Rates

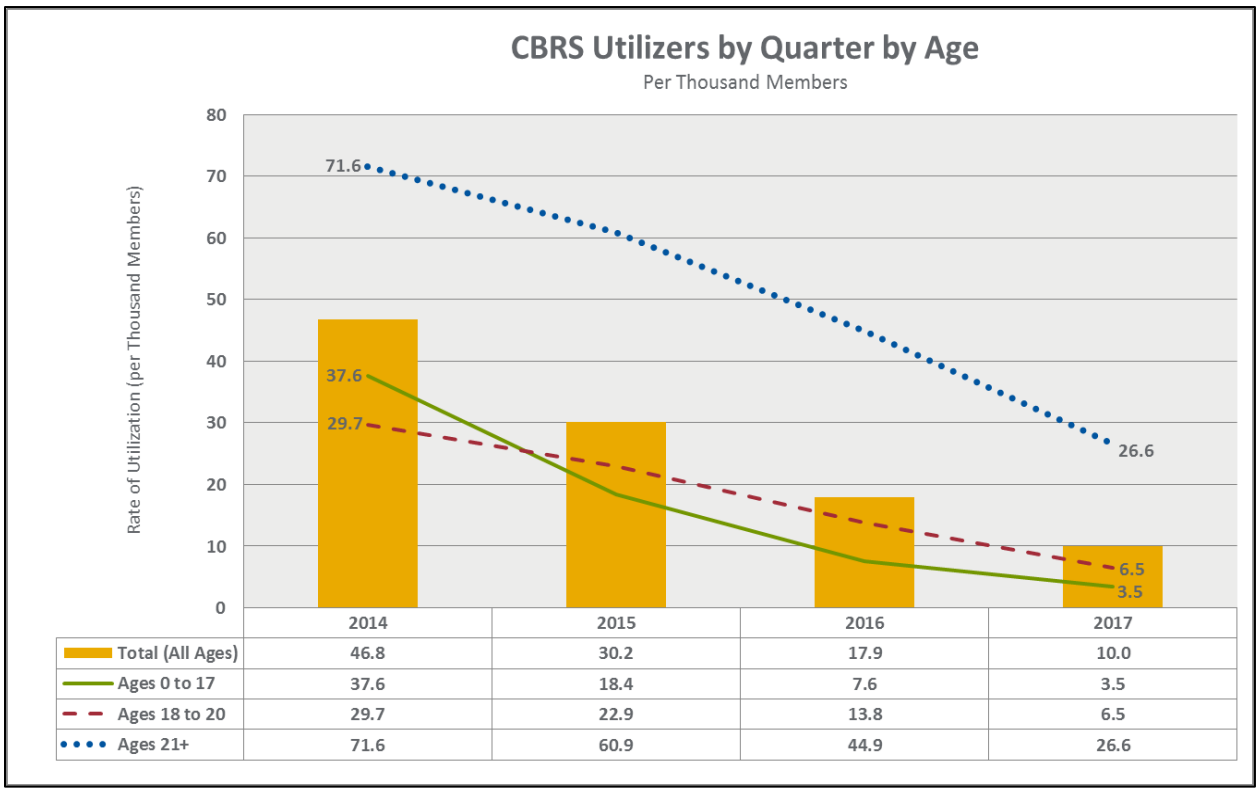
Methodology: Utilization rates are based on claims data.

The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of CBRS visits for a specific year.

Denominator is the total number of IBHP members for the same year, in thousands.

Analysis: Community-Based Rehabilitative Services, CBRS, is a set of rehabilitation services originally developed to support adults diagnosed with Schizophrenia and severe and persistent Bipolar Disorder.

CBRS utilization for all age groups combined has declined 79% since 2014, and declined 44% sequentially from 2016 to 2017. All three age groups demonstrated a reduction in utilizer rates. These changes have sustained a more clinically appropriate use of CBRS for different age groups.



	2014	2015	2016	2017
Total (All Ages)	46.8	30.2	17.9	10.0
Ages 0 to 17	37.6	18.4	7.6	3.5
Ages 18 to 20	29.7	22.9	13.8	6.5
Ages 21+	71.6	60.9	44.9	26.6

Figure 11

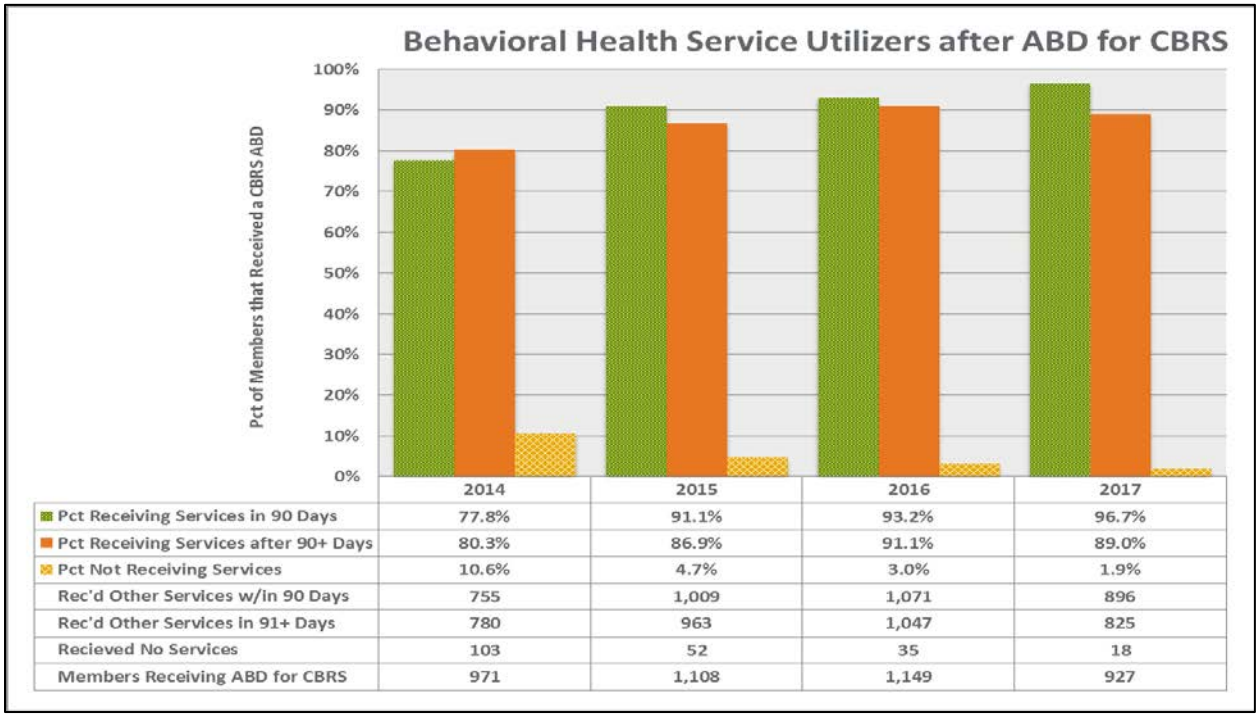
Barriers: No identified barriers***.*** CBRS is authorized according to medical necessity; utilizing evidence based nationally recognized treatment(s) for the member's documented condition.

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

Services Received Post CBRS Adverse Benefit Determination

Methodology: Based on Adverse Benefit Determination and Claims data, the graph below identifies members that received evidence based service(s) after receiving an Adverse Benefit Determination (ABD) from Optum, limiting or denying requested CBRS.

Analysis: From 2014 to 2017 the use of medically necessary services has increased following denials of authorization for CBRS. Over 96% of members received therapeutic services within 90 days following the ABD, which compares to less than 80% in 2014. 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.



	2014	2015	2016	2017
Pct Receiving Services in 90 Days	77.8%	91.1%	93.2%	96.7%
Pct Receiving Services after 90+ Days	80.3%	86.9%	91.1%	89.0%
Pct Not Receiving Services	10.6%	4.7%	3.0%	1.9%
Rec'd Other Services w/in 90 Days	755	1,009	1,071	896
Rec'd Other Services in 91+ Days	780	963	1,047	825
Recieved No Services	103	52	35	18
Members Receiving ABD for CBRS	971	1,108	1,149	927

Figure 12

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

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

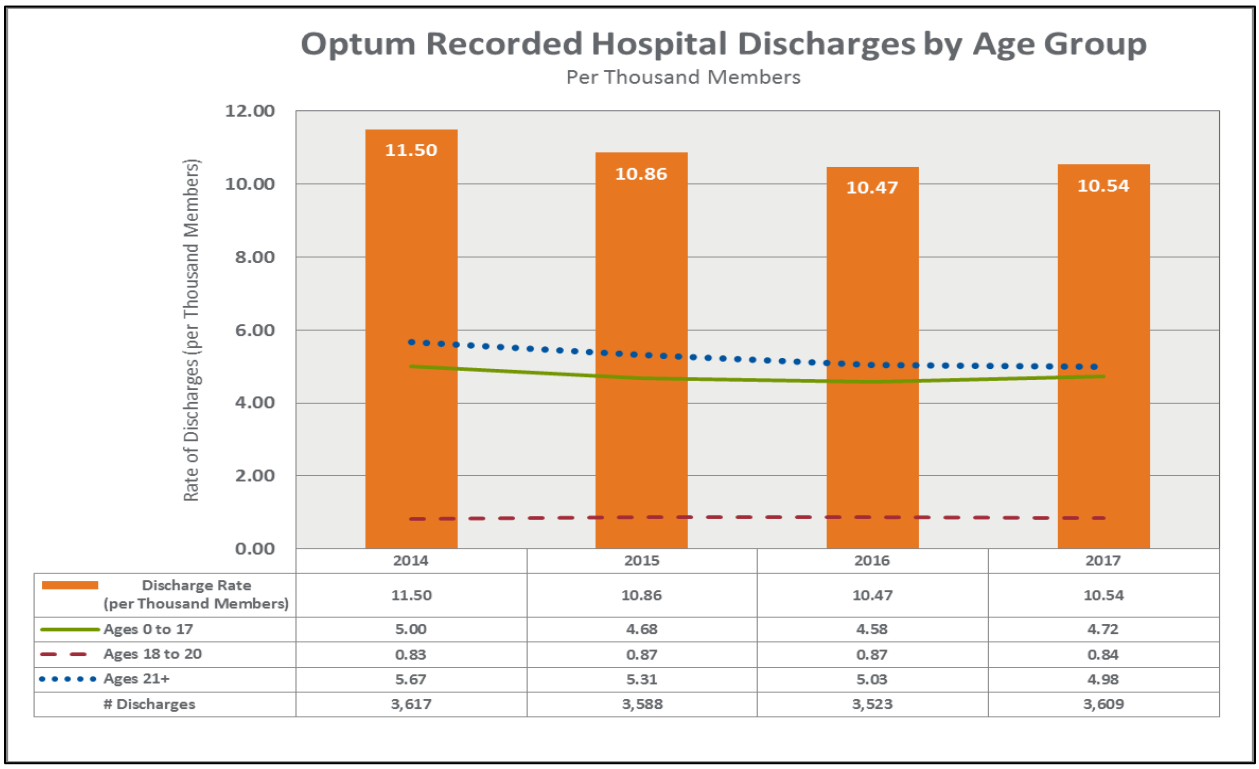
Optum promotes the continued increase in Peer Support Services in adults and transitioning youth. With Family Support Services, we anticipate the increased use of these value-added Recovery and Resiliency services for the benefit of children and their families.

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

Psychiatric Inpatient Utilization

Methodology: Information is obtained from IDHW and other community resources using hospital discharge data. A hospital stay is considered a readmission if the admission date occurred within 30-days of discharge. The data displayed indicates the rate of hospital discharges per year. To control for an increase in IBHP members over this time frame, the data has been standardized by displaying the numbers per 1,000 members.

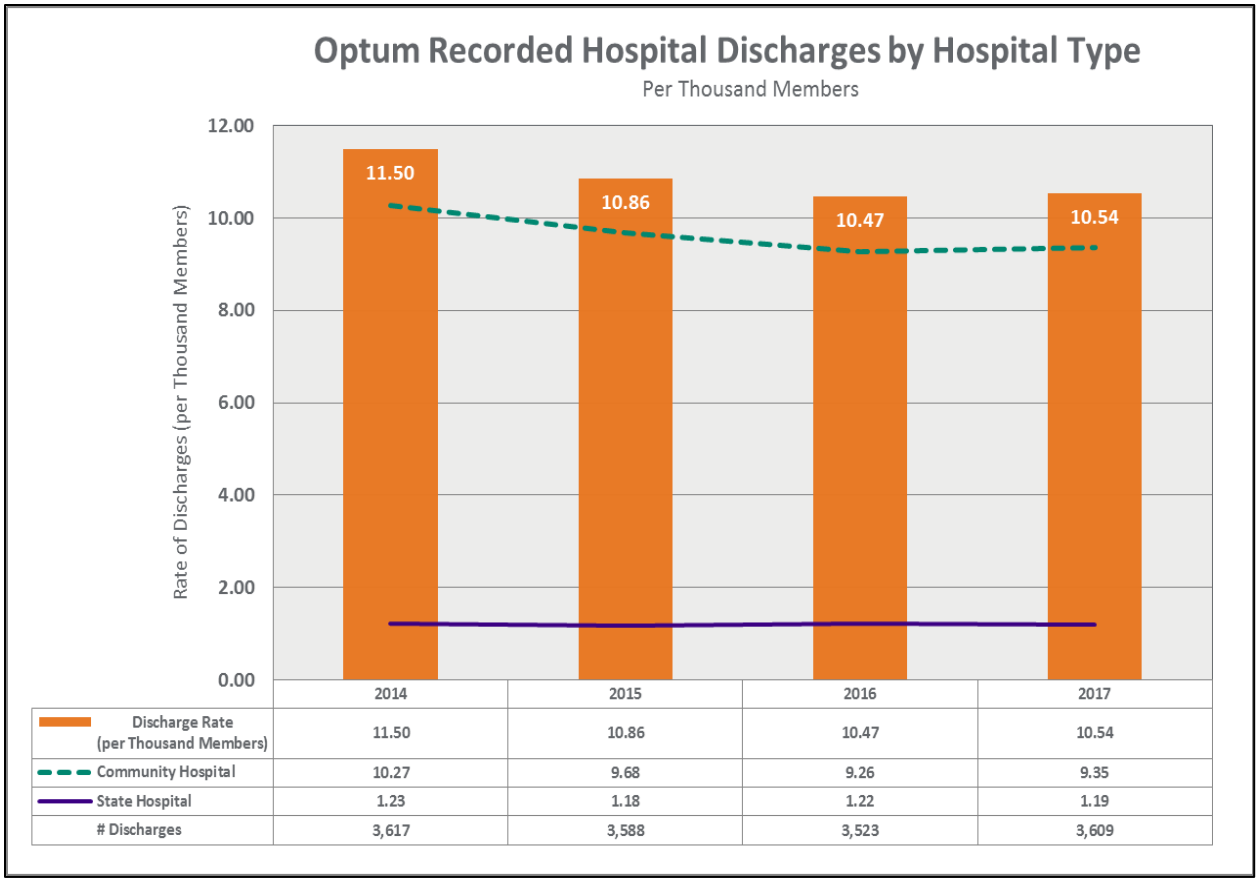
Analysis: A well performing outpatient behavioral health system is generally expected to provide members with appropriate services in the least restrictive settings. The following data track the actual rates of psychiatric hospitalization, as a type of outcome measure for the plan's performance as a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



	2014	2015	2016	2017
Discharge Rate (per Thousand Members)	11.50	10.86	10.47	10.54
Ages 0 to 17	5.00	4.68	4.58	4.72
Ages 18 to 20	0.83	0.87	0.87	0.84
Ages 21+	5.67	5.31	5.03	4.98
# Discharges	3,617	3,588	3,523	3,609

Figure 13

Figure 13 shows the overall rate of discharges decreased from 11.50 to 10.54 per 1,000 members from 2014 to 2017, which represents an 8% decrease in hospitalizations, notwithstanding a slight increase in the rate from 2016 to 2017.



	2014	2015	2016	2017
Discharge Rate (per Thousand Members)	11.50	10.86	10.47	10.54
Community Hospital	10.27	9.68	9.26	9.35
State Hospital	1.23	1.18	1.22	1.19
# Discharges	3,617	3,588	3,523	3,609

Figure 14

Figure 14 shows that during the study period from 2014 to 2017, discharges were consistent over time for State hospitals but down 9% for Community hospitals, notwithstanding a slight increase from 2016 to 2017.

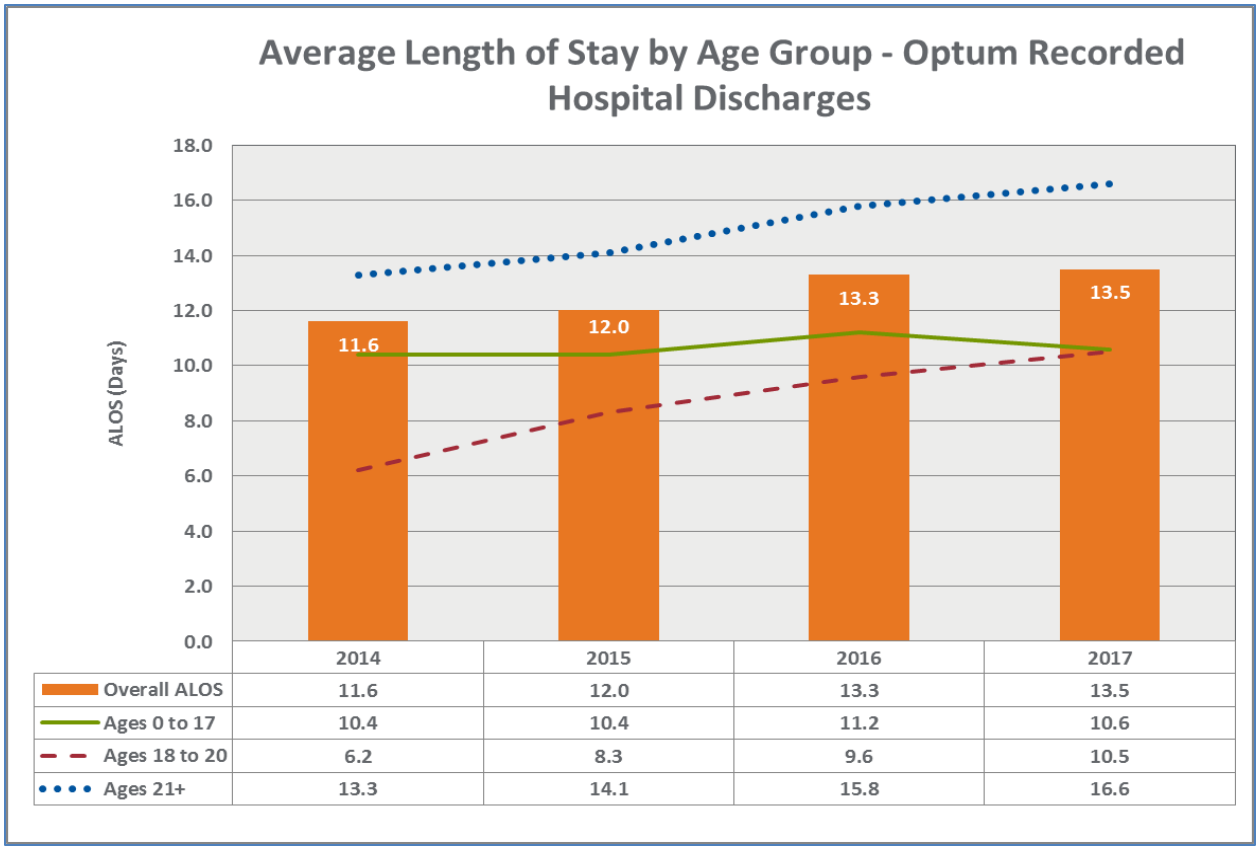
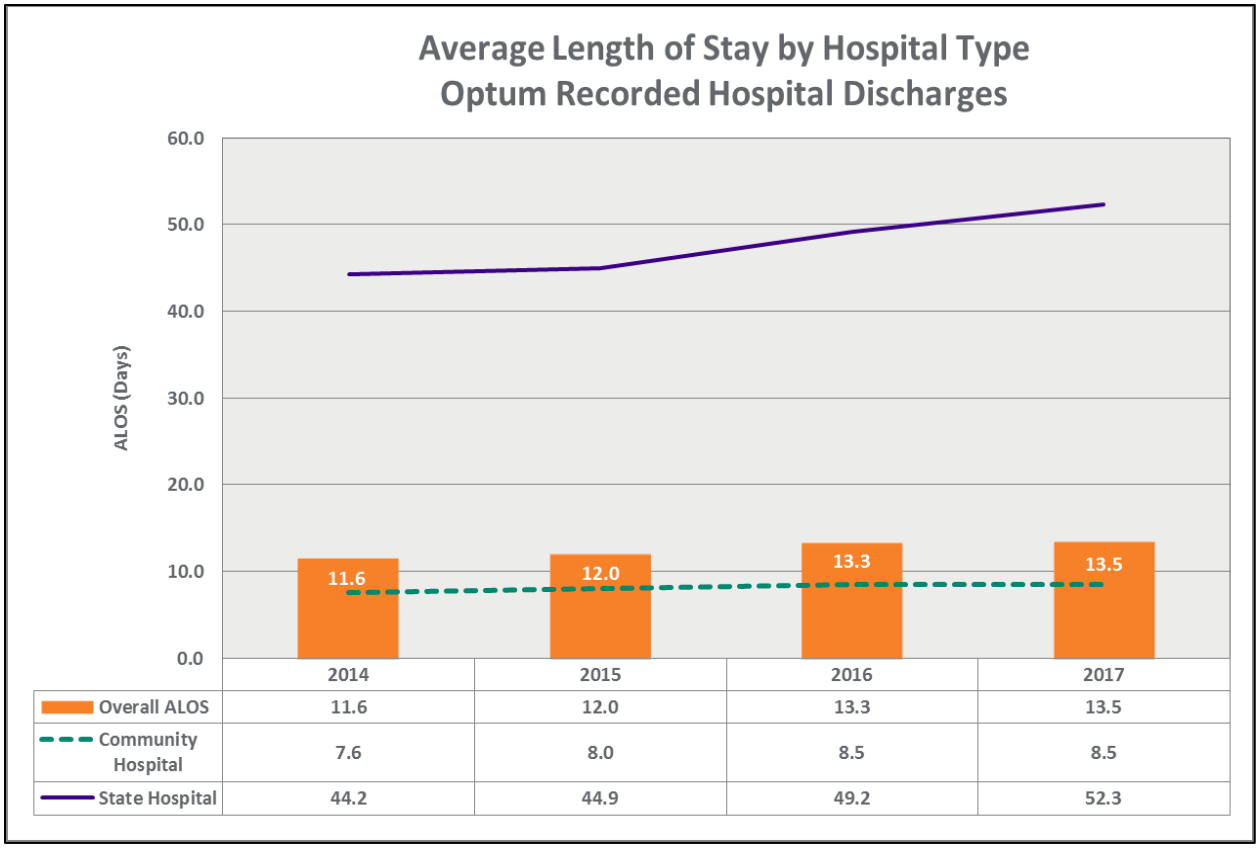


Figure 15

Figure 15 indicates that average lengths of stay for all age groups increased from 2014 to 2017 as well as each sequential year over the study period. The most significant increase was experience by the 18-20 age-group, which increased 69% over the four years.



	2014	2015	2016	2017
Overall ALOS	11.6	12.0	13.3	13.5
Community Hospital	7.6	8.0	8.5	8.5
State Hospital	44.2	44.9	49.2	52.3

Figure 16

Figure 16 shows the average length of stay by hospital type. Both State and Community hospital rates increased from 2014 to 2017, most significantly at State hospitals, which have about four times the lengths of stay as the Community hospitals.

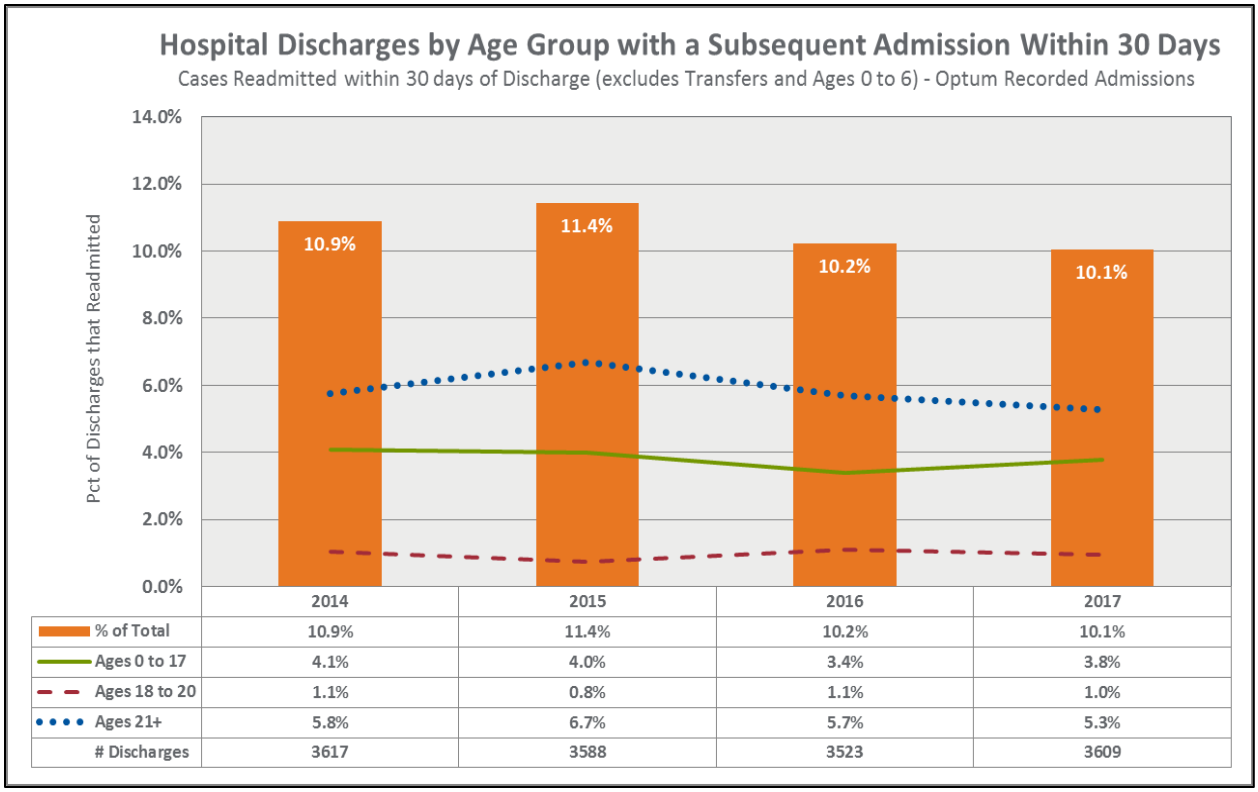
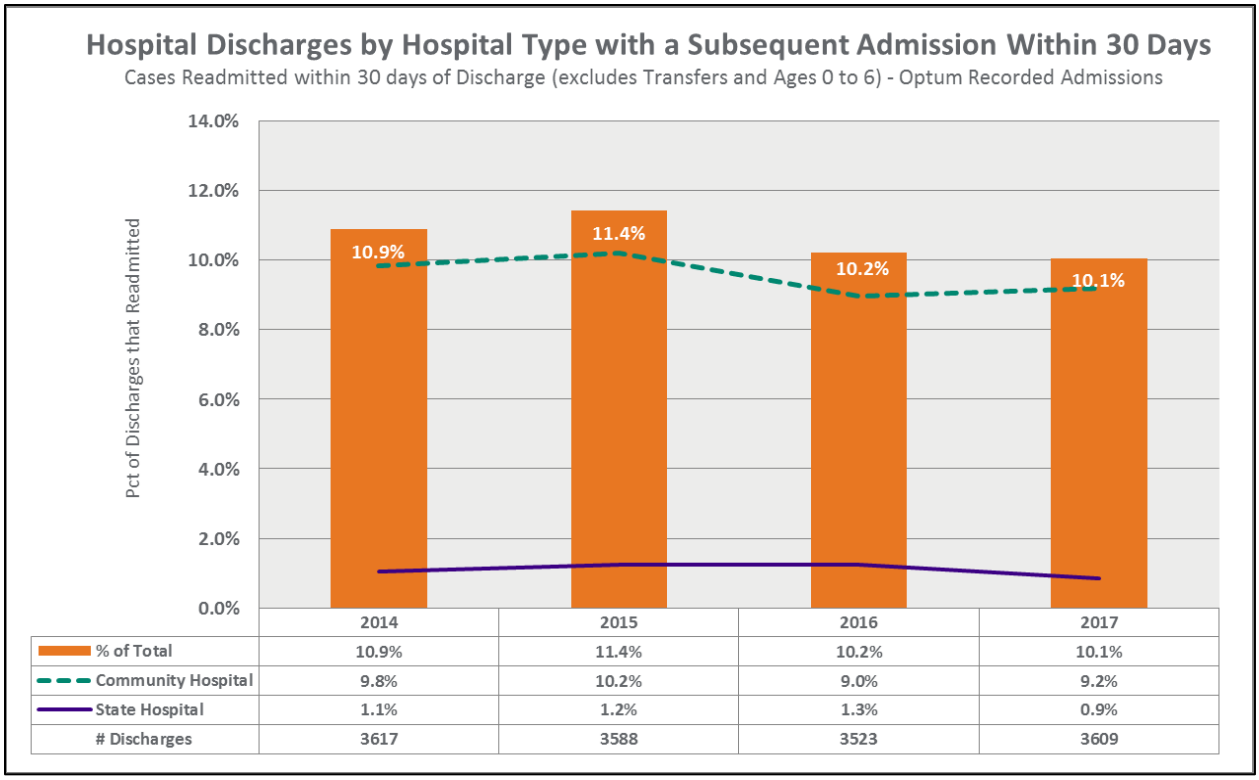


Figure 17

Figure 17 shows that during the study period from 2014 to 2017, readmissions decreased 7% year-over-year. According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals.



