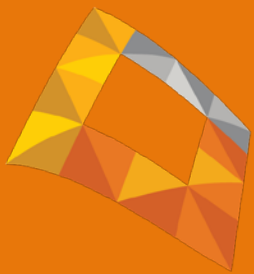


IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT

*October -
December 2017*



OPTUM®

The Idaho Behavioral Health Plan (IBHP) Quality Management and Improvement (QMI) report summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) for Calendar Year 2017. It provides an overview of outcomes data, through Quarter 4, 2017, for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

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Executive Summary – Quarter 4 - 2017

As noted in the outcomes analysis portion of this report, the overall trend for hospital re-admissions within 30 days has improved over time, and declined 32% year-over-year, which is a positive indicator that members are seeking outpatient services when appropriate. Fifty percent (50%) of discharged patients had a follow-up outpatient visit within seven days of discharge, and 70% had done so within 30 days. Peer Support services have increased over 50% from a year ago, as measured by the number of unique utilizers per 1,000 members. Optum Idaho's Field Care Coordinators continue to work with our highest need members and their providers upon inpatient discharge to help ensure the appropriate outpatient services are received within the reported seven-day requirement. The Intensive Outpatient (IOP) service was introduced in July 2017. At this time, it's too early to assess its impact on outcomes but is something that will be monitored throughout 2018.

Optum 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.

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 2017 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.

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.

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.

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.

About This Report

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

The purpose of this document is to share with internal and external stakeholders Optum Idaho's performance, outcomes and improvement activities related to services we provide to IBHP members and contracted providers. Information outlined in this report highlights quarterly performance from Quarter 4, 2017, (October through December 2017), unless otherwise noted, and provides comparative performance from each quarter.

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

Overall Effectiveness and Highlights

Optum Idaho monitors performance measures as part of our Outcomes Management and Quality Improvement Work Plan. In this report, thirty-three (33) key performance measures with performance goals were highlighted based on performance targets that are based on contractual, regulatory or operational standards. For this reporting period, Optum Idaho met or exceeded performance for 31 (94.0%) of the key measures. Optum Idaho's continues its commitment to IBHP members and families in transforming the behavioral health care system in the State of Idaho.

Quality Performance Measures and Outcomes

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

| Measure | Goal | October - December 2016 | January - March 2017 | April - June 2017 | July - September 2017 | October - December 2017 |
|---|---|--|----------------------|-------------------|---|--|
| Member Satisfaction Survey Results | | | | | | |
| Optum Support for Obtaining Referrals or Authorizations | ≥85.0% | NA | 87.0% | 76.0% | Based on Member Satisfaction Survey sampling methodology, Q2, 2017, is the most current data available. | |
| Accessibility, Availability, and Acceptability of the Clinician Network | ≥85.0% | NA | 87.0% | 87.0% | | |
| Experience with Counseling or Treatment | ≥85.0% | NA | 87.0% | 95.0% | | |
| Overall Satisfaction | ≥85.0% | NA | 81.3% | 73.0% | | |
| Provider Satisfaction Survey Results | | | | | | |
| Overall Provider Satisfaction | ≥85.0% | Changed to Annual Survey. (2017 Results will be presented in Q1, 2018, Report) | | | | |
| Accessibility & Availability | | | | | | |
| Idaho Behavioral Healthplan Membership | | | | | | |
| Membership Numbers | NA | 304,125 | 299,388 | 303,086 | 301,989 | Due to claims lag, data is reported 1 quarter in arrears |
| Member Services Call Standards | | | | | | |
| Total Number of Calls | NA | 1,412 | 1,290 | 1,345 | 1,362 | 1,295 |
| Percent Answered within 30 seconds | ≥80.0% | 82.0% | 80.0% | 85.4% | 83.0% | 86.0% |
| Average Speed of Answer (seconds) | ≤30 Seconds | 18.5 | 21.5 | 12.3 | 2.7 | 1.5 |
| Abandonment Rate | ≤3.5% internal ≤7.0 % contractual | 3.5% | 4.1% | 2.1% | 1.7% | 1.4% |

| Measure | Goal | October - December 2016 | January - March 2017 | April - June 2017 | July - September 2017 | October - December 2017 |
|---|-------------------------------------|-------------------------|----------------------|-------------------|--------------------------------------|--------------------------------------|
| Customer Service (Provider Calls) Standards | | | | | | |
| Total Number of Calls | NA | 3,086 | 2,917 | 2,861 | 4,103 | 3,135 |
| Percent Answered within 30 seconds | ≥80.0% | 98.6% | 98.4% | 98.4% | 97.1% | 99.3% |
| Average Speed of Answer (seconds) | ≤30 Seconds | 1.1 | 2.8 | 1.8 | 6.2 | 2.3 |
| Abandonment Rate | ≤3.5% internal ≤7.0% contractual | 0.41% | 0.56% | 0.44% | 0.64% | 0.00% |
| Urgent and Non-Urgent Access Standards | | | | | | |
| Urgent Appointment Wait Time (hours) | 48 hours | 32.0 | 24.0 | 27.0 | 20.0 | 21.4 |
| Non-Urgent Appointment Wait Time (days) | 10 days | 7.2 | 7.3 | 6.0 | 6.0 | 5.4 |
| 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% | 99.8%* | 99.8%* | 99.8%* | 100.0% | 99.8%* |
| Area 2 - requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties) | 100.0% | 99.9%* | 99.8%* | 99.9%* | 99.8%* | 99.8%* |
| Member Protections and Safety | | | | | | |
| Notification of Adverse Benefit Determinations | | | | | | |
| Number of Adverse Benefit Determinations (ABD's) | NA | 470 | 416 | 500 | 756 | 492 |
| Clinical ABD's (<i>began tracking Q3, 2017</i>) | NA | NA | NA | NA | 578 | 352 |
| Administrative ABD's (<i>began tracking Q3, 2017</i>) | NA | NA | NA | NA | 178 | 140 |
| Written Notification (<i>14 business days from request for services - implemented 7/1/17</i>) | 100% within 14 business days | NA | NA | NA | 100.0% (756/756) | 99.8% (491/492) |
| Initial Verbal Notification on Same Day | 100.0% | 98.9%* | 99.8%* | 99.6%* | No longer tracking | No longer tracking |
| Written Notification Sent within 1 Business Day | 100.0% | 92.9% | 98.3% | 99.8%* | New 14-day requirement tracked above | New 14-day requirement tracked above |
| Member Appeals (formerly Grievances) | | | | | | |
| Number of Appeals | NA | 17 | 15 | 17 | 51 | 30 |
| Non-Urgent Appeals | NA | 17 | 15 | 17 | 36 | 26 |
| Acknowledgement Compliance | 100% within 5 Calendar Days | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Determination Compliance | 100% within 30 Calendar Days | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Urgent Appeals | NA | 0 | 0 | 0 | 15 | 4 |
| Determination Compliance | 100% within 30 Calendar Days | NA | NA | NA | 100.0% | 100.0% |

| Measure | Goal | October - December 2016 | January - March 2017 | April - June 2017 | July - September 2017 | October - December 2017 |
|--|----------------------|-------------------------|----------------------|-------------------|-----------------------|-------------------------|
| Complaint Resolution and Tracking | | | | | | |
| Total Number of Complaints | NA | 11 | 13 | 23 | 16 | 11 |
| Percent of Complaints Acknowledged within Turnaround time | 5 days | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Number of Quality of Service Complaints | NA | 10 | 12 | 20 | 14 | 10 |
| Percent Quality of Service Resolved within Turnaround time | 100% within ≤10 days | 100.0% | 83.3% | 100.0% | 100.0% | 100.0% |
| Number of Quality of Care Complaints | NA | 1 | 1 | 3 | 2 | 1 |
| Percent Quality of Care Resolved within Turnaround time | ≤30 days | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Critical Incidents | | | | | | |
| Number of Critical Incidents Received | NA | 17 | 19 | 19 | 11 | 12 |
| Percent Ad Hoc Reviews Completed within 5 business days from notification of incident | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Response to Written Inquiries | | | | | | |
| Percent Acknowledged ≤2 business days | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Provider Monitoring and Relations | | | | | | |
| Provider Quality Monitoring | | | | | | |
| Number of Audits | NA | 39 | 128 | 164 | 148 | 79 |
| Initial Audit (Percent overall score) | ≥ 85.0% | 95.9% | 92.1% | 93.6% | 98.0% | 92.3% |
| Recredentialing Audit (Percent overall score) | ≥ 85.0% | 93.4% | 91.2% | 94.3% | 92.8% | 89.1% |
| Monitoring (Percent overall score) | ≥ 85.0% | 85.0% | 94.9% | 95.2% | 93.7% | 93.9% |
| Quality (Percent overall score) | ≥ 85.0% | NA** | 82.5% | NA** | 86.1% | NA** |
| Percent of Audits that Required a Corrective Action Plan | NA | 7.6% | 16.4% | 6.1% | 11.5% | 8.9% |
| Behavioral Health Provider and | | | | | | |
| Percent PCP is documented in member record | NA | 92.1% | 94.5% | 96.0% | 96.1% | 96.2% |
| Percent documentation in member record that communication/ collaboration occurred between behavioral health provider and primary care provider | NA | 87.2% | 73.0% | 87.0% | 79.0% | 72.0% |
| Provider Disputes | | | | | | |
| Number of Provider Disputes | NA | 15 | 13 | 6 | 45 | 88 |
| Average Number of Days to Resolve Provider Disputes | ≤30 days | 12.9 | 17.9 | 2.5 | 6.1 | 7.2 |
| Utilization Management and Care Coordination | | | | | | |
| Service Authorization Requests | | | | | | |
| Percentage Determination Completed within 14 days | 100% | 99.1% | 99.1% | 99.4% | 99.1% | 99.5%* |
| Field Care Coordination | | | | | | |
| Total Referrals to FCCs | NA | 149 | 123 | 204 | 209 | 264 |
| Average Number of Days Case Open to FCC | NA | 46 | 65 | 53.6 | 41 | 32 |

| Measure | Goal | October - December 2016 | January - March 2017 | April - June 2017 | July - September 2017 | October - December 2017 |
|---|---------|-------------------------|----------------------|--------------------|-----------------------|---------------------------------------|
| Discharge Coordination: Post Discharge Follow-Up | | | | | | |
| Number of Inpatient Discharges | NA | 842 [^] | 850 [^] | 930 [^] | 819 | Data is reported 1 Quarter in arrears |
| Percent of Members with Follow-Up Appointment or Authorization within 7 Days after discharge | NA | 46.3% [^] | 49.9% [^] | 49.8% [^] | 50.4% | |
| Percent of Members with Follow-Up Appointment or Authorization within 30 Days after discharge | NA | 66.3% [^] | 69.8% [^] | 69.5% [^] | 69.5% | |
| Readmissions | | | | | | |
| Number of Members Discharged | NA | 842 [^] | 850 [^] | 930 [^] | 819 | Data is reported 1 Quarter in arrears |
| Percent of Members Readmitted within 30 days | NA | 10.5% [^] | 8.9% [^] | 11.8% | 10.3% | |
| Inter-Rater Reliability | | | | | | |
| Inter-Rater Reliability completed annually. Results presented during Q2, 2017 | NA | NA | NA | 62.0% | Completed annually | Completed annually |
| Peer-Review Audits | | | | | | |
| PhD Peer Review Audit Results | ≥ 88.0% | ***NA | ***NA | ***NA | ***NA | Data is reported 1 Quarter in arrears |
| MD Peer Review Audit Results | ≥ 88.0% | 99.0% | 99.4% | 96.5% | 98.1% | |
| Claims | | | | | | |
| Claims Paid within 30 Calendar Days | 90.0% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% |
| Claims Paid within 90 Calendar Days | 99.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Dollar Accuracy | 99.0% | 99.7% | 99.4% | 99.9% | 99.9% | 99.4% |
| Procedural Accuracy | 97.0% | 100.0% | 99.8% | 99.8% | 100.0% | 99.5% |

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

***there were 0 quality audits during Q4, 2016 and Q2, Q4, 2017*

****there were 0 peer review audits*

[^]numbers changed to reflect accurate reporting and changes made due to updated claims reporting

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 of outpatient behavioral health care following hospital discharges.

ALERT Outcomes

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

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

Wellness Assessments

Methodology: An important part of 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 average 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 average 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 (<i>below clinical cut-off score of 12</i>). |
| 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. |

Analysis Figure 1: For adults, initial assessment scores remained consistent over the five quarters from Q4 2016 through Q4 2017, with a slight increase in follow-up adult Global Distress scores compared to initial scores for the population in treatment for Q4, though it remains lower than Q4 2016.

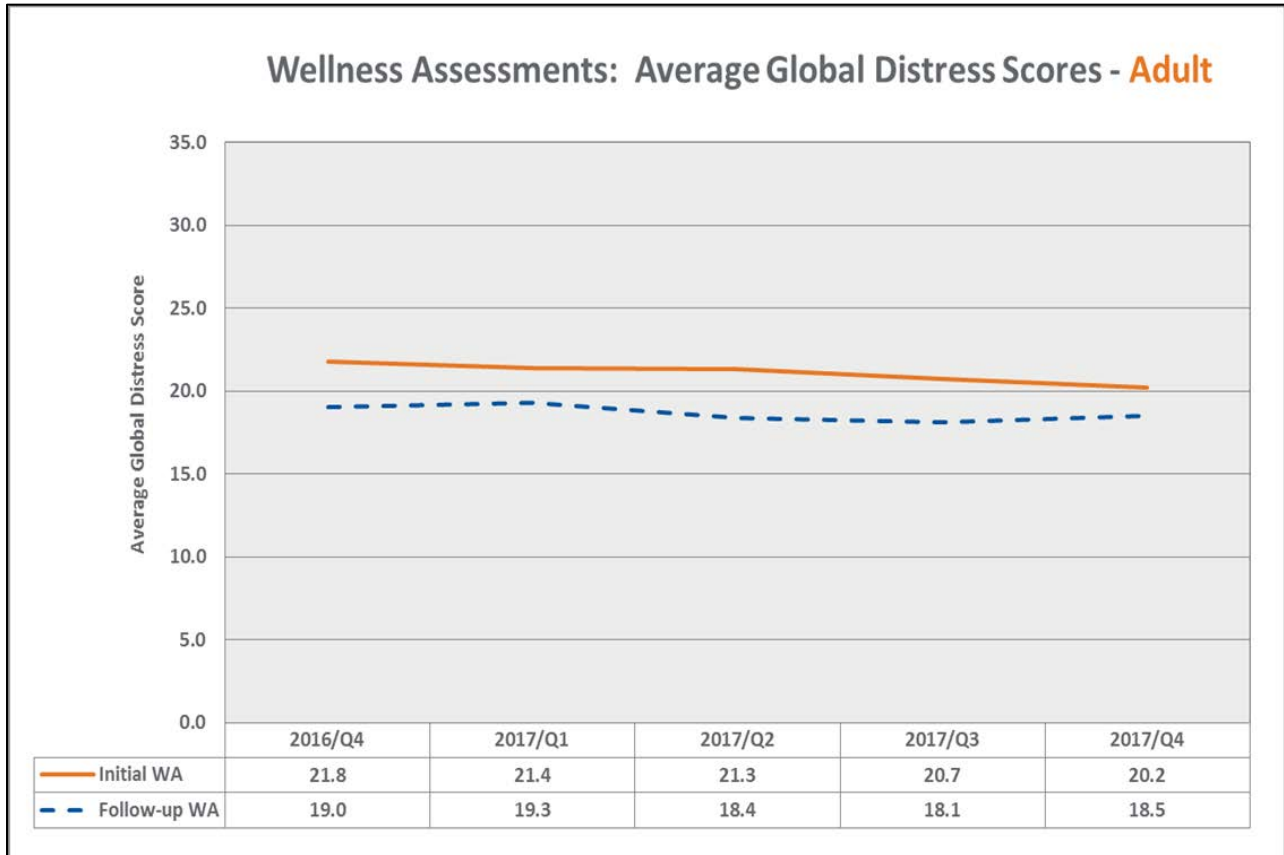


Figure 1

YOUTH global distress scores are described as follows:

| Total Score | Severity Level | Description |
|-------------|----------------|--|
| 0-6 | Low | Low level of distress (<i>below clinical cut-off score of 7</i>) |
| 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. |

Analysis Figure 2: Global Distress scores for children and youth consistently measured near 10 (Moderate) between Q4 2016 through Q4 2017.

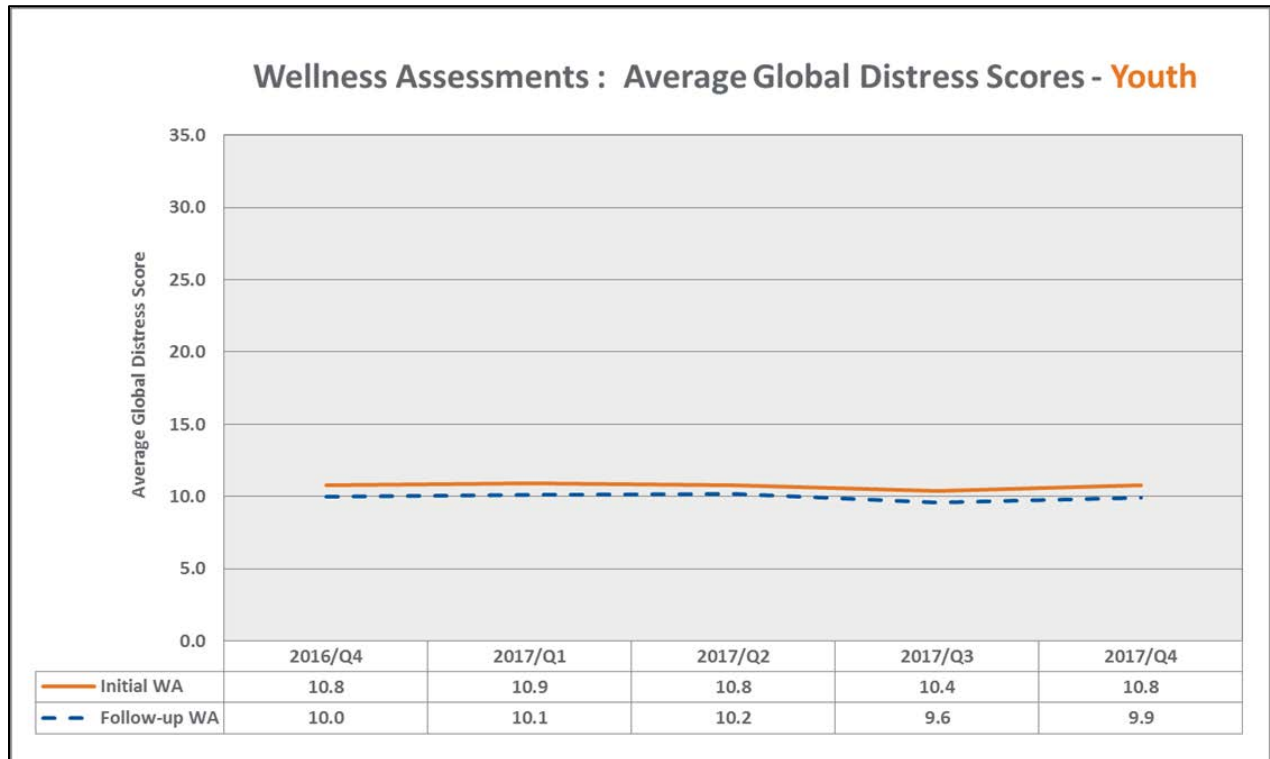


Figure 2

Caregiver Strain Level Descriptions:

| Score | Severity Level | Description |
|-------|----------------|---|
| 0-4 | Low | No or mild strain (<i>below clinical cut-off score of 4.7</i>) |
| 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. |

Analysis Figure 3: Average initial Caregiver Strain scores during 2017 remained below Q4 2016 levels, with follow-up scores in the population showing slight, but steady, improvement over the five quarter study period. Overall severity levels are at the lower end of the moderate score range.

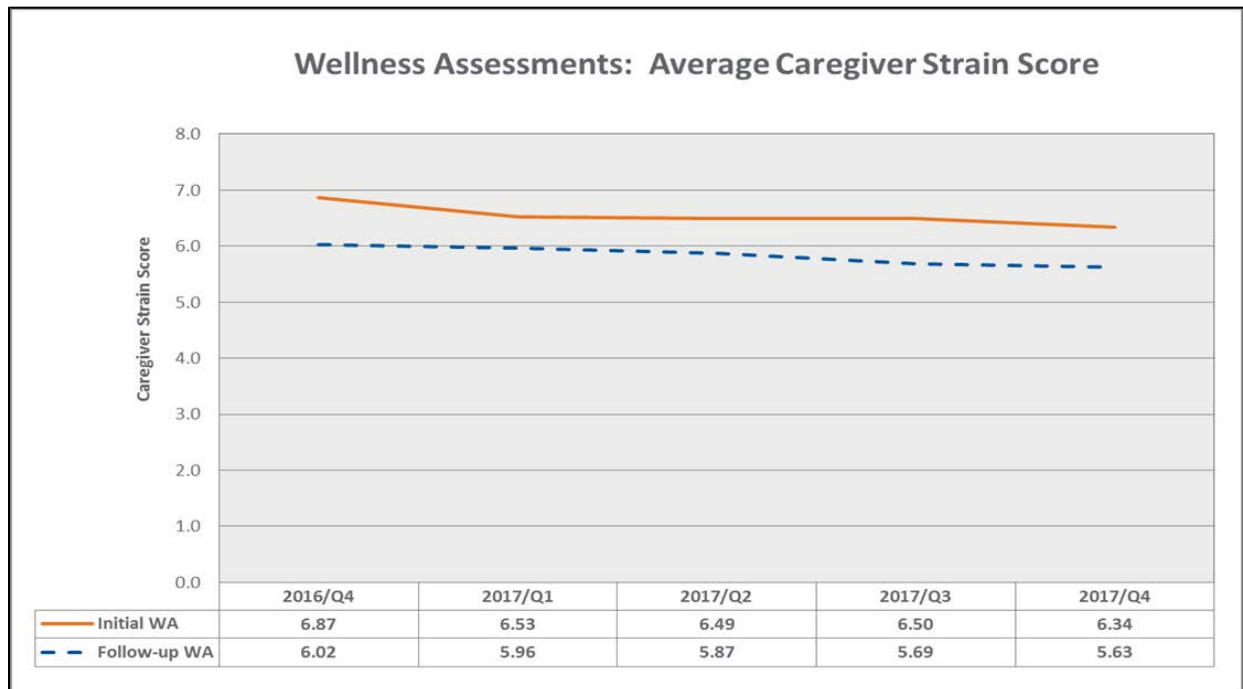


Figure 3

Adult Physical Health Score:

Analysis 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 and behavioral health problems tend to do worse than people with only behavioral health conditions. Adults scored on average between “fair” and “good” on the initial assessments during the five quarter study period. On follow-up assessments conducted over the same period, adults scored on average between “good” and “very good.” These scores have remained consistent throughout the study period.

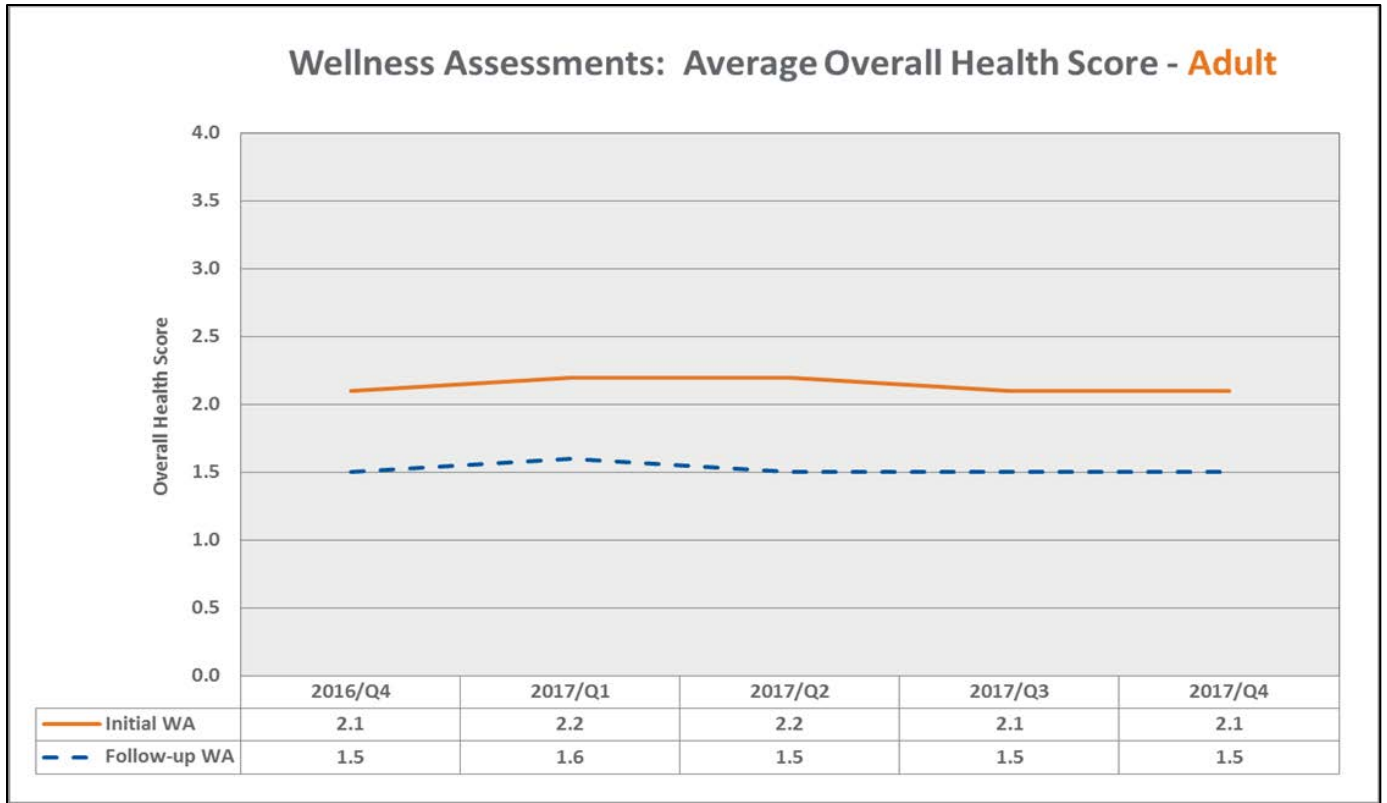


Figure 4

Child and Youth Physical Health Score:

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

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

Between Q4 2016 through Q4 2017, children and youth at baseline on initial assessment showed a consistent 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 improved scores have remained consistent throughout the study period.

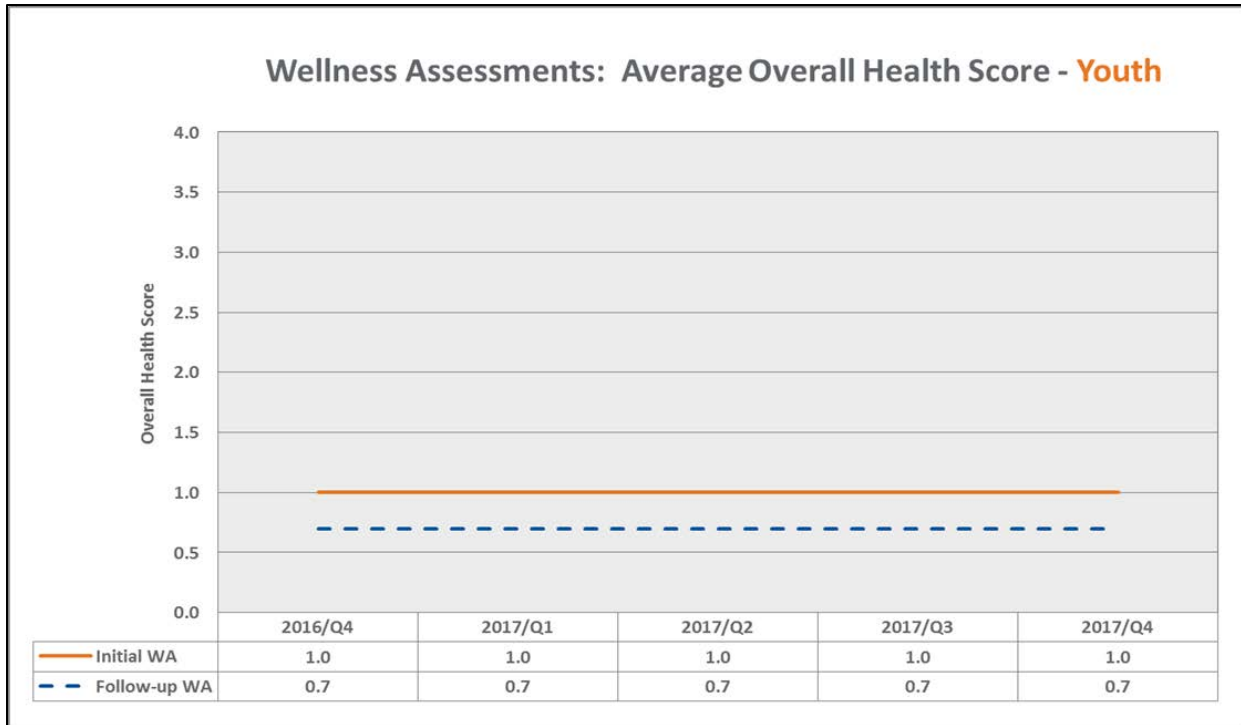


Figure 5

Barriers: No identified barriers.

