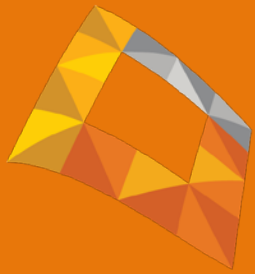


IDAHO BEHAVIORAL HEALTH PLAN

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT



OPTUM®

*January - March
2018*

The Quality Management and Utilization Management (QMUM) Report summarizes Optum Idaho's performance in accordance with the contract between the Idaho Department of Health and Welfare (IDHW), Division of Medicaid and Optum. This report highlights the outpatient behavioral health services covered by the State of Idaho and provided on behalf of Medicaid members, also known as the Idaho Behavioral Health Plan (IBHP). The QMUM report provides a quarterly calendar year view of performance and outcomes data, through Quarter 1, 2018.

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Executive Summary – Quarter 1 - 2018

As noted in the outcomes analysis portion of this report, the overall trend for hospital re-admissions within 30 days has improved each quarter over the past four quarters, and declined over 30% year-over-year, which is a positive indicator that members are seeking outpatient services when appropriate. Approximately 50% of discharged patients had a follow-up outpatient visit within seven days of discharge, and 70% within 30 days. One of the services, Peer Support, increased 50% from a year ago, as measured by the number of unique utilizers per 1,000 members. Optum'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.

Optum continues to be highly engaged across Idaho in statewide strategic planning for community engagement activities. The strategic framework ensures that Optum can provide education about access to behavioral health services for members and providers, understanding of new programs, provider engagement opportunities and continued strengthening of collaborative relationships with stakeholders that enhance behavioral health for Idahoans. In the first quarter of 2018, Optum staff participated in 73 statewide and regional events and media interviews that reached close to 75,000 people.

Outreach efforts included hosting five Provider Meet and Greet events designed to deliver valuable information to providers and allow meaningful interaction with Optum regional staff. Four of those events included training on Integrated Behavioral Health which provided one Continuing Education Credit. Providers appreciated this model and requested more education to be held during meet and greets. Planning is underway for the next round of training that will be included in upcoming meetings.

Optum continues to attend Regional Behavioral Health Board meetings as well as participate in various committee and subcommittee meetings. Optum's Chief Medical Officer, Dr. Ronald Larsen, presented information about the Intensive Outpatient Program (IOP) to the Behavioral Health Boards in Regions 2 and 3. He also met with healthcare leaders in Region 2 to explore IOP models for frontier regions of Idaho.

As part of the Youth Empowerment Services (YES) System of Care, Respite is now a Medicaid-reimbursed service for children and adolescents who meet functional, diagnostic, and Medicaid eligibility requirements. Critical to the successful implementation of all YES services, Optum has an increased focus on Education and Training development. All Respite workers will be required to complete training to be in-network Respite providers with Optum.

There is continued interest in the screening of the documentaries, *Resilience* and *Paper Tigers*. Optum Idaho purchased the rights to screen these movies which deal with the effects of Adverse Childhood Experiences (ACEs) on physical health and learning in schools. Since

January 1, 2018, more than 500 people viewed these films. Screenings happened at a variety of meetings including, statewide conferences such as Head Start and NAMI as well as local meetings including Panhandle Health and Meridian Middle School. Optum continues to work with stakeholders who are interested in these films with the goal of advancing conversations about ACEs and connecting stakeholders with resources to help them develop action plans to address these issues.

Together with community partners, we strive to make our communities better; one person, one family, one community at a time. Every individual and every family has a unique road to wellness, health, and hope; just as every community has its own ways to support and assist the people who live there.

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 1, 2018, (January through March 2018), 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-five (35) 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 33 (94.3%) 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	January - March 2017	April - June 2017	July - September 2017	October - December 2017	January - March 2018
Member Satisfaction Survey Results						
Optum Support for Obtaining Referrals or Authorizations	≥85.0%	87.0%	76.0%	85.0%	Based on Member Satisfaction Survey sampling methodology, Q3, 2017, is the most current data available.	
Accessibility, Availability, and Acceptability of the Clinician Network	≥85.0%	87.0%	87.0%	94.0%		
Experience with Counseling or Treatment	≥85.0%	87.0%	95.0%	93.0%		
Overall Satisfaction	≥85.0%	81.3%	73.0%	89.0%		
Provider Satisfaction Survey Results						
Annual Overall Provider Satisfaction	≥85.0%				2016 Results 75.0%	2017 Results 77.0%
Accessibility & Availability						
Idaho Behavioral Healthplan Membership						
Membership Numbers	NA	299,388	303,086	301,989	303,831	Due to claims lag, data is reported 1 quarter in arrears
Member Services Call Standards						
Total Number of Calls	NA	1,290	1,345	1,362	1,295	1,123
Percent Answered within 30 seconds	≥80.0%	80.0%	85.4%	83.0%	86.0%	82.1%
Average Speed of Answer (seconds)	≤30 Seconds	21.5	12.3	2.7	1.5	4.0
Abandonment Rate	≤3.5% internal ≤7.0 % contractual	4.1%	2.1%	1.7%	1.4%	1.5%

Measure	Goal	January - March 2017	April - June 2017	July - September 2017	October - December 2017	January - March 2018
Customer Service (Provider Calls) Standards						
Total Number of Calls	NA	2,917	2,861	4,103	3,135	3,320
Percent Answered within 30 seconds	≥80.0%	98.4%	98.4%	97.1%	99.3%	98.0%
Average Speed of Answer (seconds)	≤30 Seconds	2.8	1.8	6.2	2.3	3.9
Abandonment Rate	≤3.5% internal ≤7.0% contractual	0.56%	0.44%	0.64%	0.00%	0.00%
Urgent and Non-Urgent Access Standards						
Urgent Appointment Wait Time (hours)	48 hours	24.0	27.0	20.0	21.4	22.2
Non-Urgent Appointment Wait Time (days)	10 days	7.3	6.0	6.0	5.4	4.3
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%*	100.0%	99.8%*	99.8%*
Area 2 - requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	100.0%	99.8%*	99.9%*	99.8%*	99.8%*	99.8%*
Member Protections and Safety						
Notification of Adverse Benefit Determinations						
Number of Adverse Benefit Determinations (ABD's)	NA	416	500	756	492	504
Clinical ABD's (<i>began tracking Q3, 2017</i>)	NA	NA	NA	578	352	351
Administrative ABD's (<i>began tracking Q3, 2017</i>)	NA	NA	NA	178	140	153
Written Notification (<i>14 calendar days from request for services - implemented 7/1/17</i>)	100% within 14 calendar days	NA	NA	100.0% (756/756)	99.8% (491/492)	100.0% (504/504)
Initial Verbal Notification on Same Day	100.0%	99.8%*	99.6%*	No longer tracking	No longer tracking	No longer tracking
Written Notification Sent within 1 Business Day	100.0%	98.3%	99.8%*	New 14-day requirement tracked above	New 14-day requirement tracked above	New 14-day requirement tracked above
Member Appeals (formerly Grievances)						
Number of Appeals	NA	15	17	51	30	23
Non-Urgent Appeals	NA	15	17	36	26	17
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	15	4	6
Determination Compliance	100% within 30 Calendar Days	NA	NA	100.0%	100.0%	100.0%

Measure	Goal	January - March 2017	April - June 2017	July - September 2017	October - December 2017	January - March 2018
Complaint Resolution and Tracking						
Total Number of Complaints	NA	13	23	16	11	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	12	20	14	10	9
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	83.3%	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints	NA	1	3	2	1	2
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	19	19	11	12	14
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	128	164	148	79	275
Initial Audit (Percent overall score)	≥ 85.0%	92.1%	93.6%	98.0%	92.3%	92.2%
Recredentialing Audit (Percent overall score)	≥ 85.0%	91.2%	94.3%	92.8%	89.1%	89.6%
Monitoring (Percent overall score)	≥ 85.0%	94.9%	95.2%	93.7%	93.9%	90.0%
Quality (Percent overall score)	≥ 85.0%	82.5%	NA**	86.1%	NA**	NA**
Percent of Audits that Required a Corrective Action Plan	NA	16.4%	6.1%	11.5%	8.9%	24.0%
Behavioral Health Provider and						
Percent PCP is documented in member record	NA	94.5%	96.0%	96.1%	96.2%	94.8%
Percent documentation in member record that communication/ collaboration occurred between behavioral health provider and primary care provider	NA	73.0%	87.0%	79.0%	72.0%	75.0%
Provider Disputes						
Number of Provider Disputes	NA	13	6	45	24	55
Percent Provider Dispute Determinations made within 30 calendar days from request	100% within 30 Calendar Days	92.3%	100.0%	100.0%	100.0%	100.0%
Average Number of Days to Resolve Provider Disputes	≤30 days	17.9	2.5	6.1	4.6	7.1
Utilization Management and Care Coordination						
Service Authorization Requests						
Percentage Determination Completed within 14 days	100%	99.1%	99.4%	99.1%	99.5%*	99.1%
Field Care Coordination						
Total Referrals to FCCs	NA	123	204	209	264	136
Average Number of Days Case Open to FCC	NA	65	53.6	41	32	46

Measure	Goal	January - March 2017	April - June 2017	July - September 2017	October - December 2017	January - March 2018
Discharge Coordination: Post Discharge Follow-Up						
Number of Inpatient Discharges	NA	850 [^]	930 [^]	819 [^]	1009	Data is reported 1 Quarter in arrears
Percent of Members with Follow-Up Appointment or Authorization within 7 Days after discharge	NA	49.9% [^]	49.8% [^]	50.4% [^]	47.0%	
Percent of Members with Follow-Up Appointment or Authorization within 30 Days after discharge	NA	69.8% [^]	69.5% [^]	69.5% [^]	67.9%	
Readmissions						
Number of Members Discharged	NA	850 [^]	930 [^]	820 [^]	1009	Data is reported 1 Quarter in arrears
Percent of Members Readmitted within 30 days	NA	8.9% [^]	11.8%	10.2% [^]	9.2%	
Inter-Rater Reliability						
Inter-Rater Reliability completed annually. Results presented during Q2, 2017	NA	NA	62.0%	Completed annually	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%	99.4%	96.5%	98.1%	94.0%	
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%	99.4%	99.9%	99.9%	99.4%	99.7%
Procedural Accuracy	97.0%	99.8%	99.8%	100.0%	99.5%	100.0%

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

***there were 0 quality audits*

****there were 0 PhD peer review audits*

[^]numbers changed to reflect additional claims updates

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 and follow-up assessment scores remained consistent over the five quarters from Q1 2017 through Q1 2018.

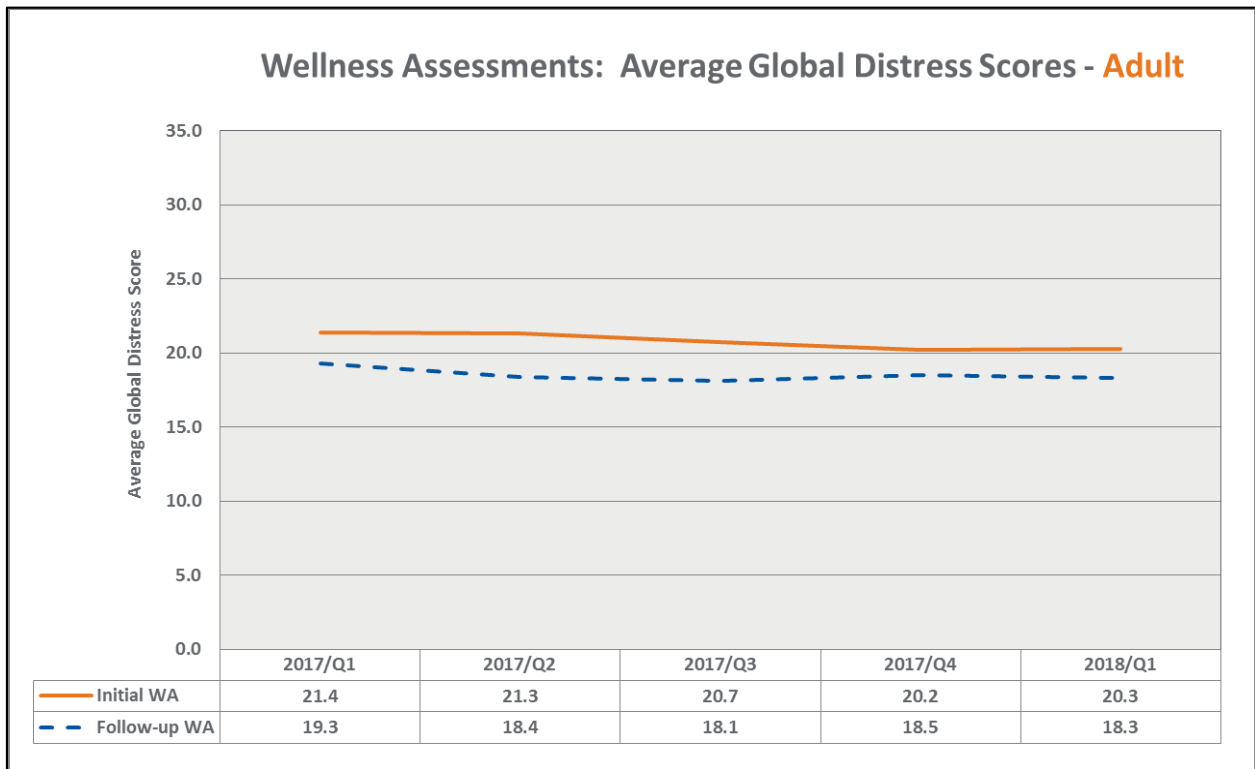


Figure 1

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 Q1 2017 through Q1 2018.

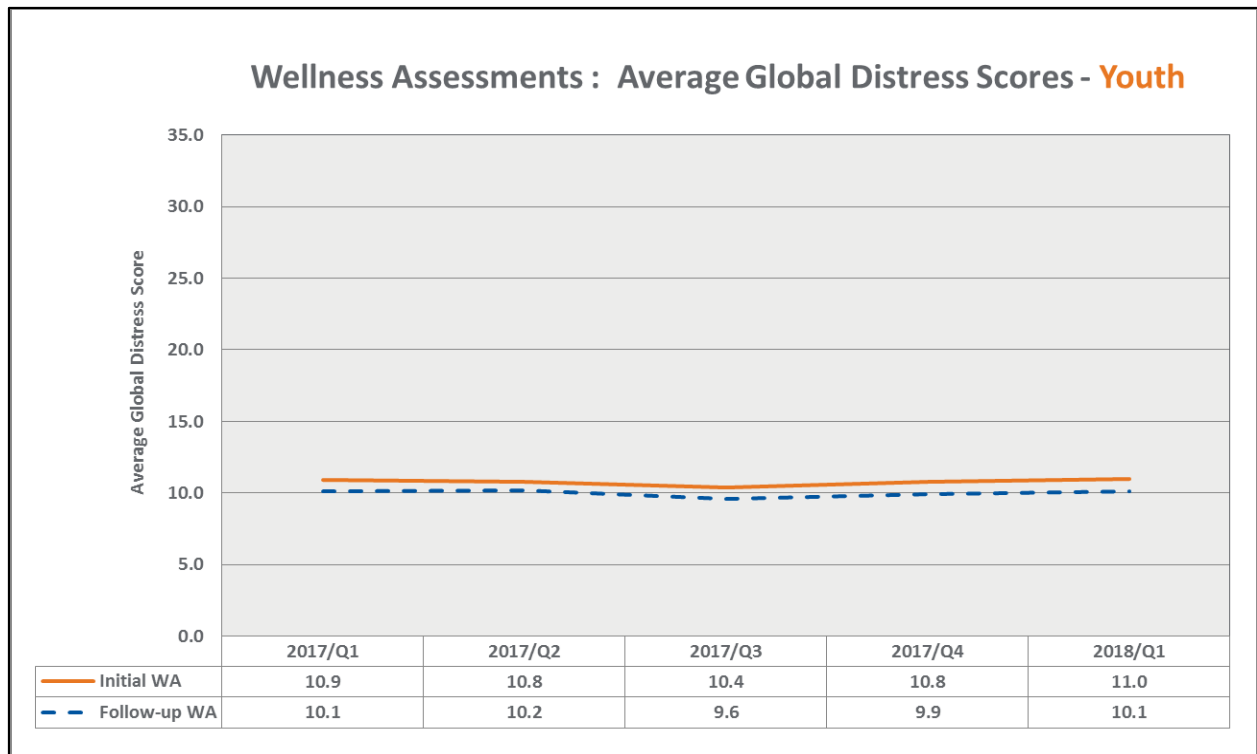


Figure 2

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: Both initial and follow-up average Caregiver Strain scores improved throughout 2017. Overall severity levels are at the lower end of the moderate score range, but the 5% increase in Q1 2018 will be monitored.

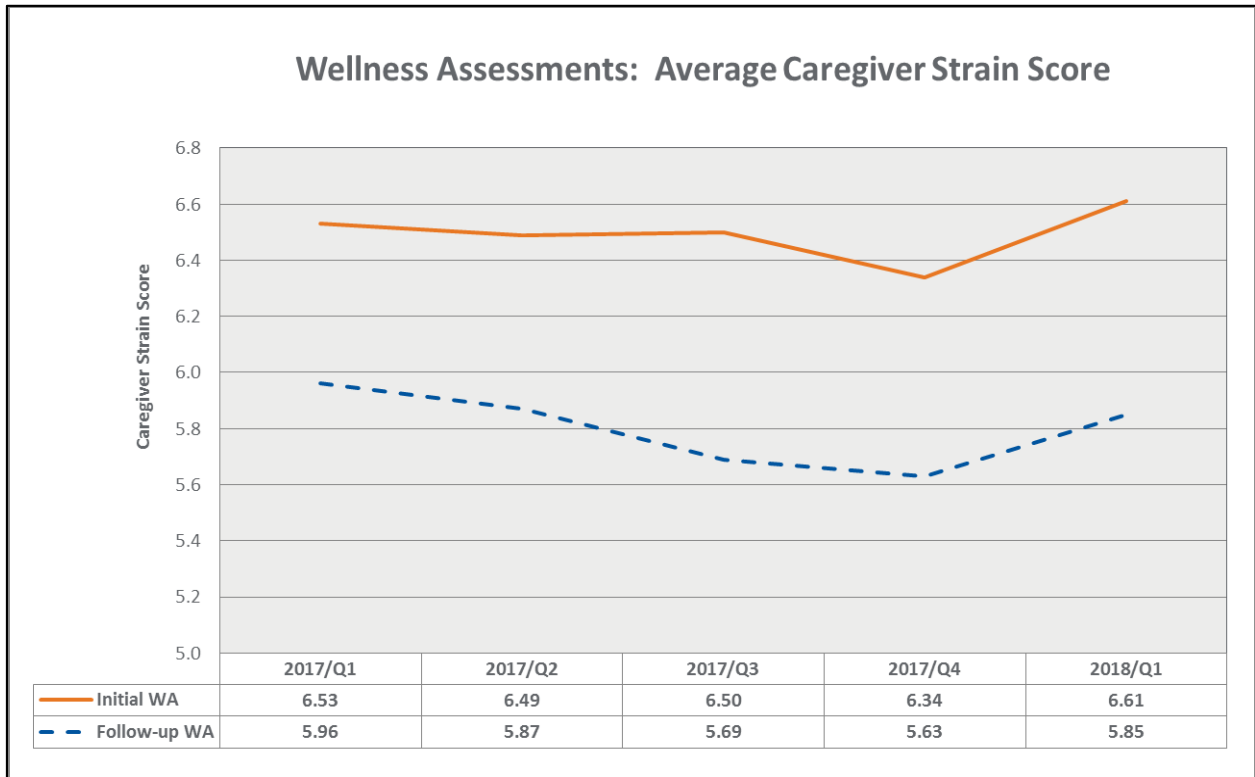


Figure 3

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.

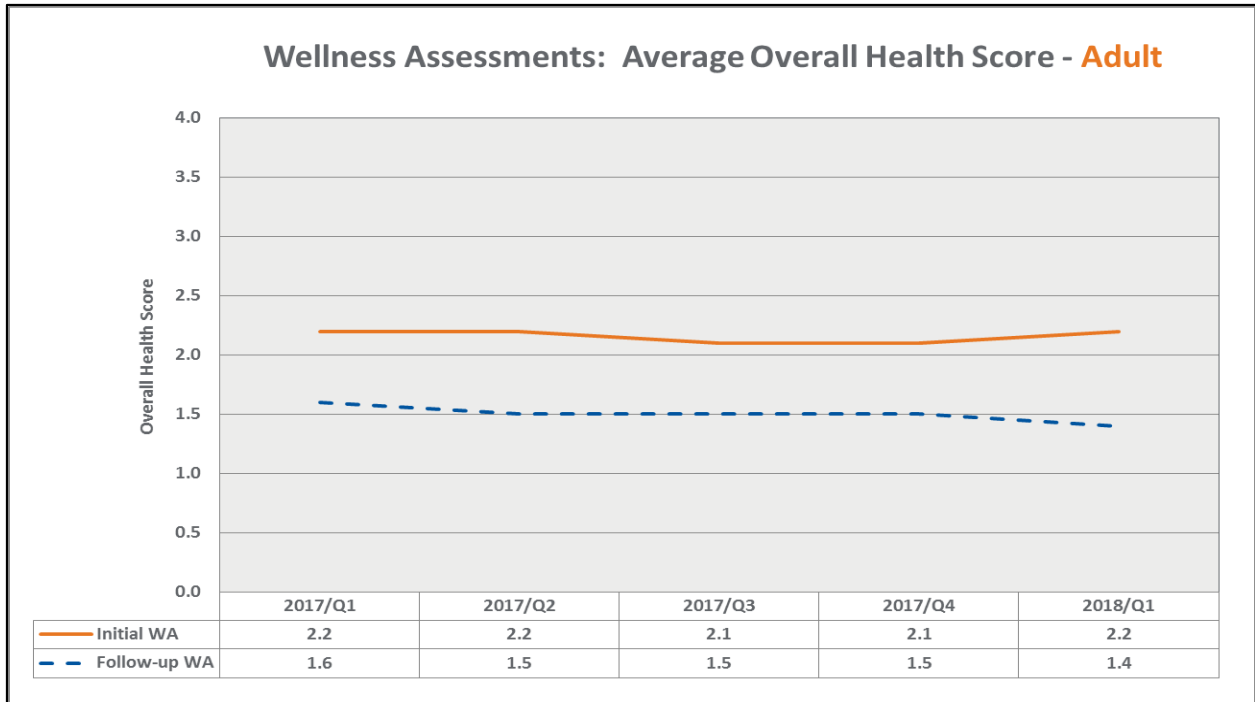


Figure 4

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 Q1 2017 through Q1 2018, 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.

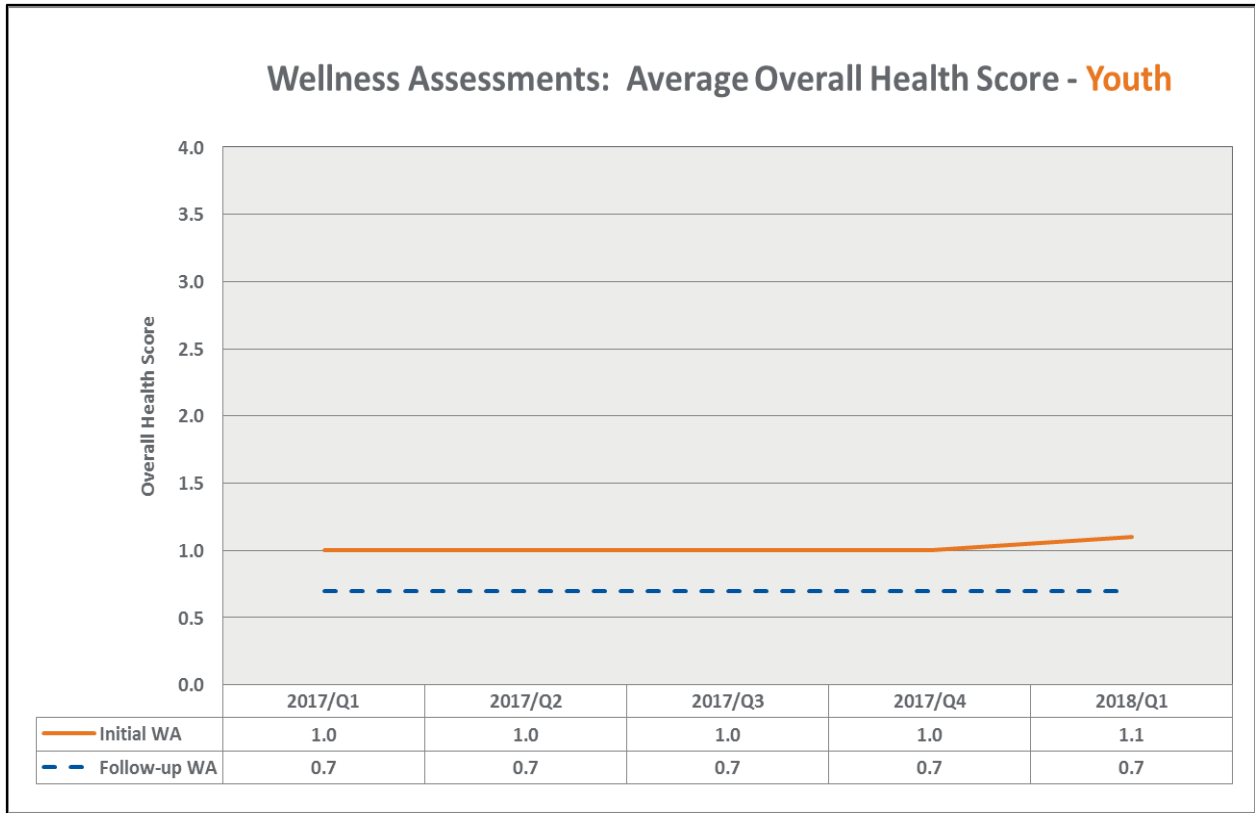


Figure 5

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 increased 1.9% from Q4 2016 to Q4 2017. Year-over-year utilization up for youth and young adults, but was slightly down for the over-21 population.