	2014	2015	2016	2017
% of Total	10.9%	11.4%	10.2%	10.1%
Community Hospital	9.8%	10.2%	9.0%	9.2%
State Hospital	1.1%	1.2%	1.3%	0.9%
# Discharges	3617	3588	3523	3609

Figure 18

Figure 18 shows readmissions percentages by hospital type. During the study period 2014 to 2017, the readmission rate declined for both State and Community hospitals, though both also experienced increases from 2014 to 2015.

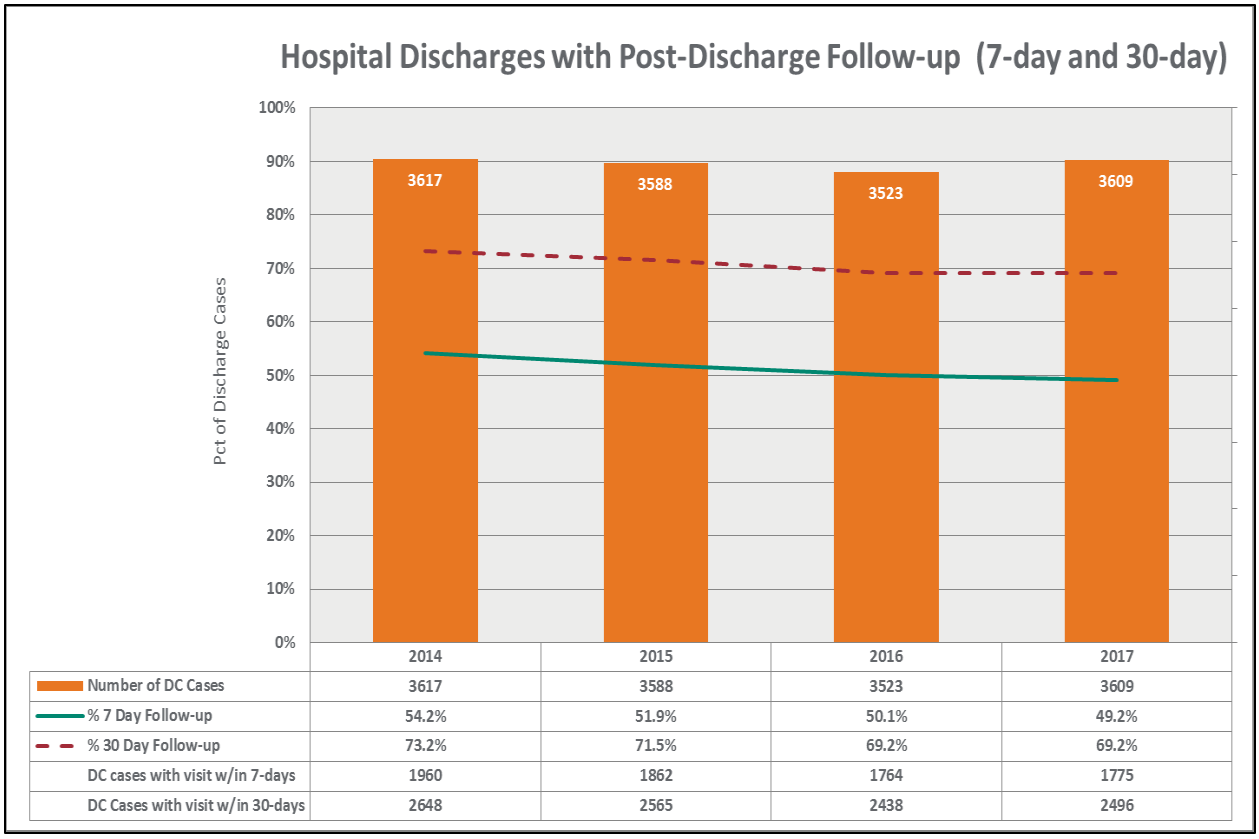
Hospital Discharges with Post Discharge Follow-up

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

Analysis: Figure 19 shows Hospital Discharges with Post-Discharge Follow-up. One of the goals of care coordination is the continuity of care and the successful transition of members from inpatient to outpatient care. One of the measures for this is a HEDIS metric that examines the percentage of members who are discharged from inpatient care and subsequently receive an outpatient behavioral health visit within 7 days and 30 days. The attendance rates for post-discharge outpatient services have leveled in the last two years though are down from the beginning of the study period for both 7- and 30-day follow-up metrics.

Barriers: Responsibility for arranging post-discharge outpatient appointments for behavioral health services rests with hospital discharge planners. Optum has an outpatient-only contract; as a result, hospitals and their staff responsible for discharge planning fall outside our management. However, within the Optum Idaho care coordination system, Optum discharge coordinators attempt to verify that appointments are scheduled and attended, but do not ensure—and sometimes are unable to ensure—that these appointments are done due to timely hospital discharge information.

Opportunities and Interventions: Optum Idaho will continue to monitor the discharge data and the continuity and care.



	2014	2015	2016	2017
Number of DC Cases	3617	3588	3523	3609
% 7 Day Follow-up	54.2%	51.9%	50.1%	49.2%
% 30 Day Follow-up	73.2%	71.5%	69.2%	69.2%
DC cases with visit w/in 7-days	1960	1862	1764	1775
DC Cases with visit w/in 30-days	2648	2565	2438	2496

Figure 19

Note: DC is an abbreviation for discharge.

Psychiatric Emergency Room Utilization Rates

Methodology: Data is provided by IDHW. Utilization is given as visits per 1,000 members in the IBHP for each year.

Analysis: Figure 20 displays the utilization trends of Idaho Emergency Room visits for psychiatric care. Over the four year study period, beginning in 2014, emergency room utilization has trended down, though it is up slightly from 2016 to 2017.

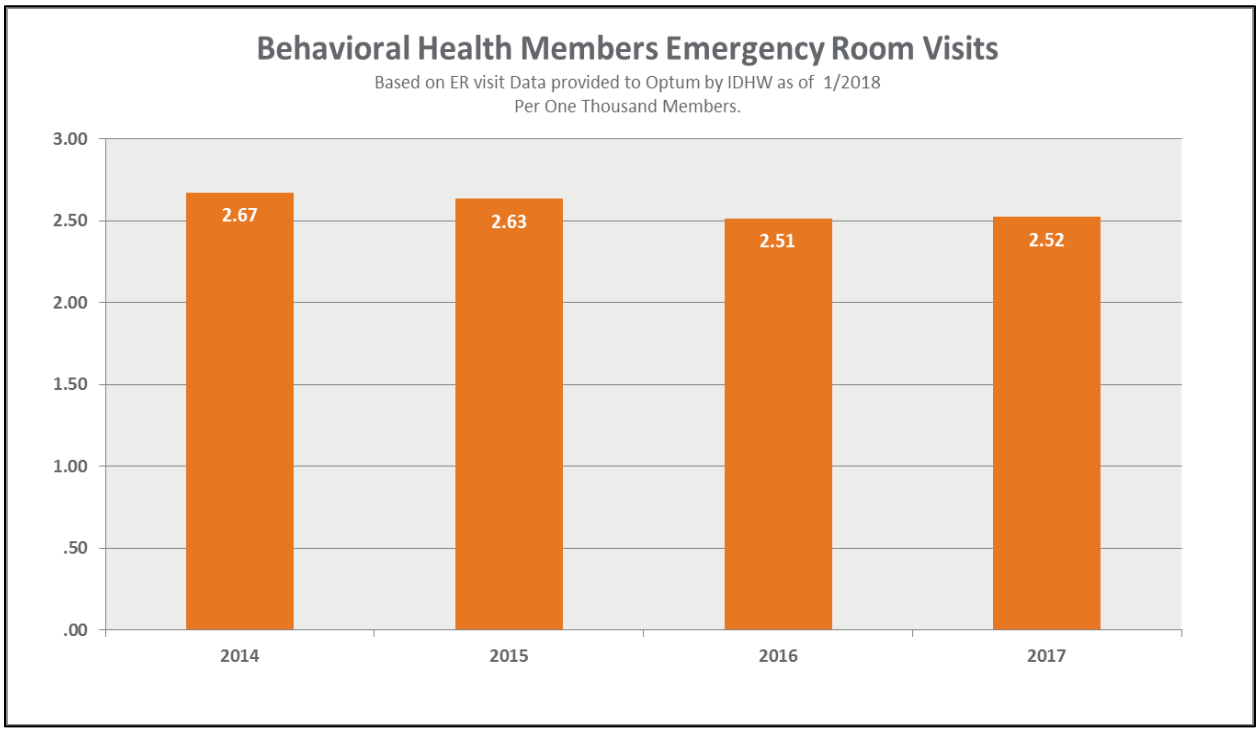


Figure 20

Member Satisfaction Survey Results

Optum Behavioral Health monitors member satisfaction with behavioral health services. Beginning with Quarter 1, 2017, a new Member Satisfaction Survey, the *Optum Consumer Net Promoter Score Behavioral Health Survey* (CNPS BH Survey) was implemented. The Net Promoter Score, or NPS, is based on the fundamental perspective that every company's consumers can be divided into three categories: Promotors, Passives, and Detractors. By asking one question – *How likely it is that you would recommend [company] to a friend or colleague* – companies can track these groups and get a measure of performance through consumers' eyes.

Consumers respond on a 0-to-10 point rating scale and are categorized as follows:

- Promoters (score 9-10) are loyal enthusiasts.
- Passives (score 7-8) are satisfied but unenthusiastic customers.
- Detractors (score 0-6) are unhappy customers.

The NPS item was scored on an 11-point scale ranging from 0 = 'Not at all Likely' to 10 = 'Extremely Likely'. The NPS score is calculated by subtracting the % of Detractors (those respondents that endorsed a score of 0-6) from the % of Promoters (those respondents that endorsed a score of 9-10).

Methodology: Optum surveys Optum Idaho Behavioral Health Plan adults 18 years of age and older and parents of children aged 11 years or younger. The survey is administered through a live telephone interview. Translation services are available to members upon request.

To be eligible for the survey, the member must have received services during the 90 days prior to the survey and have a valid telephone number on record. A random sample of individuals eligible for the survey is selected and called until the desired quota was met or the sample was exhausted. Members who have accessed services in multiple quarters are eligible for the survey only once every six months.

The survey includes questions about the member's experience with Optum and in treatment. The survey targets satisfaction in the following domains:

- Overall satisfaction
- Optum support for obtaining referrals or authorizations
- Accessibility, availability, and acceptability of the clinician network
- Claims customer service
- Counseling and treatment
- Net Promoter Score

2014 – 2016 Overall Performance Results

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

2017 Overall Performance Results

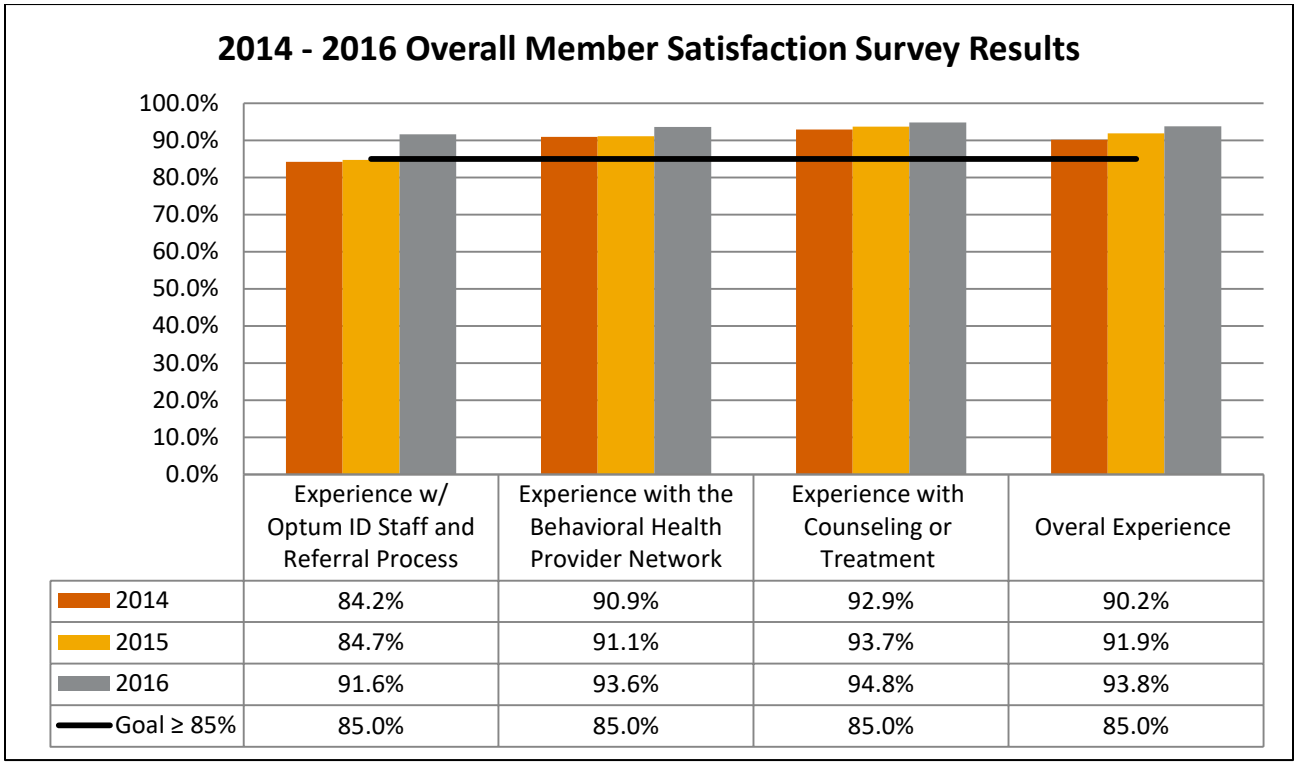
Member Satisfaction Survey	Performance Goal	2017
Overall Satisfaction (Goal: ≥85.0%)	≥85.0%	80.3%
Optum support for obtaining referrals or authorizations	≥85.0%	80.0%
Accessibility, availability, and acceptability of the clinician network	≥85.0%	89.0%

Member Satisfaction Survey	Performance Goal	2017
Counseling and Treatment	≥85.0%	95.0%
Net Promoter Score (NPS): How likely it is that you would recommend Optum to a friend or colleague?		11
Promoters		44%
Passives		23%
Detractors		33%

Analysis: As stated above, a new Member Satisfaction Survey was implemented in 2017. Results are presented in this Annual Evaluation from previous surveys (2014 - 2016) and the 2017 results based on the new survey.

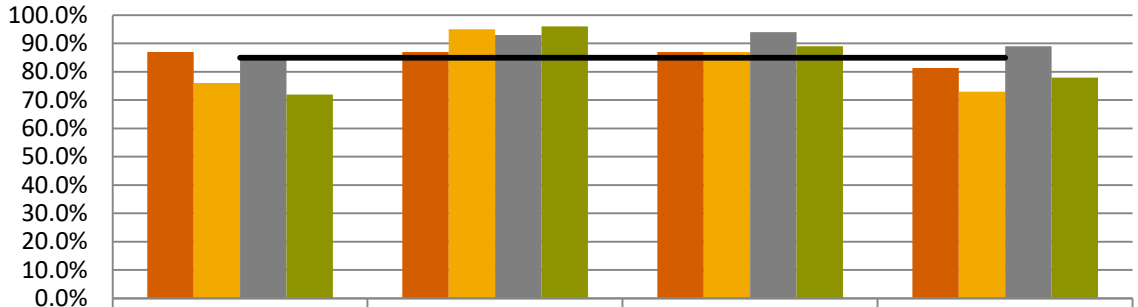
Surveys are now completed by telephone. The number of calls made during 2017 was 1,636 with a response rate of 14% (226). Translation services were offered but none were requested resulting in 100% of the surveys being conducted in English.

Overall Net Promotor Score was: Promoters: 44%, Detractors: 33%, and Passives: 23%.



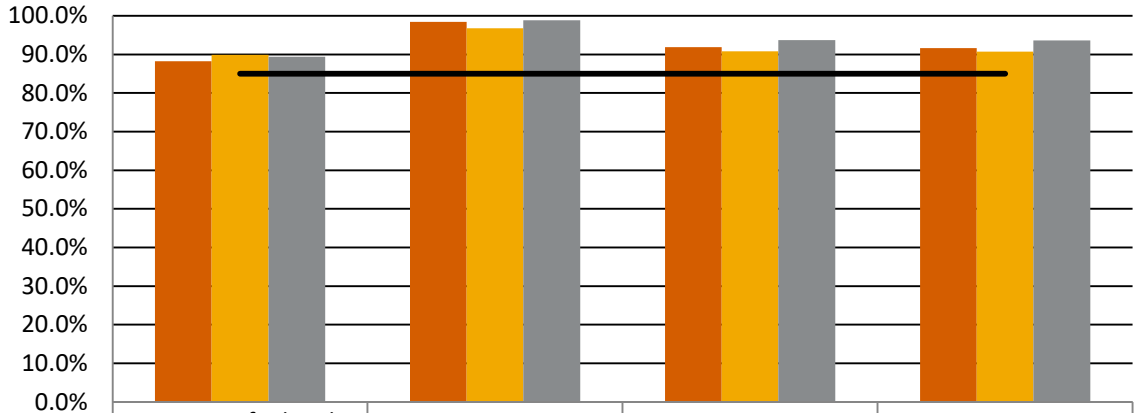
	Experience w/ Optum ID Staff and Referral Process	Experience with the Behavioral Health Provider Network	Experience with Counseling or Treatment	Overal Experience
2014	84.2%	90.9%	92.9%	90.2%
2015	84.7%	91.1%	93.7%	91.9%
2016	91.6%	93.6%	94.8%	93.8%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%

2017 Overall Member Satisfaction Survey Results

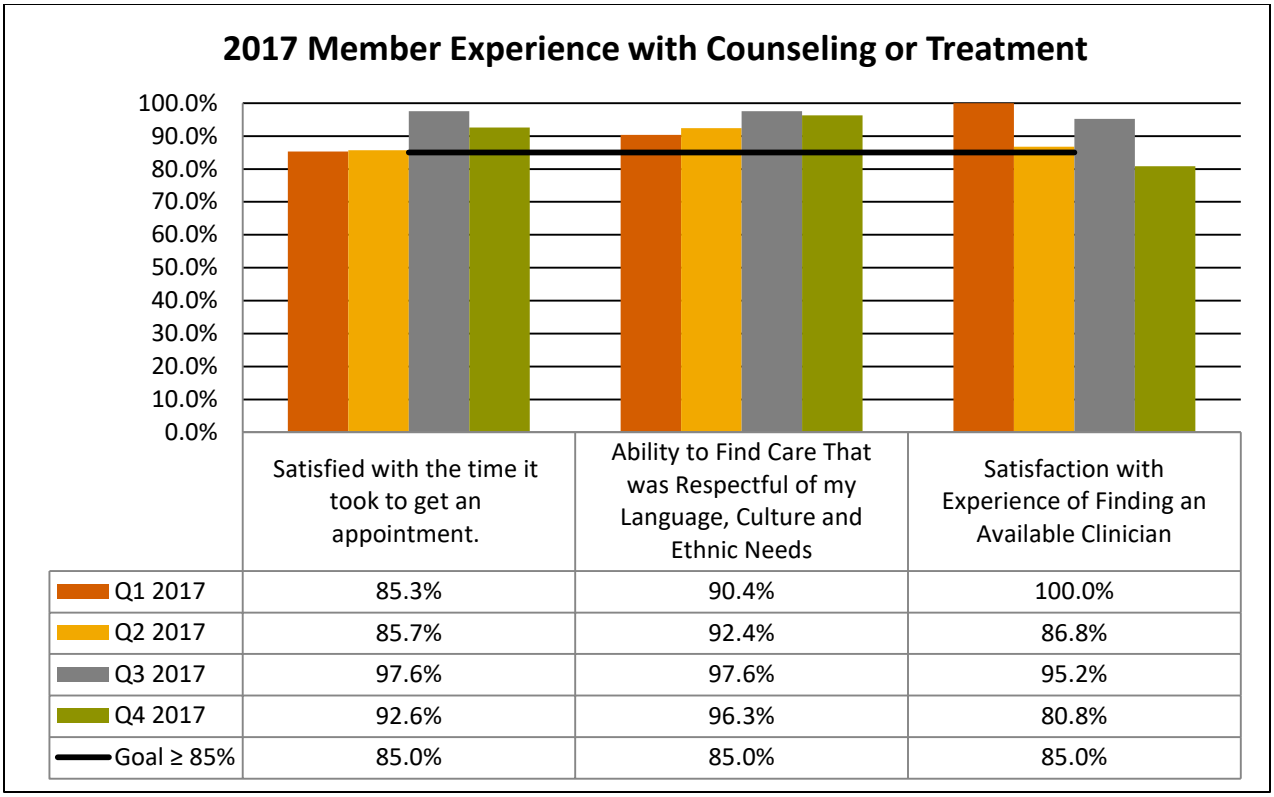


	Optum Support for Obtaining Referrals or Authorizations	Counseling and Treatment	Accessibility, Availability, and Acceptability of the Clinician Network	Overall Satisfaction
Q1 2017	87.0%	87.0%	87.0%	81.3%
Q2 2017	76.0%	95.0%	87.0%	73.0%
Q3 2017	85.0%	93.0%	94.0%	89.0%
Q4 2017	72.0%	96.0%	89.0%	78.0%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%

2014 - 2016 Member Experience with Counseling or Treatment



	I was satisfied with the time it took to get an appointment with my primary provider	The care I received was respectful of my language, cultural, and ethnic needs.	I was satisfied with the choice of providers available to me.	My provider helps me get the services I need when I need them.
2014	88.2%	98.4%	91.9%	91.6%
2015	89.9%	96.8%	90.8%	90.7%
2016	89.4%	98.8%	93.7%	93.6%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%



	Satisfied with the time it took to get an appointment.	Ability to Find Care That was Respectful of my Language, Culture and Ethnic Needs	Satisfaction with Experience of Finding an Available Clinician
Q1 2017	85.3%	90.4%	100.0%
Q2 2017	85.7%	92.4%	86.8%
Q3 2017	97.6%	97.6%	95.2%
Q4 2017	92.6%	96.3%	80.8%
Goal ≥ 85%	85.0%	85.0%	85.0%

Barriers: The Optum Idaho performance goal for Overall Satisfaction is ≥85.0%. While the annual survey results fell below ≥85.0%, Optum will continue to monitor and identify trends.

Opportunities and Interventions: As the new survey was implemented during 2017, Optum will monitor and compare to the 2018 results and identify any trends.

Provider Satisfaction Survey Results

In 2016, Optum Idaho changed from a quarterly provider satisfaction survey to an annual survey to align with national standard. The goal of the research design of the Provider Satisfaction Survey is to provide representative and reliable measurement of providers' experiences with, attitudes toward, and suggestions for Optum Idaho. Fact Finders, Inc. is an independent health research company and conducts the survey for Optum.

Methodology: Optum Idaho forwarded to Fact Finders a database comprising all providers currently in the Optum Idaho provider network. The survey was designed to contact every provider to give them an opportunity to participate in the research. To accommodate the schedules of busy providers and include in the research as many of the providers as possible, a multi-stage, multi-mode coordinated data collection effort was employed. As soon as providers participated in the survey, they were removed from the active sample so there would be no further outreach to the practice.

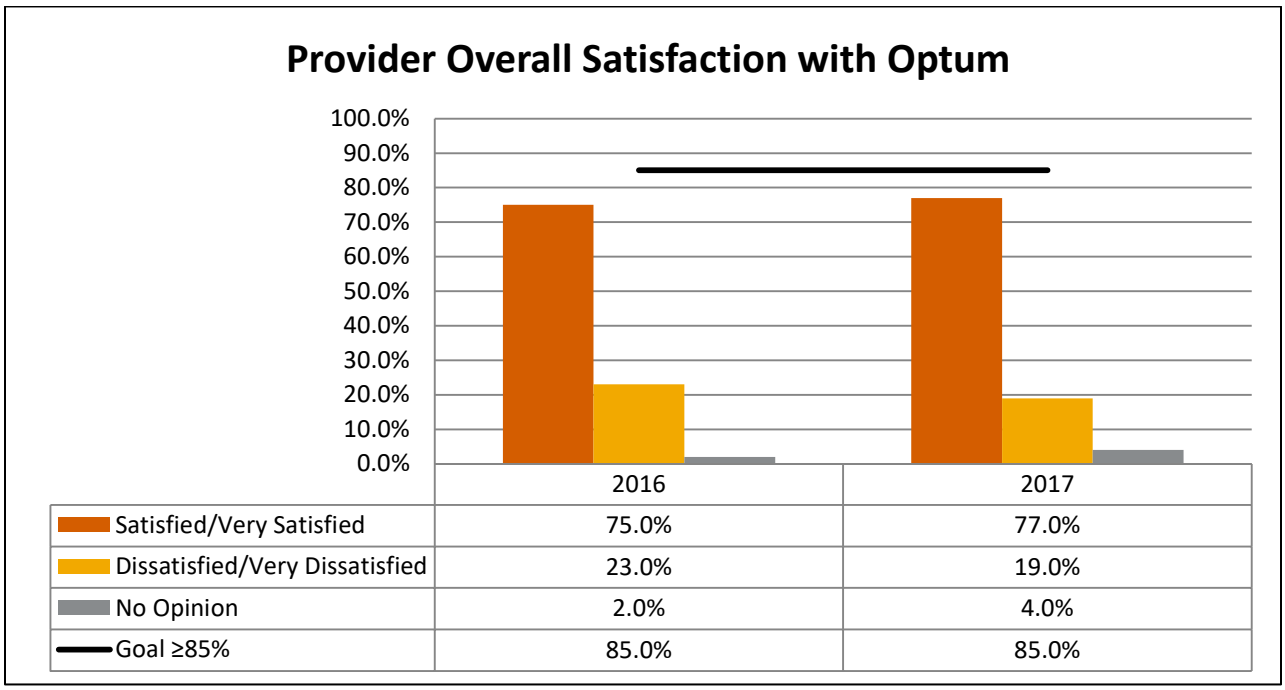
There are 3 modes for providers to complete the survey:

1. Outbound Telephone Call from Fact Finders
2. Inbound Telephone from Provider to Fact Finders
3. Online Survey

2016 - 2017 Overall Performance Results

Overall Provider Satisfaction Survey	Performance Goal	2016	2017
Satisfied/Very Satisfied	≥85.0%	75%	77%
Dissatisfied/Very Dissatisfied	NA	23%	19%
No Opinion	NA	2%	4%

Analysis: Overall Provider satisfaction for 2017 was 77%, a slight increase from 2016 at 75%.



Barriers: The Optum Idaho performance goal for Overall Satisfaction is ≥85.0%. While the annual survey results fell below ≥85.0%, Optum will continue to monitor and identify trends.

Opportunities and Interventions: Action plans for 2018 include:

- Continue process for regular piloting initiatives with provider and seeking input.
- Create subcommittees of the Provider Advisory Committee for special topics.
- Increase visits and meetings with provider associations and offices.
- Introduce and educate providers on the use of the Net Promotor Score.

Performance Improvement

A continuous quality improvement (CQI) process is embedded within the structure of Optum Idaho's QI program to review contractual requirements. 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 projects to include Community Health Initiatives (CHI) as well as improvement projects related to contract and operational initiatives. All improvement initiatives and projects are reviewed by the Optum Idaho QAPI committee on a monthly basis.