Opportunities and Interventions: No opportunities for improvement were identified.

Individual Therapy Utilization Rates

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

Analysis: Individual Therapy is important for many behavioral health disorders. In general, according to the Treatment Guidelines of the American Psychiatric Association, Individual Therapy is an expected, evidence-based practice for adult mental disorders except for dementia. According to the Practice Parameters of the American Academy of Child and Adolescent Psychiatry, Individual Therapy is a central part of treatment in some disorders, such as Post-Traumatic Stress Disorder, and in limited respects for others. For some disorders, for instance, Individual Therapy is limited to Problem-Solving Skills Training only for children of school age. In contrast to adults, family-based interventions are the most important and the most commonly expected for children and youth. It is expected, therefore, that there should be more adult utilizers of Individual Therapy than what would be seen with children.

Examination of the data for the age groups 0-17 years, 18-20 years, and 21+ years, shows a clear predominance of utilizers of Individual Therapy in the adult group and many fewer for

children and transitioning youth. Overall utilization of Individual Therapy decreased 6.0% from Q2 2017 to Q3 2017. Year-over-year utilization was essentially flat, with increases in the 0-17 and 18-20 age populations, offset by a decline in the +21 age population.

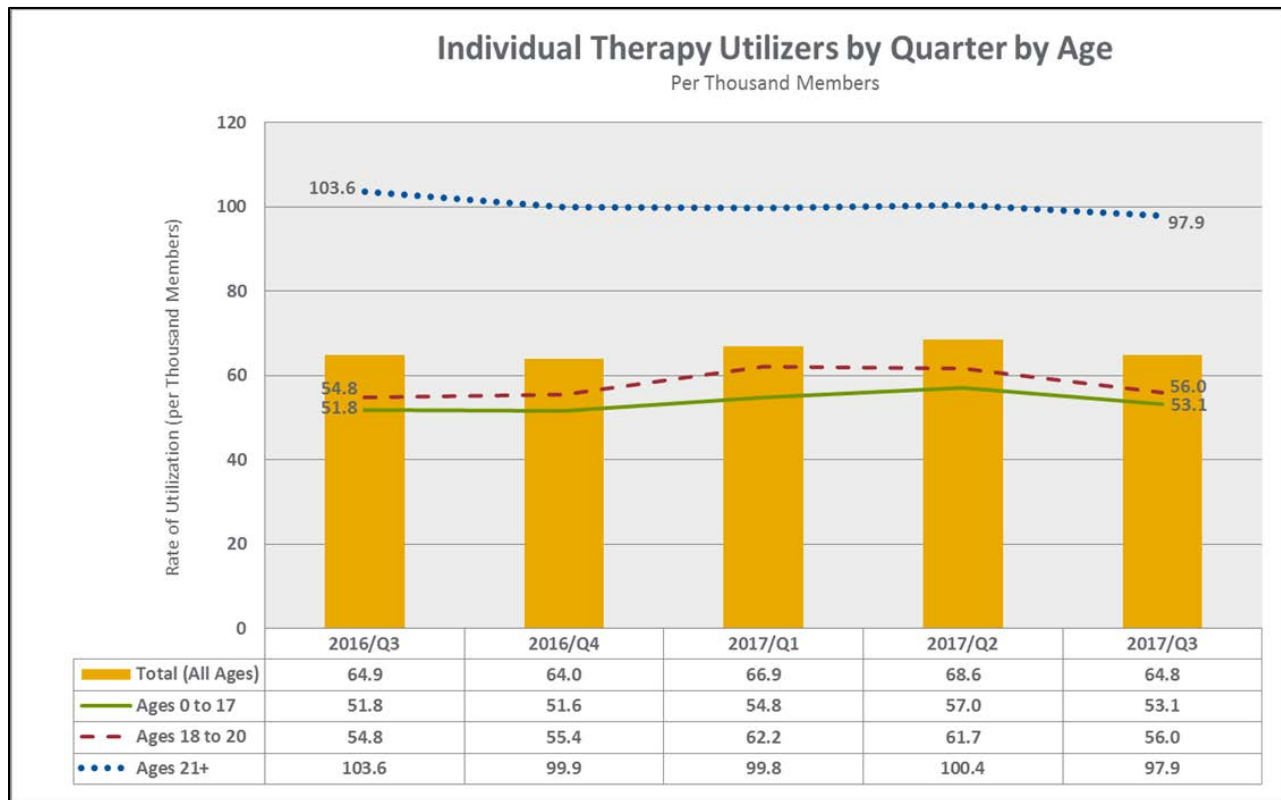


Figure 6

Barriers: No identified barriers.

Opportunities and Interventions: Continued recommendation for evidence based Individual Psychotherapy for appropriate diagnostic categories.

Family Therapy Utilization Rates

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

Analysis: Over the past 4 quarters of claims data, beginning Q4 2016, an upward trend in the utilizer rates for Family Therapy is exhibited in the 18-20 year group, growing 21% over that time frame. The 0-17 year group was seasonally higher in the first half of 2017 but was flat from a year ago. Adults 21+ have trended down over the last year, and are down 15% from Q3 2016 to Q3 2017.

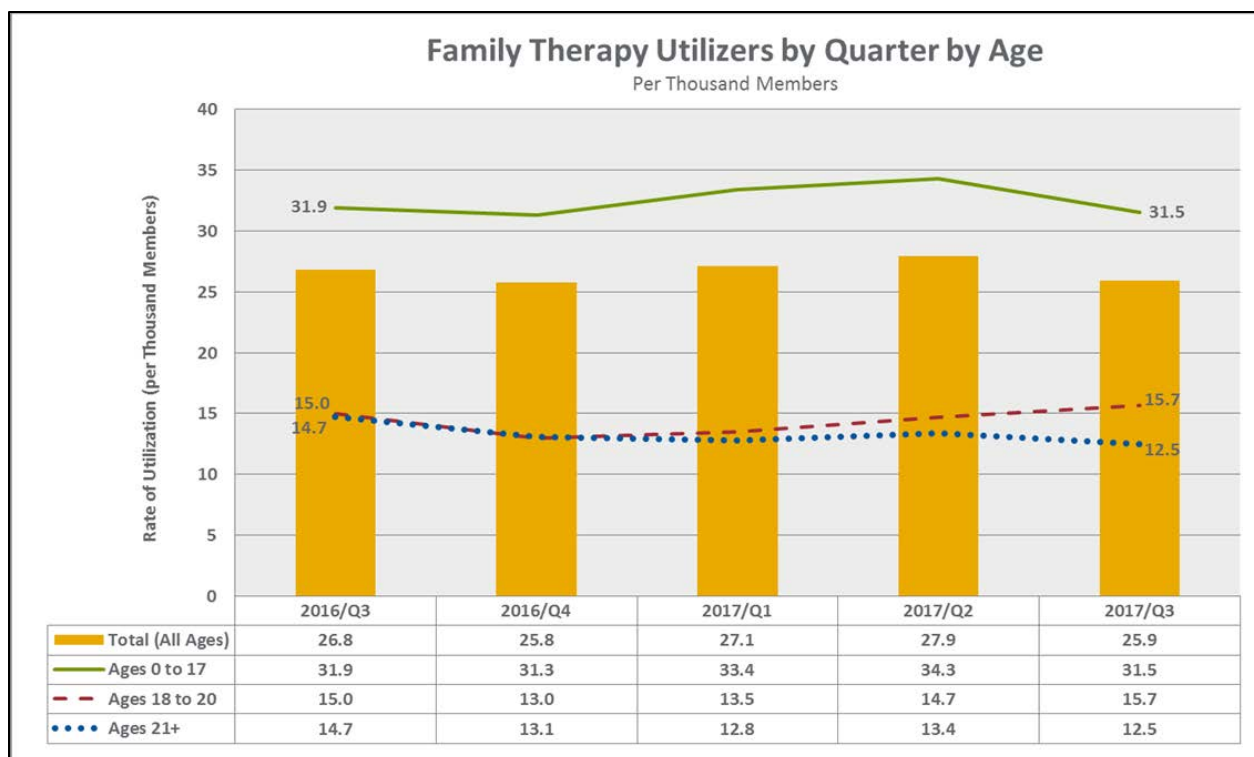


Figure 7

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-day period allowed for providers to file claims. The rate of utilization is calculated as follows:

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

Analysis: Per Optum Idaho’s Level of Care Guidelines, only members 18 years and over meet criteria for Peer Support Services. When members 18-20 years old and members 21 and over are examined, the Q3 2017 utilization for Peer Support increased 51% and 54% respectively. This positive trend correlates with Optum’s changes in Peer Support utilization management and with increased community and provider training and awareness efforts.

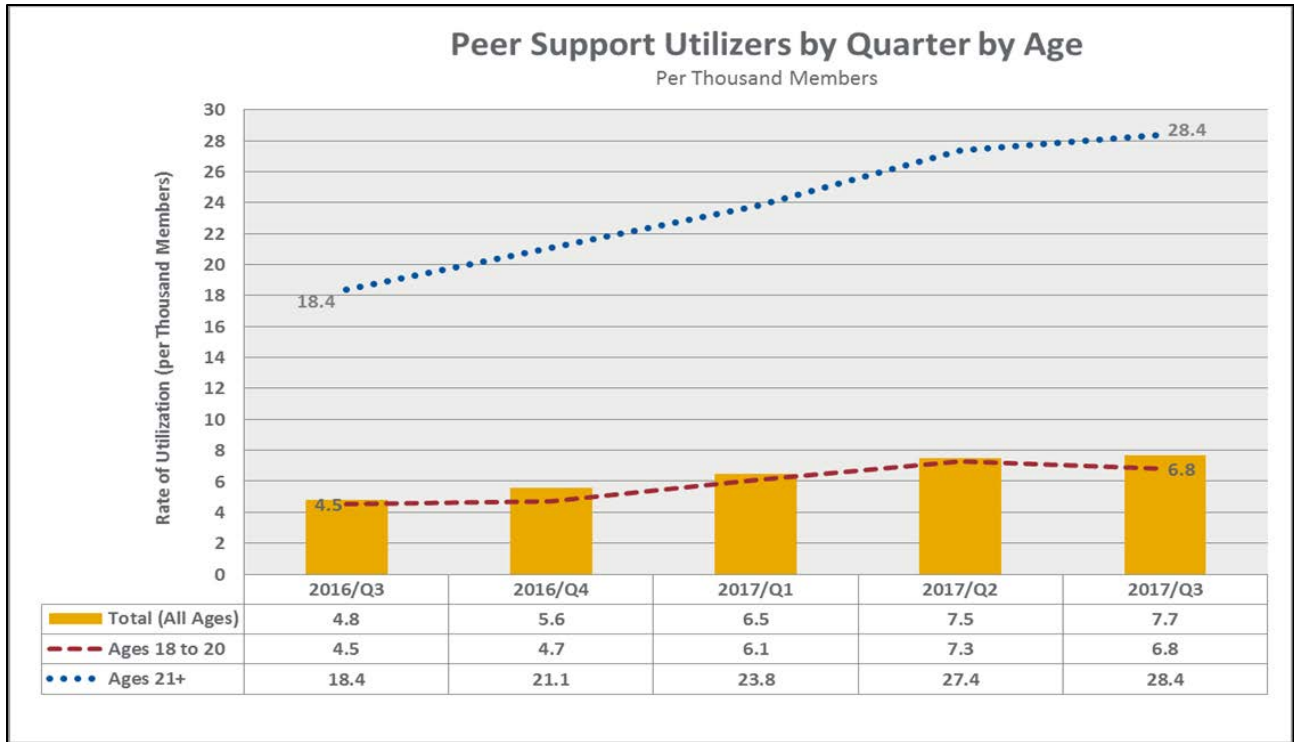


Figure 8

Barriers: One barrier is the variation of provider agencies across the state offering this service. The lack of extensive historical experience with Peer Support for providers in the State of Idaho is a likely factor, as the benefits of using Peer Support are unfamiliar to some providers.

Opportunities and Interventions: Peer support is an evidence-based intervention that has demonstrated benefit for reducing hospital readmissions for persons with Serious Mental Illness and for reducing depressive symptoms. Optum Idaho supports the utilization of this service, particularly in those groups for which the medical literature describes medical necessity. Consistency within the service needs further exploration.

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 for providers to file claims.

The rate of utilization is calculated as follows:

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

Analysis: Case Management Services utilization rates have flattened and remained steady for all age groups in the three quarters ending Q3 2017.

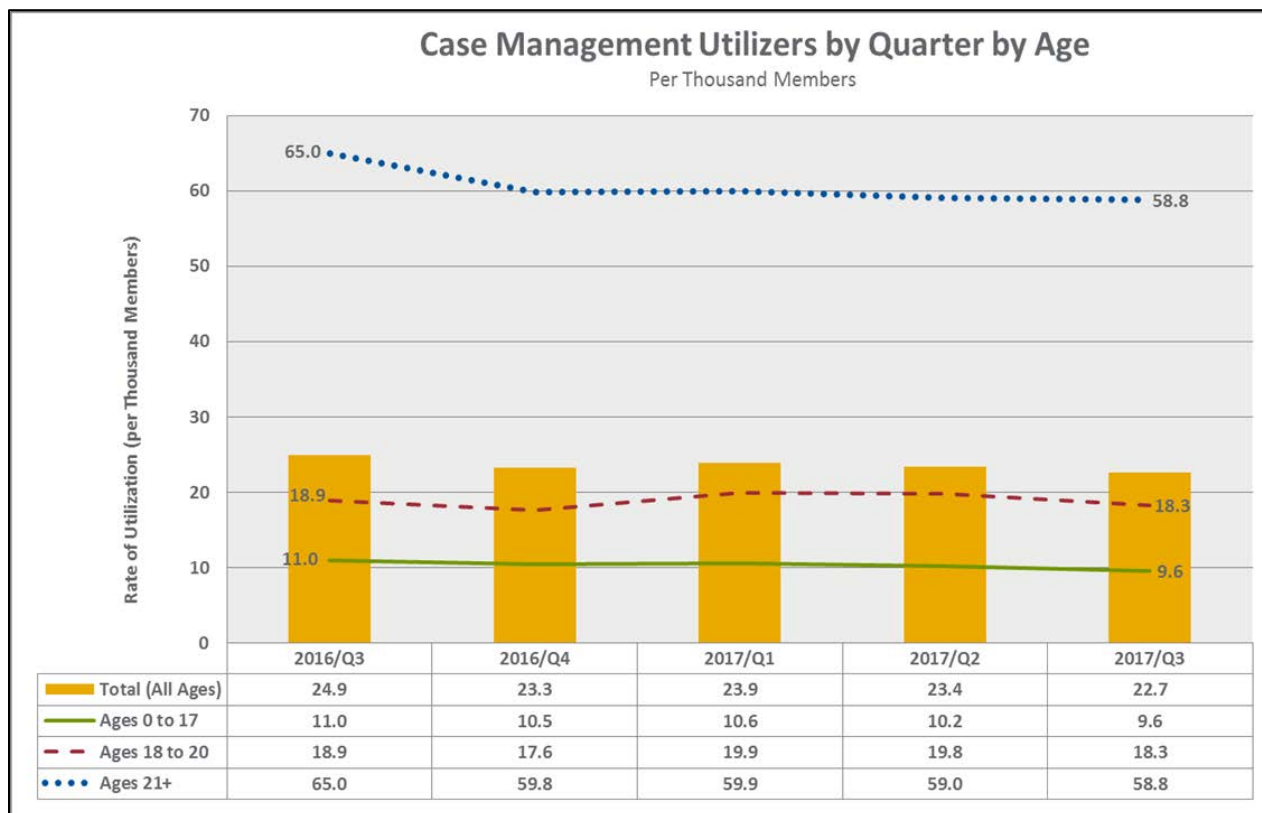


Figure 9

Barriers: No barriers were identified.

Opportunities and Interventions: Optum Idaho will continue to work with educating our Provider network concerning appropriate use of Case Management services.

Prescriber Visit Utilization Rates

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

Analysis: The utilization rate for total behavioral health prescription visits has remained essentially flat over the five quarters ending Q3 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.

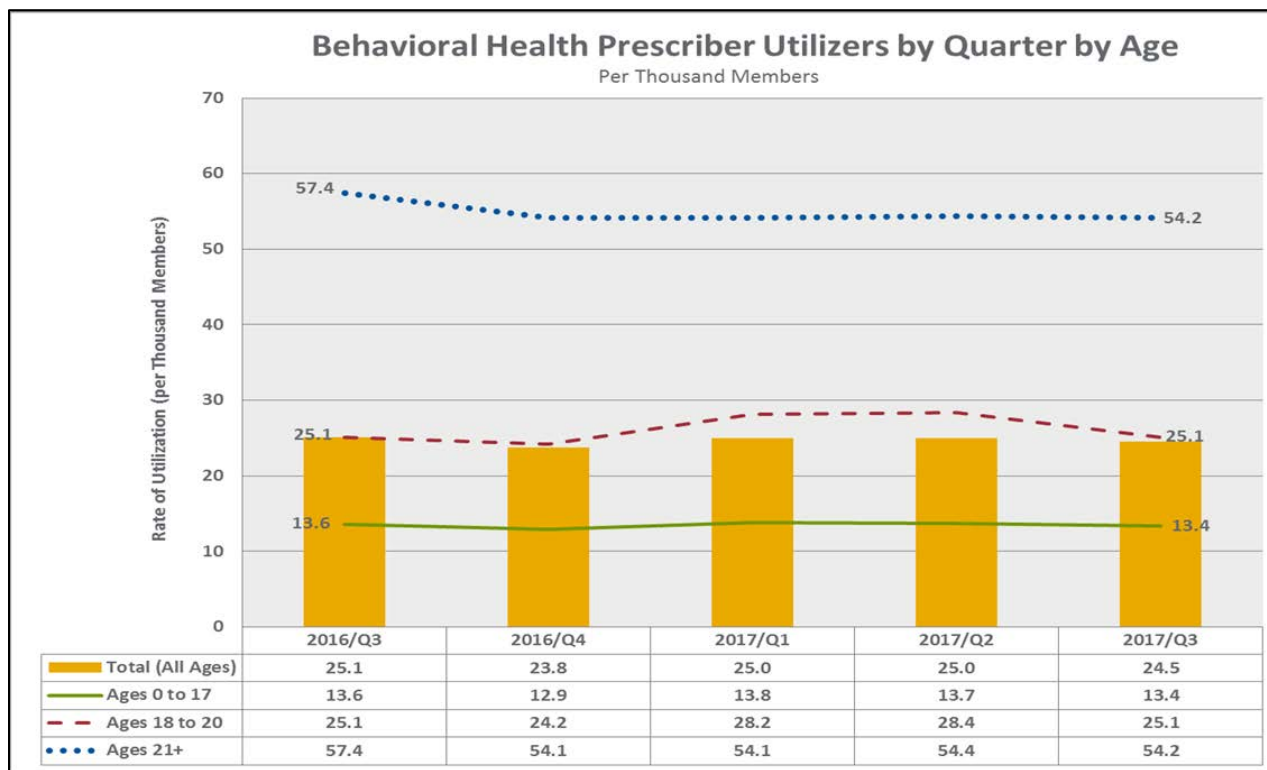


Figure 10

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, thereby limiting the number of quarters that can be displayed. Reliable data requires waiting for the 90-day claims lag allowed providers to file claims. The rate of utilization is calculated as follows:
 Numerator is the number of unique utilizers of CBRS visits for a specific quarter.
 Denominator is the total number of IBHP members for the same quarter, in thousands.

Analysis: Community-Based Rehabilitative Services, CBRS, is a set of rehabilitation services originally developed to support adults diagnosed with Schizophrenia and severe and persistent Bipolar Disorder. Between Q3 2016 and Q3 2017, the reduction in CBRS for all age groups combined was 44.7%. All three age groups demonstrated a reduction in utilizer rates, with the 0-17 year group, the 18-20 year group, and the 21+ year group showing reductions of 50%, 51.6%, and 42.6% respectively within the study period. These changes have sustained a more clinically appropriate use of CBRS for the different age groups.

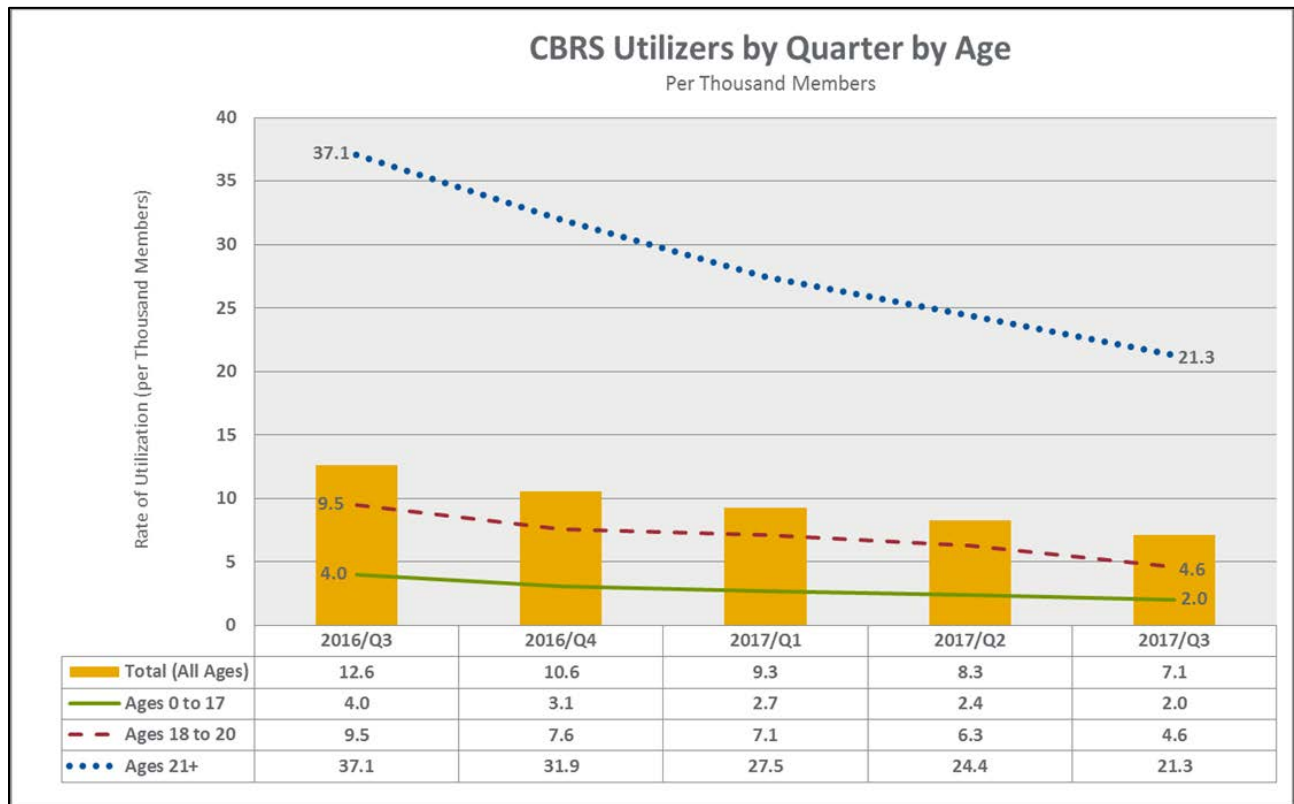


Figure 11

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) letter.

Analysis: 97.8% of members who received an ABD for CBRS services in Q3 2017 received evidenced-based therapeutic services within 90 days of the ABD. This is up from 94.3% in Q4

2016. Evidenced based services utilized after 90 days has decreased in each successive quarter over the study period. 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.

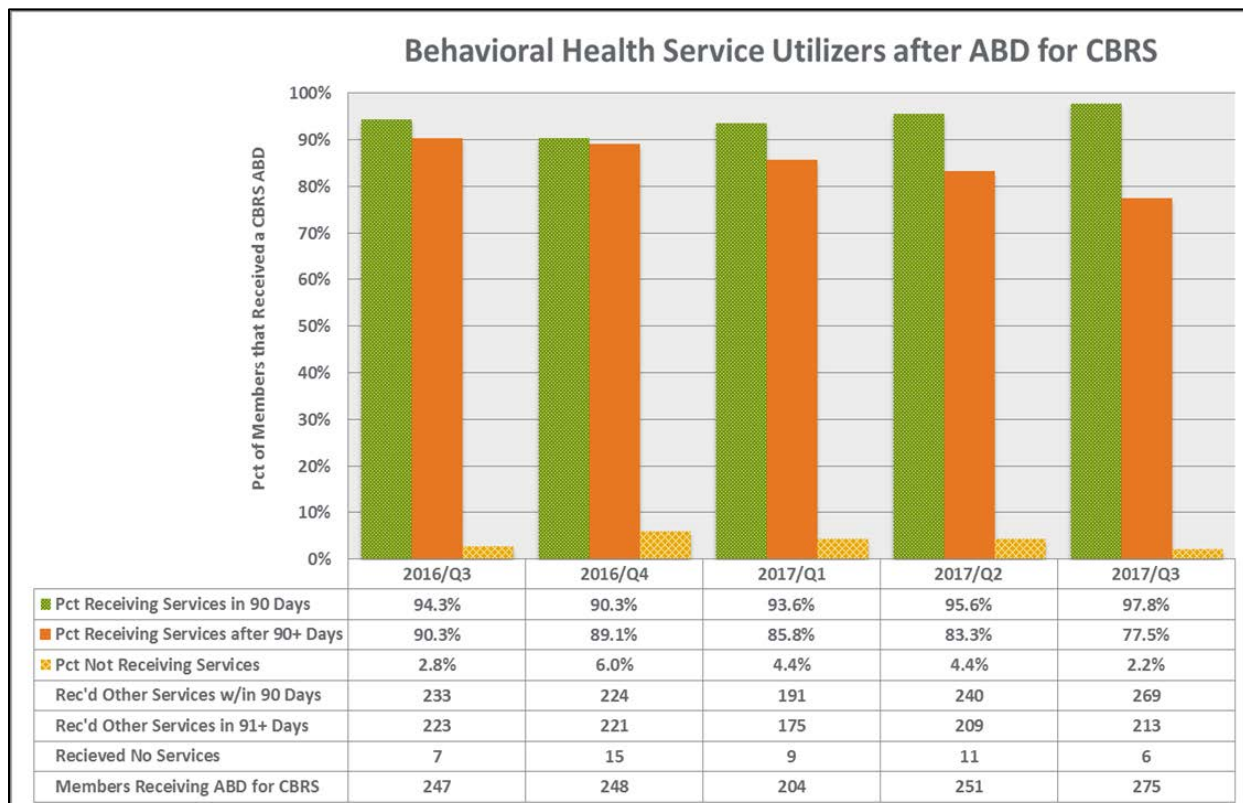


Figure 12

Barriers: Although progressively changing, some limited provider familiarity with evidence-based therapies as well as 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, Optum anticipates 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 quarter. To control for an increase in IBHP members over this time frame, the data has been standardized by displaying the numbers per 1,000 members.

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

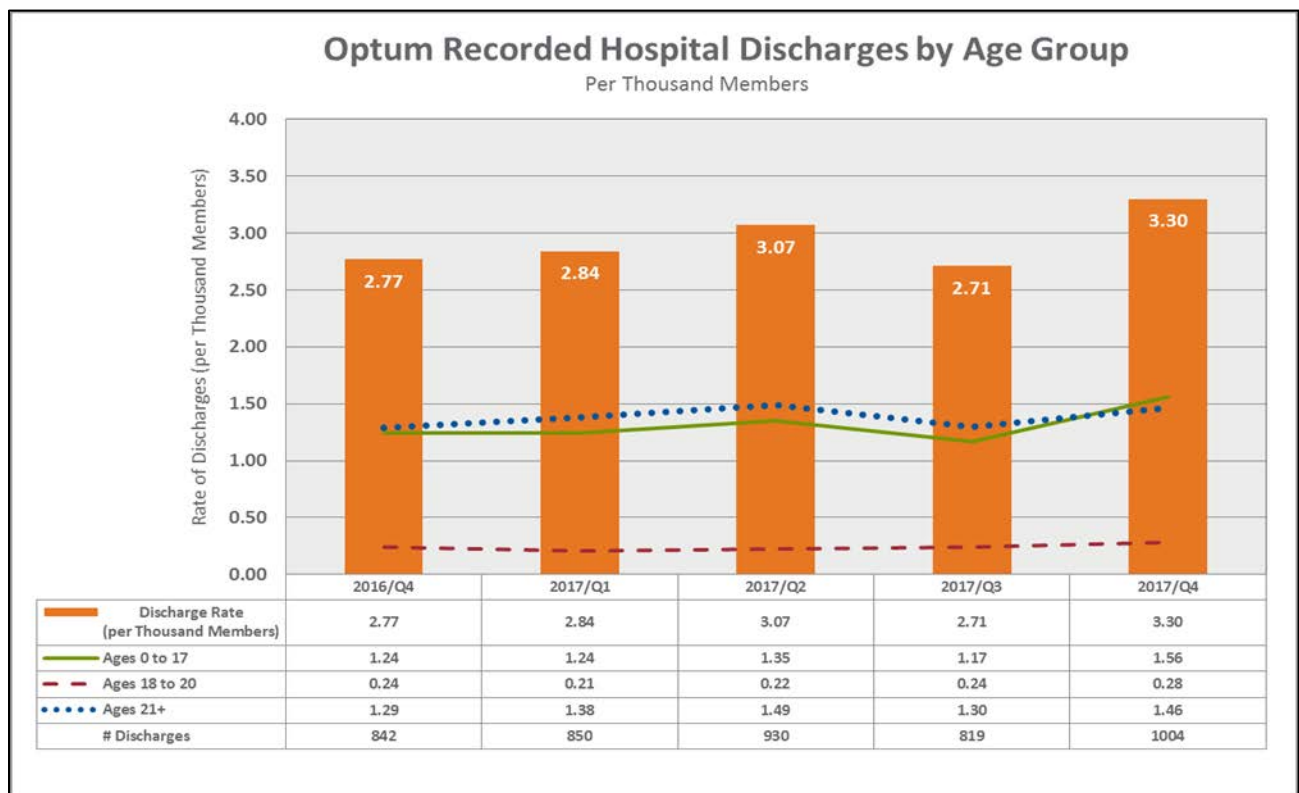


Figure 13

Figure 13 shows the overall rate of discharges decreased year-over-year from 2.77 to 3.30 per 1,000 members, which represents a 19.1% increase in hospitalizations.