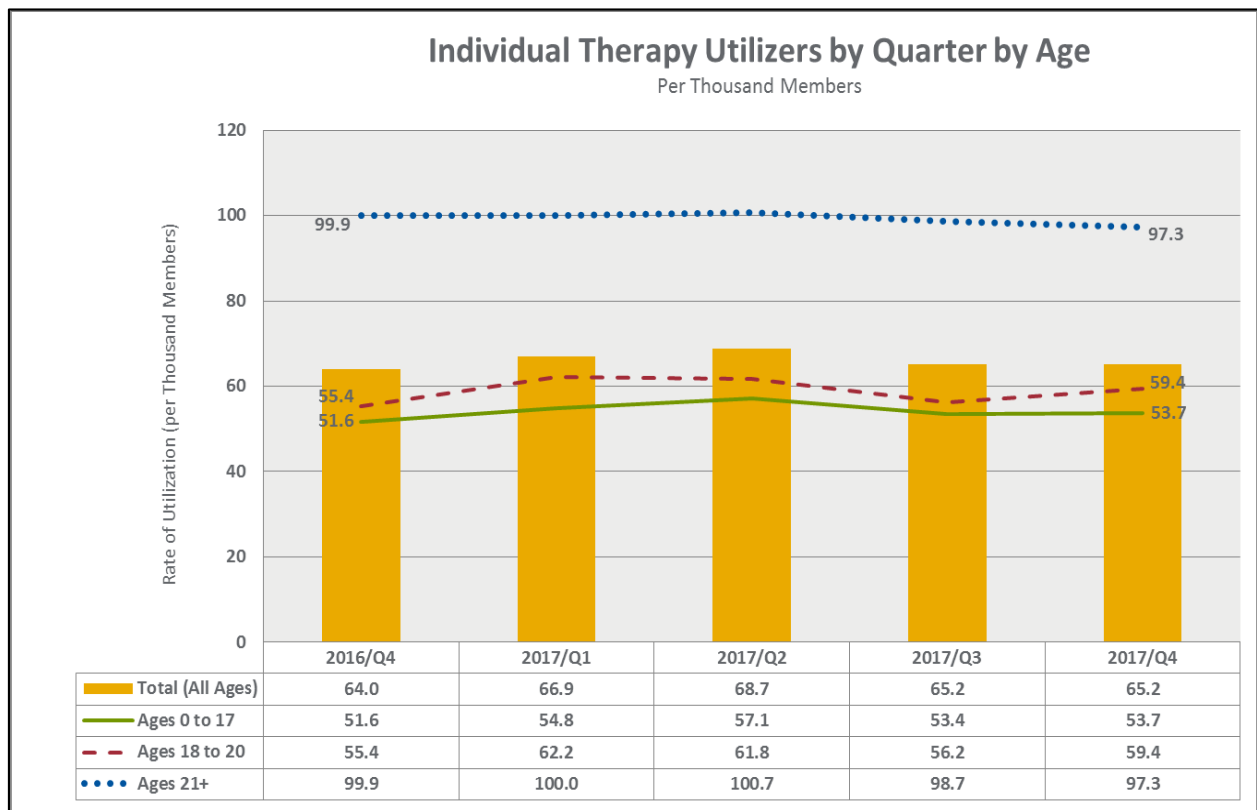


Figure 6

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: On average, the utilization rate of Family Therapy is consistent from Q3 2016 to Q4 2017, notwithstanding a slight increase, then subsequent decrease, during 2017.

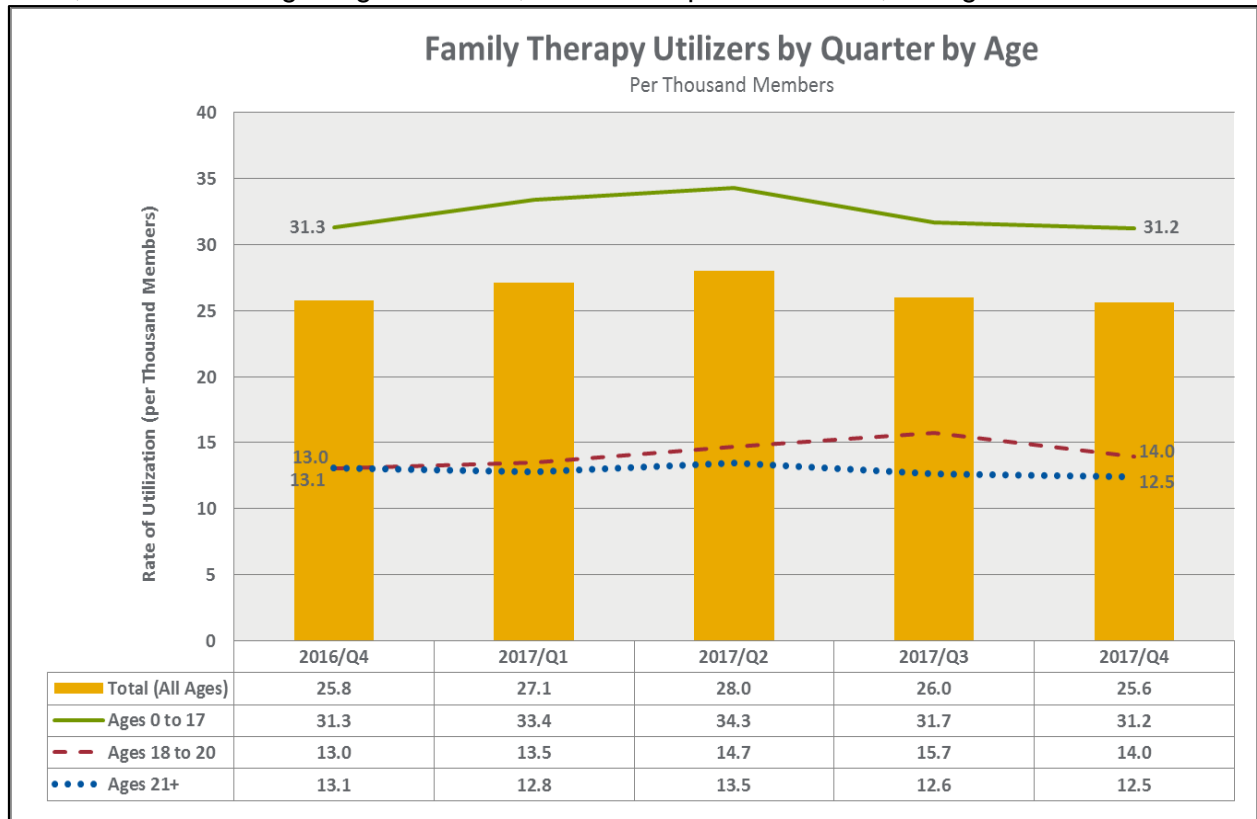


Figure 7

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 Q4 2017 utilization for Peer Support increased 55% and 49% respectively. This positive trend correlates with Optum’s changes in Peer Support utilization management and with increased community and provider training and awareness efforts.

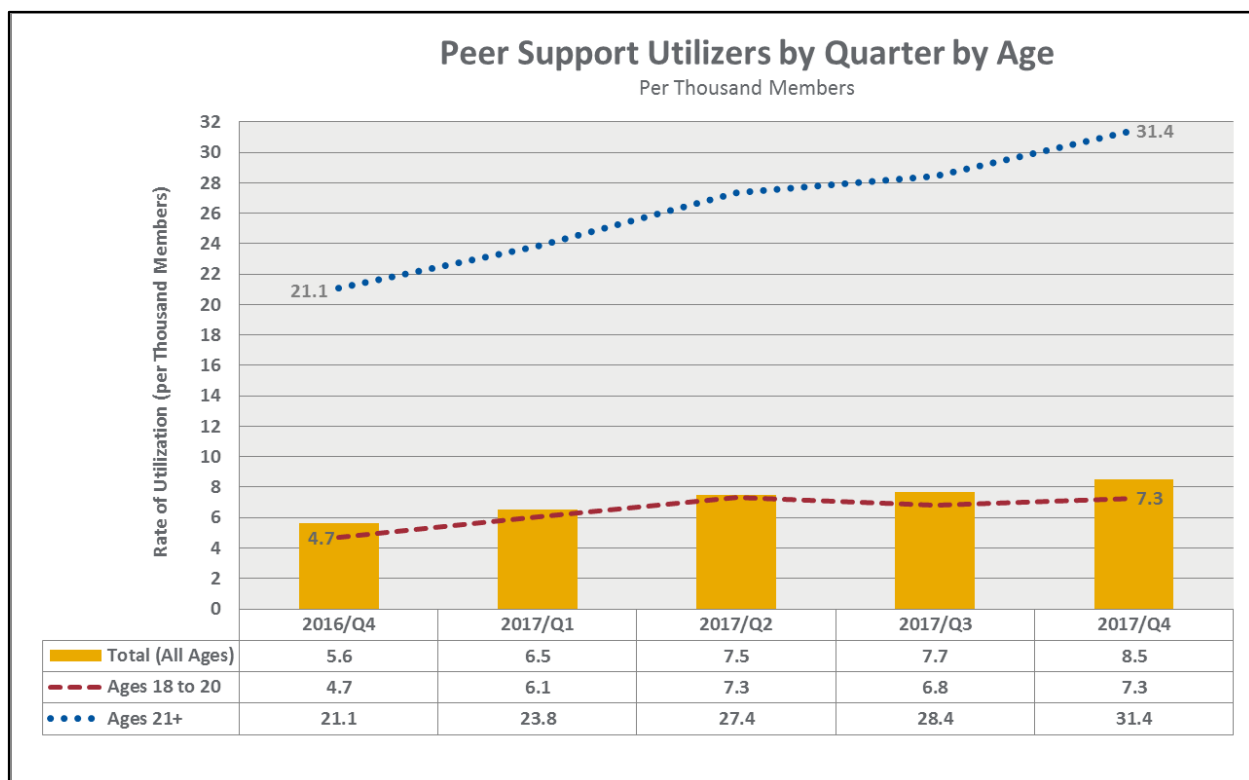


Figure 8

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 for young adults 18-20 is up slightly (~1%), but are down approximately 1-2% for Children & Youth and adults over 21.

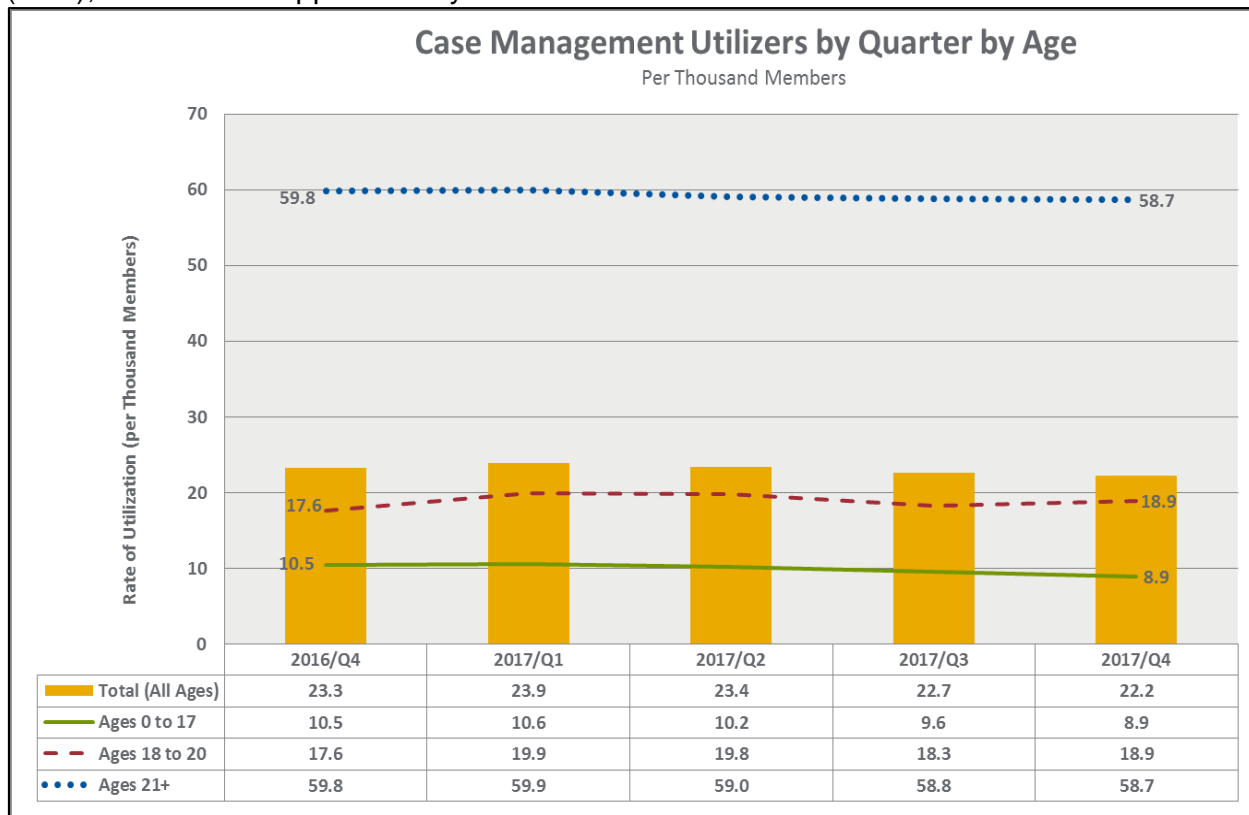


Figure 9

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 Q4 2017, albeit with an increase and subsequent decrease during 2017 within the 18-20 population.

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.

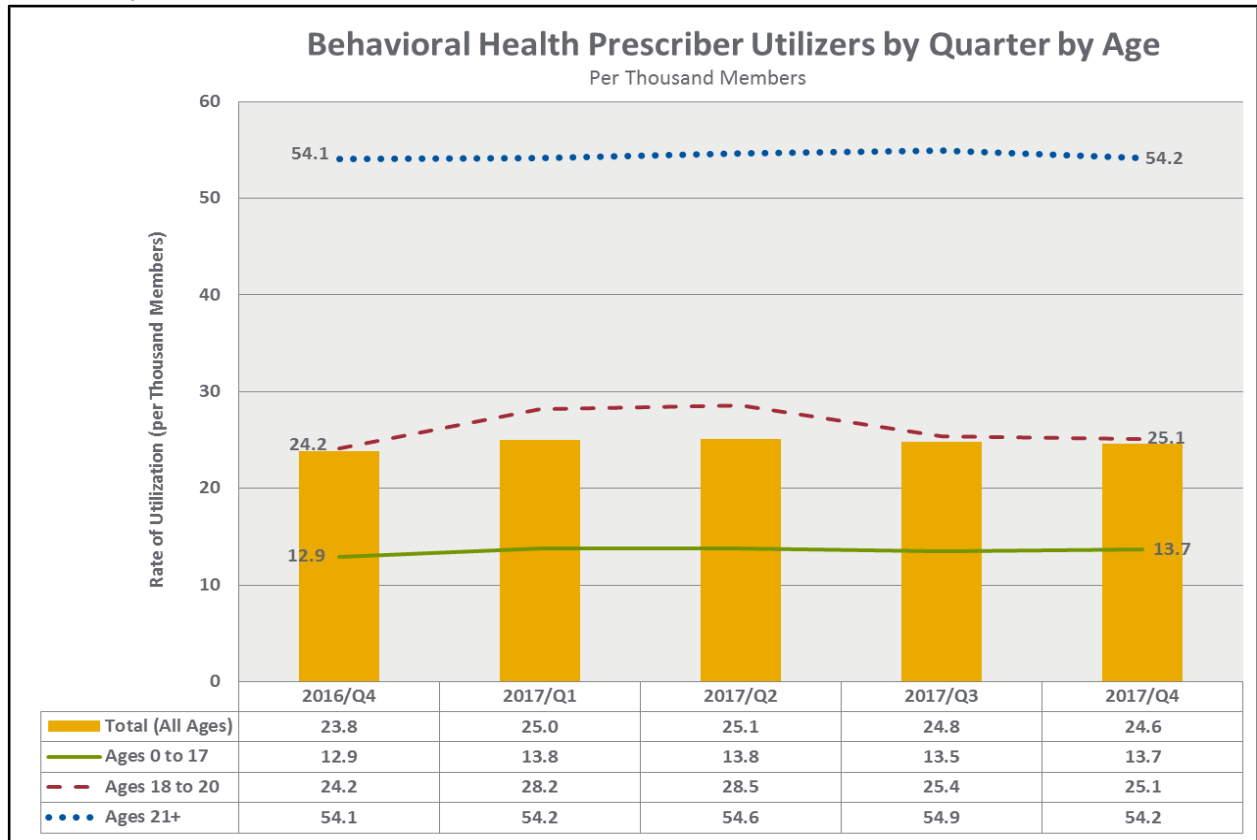


Figure 10

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 Q4 2016 and Q4 2017, the reduction in CBRS for all age groups combined was 43%. 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 52%, 53%, and 42% respectively within the study period. These changes have sustained a more clinically appropriate use of CBRS for the different age groups.

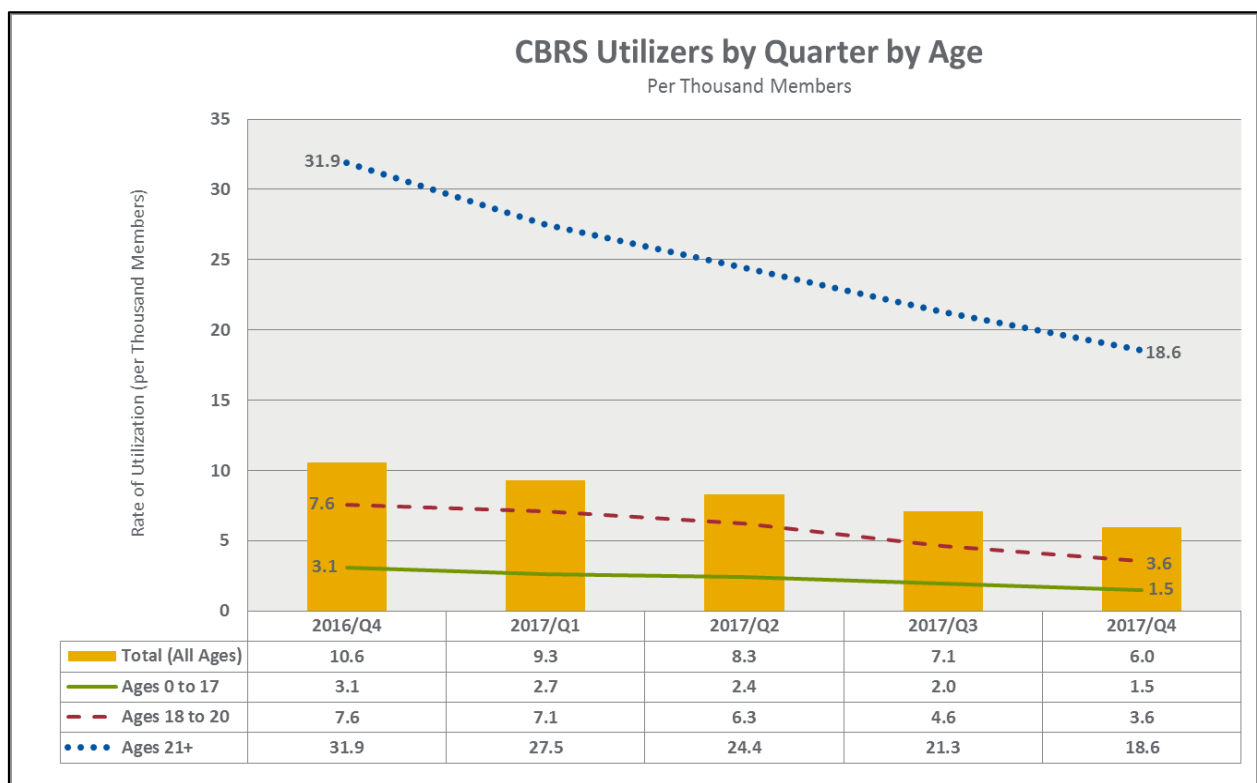


Figure 11

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: 96.3% of members who received an ABD for CBRS services in Q4 2017 received evidenced-based therapeutic services within 90 days of the ABD. This is up from 90.2% 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.

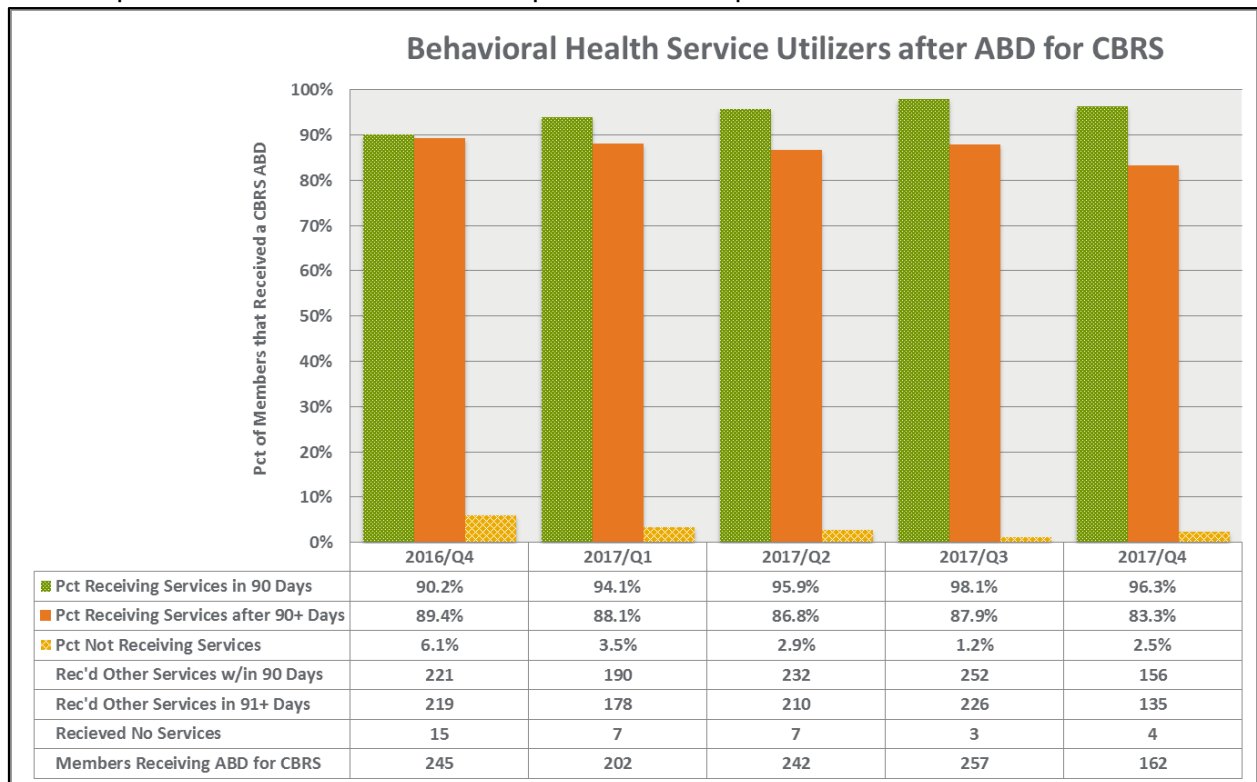


Figure 12

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.

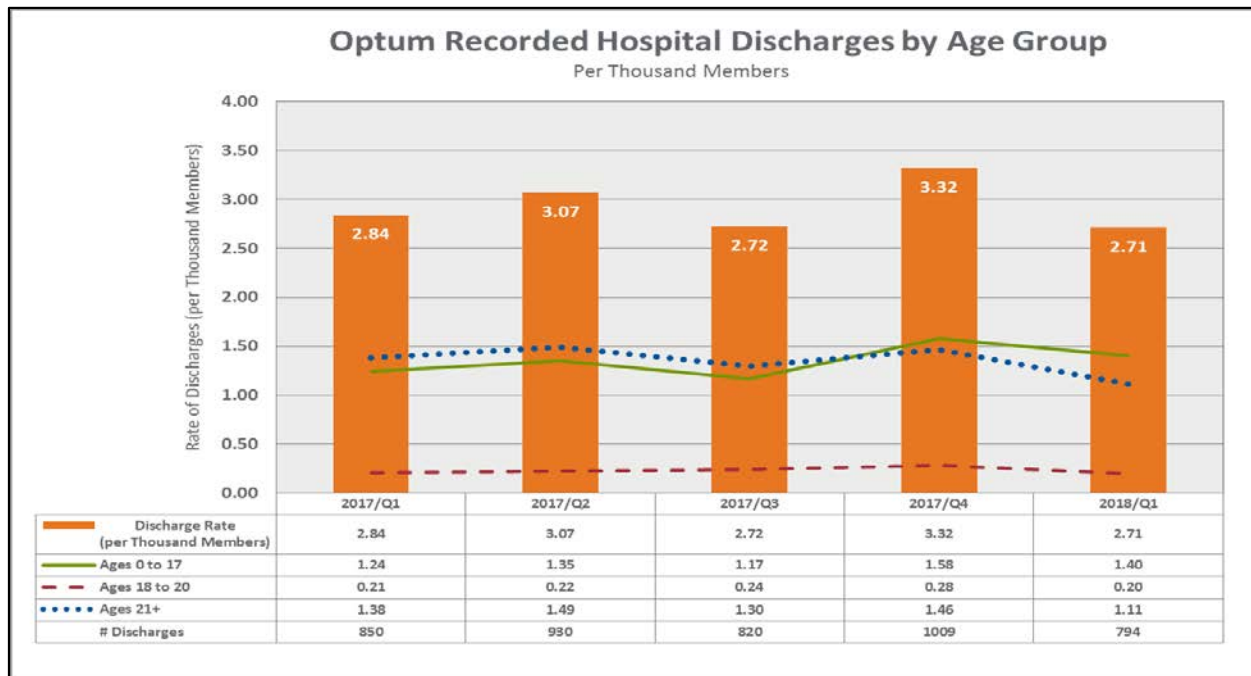


Figure 13

Figure 13 shows the overall rate of discharges decreased year-over-year from 2.84 to 2.71 per 1,000 members, which represents a 1% increase in hospitalizations, notwithstanding temporary rises in the discharge rate in Q2 and Q4 2017.