The following is a list of the ***Projects and Performance Improvement Projects and status during 2017:***

Project	Date Initiated	Quality Committee Oversight	Status in 2017	Key Accomplishments	Performance Improvement Project?
ALERT Peer Review	10/2/15	Quality Assurance Performance Improvement Committee and Clinical and Services Advisory Committee	Closed 3/17/17	•Provider's compliance in returning ALERT calls in regards to wellness assessment submitted and triggered algorithms. Quick Reference Guides were created; other issues were identified with process. There was improvement in provider participation. •Operational; closed by the Clinical and Services Advisory Committee (CSAC)	Yes
FCC (Field Care Coordination) Familiarity	3/22/16	Clinical and Services Advisory Committee and Provider Advisory Committee	Closed 3/21/17	•Provider communication was developed and distributed in February, 2017. •FCC Manager will work with Network Director to ensure that FCC familiarity questions are included in the next Provider Satisfaction Survey. •Will continue ongoing promotion and clarification of FCC roles and availability. • Operational; closed by CSAC.	Yes
Communication Plan for Youth Transition	6/28/16	Clinical and Services Advisory Committee	Closed 3/21/17	•Developed and executed a process to send letters to members turning 18 within 12 months as well as their outpatient behavioral health providers. Communication intended to help members avoid potential gaps in services and advise them of services that my help ease their functional	Yes

Project	Date Initiated	Quality Committee Oversight	Status in 2017	Key Accomplishments	Performance Improvement Project?
				transition from child to adult status. •A total of 1600 letters have been sent. •We will continue to monitor the number of responses •Will identify trends. • Operational; closed by CSAC.	
Task Force for Youth Transition	6/28/16	Clinical and Services Advisory Committee	Closed 3/21/17	•This process if fully functional and can be included as part of Clinical Operations. •FCC's are participating in existing subcommittees that address Youth Transition issues. •Will continue to monitor and solicit feedback. •Developed additional talking points. •Closed by CSAC	Yes
IOP-Phase 1 (Intensive Outpatient Program)	9/1/16	Clinical and Services Advisory Committee	Closed 10/11/17	•Internal Training Complete. •IOP audits began. •Conference call with providers to outline contracting and service request process. •Web-based Service Requests Form implementation	No
A & G Mega Rule	3/29/17	Quality Assurance Performance Improvement Committee	Closed 8/30/17	• Provider Alert sent to Network • Provider Manual and Member Handbook approved. • Optum Idaho staff educated and trained to changes. •Revised Monthly report (SR08). •Went live with the new regulatory changes on 7/1/17. •Presented closure report to Executive committee. Closure report approved.	No
LEAN (UM Service Request Process Improvement)	3/9/17	Clinical and Services Advisory Committee	Closed 9/27/17	•Providers trained on change to Peer-to-Peer and notification process. •Obtained IT approval for LINX upgrade. •Business case approved. •Linx upgrade approved	Yes

Project	Date Initiated	Quality Committee Oversight	Status in 2017	Key Accomplishments	Performance Improvement Project?
				and estimated to go live during Q4.	
Respite	5/26/17	Clinical and Services Advisory Committee	Open	•Project Charter completed. •Draft Level of Care Guidelines in review. •Draft Communication Plan developed. •Level of Care Guidelines approved. •Provider Communication on target.	No
IOP – Phase II	6/27/17	Clinical and Services Advisory Committee	Open	•Readiness Assessment closed. •Training content completed.	No
Service Request Forms	3/1/17	Clinical and Services Advisory Committee	Closed 9/30/17	•Forms for all services except IOP went live 7/1/17. All providers were required to start using on 8/1/17. •IOP forms went live 9/1/17.	Yes
Administrative Denial	9/27/17	Quality Assurance Performance Improvement Committee	Open	•Continued to monitor •All milestones completed	No
BH Intervention at Medical Appointment	9/1/17	Clinical and Services Advisory Committee	Open	•Project plan in development •Met with stakeholders from Idaho Professional Counselors Association (IPCA) •Sent provider communication Scheduled provider call	Yes
Appointment Reminder Program	10/4/17	Clinical and Services Advisory Committee	Open	•Project approved Project on hold due to vendor issues.	Yes
Prior Authorization Parity	10/2/17	Clinical and Services Advisory Committee	Open	•Kickoff meeting took place on 10/2 and project plan in development. •Decisions finalized and approved for Phase I of project. •All changes effective 1/1/18 on track and communicated to providers.	No

Project	Date Initiated	Quality Committee Oversight	Status in 2017	Key Accomplishments	Performance Improvement Project?
				•Parity meetings with national team will restart in January to review their findings on additional analysis as well as discuss YES services being implemented 7/1/18.	
Person Centered Plan	9/13/17	Clinical and Services Advisory Committee	Open	•Project plan development. •Person centered plan template and checklist in development •Drafts for Call Scripts for member call lines completed.	No
School-Based Behavioral Health Care	10/11/17	Clinical and Services Advisory Committee	Open	•Boise Area providers notified of RFP. •6 agencies responded.	No
Community Funding for ACE's Survey	9/1/17	Recovery & Resiliency Council	Open	•Approved internally •United Foundation also approved	No
Recovery Center 2018 CHI Funding	9/1/17	Recovery & Resiliency Council	Open	• Moving forward to approve	No

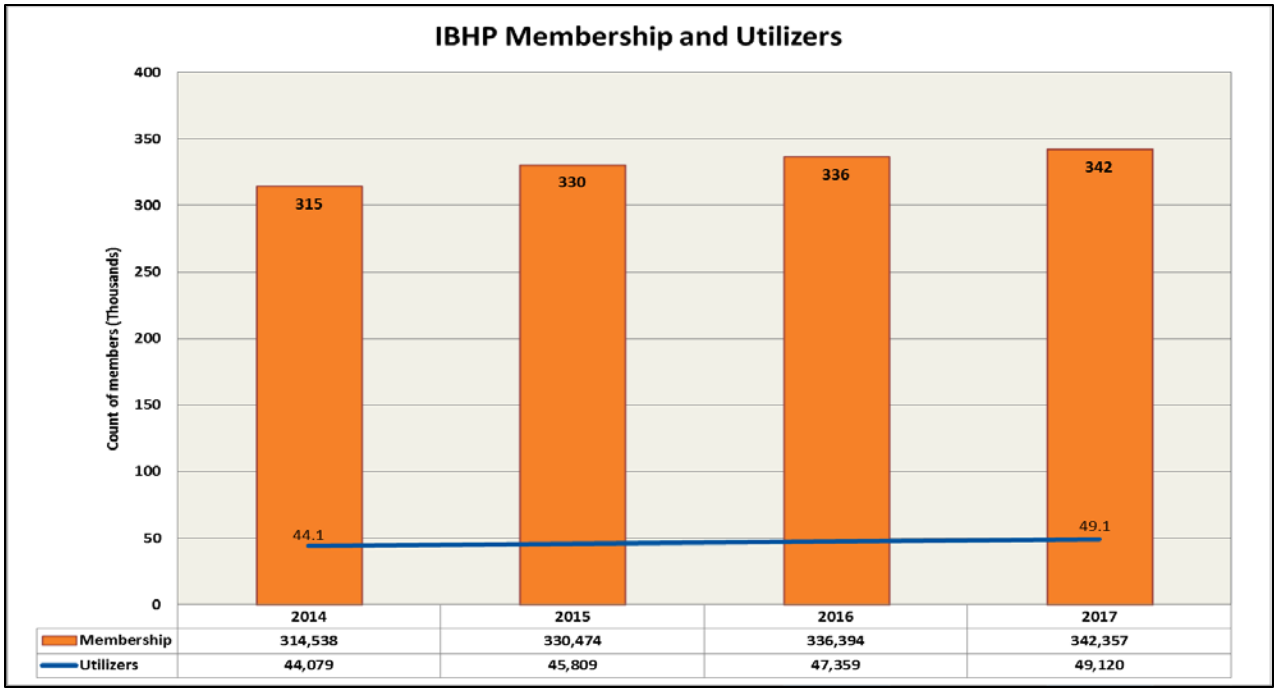
Analysis: The table above highlights 18 projects that were in process during 2017. Of the total number, 8 were Performance Improvement Projects. During the year, 8 of the projects were closed: *ALERT Peer Review, FCC Familiarity, Communication Plan for Youth Transition, Task Force for Youth Transition, IOP Phase I, A & G Mega Rule, LEAN (UM Service Request Process Improvement), Service Request Forms*. Ten (10) projects carried over into 2018.

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

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.



Analysis: Over the past 4 years, membership numbers and utilizers have increased.

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

Member Services Call Standards

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

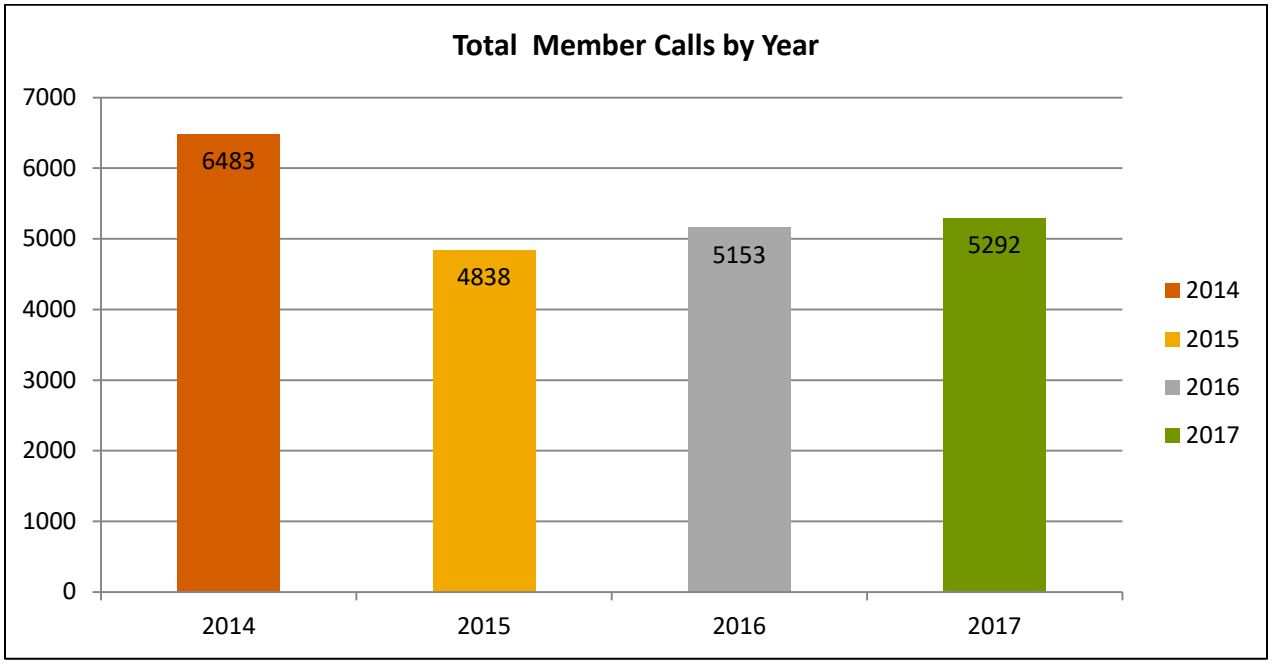
To ensure we meet our member's needs in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to answer and call abandoned rate. Data source is Avaya's Communication system (ProtoCall).

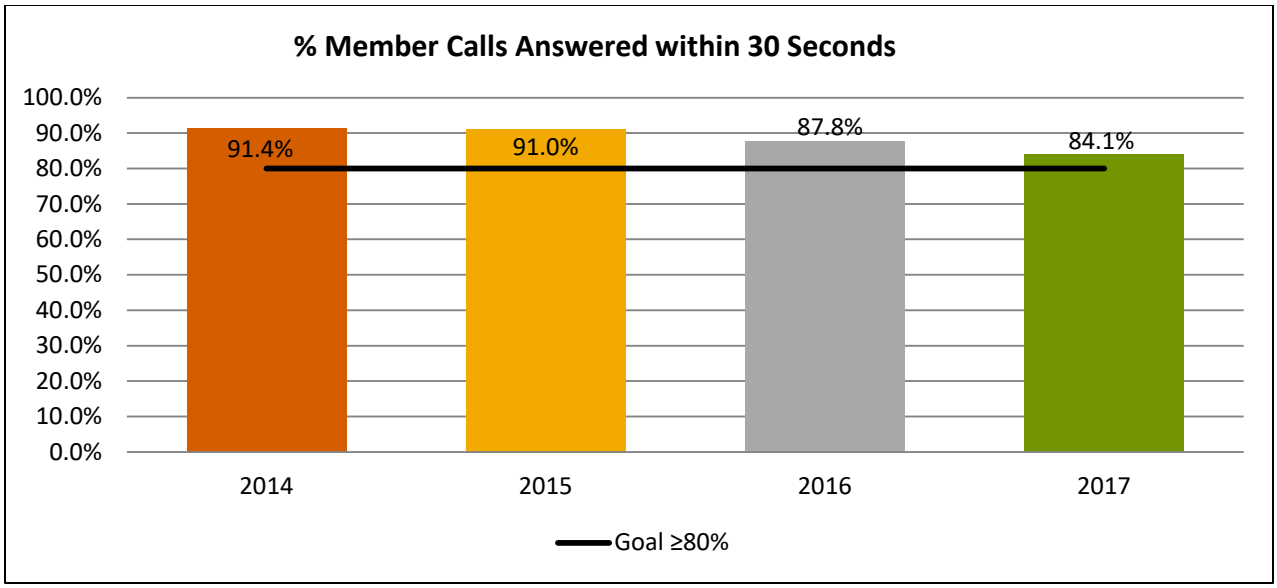
2014 – 2017 Overall Performance Results

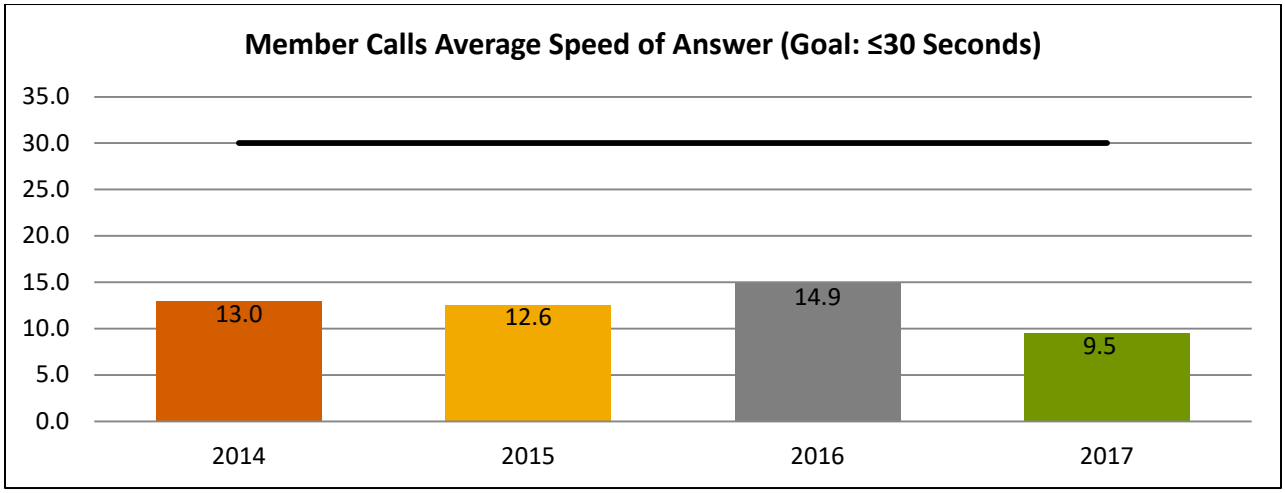
Member Service Line	Optum Idaho Standards	IBHP Contract Standards	2014	2015	2016	2017
Total Number of Calls	NA	NA	6,483	4,838	5,153	5,292

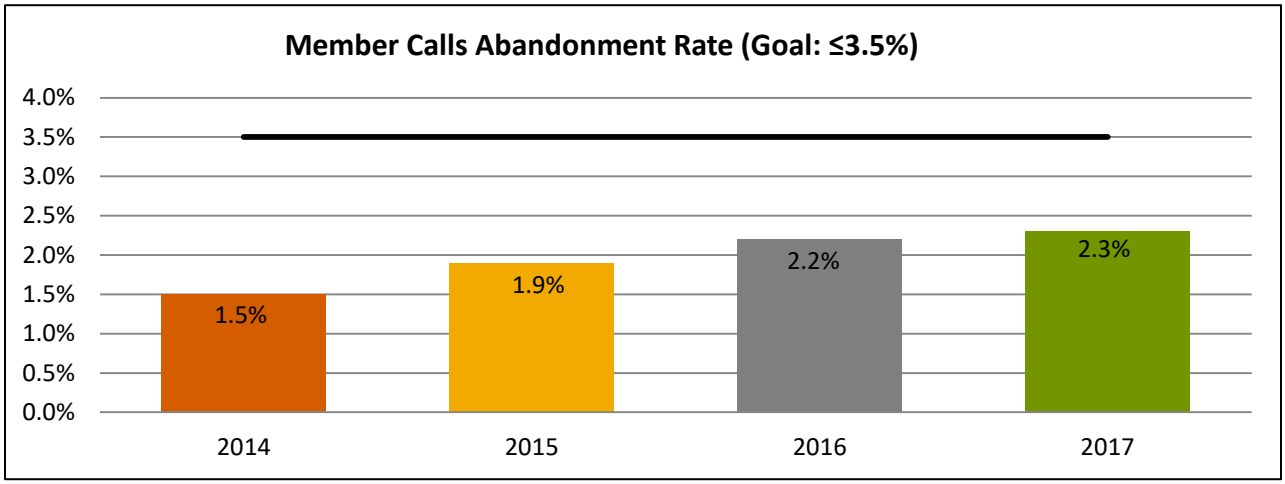
Member Service Line	Optum Idaho Standards	IBHP Contract Standards	2014	2015	2016	2017
Percent of Calls Answered Within 30 Seconds	≥80.0%	None	91.4%	91.0%	87.8%	84.1%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	13.0 sec	12.6 sec	14.9 sec	9.5 sec
Abandonment Rate	≤3.5%	≤7%	1.5%	1.9%	2.2%	2.3%

Analysis: The Member Services and Crisis Line received a total of 5,292 calls during 2017. Optum Idaho again exceeded all established performance call standards during 2017, including calls answered within 30 seconds, average speed to answer, and call abandonment rate.




% Member Calls Answered within 30 Seconds
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
91.4%
91.0%
87.8%
84.1%
2014
2015
2016
2017
Goal ≥80%


Member Calls Average Speed of Answer (Goal: ≤30 Seconds)
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
13.0
12.6
14.9
9.5
2014
2015
2016
2017


Member Calls Abandonment Rate (Goal: ≤3.5%)
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
1.5%
1.9%
2.2%
2.3%
2014
2015
2016
2017

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

Customer Service (Provider Calls) Standards

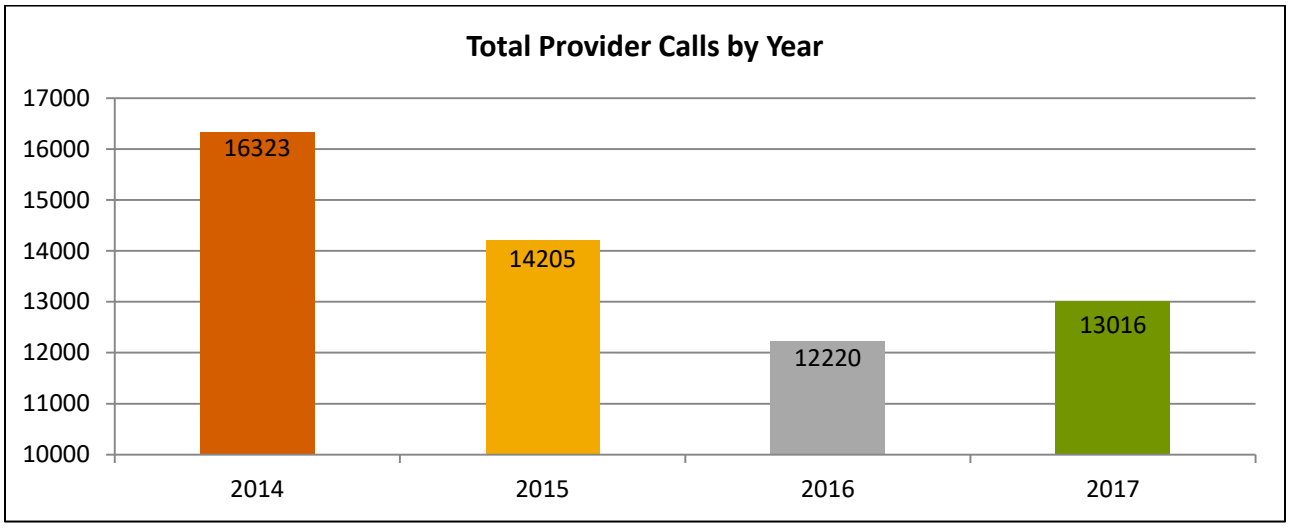
Methodology: The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho. To ensure the needs of our providers and stakeholders are met in a timely and efficient manner, Optum established performance targets that exceeded IBHP contractual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

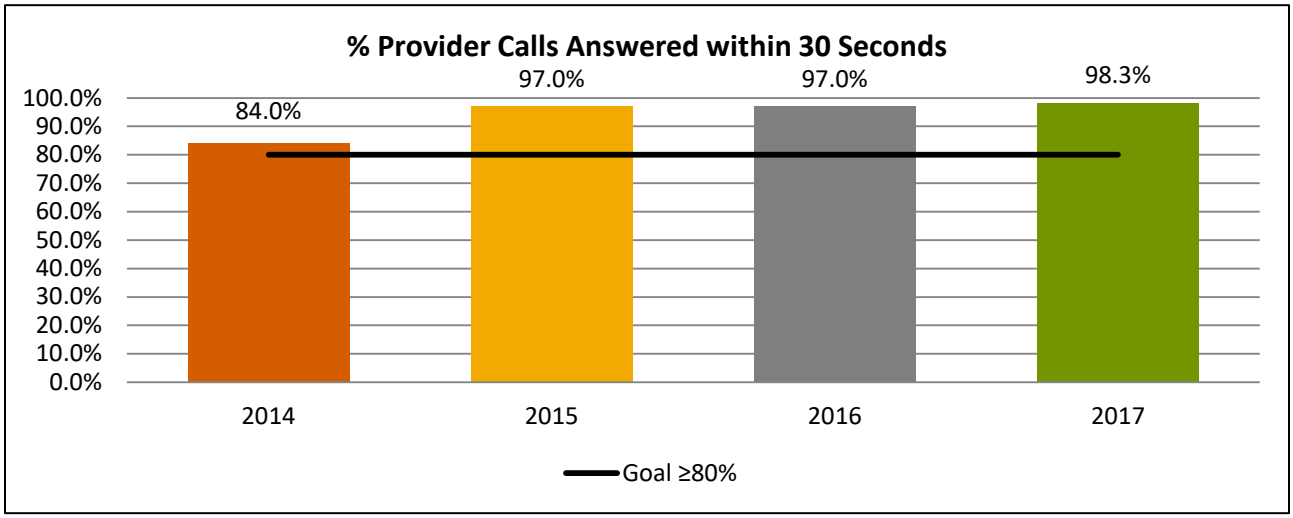
2014 – 2017 Overall Performance Results

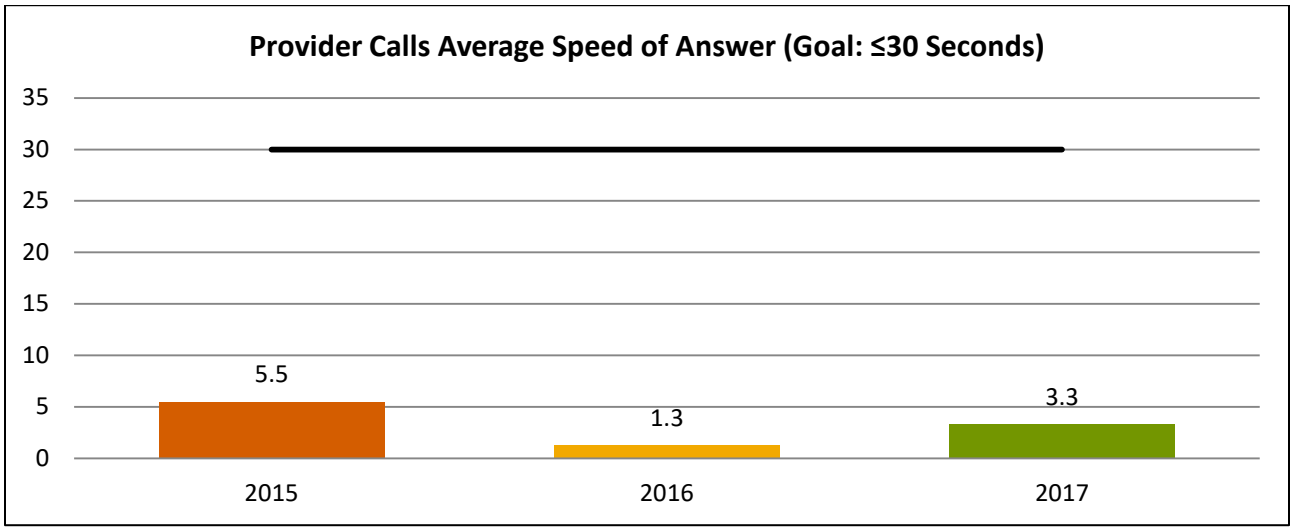
Customer Service (Provider) Line	Optum Idaho Standards	IBHP Contract Standards	2014	2015	2016	2017
Total Number of Calls	NA	NA	16,323	14,205	12,220	13,016
Percent of Calls Answered Within 30 Sec	≥80.0%	None	84.0%	97.0%	97.0%	98.3%
Average Speed of Answer*	≤30 Seconds	120 seconds (2 minutes)	NA*	5.5 sec	1.3 sec	3.3 sec
Abandonment Rate	≤3.5%	≤7%	2.9%	0.6%	0.3%	0.4%

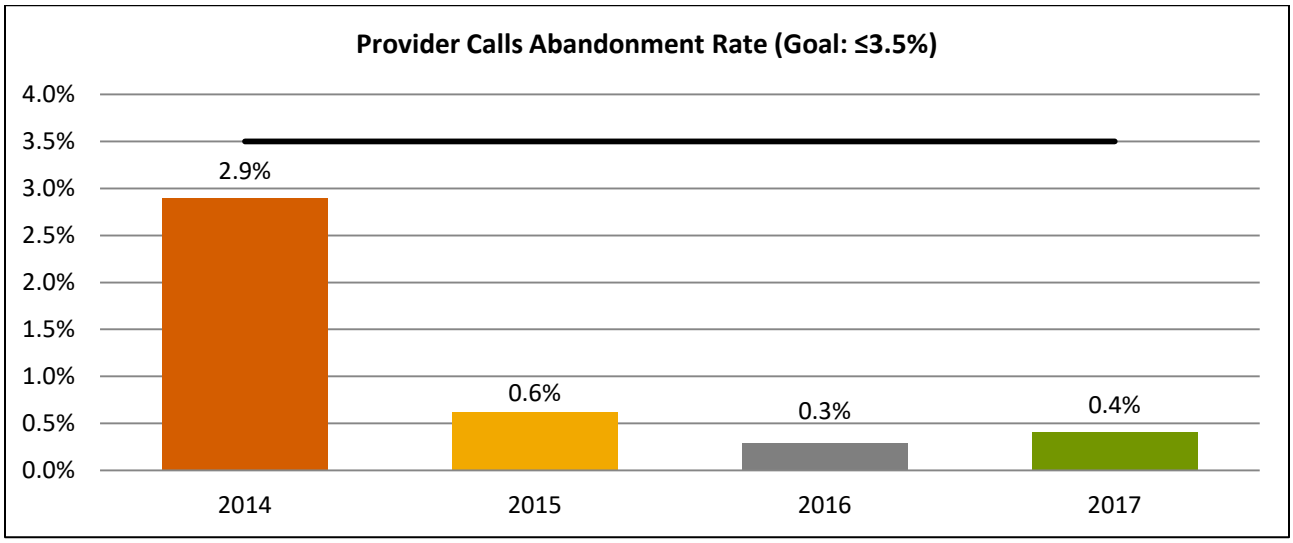
***** began tracking in 2015

Analysis: The Customer Service Line received 13,016 calls during 2017. Optum Idaho again exceeded all established performance call standards during 2017, including calls answered within 30 seconds, average speed of answer, and call abandonment rate.