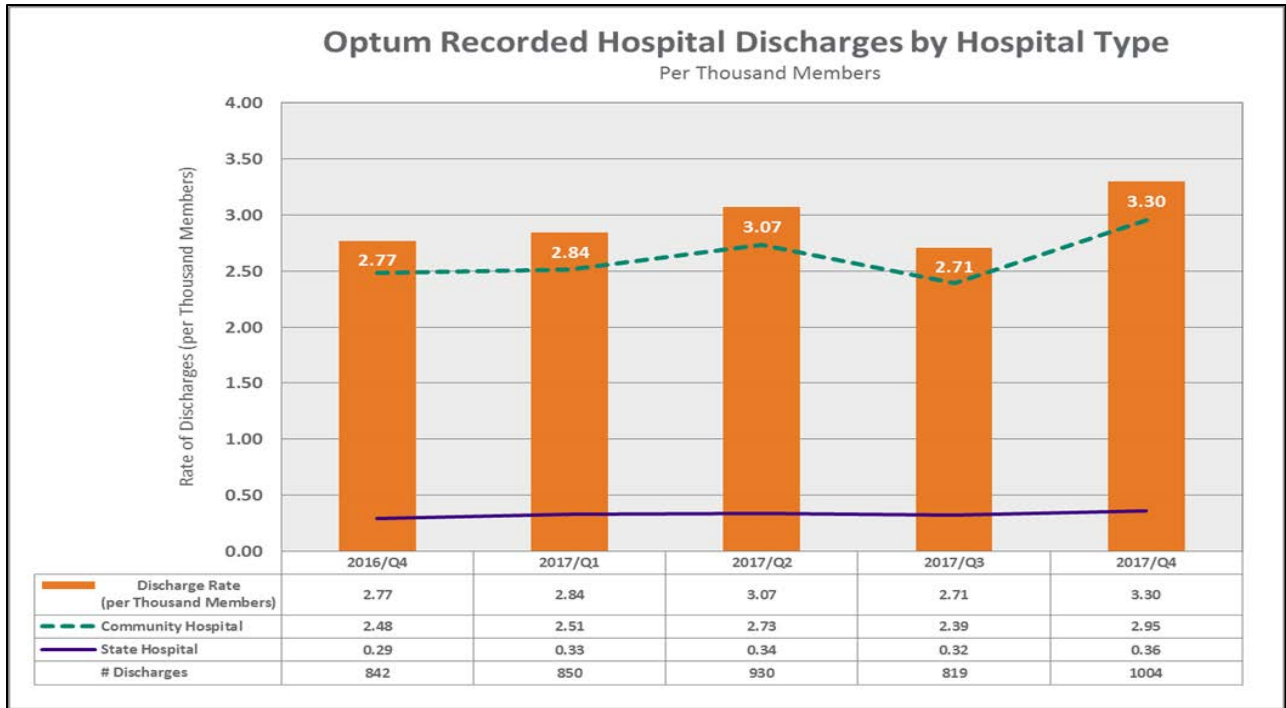


Figure 14

Figure 14 shows that during the study period from Q4 2016 through Q4 2017, discharges were consistent over time from the State Hospitals and increased 22.9% at community hospitals.

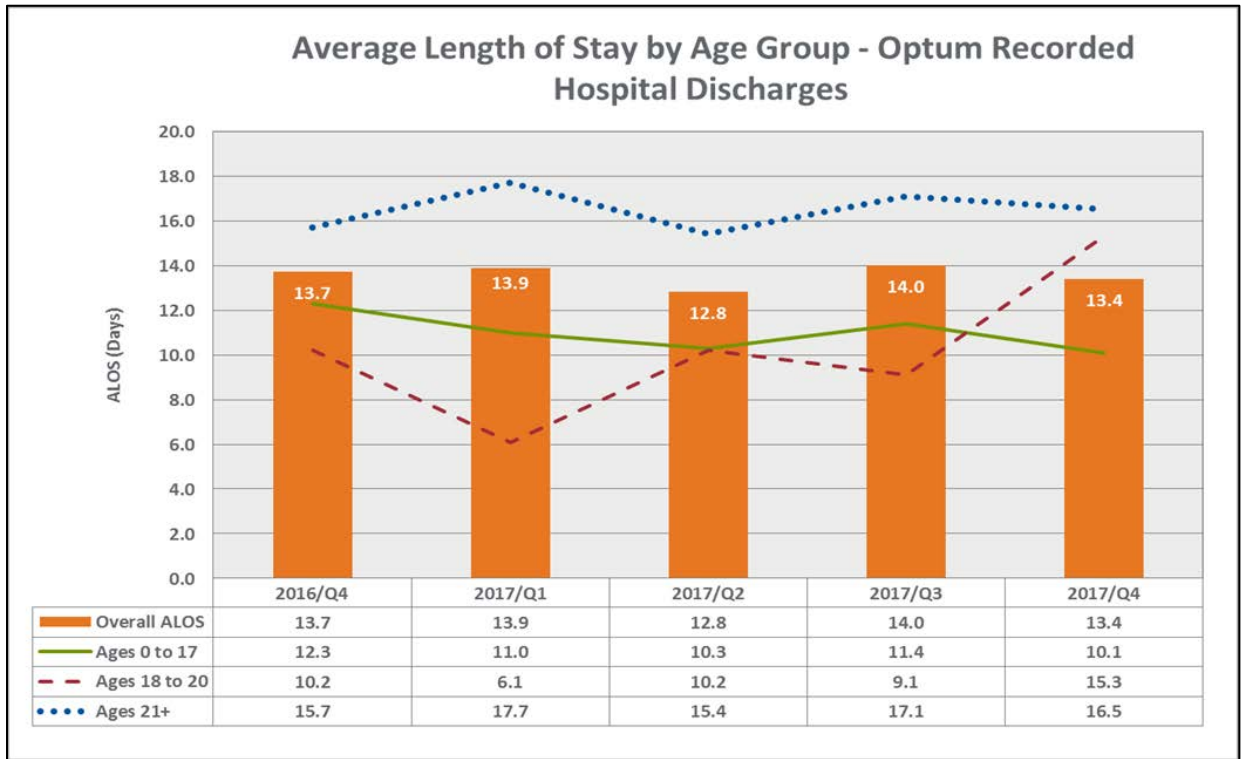


Figure 15

Figure 15 indicates that from Q4 2016 through Q4 2017, based on information reported to Optum Idaho from hospitals, the overall average length of stay was down slightly, or 2.2%.

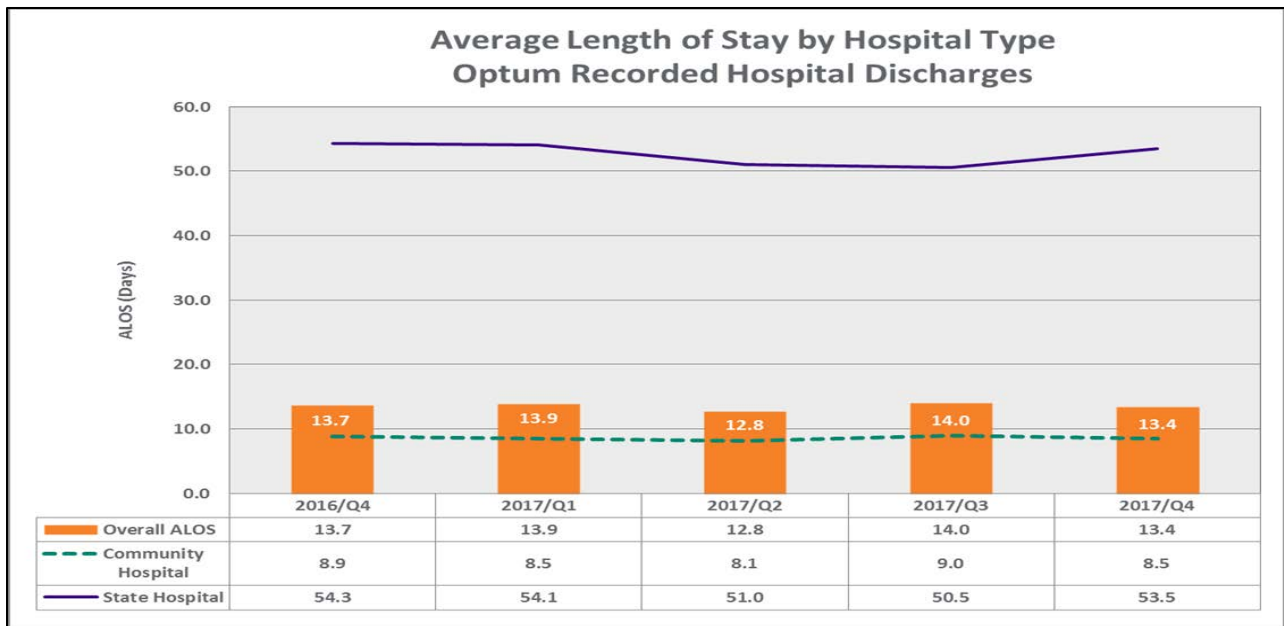


Figure 16

Figure 16 shows the average length of stay by hospital type. Both State and Community hospital rates vary from quarter to quarter, but are essentially flat over the 5 quarter study period.

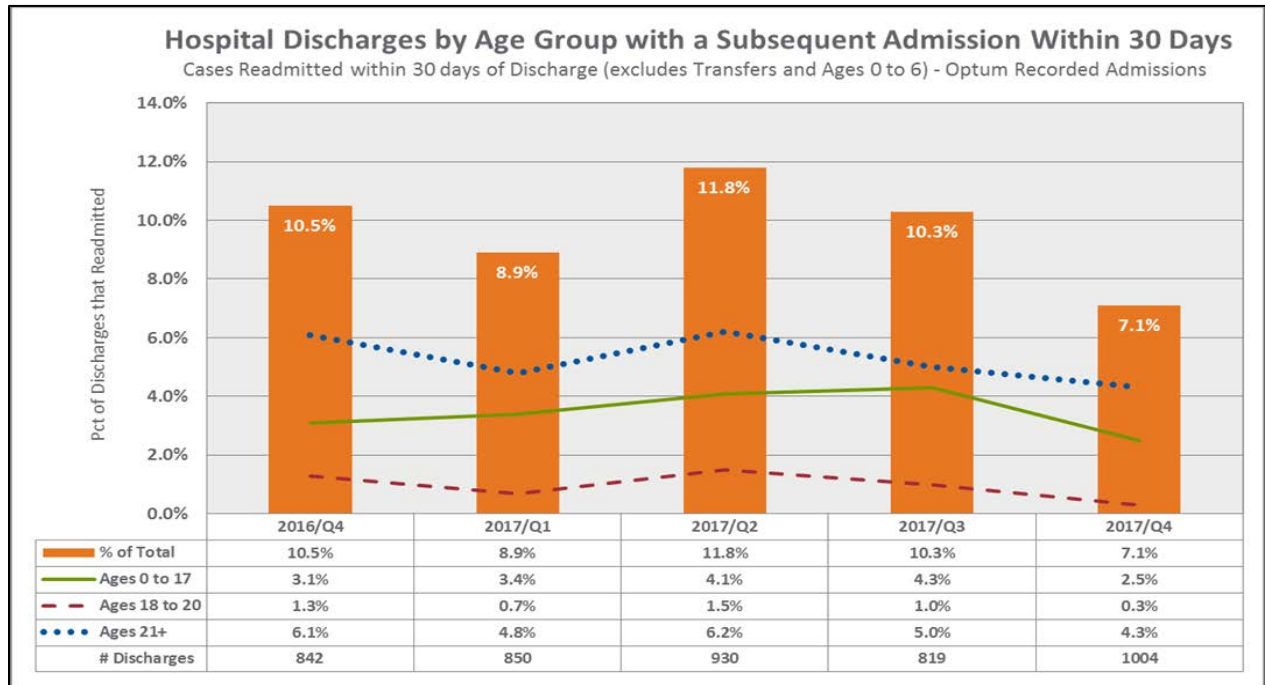


Figure 17

Figure 17 shows that during the study period from Q4 2016 through Q4 2017, readmissions decreased 32.4% year-over-year and sequentially across the three previous quarters. According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals.

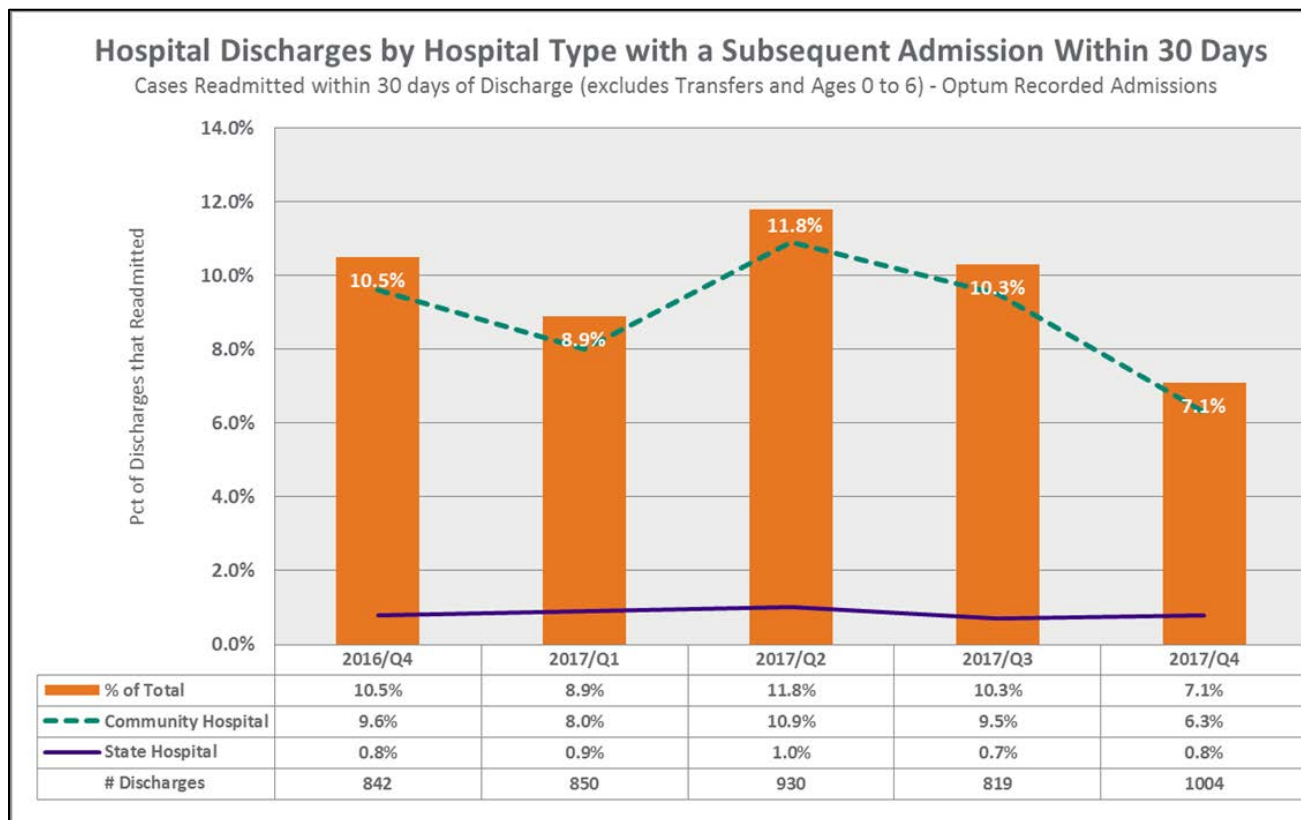


Figure 18

Figure 18 shows readmissions percentages by hospital type. During the study period from Q4 2016 through Q4 2017, the readmission rate for state hospitals was flat and was down 34.4% for community hospitals, notwithstanding a Q2 2017 increase and subsequent improvement in the latter.

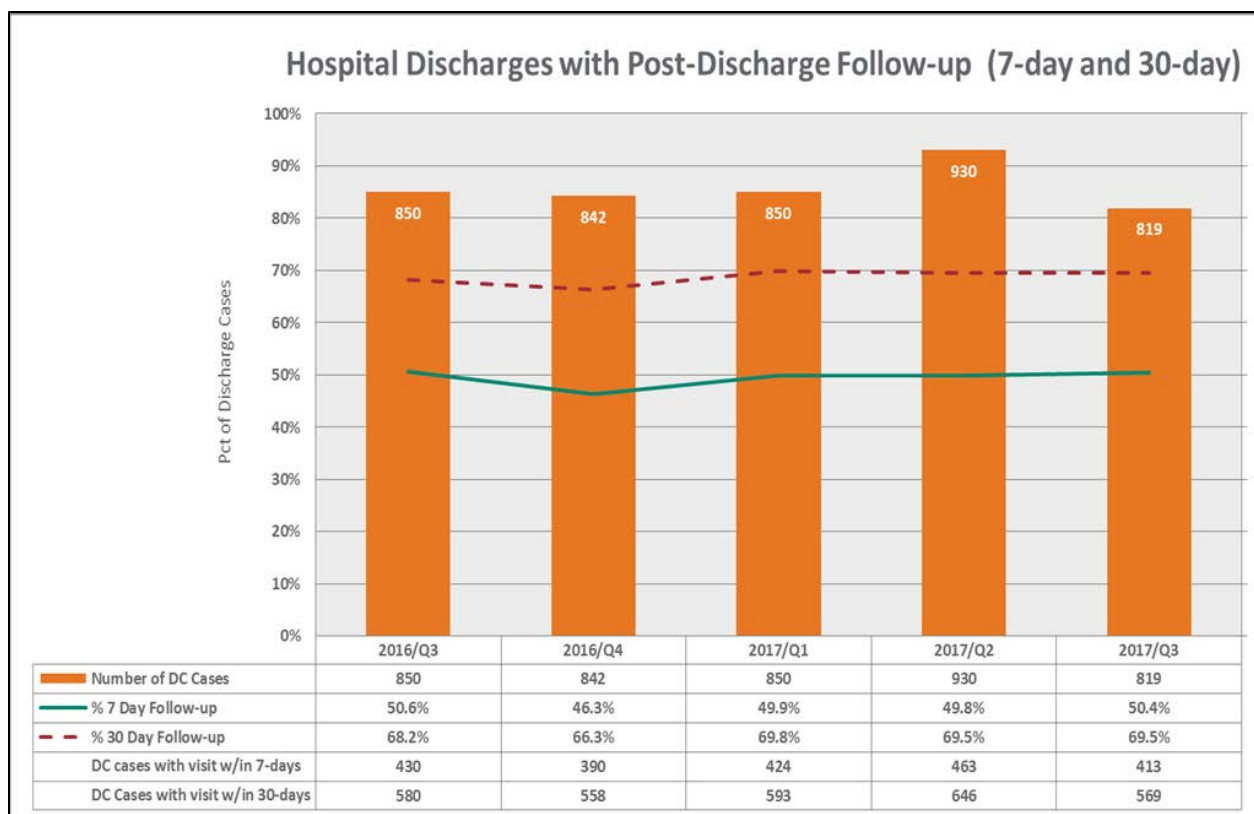


Figure 19

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 been consistent over the previous five quarters at approximately 50% for 7 days and 70% for 30 days post-discharge.

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 often 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.

Psychiatric Emergency Room Utilization Rates

Methodology: Psychiatric Emergency Room utilization data was provided by IDHW for dates September 2016 to May 2017. Utilization is given as visits per 1,000 members in the IBHP for each month.

Analysis: Figure 20 displays the utilization trends of Idaho Emergency Room visits for psychiatric care. Over the 5 month period ending June 2017—the most recent for which data is available—emergency room utilization had trended upwards from February, and then declined in June.

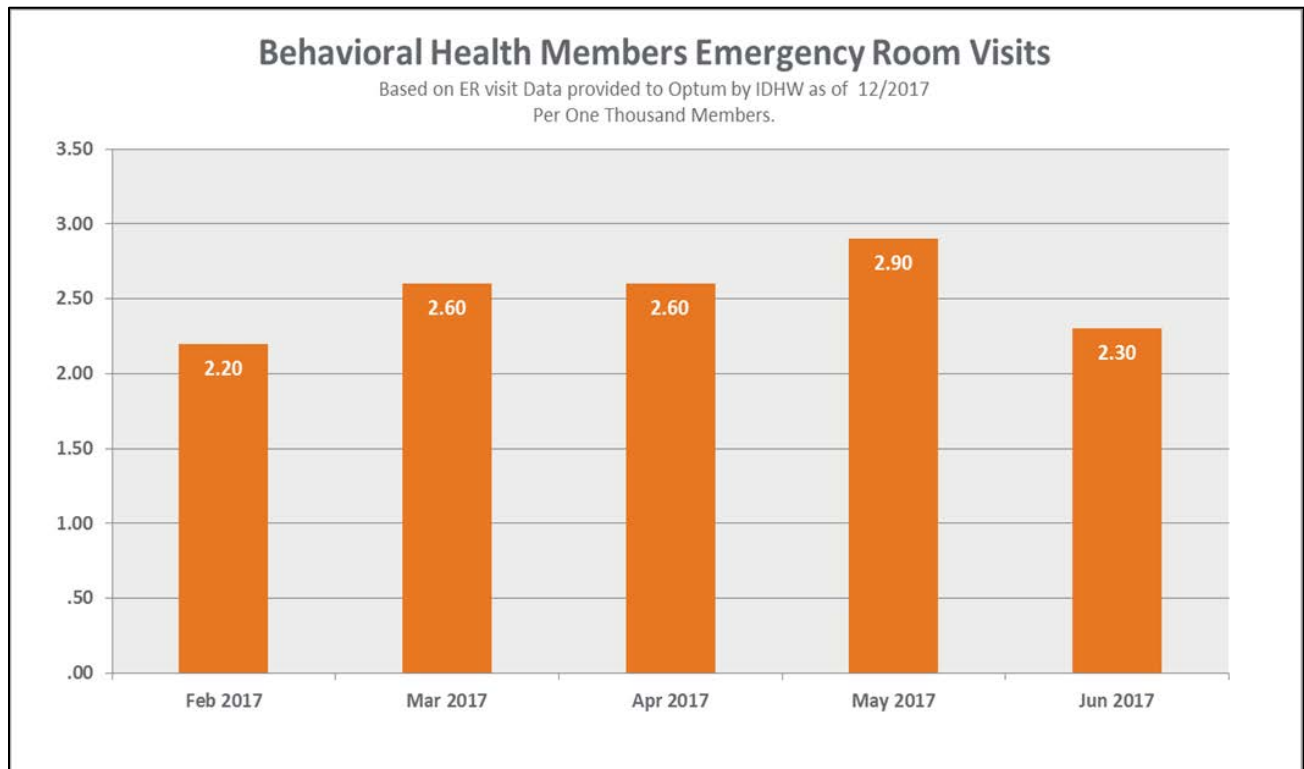


Figure 20

Barriers: No identified barriers.

Opportunities and Interventions: Further research is needed to determine and assess the factors that lead to emergency room visits so that members can receive the appropriate behavioral healthcare subsequent to those visits.

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: Promoters, 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 surveys are conducted over a 3-month period of time after the quarter services were rendered. Because of this, there is a lag in data reporting.

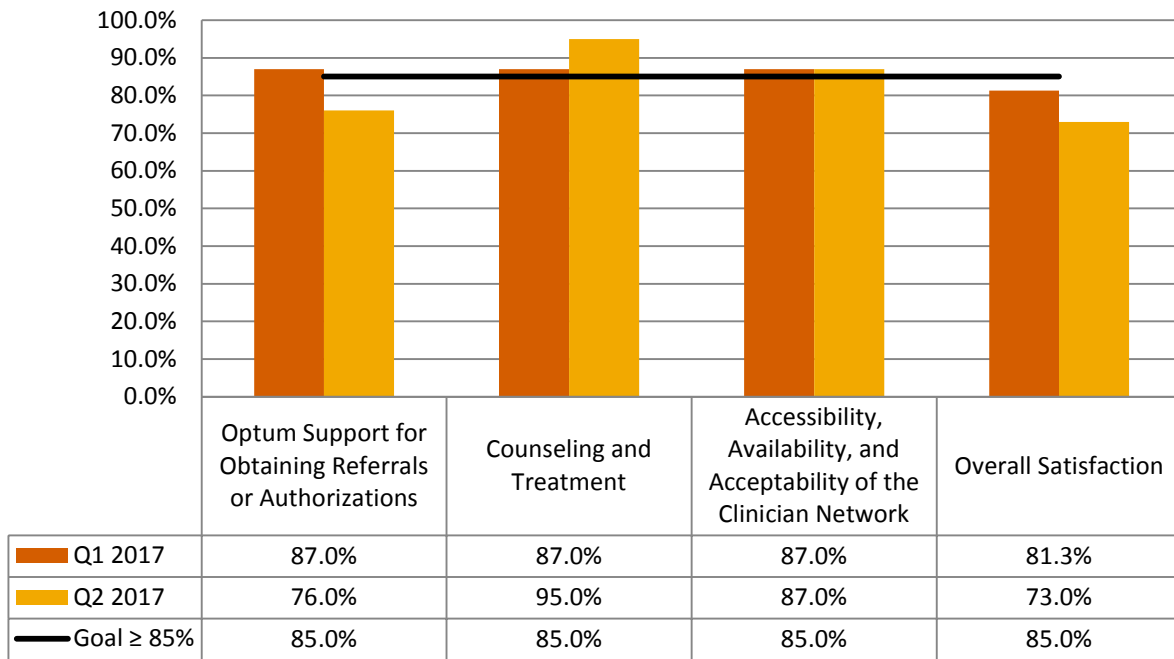
The survey includes questions about the member's experience with Optum and in treatment. The survey targets satisfaction in the following domains:

- 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

Quarterly Performance Results

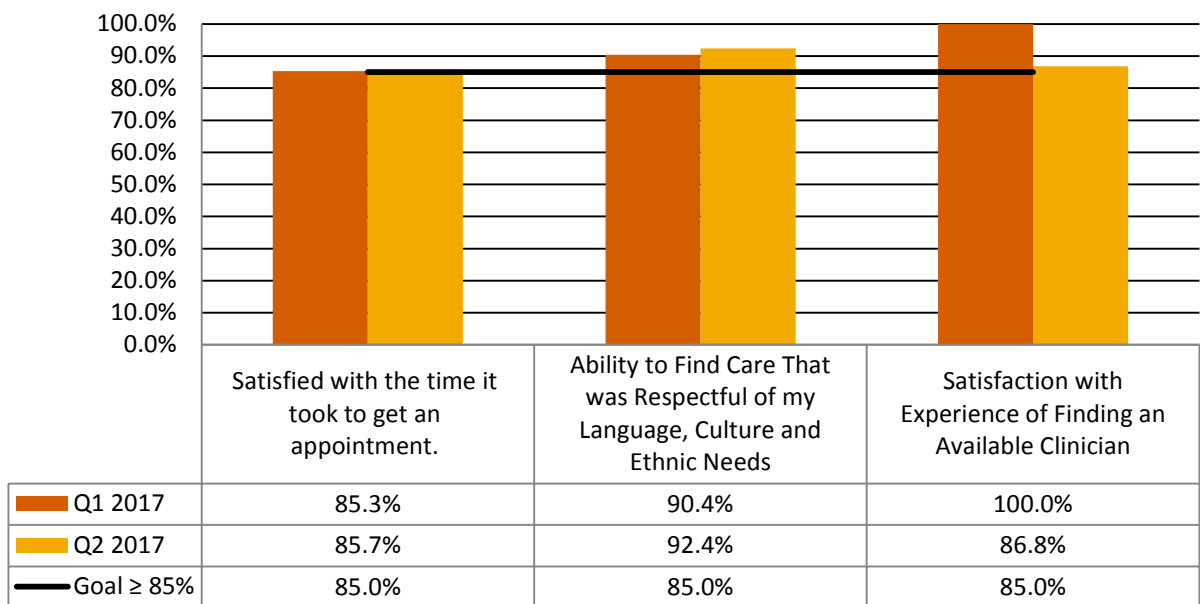
| Key Consumer Measures | Q1 2017 | Q2 2017 | YTD |
|--|---------|---------|-------|
| Overall Satisfaction (Goal: ≥85.0%) | 81.3% | 73.0% | 77.0% |
| Optum support for obtaining referrals or authorizations | 87.0% | 76.0% | 83.0% |
| Accessibility, availability, and acceptability of the clinician network | 87.0% | 87.0% | 87.0% |
| Counseling and Treatment | 87.0% | 95.0% | 91.0% |
| Net Promoter Score (NPS): How likely it is that you would recommend Optum to a friend or colleague? | 4 | 12 | 8 |
| Promoters | 41% | 45% | 43% |
| Passives | 21% | 23% | 22% |
| Detractors | 37% | 33% | 35% |

Overall Member Satisfaction Survey Results

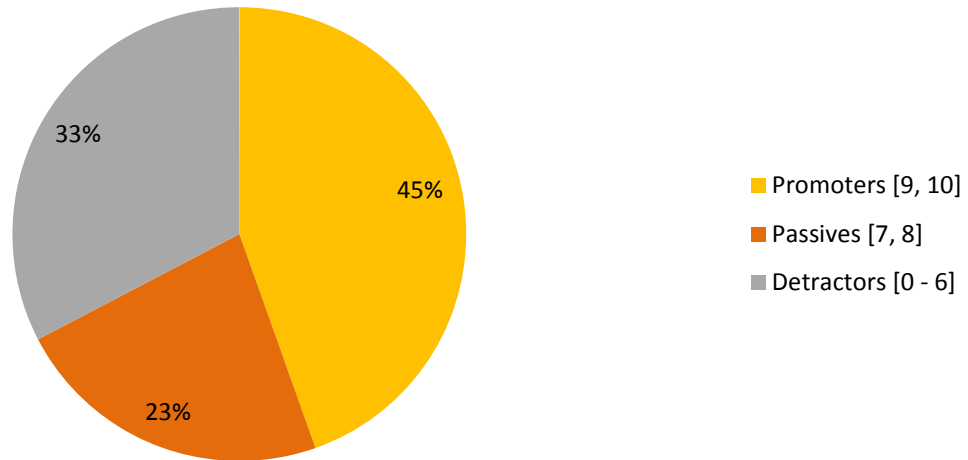


In addition, the Member Satisfaction Survey includes specific questions related to the member’s experiences with counseling and treatment. The results are in the graph, “Member Experience with Counseling or Treatment”, below.