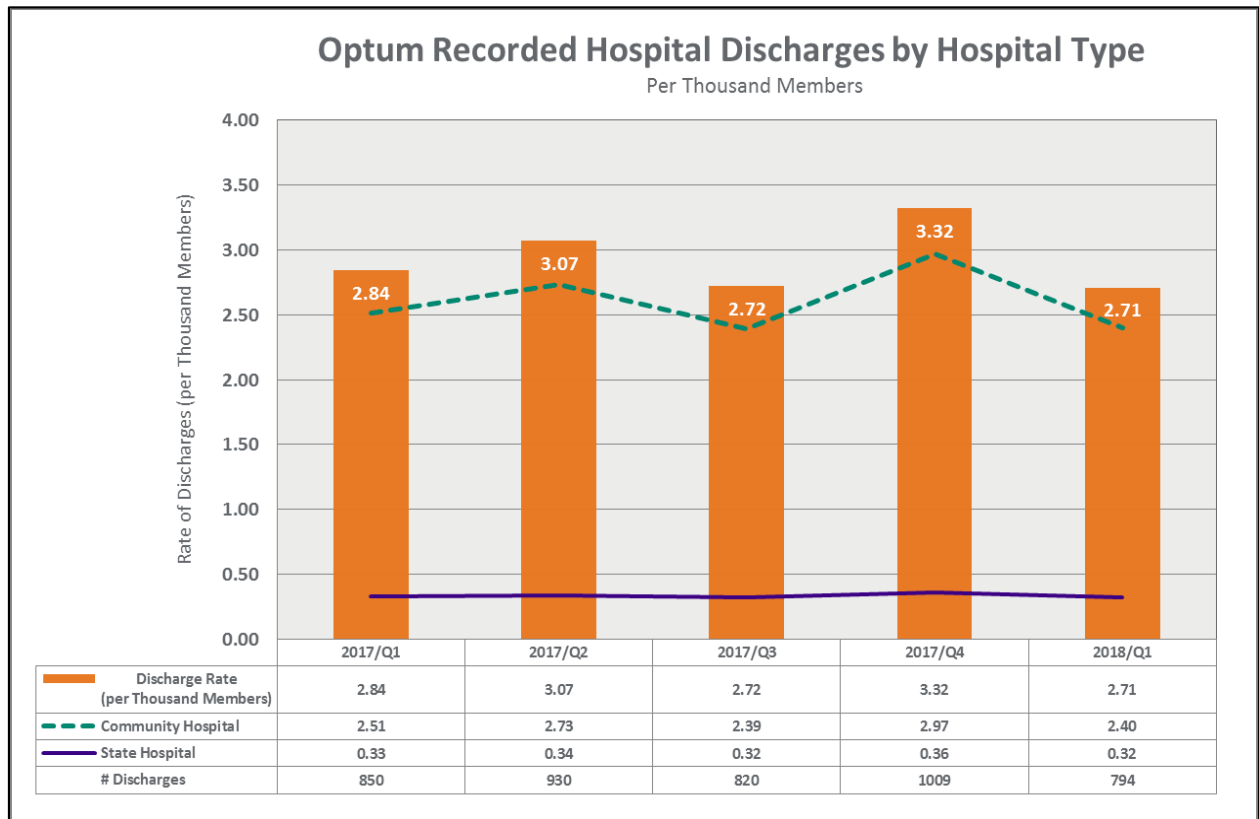


Figure 14

Figure 14 shows that during the study period from Q1 2017 through Q1 2018, discharges were consistent over time for both the State and Community hospitals, notwithstanding temporary increases in Q2 and Q4 2017 in the latter.

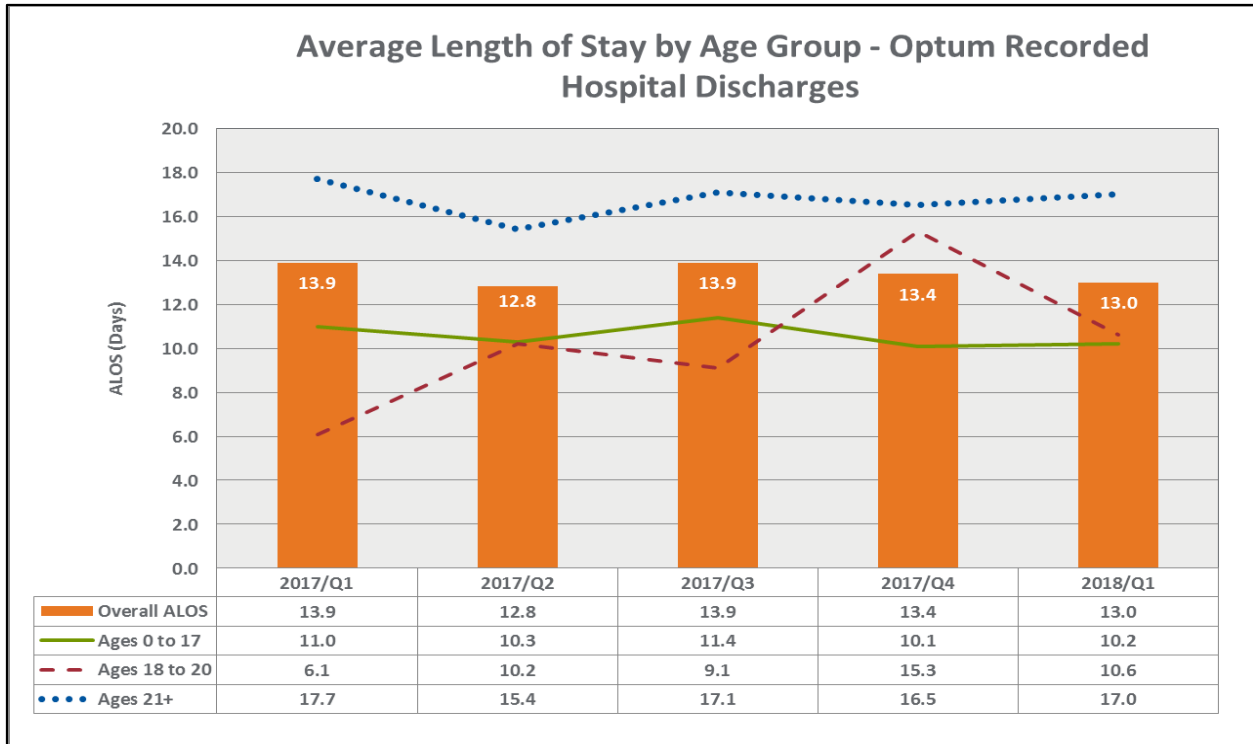


Figure 15

Figure 15 indicates that from Q1 2017 through Q1 2018, based on information reported to Optum Idaho from hospitals, the overall average length of stay was down by 6%. The 18-20 age group experienced an offsetting trend, and has 74% longer stays than a year ago.

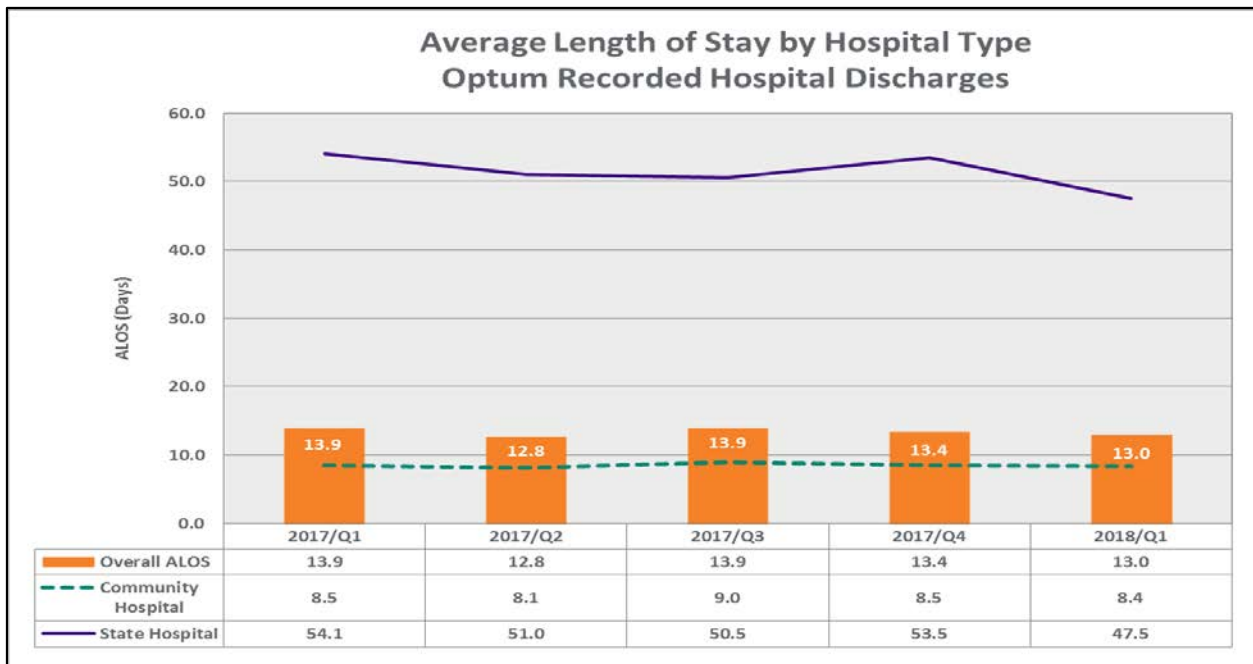


Figure 16

Figure 16 shows the average length of stay by hospital type. Both State and Community hospital rates vary from quarter to quarter, but on the whole, are down slightly over the five-quarter study period.

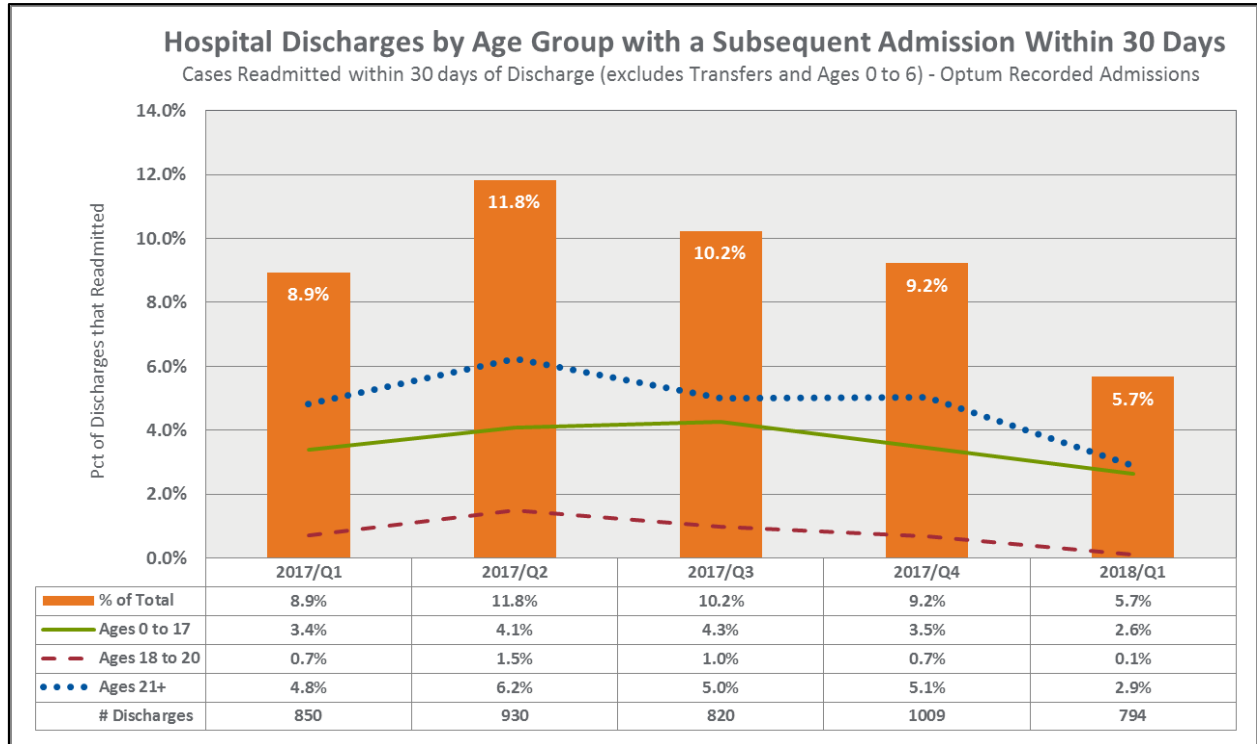


Figure 17

Figure 17 shows that during the study period from Q1 2017 through Q1 2018, readmissions decreased 36% year-over-year and sequentially across the four 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.

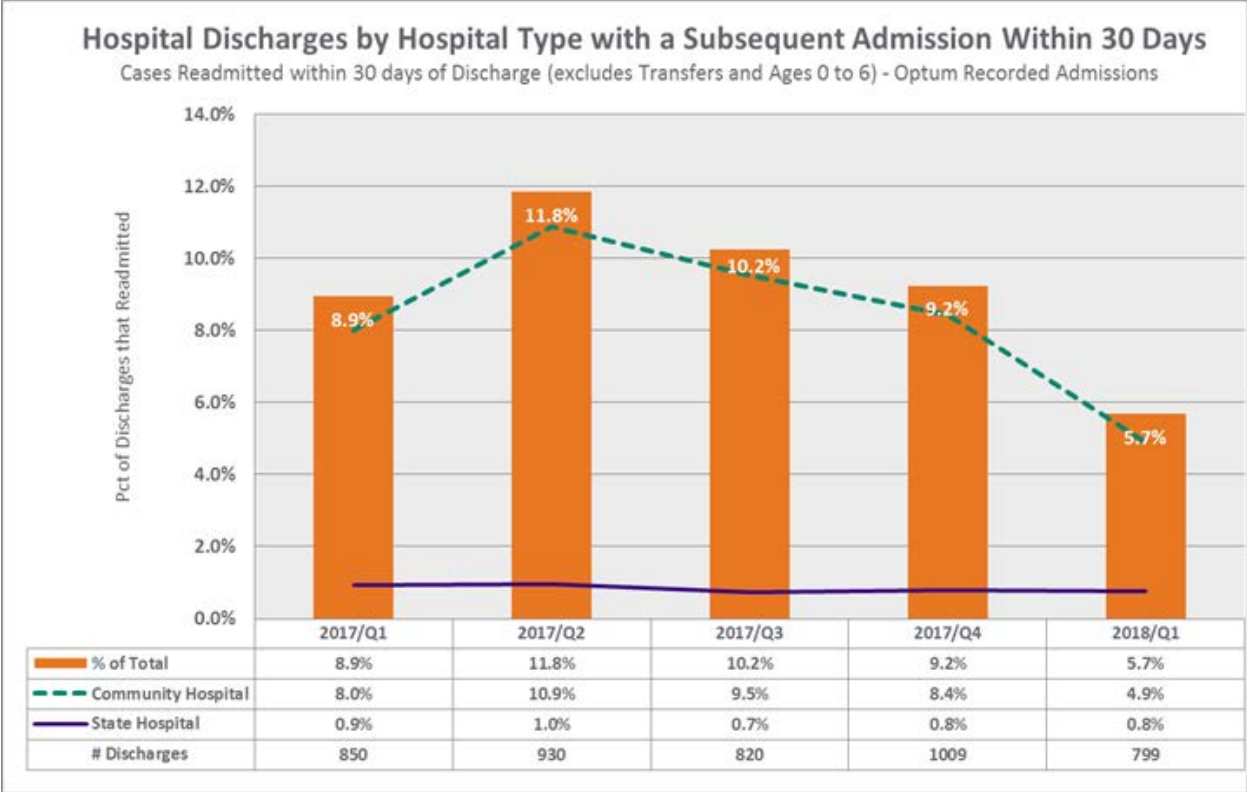


Figure 18

Figure 18 shows readmissions percentages by hospital type. During the study period from Q1 2017 through Q1 2018, the readmission rate for state hospitals was flat and was down 34.4% for community hospitals, notwithstanding a Q3 2017 increase and subsequent improvement in the latter.

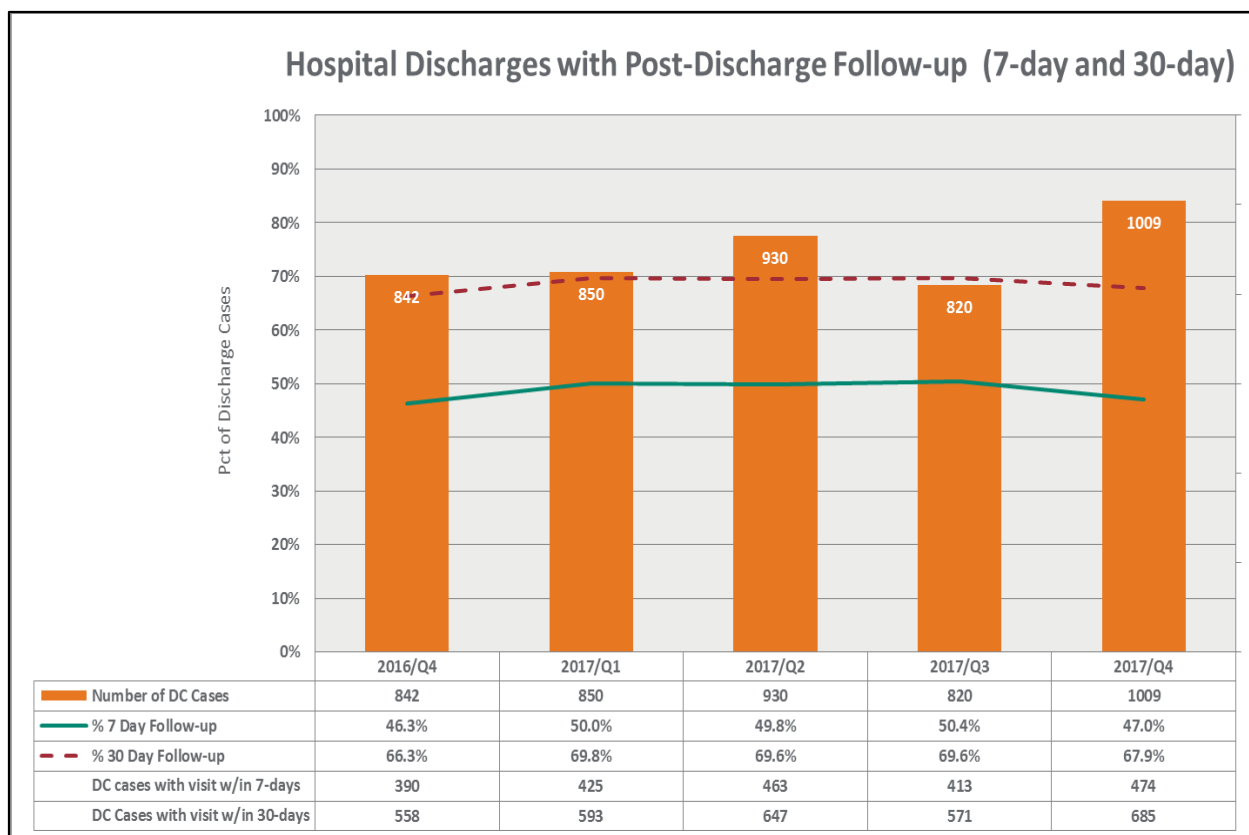


Figure 19

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, notwithstanding the seasonal declines in Q4 of each year.

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

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

Psychiatric Emergency Room Utilization Rates

Methodology: Psychiatric Emergency Room utilization data was provided by IDHW. 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 July 2017—the most recent for which data is available—emergency room utilization had trended upwards from March, and then declined to lower levels in June and July

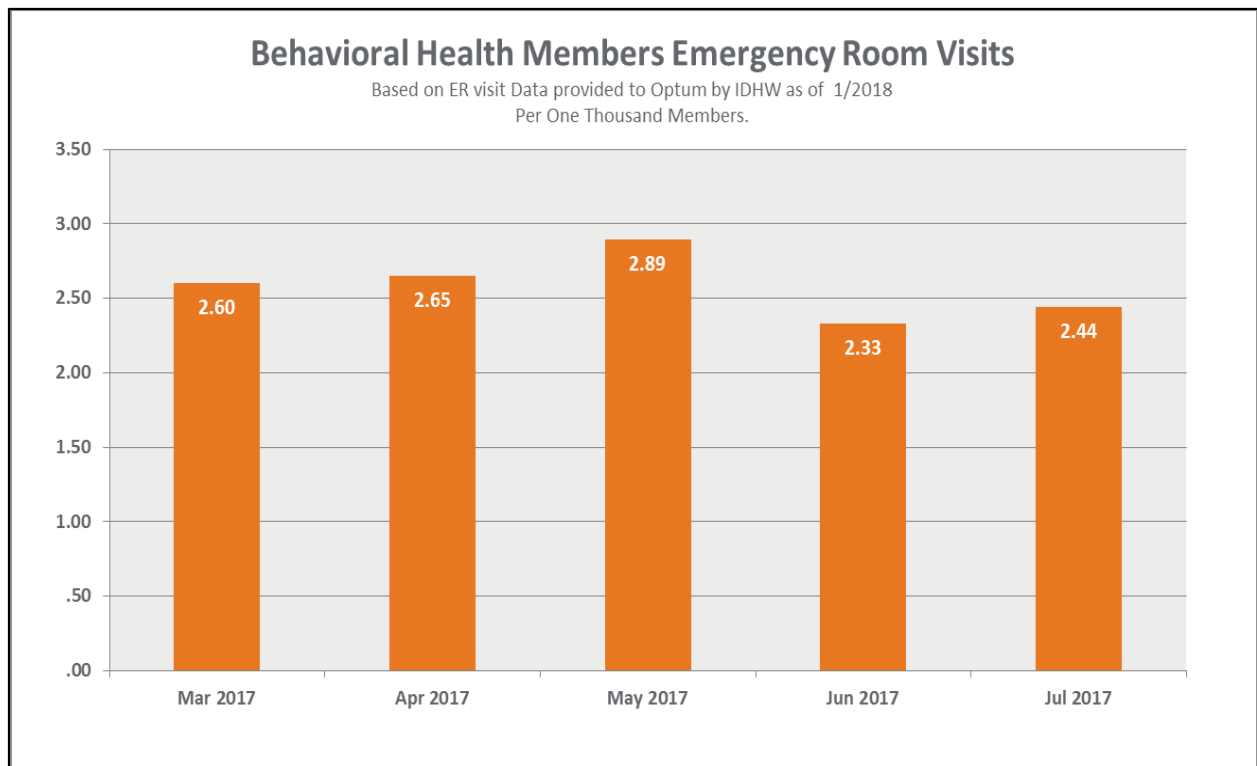


Figure 20

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.

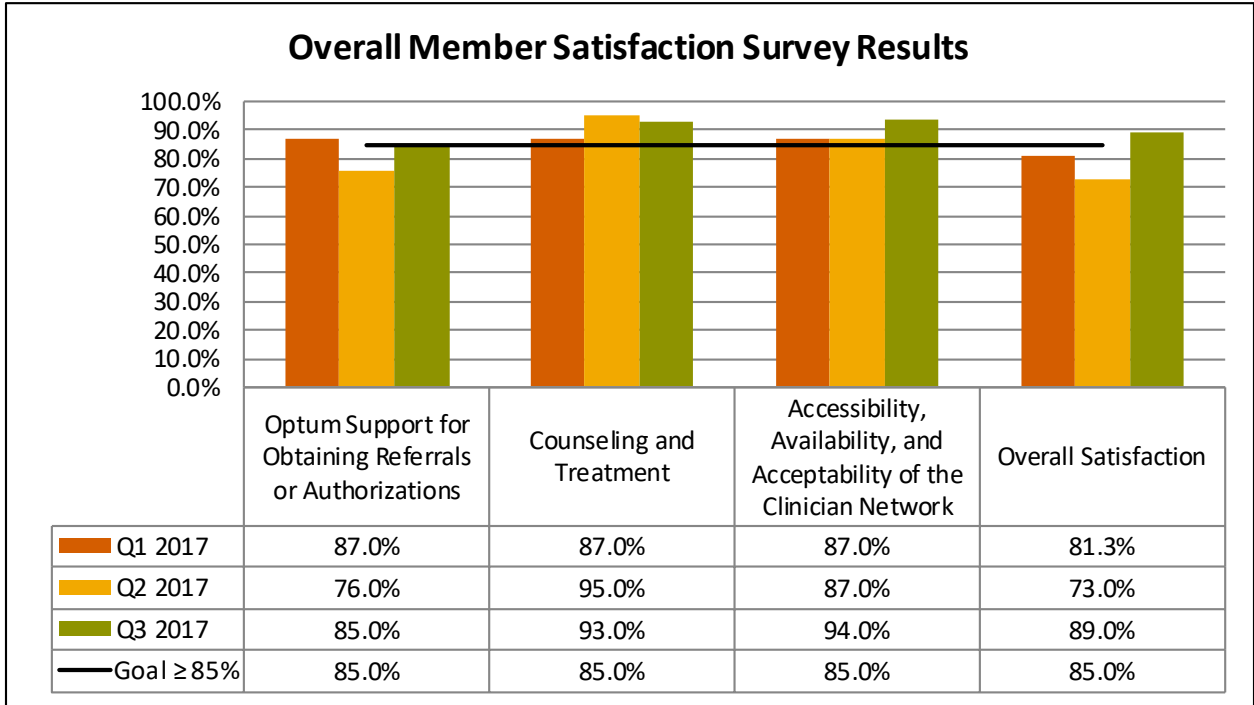
The survey includes questions about the member’s experience with Optum and in treatment. The survey targets satisfaction in the following domains:

- 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

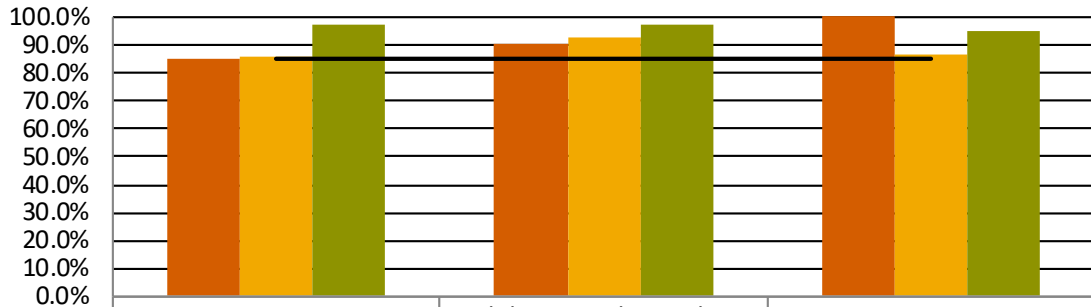
Key Consumer Measures	Q1 2017	Q2 2017	Q3 2017	YTD
Overall Satisfaction (Goal: ≥85.0%)	81.3%	73.0%	89.0%	79.0%
Optum support for obtaining referrals or authorizations	87.0%	76.0%	85.0%	83.0%
Accessibility, availability, and acceptability of the clinician network	87.0%	87.0%	94.0%	89.0%
Counseling and Treatment	87.0%	95.0%	93.0%	94.0%
Net Promoter Score (NPS): How likely it is that you would recommend Optum to a friend or colleague?	4	12	37	14

Promoters	41%	45%	57%	46%
Passives	21%	23%	23%	22%
Detractors	37%	33%	20%	32%



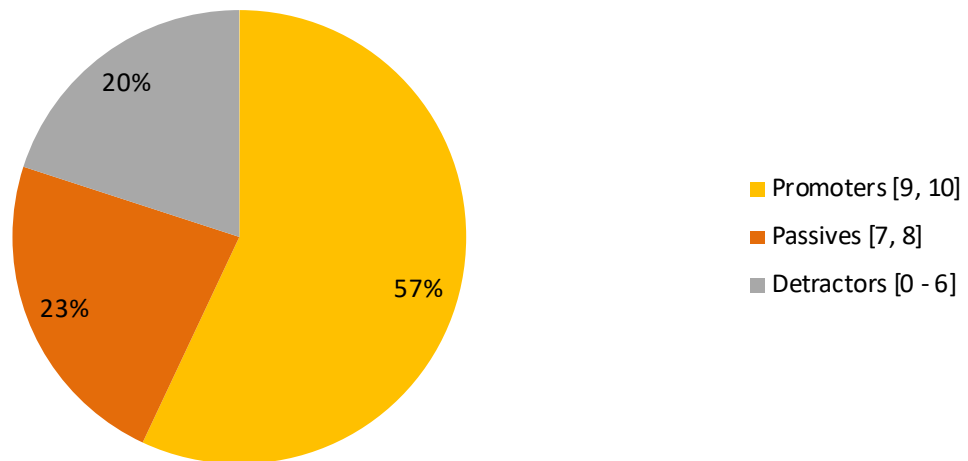
In addition, the Member Satisfaction Survey includes specific questions related to the member’s experiences with counseling and treatment. The results are in the graph, “Member Experience with Counseling or Treatment”, below.