% Provider Calls Answered within 30 Seconds
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
84.0%
97.0%
97.0%
98.3%
2014
2015
2016
2017
Goal ≥80%


Provider Calls Average Speed of Answer (Goal: ≤30 Seconds)
35
30
25
20
15
10
5
0
5.5
1.3
3.3
2015
2016
2017


Provider Calls Abandonment Rate (Goal: ≤3.5%)
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
2.9%
0.6%
0.3%
0.4%
2014
2015
2016
2017

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

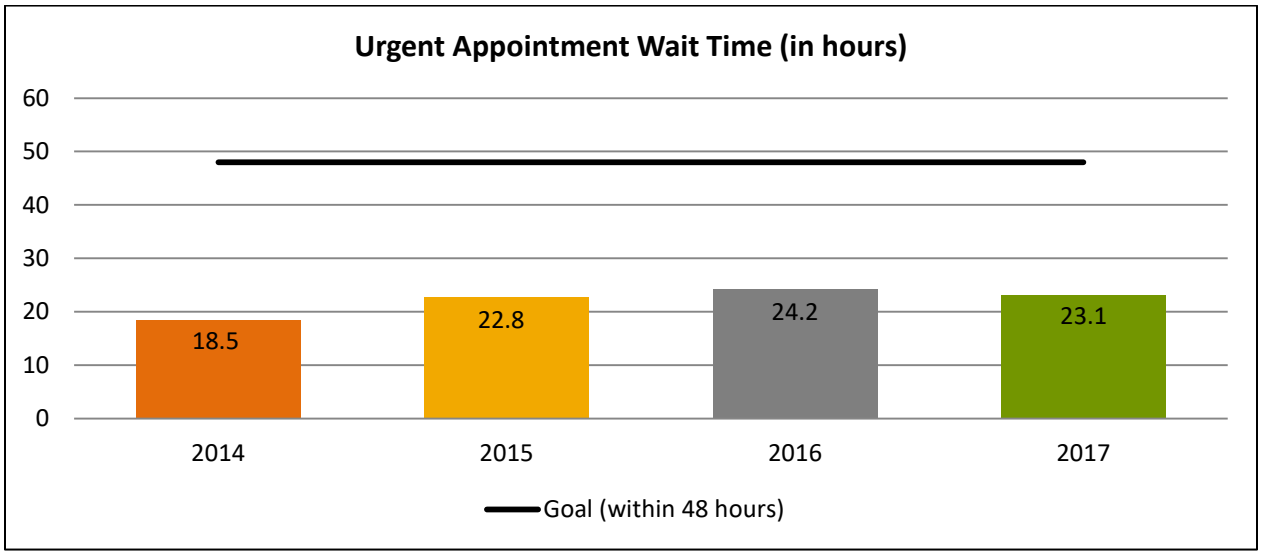
Urgent and Non-Urgent Access Standards

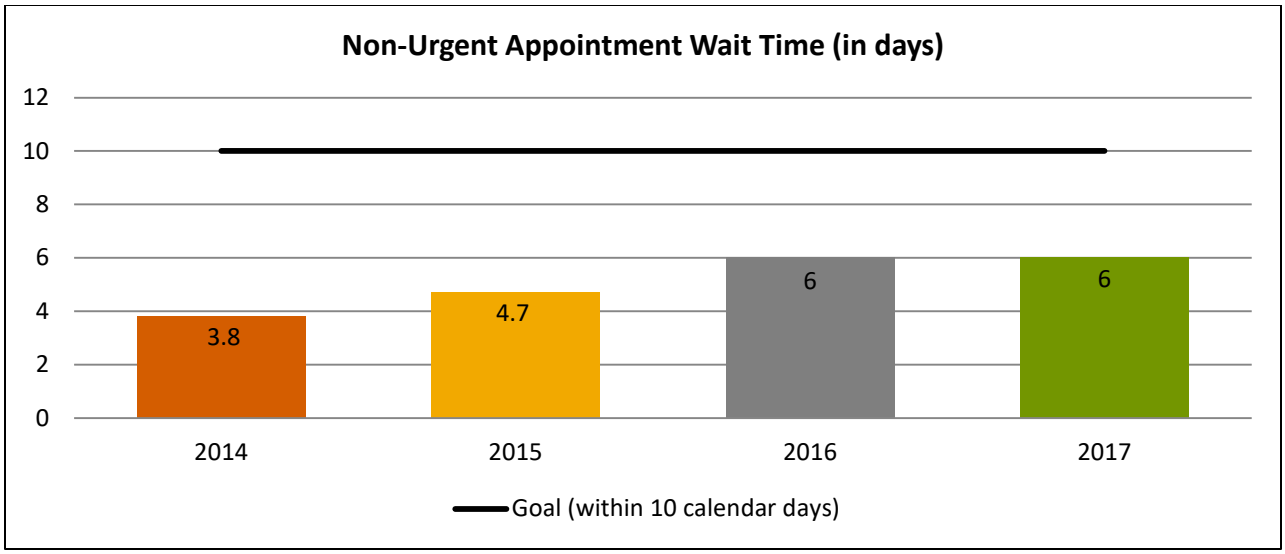
Methodology: To ensure that all members have access to appropriate treatment as needed, Optum developed, maintains, and monitors a provider network with adequate clinicians and outpatient programs. Optum requires that the network providers offer *Urgent Appointments* within 48 hours of request and *Non-urgent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

2014 – 2017 Overall Performance Results

Urgent/Non-Urgent Appointment Wait Time	Performance Goal	2014	2015	2016	2017
Urgent Appointment Wait Time	Within 48 hours (hrs) from request	18.5 hrs	22.8 hrs	24.2 hrs	23.1 hrs
Non-Urgent Appointment Wait Time	Within 10 days from request	3.8 days	4.7 days	6 days	6 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. Optum Idaho again exceeded the performance goal during 2017. The overall average wait time for an urgent appointment in 2017 was 23.1 hours. The performance goal for Non-Urgent appointment wait time is 10 business days. Optum Idaho again exceeded the performance goal during 2017. The average wait time for a non-urgent appointment during 2017 was 6 days.





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

Geographic Availability of Providers

Methodology: GeoAccess reporting enables the accessibility of health care networks to be accurately measured based on the geographic locations of health care providers relative to those of the members being served. On a quarterly basis, Optum Idaho runs a report using GeoAccess™ software to calculate estimated drive distance, based on zip codes of unique members and providers/facilities. Performance standards are determined by calculating the percentage of unique members who have availability of each level of /service provider and type of provider/service within the established standards.

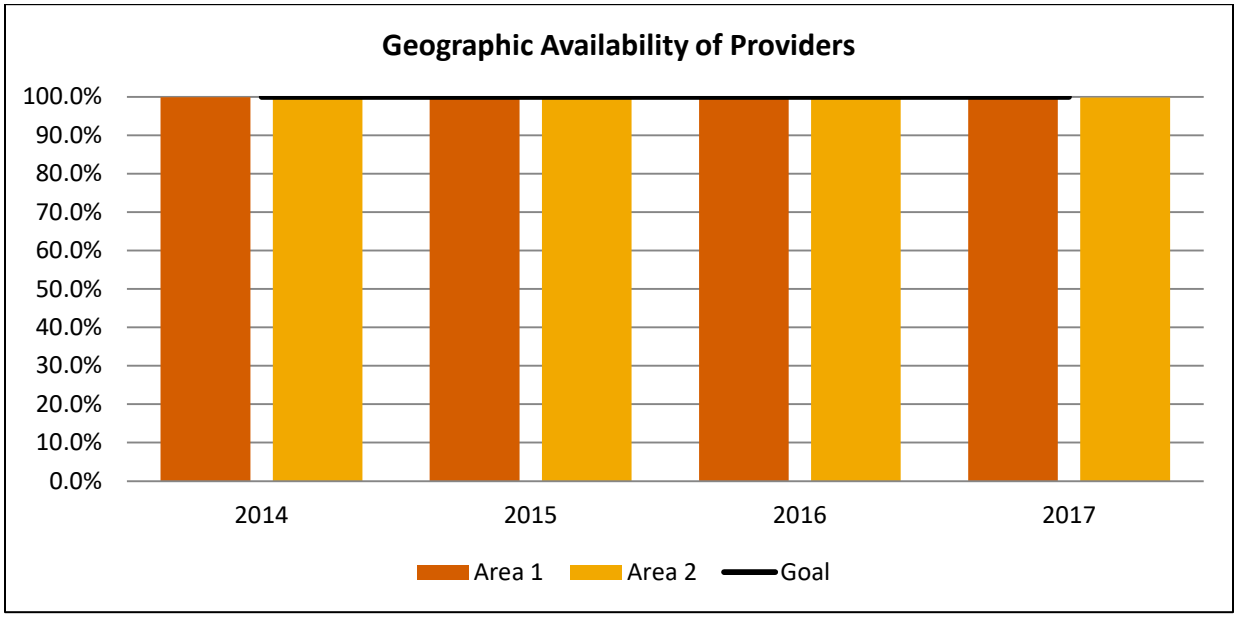
Optum Idaho's contract availability standards for "Area 1" requires one (1) provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties. For the remaining 41 counties (37 remaining within the state of Idaho and 4 neighboring state counties) in "Area 2" Optum Idaho's standard is one (1) provider in 45 miles.

2014 – 2017 Overall Performance Results

Geographic Availability of Providers	Performance Goal	2014	2015	2016	2017
Area 1 (within 30 miles)	100.0%	99.9	99.8	99.8	99.9
Area 2 (within 45 miles)	100.0%	99.8	99.9	99.8	99.8

Analysis: During 2017, Optum Idaho continued to meet contract provider availability standards. Area 1 availability standards were met at 99.9% and Area 2 availability standards were met at 99.8%. (Performance is viewed as meeting the goal due to established rounding methodology – rounding to the nearest whole number). As of December 2017, the IBHP had 4,634 providers, an increase from 4,359 at the end of 2016, practicing in 708 locations

(compared to 671 at the end of 2016), which consist of individually credentialed, and roster clinicians and agencies.



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

Member Protections and Safety

Optum's policies, procedures and guidelines, along with the quality monitoring programs, are designed to help ensure the health, safety and appropriate treatment of Optum 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, make a determination to authorize services or deny services in total or in part, and mail the ABD

notification if the decision was to deny services in total or in part. An ABD can be based from Clinical or Administrative guidelines.

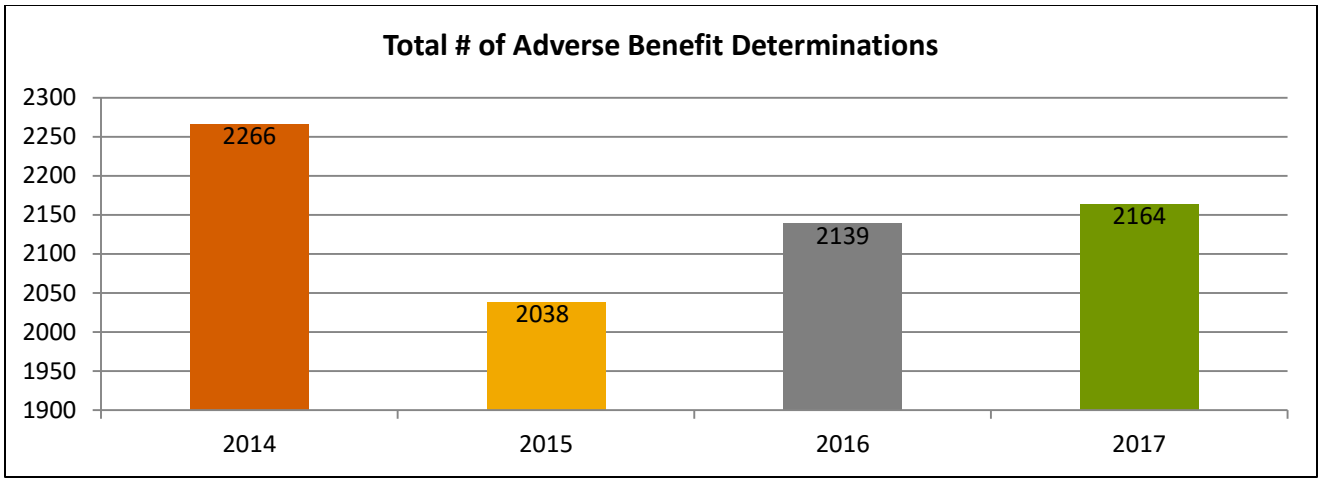
2014 – 2016 Overall Performance Results

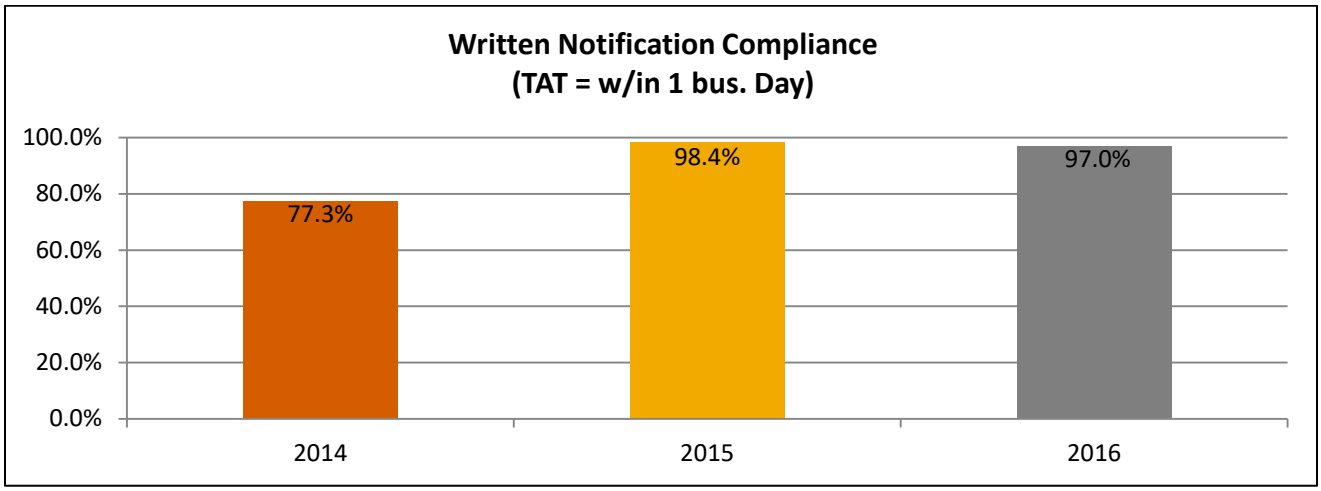
Notification of ABD	Performance Goal	Target	2014	2015	2016
Total # of ABD's	NA	NA	2,266	2,038	2,139
Written Notification	Written notice is sent within 1 business day following verbal notification	100.0%	77.3%	98.4%	97.0%

2017 Overall Performance Results

Notification of ABD	Performance Goal	Target	Q1 2017	Q2 2017	Q3 2017	Q4 2017
Total # ABD's	NA	NA	416	500	756	492
Clinical ABD's	NA	NA	NA	NA	578	352
Administrative ABD's	NA	NA	NA	NA	178	140
Written Notification	14 calendar days from request for services	NA	NA	NA	100.0% (756/756)	99.8% (491/492)
Initial Verbal Notification to Provider	1 business day from determination date	100.0%	99.8%	99.6%	No longer tracking	No longer tracking
Written Notification	1 business day from verbal notification	100.0%	98.3% (409/416)	99.8% (499/500)	New 14 day requirement above	New 14 day requirement above

Analysis: Optum's performance ABD goals were revised at the beginning of Q3, 2017, as a result of new federal regulations and Optum performance initiatives. Optum eliminated the requirement for verbal notifications for standard service requests and revised the timeframe of ABD notifications to be mailed within 14 calendar days from receipt of the service request. Additionally, Optum began issuing Administrative Denials in Q3. Administrative denials are issued when service requests fall outside of administrative guidelines set by Optum Idaho.





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

Member Appeals (formerly grievances)

Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an adverse benefit determination that resulted in member financial liability or denied services. All non-urgent appeals are required to be reviewed and resolved within 30 days. Urgent appeals are required to be reviewed and resolved within 72 hours. Additionally, all non-urgent appeals are required to be acknowledged within 5 calendar days from receipt of the complaint with an acknowledgement letter. Urgent appeal requests do not require an acknowledgement letter. All appeals are upheld, overturned, or partially overturned.

2014 – 2017 Overall Performance Results

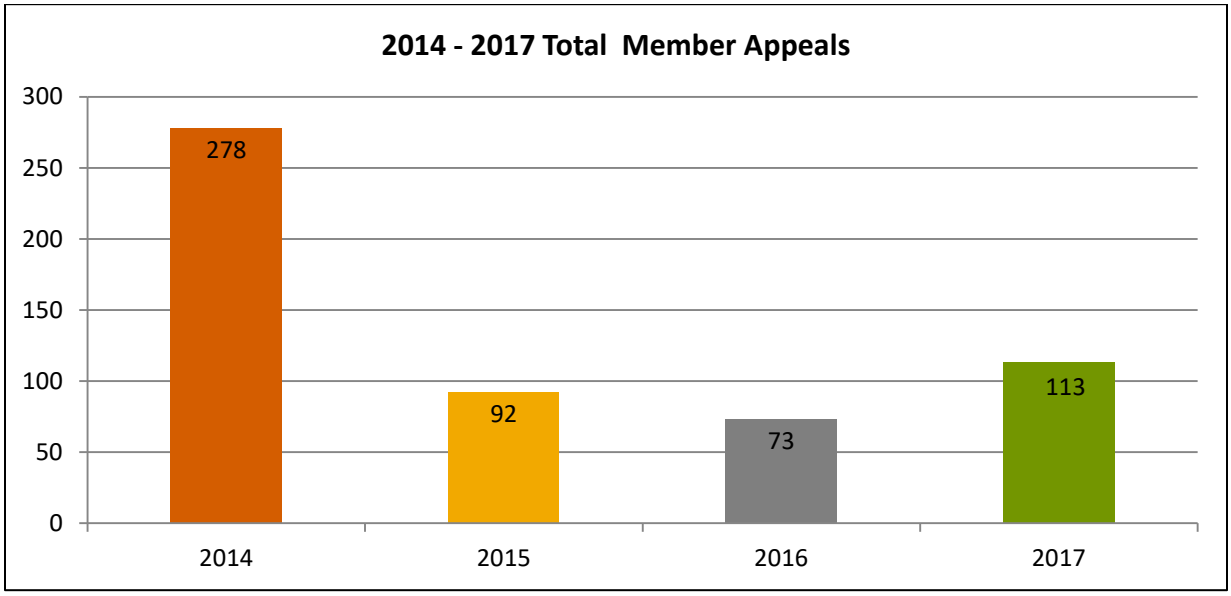
Appeals	Performance Goal	2014	2015	2016	2017
Number of Member Appeals	NA	278	92	73	113
Average Number of Days to Resolution	30 Days	9.8	11.5	15.5	7.9

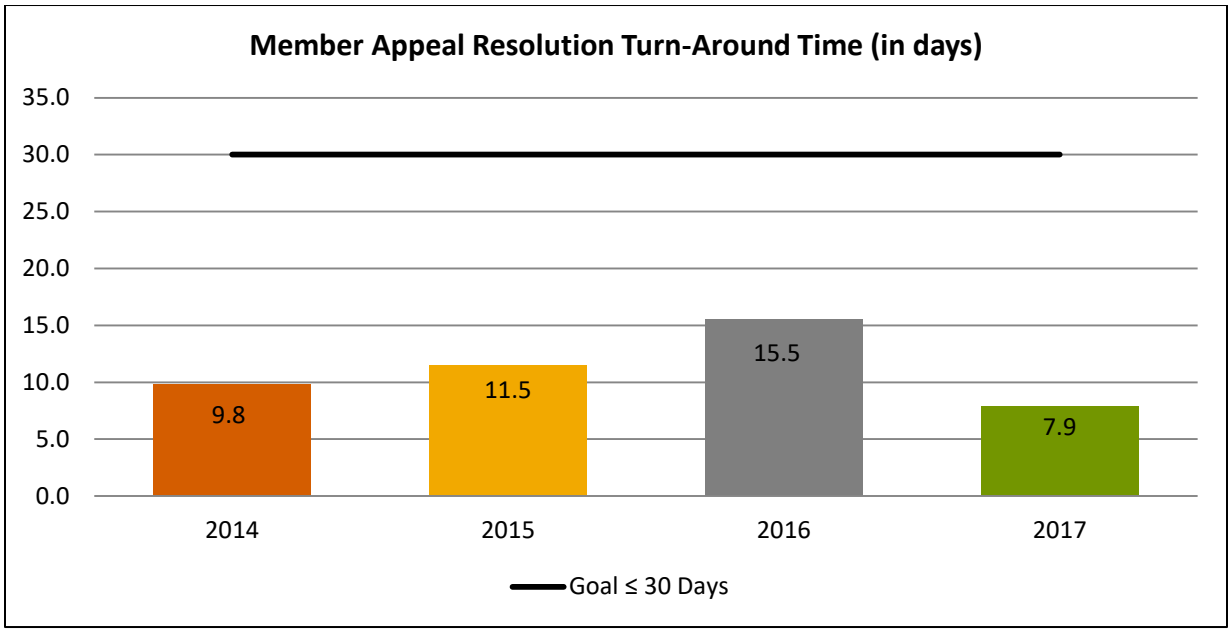
Non-Urgent Appeals	Performance Goal	Q3 2017	Q4 2017
Total Appeal Determinations	NA	36	26
Acknowledgement Compliance	5 Calendar Days	100.0%	100.0%
Determination Compliance	30 Calendar Days	100.0%	100.0%
Average Days to Resolve	30 Calendar Days	5.4	4.3
Overturned Non-Urgent Appeals	NA	4	1
Partially Overturned Non-Urgent Appeals	NA	5	16

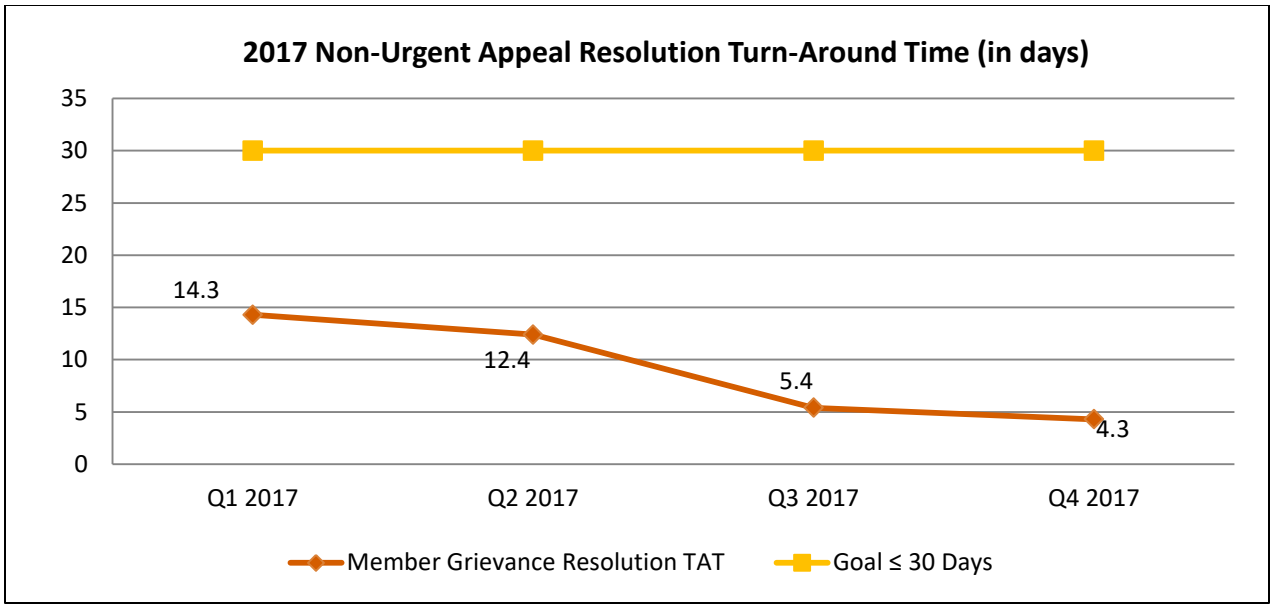
Urgent Appeals	Performance Goal	Q3 2017	Q4 2017
Total Appeal Determinations	NA	15	4
Determination Compliance	72 Hours	100.0%	100.0%
Average Hours to Resolve	72 Hours	27.4	23.0
Overturned Urgent Appeals	NA	7	2
Partially Overturned Urgent Appeals	NA	4	0

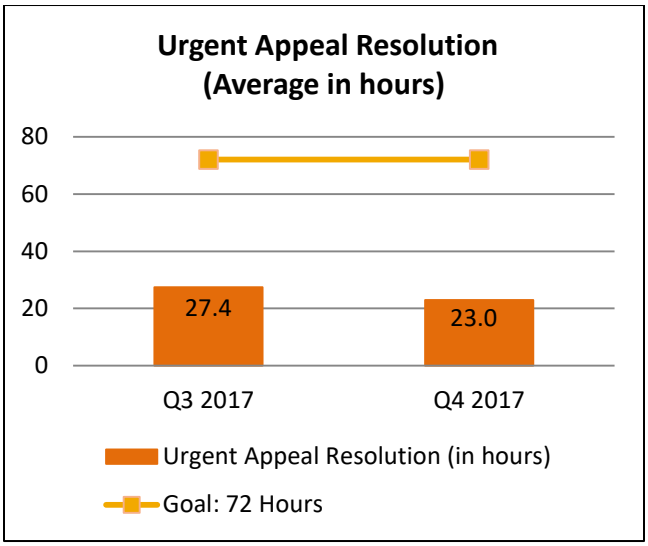
Analysis: The CMS Mega Rule, released July 1, 2017, impacted Optum Idaho's appeal process by allowing easier requests for urgent appeals and adjusting turnaround time requirements. As of July 1, 2017 members get 60 days from the date of the Adverse Benefit

Determination letter to file an appeal – up from the previous deadline of 30 days. Optum met all turnaround requirements and performance goals in 2017.









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

Complaint Resolution and Tracking

Methodology: A complaint is an expression of dissatisfaction logged by a member, a member's authorized representative or a provider concerning the administration of the plan and services received. This is also known as a Quality of Service (QOS) complaint. A concern that relates to the quality of clinical treatment services provided by an individual provider or agency in the Optum Idaho network is a Quality of Care (QOC) concern.

Complaints are collected and grouped into the following broad categories: Benefit, Service (and Attitude), Access (and Availability), Billing & Financial, Quality of Care, Privacy Incident, and Quality of Practitioner Office Site.