Member Experience with Counseling or Treatment



How likely would you be to recommend Optum to a friend or colleague? (scale 0 to 10 with 0 being not at all likely and 10 being extremely likely)
Net Promoter Score: 12



Analysis: The Quarter 2, 2017, results for Optum Idaho included surveys conducted from July 1, 2017, through September 30, 2017. The total number of members who responded to the survey was 80 and the response rate was 13%. Of the total interviews conducted, none (0%) resulted in a request for translation services. All (100%) of the surveys completed were conducted in English.

Member Overall Satisfaction was 73.0%. The Net Promotor Score was 12; Promoters – 45%, Passives 23%, and Detractors, 33%.

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

Opportunities and Interventions: Optum Idaho will continue to monitor and identify trends.

Provider Satisfaction Survey Results

In 2016, Optum Idaho made the decision to change from a quarterly provider satisfaction survey to an annual survey to better align with national standards. The new survey was executed during the 4th Quarter of 2016 and reported on the Q1 2017 Quarterly Report. These same 2016 provider satisfaction results are presented below for reference only. The 2017 survey results will be reported on the Q1 2018 Quarterly Report.

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.

All of the data collection was conducted by Fact Finders. Fact Finders reached out to every provider. 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.

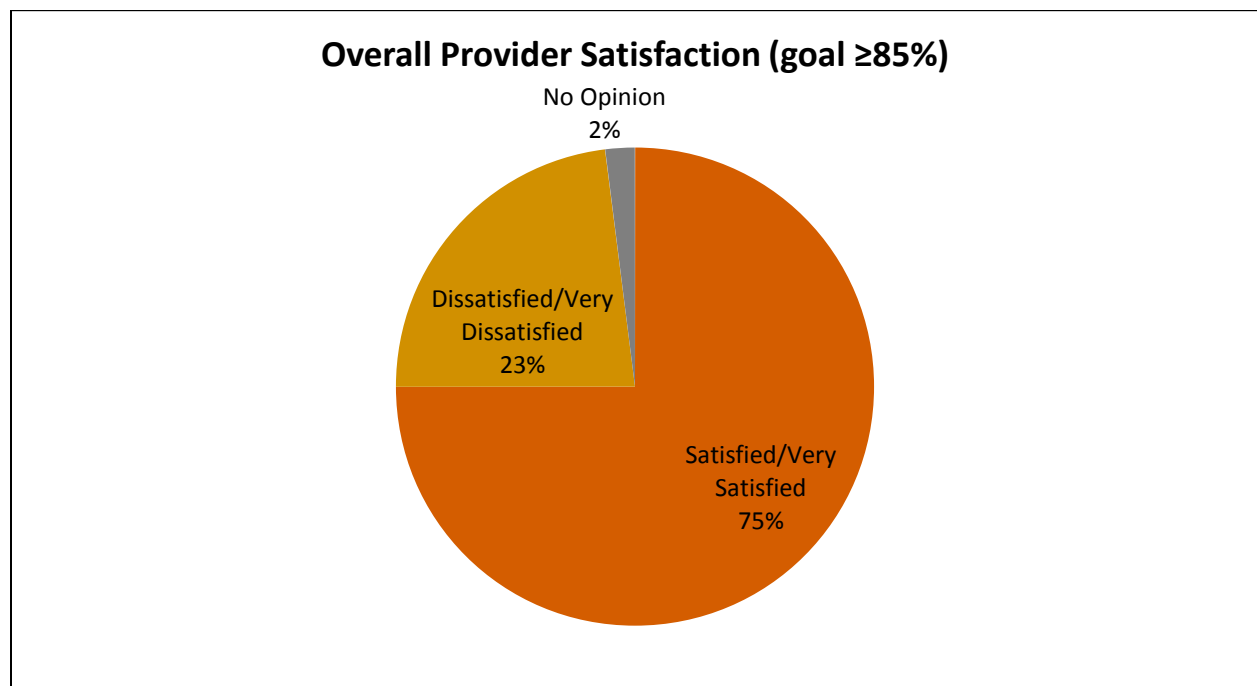
There are 3 modes for providers to complete the survey:

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

Analysis: As this is an annual satisfaction survey, the results presented here are the same as those presented in the Q1, Q2, and Q3, 2017 reports. They are presented for reference only with no additional information.

There was a 50% response rate to the first annual survey. **Overall Satisfaction with Optum:**

- Very Satisfied/Satisfied: 75%
- Dissatisfied/Very Dissatisfied: 23%
- No Opinion: 2%



Barriers: The Optum Idaho performance goal for Overall Satisfaction is ≥85.0%. While the annual survey results fell below ≥85.0%, it was the first annual survey so results from future

surveys will be monitored to identify trends. Optum Idaho will look at the areas within the survey that need improvement and identify interventions.

Opportunities and Interventions: The 2017 Annual Survey was sent in November, 2017. Results will be presented in the Quarter 1, 2018 report.

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.

Performance Improvement Projects (PIP)

| Performance Improvement Project (PIP) | Description | Department/Committee Oversight | Status | Key Accomplishments |
|--|--|--|---------------|--|
| BH Intervention at Medical Appointment | Per the customer’s request, Optum is to add codes 96150-96154 to all IBHP FQHC and non-FQHC Provider fee schedules. These codes are for Member behavioral intervention at medical visits (medical visit required with a primary medical diagnosis). These codes are for services intended to assess factors that may affect the recovery or progression of a diagnosed physical health problem or illness. | Clinical & Services Advisory Committee | Green | <ul style="list-style-type: none"> Project plan in development Met with stakeholders from Idaho Professional Counselors Association (IPCA) Sent provider communication Scheduled provider call |
| Appointment Reminder Program | This project to add additional hospitals to the program will begin in September, 2017. The first step will be to gain all necessary formal approvals, as outlined in the milestones below. The training deck will be updated to include information about the program and process. It will be presented | Clinical & Services Advisory Committee | Green | <ul style="list-style-type: none"> Project approved Project on hold due to vendor issues. |

| Performance Improvement Project (PIP) | Description | Department/Committee Oversight | Status | Key Accomplishments |
|---------------------------------------|---|--------------------------------|--------|---------------------|
| | to the designated hospitals as an introduction to the ARP. Hospitals will be trained on the ARP process. Hospital staff will be responsible to engage members in ARP. ClientTell is the vendor that will provide reminder calls/texts to members. Optum's Discharge Coordination team will continue to work with the Optum Idaho reporting team on ongoing monitoring efforts utilizing established methods. Data will be compiled monthly and will be available to all stakeholders. | | | |

Projects

| Project | Description | Department/Committee Oversight | Status | Key Accomplishments |
|----------------------------|---|--------------------------------|--------|--|
| Respite | Implement Respite for YES Class Members. Respite is a service that seeks to provide short-term, temporary care and supervision for a Class Member to relieve a stressful situation. The goal of the service is to prevent disruption of a Class Member's placement by providing relief to caregivers and Class Members. | Operations | Green | <ul style="list-style-type: none"> •Department of Behavioral Health sent letters to current respite providers. • Level of Care Guidelines finalized and approved. • Provider communication in progress and contracting to begin. • All respite providers contracted. |
| IOP – Phase II | This project expands Optum Idaho's Intensive Outpatient Program (IOP) to include all Providers who are interested and able to provide IOP to Medicaid Members, as outlined by Optum's Level of Care Guidelines and national standards. | Clinical-UM | Green | <ul style="list-style-type: none"> •Optum communicated Readiness Assessment respondents about requesting audits. •Group therapy trainings full. •Three Provider Audits completed and contracting process started. •Group trainings completed. |
| Prior Authorization Parity | In order to be compliant with Mental Health Parity, we are re-examining the services that require prior authorization (PA) to ensure they are managed the | Clinical-UM | Green | <ul style="list-style-type: none"> •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 |

| Project | Description | Department/Committee Oversight | Status | Key Accomplishments |
|-----------------------------|--|--------------------------------|--------------|---|
| | <p>same way (or more lenient) as the medical service equivalents. Of particular interest is Category 2 (open authorizations, used for psychotherapy), as there is nothing comparable on the medical side. Other services need further analysis by Legal and Product Development.</p> | | | <p>track and communicated to providers.</p> <ul style="list-style-type: none"> •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. |
| <p>Person Centered Plan</p> | <p>The Person Centered Plan (PCP) is being implemented as part of the Youth Empowerment Services (YES) project with the Idaho Department of Health & Welfare (IDHW). It is a critical component to identifying a child or youth's strengths and needs to ensure that appropriate behavioral health services and supports are provided. Per the state's request, Optum Idaho's role is to review the PCP as created by the Division of Behavioral Health (DBH) starting January 1, 2018 to ensure that it meets federal and state guidelines.</p> | <p>Operations</p> | <p>Green</p> | <ul style="list-style-type: none"> •Project plan development. •Person centered plan template and checklist in development |

| Project | Description | Department/Committee Oversight | Status | Key Accomplishments |
|-------------------------------------|--|--------------------------------|--------|---|
| School-Based Behavioral Health Care | Optum is working with the Boise School District to implement behavioral health care services in 4 elementary and 1 high school setting, in order to increase access to mental health services and behavioral health counseling for students and families. Boise School District distributed an RFP for providers to participate in a pilot, in which providers would travel to the schools and offer behavioral health services on site. Students enrolled in the district's Community schools program are eligible for these services. Those students participating in the IBHP would receive services from an Optum Network provider. The contract for these services is between the Boise school district and providers. Optum is working with the school district to determine which candidates are network providers, is facilitating codes for travel to schools, and evaluating clinical results at the end of the school year. | Clinical-UM | Green | <ul style="list-style-type: none"> •Boise area providers were alerted by Optum about the Request for Proposal (RFP) •Six agencies responded. •School Principals are interviewing candidates. |
| Community Funding for ACE's Survey | Collect the baseline data for the state of Idaho regarding scores on ACE's to understand if our prevention and intervention efforts are proving a positive momentum of ending childhood trauma through addition of 11 questions to the Behavioral Risk Factor Surveillance System (BRFSS) yearly survey. | Recovery & Resiliency | Green | <ul style="list-style-type: none"> •Internal team approved funding. •United Foundation approved funding. |
| Recovery Center 2018 CHI Funding | Recovery centers were funded for two years in support of and on behalf of the statewide recovery community model. The recovery centers are requesting funding from Optum to help them maintain their mission and serve our members and others in our communities. We want to promote a collaboration with them that will strengthen the recovery oriented system of care in Idaho. | Recovery & Resiliency | Yellow | <ul style="list-style-type: none"> •Presenting to Executive Steering Committee for final approval before presenting to Medicaid. •Document completed ; to be presented to Medicaid for approval. |

Project Closures

| Project | Description | Department Oversight | Status | Key Accomplishments |
|---|--|------------------------------|--------|--|
| LEAN (UM Service Request Process Improvement) | Due to a new Center for Medicare Services (CMS) regulation, the Optum Idaho Utilization Management and Quality teams have a need to reduce turn-around time (TAT) on the Adverse Benefit Determination (ABD) process from the current \approx 16 calendar days TAT to \approx <14 calendar days by 7/1/2017, in order to meet the new regulatory requirements. | Clinical Ops, Med Dir, A & G | Closed | <ul style="list-style-type: none"> •Linux upgrade approved and estimated to go live during Q4. •Meeting to discuss possible project closure. • After meeting all requirements, project closed. |
| Service Request Form | Ensure implementation questions/concerns are addressed. | Clinical-UM | Closed | <ul style="list-style-type: none"> •After meeting all requirements, project closed. |
| IOP-Phase 1 (Intensive Outpatient Program) | Develop and implement Intensive Outpatient Program (IOP), a new intermediate level of care treatment program for adult and child/adolescent members. The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life. | Clinical-UM | Closed | <ul style="list-style-type: none"> •Reports finalized. •After meeting all requirements, project closed. Will continue to work with IOP providers, as needed. |
| Administrative Denial | The objective of this project is for the QI Departments Appeals and Grievances (A & G) team to develop administrative denial notification letters and subsequent appeal rights and processes in order to align with the code of federal regulations (CRF) Medicaid Managed Care rule (42 CFR §438.400-§438.424) and newly implemented Optum Idaho UM administrative denial procedures. | Quality | Closed | <ul style="list-style-type: none"> •Presented project charter to Executive Steering Committee and it was approved. •Continued monitoring resulting in no adverse findings. •All milestones complete. Continued monitoring has resulted in zero adverse findings. •Ready for closure. |

Analysis: During Quarter 4, there were 9 projects in progress (including 2 PIPs). Four (4) projects were closed.

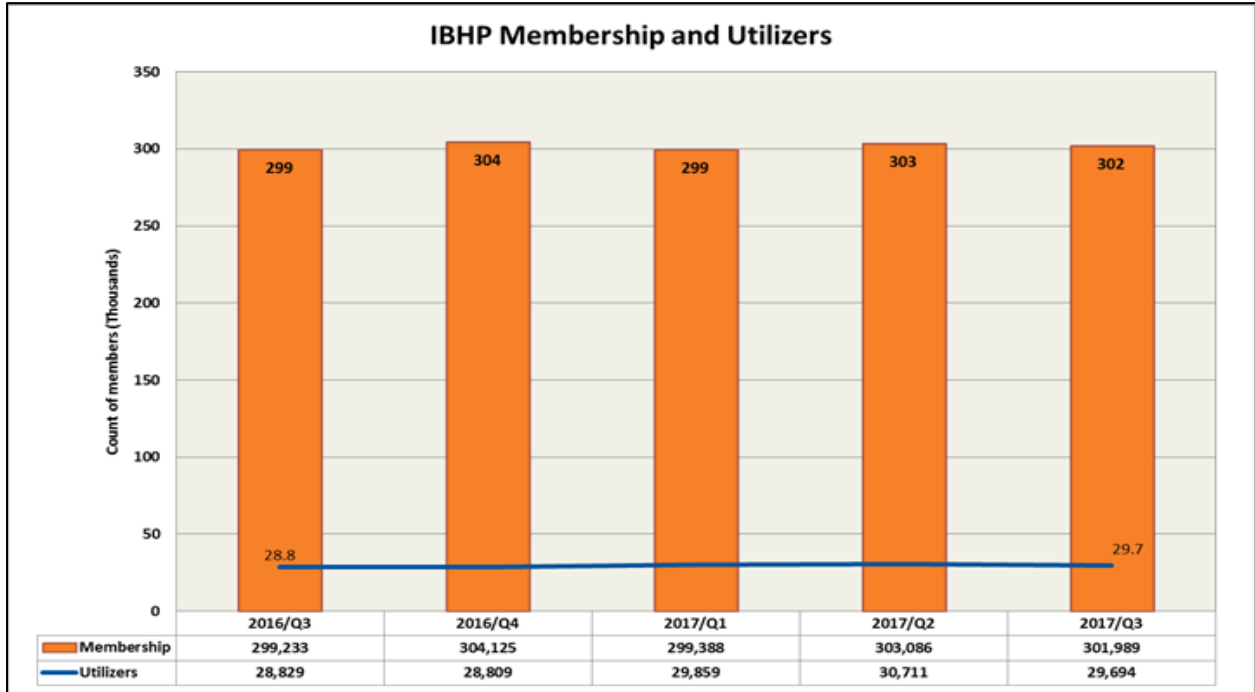
Barriers: Based on the above analysis, no barriers were identified.

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



Analysis: Membership and utilizer numbers decreased slightly during the quarter.

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

Opportunities and Interventions: No opportunities for improvement were identified

Member Services Call Standards

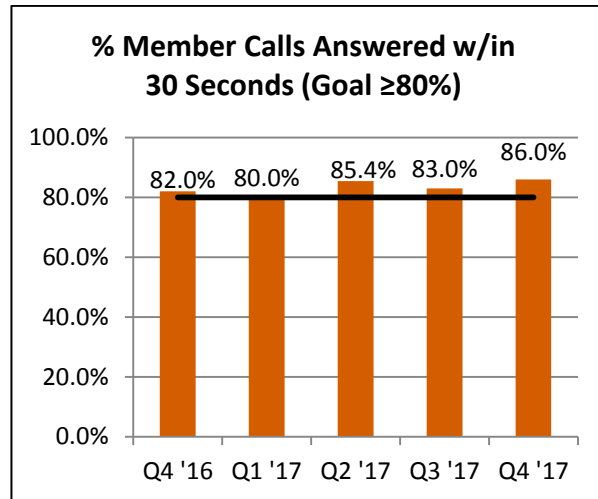
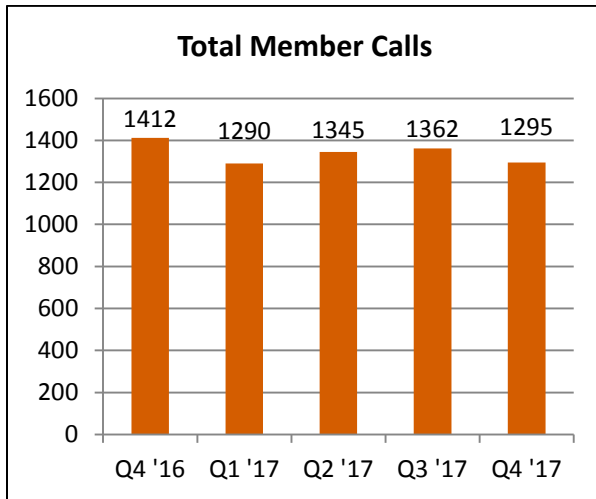
Methodology: Optum Idaho provides access to care 24 hours a day, seven days a week, 365 days per year through our toll-free Member Access and Crisis Line. This line is answered by a team of Masters-level behavioral health clinicians who are trained to assess the member’s needs, provide counseling as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

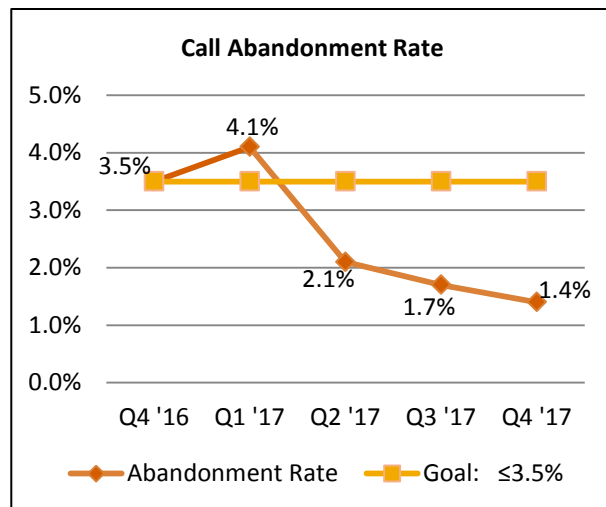
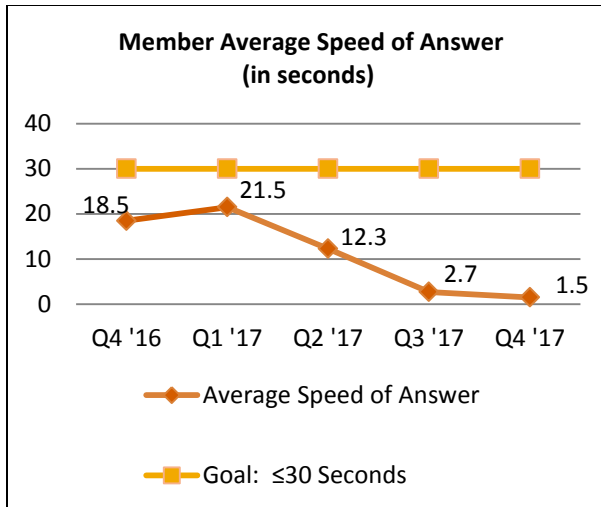
To ensure member’s needs are met in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate ($\leq 7\%$). Data source is Avaya’s Communication system (ProtoCall).

Quarterly Performance Results

| Member Service Line | Optum Idaho Standards | IBHP Contract Standards | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|---|-----------------------|-------------------------|----------|----------|----------|---------|---------|
| Total Number of Calls | NA | NA | 1,412 | 1,290 | 1,345 | 1,362 | 1,295 |
| Percent of Calls Answered Within 30 Sec | ≥80.0% | None | 82.0% | 80.0% | 85.4% | 83.0% | 86.0% |
| Average Speed of Answer | ≤30 Seconds | 120 seconds (2 minutes) | 18.5 sec | 21.5 sec | 12.3 sec | 2.7 sec | 1.5 sec |
| Abandonment Rate | ≤3.5% | ≤7% | 3.5% | 4.1% | 2.1% | 1.7% | 1.4% |

Analysis: During Q4, the Member Services and Crisis Line received a total of 1,295 calls. During Q4, 86.0% of calls were answered within 30 seconds (goal ≥80%). The average speed to answer was met at 1.5 seconds. The call abandoned rate was 1.4% which met the Optum Idaho Standards goal of ≤3.5% and the IBHP Contractual Standards goal of ≤7.0%. Optum Idaho will continue to monitor and identify trends.





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

Opportunities and Interventions: No opportunities for improvement were identified.

Customer Service (Provider Calls) Standards

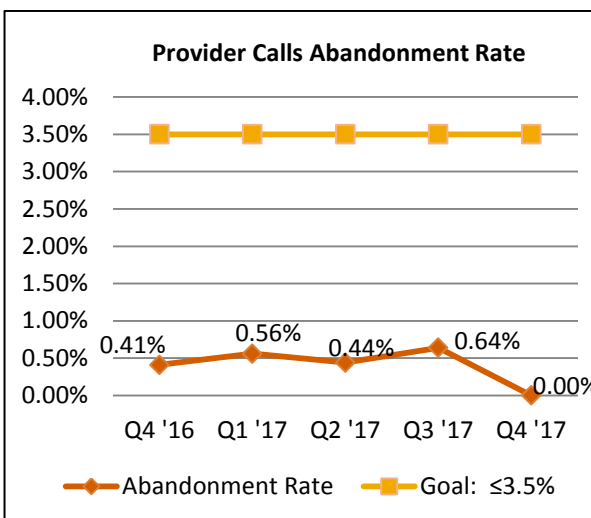
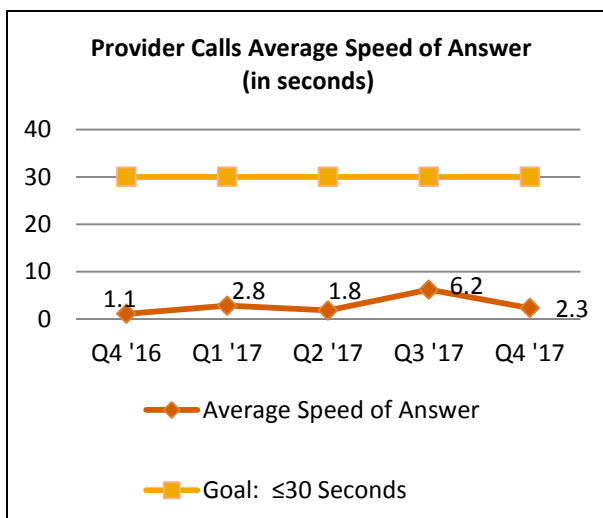
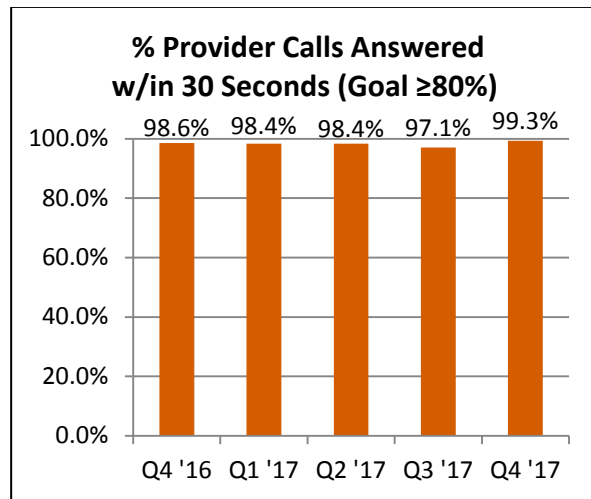
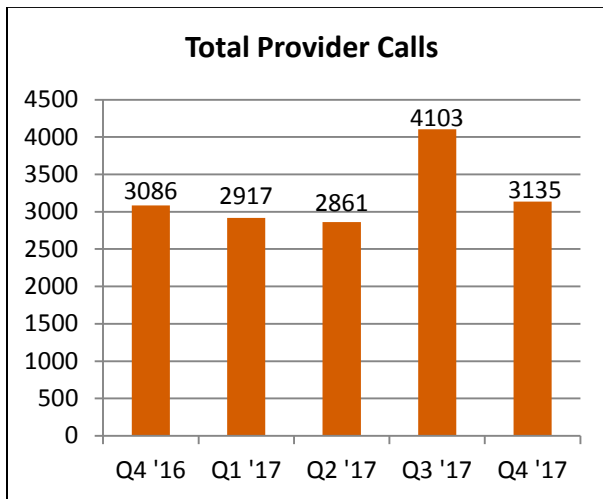
Methodology: The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho. To ensure the needs of our providers and stakeholders are met in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual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

Quarterly Performance Results

| Customer Service Line (Provider Calls) | Optum Idaho Standards | IBHP Contract Standards | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|---|-----------------------|-------------------------|---------|---------|---------|---------|---------|
| Total Number of Calls | NA | NA | 3,086 | 2,917 | 2,861 | 4,103 | 3,135 |
| Percent of Calls Answered Within 30 Seconds | ≥80.0% | None | 98.6% | 98.4% | 98.4% | 97.1% | 99.3% |
| Average Speed of Answer | ≤30 Seconds | 120 seconds (2 minutes) | 1.1 sec | 2.8 sec | 1.8 sec | 6.2 sec | 2.3 sec |
| Abandonment Rate | ≤3.5% | ≤7% | 0.41% | 0.56% | 0.44% | 0.64% | 0% |

Analysis: The total number of Customer Service provider calls during Q4 was 3,135. Customer service call standards met performance goals for all three customer service line measures again during Q4. The percent of calls answered within 30 seconds was at 99.3%, remaining above

the goal of ≥80%. The average speed of answer was at 2.3 seconds during Q4, which continued to meet the goal. The call abandonment rate was 0% continuing to meet both the Optum Idaho internal goal of ≤3.5% and the IBHP Contract Standard of ≤ 7%.