Member Experience with Counseling or Treatment



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

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: 37



Analysis: The Quarter 3, 2017, results for Optum Idaho included surveys conducted from October 1, 2017, through December 31, 2017. The total number of members who responded to the survey was 44 and the response rate was 14%. 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 89.0% an increase from 73.0% during Q2. The Net Promotor Score was 37 which was an increase from 13 during Q2; Promotors – 57%, Passives 23%, and Detractors, 20%.

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

The goal of the research design of the Provider Satisfaction Survey is to provide representative and reliable measurement of providers' experiences with, attitudes toward, and suggestions for Optum Idaho. Fact Finders, Inc. is an independent health research company and conducts the survey for Optum.

Methodology: Optum Idaho forwarded to Fact Finders a database comprising all providers currently in the Optum Idaho provider network. The survey was designed to contact every provider to give them an opportunity to participate in the research.

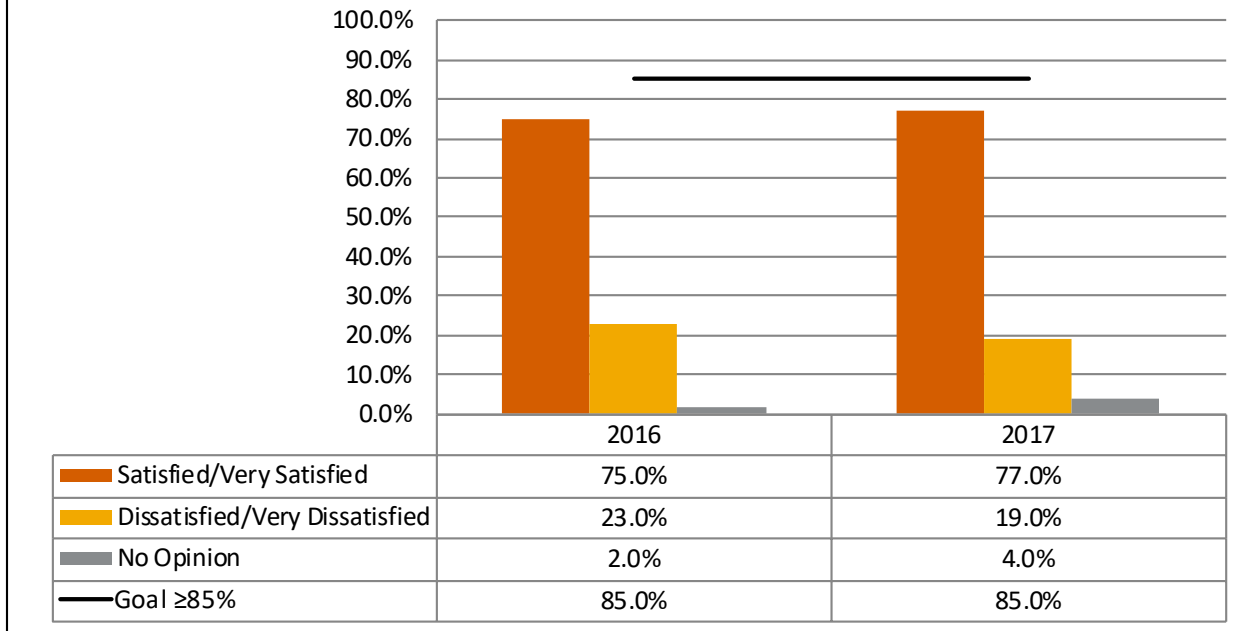
All of the data collection was conducted by Fact Finders. Fact Finders reached out to every provider. To accommodate the schedules of busy providers and include in the research as many of the providers as possible, a multi-stage, multi-mode coordinated data collection effort was employed. As soon as 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: There was a 27% response rate to the 2017 Survey. Overall satisfaction for 2017 was 77.0%, an increase from 75.0% during 2016.

Provider Overall Satisfaction with Optum



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

Opportunities and Interventions: Action plans for 2018 include:

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

Performance Improvement

A continuous quality improvement (CQI) process is embedded within the structure of Optum Idaho's QI program to review contractual requirements. The CQI process provides the mechanism by which improvement projects and initiatives are developed so that barriers to delivering optimal behavioral health care and services can be identified, opportunities prioritized, and interventions implemented and evaluated for their effectiveness in improving performance. The Optum Idaho quality committee structure routinely oversees and monitors projects to include Community Health Initiatives (CHI) as well as improvement projects related to contract and operational initiatives. All improvement initiatives and projects are reviewed by the Optum Idaho QAPI committee on a monthly basis.

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"> • Provider meet and greet trainings in progress across the state. • Fee schedule build in progress.
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 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.	Clinical & Services Advisory Committee	Green	<ul style="list-style-type: none"> • Received finalized proposal from new Vendor. • Roll out dates to be determined.

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"> •Received draft training modules from Altarum. • Medicaid, Providers, internal staff reviewing the training modules. • Revising Respite LOCG's to include information about medication, outline that services must be on PCP.
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"> •All tasks completed. When 3 newly contracted agencies have successfully billed, project will be closed. •Regional Network Managers outreaching to providers to discuss why claims have not been submitted; troubleshoot concerns.
Prior Authorization Parity II	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 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.	Clinical-UM	Green	<ul style="list-style-type: none"> •Grid of all existing and new services created and being used in parity meetings. •Review of the state's PT/OT/ST service supports our use of threshold review and outlier management.
Person Centered Plan	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	Operations	Green	<ul style="list-style-type: none"> •PCP Manager developing process to disseminate fact sheets to members/families. •Fee schedule transitioned to separate project: case consultation. •PDF template released to DBH for use.

Project	Description	Department/Committee Oversight	Status	Key Accomplishments
	<p>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>School-Based Behavioral Health Care</p>	<p>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.</p>	<p>Clinical-UM</p>	<p>Green</p>	<ul style="list-style-type: none"> •Communication of travel modifier to Terry Reilly and Real Solutions as they have already begun providing services.
<p>Community Funding for ACEs Survey</p>	<p>Collect the baseline data for the state of Idaho regarding scores on ACEs 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.</p>	<p>Recovery & Resiliency</p>	<p>Green</p>	<ul style="list-style-type: none"> •Working with ICTF on details regarding communication from all parties.

Project	Description	Department/Committee Oversight	Status	Key Accomplishments
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"> • Collaborative discussion on increasing the funding amount and rules.
Child & Youth Skills Building	This project will meet the need to implement Skills Building as a part of the Youth Empowerment Services (YES) project. YES services for children will offer a more robust continuum of care for children and adolescents. Skills Building is a YES defined service that focuses on member's identified functional needs. Moving forward, we want to promote a teaming approach with the member's behavioral health care team. Optum Idaho will partner with multiple established clinical research and educational organizations using several phased iterations of training. These trainings will focus on Skills Building intervention trainings that address the 5 most prevalent SED diagnostic groups in Idaho (Trauma, ADHD, Conduct Disorder, Depression, Anxiety).	Clinical-UM	Green	<ul style="list-style-type: none"> • Agreement from PRA to partner with Optum ID on provider training teaming approach. • CHI request is ready pending final details from REACH and PRA.
Adult Skills Building	To promote a comprehensive continuum of care for adults, we have identified an opportunity to efficiently and effectively utilize Skill Interventions to enhance the system of care. This project will increase access to Skill Interventions for Adults with SPMI and SMI as defined by 42 CFR 483.102(b)(1) and IDHW. This will	Clinical-UM	Yellow	<ul style="list-style-type: none"> • Draft ANSA form developed to be attached to the Service Request Form. • Decision to offer conference call to any interested providers to gauge provider interest.

Project	Description	Department/Committee Oversight	Status	Key Accomplishments
	<p>be a pilot project for 6 months that introduces the Life Functioning Domain of the Adult Needs and Strengths Assessment (ANSA) tool that providers will use to identify Functional Needs to build a rehabilitation plan with specific Skill Interventions, and document the progress or outcome of the intervention for each functional need.</p>			
<p>Infant Toddler Behavioral Health</p>	<p>The goal of this project is to enhance workforce development by providing an educational opportunity to providers in strengthening their skills in the Infant Toddler Behavioral Health arena, which is focused on Members age 5 and under having a history of trauma, neglect, and anxiety resulting in developmental pauses. Optum will create infrastructure and offer training for the Michigan Association for Infant Mental Health (MI-AIMH) credentialing process in conjunction with a contracting organization for providers to become subject matter experts and service providers in Infant Toddler Behavioral Health care.</p>	<p>Clinical-UM</p>	<p>Green</p>	<ul style="list-style-type: none"> • 28 providers completed the early childhood training from Reach. • CHI proposal written and in final stages of review by Optum.
<p>Telemental Health</p>	<p>A project team will research TMH to detail state and federal regulations (including HIPAA), licensure requirements, technical elements and contract requirements that impact expansion of the services. The team will engage the Provider Advisory Committee to structure the appropriate utilization in Idaho and a means to pilot the services. Steps to operationalize the plan will be detailed and completed, communicating the plan to the Provider Network and</p>	<p>Network</p>	<p>Green</p>	<ul style="list-style-type: none"> • Developing project plan.

Project	Description	Department/Committee Oversight	Status	Key Accomplishments
	stakeholders. The project will also provide education and visibility on current allowed services to expand utilization.			

Project Closures

Project	Description	Department Oversight	Status	Key Accomplishments
Prior Authorization Parity I	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 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.	Clinical-UM	Closed	<ul style="list-style-type: none"> • Claim audit successful.

Analysis: During Quarter 1, there were 13 projects in progress (including 2 PIPs). One (1) project was closed.

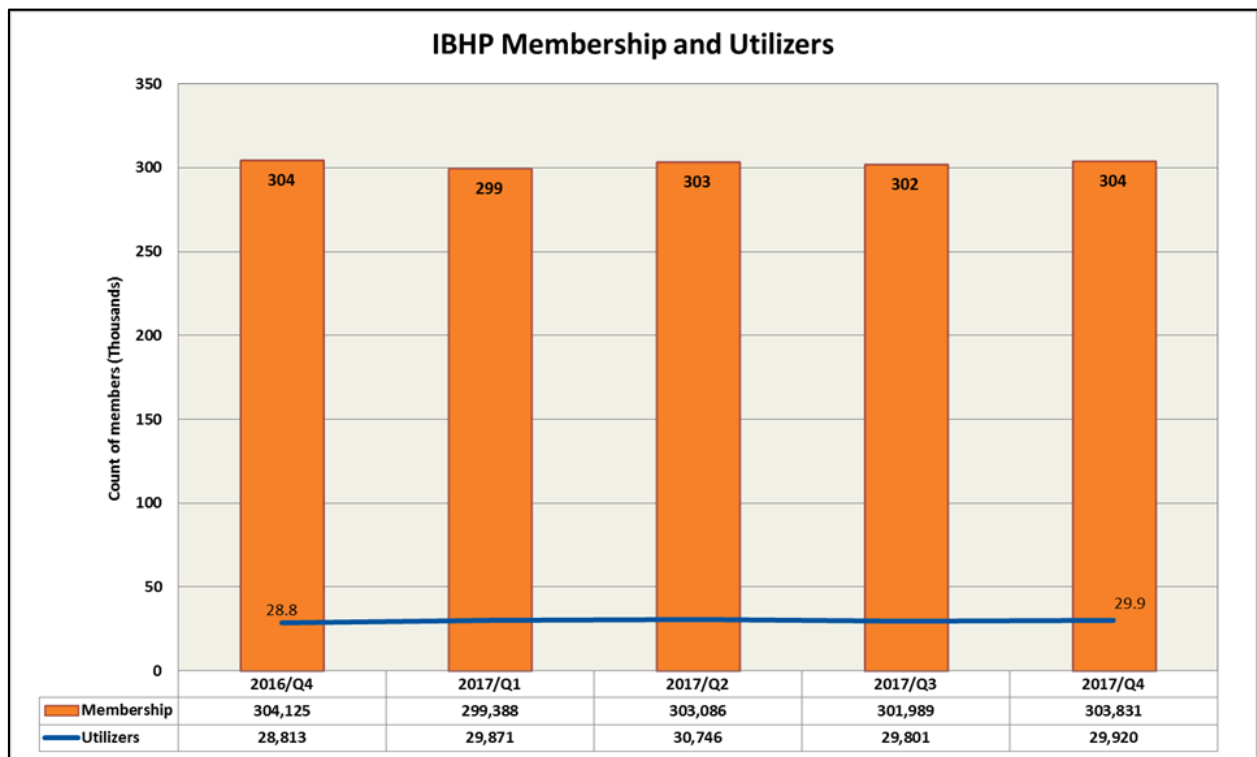
Barriers: Based on the above analysis, no barriers were identified.

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 increased 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

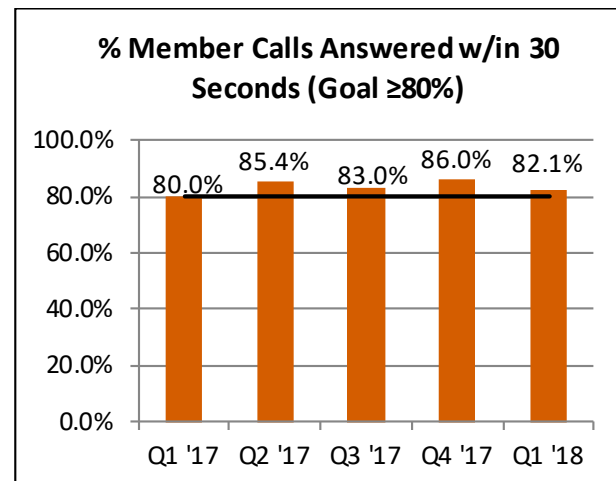
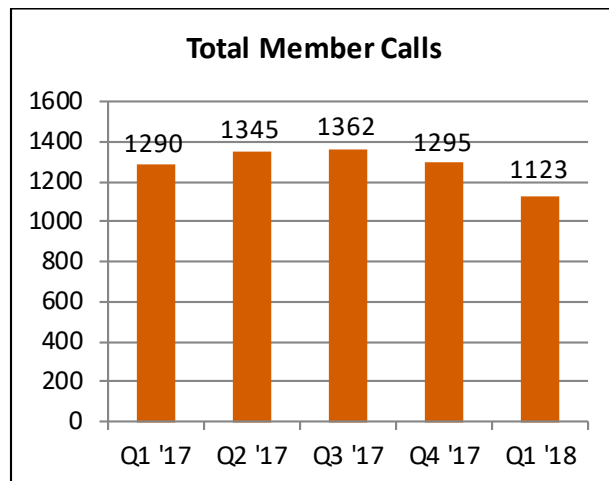
Methodology: Optum Idaho provides access to care 24 hours a day, seven days a week, 365 days per year through our toll-free Member Access and Crisis Line. This line is answered by a team of Masters-level behavioral health clinicians who are trained to assess the member’s needs, provide counseling as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

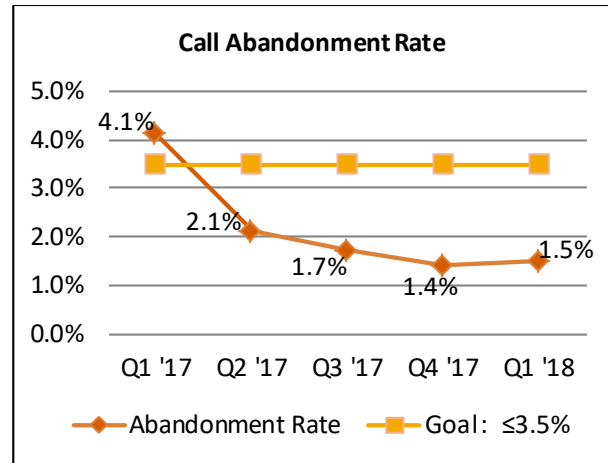
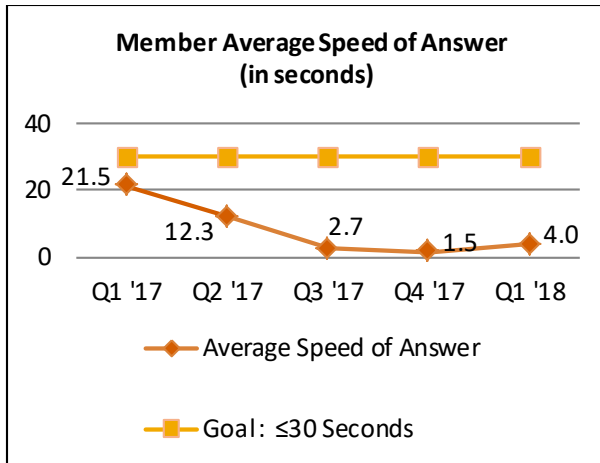
To ensure member’s needs are met in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to answer (120 seconds) and call abandoned rate ($\leq 7\%$). Data source is Avaya’s Communication system (ProtoCall).

Quarterly Performance Results

Member Service Line	Optum Idaho Standards	IBHP Contract Standards	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Total Number of Calls	NA	NA	1,290	1,345	1,362	1,295	1,123
Percent of Calls Answered Within 30 Sec	≥80.0%	None	80.0%	85.4%	83.0%	86.0%	82.1%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	21.5 sec	12.3 sec	2.7 sec	1.5 sec	4.0 sec
Abandonment Rate	≤3.5%	≤7%	4.1%	2.1%	1.7%	1.4%	1.5%

Analysis: During Q1, the Member Services and Crisis Line received a total of 1,123 calls. During the same period of time, 82.1% of calls were answered within 30 seconds (goal ≥80%). The average speed to answer was met at 4.0 seconds. The call abandoned rate was 1.5% 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

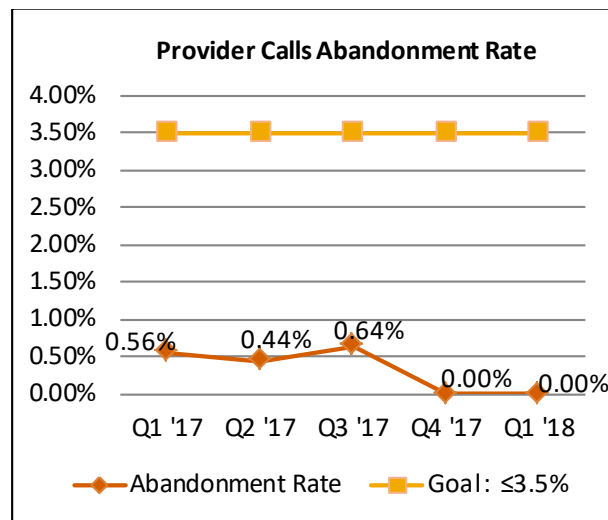
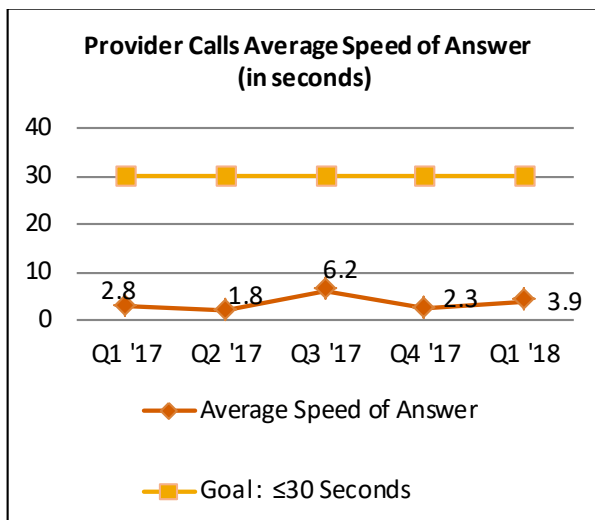
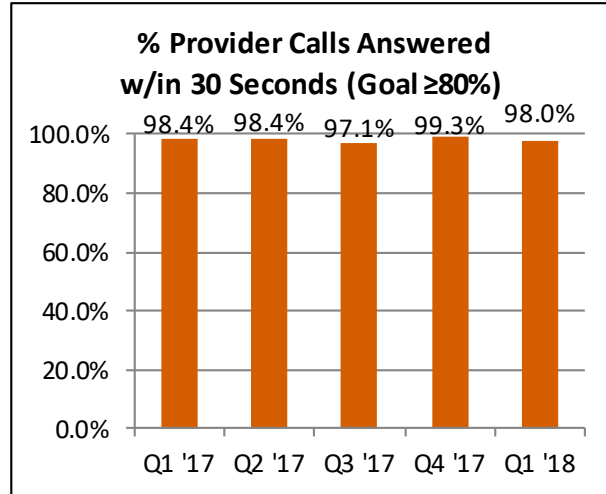
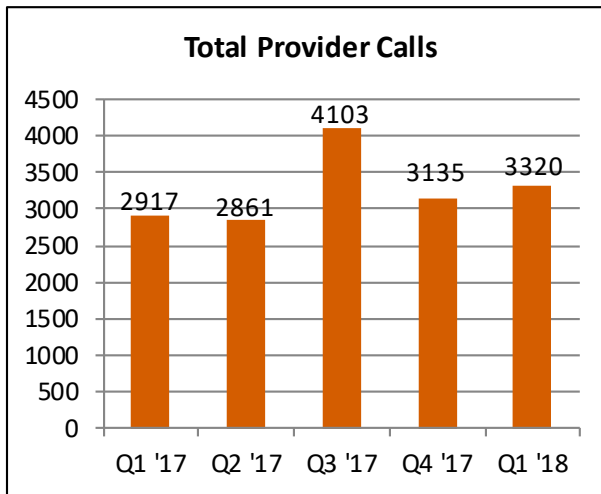
Methodology: The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho. To ensure the needs of our providers and stakeholders are met in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual 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	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Total Number of Calls	NA	NA	2,917	2,861	4,103	3,135	3,320
Percent of Calls Answered Within 30 Seconds	≥80.0%	None	98.4%	98.4%	97.1%	99.3%	98.0%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	2.8 sec	1.8 sec	6.2 sec	2.3 sec	3.9 sec
Abandonment Rate	≤3.5%	≤7%	0.56%	0.44%	0.64%	0%	0%

Analysis: The total number of Customer Service provider calls during Q1 was 3,320. Customer service call standards met performance goals for all three customer service line measures again during Q1. The percent of calls answered within 30 seconds was at 98.0%, remaining above the goal of ≥80%. The average speed of answer was at 3.9 seconds during Q1, which

continued to meet the goal. The call abandonment rate was 0% continuing to meet both the Optum Idaho internal goal of $\leq 3.5\%$ and the IBHP Contract Standard of $\leq 7\%$.