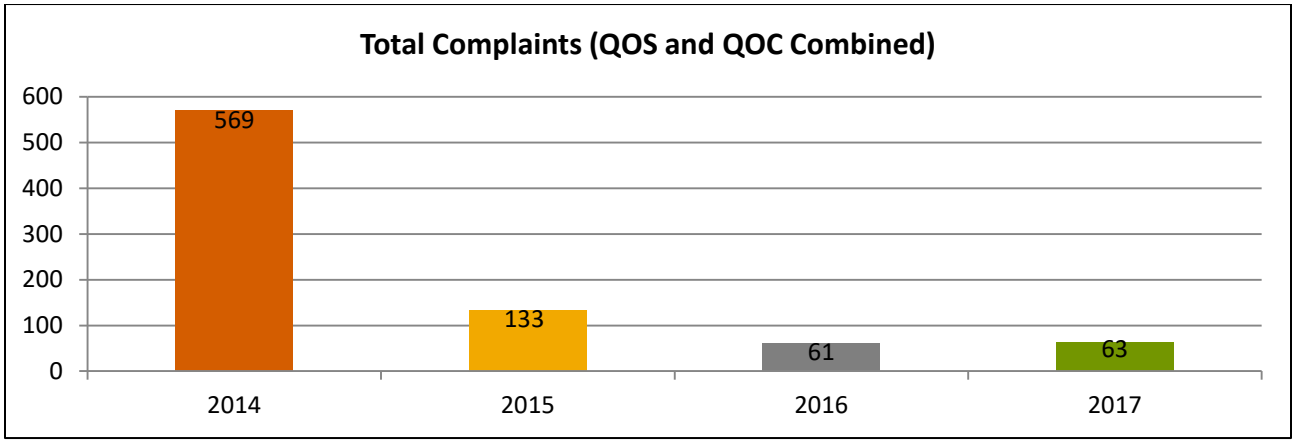
Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for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

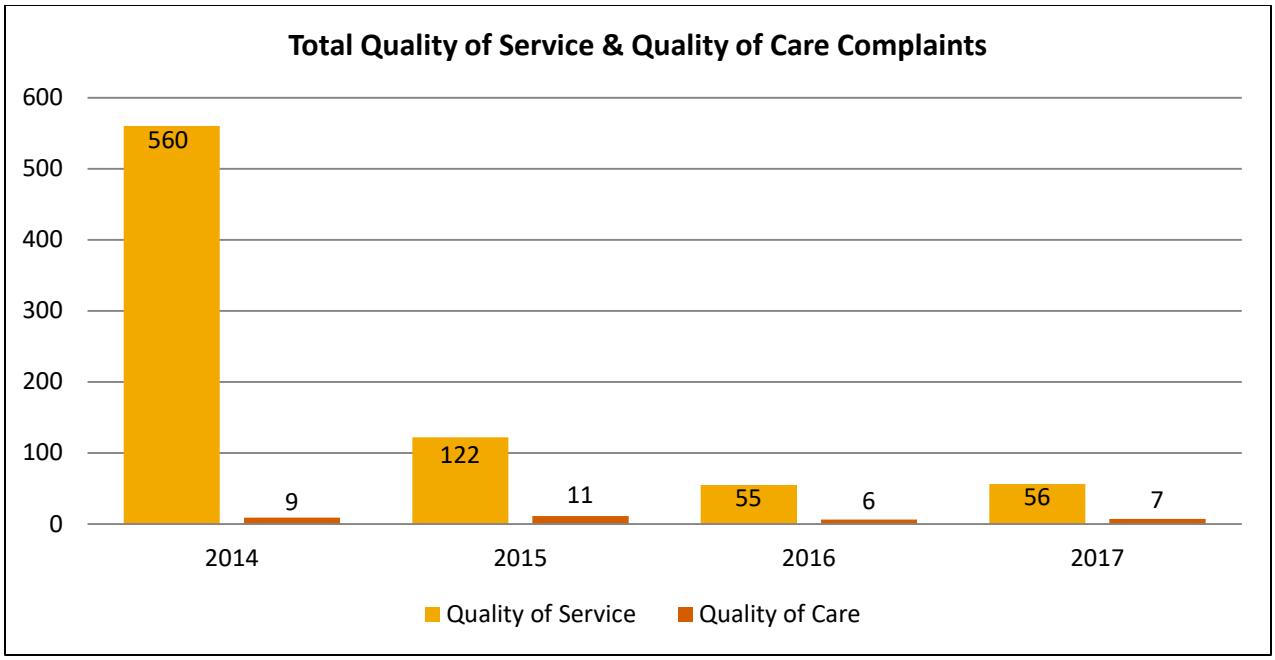
Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Calendar Days

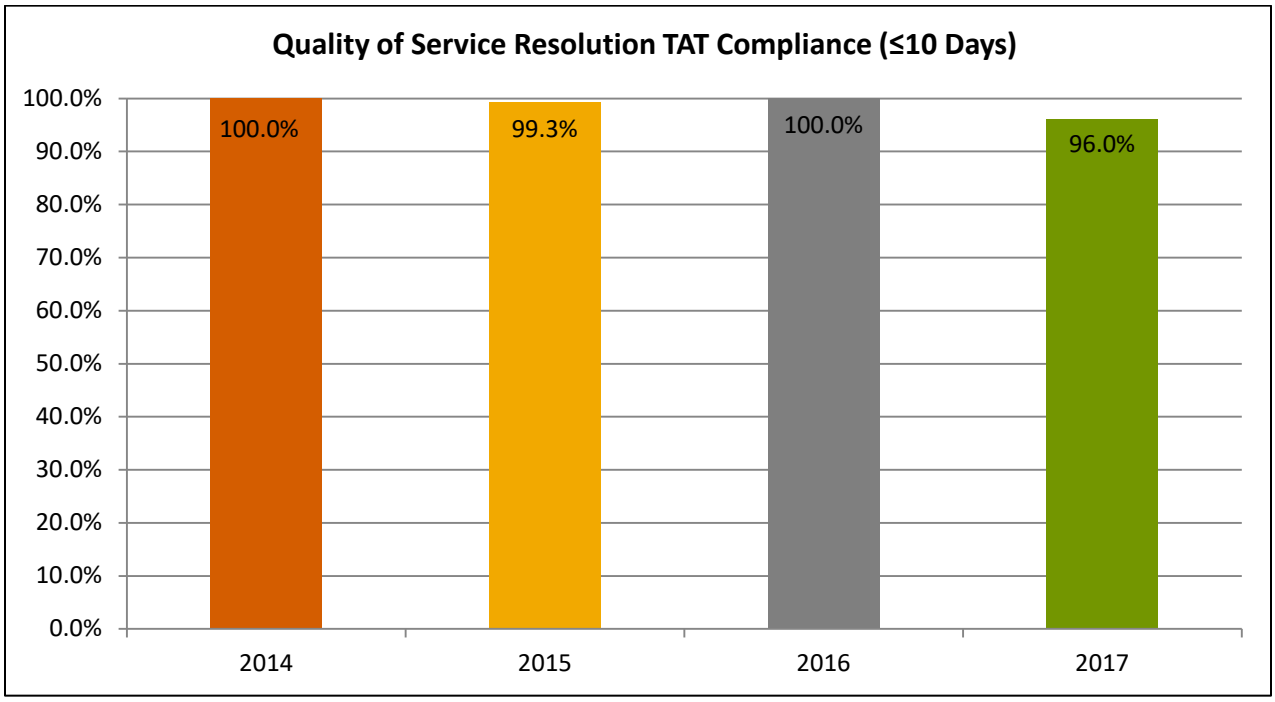
2014 – 2017 Overall Performance Results

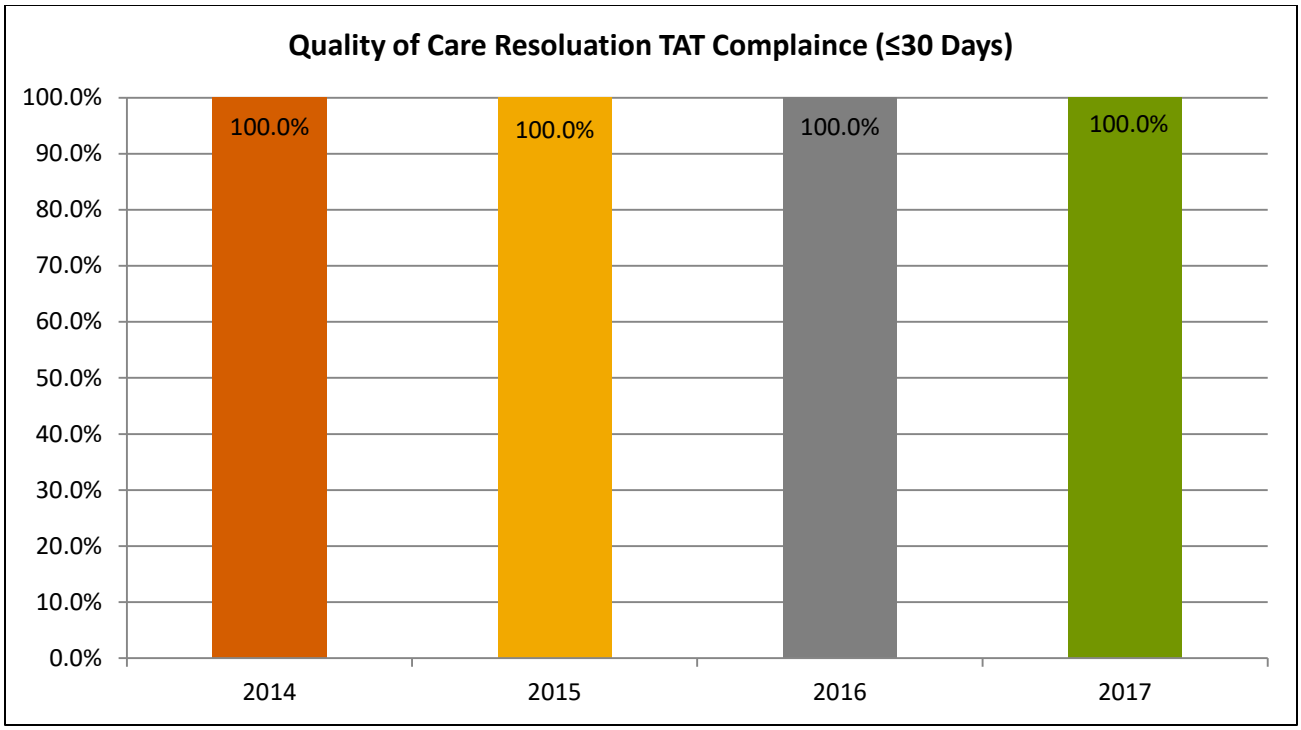
Complaints	Performance Goal	2014	2015	2016	2017
Number of Quality of Service (QOS) Complaints Received	NA	560	122	55	56
Percent QOS Complaints Resolved w/in TAT	10 Days	100.0%	99.3%	100.0%	96.4%
Number of Quality of Care Complaints (QOC) Received	NA	9	11	6	7
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%	100.0%

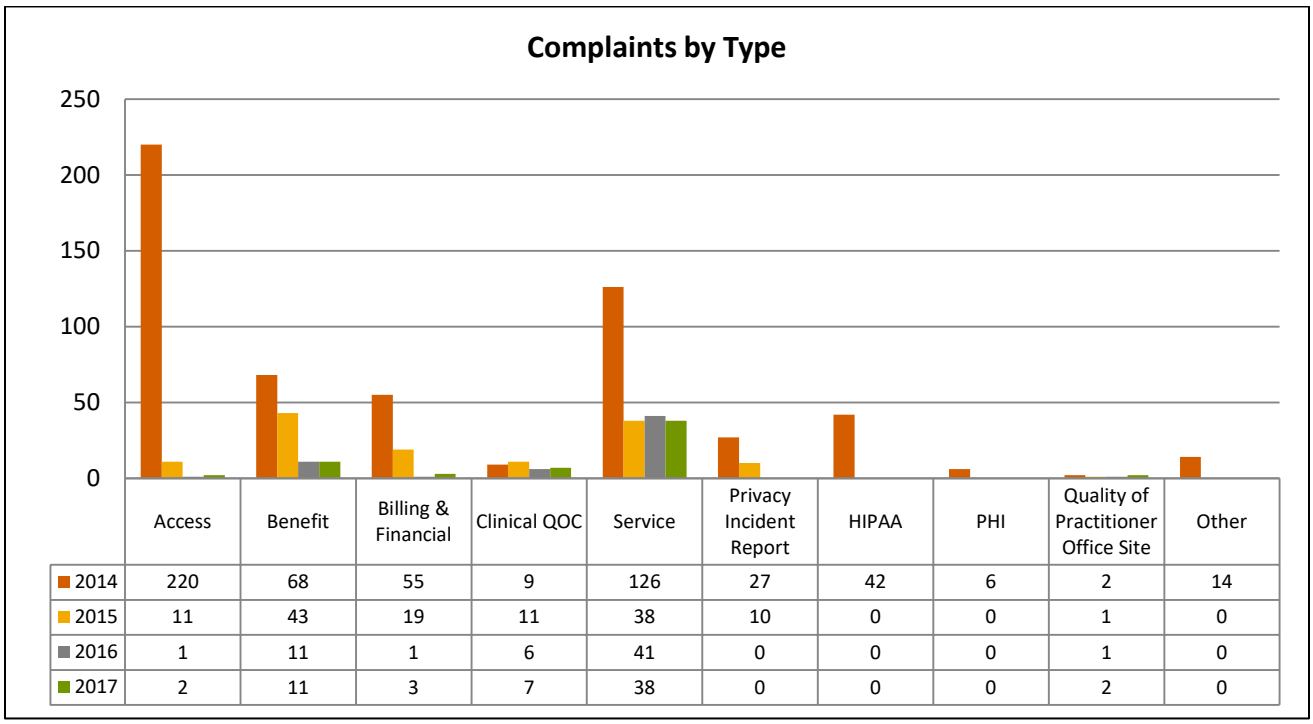
Analysis: There were 63 total complaints (QOS and QOC combined) received during 2017. Of the total complaints received during 2017, 56 were identified as Quality of Service and 7 were identified as Quality of Care. Due to the nature of the complaints, during Q1, two QOS complaints fell outside the resolution turnaround time by 1 business day. Optum met the goal of QOC complaints resolved within 30 days.




Total Quality of Service & Quality of Care Complaints
600
500
400
300
200
100
0
560
9
122
11
55
6
56
7
2014
2015
2016
2017
Quality of Service
Quality of Care


Quality of Service Resolution TAT Compliance (≤10 Days)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
100.0%
99.3%
100.0%
96.0%
2014
2015
2016
2017





	Access	Benefit	Billing & Financial	Clinical QOC	Service	Privacy Incident Report	HIPAA	PHI	Quality of Practitioner Office Site	Other
2014	220	68	55	9	126	27	42	6	2	14
2015	11	43	19	11	38	10	0	0	1	0
2016	1	11	1	6	41	0	0	0	1	0
2017	2	11	3	7	38	0	0	0	2	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.
- A serious suicide attempt by a member, requiring an overnight admission to a hospital medical unit that occurred while the member was receiving treatment services.
- An unexpected death of a member that occurred while the member was receiving agency based treatment or within 12 months of a member having received MH/SA treatment.
- A serious injury requiring an overnight admission to a hospital medical unit of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of a serious physical assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a sexual assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a serious physical assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of sexual assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A homicide that is attributed to a member who was engaged in treatment at any level of care at the time of the homicide, or within the previous 60 calendar days.
- A report of an abduction of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- An instance of care ordered or provided for a member by someone impersonating a physician, nurse or other health care professional.
- High profile incidents identified by the IDHW as warranting investigation.

Within Optum ID, 3 of the above Critical Incidents are classified as Sentinel Events:

- A completed suicide by a member who has engaged in treatment at any level of care at the time of death, or within the previous 60 calendar days.
- A homicide that is attributed to a member who was engaged in treatment at any level of care at the time of the homicide, or within the previous 60 calendar days.
- An instance of care ordered or provided for a member by someone impersonating a physician, nurse or other health care professional.

Optum has a Sentinel Events Committee (SEC) to review Critical Incidents that meet Optum's definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review Critical Incidents that do not meet Optum's definition of sentinel event. The SEC and PRC make

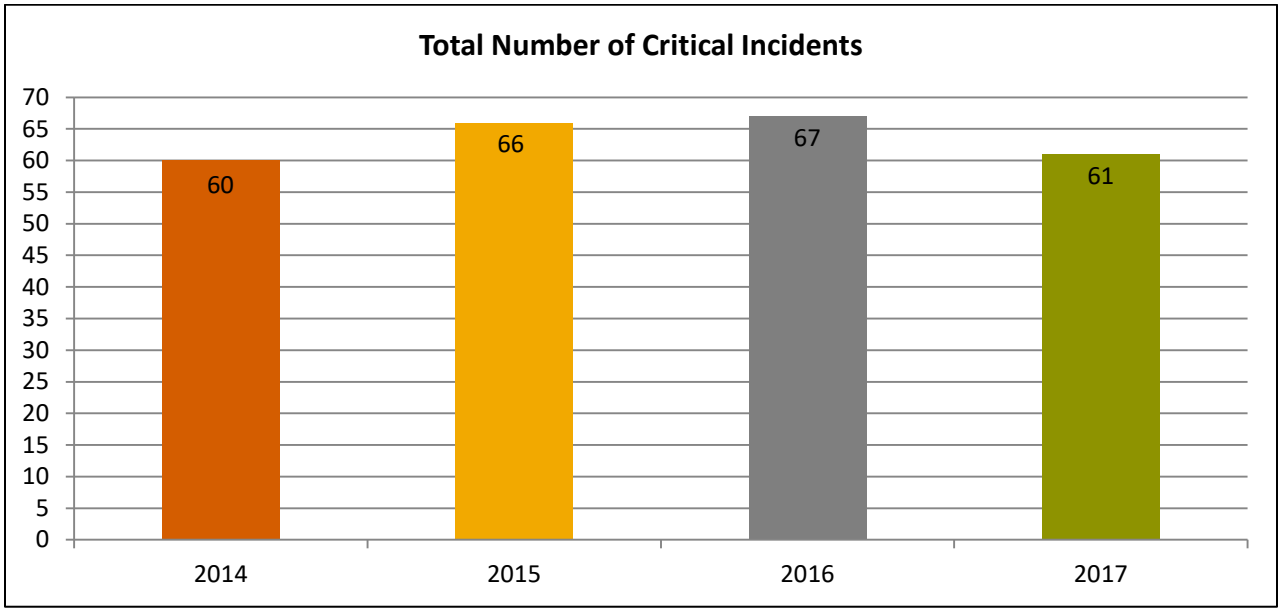
recommendations for improving patient care and safety, including recommendations that the Optum Provider Quality Specialists conduct site audits and/or record reviews of providers in the Optum network as well as providers working under an accommodation agreement with Optum to provide services to members. The SEC and PRC may provide providers with written feedback related to observations made as a result of the review of the Critical Incident. Critical Incident Ad-hoc review is completed within 5 days from notification of incident.

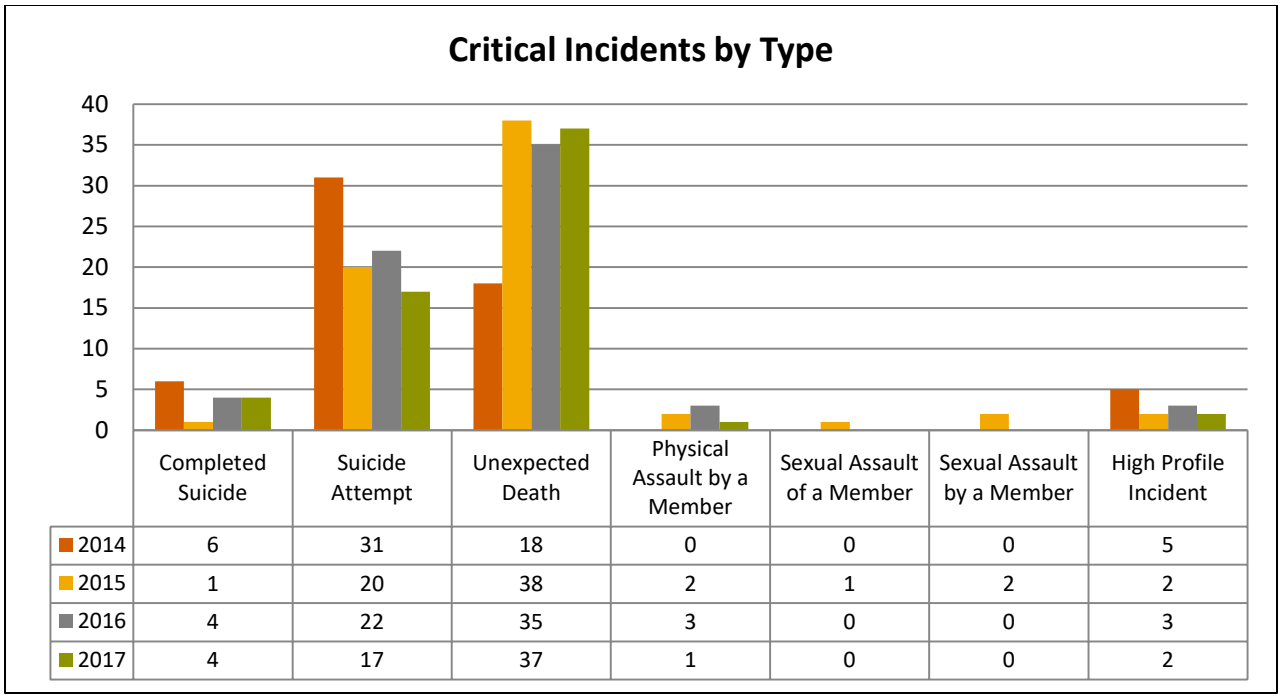
2014 – 2017 Overall Performance Results

Critical Incidents	Performance Goal	2014	2015	2016	2017
Number of CI's Received	NA	60	66	67	61
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100.0%	100.0%	100.0%	100.0%

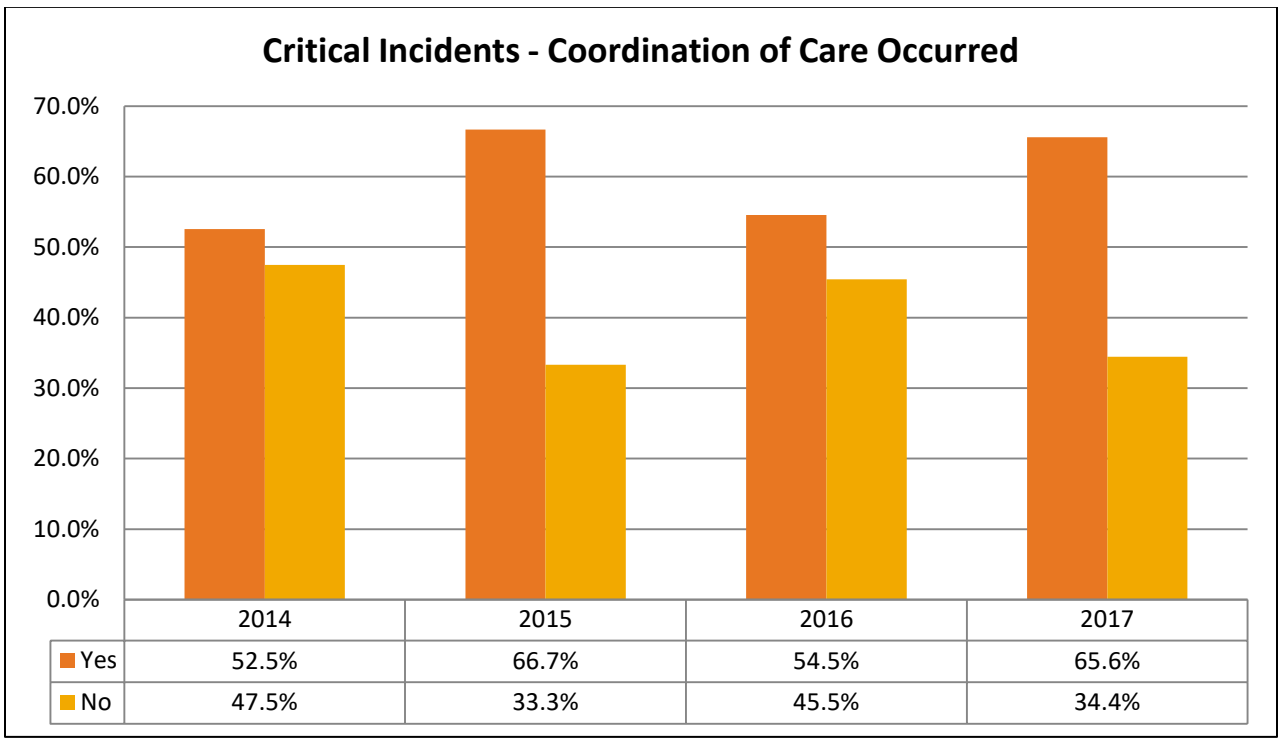
Analysis: There were 61 Critical Incidents reported during 2017. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was again met. The highest numbers of Critical Incidents reported in 2017 were in the category of Unexpected Deaths. Coordination of care occurred between the behavioral health provider and the member's primary care provider (PCP) in 65.6% of cases. Of the 61 reported Critical Incidents in 2017, 18.0% of males and 62.3% of females showed that member had a co-morbid health condition. Of the cases reported in 2017, 91.8% of the cases were adults (18+) and 8.2% were children/adolescents (17 and below). Further analysis showed that the average age for males was 37 and females 47.

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

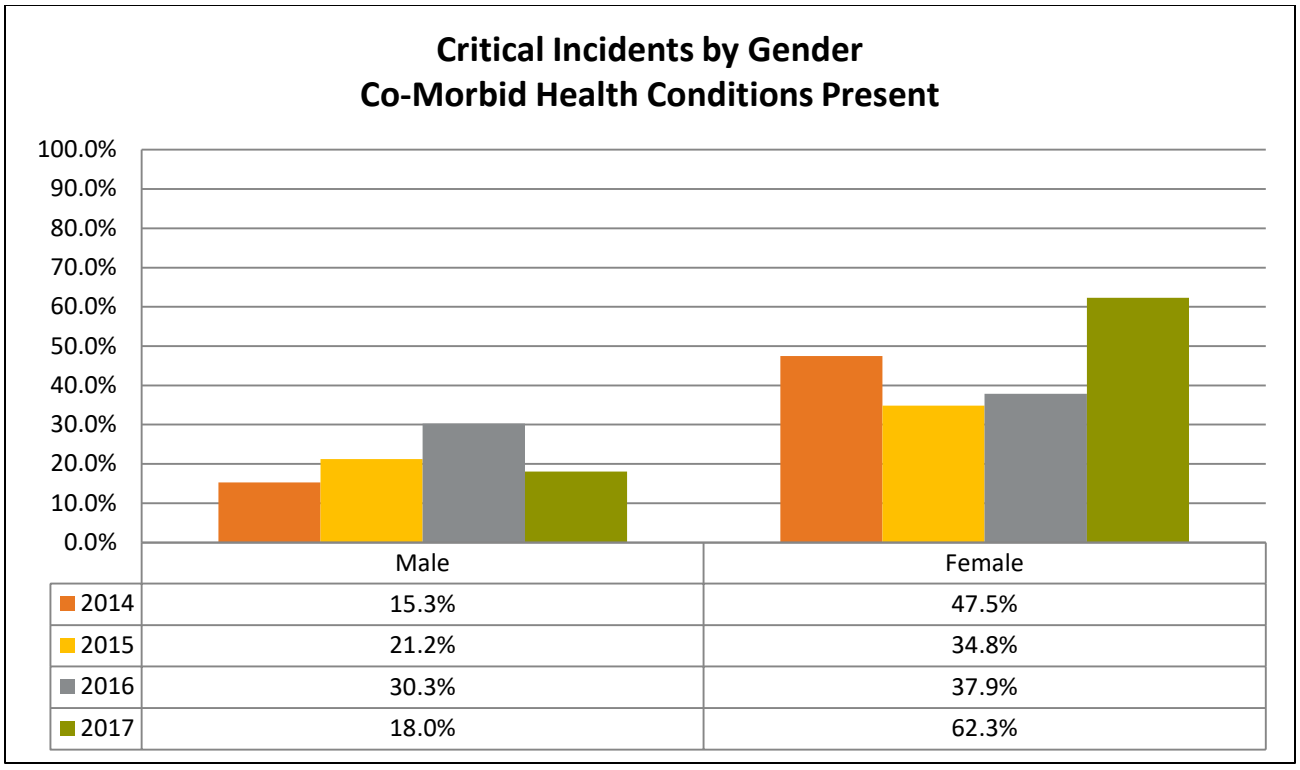




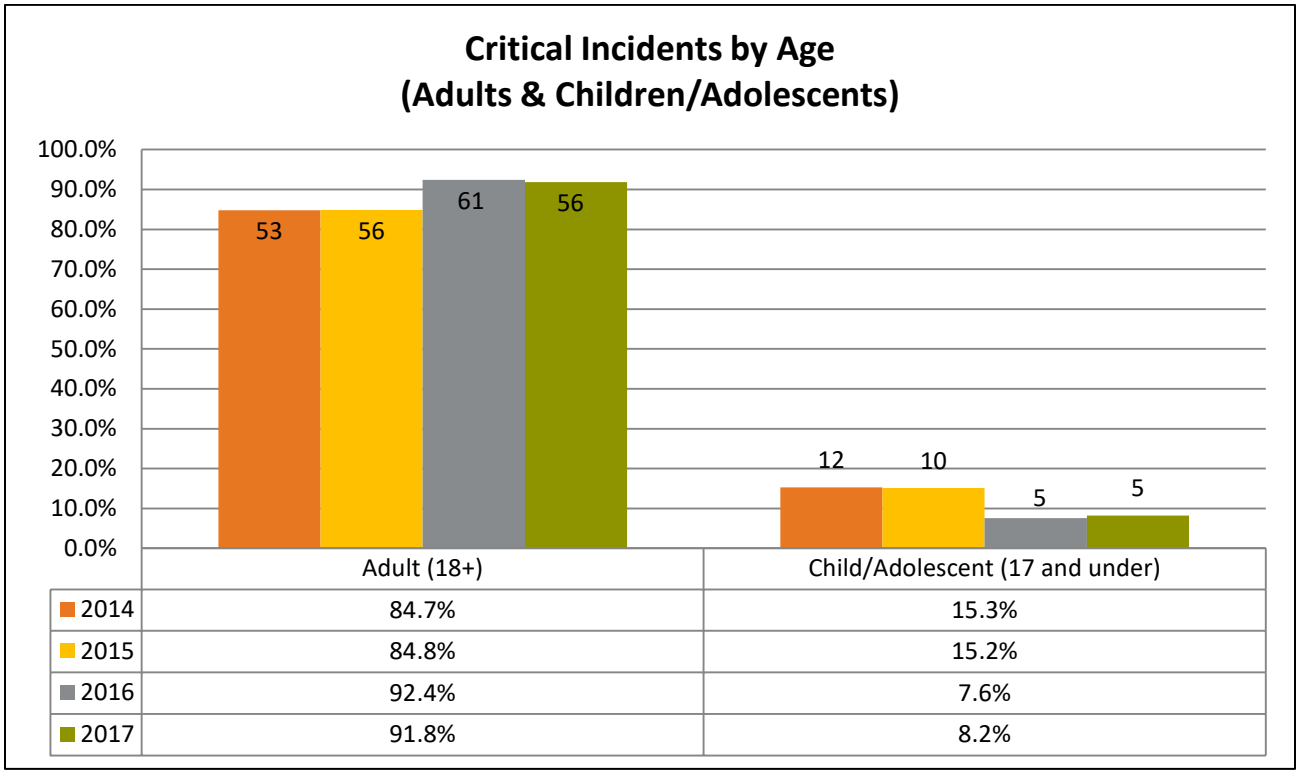
	Completed Suicide	Suicide Attempt	Unexpected Death	Physical Assault by a Member	Sexual Assault of a Member	Sexual Assault by a Member	High Profile Incident
2014	6	31	18	0	0	0	5
2015	1	20	38	2	1	2	2
2016	4	22	35	3	0	0	3
2017	4	17	37	1	0	0	2