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

Opportunities and Interventions: No opportunities for improvement were identified

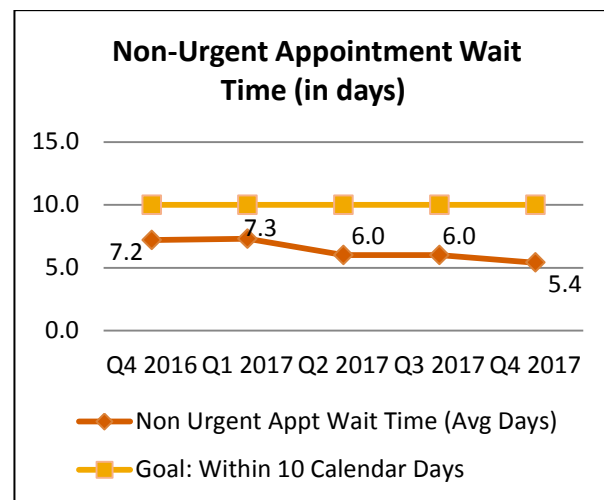
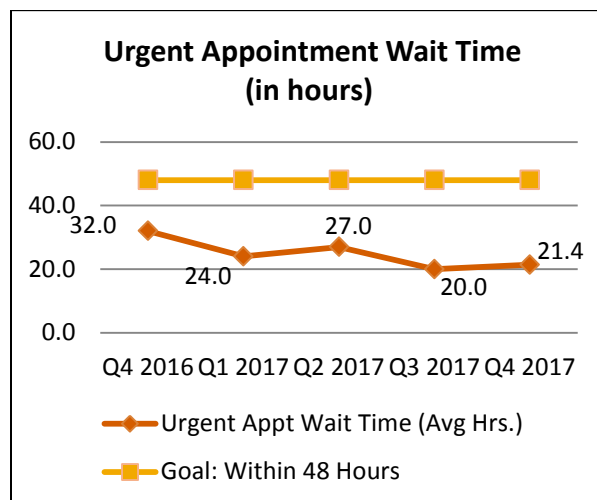
Urgent and Non-Urgent Access Standards

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

Quarterly Performance Results

| Urgent/Non-Urgent Appointment Wait Time | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|---|------------------------------|------------|------------|------------|------------|------------|
| Urgent Appointment Wait Time | Within 48 hours from request | 32.0 hours | 24.0 hours | 27.0 hours | 20.0 hours | 21.4 hours |
| Non-Urgent Appointment Wait Time | Within 10 days from request | 7.2 days | 7.3 days | 6.0 days | 6.0 days | 5.4 days |

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. During Q4, the average Urgent Appointment wait time was 21.4 hours. The performance goal for Non-Urgent Appointment wait time is an appointment within 10 days. This goal was again met during Q4 at an average of 5.4 days.



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

Opportunities and Interventions: No opportunities for improvement were identified

Geographic Availability of Providers

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

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

Quarterly Performance Results

| Geographic Availability of Providers | | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|--------------------------------------|-------------------|------------------|---------|---------|---------|---------|---------|
| Area 1 | (within 30 miles) | 100.0% | 99.8% | 99.8% | 99.8% | 100.0% | 99.8% |
| Area 2 | (within 45 miles) | 100.0% | 99.9% | 99.8% | 99.9% | 99.8% | 99.8% |

Analysis: Optum Idaho continued to meet contract availability standards. During Q4, Area 1 availability standards were met at 99.8% and Area 2 availability standards were met at 99.8%. Our performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number).

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

Opportunities and Interventions: No opportunities for improvement were identified.

Member Protections and Safety

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

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

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

Notification of Adverse Benefit Determination

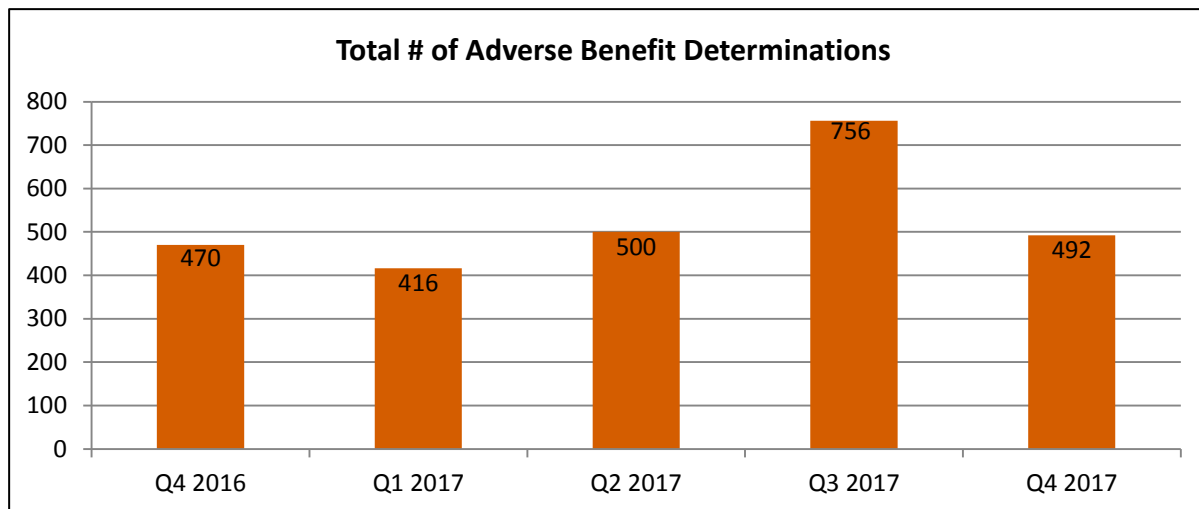
Methodology: Adverse Benefit Determinations (ABD’s) are maintained in the Linx database. When a request for services is received, Optum has 14 days to review the case, make a determination to authorize services or deny services in total or in part, and mail the ABD notification if the decision was to deny services in total or in part. An ABD can be based from Clinical or Administrative guidelines.

Quarterly Performance Results

| Notification of ABD | Performance Goal | Target | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|---|--|--------|-----------------|-----------------|-----------------|------------------------------|------------------------------|
| Total # ABD's | NA | NA | 470 | 416 | 500 | 756 | 492 |
| Clinical ABD's | NA | NA | NA | NA | NA | 578 | 352 |
| Administrative ABD's | NA | NA | NA | NA | NA | 178 | 140 |
| Written Notification | 14 business days from request for services | NA | NA | NA | NA | 100.0% (756/756) | 99.8% (491/492) |
| Initial Verbal Notification to Provider | 1 business day from determination date | 100.0% | 98.9% | 99.8% | 99.6% | No longer tracking | No longer tracking |
| Written Notification | 1 business day from verbal notification | 100.0% | 92.9% (437/470) | 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 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.

In Q4, Optum issued 492 ABDs – 352 Clinical and 140 Administrative. All but one were mailed within 14 calendar days.



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

Opportunities and Interventions: No opportunities for improvement were identified.

Member Appeals

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.

Quarterly Performance Results

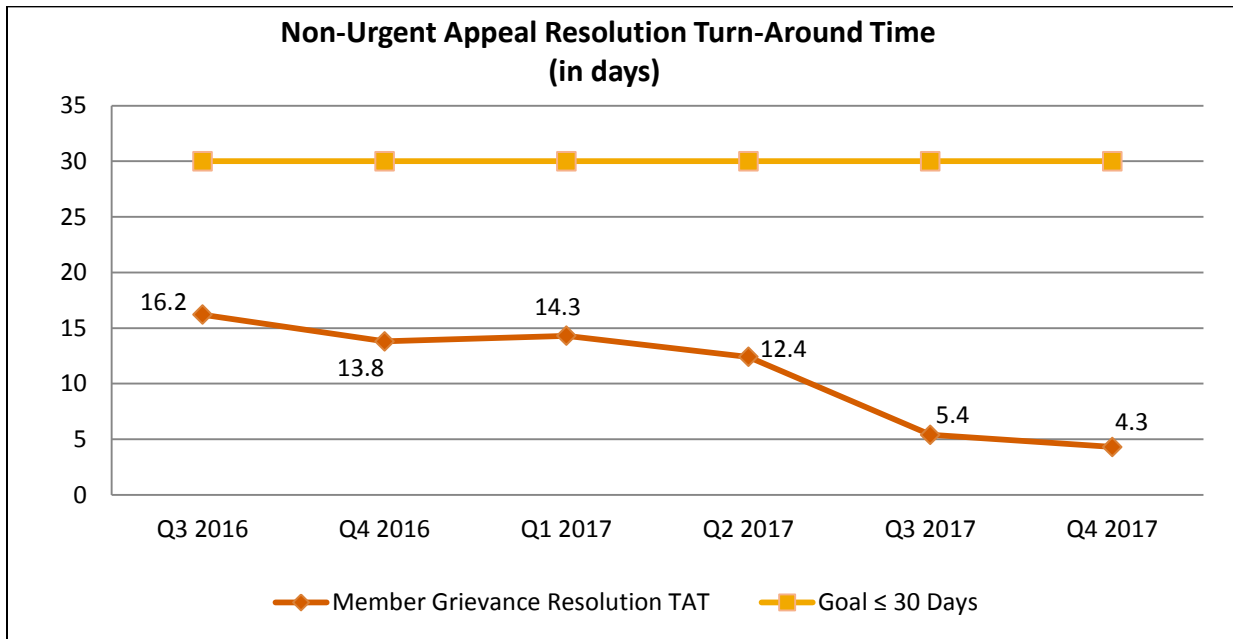
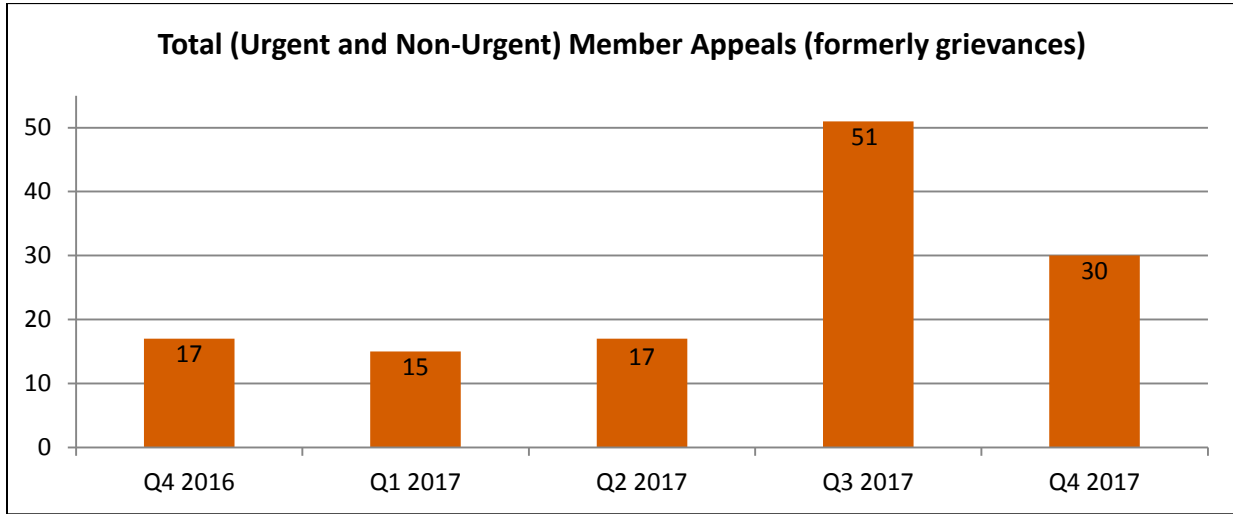
| Appeals | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 |
|---|------------------|---------|---------|---------|
| Number of Member Appeals | NA | 17 | 15 | 17 |
| Average Number of Days to Resolution | 30 Days | 13.8 | 14.3 | 12.4 |
| Number of Overturned Appeals | NA | 1 | 1 | 1 |
| Number of Partially Overturned Appeals | NA | 2 | 2 | 0 |
| % of Appeals Overturned or Partially Overturned | NA | 17.6% | 20.0% | 6.0% |

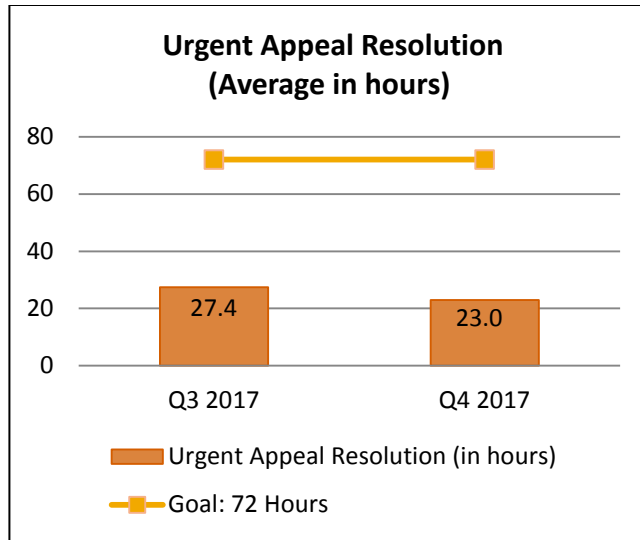
| Non-Urgent Appeals | Performance Goal | Q3 2017 | Q4 2017 | | |
|---|------------------|---------|---------|--|--|
| Total Appeal Determinations | NA | 36 | 26 | | |
| Acknowledgement Compliance | 5 Calendar Days | 100.0% | 100.0% | | |
| Determination Compliance | 30 Calendar Days | 100.0% | 100.0% | | |
| Average Days to Resolve | NA | 5.4 | 4.35 | | |
| 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 | NA | 27.4 | 23.0 | | |

| Urgent Appeals | Performance Goal | Q3 2017 | Q4 2017 | | |
|------------------------------------|------------------|---------|---------|--|--|
| Overtured Urgent Appeals | NA | 7 | 2 | | |
| Partially Overtured Urgent Appeals | NA | 4 | 0 | | |

Analysis: In Q4, Optum Idaho received 26 non-urgent appeals and 4 urgent appeal requests, for a total of 30 appeals. All non-urgent and urgent appeals met the respective performance goals.





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

Opportunities and Interventions: No opportunities for improvement were identified.

Complaint Resolution and Tracking

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

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

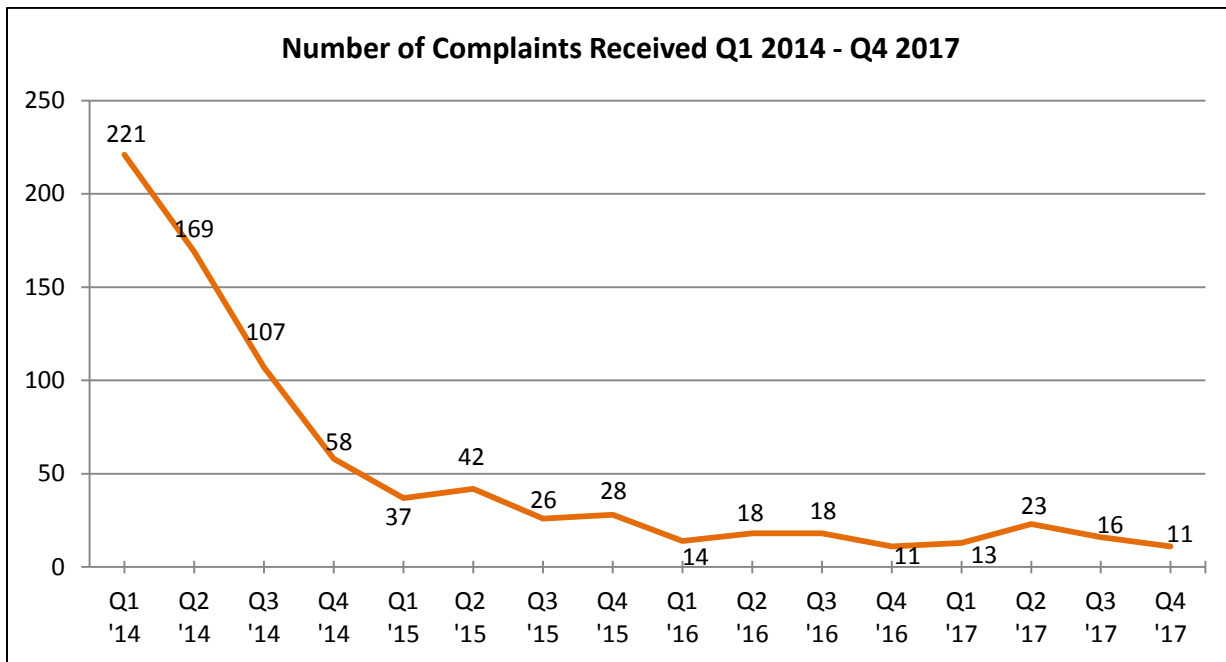
Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for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

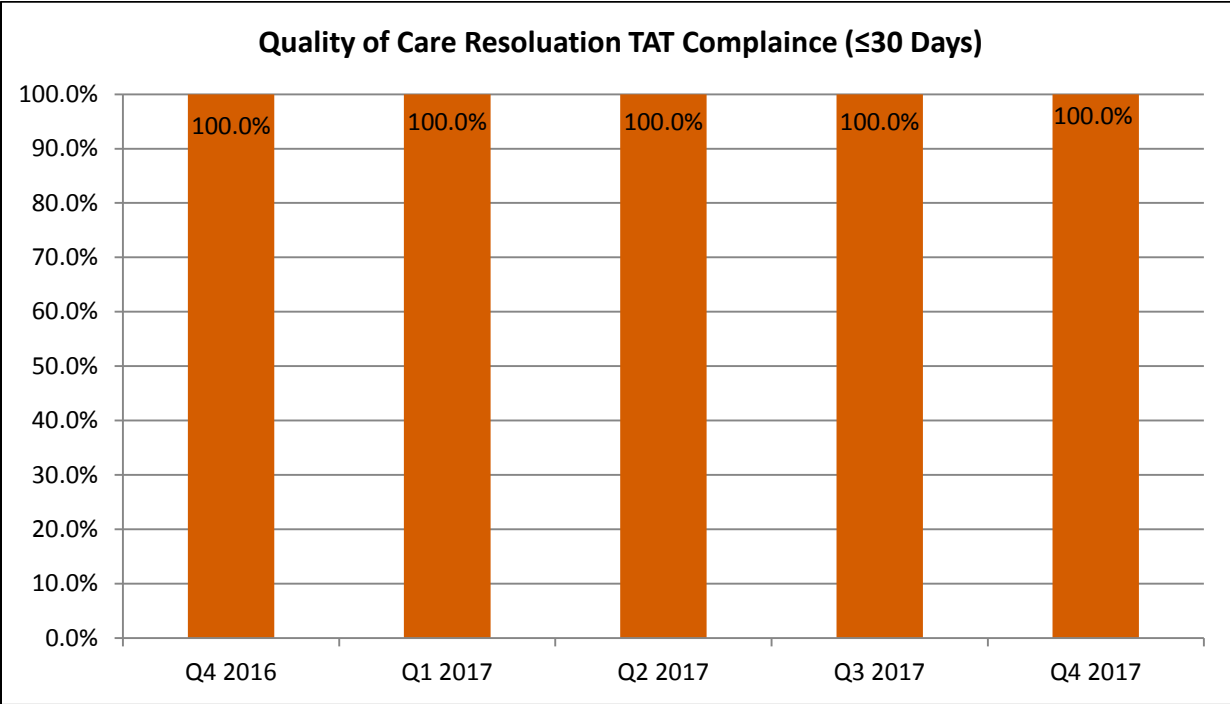
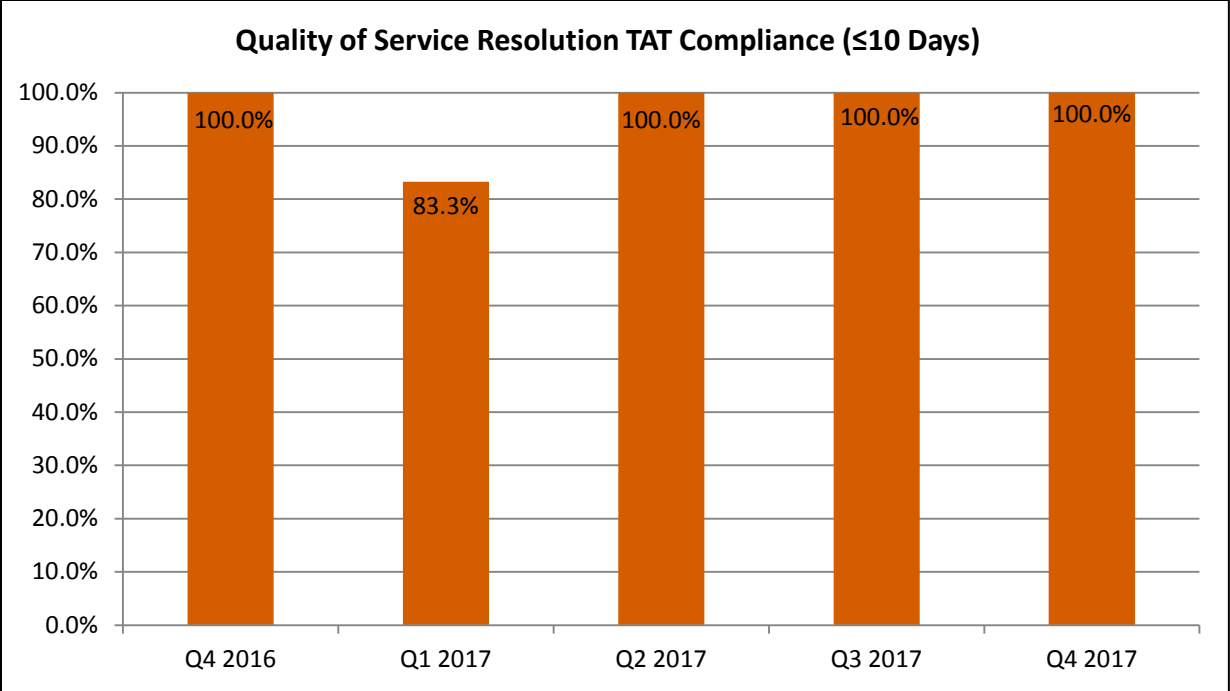
| Complaint Resolution and Tracking Timeframes | Acknowledged | Resolved |
|--|-----------------|------------------|
| Quality of Service (QOS) Complaints | 5 Business Days | 10 Business Days |
| Quality of Care (QOC) Concerns | 5 Business Days | 30 Calendar Days |

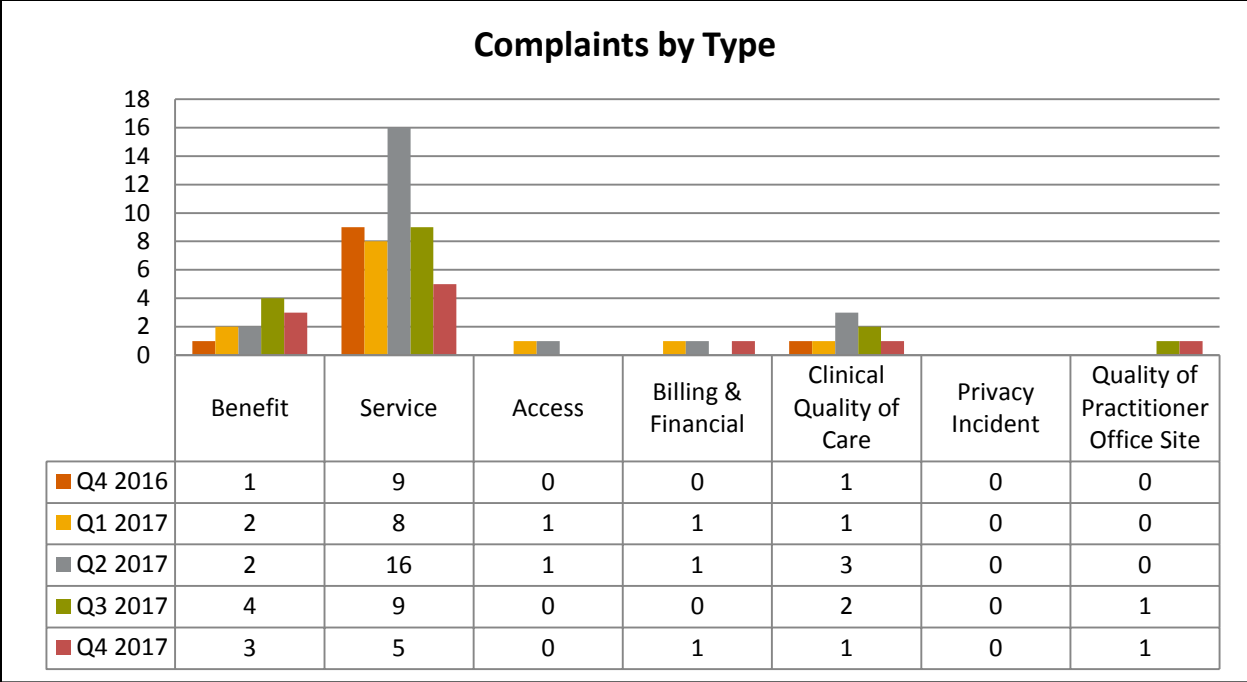
Quarterly Performance Results

| Complaints | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|--|------------------|---------|---------|---------|---------|---------|
| Number of Quality of Service (QOS) Complaints Received | NA | 10 | 12 | 20 | 14 | 10 |
| Percent QOS Complaints Resolved w/in TAT | 10 Days | 100.0% | 83.3% | 100.0% | 100.0% | 100.0% |
| Number of Quality of Care Complaints (QOC) Received | NA | 1 | 1 | 3 | 2 | 1 |
| Percent QOC Complaints Resolved w/in TAT | 30 Days | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Analysis: During Q4, there were 11 total complaints processed. Ten (10) were Quality of Service complaints, and 1 was a Quality of Care concerns. Optum Idaho was at 100% compliance for all acknowledgement and resolution turnaround times.







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

Opportunities and Interventions: No opportunities for improvement were identified.

Critical Incidents

Methodology: To improve the overall quality of care provided to our members, Optum Idaho employs peer reviews for occurrences related to members that have been identified as potential Critical Incidents (CI). Providers are required to report potential Critical Incidents to Optum Idaho within 24 hours of being made aware of the occurrence. A Critical Incident is a serious, unexpected occurrence involving a member that is believed to represent a possible Quality of Care Concern on the part of the provider or agency providing services, which has, or may have, detrimental effects on the member, including death or serious disability, that occurs during the course of a member receiving behavioral health treatment. Optum Idaho classifies a Critical Incident as being any of the following events:

- A completed suicide by a member who was engaged in treatment at any level of care at the time of the death, or within the previous 60 calendar days (also defined as a sentinel event).
- A serious suicide attempt by a member who was engaged in treatment services at any level of care that required an overnight admission to a hospital medical unit.
- An unexpected death of a member that occurred while the member was engaged in treatment services at any level of care or within 12 months of a member having received treatment services.
- A serious injury of a member that required an overnight admission to a hospital medical unit that occurred on an agency’s premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based

services.

- A report of a serious physical assault of a member that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- A report of a sexual assault of a member that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- A report of sexual assault by a member that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- A report of an abduction of a member that occurred on an agency's premises or in the community at the time that the member was receiving treatment services at any level of care, including home-based services.
- High profile incidents identified by the IDHW as warranting investigation.

Optum has a Sentinel Events Committee (SEC) to review Critical Incidents that meet Optum's definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review Critical Incidents that do not meet Optum's definition of sentinel event. The SEC and PRC make recommendations for improving patient care and safety, including recommendations that the Provider Quality Specialists conduct site audits and/or record reviews of providers in the Optum Idaho network as well as providers working under an accommodation agreement with Optum Idaho to provide services to members. The SEC and PRC may provide providers with written feedback related to observations made as a result of the review of the Critical Incident. Critical Incident Ad-hoc review is completed within 5 days from notification of incident.