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

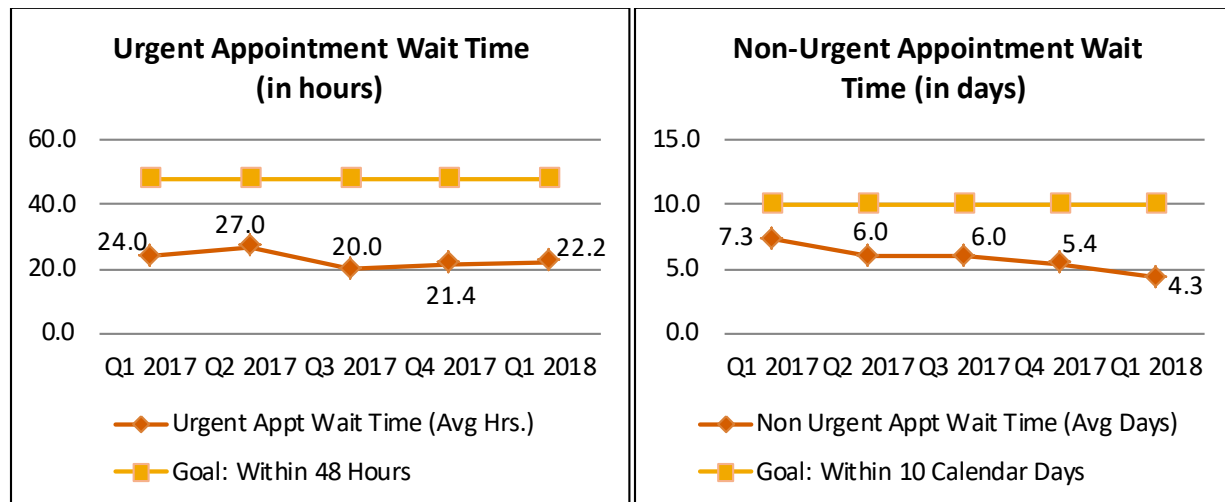
Methodology: As part of Optum Idaho’s Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, Optum developed, maintains, and monitors a network with adequate numbers and types of clinicians and outpatient programs. Optum requires that network providers 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	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Urgent Appointment Wait Time	Within 48 hours from request	24.0 hours	27.0 hours	20.0 hours	21.4 hours	22.2 hours
Non-Urgent Appointment Wait Time	Within 10 days from request	7.3 days	6.0 days	6.0 days	5.4 days	4.3 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. During Q1, the average Urgent Appointment wait time was 22.2 hours. The performance goal for Non-Urgent Appointment wait time is an appointment within 10 days. This goal was again met during Q1 at an average of 4.3 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	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Area 1	(within 30 miles)	100.0%	99.8%	99.8%	100.0%	99.8%	99.8%
Area 2	(within 45 miles)	100.0%	99.8%	99.9%	99.8%	99.8%	99.8%

Analysis: Optum Idaho continued to meet contract availability standards. During Q1, 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

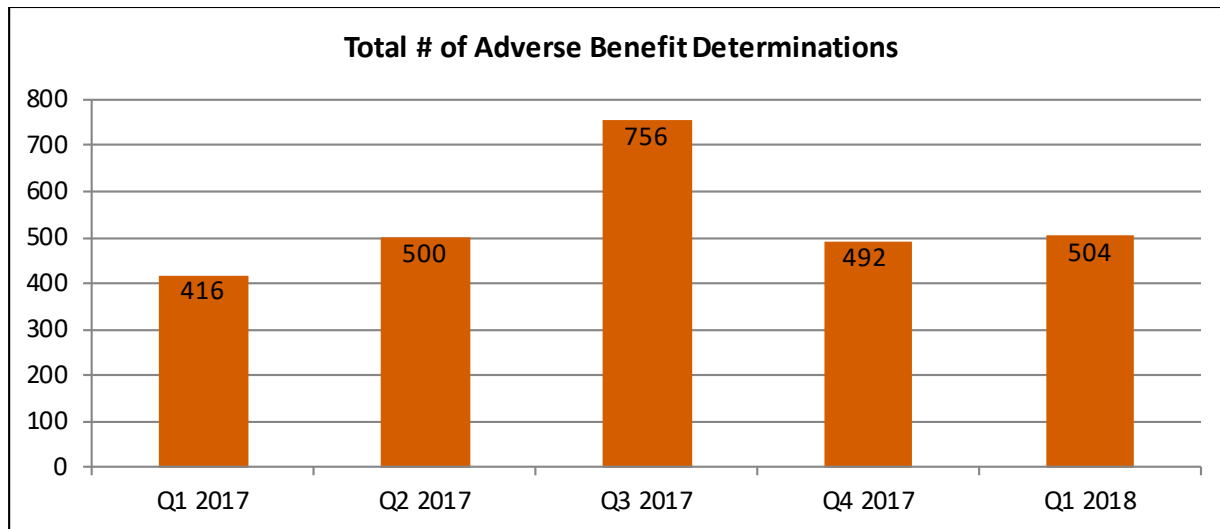
Methodology: Adverse Benefit Determinations (ABD's) are maintained in the Linx database. When a request for services is received, Optum has 14 days to review the case, make a determination to authorize services or deny services in total or in part, and mail the ABD notification if the decision was to 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	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Total # ABD's	NA	NA	416	500	756	492	504
Clinical ABD's	NA	NA	NA	NA	578	352	351
Administrative ABD's	NA	NA	NA	NA	178	140	153
Written Notification	14 calendar days from request for services	NA	NA	NA	100.0% (756/756)	99.8% (491/492)	100.0% (504/504)
Initial Verbal Notification to Provider	1 business day from determination date	100.0%	99.8%	99.6%	No longer tracking	No longer tracking	No longer tracking
Written Notification	1 business day from verbal notification	100.0%	98.3% (409/416)	99.8% (499/500)	New 14 day requirement above	New 14 day requirement above	New 14 day requirement above

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

In Q1, Optum issued 504 ABDs – 351 Clinical and 153 Administrative. All written notifications 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.

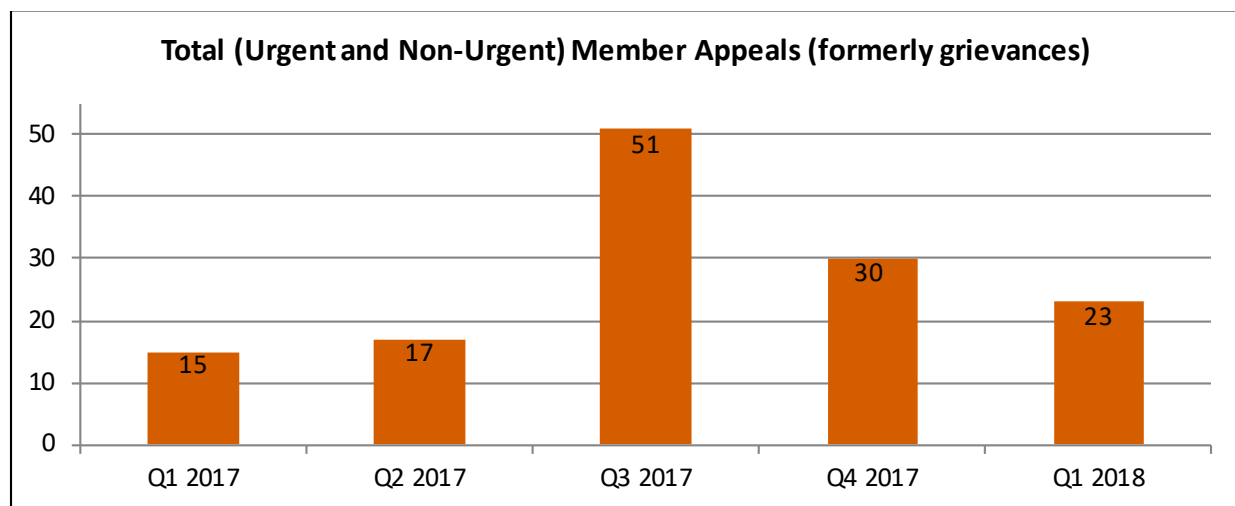
Quarterly Performance Results

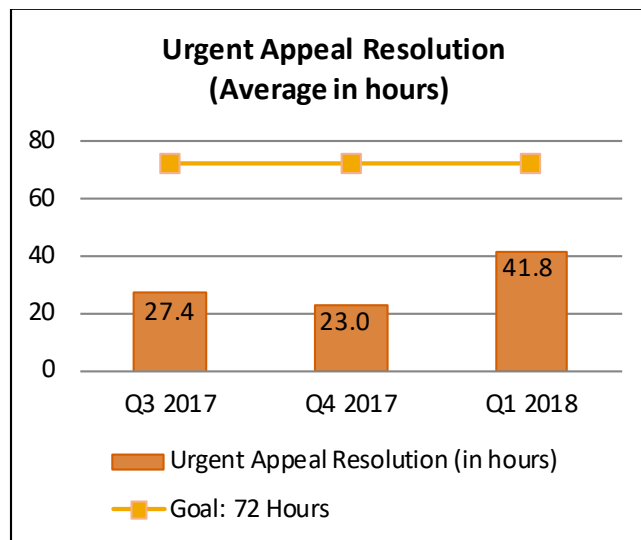
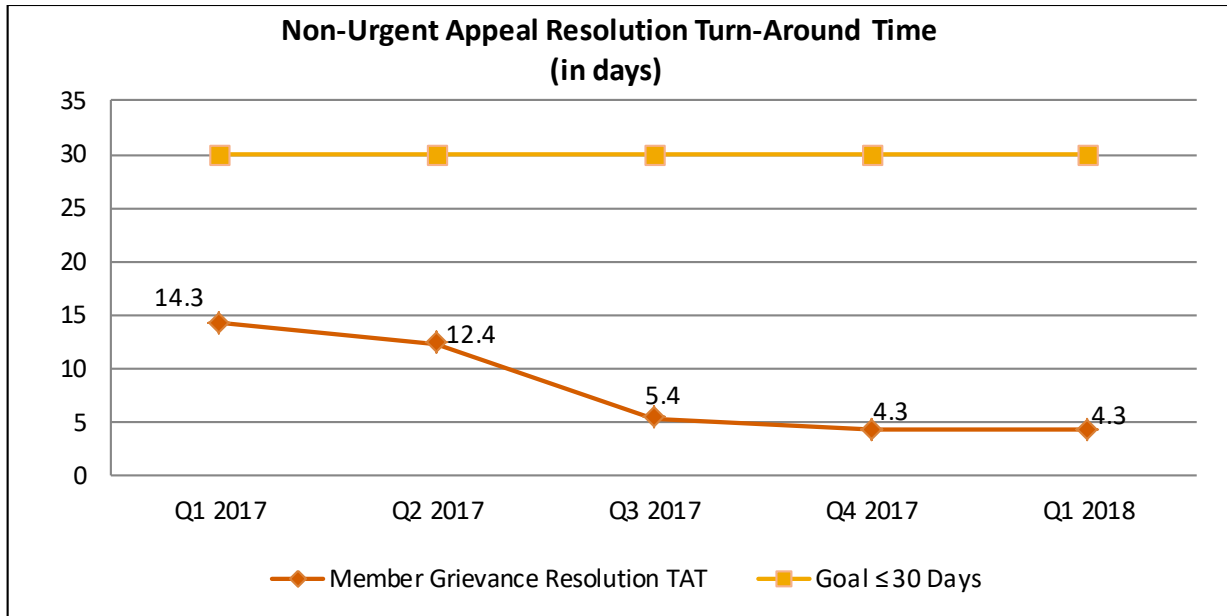
Appeals	Performance Goal	Q4 2016	Q1 2017	Q2 2017
Number of Member Appeals	NA	17	15	17
Average Number of Days to Resolution	30 Days	13.8	14.3	12.4
Number of Overturned Appeals	NA	1	1	1
Number of Partially Overturned Appeals	NA	2	2	0
% of Appeals Overturned or Partially Overturned	NA	17.6%	20.0%	6.0%

Non-Urgent Appeals	Performance Goal	Q3 2017	Q4 2017	Q1 2018	
Total Appeal Determinations	NA	36	26	17	
Acknowledgement Compliance	5 Calendar Days	100.0%	100.0%	100.0%	
Determination Compliance	30 Calendar Days	100.0%	100.0%	100.0%	
Average Days to Resolve	NA	5.4	4.35	4.35	
Overtured Non-Urgent Appeals	NA	4	1	2	
Partially Overtured Non-Urgent Appeals	NA	5	16	10	

Urgent Appeals	Performance Goal	Q3 2017	Q4 2017	Q1 2018	
Total Appeal Determinations	NA	15	4	6	
Determination Compliance	72 Hours	100.0%	100.0%	100.0%	
Average Hours to Resolve	NA	27.4	23.0	41.8	
Overtured Urgent Appeals	NA	7	2	0	
Partially Overtured Urgent Appeals	NA	4	0	5	

Analysis: In Q1, Optum Idaho received 17 non-urgent appeals and 6 urgent appeal requests, for a total of 23 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.

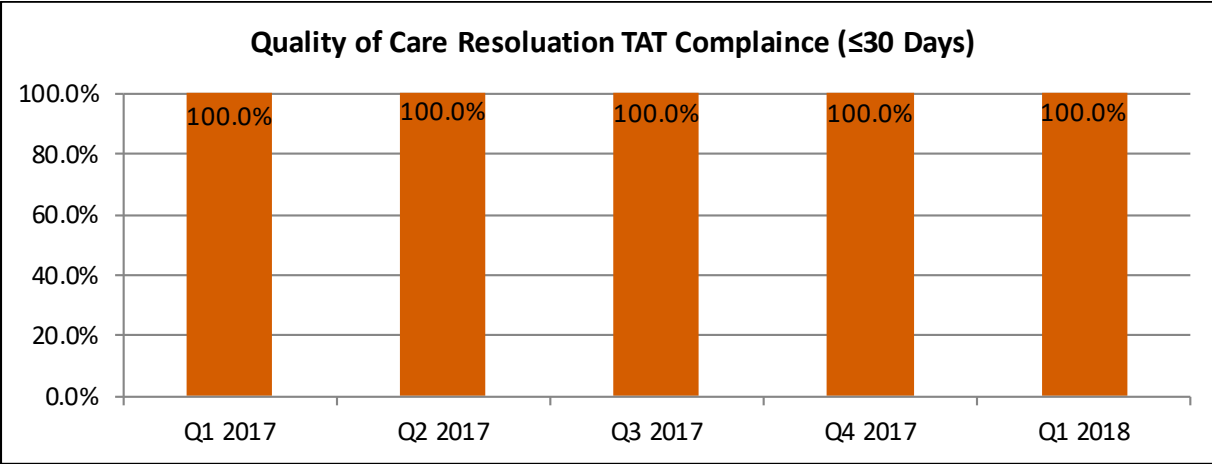
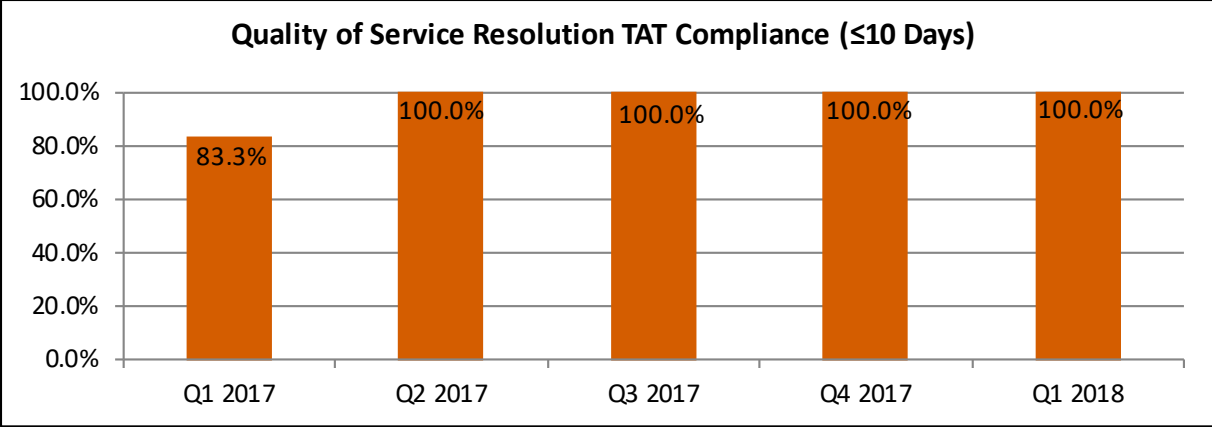
Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for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

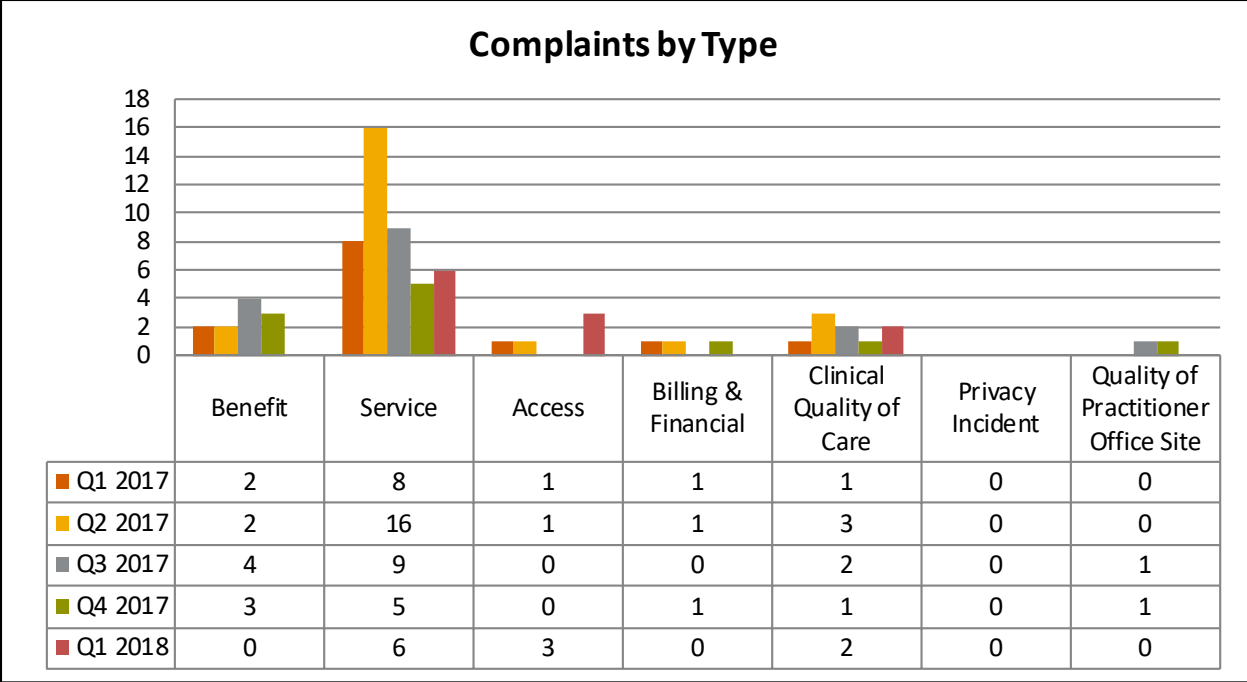
Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Calendar Days

Quarterly Performance Results

Complaints	Performance Goal	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Number of Quality of Service (QOS) Complaints Received	NA	12	20	14	10	9
Percent QOS Complaints Resolved w/in TAT	10 Days	83.3%	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints (QOC) Received	NA	1	3	2	1	2
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%	100.0%	100.0%

Analysis: During Q1, there were 11 total complaints processed. Ten (9) were Quality of Service complaints, and 2 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.

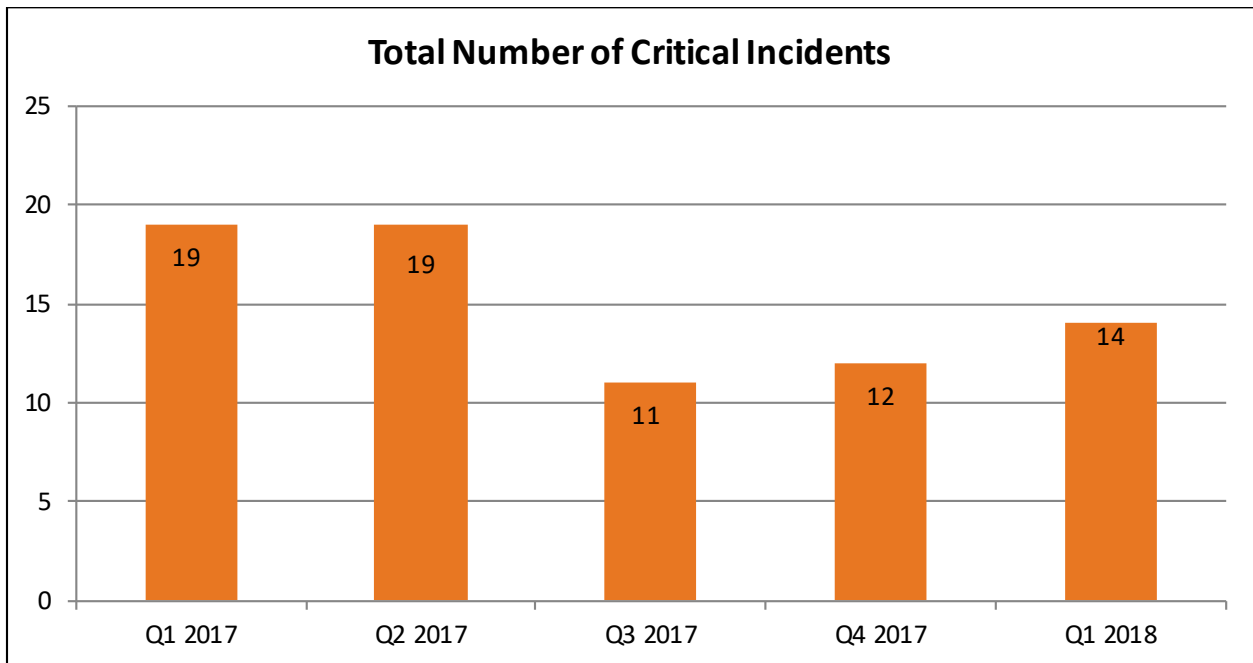
Optum has a Sentinel Events Committee (SEC) to review Critical Incidents that meet Optum’s definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review Critical Incidents that do not meet Optum’s definition of sentinel event. The SEC and PRC make recommendations for improving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

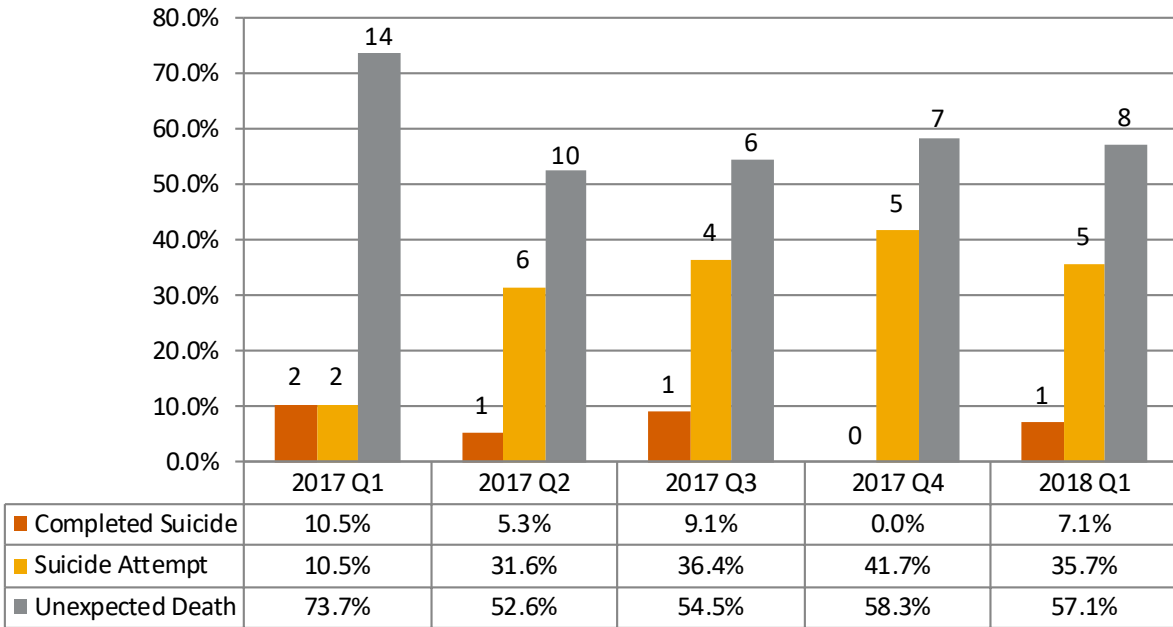
Critical Incidents	Performance Goal	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Number of CI's Received	NA	19	19	11	12	14
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100%	100%	100%	100%	100%

Analysis: There were 14 Critical Incidents reported during Q1. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. The highest number of Critical Incidents fell in the category of unexpected deaths. Of the 14 Critical Incidents reported, 8 (57.1%) were from unexpected deaths, 5 (35.7%) were from suicide attempts, and 1 (7.1%) was from a completed suicide. These 3 categories have been consistently reported at a higher rate than any other Critical Incident categories over the last 4 quarters.

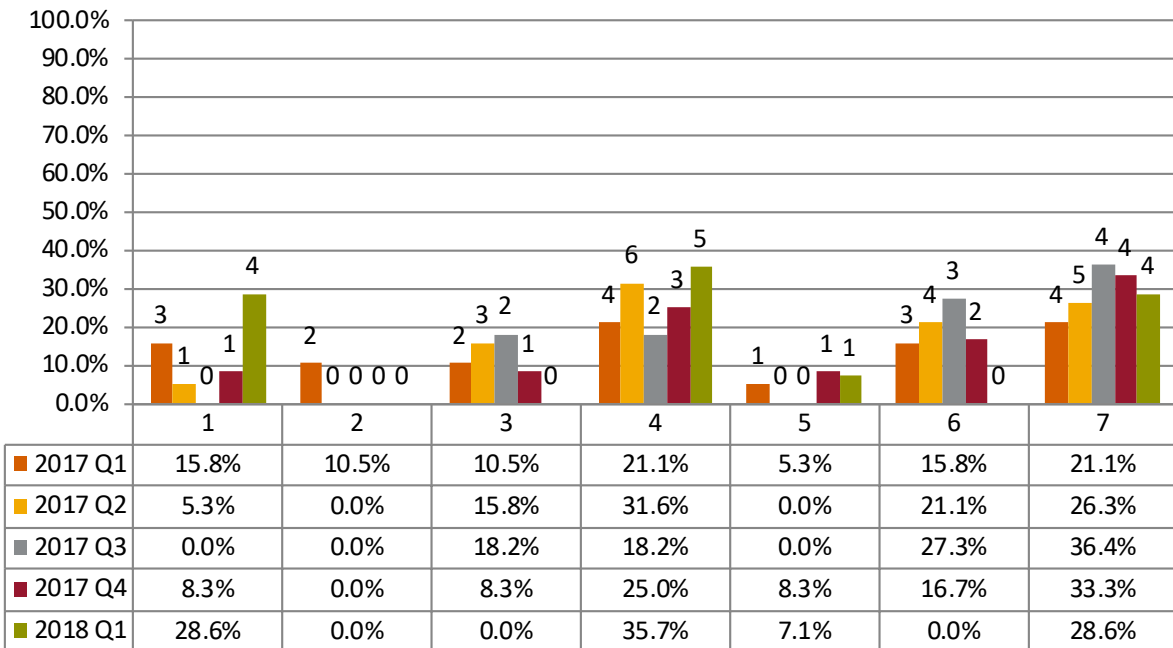
Further analysis showed that during Q1, Region 4 reported the highest number (5) of critical incidents at 35.7%, followed by Regions 1 and 7 with 4 reported CI's each. Coordination of Care between the behavioral health provider and the Primary Care Provider (PCP) occurred in 12 (85.7%) of the total cases. Of the 14 reported Critical Incidents, 5 (35.7%) males and 8 (57.1%) females showed that member had a co-morbid health condition. Of the cases reported, 13 (92.9%) were adults (18+) and 1 (7.1%) was a child/adolescent (17 and under). The average age for males was 27 and females 46. Of the cases reported, 4 (28.6%) were males and 10 (71.4%) were females. No providers were put on unavailable status due to a Critical Incident.