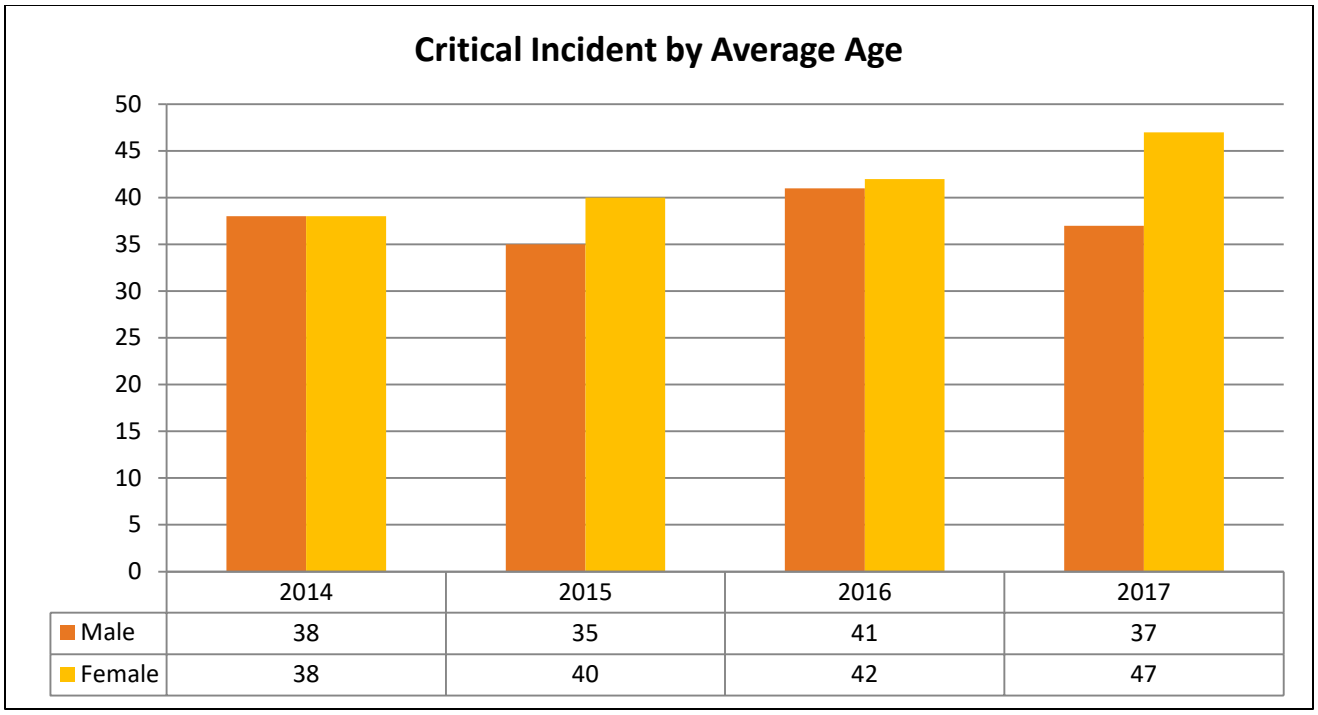
	2014	2015	2016	2017
Yes	52.5%	66.7%	54.5%	65.6%
No	47.5%	33.3%	45.5%	34.4%

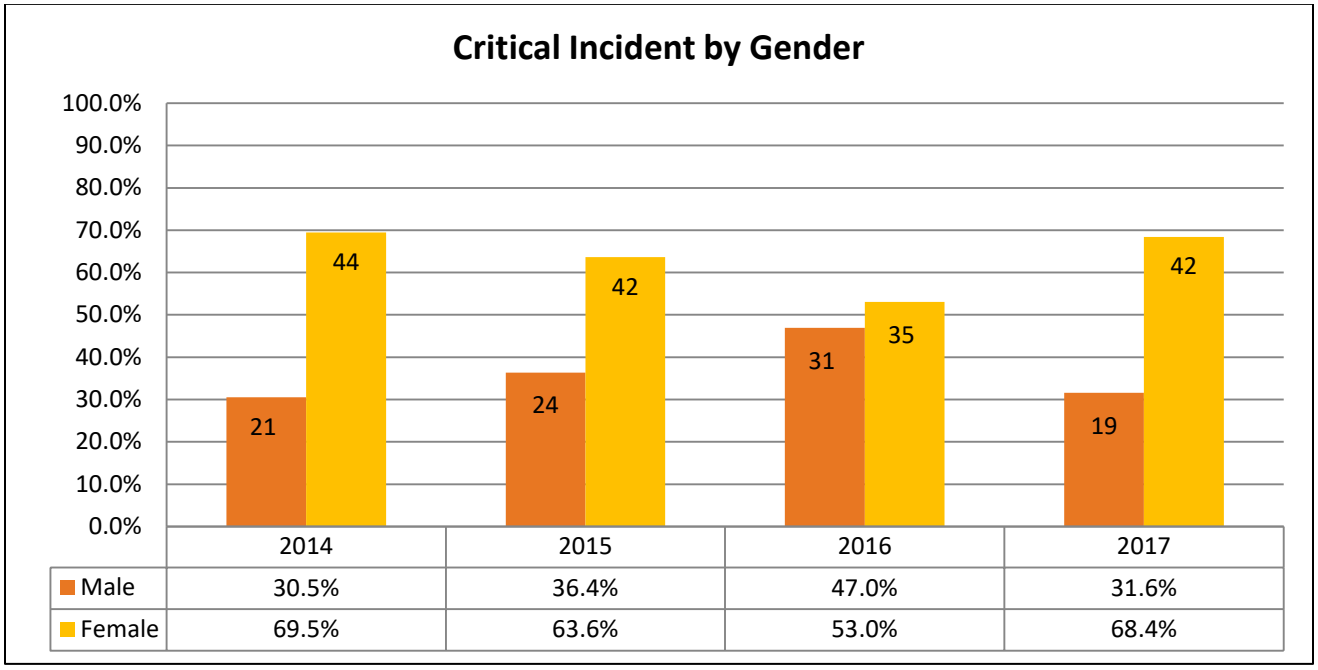


	Male	Female
2014	15.3%	47.5%
2015	21.2%	34.8%
2016	30.3%	37.9%
2017	18.0%	62.3%



	Adult (18+)	Child/Adolescent (17 and under)
2014	84.7%	15.3%
2015	84.8%	15.2%
2016	92.4%	7.6%
2017	91.8%	8.2%





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

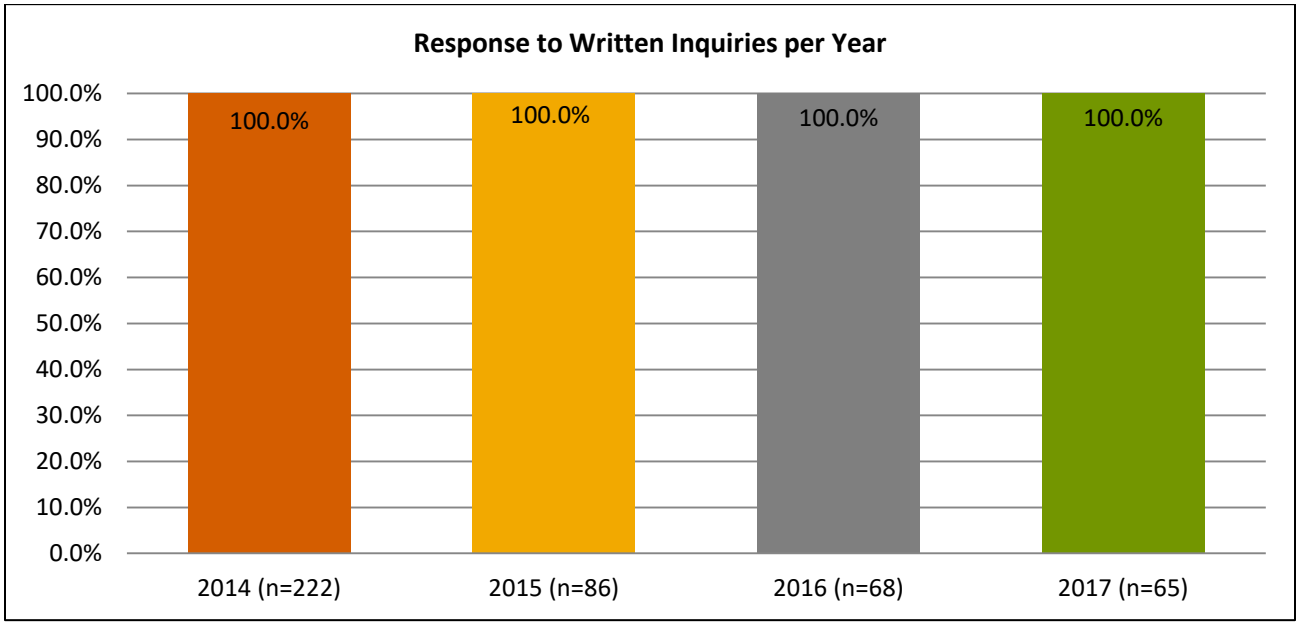
Response to Written Inquiries

Methodology: Optum Idaho's policy is to respond to all phone calls, voice mail and email/written inquiries within two (2) business days. This data is maintained and tracked in an internal database by Optum's Customer Service Department.

2014 – 2017 Overall Performance Results

Customer Service Response to Written Inquiries	Performance Goal	2014	2015	2016	2017
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 consistently met during 2017.



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

Provider Monitoring and Relations

Provider Quality Monitoring

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

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

Methodology: The Optum Provider Quality Specialists complete treatment record reviews and site audits to facilitate communication, coordination and continuity of care and to promote efficient, confidential and effective treatment, and to provide a standardized review of practitioners and facilities on access, clinical record keeping, quality, and administrative efficiency in their delivery of behavioral health services.

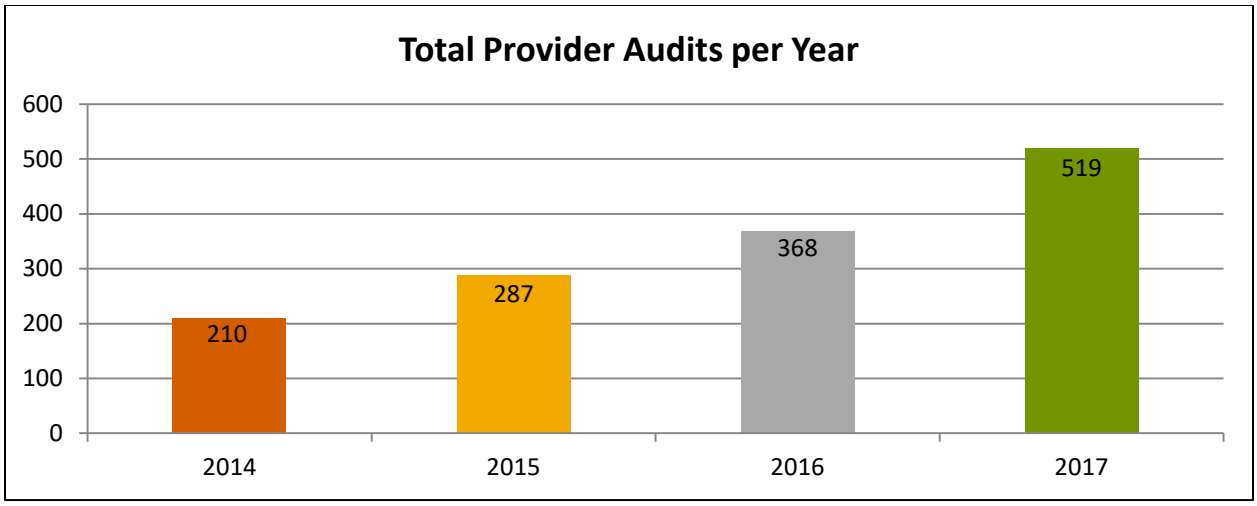
Monitoring audits occur through site visits and treatment record reviews. The main objectives are: determine the clinical proficiency of the Optum Idaho network by conducting site audits and implementing performance measurement; provide quality oversight of the Optum Idaho network; and educate providers on the clinical "best practice" and effective treatment planning.

The provider will receive verbal feedback at the conclusion of the site visit and written feedback within 30 days of the site visit. Scores above 85% are considered passing. A score between 80-84% requires submission of a corrective action plan. A score of 79% or below requires submission of a corrective action plan and participation in a re-audit within 4 – 6 months. Audit types and scores are tracked in an internal Excel tracking spreadsheet.

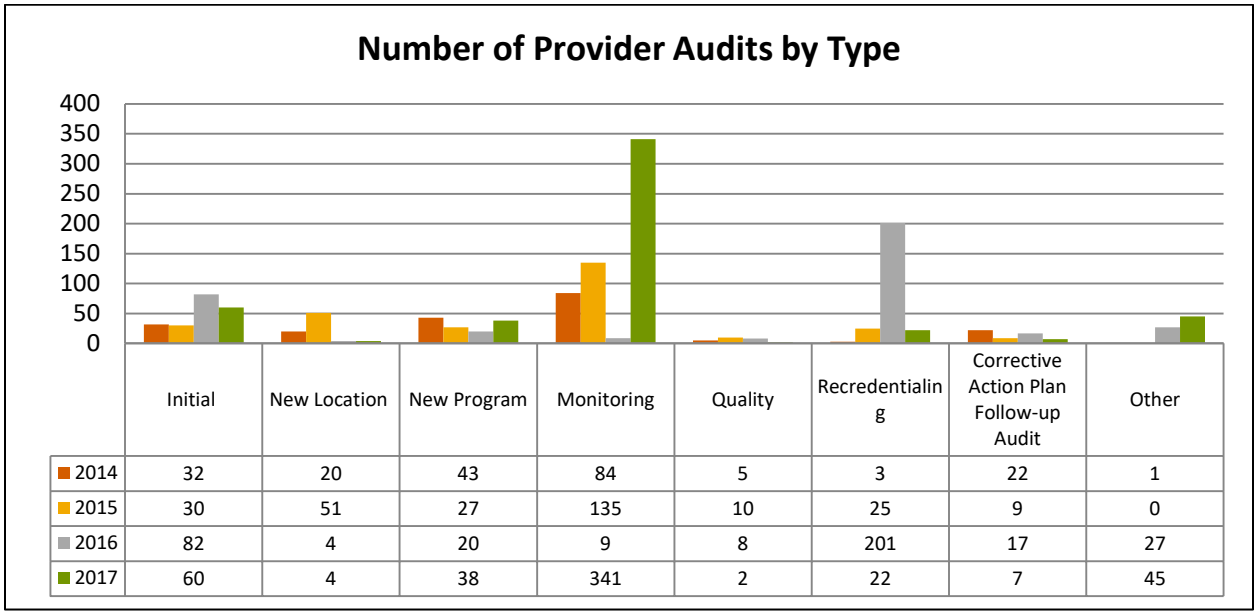
2014 – 2017 Overall Performance Results

Treatment Record Audit	Performance Goal	2014	2015	2016	2017
Number of Audits Conducted	NA	210	287	368	519
Initial Audit (Average overall score)	85.0%	92.0%	97.0%	96.0%	94.0%
Re-credentialing Audit (Average overall score)	85.0%	96.0%	97.0%	94.0%	92.0%
Monitoring (Average overall score)	85.0%	89.4%	90.1%	76.0%	94.4%
Quality (Average overall score)	85.0%	86.0%	94.0%	95.4%	85.0%
Percent of Audits Not Requiring a Corrective Action Plan	NA	81.3%	82.2%	90.5%	89.4%
Percent of Audits Requiring a Corrective Action Plan	NA	18.7%	17.8%	9.5%	11.0%

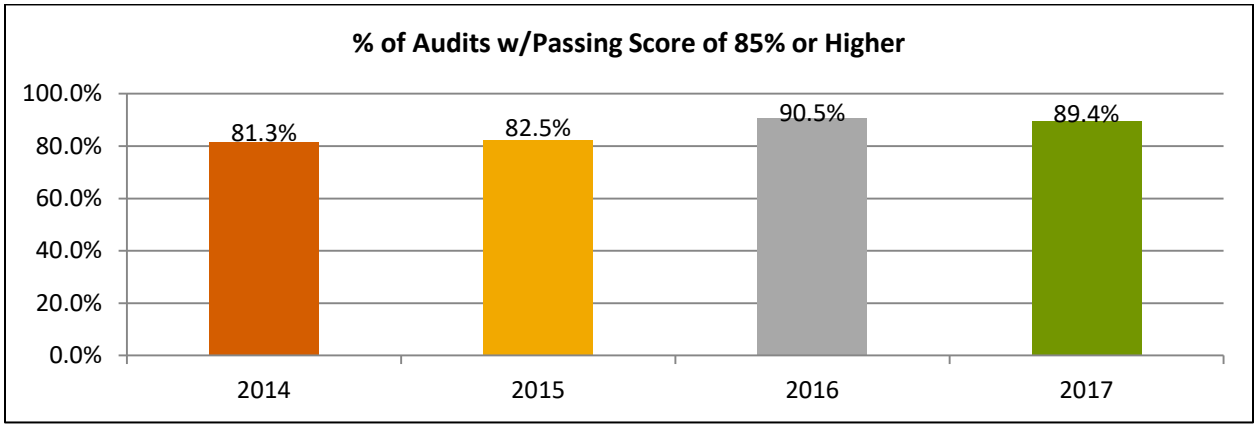
Analysis: A total of 519 audits were conducted during 2017, which is an increase from 368 audits completed during 2016. During 2017, 89.4% (464) of audits received a passing score (≥85%) and did not require a Corrective Action Plan. Corrective Action Plans were implemented for 11.0% (55) of the audits that were completed during 2017. Overall average audit score per region and the number of audits completed per region are highlighted in graphs below.

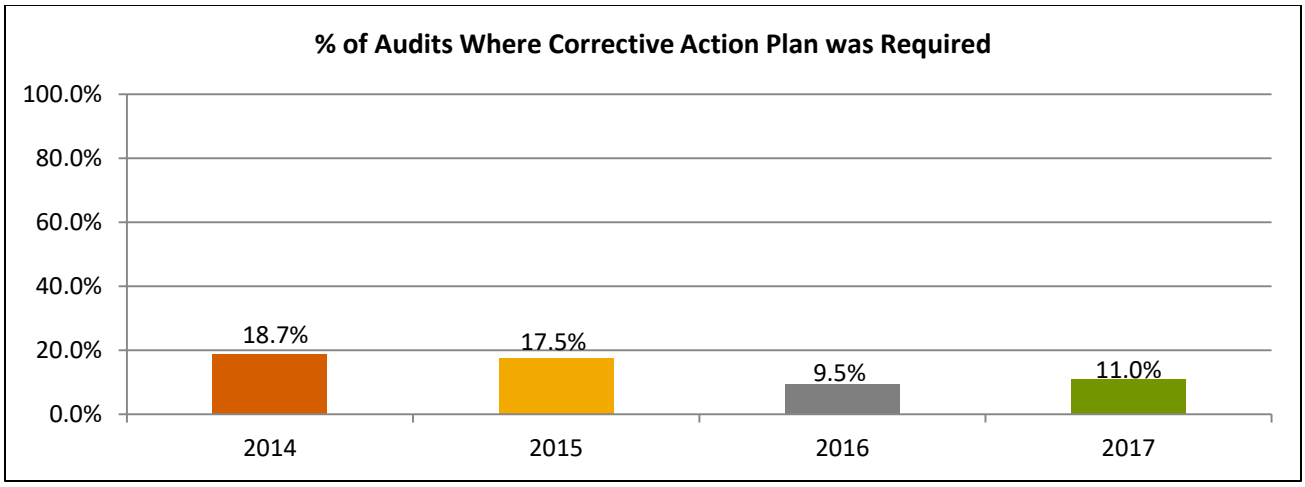


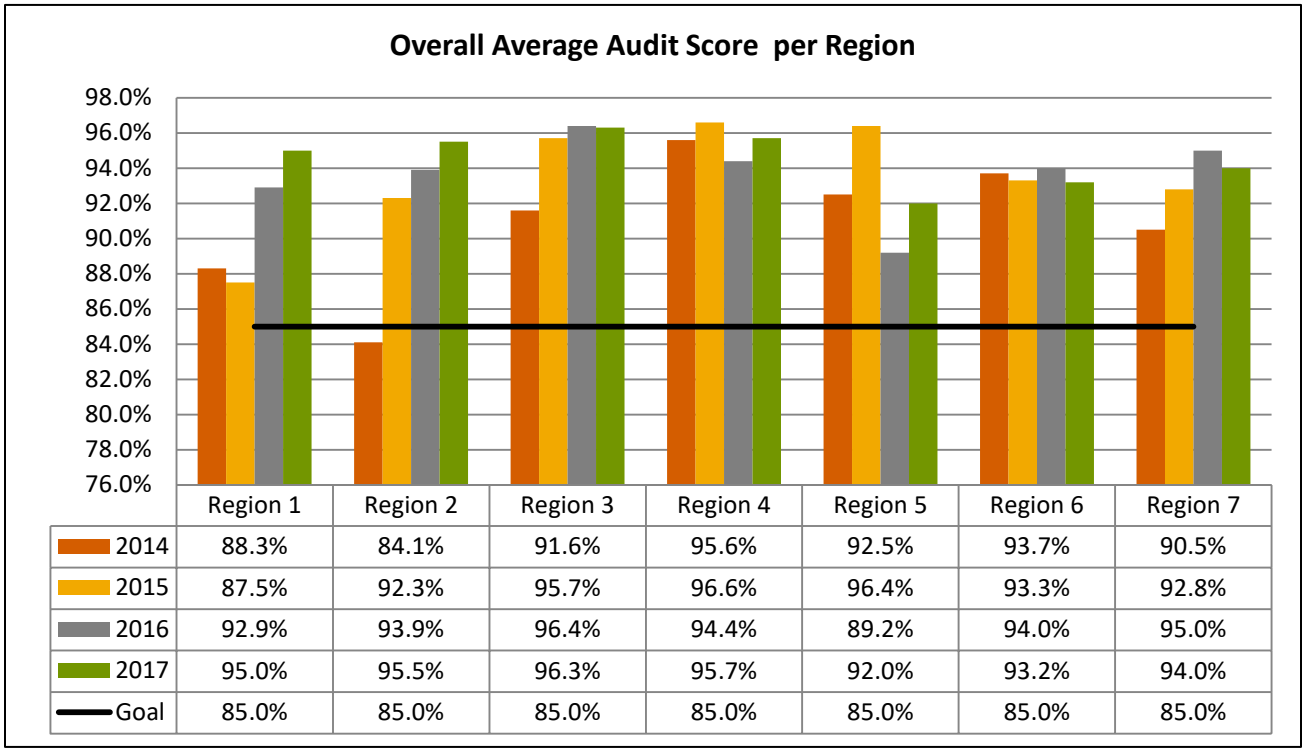
Number of Provider Audits by Type



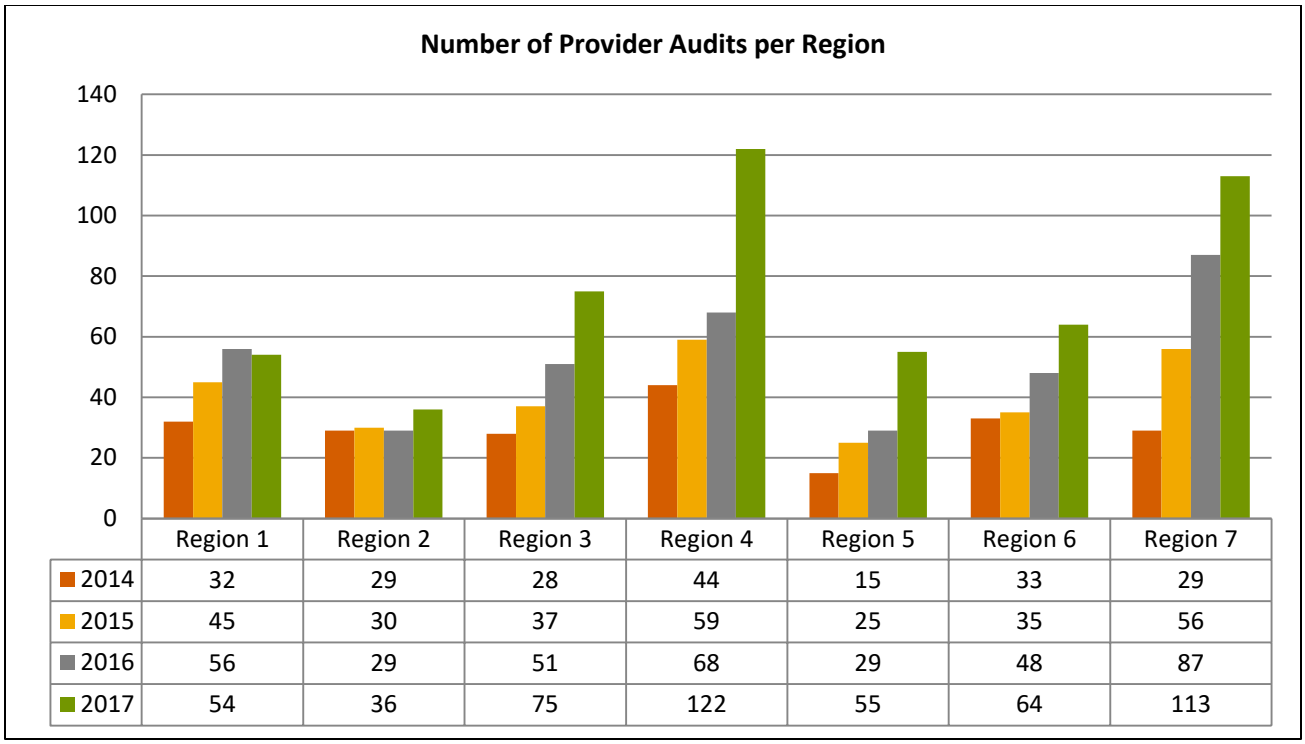
	Initial	New Location	New Program	Monitoring	Quality	Recredentialing	Corrective Action Plan Follow-up Audit	Other
2014	32	20	43	84	5	3	22	1
2015	30	51	27	135	10	25	9	0
2016	82	4	20	9	8	201	17	27
2017	60	4	38	341	2	22	7	45





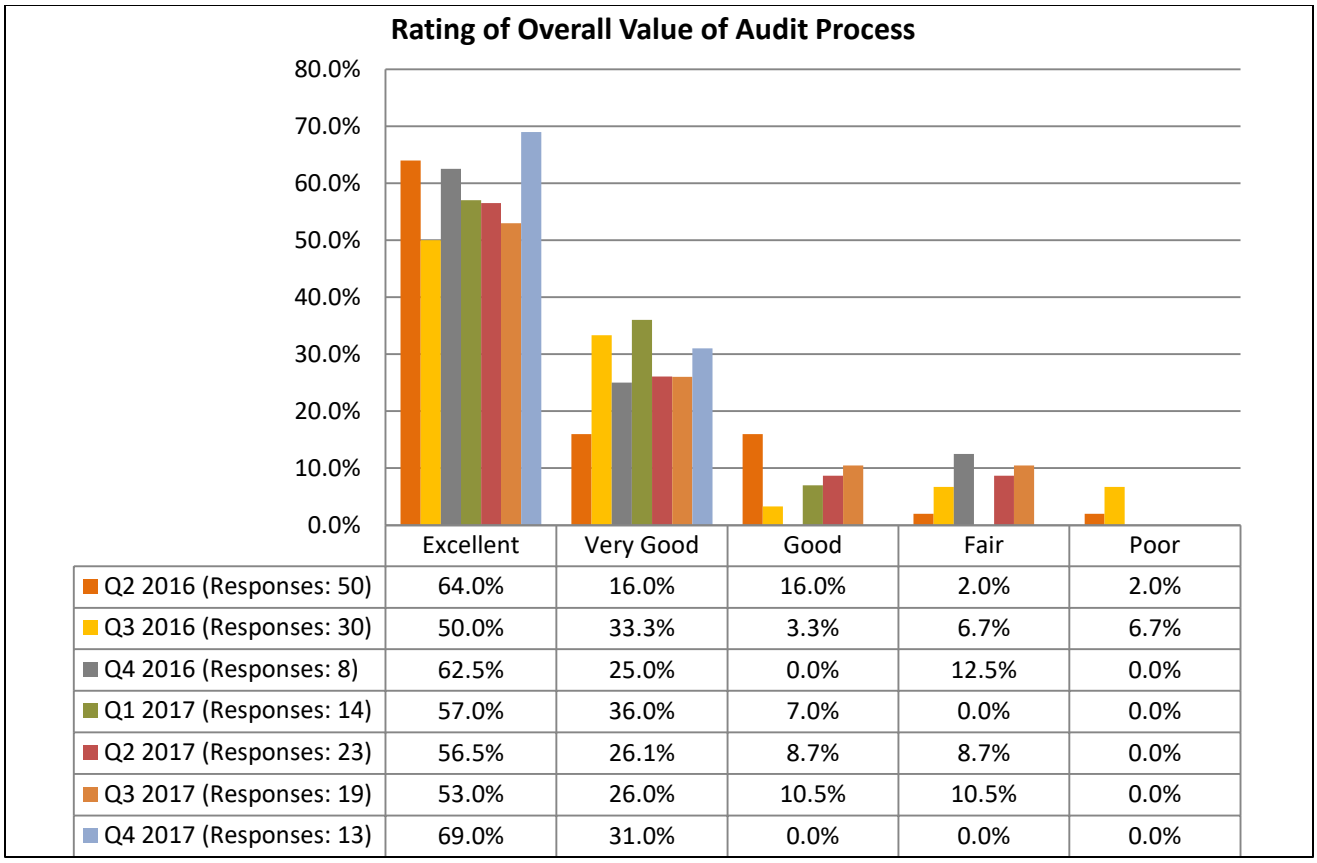


	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
2014	88.3%	84.1%	91.6%	95.6%	92.5%	93.7%	90.5%
2015	87.5%	92.3%	95.7%	96.6%	96.4%	93.3%	92.8%
2016	92.9%	93.9%	96.4%	94.4%	89.2%	94.0%	95.0%
2017	95.0%	95.5%	96.3%	95.7%	92.0%	93.2%	94.0%
Goal	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