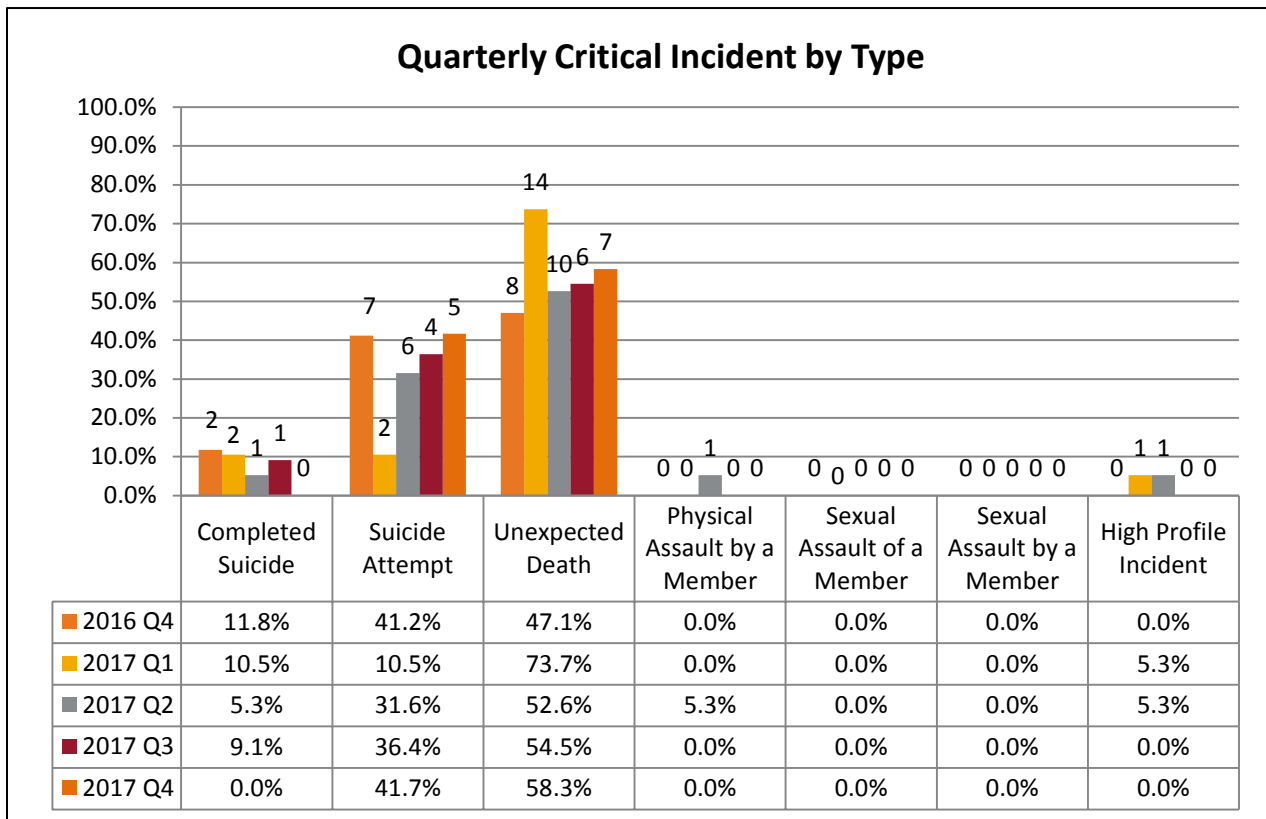
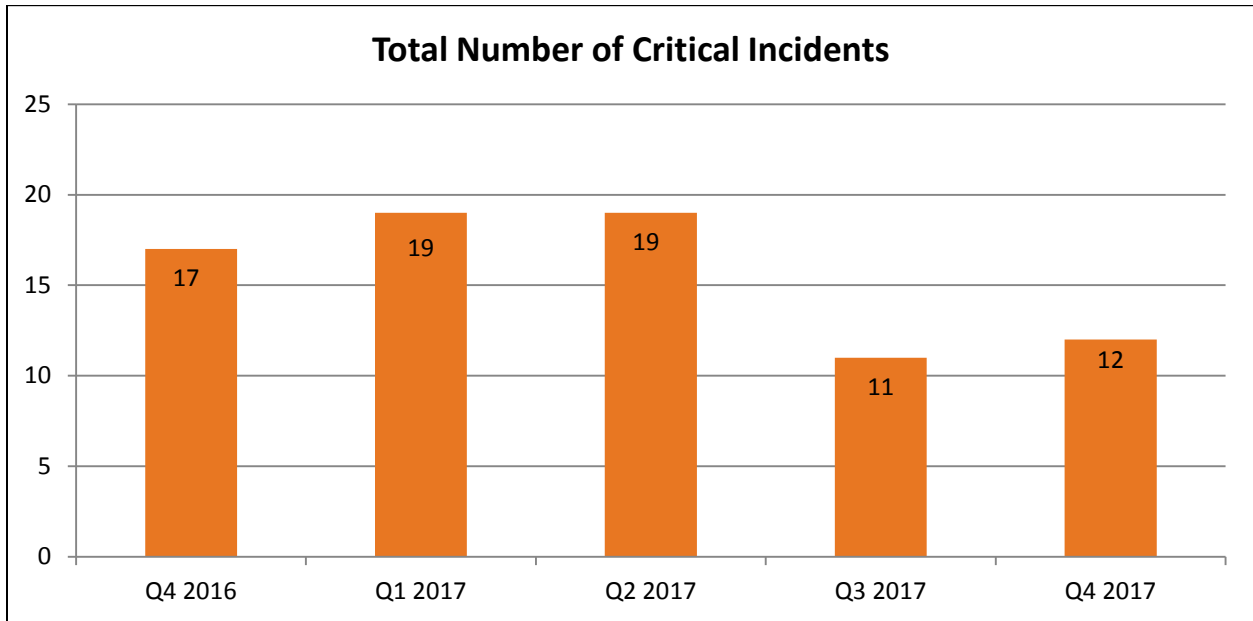
Quarterly Performance Results

| Critical Incidents | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|--|------------------|---------|---------|---------|---------|---------|
| Number of CI's Received | NA | 17 | 19 | 19 | 11 | 12 |
| CI Ad-hoc Review: % completed within 5 business days from notification of incident | 100% | 100% | 100% | 100% | 100% | 100% |

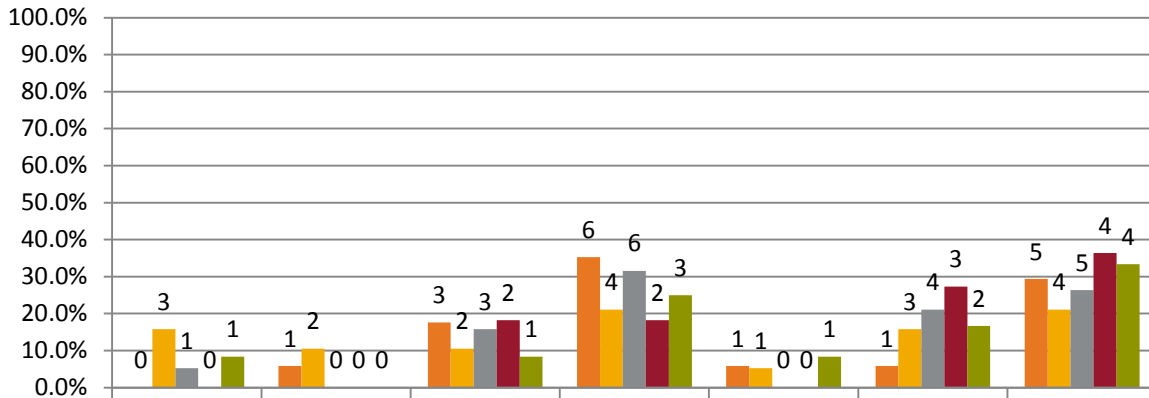
Analysis: There were 12 Critical Incidents reported during Q4. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. Again during Q4, the highest number of Critical Incidents fell in the category of unexpected deaths. Of the 12 Critical Incidents reported, 7 (58.3%) were from unexpected deaths. In addition, 5 (41.7%) were from suicide attempts.

Further analysis showed that during Q4, Region 7 reported the highest number (4) of critical incidents at 33.3%, followed by Region 4 with 3 reported at 25.0%. Coordination of Care between the behavioral health provider and the Primary Care Provider (PCP) occurred in 8 (66.7%) of the total cases. Of the 12 reported Critical Incidents, 1 (8.3%) male and 8 (66.7%) females showed that member had a co-morbid health condition. Of the cases reported, 10 (83.3%) were adults (18+) and 2 (16.7%) were child/adolescent (17 and under). The average

age for males was 39 and females 43. Of the cases reported, 3 (25.0%) were males and 9 (75.0%) were females. No providers were put on unavailable status due to a Critical Incident.

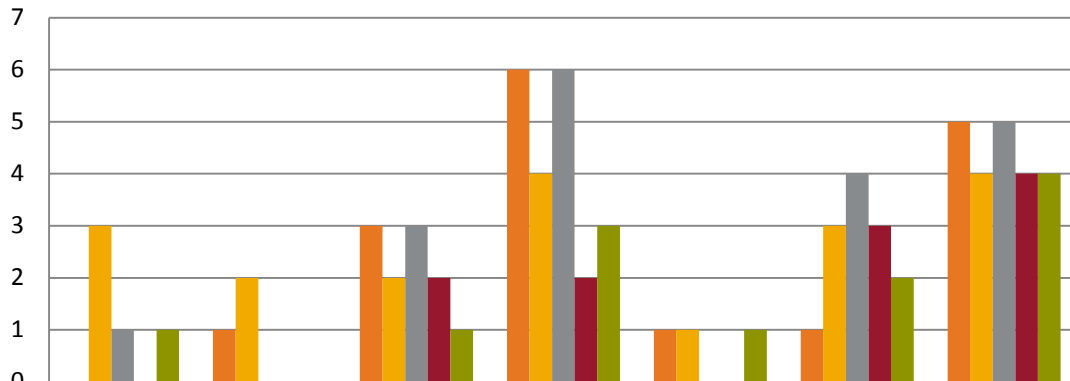


Quarterly Critical Incident by Region



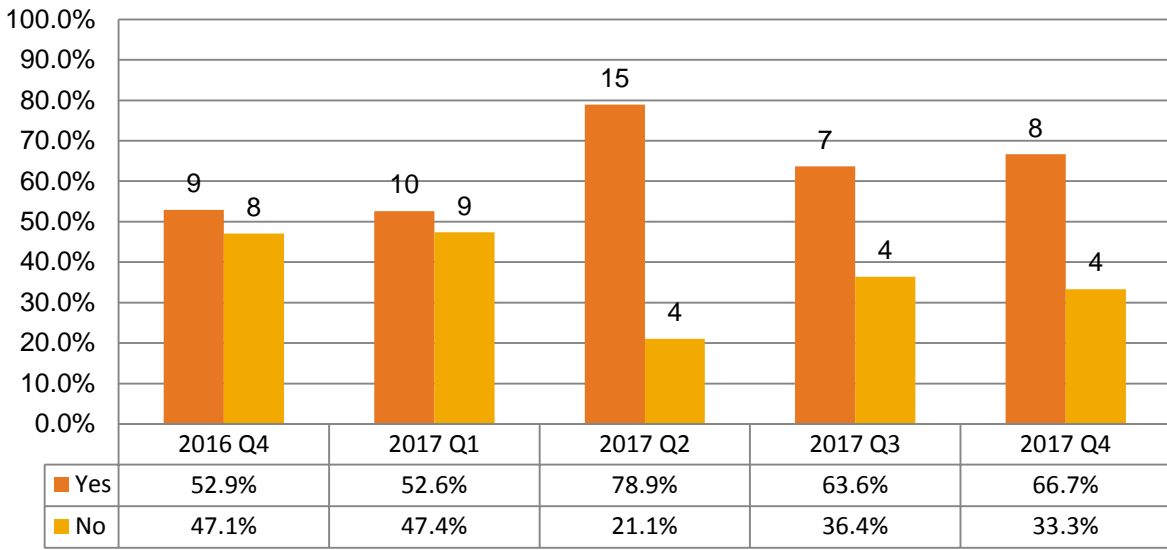
| | | | | | | | |
|---------|-------|-------|-------|-------|------|-------|-------|
| 2016 Q4 | 0.0% | 5.9% | 17.6% | 35.3% | 5.9% | 5.9% | 29.4% |
| 2017 Q1 | 15.8% | 10.5% | 10.5% | 21.1% | 5.3% | 15.8% | 21.1% |
| 2017 Q2 | 5.3% | 0.0% | 15.8% | 31.6% | 0.0% | 21.1% | 26.3% |
| 2017 Q3 | 0.0% | 0.0% | 18.2% | 18.2% | 0.0% | 27.3% | 36.4% |
| 2017 Q4 | 8.3% | 0.0% | 8.3% | 25.0% | 8.3% | 16.7% | 33.3% |

Number of Critical Incidents by Region

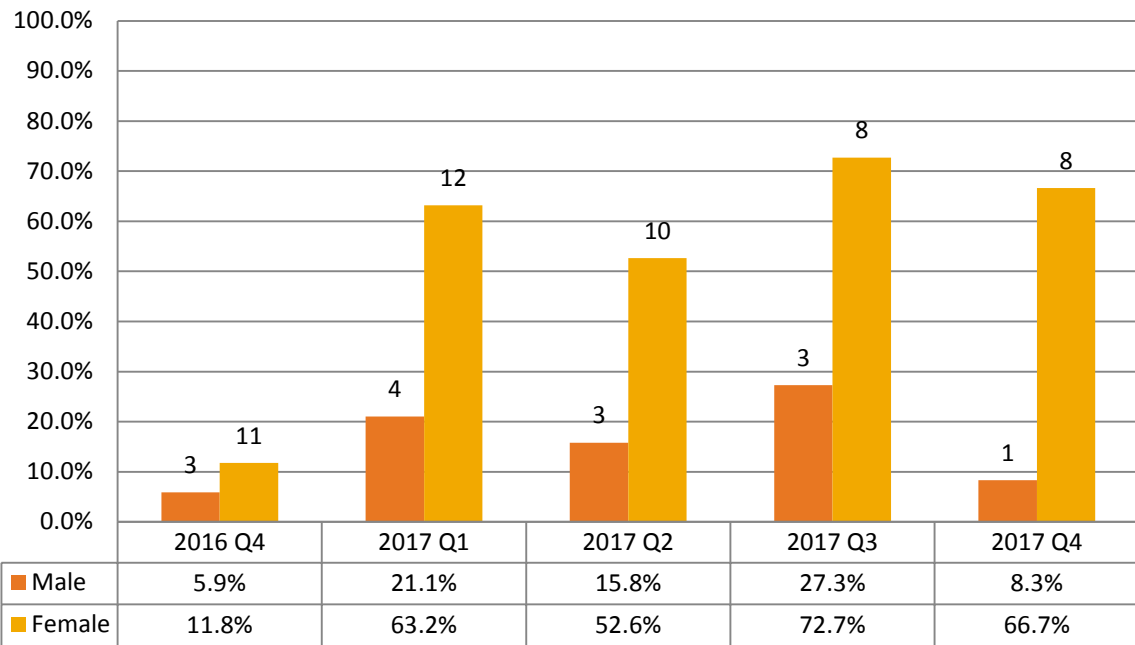


| | | | | | | | |
|---------|---|---|---|---|---|---|---|
| 2016 Q4 | 0 | 1 | 3 | 6 | 1 | 1 | 5 |
| 2017 Q1 | 3 | 2 | 2 | 4 | 1 | 3 | 4 |
| 2017 Q2 | 1 | 0 | 3 | 6 | 0 | 4 | 5 |
| 2017 Q3 | 0 | 0 | 2 | 2 | 0 | 3 | 4 |
| 2017 Q4 | 1 | 0 | 1 | 3 | 1 | 2 | 4 |

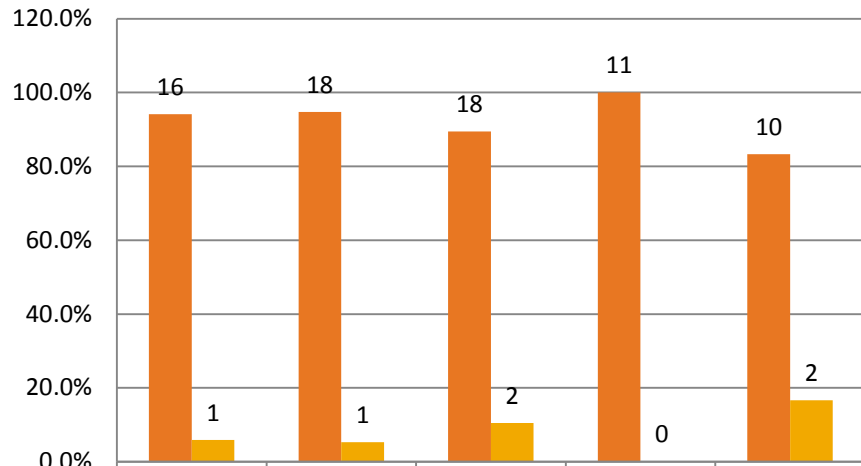
Quarterly Critical Incidents-Coordination of Care Occurred



Quarterly Critical Incidents- Co-Morbid Health Conditions Present (by gender)

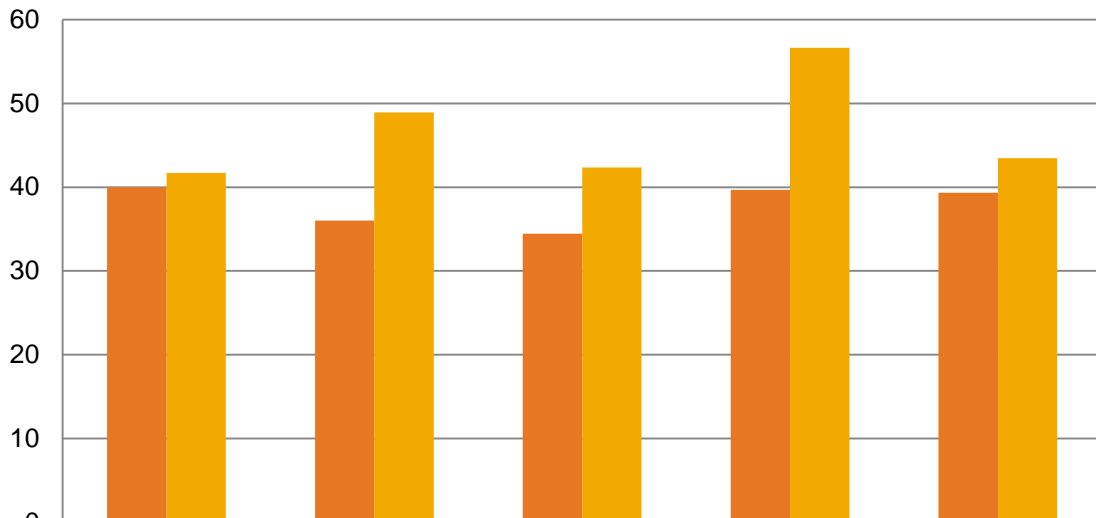


Quarterly Critical Incidents by Age (Adults & Children/Adolescents)

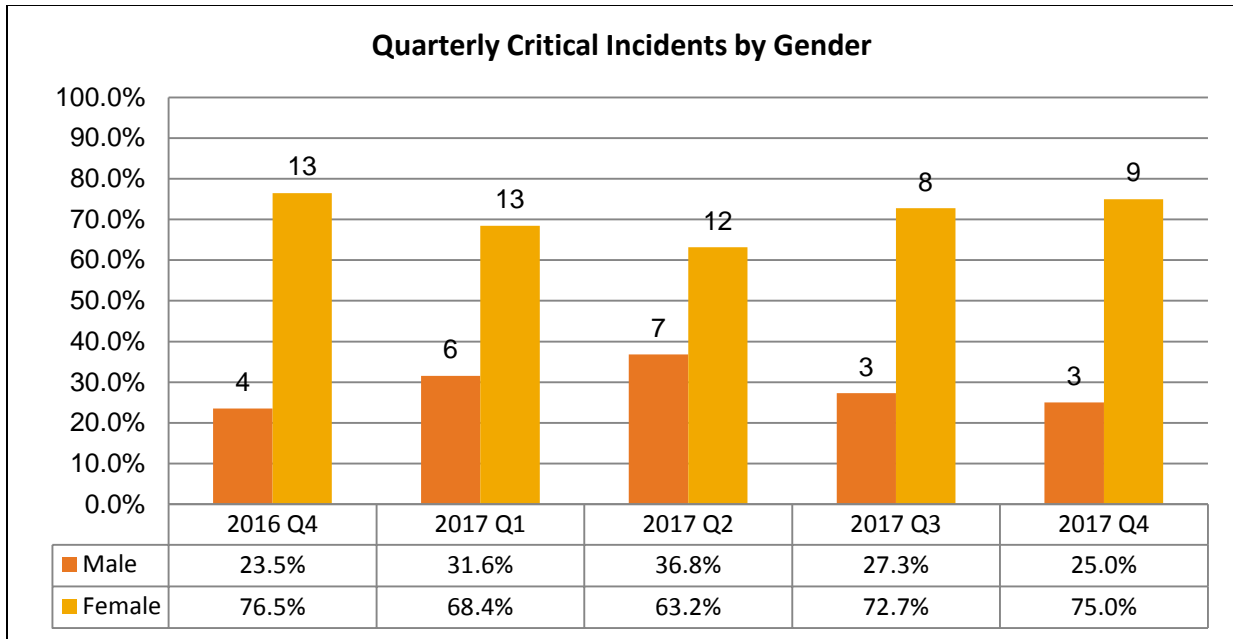


| | | | | | |
|-----------------------------------|-------|-------|-------|--------|-------|
| ■ Adult (18+) | 94.1% | 94.7% | 89.5% | 100.0% | 83.3% |
| ■ Child/Adolescent (17 and under) | 5.9% | 5.3% | 10.5% | 0.0% | 16.7% |

Quarterly Critical Incidents by Average Age



| | | | | | |
|----------|----|----|----|----|----|
| ■ Male | 40 | 36 | 34 | 40 | 39 |
| ■ Female | 42 | 49 | 42 | 57 | 43 |



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

Opportunities and Interventions: No opportunities for improvement were identified.

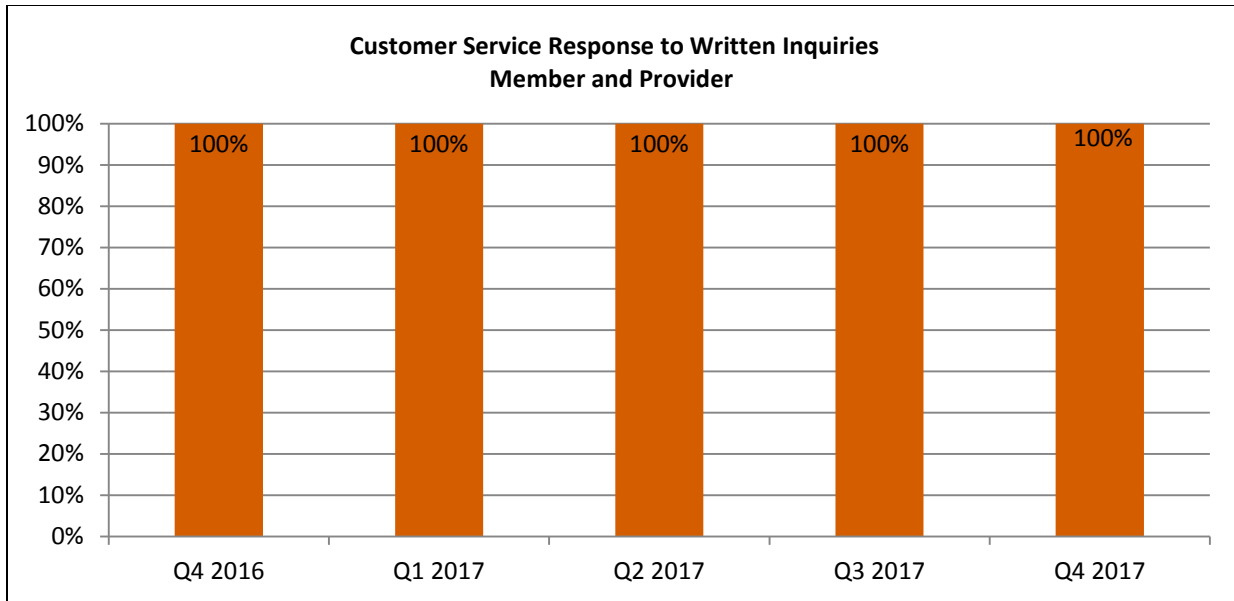
Response to Written Inquiries

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

Quarterly Performance Results

| Customer Service Response to Written Inquiries | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|--|------------------|---------|---------|---------|---------|---------|
| Percent Acknowledged ≤ 2 business days | 100% | 100% | 100% | 100% | 100% | 100% |

Analysis: The data summarizes Optum Idaho Customer Service responsiveness to written inquiries to both members and providers. The data indicated that the standard of 100% acknowledged within 2 business days was again met during Q4.



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

Opportunities and Interventions: No opportunities for improvement were identified.

Provider Monitoring and Relations

Provider Quality Monitoring

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

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

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

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

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

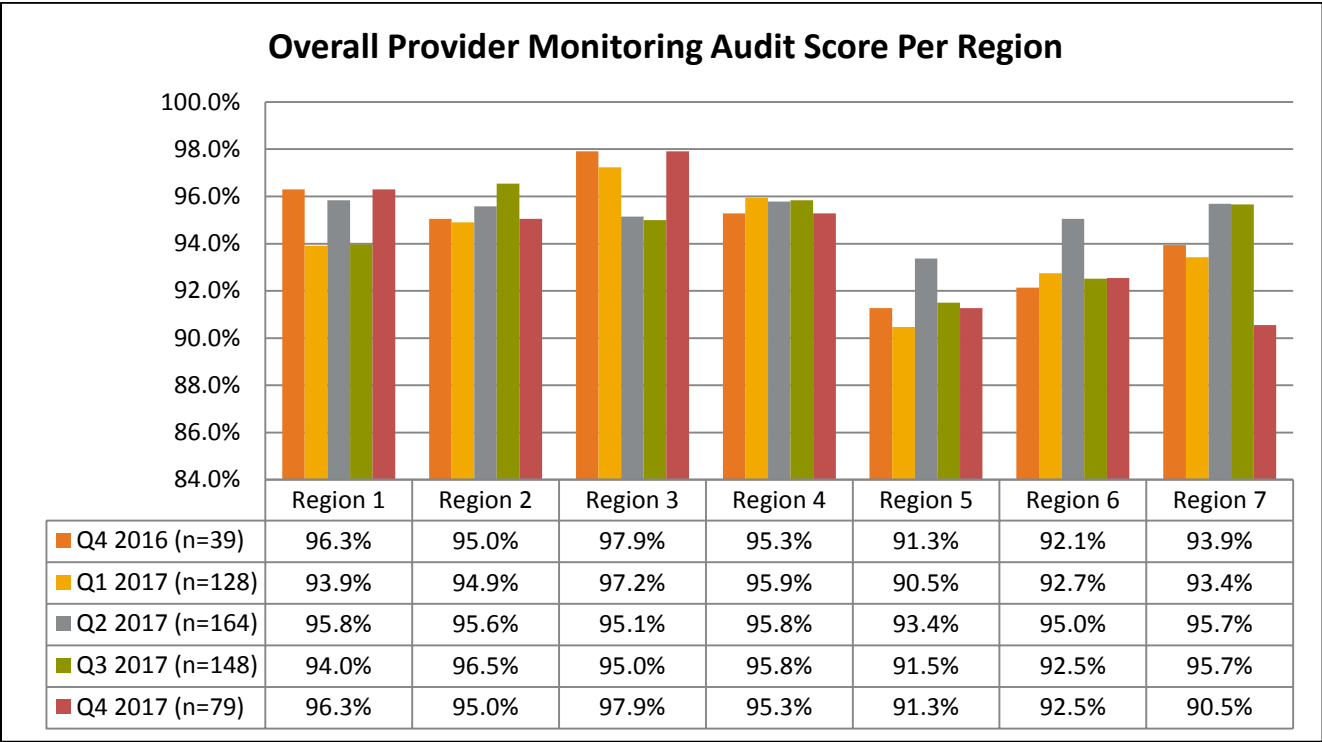
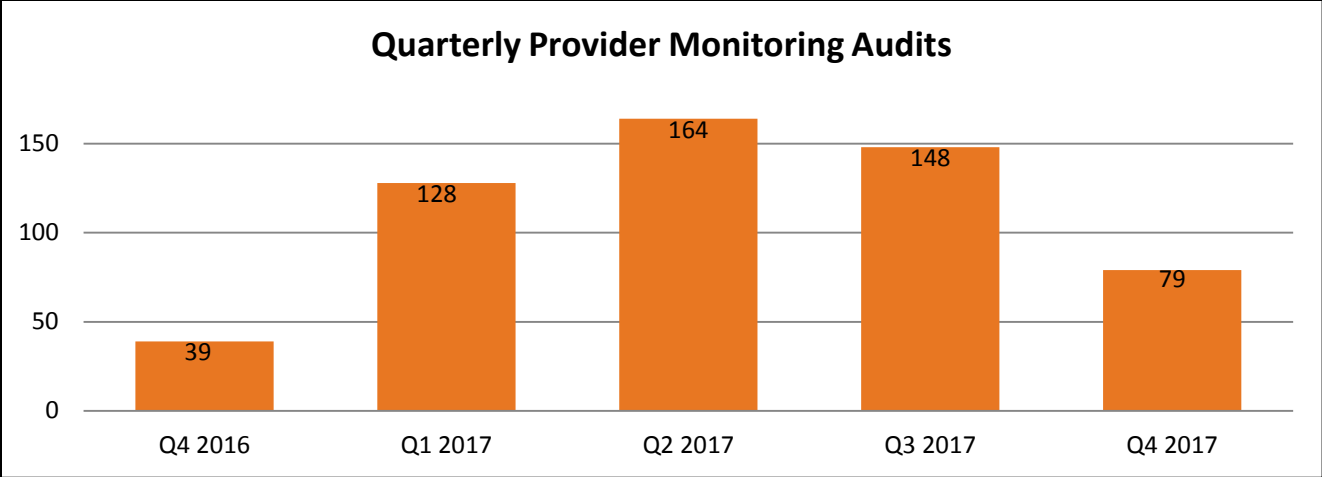
Quarterly Performance Results

| Treatment Record Audit | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|--|------------------|---------|---------|---------|---------|---------|
| Number of Audits Conducted | NA | 39 | 128 | 164 | 148 | 79 |
| Initial Audit (Average overall score) | 85.0% | 95.9% | 92.1% | 93.6% | 98.0% | 92.3% |
| Recredentialing Audit (Average overall score) | 85.0% | 93.4% | 91.2% | 94.3% | 92.8% | 89.1% |
| Monitoring (Average overall score) | 85.0% | 85.0% | 94.9% | 95.2% | 93.7% | 93.9% |
| Quality (Average overall score) | 85.0% | NA* | 82.5%** | NA* | 86.1% | NA* |
| Percent of Audits Requiring a Corrective Action Plan | NA | 7.6% | 16.4% | 6.1% | 11.5% | 8.9% |

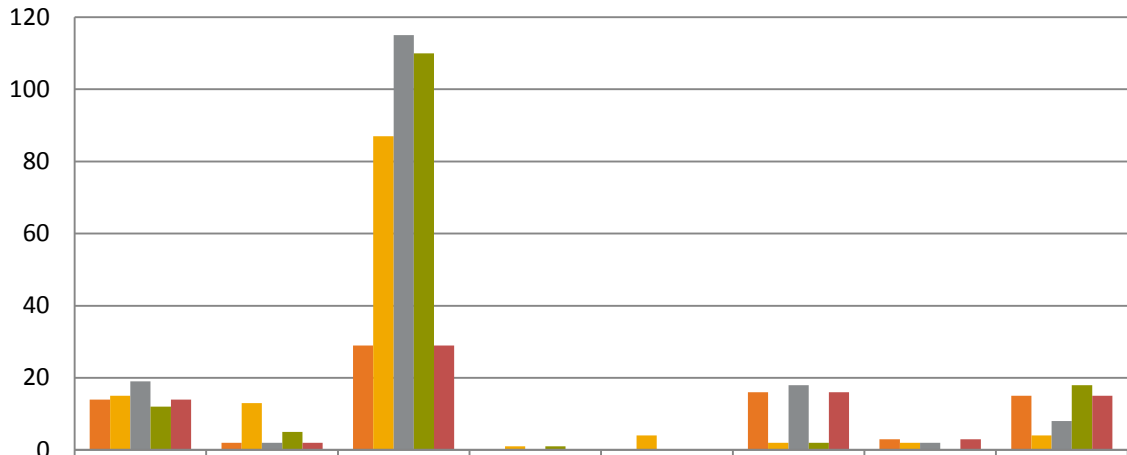
*There were no quality audits during Q4, 2016 and Q2 2017. **There was only 1 Quality audit during Q1, 2017.