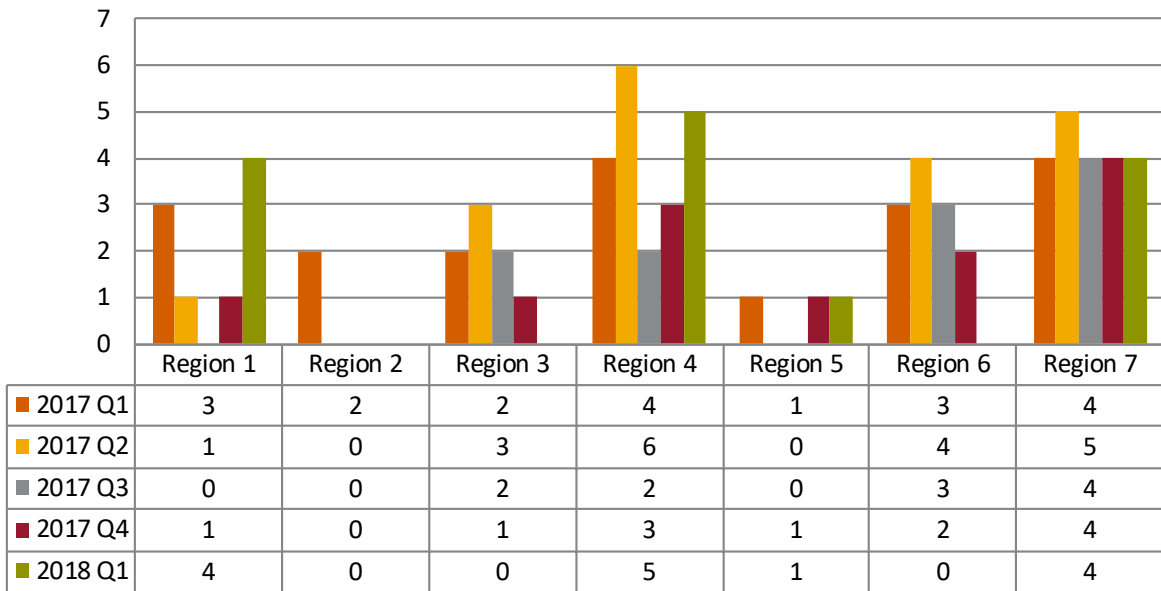
Quarterly Critical Incidents by Highest Reported Incidents



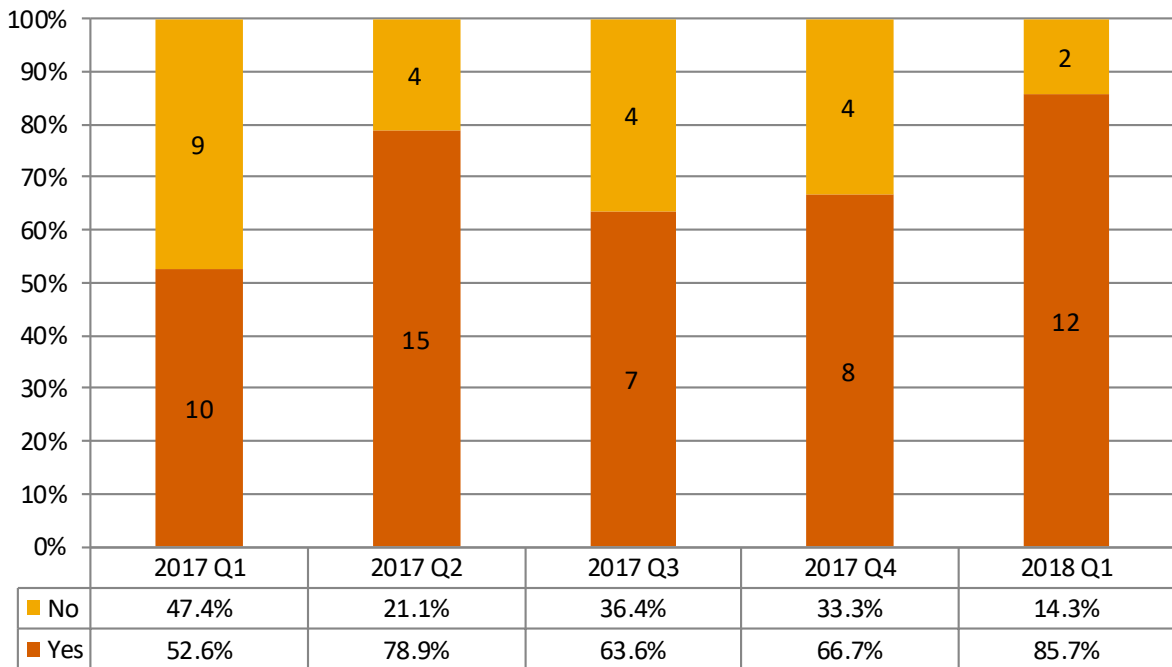
Quarterly Critical Incidents by Region

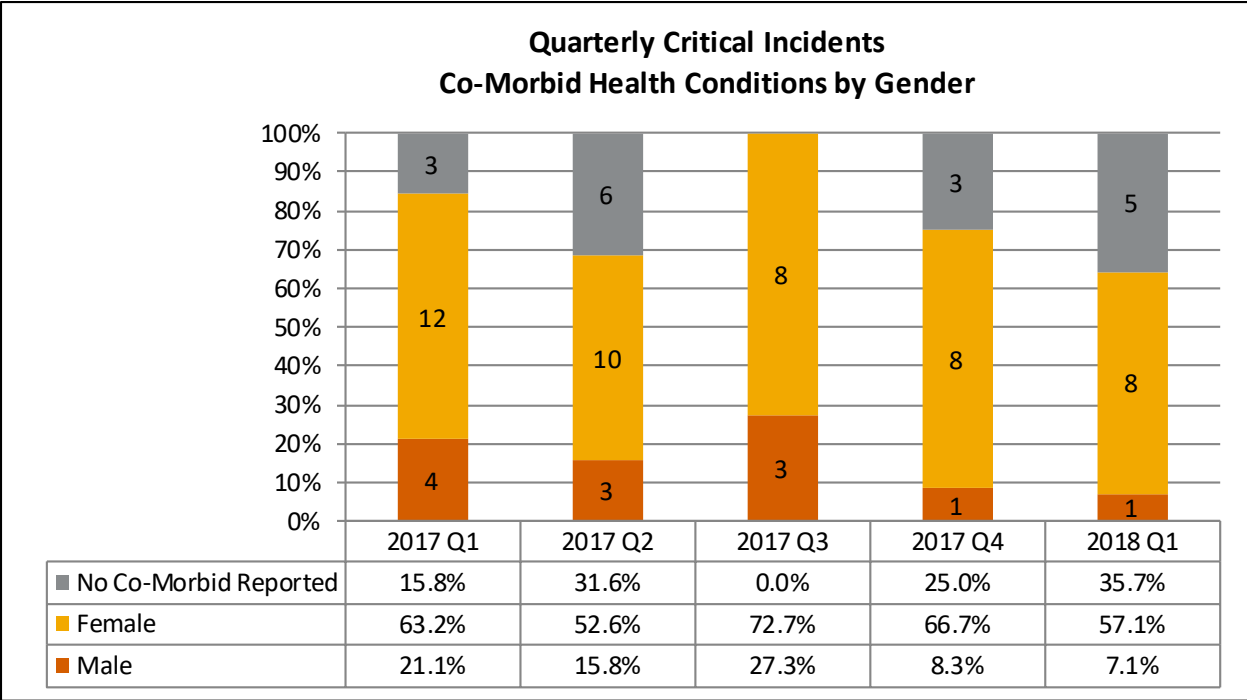
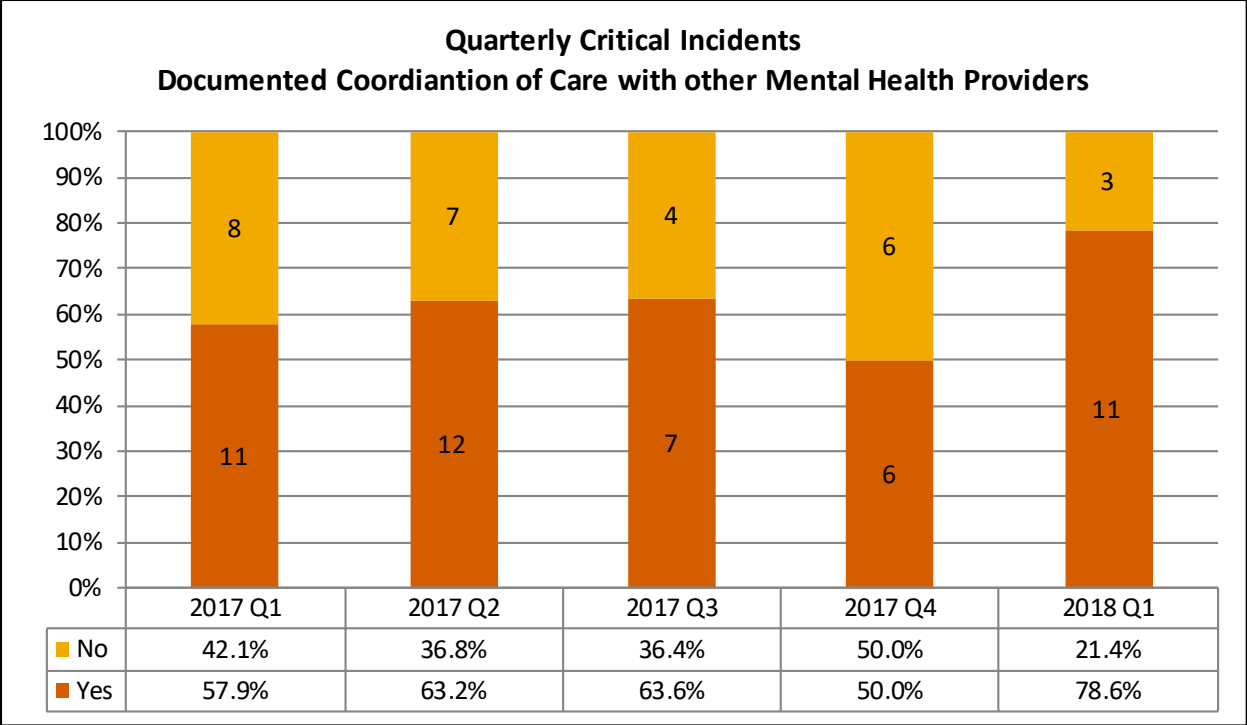


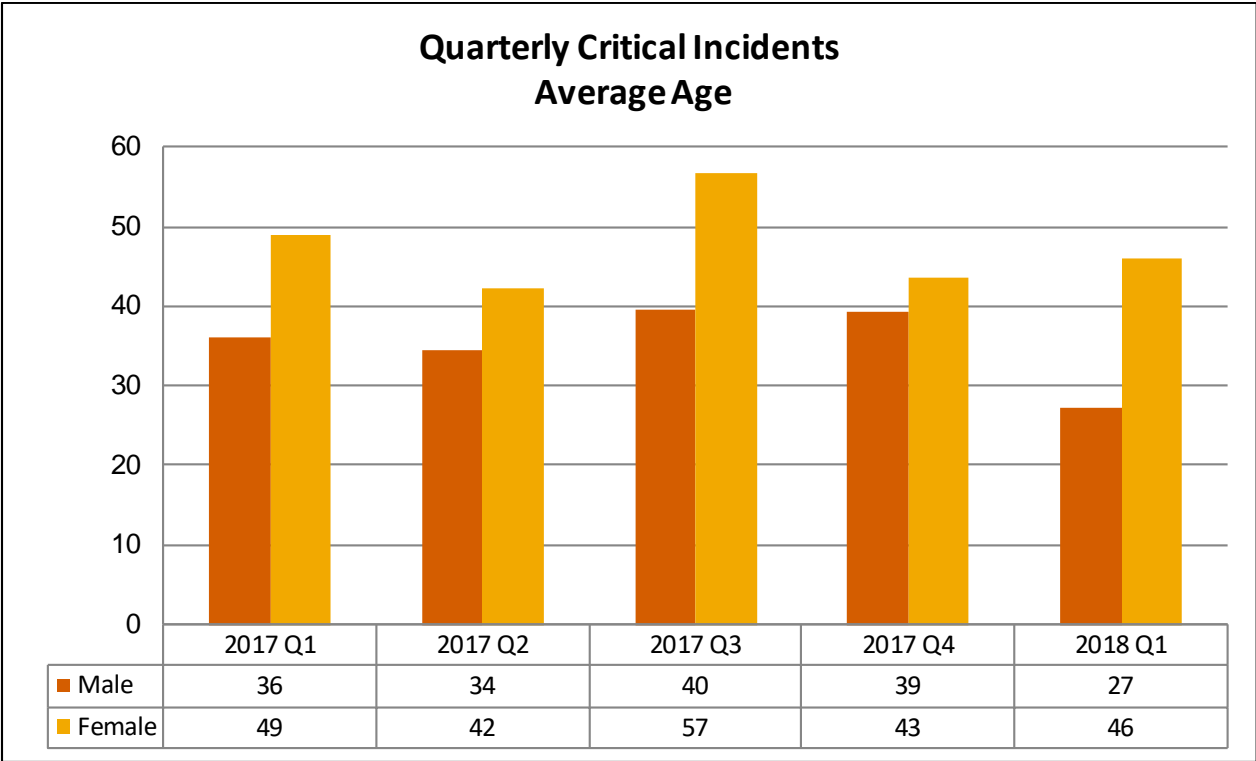
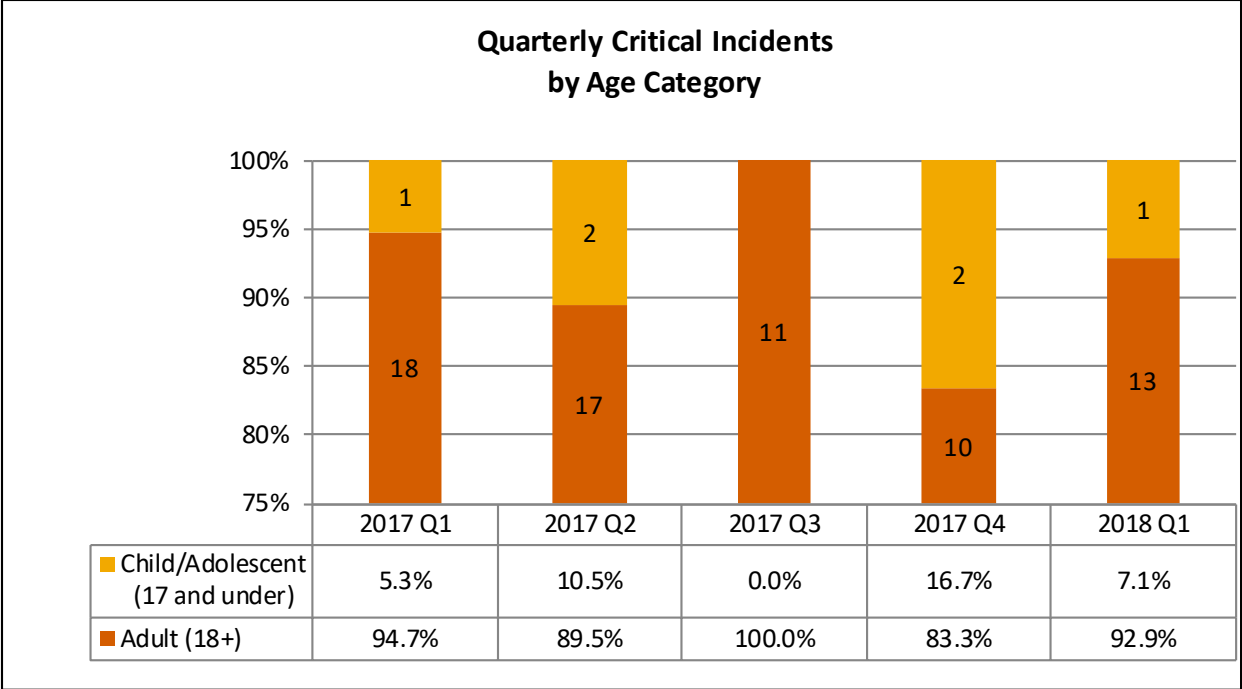
**Quarterly Critical Incidents
Number of Critical Incidents by Region**

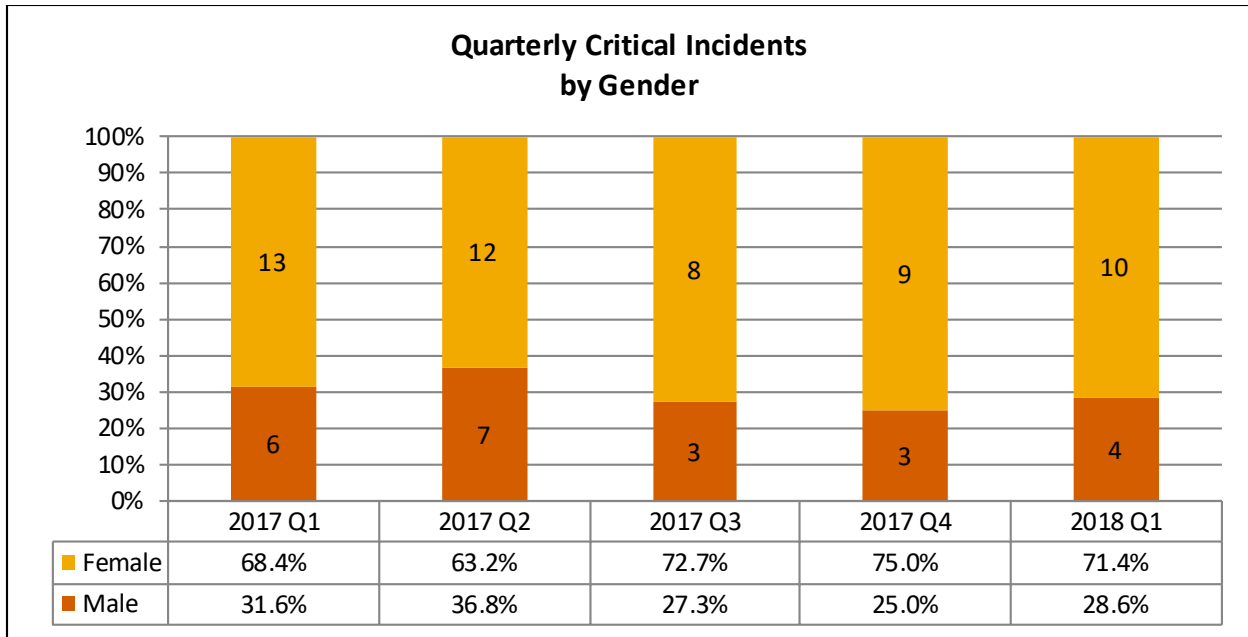


**Quarterly Critical Incidents
Documented Coordination of Care with Primary Care Provider**









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

Opportunities and Interventions: No opportunities for improvement were identified.

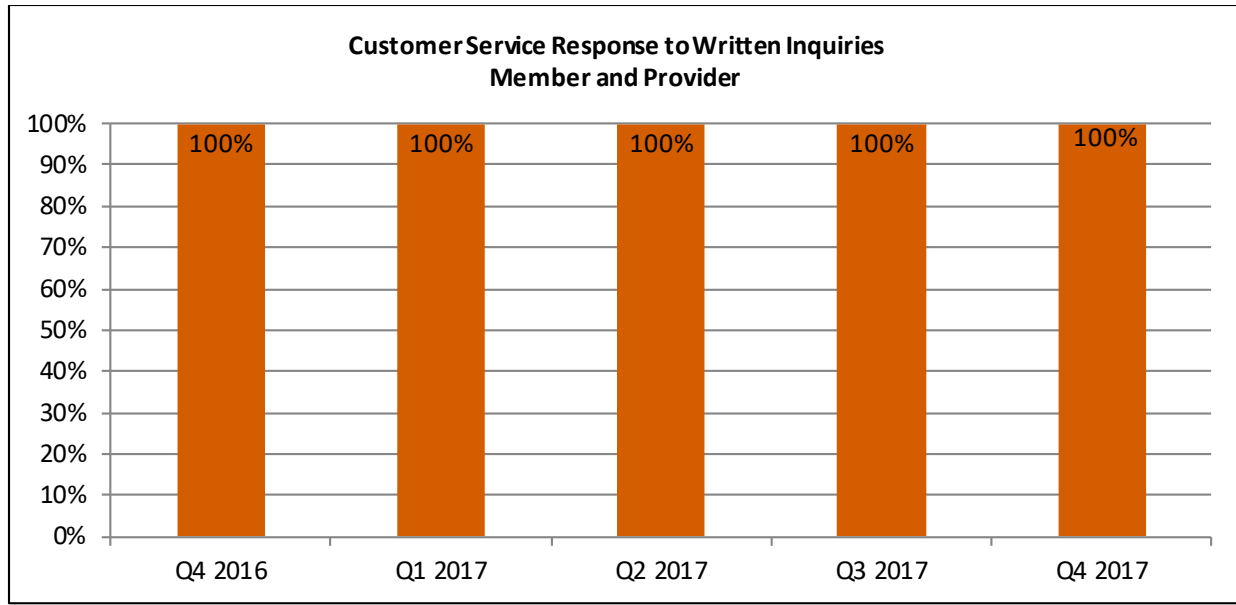
Response to Written Inquiries

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	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
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 Q1.



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

Opportunities and Interventions: No opportunities for improvement were identified.

Provider Monitoring and Relations

Provider Quality Monitoring

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

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

Methodology: The Optum 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 to 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.

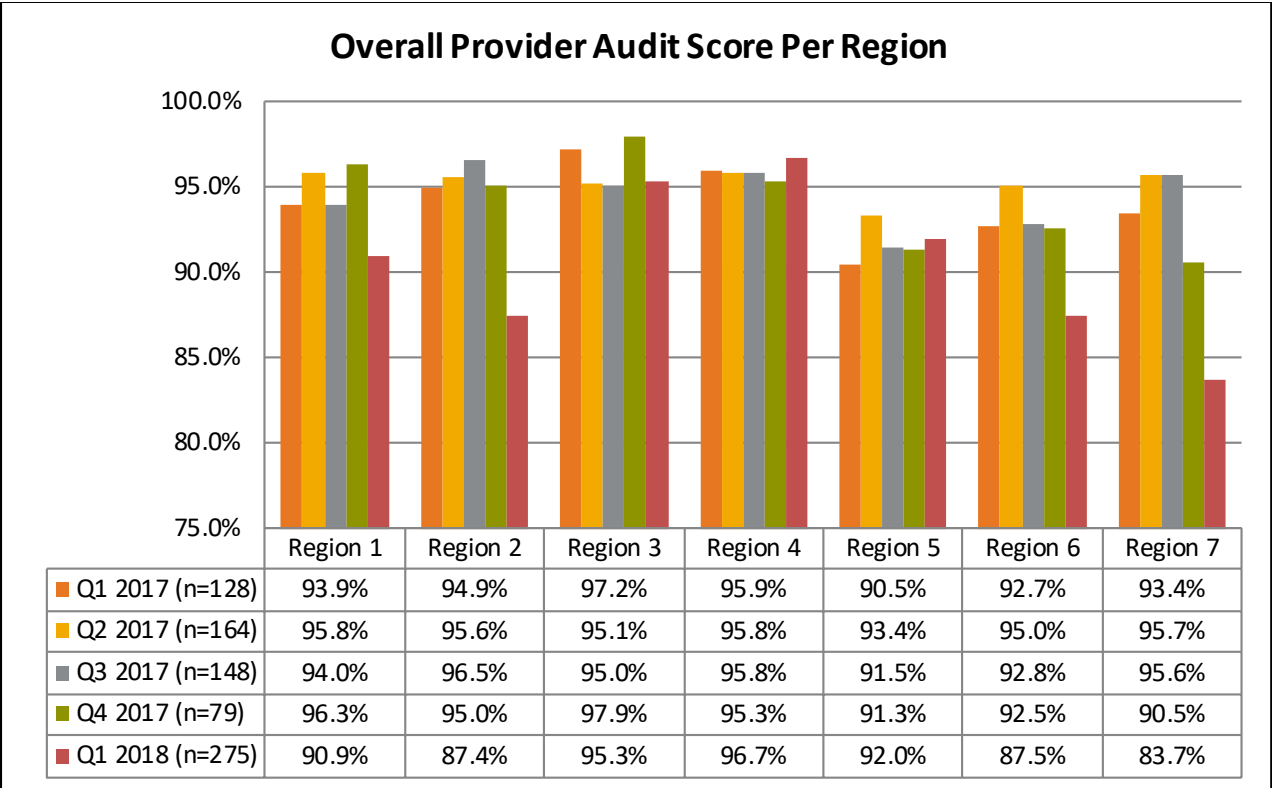
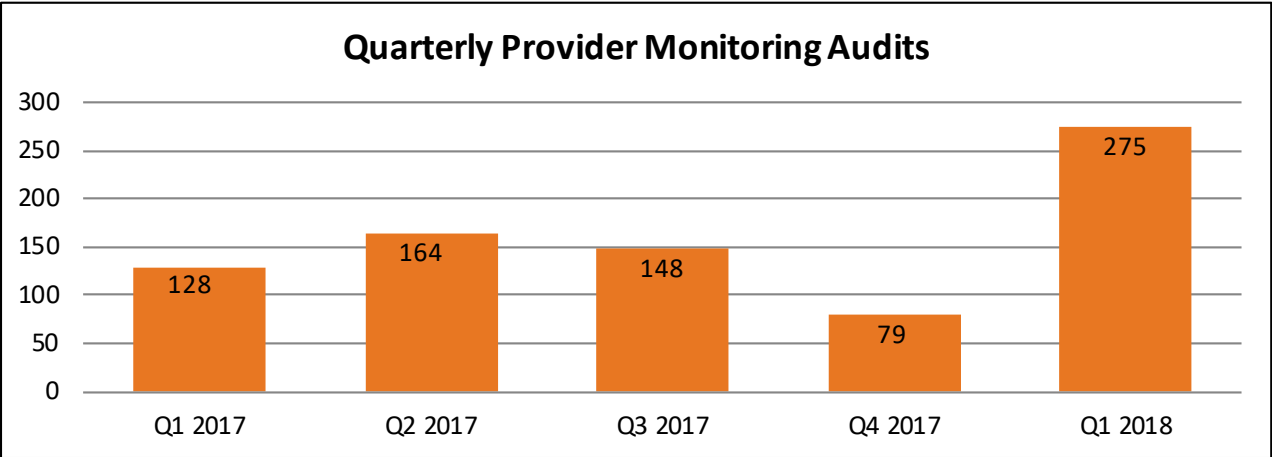
Quarterly Performance Results

Treatment Record Audit	Performance Goal	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Number of Audits Conducted	NA	128	164	148	79	275
Initial Audit (Average overall score)	85.0%	92.1%	93.6%	98.0%	92.3%	92.2%
Recredentialing Audit (Average overall score)	85.0%	91.2%	94.3%	92.8%	89.1%	89.6%
Monitoring (Average overall score)	85.0%	94.9%	95.2%	93.7%	93.9%	90.0%
Quality (Average overall score)	85.0%	82.5%**	NA*	86.1%	NA*	NA*
Percent of Audits Requiring a Corrective Action Plan	NA	16.4%	6.1%	11.5%	8.9%	24.0%

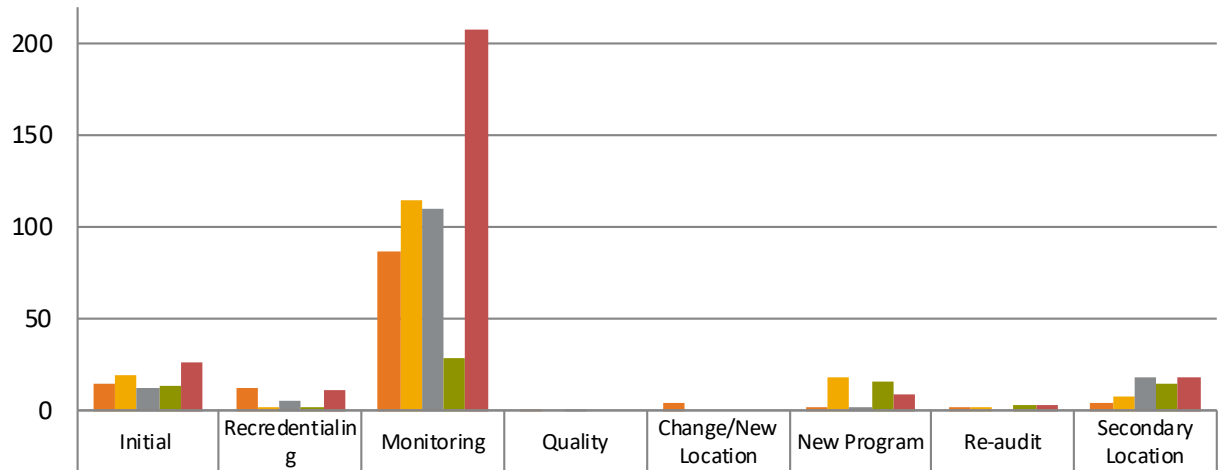
*There were no quality audits. **There was only 1 Quality audit during Q1, 2017.