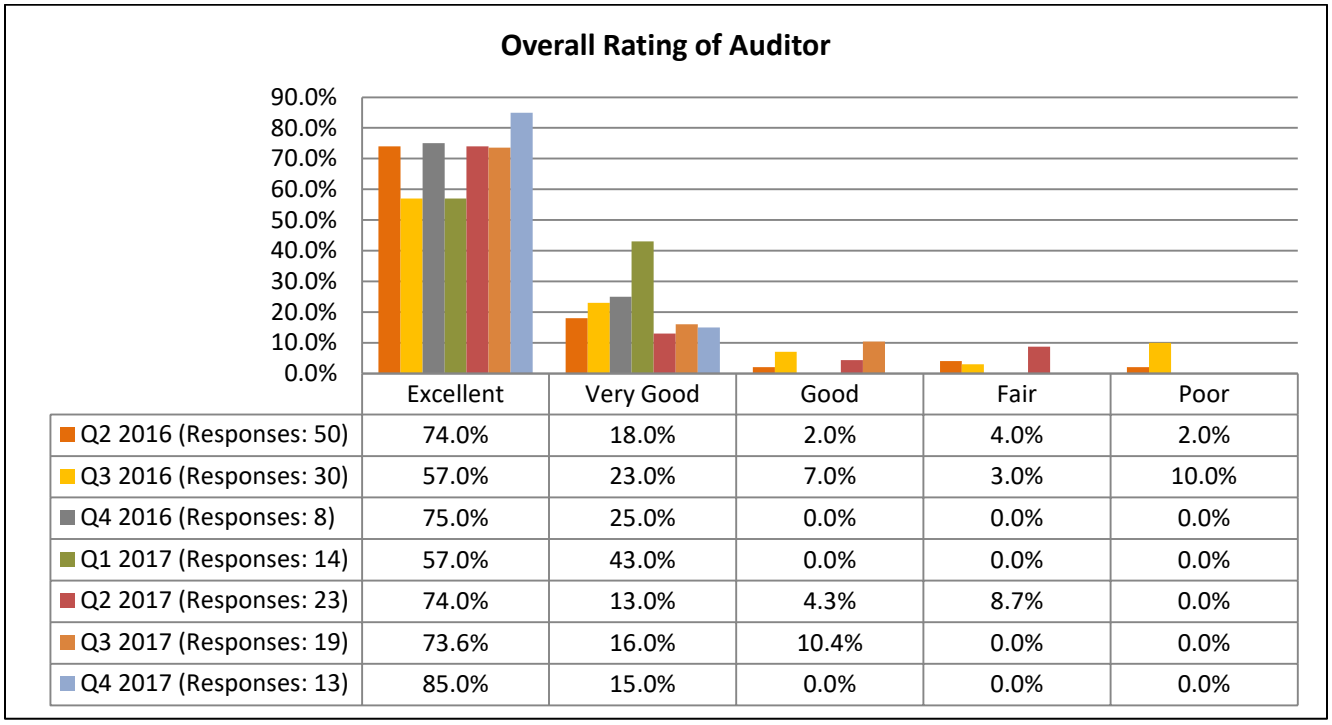


	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
2014	32	29	28	44	15	33	29
2015	45	30	37	59	25	35	56
2016	56	29	51	68	29	48	87
2017	54	36	75	122	55	64	113

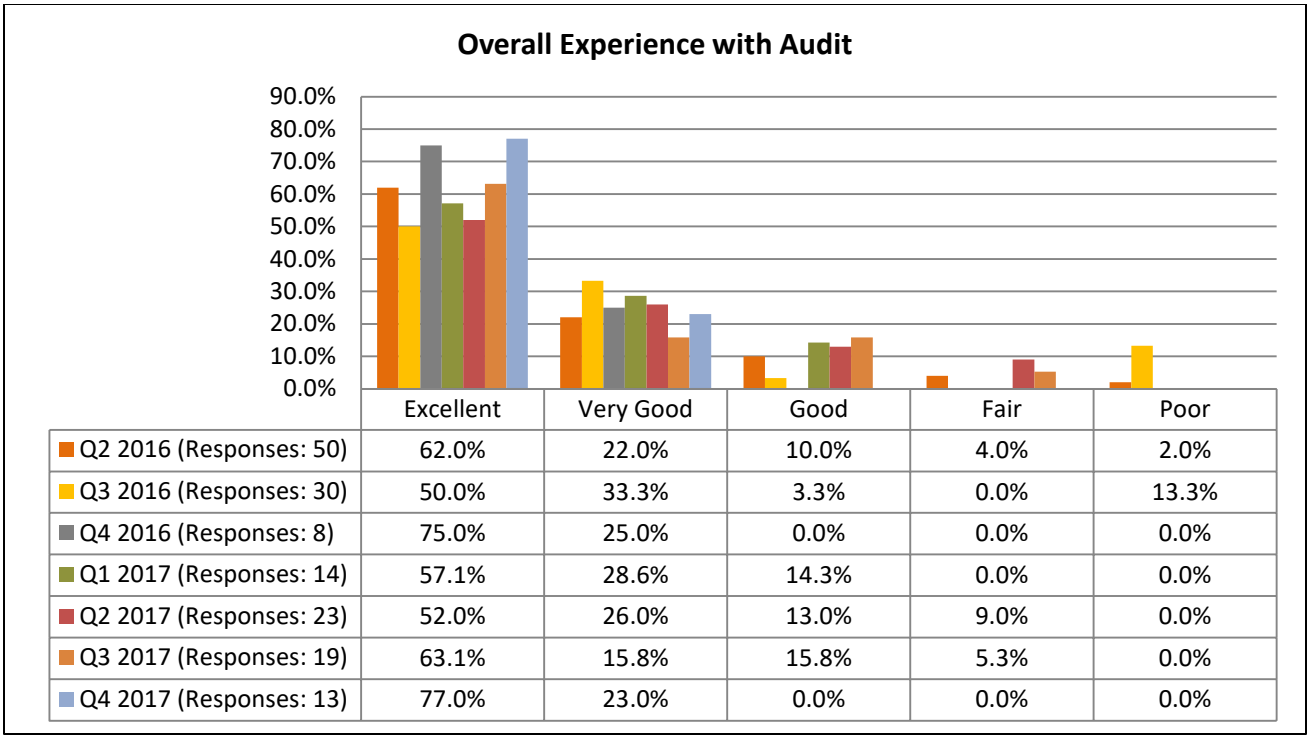
In addition, network providers are given the opportunity to rate the Provider Quality Monitoring Audit process in a Satisfaction Survey. Beginning in Q1, 2016, Optum Idaho began using a new Satisfaction Survey for providers to complete once an audit is completed. The survey used to gather this information is through the Qualtrics Survey Application. The survey is sent to providers by email. If an email address is not on file, the provider will not receive the survey. Surveys are emailed every other week to providers who were audited within the previous 2 weeks. Providers have 4 weeks to complete and return the survey. Results were tabulated beginning in Q2, 2016. As there is not a complete years' worth of data for 2016, results below are tabulated by quarters through 2017. The rating of overall value of audit process, overall rating of auditor, and overall experience with audit has remained consistently high (Excellent) throughout the reporting period.



	Excellent	Very Good	Good	Fair	Poor
Q2 2016 (Responses: 50)	64.0%	16.0%	16.0%	2.0%	2.0%
Q3 2016 (Responses: 30)	50.0%	33.3%	3.3%	6.7%	6.7%
Q4 2016 (Responses: 8)	62.5%	25.0%	0.0%	12.5%	0.0%
Q1 2017 (Responses: 14)	57.0%	36.0%	7.0%	0.0%	0.0%
Q2 2017 (Responses: 23)	56.5%	26.1%	8.7%	8.7%	0.0%
Q3 2017 (Responses: 19)	53.0%	26.0%	10.5%	10.5%	0.0%
Q4 2017 (Responses: 13)	69.0%	31.0%	0.0%	0.0%	0.0%



	Excellent	Very Good	Good	Fair	Poor
Q2 2016 (Responses: 50)	74.0%	18.0%	2.0%	4.0%	2.0%
Q3 2016 (Responses: 30)	57.0%	23.0%	7.0%	3.0%	10.0%
Q4 2016 (Responses: 8)	75.0%	25.0%	0.0%	0.0%	0.0%
Q1 2017 (Responses: 14)	57.0%	43.0%	0.0%	0.0%	0.0%
Q2 2017 (Responses: 23)	74.0%	13.0%	4.3%	8.7%	0.0%
Q3 2017 (Responses: 19)	73.6%	16.0%	10.4%	0.0%	0.0%
Q4 2017 (Responses: 13)	85.0%	15.0%	0.0%	0.0%	0.0%



	Excellent	Very Good	Good	Fair	Poor
Q2 2016 (Responses: 50)	62.0%	22.0%	10.0%	4.0%	2.0%
Q3 2016 (Responses: 30)	50.0%	33.3%	3.3%	0.0%	13.3%
Q4 2016 (Responses: 8)	75.0%	25.0%	0.0%	0.0%	0.0%
Q1 2017 (Responses: 14)	57.1%	28.6%	14.3%	0.0%	0.0%
Q2 2017 (Responses: 23)	52.0%	26.0%	13.0%	9.0%	0.0%
Q3 2017 (Responses: 19)	63.1%	15.8%	15.8%	5.3%	0.0%
Q4 2017 (Responses: 13)	77.0%	23.0%	0.0%	0.0%	0.0%

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

Coordination of Care

Methodology: To coordinate and manage care between behavioral health and medical professionals, Optum requires providers to obtain the member's consent to exchange appropriate treatment information with medical care professionals (e.g. primary care physicians, medical specialists). Optum requires that coordination and communication take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to members in several ways:

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

Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum expects providers to make a "good faith" effort at communicating with other behavioral health

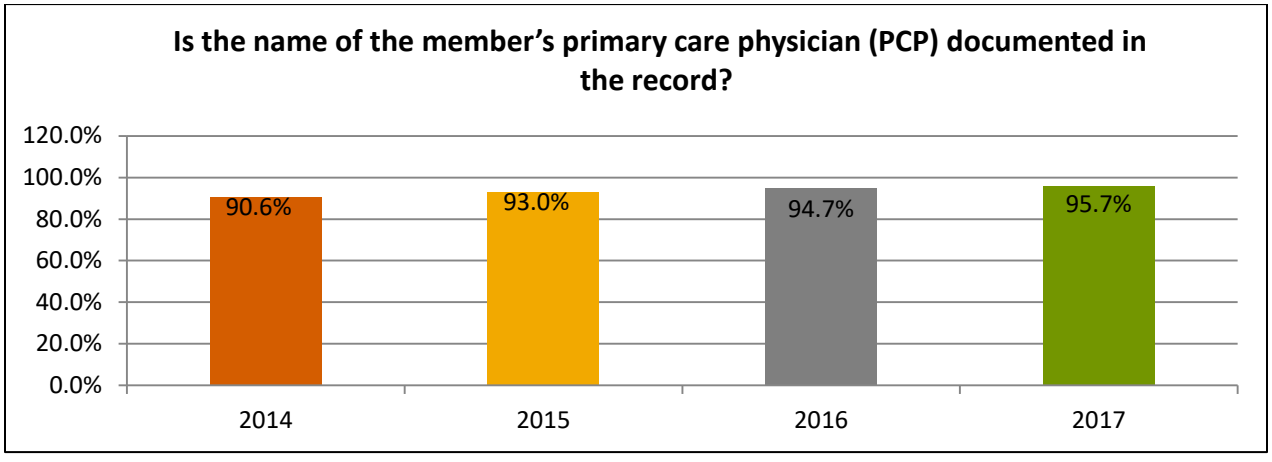
clinicians or facilities and any medical care professionals who are treating the member as part of an overall approach to coordinating care.

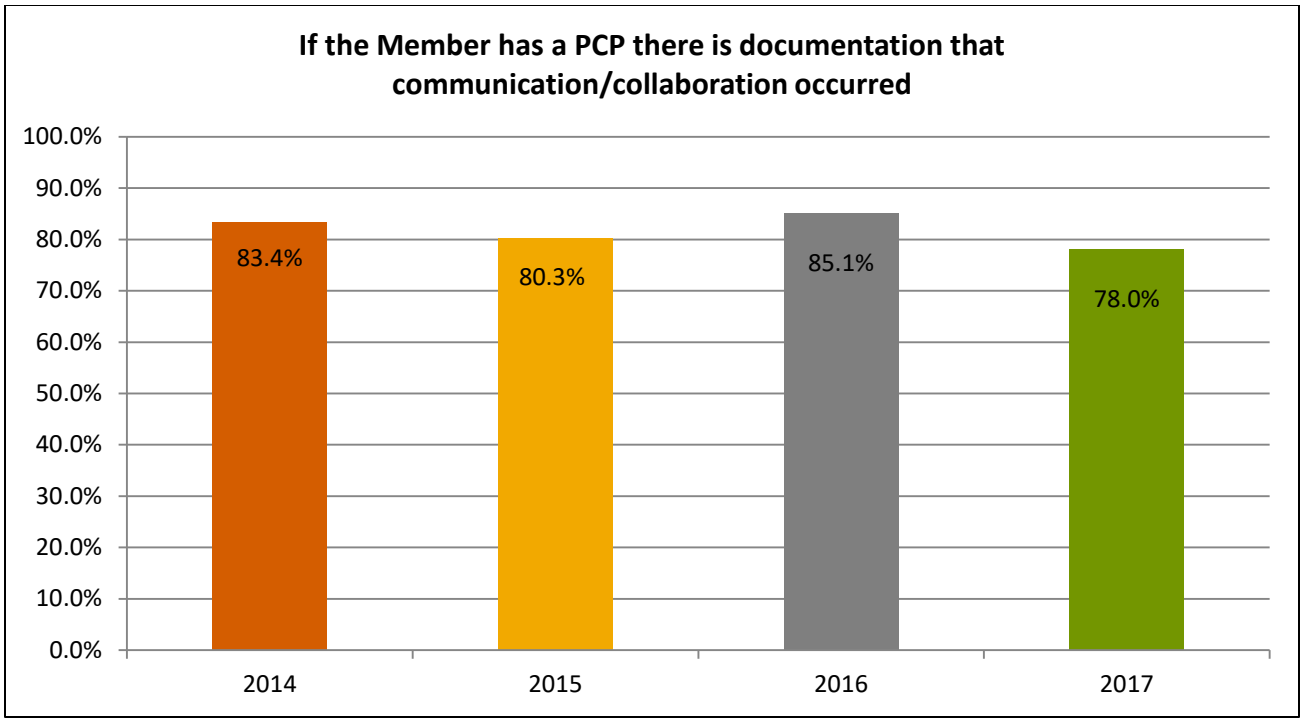
The Optum Idaho Provider Quality Specialist staff use a Treatment Record Review Audit Tool to ensure Coordination of Care between providers is taking place. Below are the questions and results from the audit tool. In any circumstance where a deficiency is identified, auditors provide feedback and communicate expectations to providers.

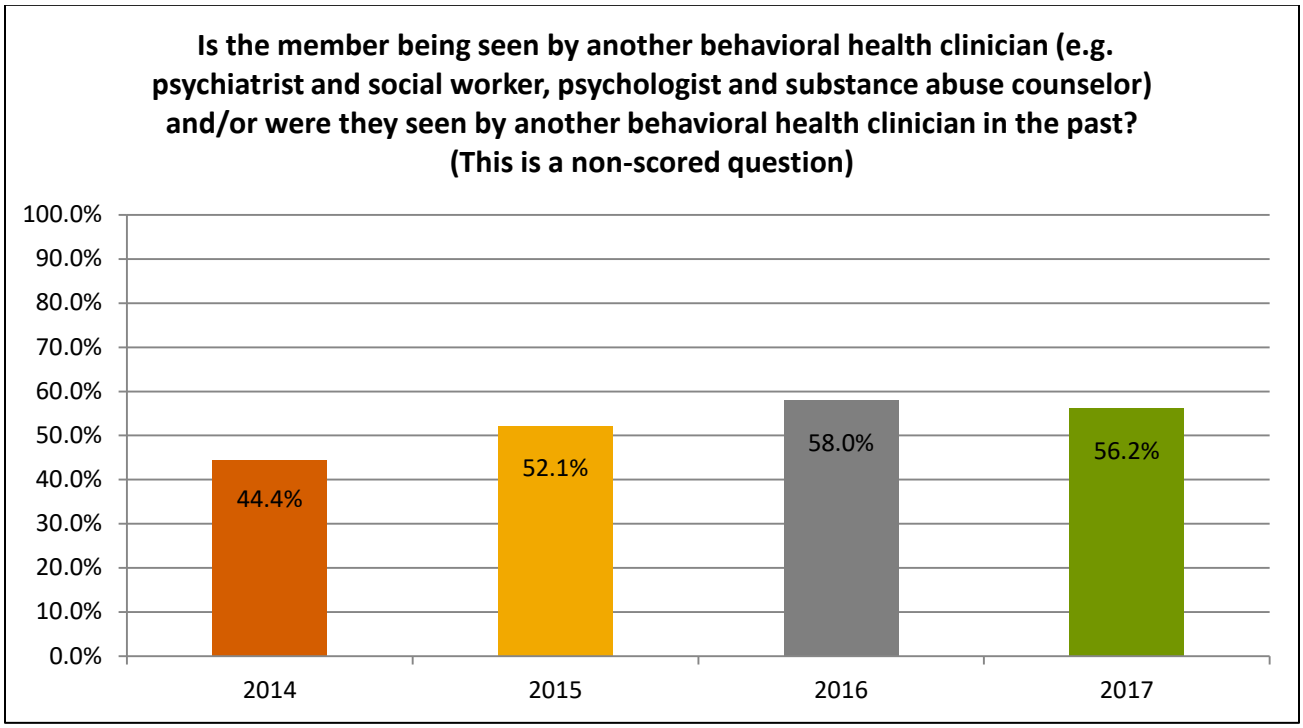
2014 – 2017 Overall Performance Results

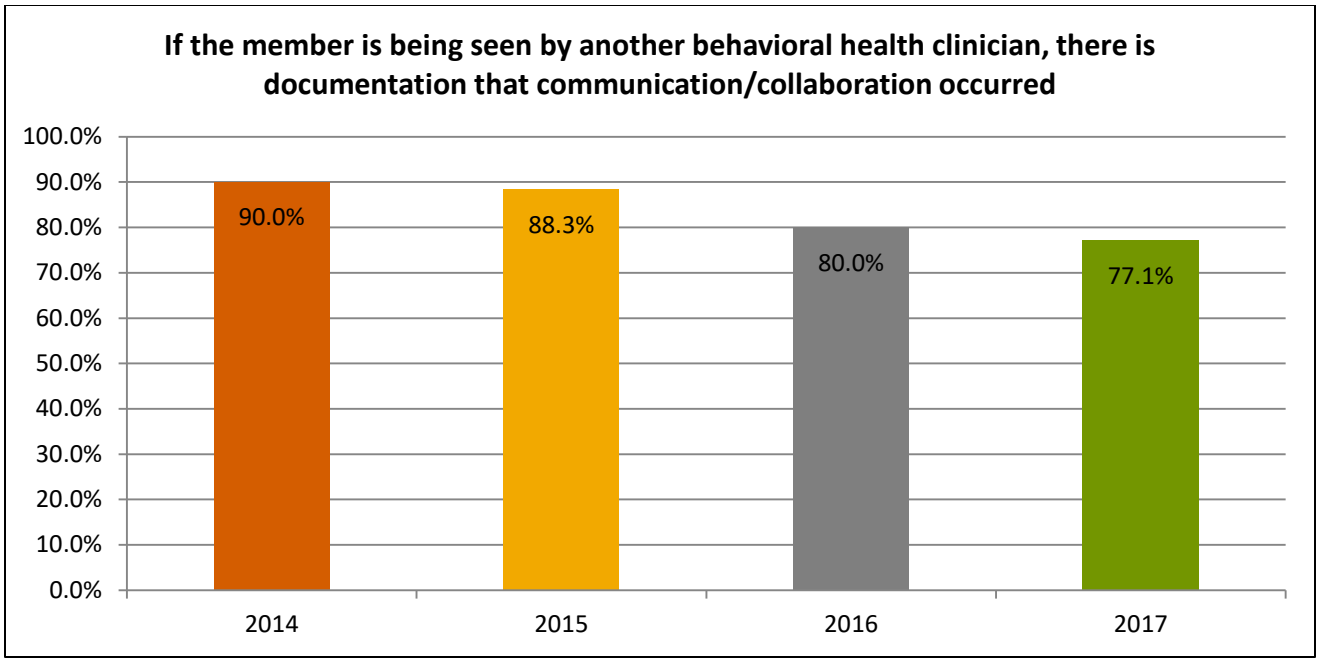
Coordination of Care (% answered in the affirmative)	Performance Goal	2014	2015	2016	2017
Is the name of the member's primary care physician (PCP) documented in the record?	NA	90.6 %	93.0%	94.7%	95.7%
If the Member has a PCP there is documentation that communication/collaboration occurred	NA	83.4%	80.3%	85.1%	78.0%
Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor) and/or were they seen by another behavioral health clinician in the past? This is a non-scored question.	NA	44.4%	52.1%	58.0%	56.2%
If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred.	NA	90.0%	88.3%	80.0%	77.1%

Analysis: Coordination of Care audits completed during 2017 revealed that 95.7% of member records reviewed had documentation of the name of the member's PCP. Of those, 78.0% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. The results also revealed that that 56.2% 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, 77.1% indicated that communication/collaboration had occurred.




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%
83.4%
80.3%
85.1%
78.0%
2014
2015
2016
2017


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)
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
44.4%
52.1%
58.0%
56.2%
2014
2015
2016
2017



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

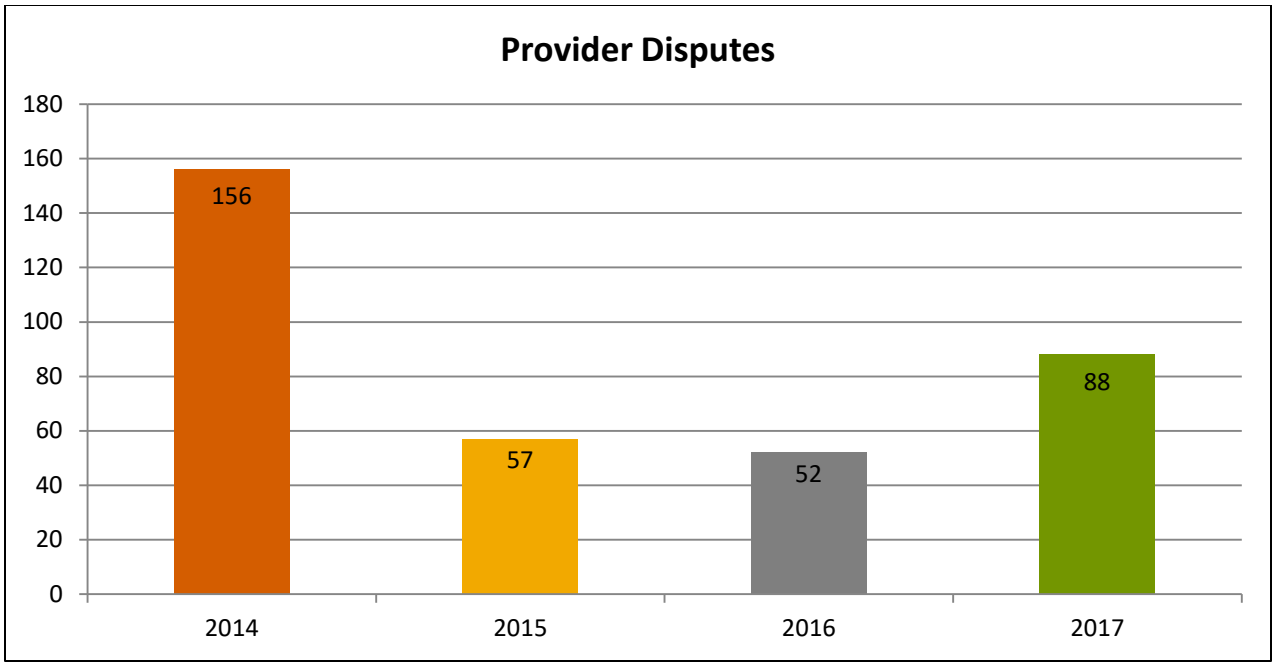
Provider Disputes

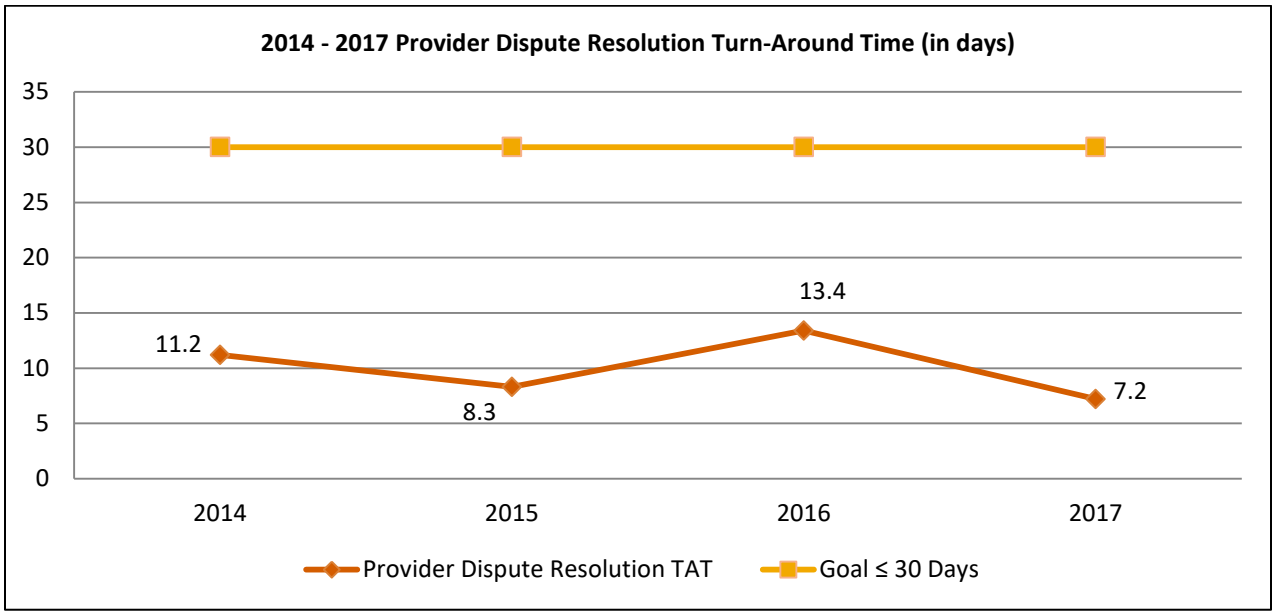
Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is believed to have been incorrectly issued. A denied claim or an Administrative ABD are the two most common disputed items. Provider disputes require that a written resolution notice be sent within 30 days following the request for consideration.