Analysis: During Q4, seventy-nine (79) Provider Audits were completed on Optum Idaho network providers. Of the 79 audits completed, 91.1% received a passing score. Corrective action plans were implemented for 8.9% of the audits. Overall audit scores per region and per audit type are reflected in graphs below.

Also, network providers are given the opportunity to rate the Provider Quality Monitoring Audit process in a Satisfaction Survey. In Q1, 2016, Optum Idaho began using a new Satisfaction Survey for providers to complete once a monitoring audit is completed. The survey used to gather this information is through the Qualtrics Survey Application which was approved by United Health Group. The survey is sent to providers by email. If an email address is not on file, the provider will not receive the survey. Surveys are emailed every other week to providers who were audited within the previous 2 weeks. Providers have 4 weeks to complete and return the survey. The results at the end of Q4 showed that 13 responses were received. Of those responses, 69.0% (9) of providers stated that the overall value of the audit process was excellent, followed by 31.0% (4) who stated it was very good. Of those who responded, 85.0% (11) indicated that the auditor was excellent. Seventy-seven percent (77.0%) of respondents indicated that their overall experience with the audit was excellent.

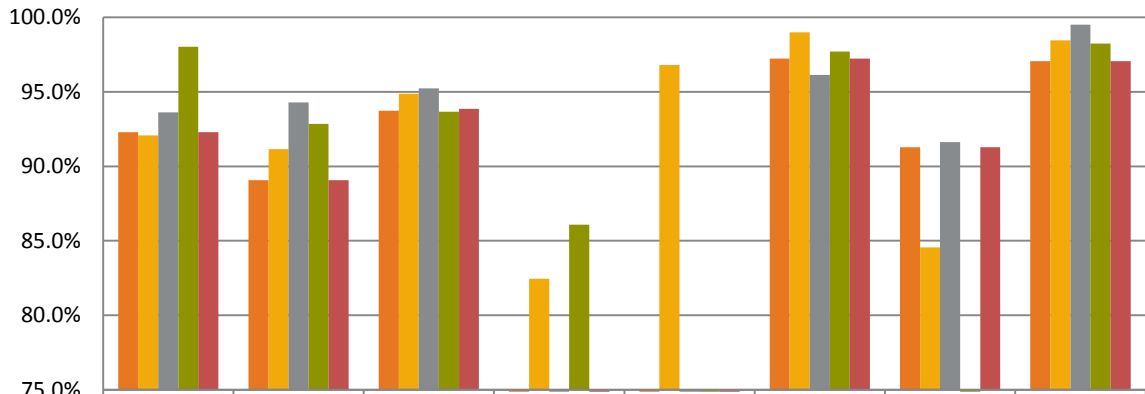


Total Number of Provider Audits by Type

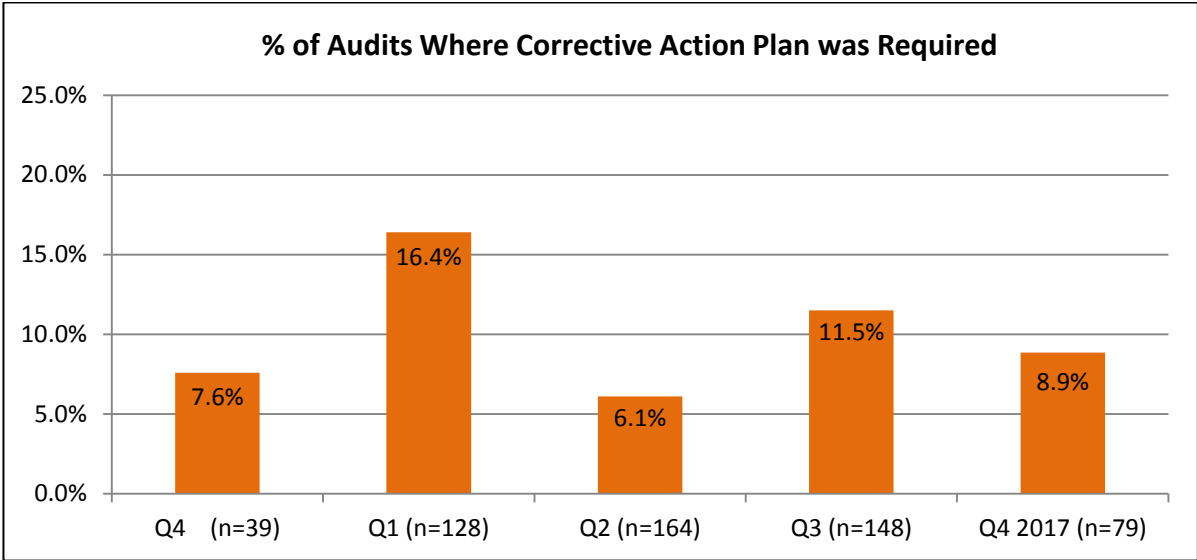
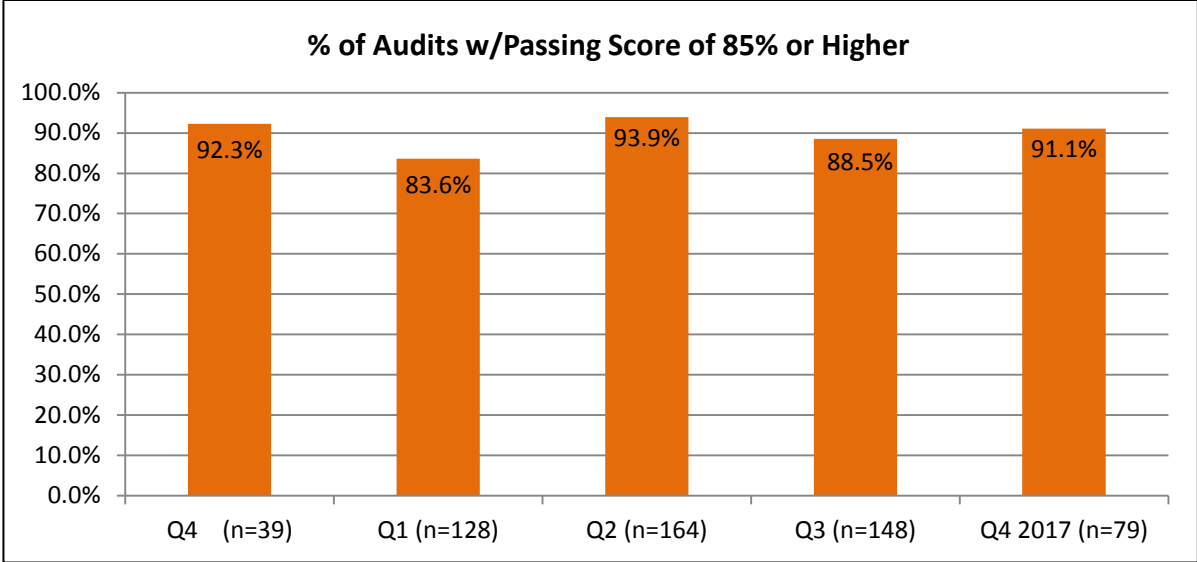


| | Initial | Recredentialing | Monitoring | Quality | Change/New Location | New Program | Re-audit | Secondary Location |
|-----------------|---------|-----------------|------------|---------|---------------------|-------------|----------|--------------------|
| Q4 2016 (n=39) | 14 | 2 | 29 | 0 | 0 | 16 | 3 | 15 |
| Q1 2017 (n=128) | 15 | 13 | 87 | 1 | 4 | 2 | 2 | 4 |
| Q2 2017 (n=164) | 19 | 2 | 115 | 0 | 0 | 18 | 2 | 8 |
| Q3 2017 (n=148) | 12 | 5 | 110 | 1 | 0 | 2 | 0 | 18 |
| Q4 2017 (n=79) | 14 | 2 | 29 | 0 | 0 | 16 | 3 | 15 |

Overall Provider Audit Score by Type

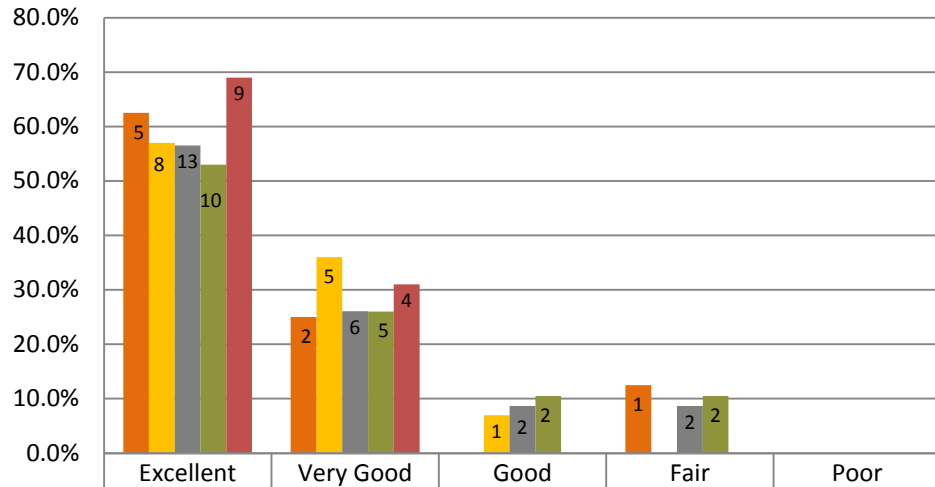


| | Initial | Recredentialing | Monitoring | Quality | Change/New Location | New Program | Re-audit | Secondary Location |
|-----------------|---------|-----------------|------------|---------|---------------------|-------------|----------|--------------------|
| Q4 2016 (n=39) | 92.3% | 89.1% | 93.7% | 0.0% | 0.0% | 97.2% | 91.3% | 97.1% |
| Q1 2017 (n=128) | 92.1% | 91.2% | 94.9% | 82.5% | 96.8% | 99.0% | 84.6% | 98.4% |
| Q2 2017 (n=164) | 93.6% | 94.3% | 95.2% | 0.0% | 0.0% | 96.1% | 91.6% | 99.5% |
| Q3 2017 (n=148) | 98.0% | 92.8% | 93.7% | 86.1% | 0.0% | 97.7% | 0.0% | 98.2% |
| Q4 2017 (n=79) | 92.3% | 89.1% | 93.9% | 0.0% | 0.0% | 97.2% | 91.3% | 97.1% |



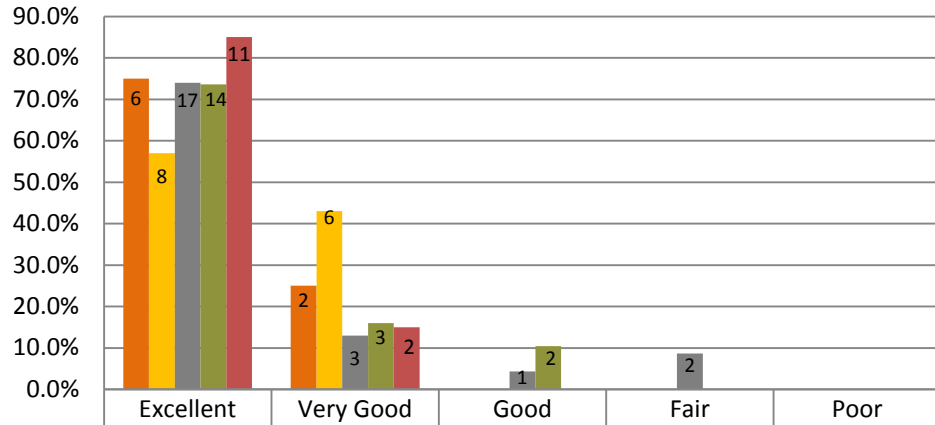
Below are the results of the surveys received back by the end of Q4 that were sent to providers regarding their rating of the Monitoring Audit Process.

Rating of Overall Value of Audit Process

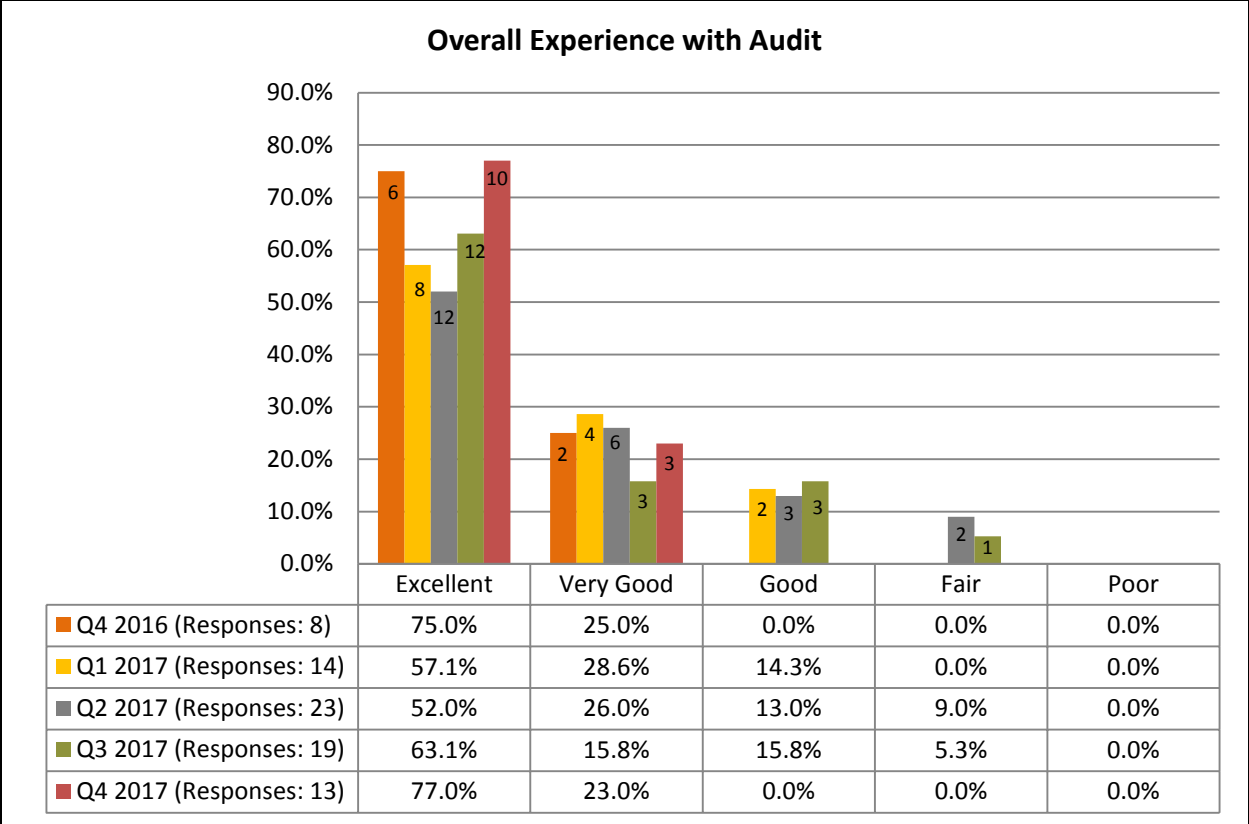


| | Excellent | Very Good | Good | Fair | Poor |
|-------------------------|-----------|-----------|-------|-------|------|
| Q4 2016 (Responses: 8) | 62.5% | 25.0% | 0.0% | 12.5% | 0.0% |
| Q1 2017 (Responses: 14) | 57.0% | 36.0% | 7.0% | 0.0% | 0.0% |
| Q2 2017 (Responses: 23) | 56.5% | 26.1% | 8.7% | 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% |

Overall Rating of Auditor



| | Excellent | Very Good | Good | Fair | Poor |
|-------------------------|-----------|-----------|-------|------|------|
| 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% |



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

Opportunities and Interventions: No opportunities for improvement were identified.

Coordination of Care

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

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

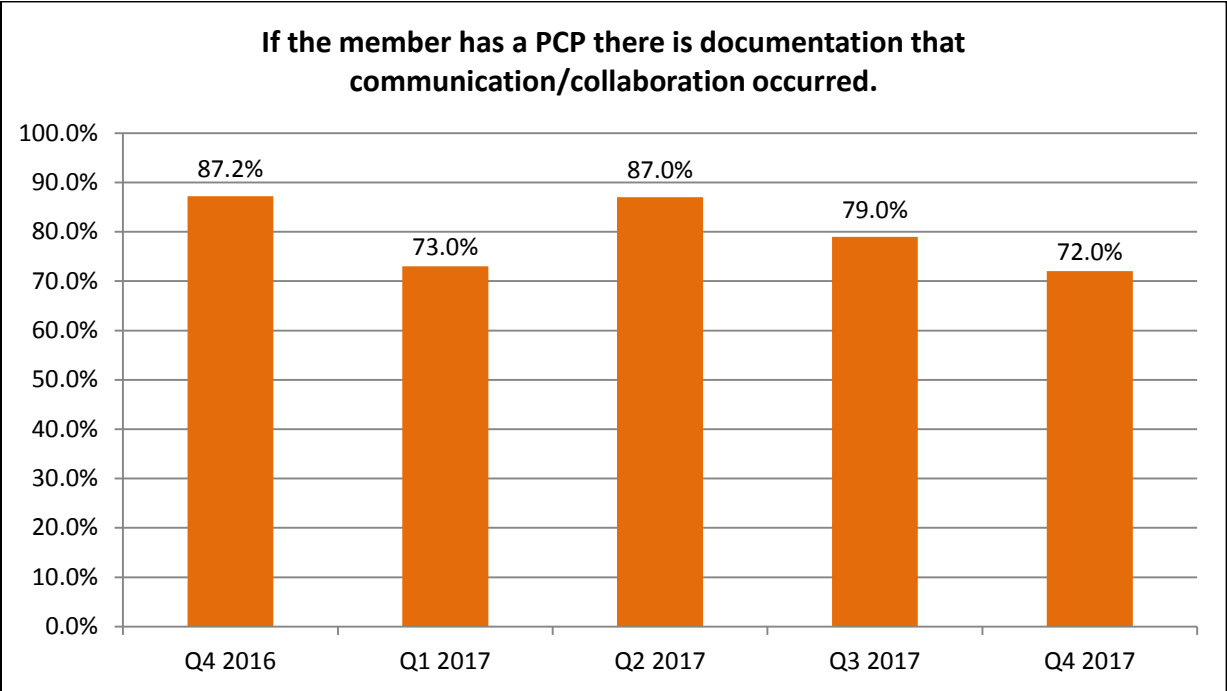
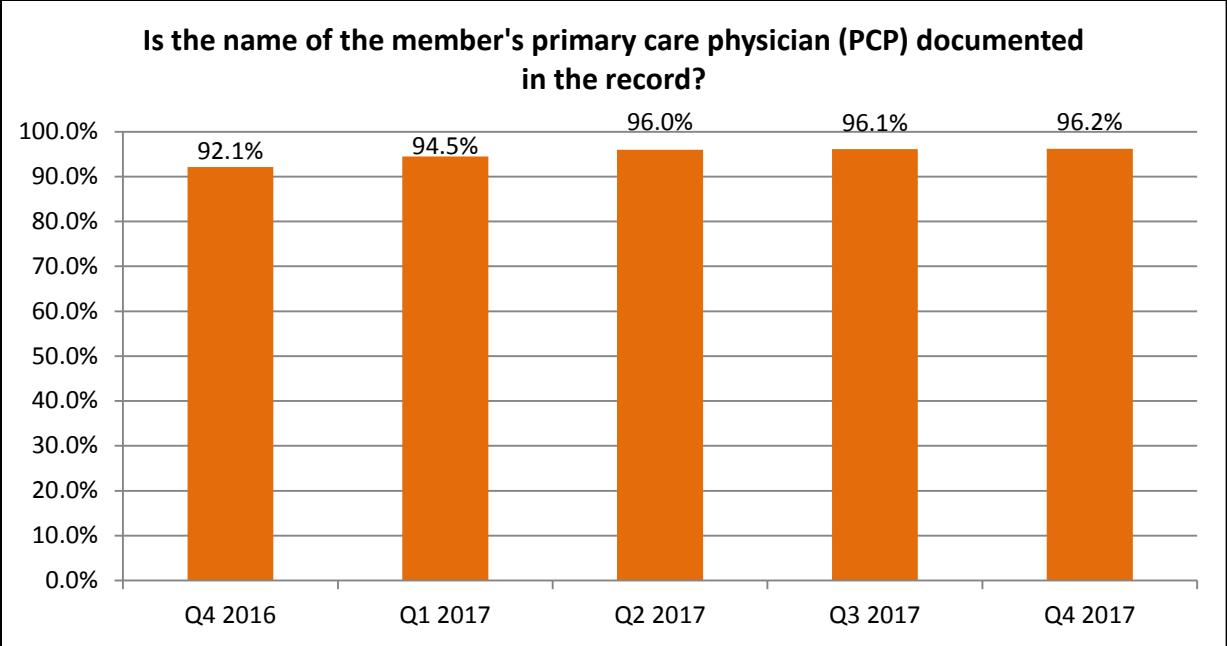
Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expect providers to make a “good faith” effort at communicating with other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

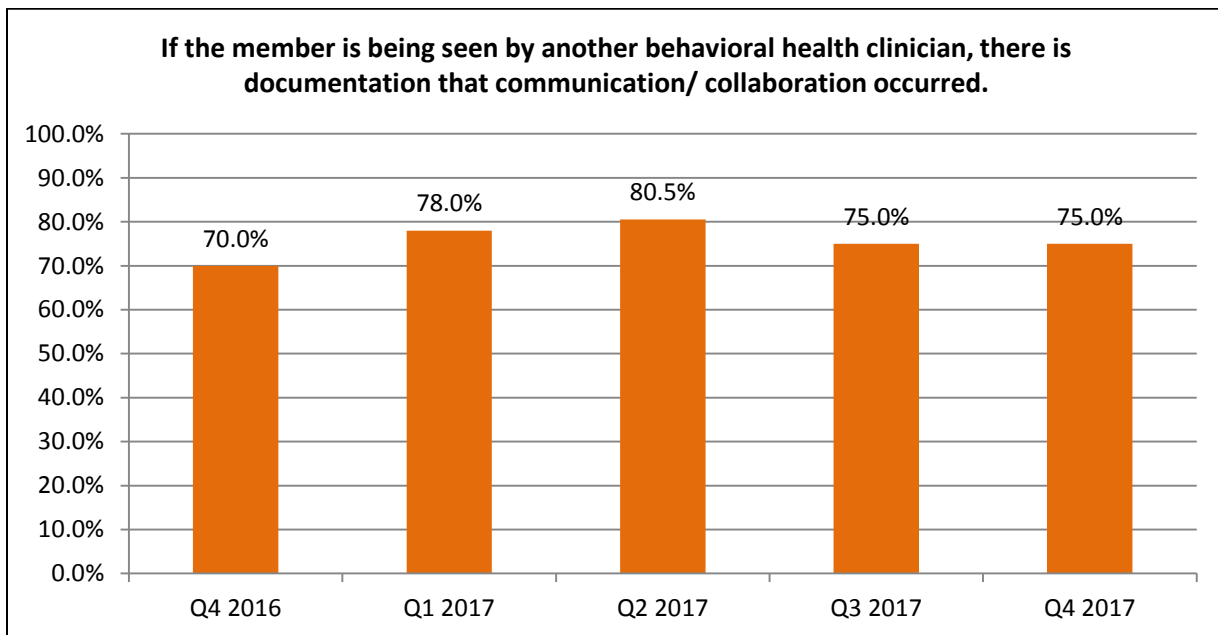
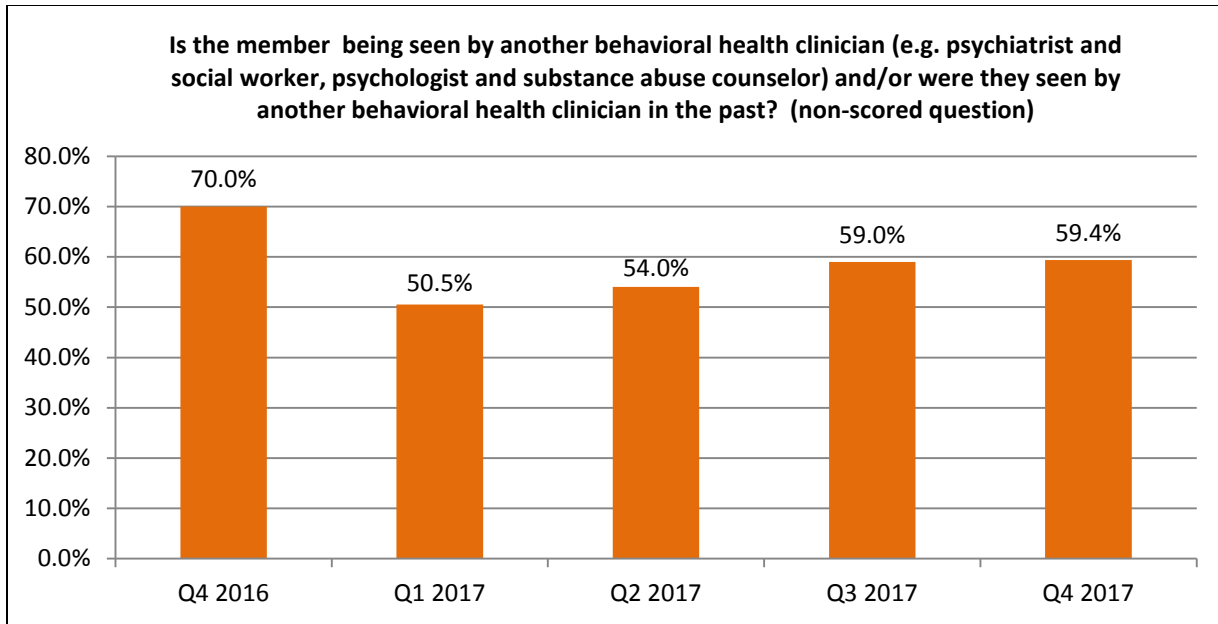
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff.

Quarterly Performance Results

| Coordination of Care (% answered in the affirmative) | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|--|------------------|---------|---------|---------|---------|---------|
| Is the name of the member’s primary care physician (PCP) documented in the record? | NA | 92.1% | 94.5% | 96.0% | 96.1% | 96.2% |
| If the Member has a PCP there is documentation that communication/collaboration occurred | NA | 87.2% | 73.0% | 87.0% | 79.0% | 72.0% |
| 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 | 70.0% | 50.5% | 54.0% | 59.0% | 59.4% |
| If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred. | NA | 70.0% | 78.0% | 80.5% | 75.0% | 75.0% |

Analysis: Coordination of Care audits completed during Q4 revealed that 96.2% of member records reviewed had documentation of the name of the member’s PCP. Of those, 72.0% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member’s PCP. Audit results also showed that 59.4% of the records indicated 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, 75.0% indicated that communication/collaboration had occurred.





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

Opportunities and Interventions: No opportunities for improvement were identified.