Analysis: During Q1, there were 275 Provider Audits completed on Optum Idaho network providers. Of the 275 audits completed, 76.0% received a passing score. Corrective action plans were implemented for 24.0% of the audits. Overall audit scores per region and per audit type are reflected in graphs below.

Network providers are given the opportunity to rate the Provider Quality Monitoring Audit process in a Satisfaction Survey. In Q1, 2016, Optum Idaho began using a new Satisfaction Survey for providers to complete once a monitoring audit is completed. 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 Q1 showed that 15 responses were received. Of those responses, 67.0% (10) of providers stated that the overall value of the audit process was excellent, followed by 33.0% (5) who stated it was very good. Of those who responded, 87.0% (13) indicated that the auditor was excellent. Eight-seven percent (87.0%) of respondents indicated that their overall experience with the audit was excellent.

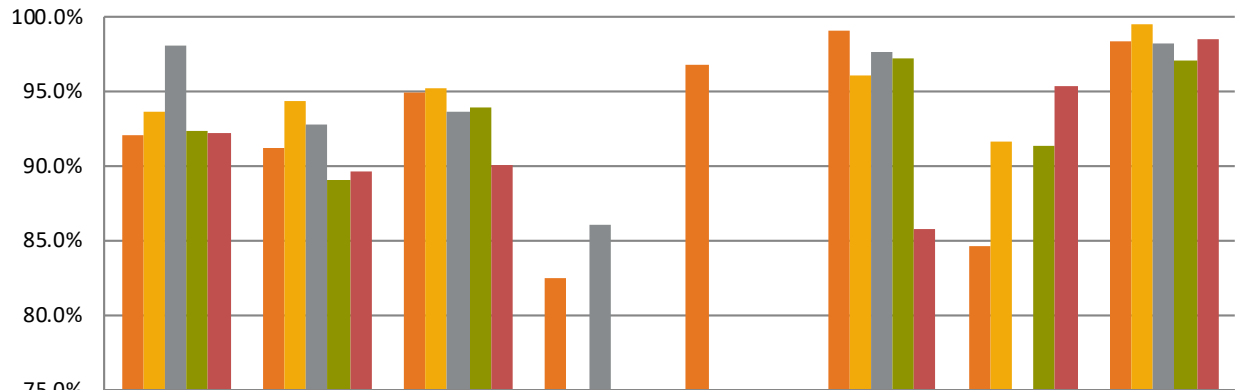


Total Number of Provider Audits by Type

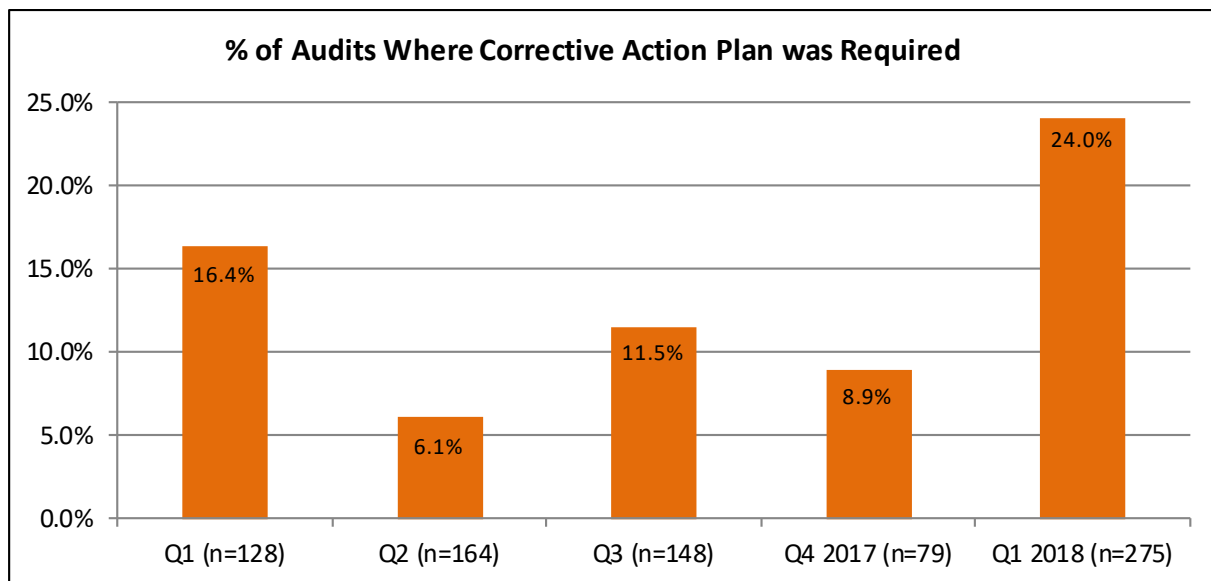
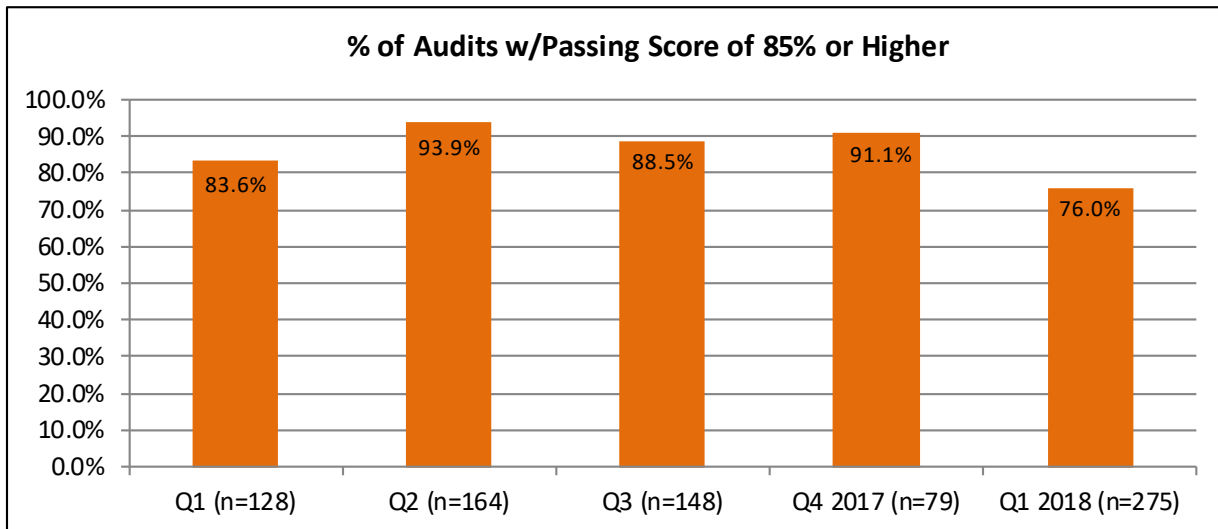


	Initial	Recredentialing	Monitoring	Quality	Change/New Location	New Program	Re-audit	Secondary Location
Q1 2017 (n=128)	15	13	87	1	4	2	2	4
Q2 2017 (n=164)	19	2	115	0	0	18	2	8
Q3 2017 (n=148)	12	5	110	1	0	2	0	18
Q4 2017 (n=79)	14	2	29	0	0	16	3	15
Q1 2018 (n=275)	26	11	208	0	0	9	3	18

Overall Provider Audit Score by Type

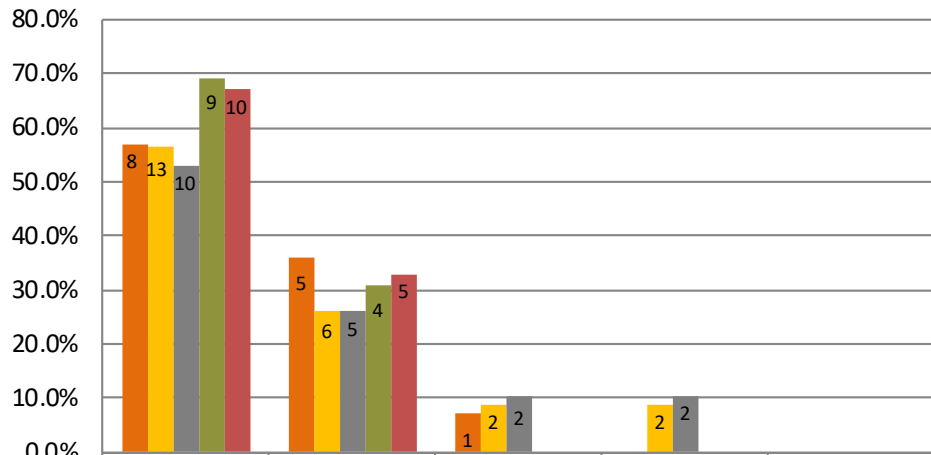


	Initial	Recredentialing	Monitoring	Quality	Change/New Location	New Program	Re-audit	Secondary Location
Q1 2017 (n=128)	92.1%	91.2%	94.9%	82.5%	96.8%	99.0%	84.6%	98.4%
Q2 2017 (n=164)	93.6%	94.3%	95.2%	0.0%	0.0%	96.1%	91.6%	99.5%
Q3 2017 (n=148)	98.0%	92.8%	93.7%	86.1%	0.0%	97.7%	0.0%	98.2%
Q4 2017 (n=79)	92.3%	89.1%	93.9%	0.0%	0.0%	97.2%	91.3%	97.1%
Q1 2018 (n=275)	92.2%	89.6%	90.0%	0.0%	0.0%	85.8%	95.4%	98.5%



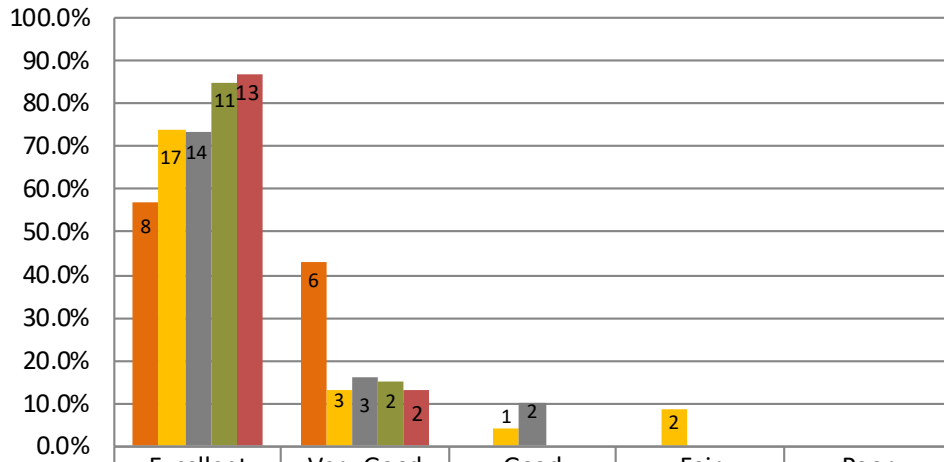
Below are the results of the surveys received back by the end of Q1 that were sent to providers regarding their rating of the Monitoring Audit Process.

Rating of Overall Value of Audit Process



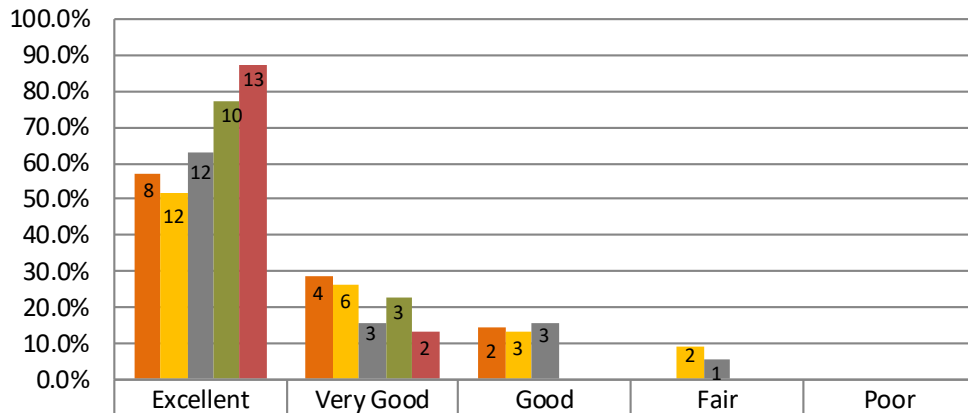
	Excellent	Very Good	Good	Fair	Poor
■ Q1 2017 (Responses: 14)	57.0%	36.0%	7.0%	0.0%	0.0%
■ Q2 2017 (Responses: 23)	56.5%	26.1%	8.7%	8.7%	0.0%
■ Q3 2017 (Responses: 19)	53.0%	26.0%	10.5%	10.5%	0.0%
■ Q4 2017 (Responses: 13)	69.0%	31.0%	0.0%	0.0%	0.0%
■ Q1 2018 (Responses: 15)	67.0%	33.0%	0.0%	0.0%	0.0%

Overall Rating of Auditor



	Excellent	Very Good	Good	Fair	Poor
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%
Q1 2018 (Responses: 15)	87.0%	13.0%	0.0%	0.0%	0.0%

Overall Experience with Audit



	Excellent	Very Good	Good	Fair	Poor
Q1 2017 (Responses: 14)	57.1%	28.6%	14.3%	0.0%	0.0%
Q2 2017 (Responses: 23)	52.0%	26.0%	13.0%	9.0%	0.0%
Q3 2017 (Responses: 19)	63.1%	15.8%	15.8%	5.3%	0.0%
Q4 2017 (Responses: 13)	77.0%	23.0%	0.0%	0.0%	0.0%
Q1 2018 (Responses: 15)	87.0%	13.0%	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.

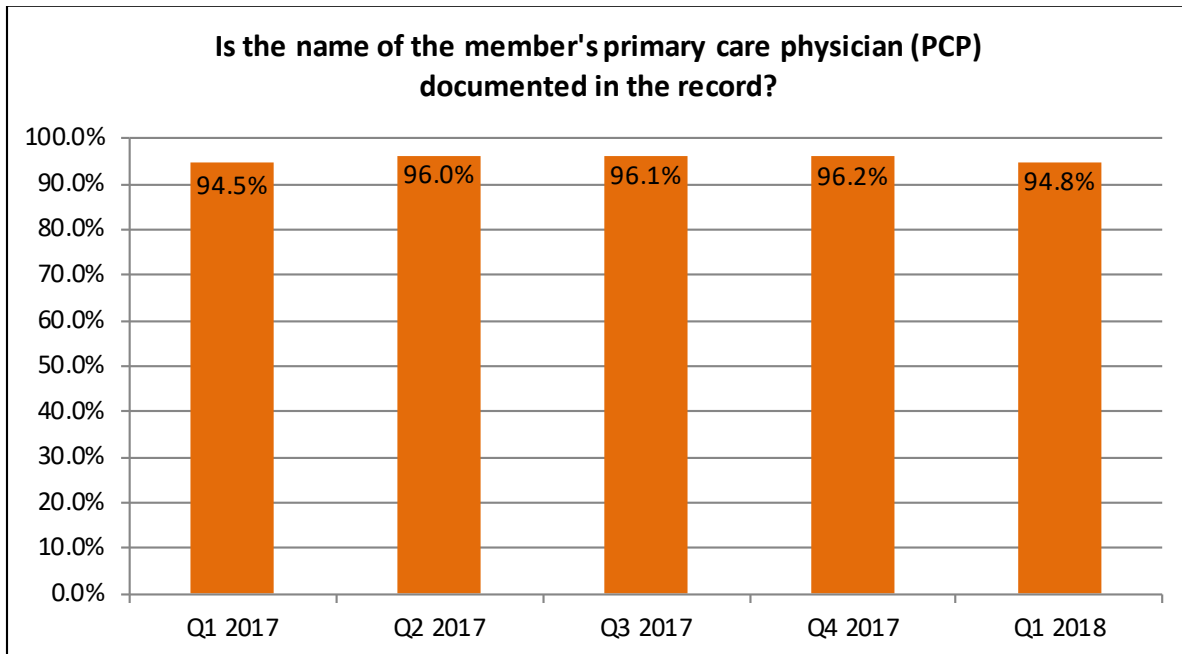
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff.

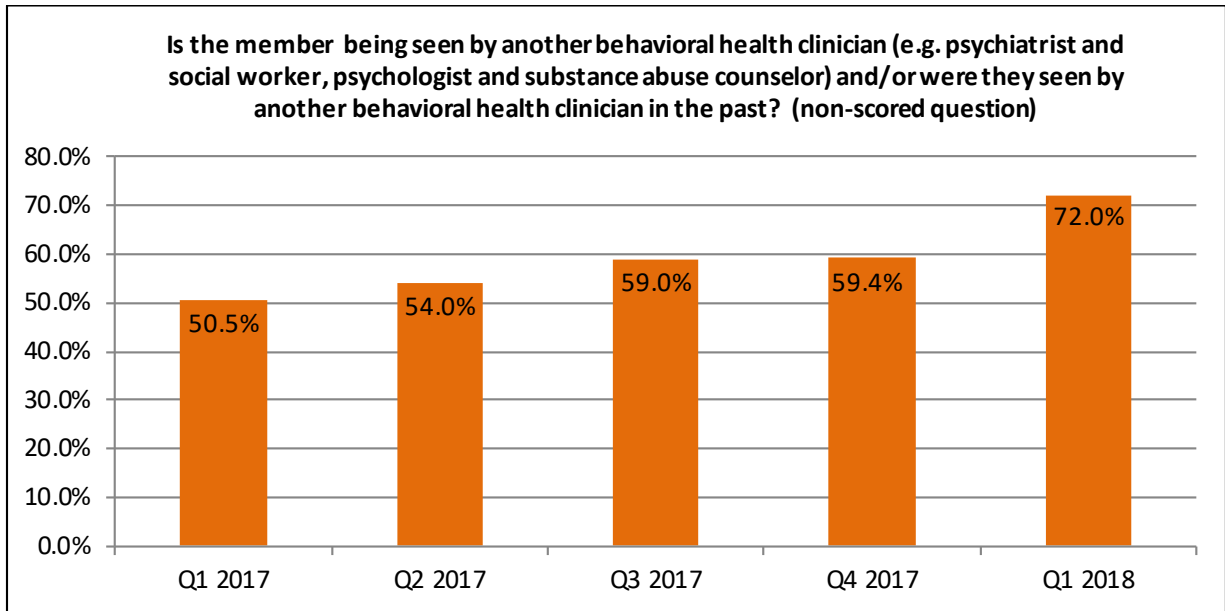
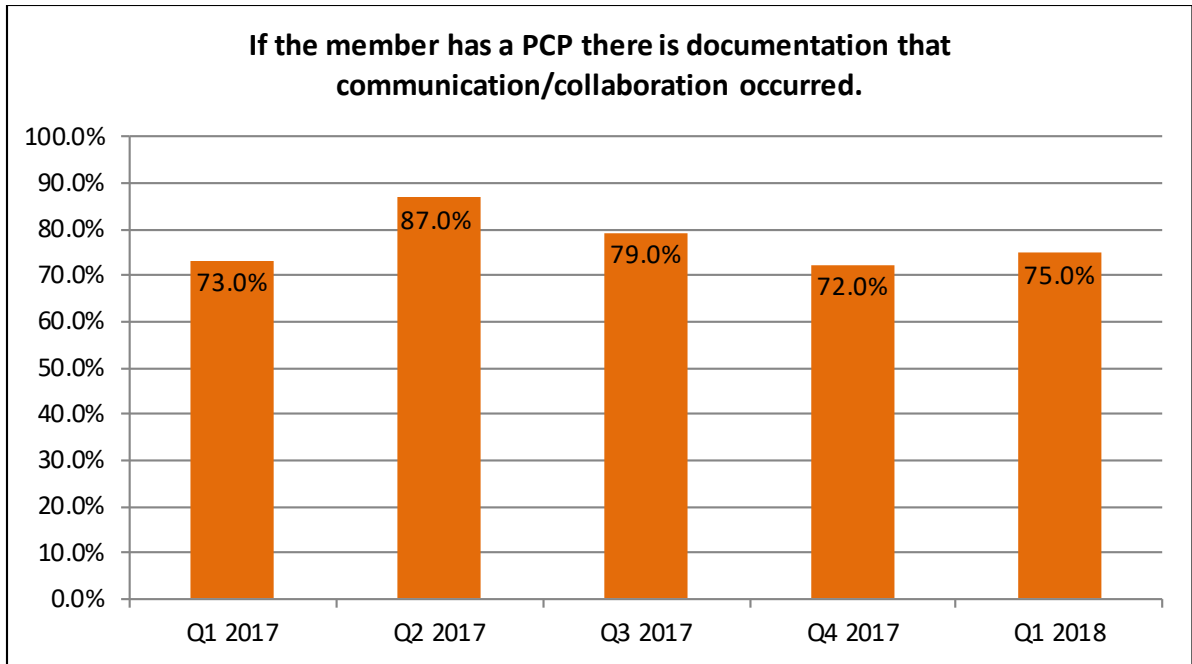
Quarterly Performance Results

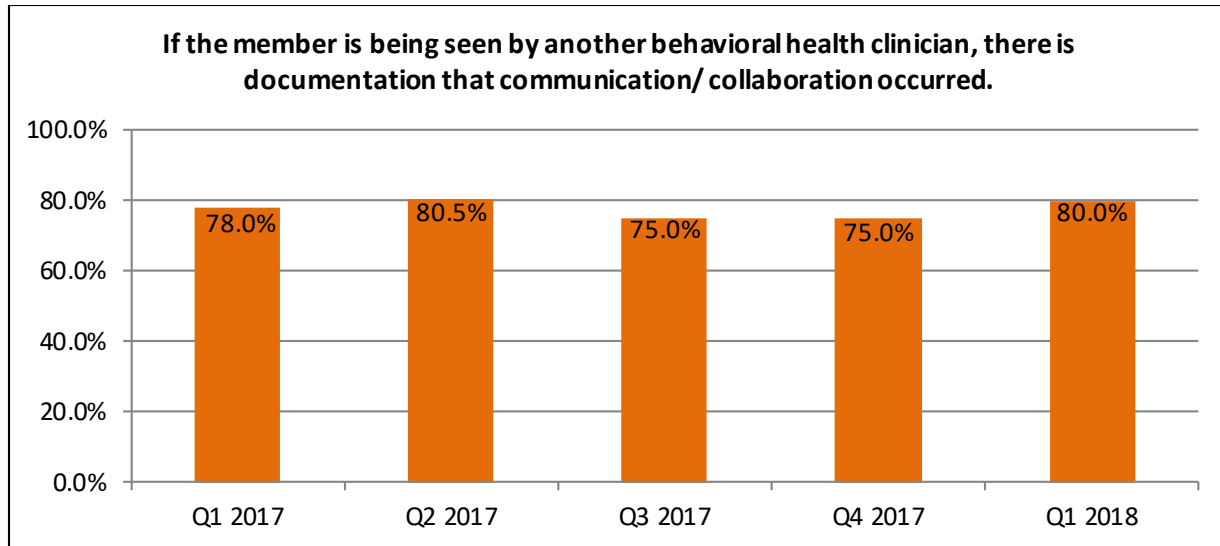
Coordination of Care (% answered in the affirmative)	Performance Goal	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Is the name of the member’s primary care physician (PCP) documented in the record?	NA	94.5%	96.0%	96.1%	96.2%	94.8%
If the Member has a PCP there is documentation that communication/collaboration occurred	NA	73.0%	87.0%	79.0%	72.0%	75.0%

Coordination of Care (% answered in the affirmative)	Performance Goal	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
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	50.5%	54.0%	59.0%	59.4%	72.0%
If the member is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.	NA	78.0%	80.5%	75.0%	75.0%	80.0%

Analysis: Coordination of Care audits completed during Q1 revealed that 94.8% of member records reviewed had documentation of the name of the member's PCP. Of those, 75.0% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. Audit results also showed that 72.0% 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, 80.0% 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.