2014 – 2017 Overall Performance Results

Provider Disputes	Performance Goal	2014	2015	2016	2017
Number of Provider Disputes	NA	156	57	52	88
Average # of Days Provider Disputes Resolved	30 Days	11.2	8.3	13.4	7.2

Analysis: During 2017, there were 88 provider disputes, an increase from 52 in 2016. All were resolved within the goal of ≤30 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

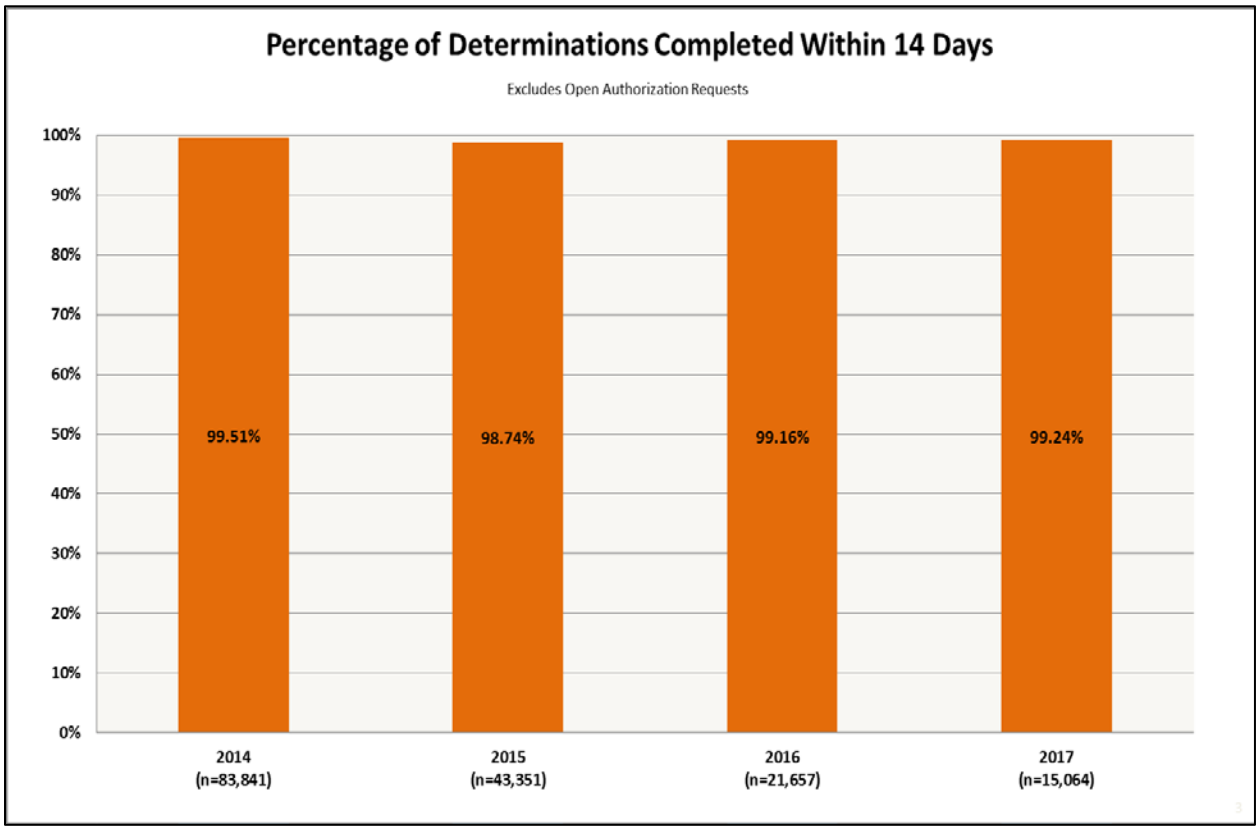
Service Authorization Requests

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.

2015 - 2017 Performance Results

Service Authorization Requests	Performance Goal	2015	2016	2017
Number of Service Authorization Requests	NA	43,351	21,657	15,064
Percent Determinations Completed within 14 days	100.0%	98.8%	99.1%	99.2%

Analysis: During 2017, there were 15,064 Service Authorization Requests. The percentage of determinations completed within 14 days was 99.2%.



Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: We continue to monitor these utilization patterns as they relate to appropriate member care and provider usage.

Field Care Coordination

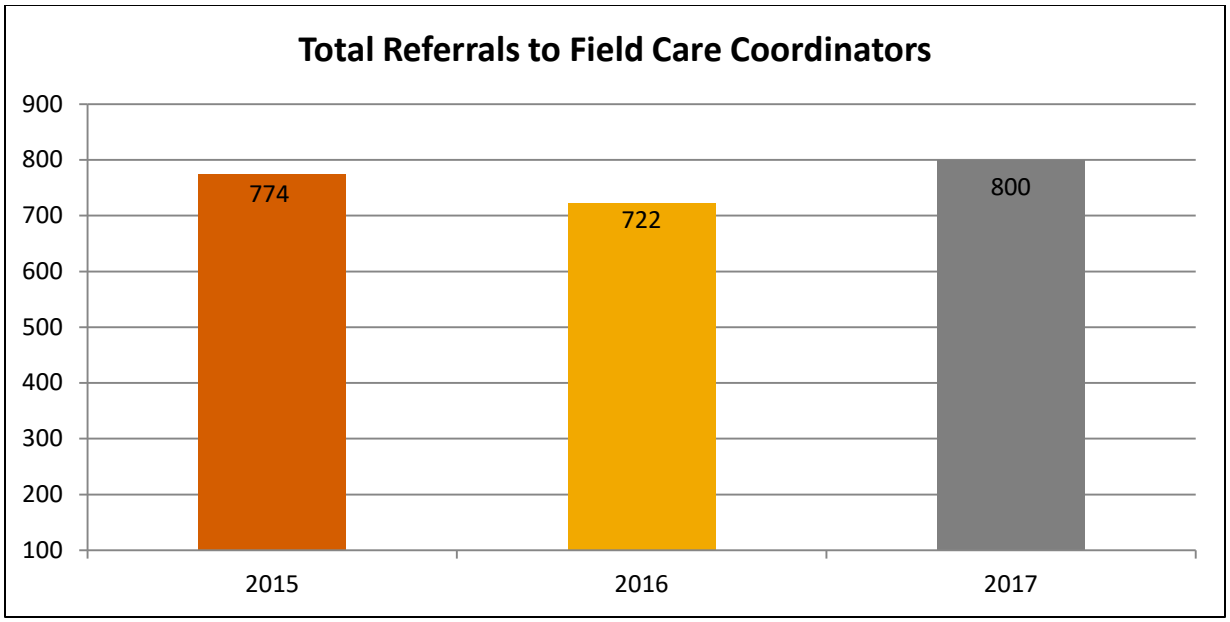
Methodology: The Field Care Coordination (FCC) program includes regionally based clinicians across the state of Idaho. They provide locally based care coordination and discharge planning support. Field Care Coordinators work with providers to help members. The FCC team focuses on member wellness, recovery,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

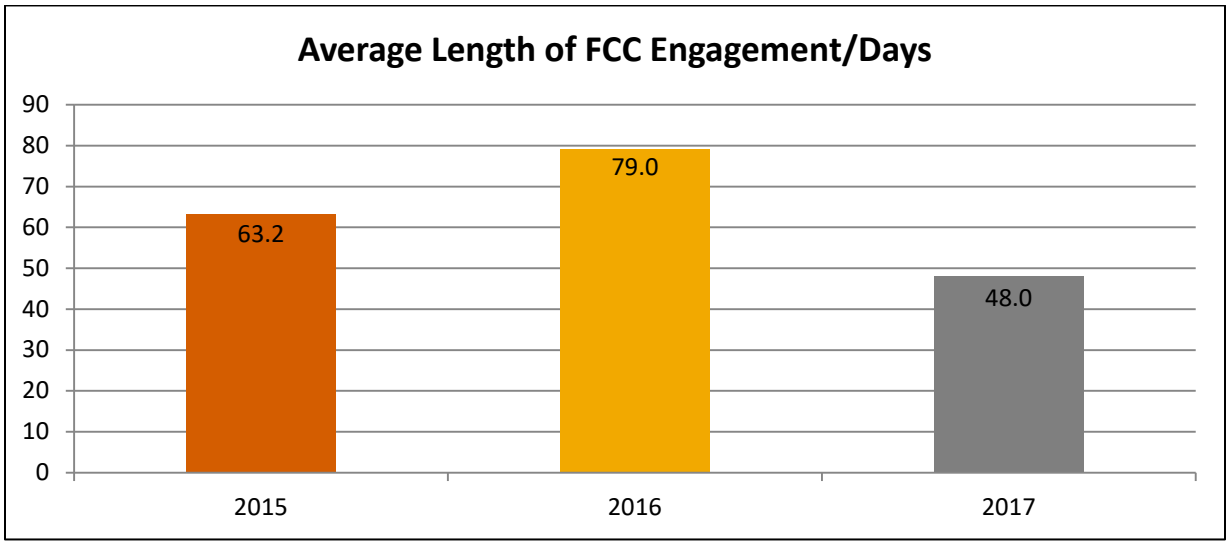
- Focusing on consumers and families who are at greatest clinical risk
- Focusing on consumer's wellness and the consumer's responsibility for his/her own health and well-being.
- Improved care coordination for consumers moving between services, especially those being discharged from 24-hour care settings.

The Field Care Coordinators receive referrals from different sources. The below table identifies the referral sources and the number of referrals made to FCC staff from 2015 to 2017.

REFERRAL SOURCES	2015	2016	2017
Discharge Coordinator	622	590	571
Utilization Reviewers	65	41	45
Providers	46	39	30
Department of Behavioral Health	15	18	48
Juvenile Justice	3	0	0
Provider Quality Specialist	5	8	2
Peer Review Committee	10	10	0
Hospitals	2	0	3
EPSDT	2	2	13
Family/Parent	1	0	4
Member Services/Crisis Line	3	1	0
Education	0	6	17
FCC Manager Referral	0	4	5
Outpatient Disposition	0	3	18
Suicide Attempt	0	0	31
Adult Corrections	0	0	13
TOTAL	**774**	**722**	**800**

Analysis: During 2017, Field Care Coordinators received 800 referrals, an increase from 722 referrals during 2016. The majority of referrals are made by Optum Idaho Discharge Coordinators. The number of days that a Field Care Coordinator keeps a case open varies by case. In 2017, the average length of an FCC case was 48 days.



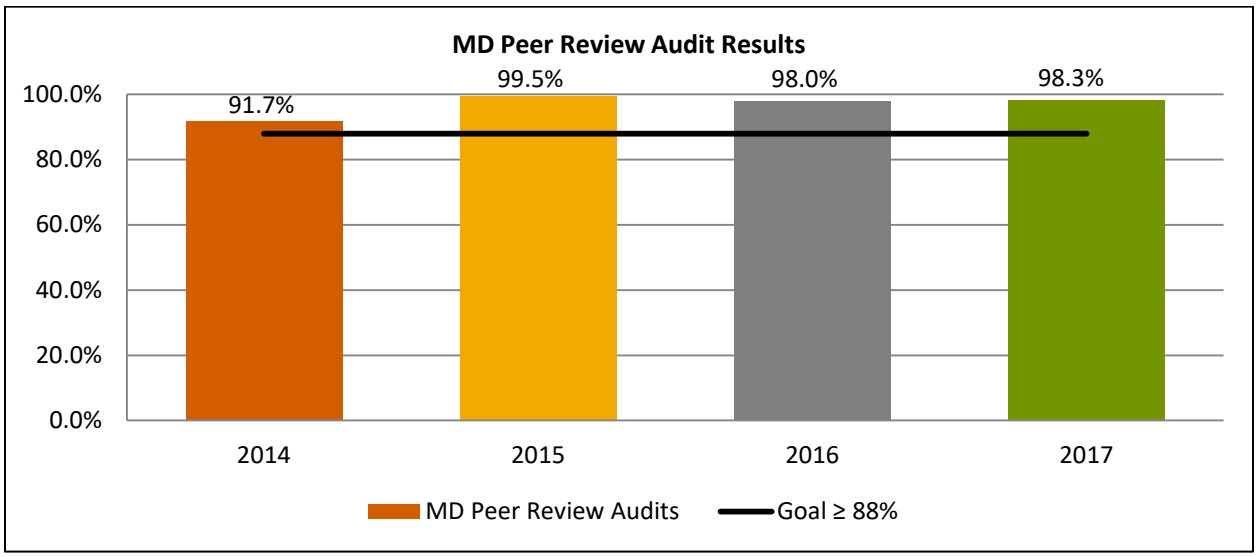


Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Peer Reviewer Audits

Methodology: Optum Idaho promotes a process for review and evaluation of the clinical documentation of non-coverage determinations and appeal reviews by Optum physicians and doctoral-level psychologists in their role as Peer Reviewers, for completeness, quality and consistency in the use of medical necessity criteria, coverage determination guidelines and adherence to standard Care Advocacy policies. Any pattern of deficiency incurred by an individual Peer Reviewer may result in clinical supervision, as needed. Optum Idaho's established target score for Peer Reviewer audits is ≥ 88%.

Analysis: During 2017, there were no PhD denial decisions that required a Peer Review Audit. The average MD audit score for 2017 was 98.3%. Based on the performance goal of ≥ 88%, audit results indicate the MD Peer Review Audits received passing scores.



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

Inter-Rater Reliability

Optum evaluates and promotes the consistent application of the Level of Care Guidelines and the Coverage Determination Guidelines by clinical personnel by providing orientation and training, routinely reviewing documentation of clinical transactions in member records, providing ongoing supervision and consultation and administering an annual assessment of inter-rater reliability (IRR). Inter-rater Reliability testing is completed annually. The analysis of the data evaluates the current assessment, a review of the results, an overview of how the process can be modified to improve the reporting of reliable measures of consistency, and a discussion of suggested next steps.

Methodology: The Assessment contained 15 questions based on 5 case studies (children and adult cases) and it was answered by 12 Care Advocate (CA) respondents and 8 Field Care Coordinators (FCC). The Assessment had multiple-choice questions with potential answers and various combinations of those answers. Each respondent completed an instrument based on the *Level of Care Guidelines* Respondents were given 1 business day to complete the instrument. Optum has established an internal performance metric of 85% for IRR.

Analysis: Using the results of the analysis described above, average score obtained for care advocate inter-rater reliability was 62% or “moderately” consistent using Kappa Scoring.

Table 1 Inter-rater Reliability Study Spring 2017 Assessment *(Experienced Personnel have >= 18 months with Optum Idaho)*						
	All CA's	Experienced CA's	Less Experienced CA's	All FCC's	Experienced FCC's	Less Experienced FCC's
Total Agreement to Standard	**62.2%**	**72.2%**	**53.3%**	**65.0%**	**69.3%**	**57.8%**
Rater 1	60%		60%	67%	67%	
Rater 2	73%	73%		93%	93%	
Rater 3	73%		73%	33%		33%
Rater 4	33%		33%	73%	73%	
Rater 5	53%		53%	47%		47%
Rater 6	73%	73%		53%	53%	
Rater 7	53%	53%		93%		93%
Rater 8	73%	73%		60%	60%	
Rater 9	73%	73%				
Rater 10	47%		47%			
Rater 11	60%		60%			
Rater 12	73%	73%				
Average	**62%**	**70%**	**54%**	**65%**	**69%**	**58%**
Standard Deviation	**13%**	**8%**	**14%**	**21%**	**15%**	**32%**

Barriers: Streamline questions – simply designed questionnaires, requiring clear-cut responses (for example, yes-or-no answers or reference to a specific LOCG guideline), yield more valid results. Questions should be constructed to garner responses that will enable the plan to identify and target specific problem areas for further testing or more intensive training. Limit number of possible responses to only A, B, C, or D, and not any combination. The large number of possible answer combinations on this test is a contributor to the score that was achieved. Having only 2-4 possible answers, increases the validity of the responses and decreases variance in potential outcomes.

Review Questions Individually - Questions having low variance but poor agreement may indicate that a question was generally misunderstood and should be reviewed for clarity and possible rewording. Approximately a third of the questions had very low agreement to standard. We recommend that we should conduct calculation of agreement to standard and variance across raters by question to identify possible questions for improvement due to poorly designed questions, vs. lack of LOCG knowledge and understanding.
Establish the Standard via Review – review test with Clinical Director and CMO and/or appropriate staff to agree on both the standard and the clarity of the questions to the LOCG's. Out of 12 Care Advocates participating in the IRR testing, 4 were new employees who had only been employed for 6 months or less.

Opportunities and Interventions: The following improvements have been initiated and have been presented to CSAC.

1. Weekly team clinical huddles (rather than monthly) were implemented in March 2017, to improve team communication and discuss operational issues
2. Bi-monthly Case Staffing (rather than monthly) with the Medical Director were implemented in March 2017.
3. End to End review of the Operational UM business processes are underway including process updates, and re-training to all work flows and UM procedures including UM Criteria-LOCGs. This is expected to be completed and implemented July 1, 2017.
4. Because scores fell below the goal, re-testing for IRR will be completed again in August 2017, to document improvements.

Population Analysis

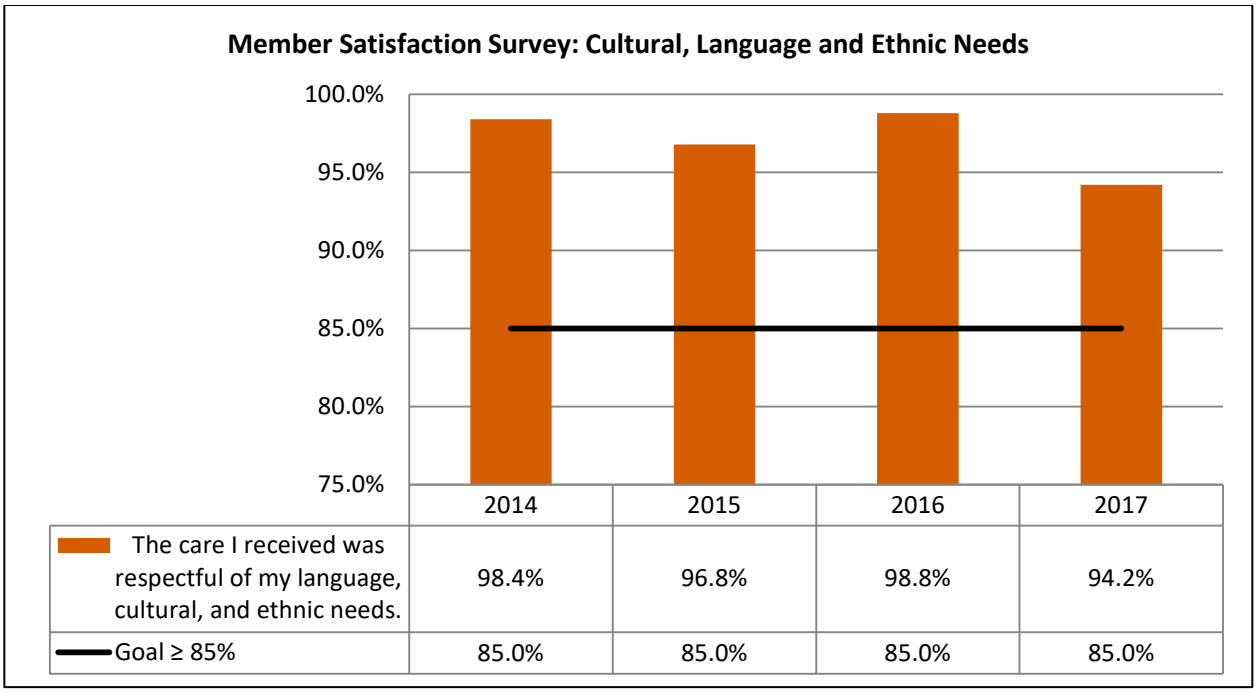
Language and Culture

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

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

*most current data available

Analysis: Hispanic or Latino counted for 12.2% of the Idaho population. This is the second highest population total, with White consisting of 93.4% (ethnic and racial backgrounds can overlap which explains for the percentage total > 100%). Again during 2017, the Member Satisfaction Survey results consistently showed that members believe the care they received was respectful of their language, cultural, and ethnic needs.



	2014	2015	2016	2017
The care I received was respectful of my language, cultural, and ethnic needs.	98.4%	96.8%	98.8%	94.2%
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.

Analysis: During 2017, Optum responded to a variety of requests for language assistance including:

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

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

Claims

Methodology: The data source for claims is Cosmos via Webtrax. Data extraction is the number of "clean" claims paid within 30 and 90 calendar days. A clean claim excludes adjustments (adjustments are any transaction that modifies (increase/decrease) the original claims payment; the original payment must have dollars applied to the deductible/ copay/ payment to provider or member) and/or resubmissions (A resubmission is correction to an

original claim that was denied by Optum) A claim will be considered processed when the claim has been completely reviewed and a payment determination has been made; this is measured from the received date to the paid date (check), plus two days for mail time. Company holidays are included.

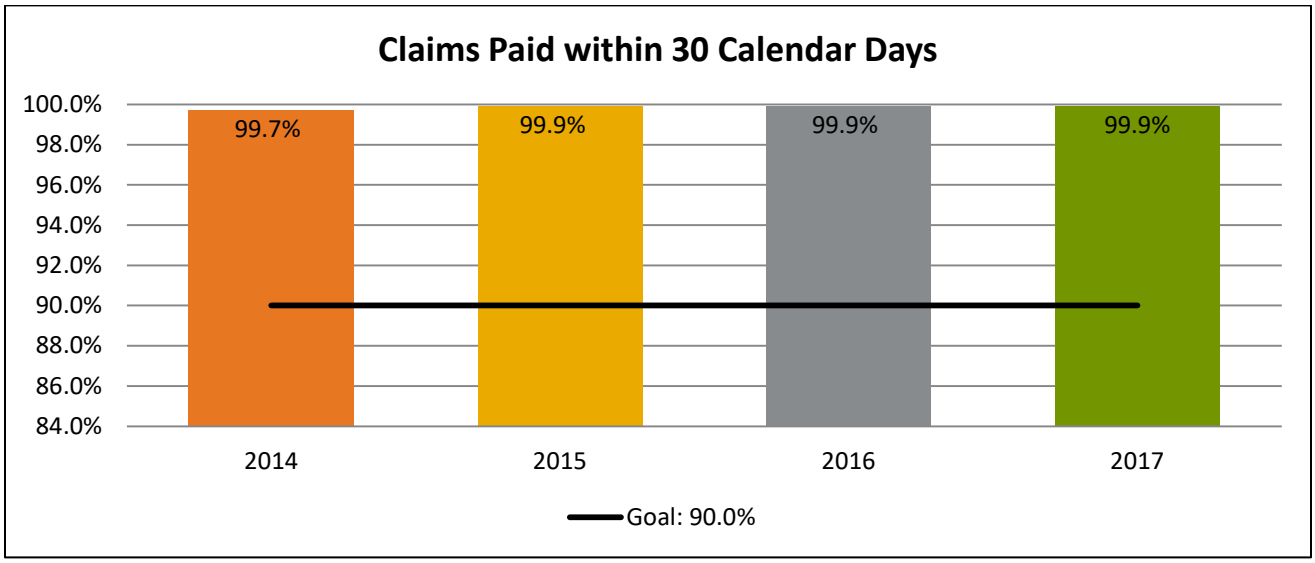
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid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

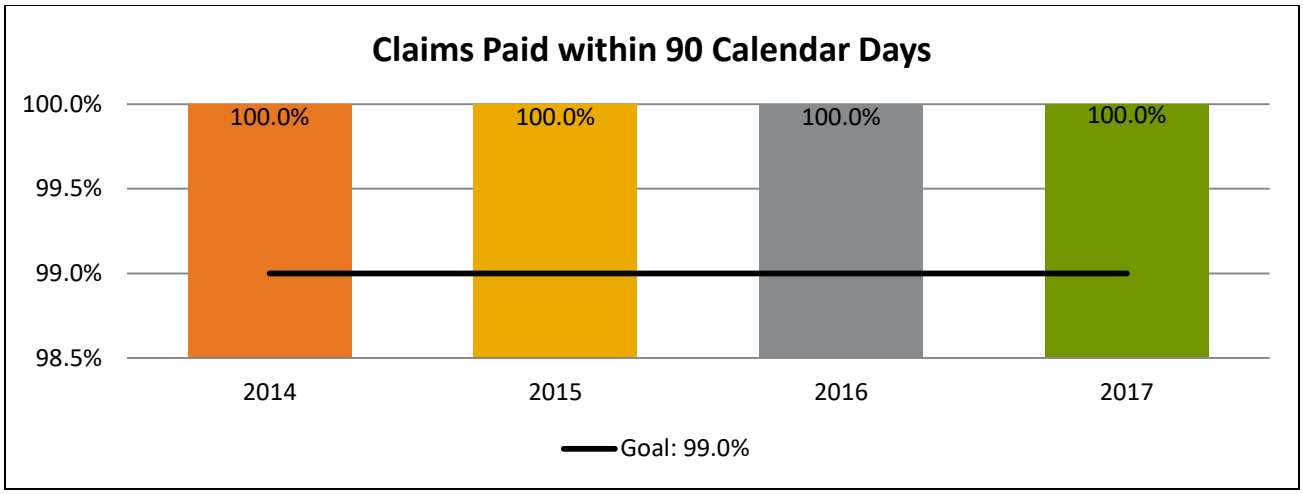
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial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

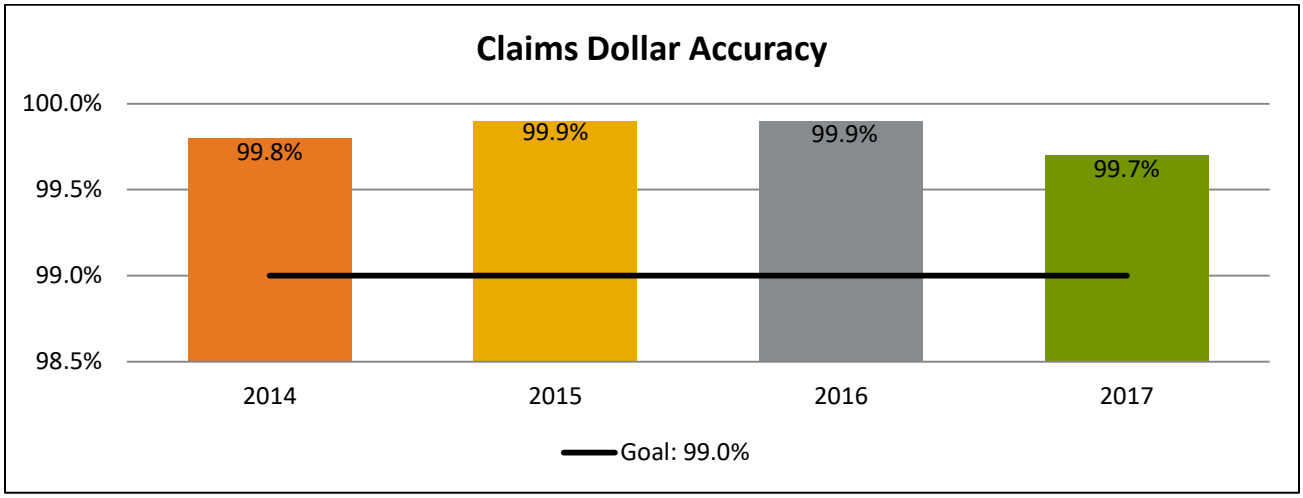
2014 – 2017 Overall Performance Results

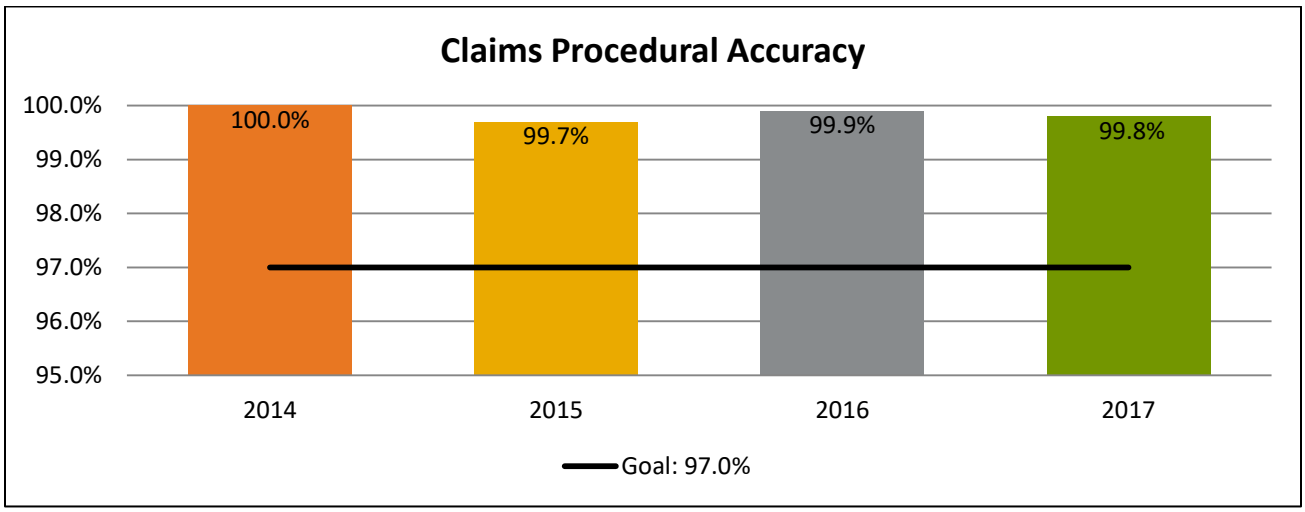
Claims	Performance Goal	2014	2015	2016	2017
Paid within 30 days	90.0%	99.7%	99.9%	99.9%	99.9%
Paid within 90 days	99.0%	100.0%	100.0%	100.0%	100.0%
Dollar Accuracy	99.0%	99.8%	99.9%	99.9%	99.7%
Procedural Accuracy	97.0%	100.0%	99.7%	99.9%	99.8%

Analysis: The data shows that all performance goals were met again during 2017.









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