Provider Disputes

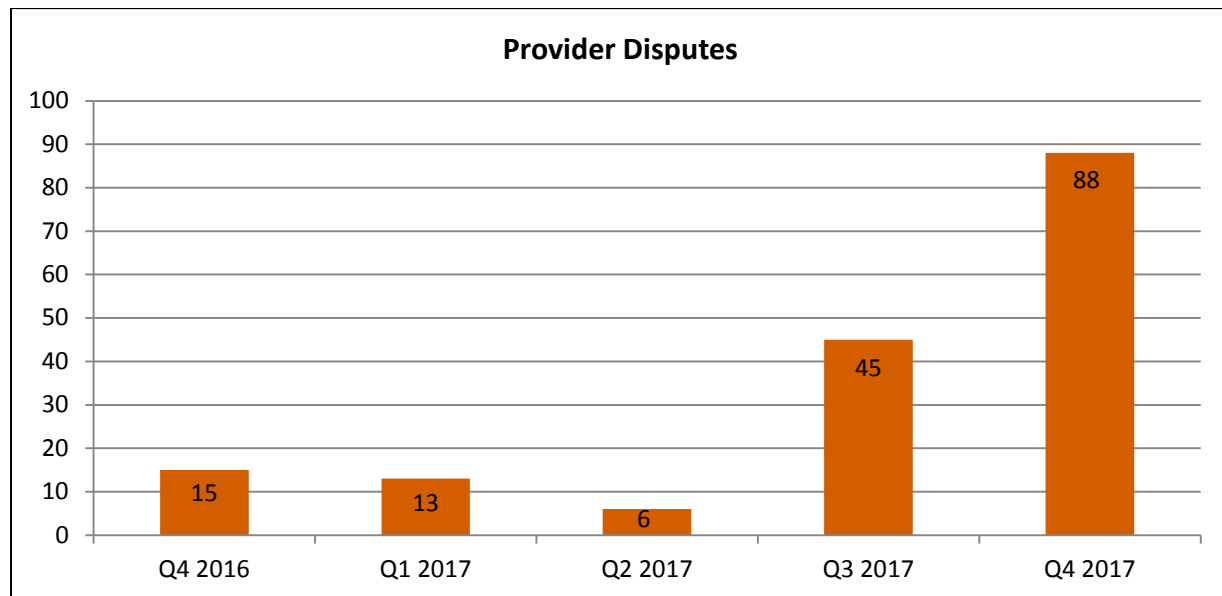
Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is

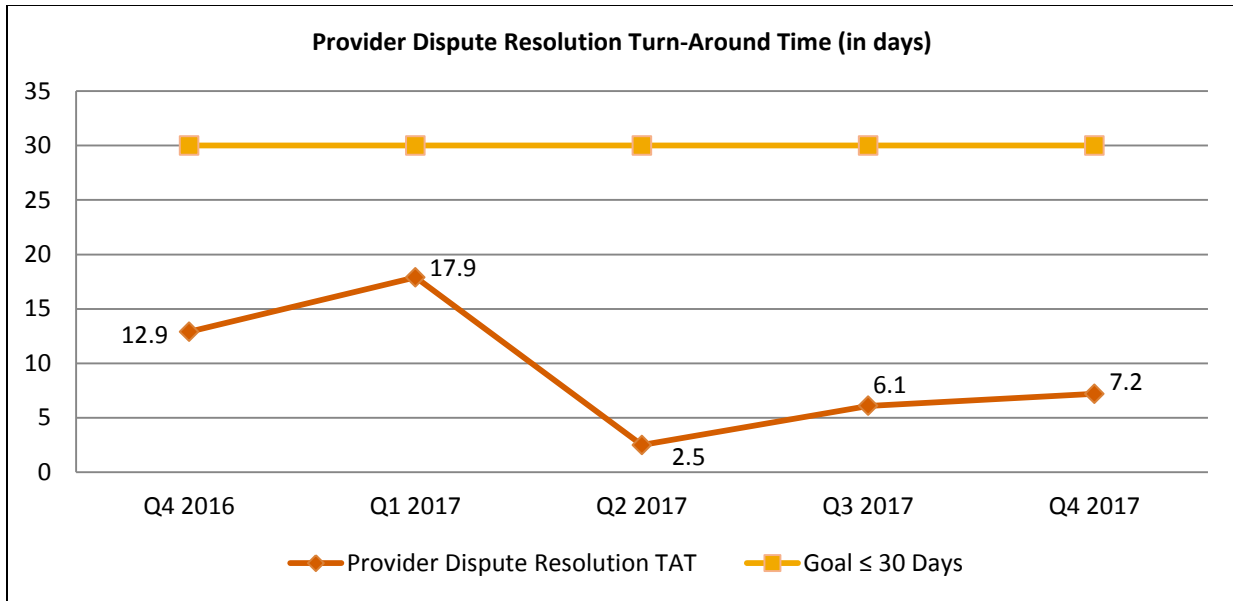
believed to have been incorrectly issued. A denied claim or an Administrative ABD are the two most common disputed items. Provider disputes require that a written resolution notice be sent within 30 days following the request for consideration.

Quarterly Performance Results

| Provider Disputes | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|--|------------------|---------|---------|---------|---------|---------|
| Number of Provider Disputes | NA | 15 | 13 | 6 | 45 | 88 |
| Average # of Days Provider Disputes Resolved | ≤30 Days | 12.9 | 17.9 | 2.5 | 6.1 | 7.2 |
| Number of Disputes Fully Overturned | NA | 3 | 1 | 1 | 39 | 61 |
| Number of Disputes Partially Overturned | NA | 0 | 2 | 0 | 4 | 6 |
| % of Disputes Overturned or Partially Overturned | NA | 20.0% | 23.0% | 1.6% | 96.0% | 76.0% |

Analysis: During Q4, there were 88 Provider Disputes. Of the 88 disputes, 67 were overturned – 61 were fully overturned and 6 were partially overturned. All disputes were resolved within the turnaround time. The overall average turnaround time was 7.2 days.





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

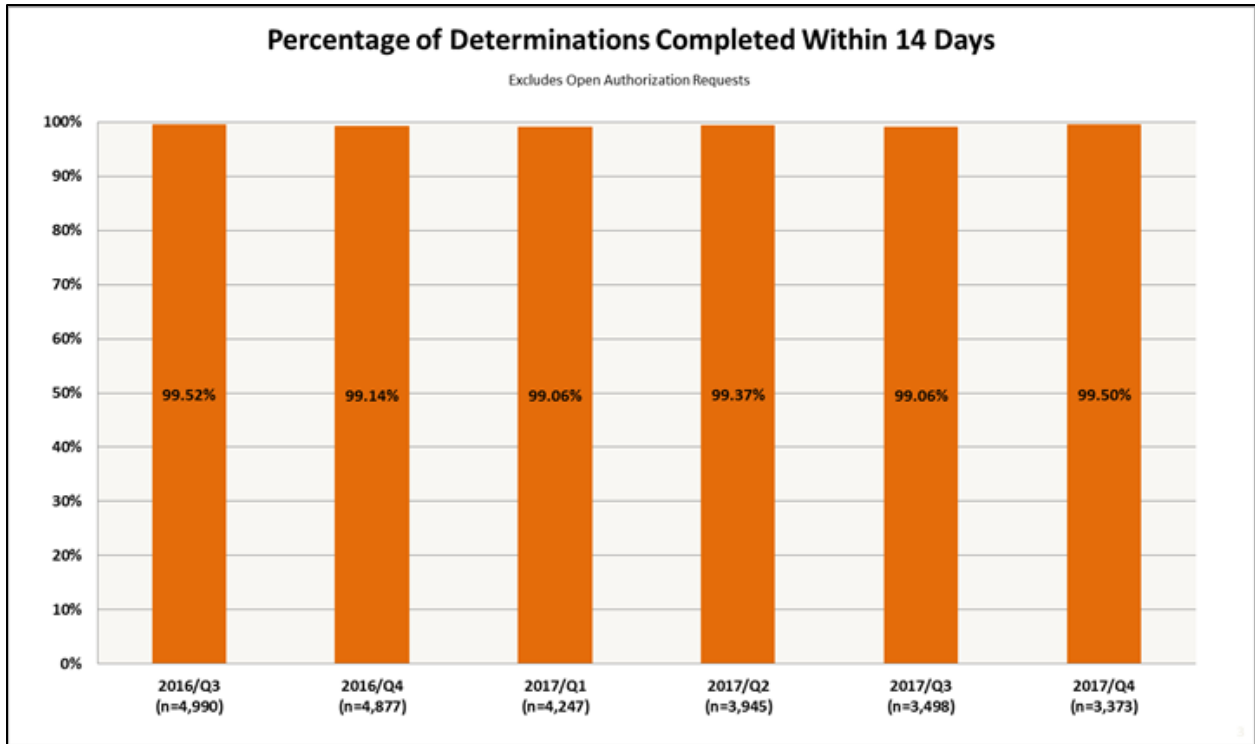
Opportunities and Interventions: There appears to be no root cause for the increase in Q4 Provider Dispute volume. Optum will continue to monitor the volume of Provider Disputes and any potential root causes.

Utilization Management and Care Coordination

Service Authorization Requests

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

| Service Authorization Requests | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|---|------------------|---------|---------|---------|---------|---------|
| Number of Service Authorization Requests | NA | 4,878 | 4,247 | 3,948 | 3,498 | 3,373 |
| Percent Determinations Completed within 14 days | 100.0% | 99.1% | 99.1% | 99.4% | 99.1% | 99.5% |



Field Care Coordination

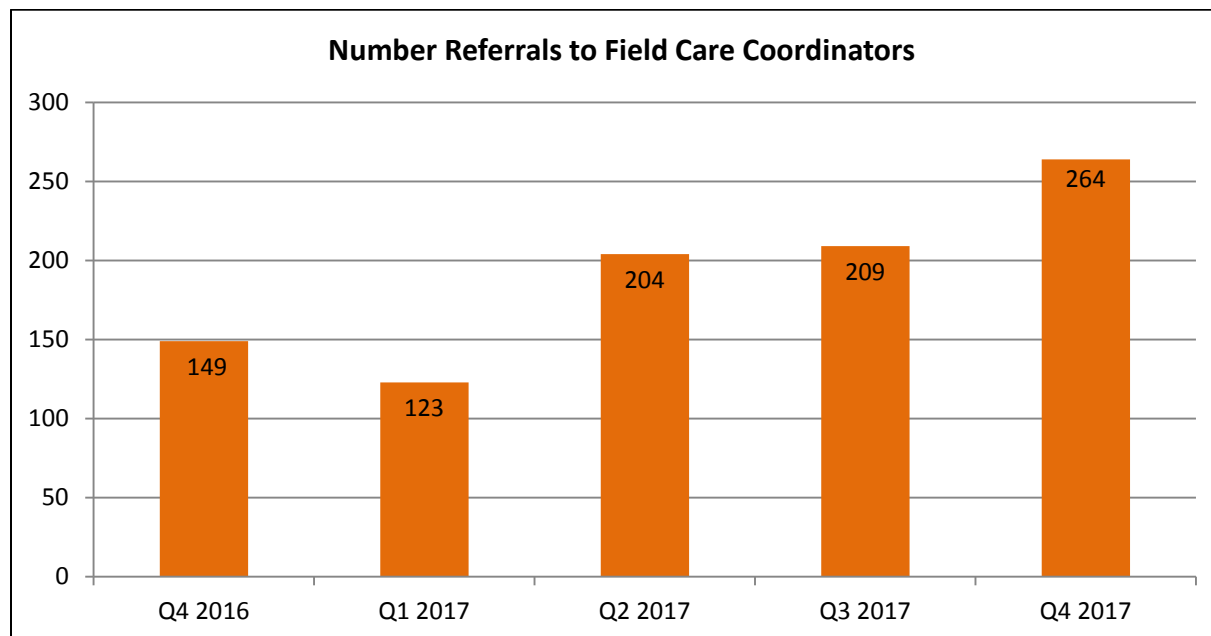
Methodology: The Field Care Coordination (FCC) program includes regionally based clinicians across the state of Idaho. They provide locally based care coordination and discharge planning support. Field Care Coordinators work with the provider to help members. The FCC team focuses on member wellness,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

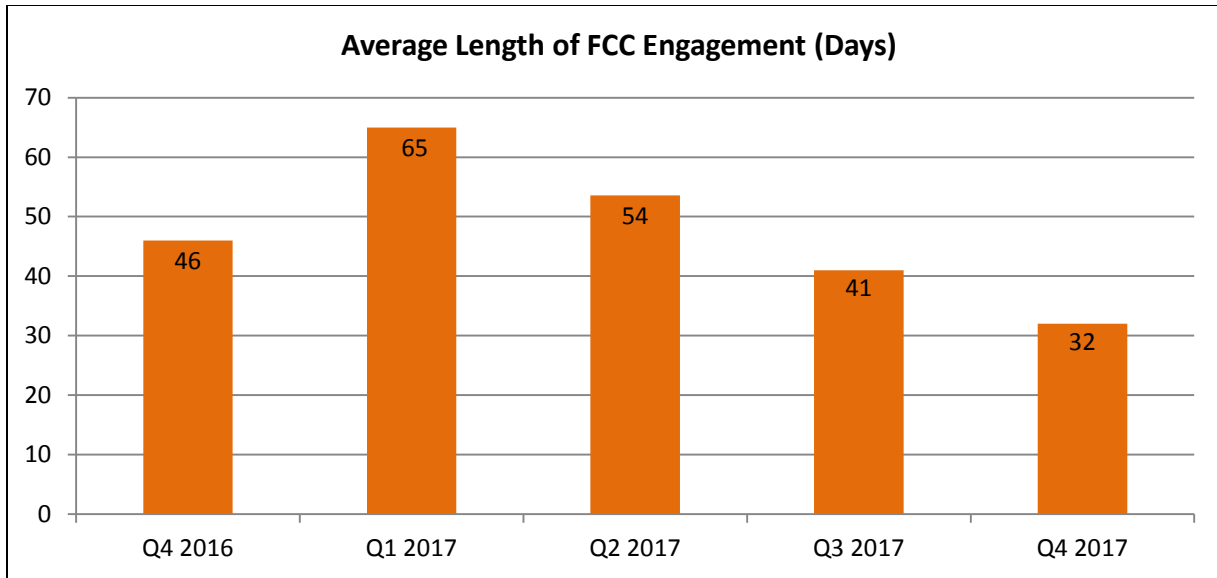
- Focusing on members and member families who are at greatest clinical risk
- Focusing on member’s wellness and the member’s responsibility for his/her own health and well-being.
- Improved care coordination for members moving between services, especially those being discharged from 24-hour care settings.

The Field Care Coordinators receive referrals from different sources. The below table identifies the referral sources and the number of referrals made to FCC staff during Q4, 2016 through Q4, 2017.

| Referral Sources | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 |
|-----------------------------|------------|------------|------------|------------|------------|
| Discharge Coordinator | 112 | 83 | 161 | 145 | 182 |
| Utilization Reviewers | 8 | 13 | 14 | 10 | 8 |
| Providers | 5 | 4 | 6 | 14 | 6 |
| Dept of Behavioral Health | 6 | 6 | 6 | 16 | 20 |
| Juvenile Justice | 0 | 0 | 0 | 0 | 0 |
| Provider Quality Specialist | 3 | 2 | 0 | 0 | 0 |
| Peer Review Committee | 2 | 0 | 0 | 0 | 0 |
| Hospitals | 0 | 0 | 0 | 0 | 3 |
| EPSDT | 0 | 0 | 0 | 4 | 9 |
| Family/Parent | 0 | 0 | 0 | 4 | 0 |
| Member Services/Crisis Line | 0 | 0 | 0 | 0 | 0 |
| Education | 6 | 10 | 4 | 2 | 1 |
| FCC Manager Referral | 4 | 1 | 3 | 0 | 1 |
| Outpatient Disposition | 3 | 4 | 10 | 4 | 0 |
| Suicide Attempt | NA | NA | NA | 10 | 21 |
| Adult Corrections | NA | NA | NA | NA | 13 |
| Total | 149 | 123 | 204 | 209 | 264 |

Analysis: During Q4, Field Care Coordinators received 264 referrals. Of these referrals, 182 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement during Q4 was 32 days.





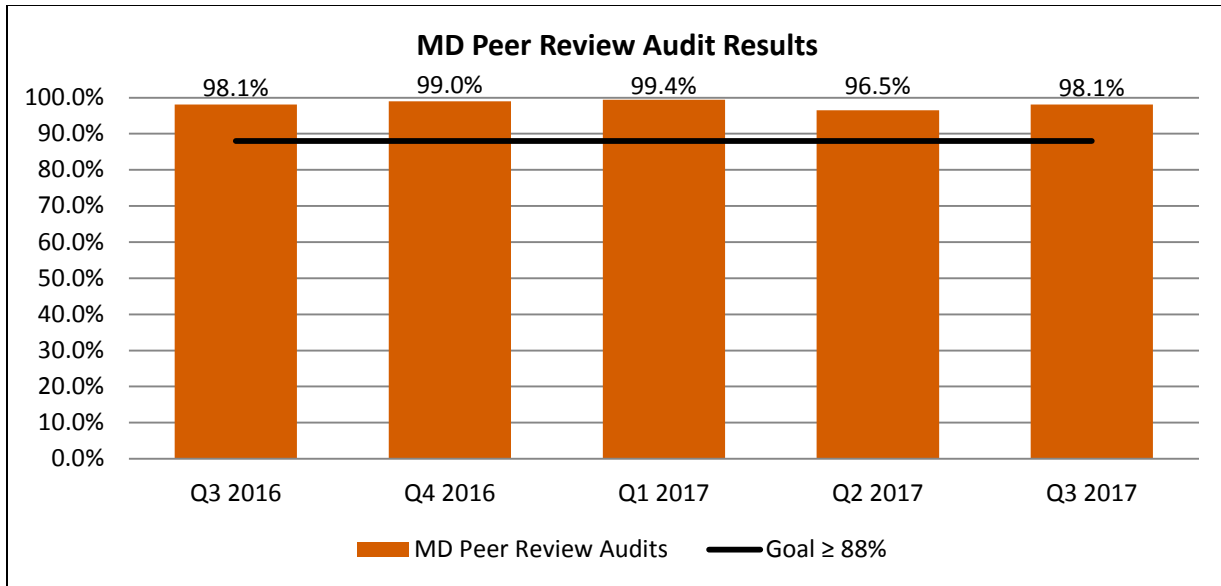
Barriers: Based on the above analysis, no barriers were identified.

Opportunities and Interventions: No opportunities for improvement were identified. The data will continue to be monitored to identify trends.

Peer Reviewer Audits

Methodology: Optum Idaho promotes a process for review and evaluation of the clinical documentation of adverse benefit determinations and appeal reviews by Optum physicians, nurse practitioners, 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 $\geq 88\%$.

Analysis: This date is reported one quarter in arrears. During Q3, there were no PhD denial decisions that required a Peer Review Audit. The MD Peer Review Audit result was at 98.1%.



Inter-Rater Reliability

Optum Idaho evaluates and promotes the consistent application of the Level of Care Guidelines and the Coverage Determination Guidelines by clinical personnel by providing orientation and training, routinely reviewing documentation of clinical transactions in member records, providing ongoing supervision and consultation and administering an annual assessment of inter-rater reliability. The most recent results were included in the Q2, 2017 Quarterly report. Inter-rater Reliability testing is completed annually.

Population Analysis

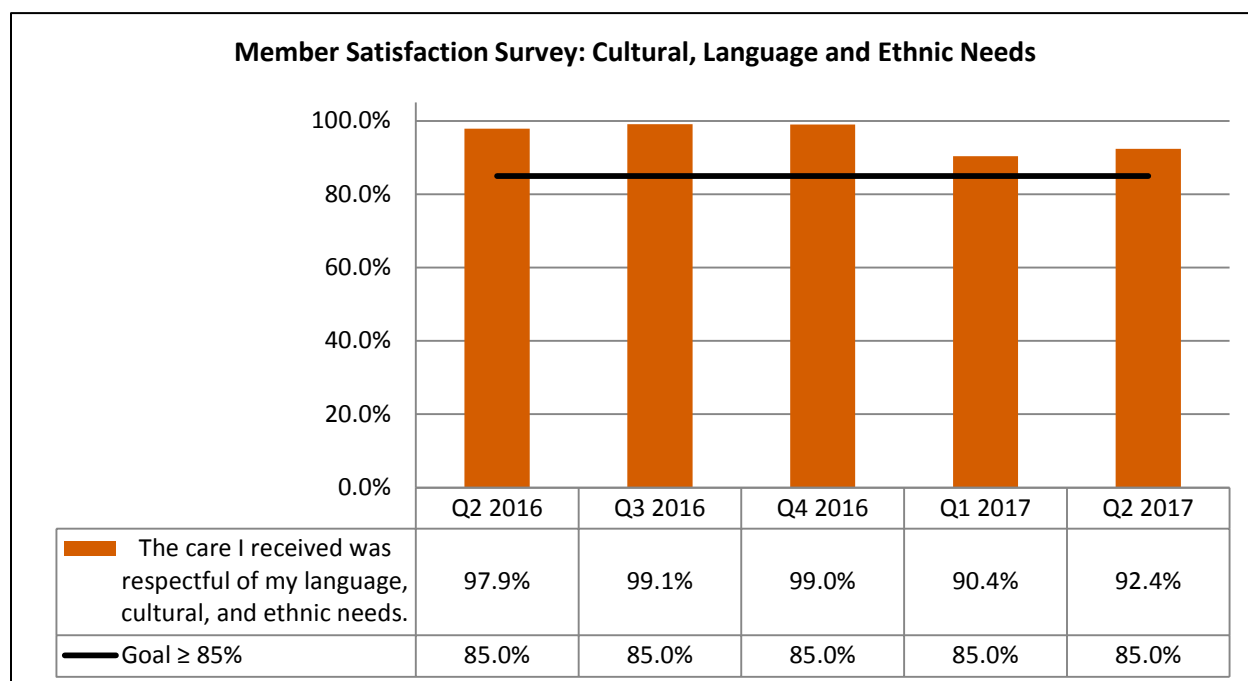
Language and Culture

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

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

*most current data available

Analysis: Hispanic or Latino counted for 12.2 % of the Idaho population an increase from 11.2% from the 2010 Census results. This is the second highest population total, with White consisting of 93.4% (an increase from 89.1% from the 2010 Census results). Ethnic and racial backgrounds can overlap which explains for the percentage total > 100%. The Member Satisfaction Survey results show that 92.4% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q2 2017 data is the most current data available.



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

Opportunities and Interventions: No opportunities for improvement were identified.

Results for Language and Culture

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

Quarterly Performance Results

| Language Assistance Requests by Type | # of Requests |
|---|---------------|
| Member Written Communication | 6 |
| Member Written Communication Formatted to Large Print | 5 |
| Language Service Associates | 28 |
| Languages Represented | 11 |
| Do Not Mail List | 14 |

Analysis: During Q4, Optum Idaho responded to 64 requests for language assistance. Predominant request was for Spanish followed by Farsi, and then Arabic.

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

Opportunities and Interventions: No opportunities for improvement were identified.

Claims

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

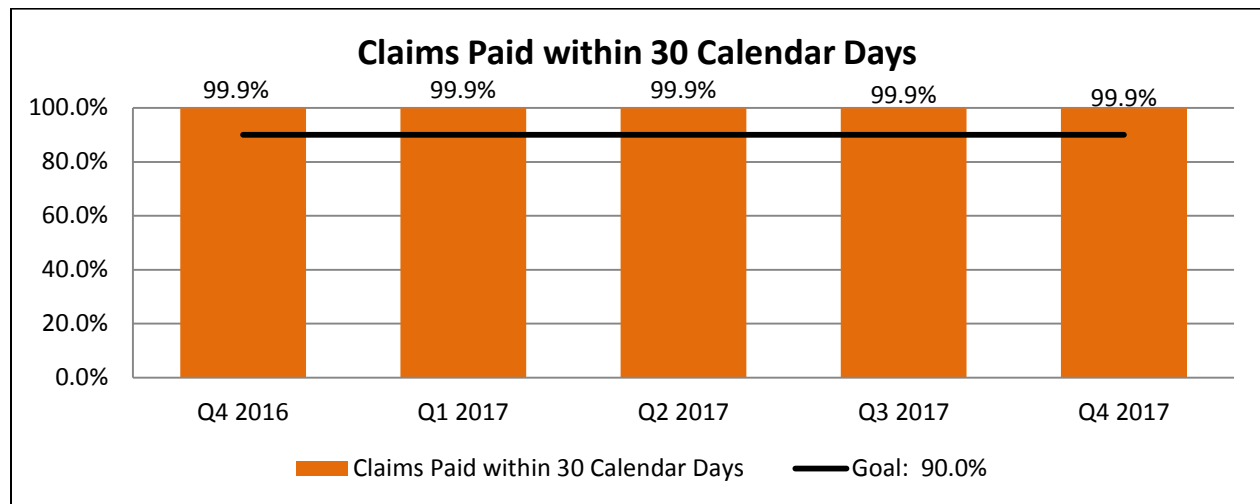
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid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

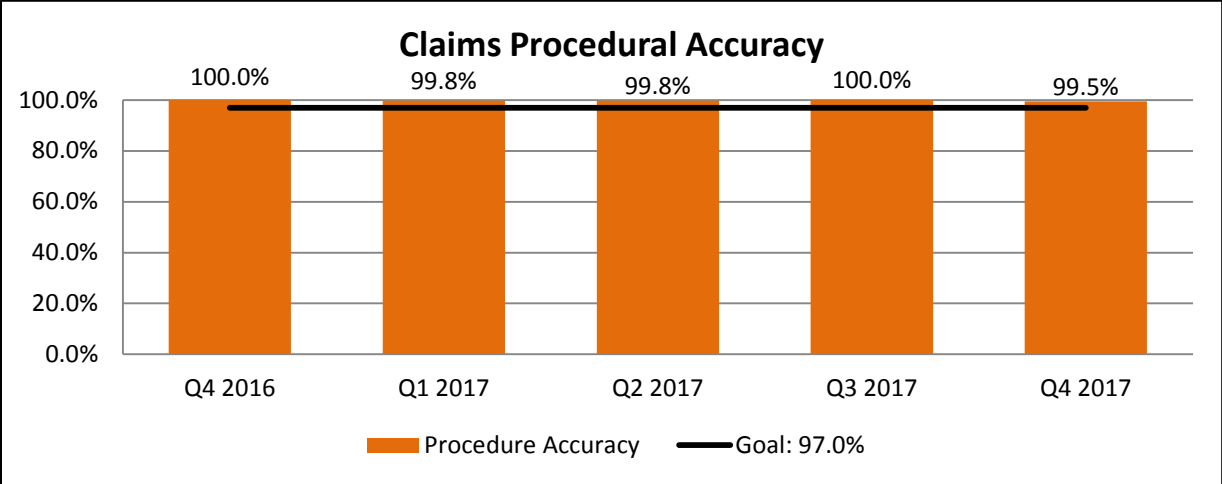
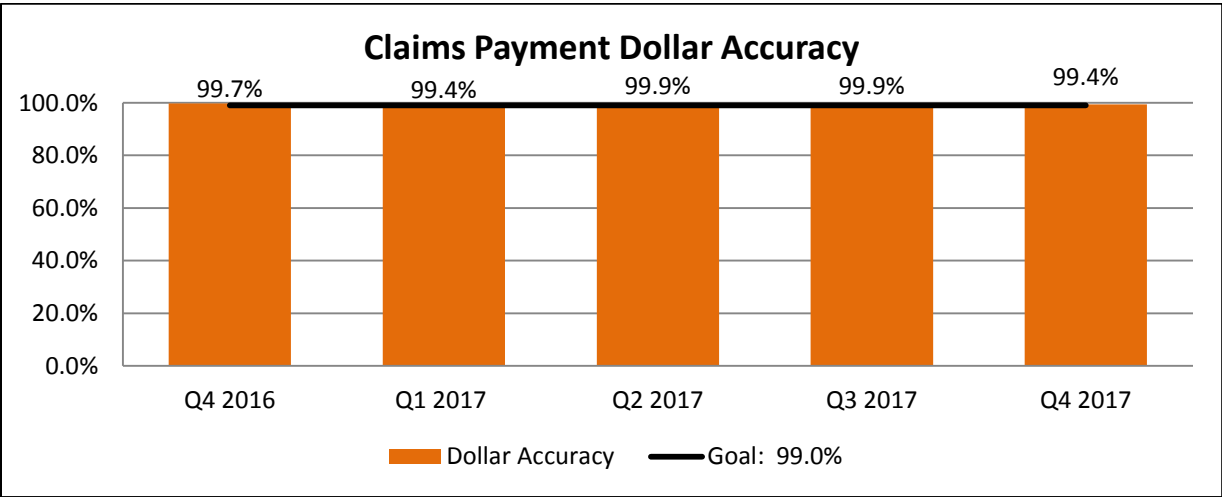
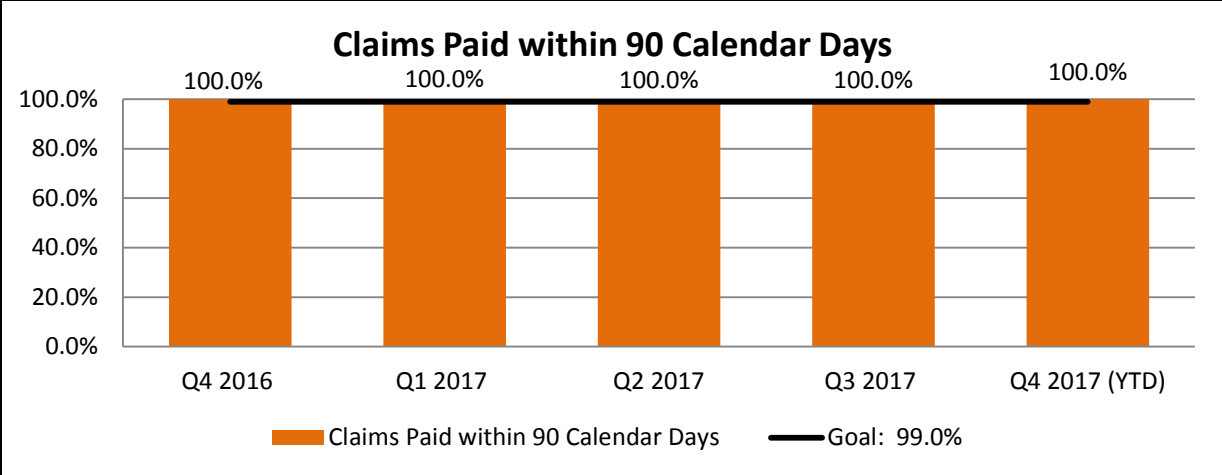
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial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

Quarterly Performance Results:

| Claims | Performance Goal | Q4 2016 | Q1 2017 | Q2 2017 | Q3 2017 | Q4 2017 YTD |
|---------------------|------------------|---------|---------|---------|---------|-------------|
| Paid within 30 days | 90.0% | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% |
| Paid within 90 days | 99.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Dollar Accuracy | 99.0% | 99.7% | 99.4% | 99.9% | 99.9% | 99.4% |
| Procedural Accuracy | 97.0% | 100.0% | 99.8% | 99.8% | 100.0% | 99.5% |

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





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

Opportunities and Interventions: No opportunities for improvement were identified.