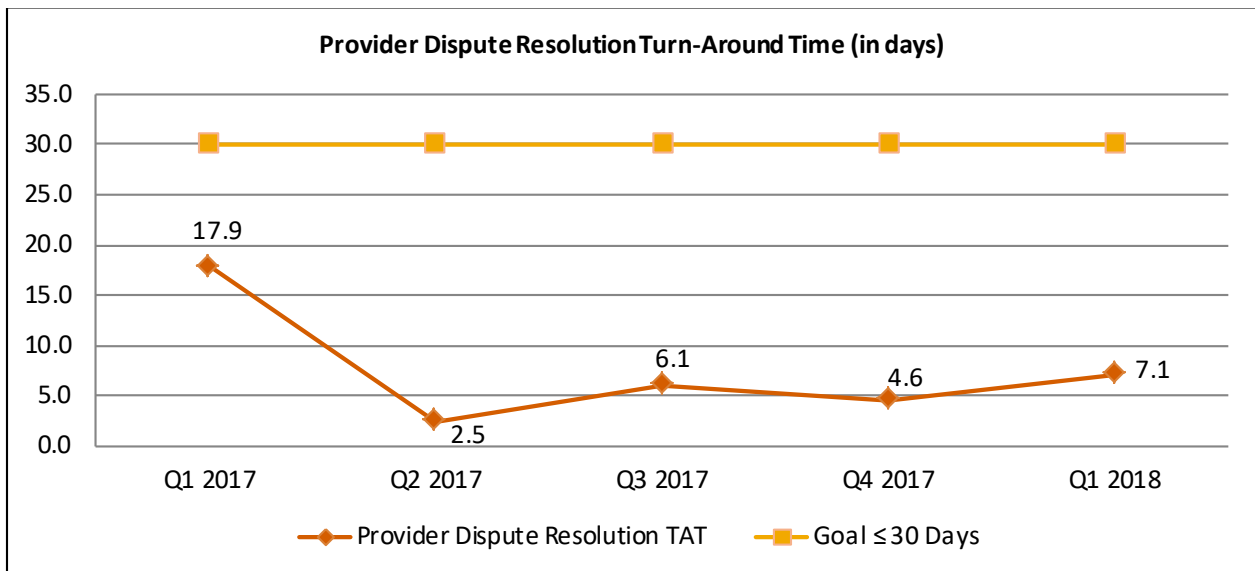
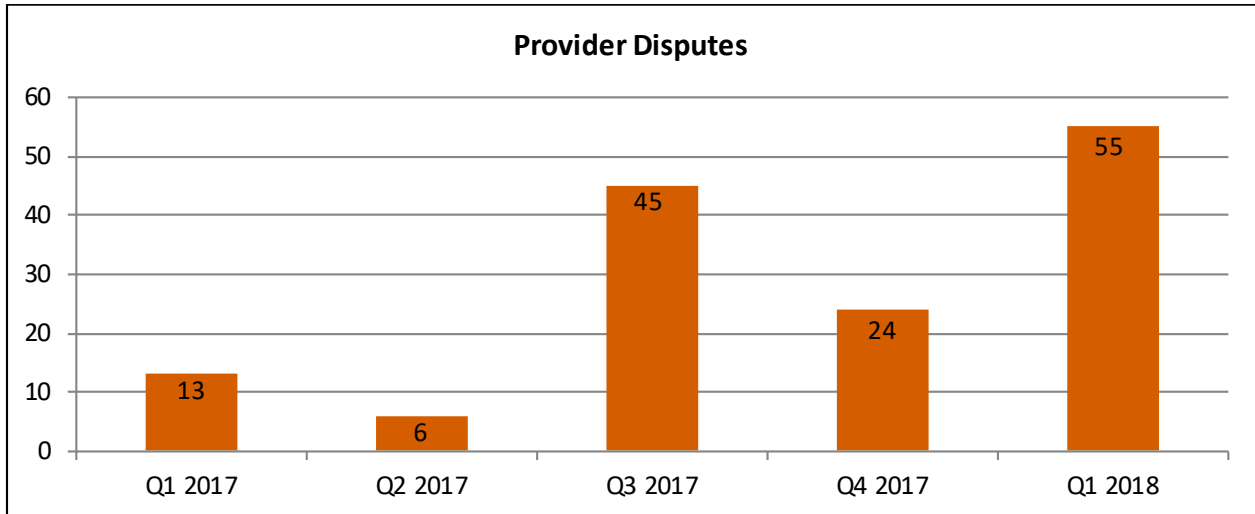
Provider Disputes

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	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Number of Provider Disputes	NA	13	6	45	24	55
Percent Provider Dispute Determinations made within 30 calendar days from request	100% within 30 Calendar Days	92.3%	100.0%	100.0%	100.0%	100.0%
Average # of Days Provider Disputes Resolved	≤30 Days	17.9	2.5	6.1	4.6	7.1
Number of Disputes Fully Overturned	NA	1	1	39	20	27
Number of Disputes Partially Overturned	NA	2	0	4	0	4
% of Disputes Overturned or Partially Overturned	NA	23.1%	16.6%	95.6%	83.3%	56.4%

Analysis: During Q1, there were 55 Provider Disputes. Of the 55 disputes, 27 were fully overturned and 4 were partially overturned. All disputes were resolved within the turnaround time. The overall average turnaround time was 7.1 days.



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

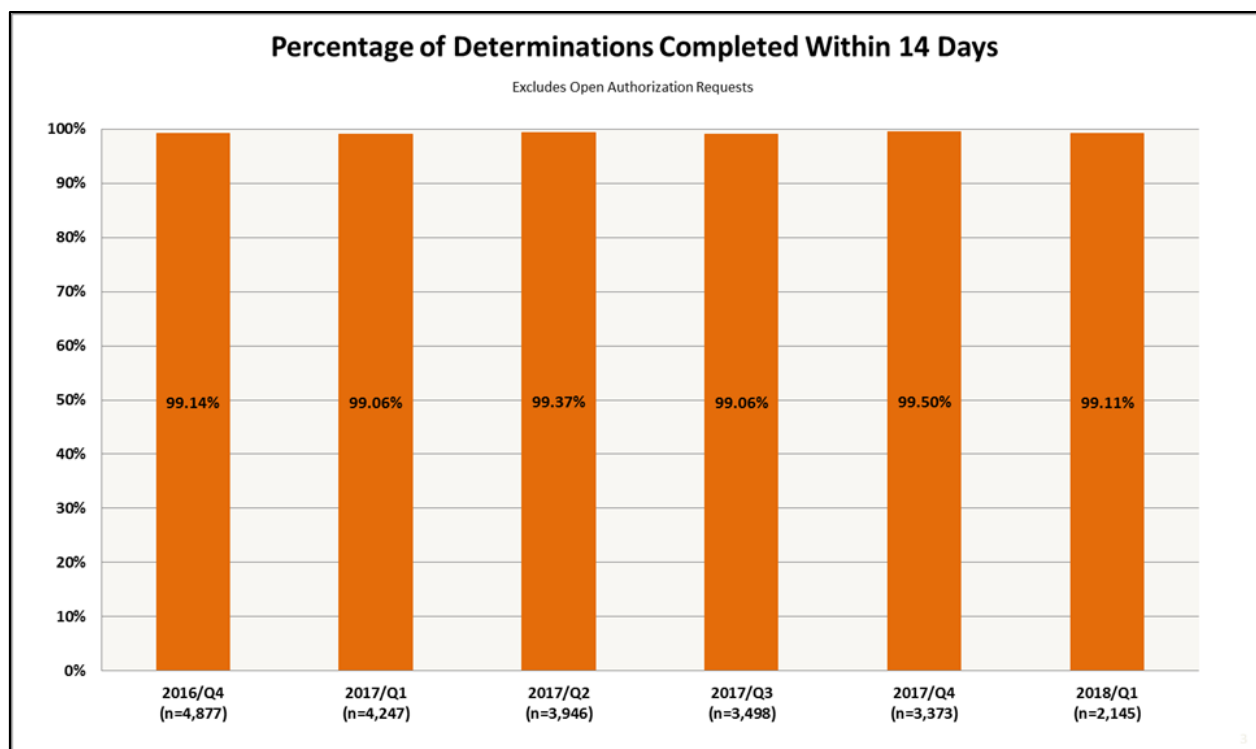
Opportunities and Interventions: No opportunities for improvement were identified.

Utilization Management and Care Coordination

Service Authorization Requests

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

Service Authorization Requests	Performance Goal	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Number of Service Authorization Requests	NA	4,247	3,948	3,498	3,373	2,145
Percent Determinations Completed within 14 days	100.0%	99.1%	99.4%	99.1%	99.5%	99.1%



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

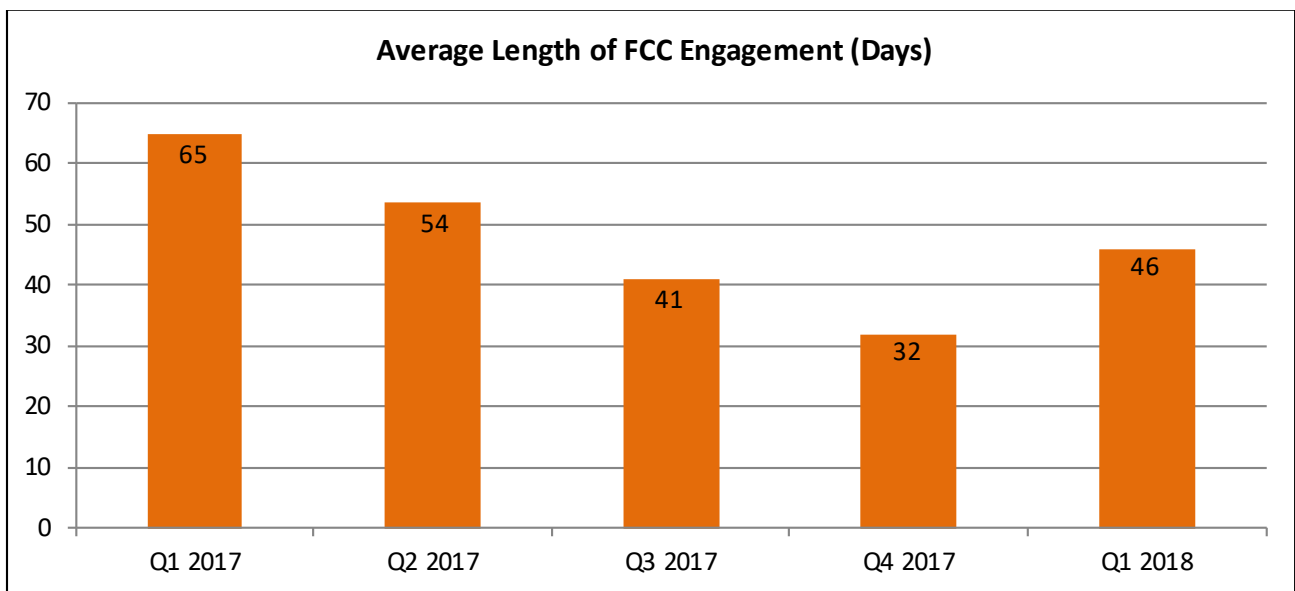
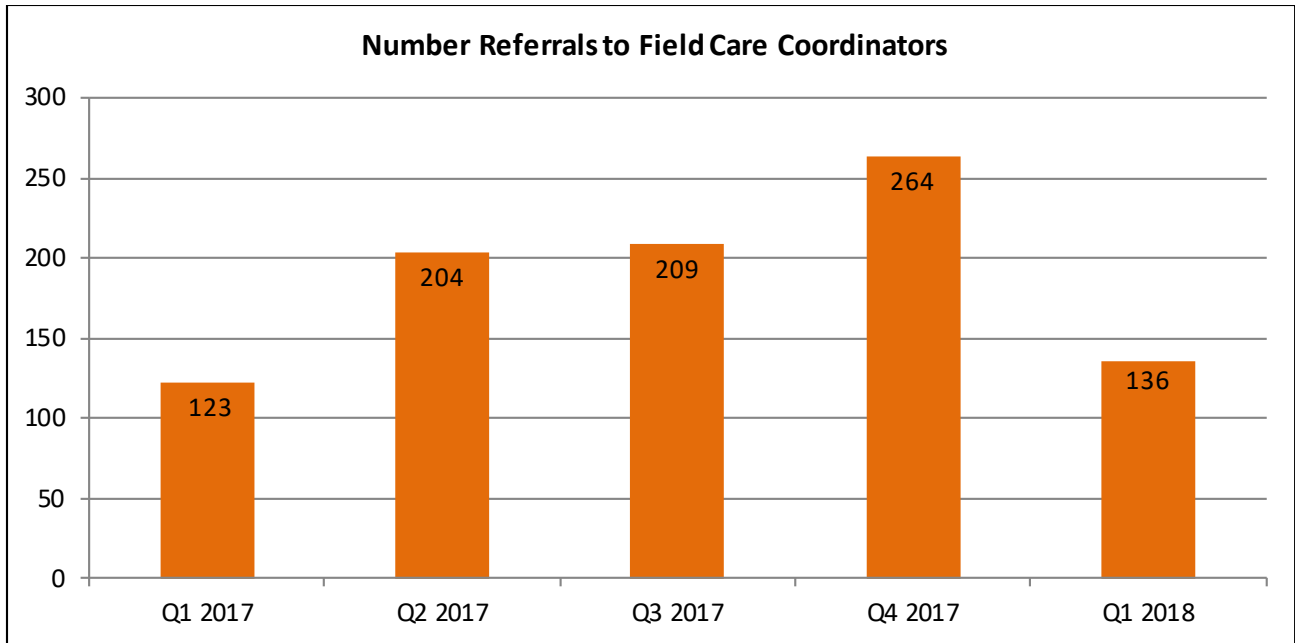
team focuses on member wellness, recovery, resiliency, and an increase in overall functioning. They do this through:

- 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 the last five quarters.

Referral Sources	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Discharge Coordinator	83	161	145	182	76
Utilization Reviewers	13	14	10	8	3
Providers	4	6	14	6	2
Dept of Behavioral Health	6	6	16	20	17
Juvenile Justice	0	0	0	0	0
Provider Quality Specialist	2	0	0	0	0
Peer Review Committee	0	0	0	0	0
Hospitals	0	0	0	3	0
EPSDT	0	0	4	9	4
Family/Parent	0	0	4	0	0
Member Services/Crisis Line	0	0	0	0	0
Education	10	4	2	1	1
FCC Manager Referral	1	3	0	1	2
Outpatient Disposition	4	10	4	0	0
Suicide Attempt	NA	NA	10	21	29
Adult Corrections	NA	NA	NA	13	0
Telligen	NA	NA	NA	NA	2
Total	123	204	209	264	136

Analysis: During Q1, Field Care Coordinators received 136 referrals. Of these referrals, 76 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement during Q1 was 46 days. A new referral source, Telligen, category was added during Q1, Telligen is the company that manages inpatient behavioral health services.



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

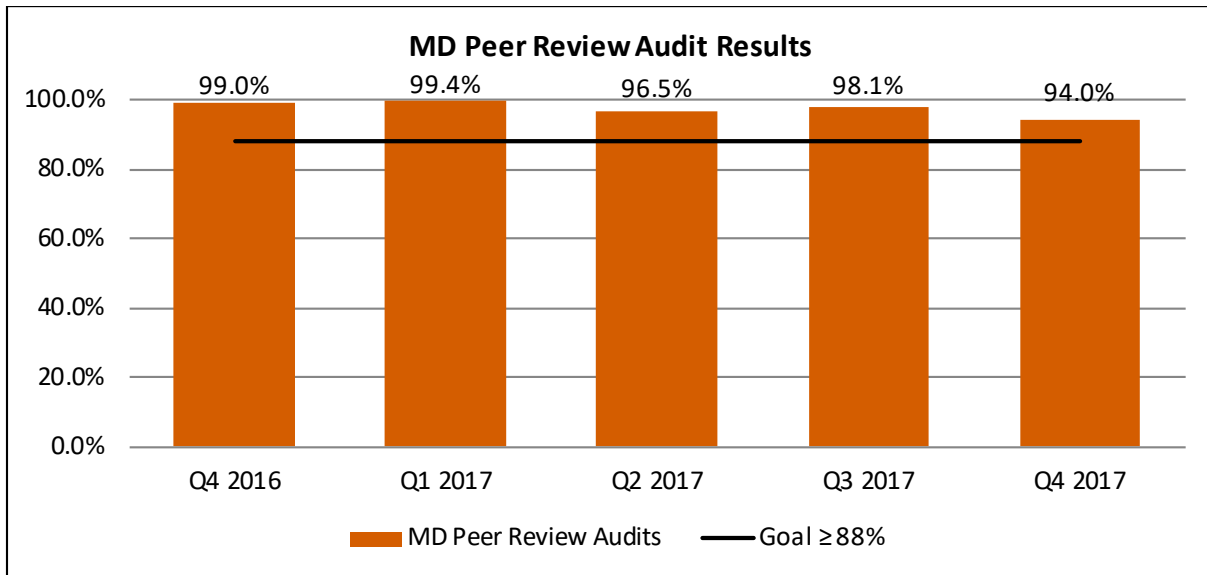
Opportunities and Interventions: No opportunities for improvement were identified.

Peer Reviewer Audits

Methodology: Optum Idaho promotes a process for review and evaluation of the clinical documentation of 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 Q4, there were no PhD denial decisions that required a Peer Review Audit. The MD Peer Review Audit result was at 94.0%.



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

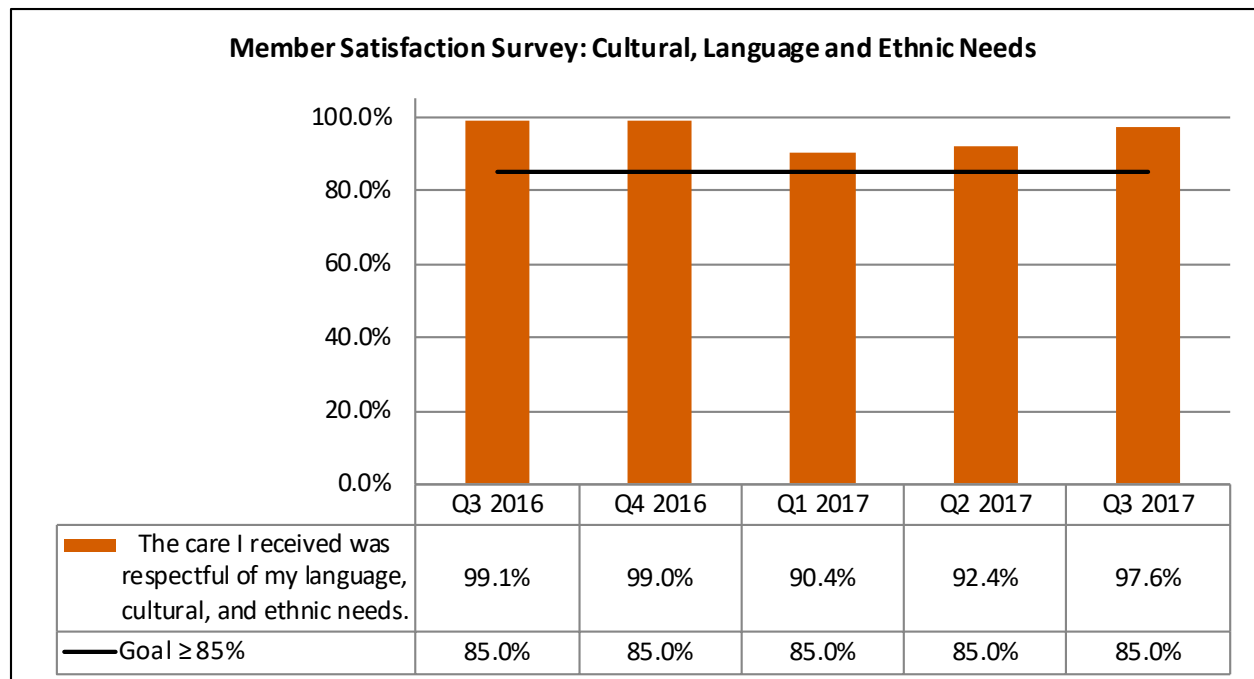
Survey to gauge whether the care that the member receives is respectful to their cultural and linguistic needs.

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, Q3 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	1
Member Written Communication Formatted to Large Print	2
Language Service Associates	26
Languages Represented	6
Do Not Mail List	4

Analysis: During Q1, Optum Idaho responded to 39 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

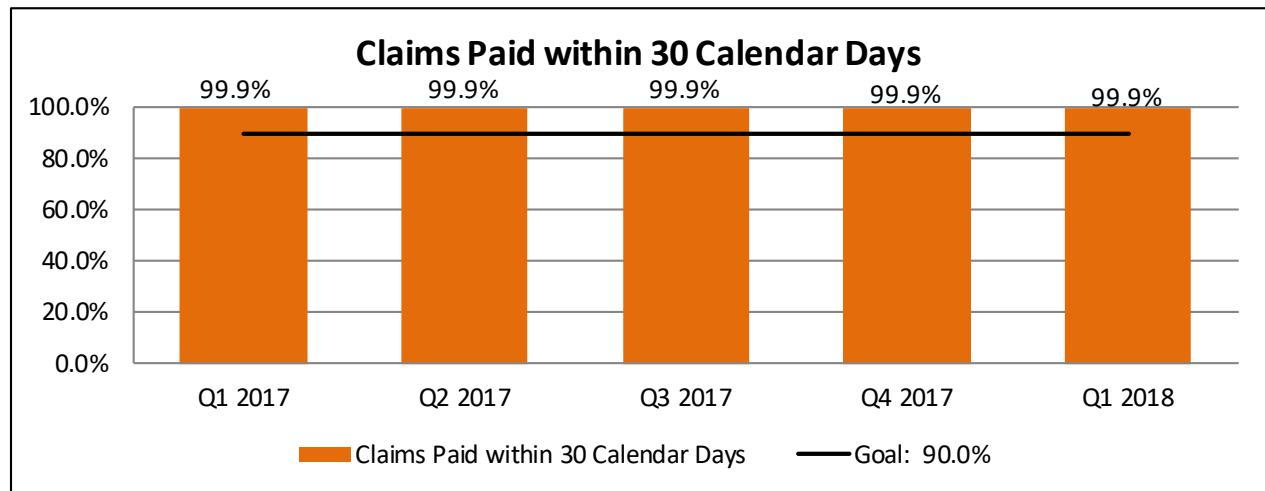
correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid dollars minus overpayments and underpayments divided by the total paid dollars).

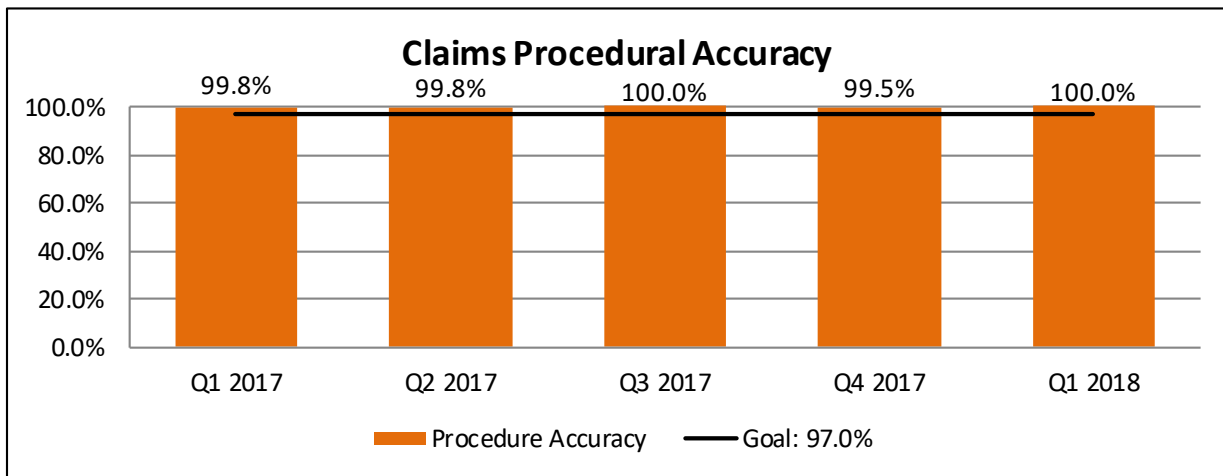
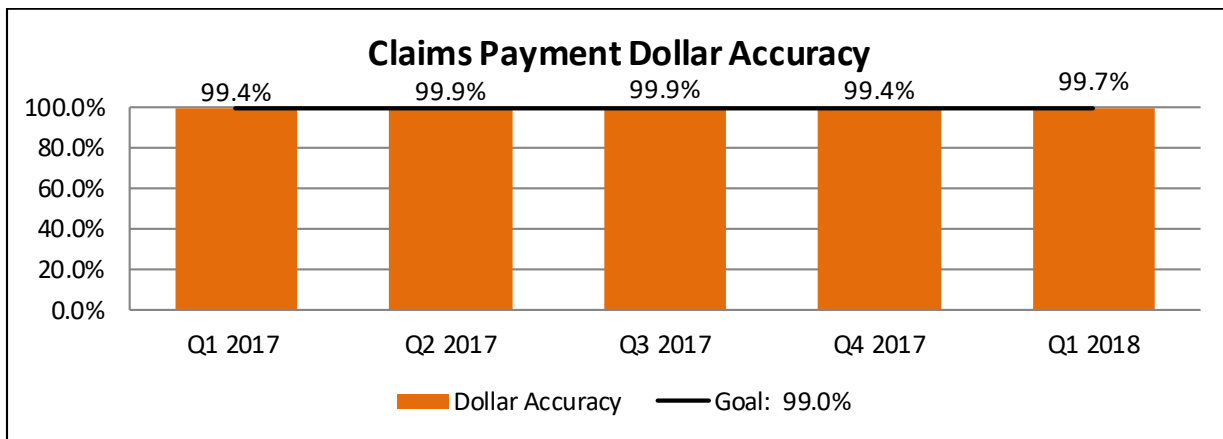
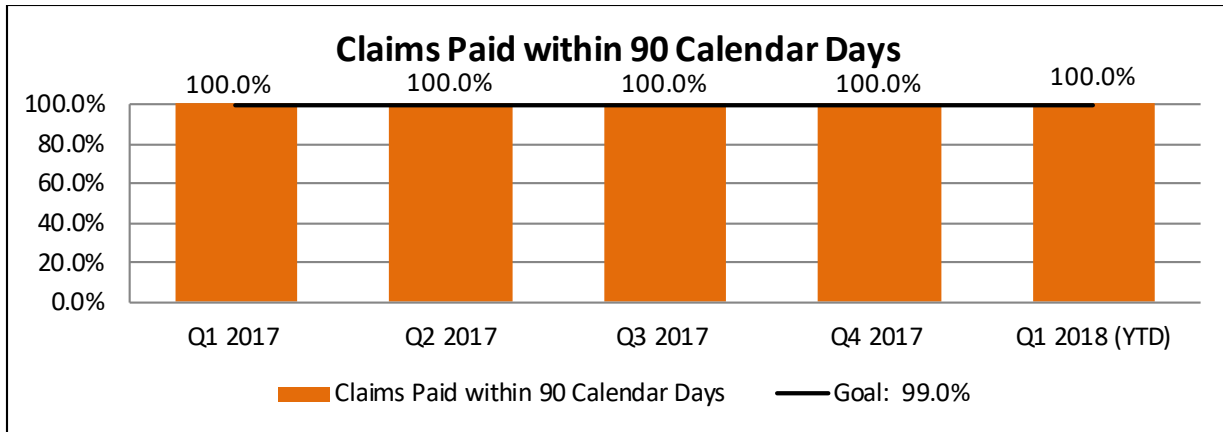
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial 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	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018 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%	99.4%	99.9%	99.9%	99.4%	99.7%
Procedural Accuracy	97.0%	99.8%	99.8%	100.0%	99.5%	100.0%

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.