

IDAHO BEHAVIORAL HEALTH PLAN

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT



OPTUM®

*July - September
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 3, 2018.

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Executive Summary – Quarter 3 - 2018

As noted in the Outcomes Analysis portion of this report, the overall trend for hospital re-admissions within 30 days has improved over time, with a 61% year-over-year reduction, which is a positive indicator that members are seeking outpatient services when appropriate. One of those services is Peer Support, which increased 33% (when measured by the number of unique utilizers per 1,000 members) between Q2 2017 and Q2 2018—the most recent quarters for which data is available. Optum Idaho’s Field Care Coordinators continue to work with our highest need members and their providers upon inpatient discharge to help ensure the appropriate outpatient services are received soon after the members’ discharge. Starting in Quarter 3, 2018, Community Based Rehabilitation Services (CBRS) was transformed to Skills Building for both adults and youth. This enhanced service focuses on competency in social, communication and behavioral skills, and allows providers to deliver a structured process for addressing members’ functional deficits in a timelier manner.

During Quarter 3, 2018, Optum Idaho’s Community Programs and Media Activities reached thousands of people throughout the state. Optum team members across the state participated in 75 meetings, events and media coverage that reached more than 220,000 people.

In August and September, Optum Idaho partnered with stakeholders to create IROAR the Idaho Recovery Open Awareness Ride (Powered by Optum.) IROAR served as a fundraiser, celebrated National Recovery Month and shared the message that recovery is possible for everyone, while removing the stigma associated with substance use disorders and mental health issues. The 1,400 mile motorcycle ride stopped at every recovery center in Idaho. The centers hosted a variety of activities including: pancake breakfasts, picnics, concerts and parties to celebrate IROAR. Optum Idaho staff members were at each event and presented the recovery centers a check for \$15,000 to support their work. Some staff members even road along for portions of the trip. A ten foot by four foot banner was created to be carried on the trip. Hundreds of people signed the banner with words of encouragement and added their names to those who are in recovery or supporting a friend or family member.

The banner was presented on the steps of the state capitol building and will be shared across all recovery centers throughout the year so they can display it at their offices.

The results of the first IROAR include:

- A total of 68 riders participated
- Recovery centers raised more than \$12,000 from donations at the events
- Optum Idaho donated \$15,000 to each recovery center in Idaho
- The ride generated news stories across Idaho

The Optum Idaho team pitched local media interviews in areas where riders would be traveling through parts of the state during the celebration. As a result, [KIFI](#) , [KIDK](#) , [KIVI](#) and [EastIdahoNews.com](#) covered the event as it made its way through their specific area of the state.

Dr. Ronald Larsen conducted TV interviews about the increase in Senior Suicides in Idaho and around the nation. Dr. Larsen was invited to talk to reporters about this serious issue on [Boise State Public Radio - Idaho Matters](#) and [KBOI](#).

Optum sponsored and participated in a wide variety of stakeholder and professional events and conferences during Quarter 3 including:

Nampa Kindness Day - 1,300 Optum branded bags stuffed with Optum information were distributed.

The Region 4 Community Resource Fair - for people transitioning out of incarceration. More than 500 people attended.

NAMI Treasure Valley Walk – Optum sponsored this event that was attended by 300 people.

Together with community partners, we continue our focus on an outcomes driven, recovery-centered system of care for Idaho members. With the right support, people can and do recover to live full lives.

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 3, 2018, (July through September 2018), unless otherwise noted, and provides comparative performance.

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

Overall Effectiveness and Highlights

Optum Idaho monitors performance measures as part of our Outcomes Management and Quality Improvement Work Plan. In this report, thirty-three (33) key performance measures with performance goals were highlighted based on performance targets that are based on contractual, regulatory or operational standards. For this reporting period, Optum Idaho met or exceeded performance for 26 (79.0%) of the key measures. Optum Idaho's continues its commitment to IBHP members and families in transforming the behavioral health care system in the State of Idaho.

Quality Performance Measures and Outcomes

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

Measure	Goal	July - September 2017	October - December 2017	January - March 2018	April - June 2018	July - September 2018
Member Satisfaction Survey Results						
Optum Support for Obtaining Referrals or Authorizations	≥85.0%	85.0%	72.0%	83.0%		Based on Member Satisfaction Survey sampling methodology, Q1, 2018, is the most current data available
Accessibility, Availability, and Acceptability of the Clinician Network	≥85.0%	94.0%	89.0%	89.0%		
Experience with Counseling or Treatment	≥85.0%	93.0%	96.0%	91.0%		
Overall Satisfaction	≥85.0%	89.0%	78.0%	78.0%		
Provider Satisfaction Survey Results						
Annual Overall Provider Satisfaction	≥85.0%		2016 Results 75.0%	2017 Results 77.0%		Survey Completed Annually
Accessibility & Availability						
Idaho Behavioral Healthplan Membership						
Membership Numbers	NA	301,989	303,831	292,602	276,824	Due to claims lag, data is reported 1 quarter in arrears
Member Services Call Standards						
Total Number of Calls	NA	1,362	1,295	1,123	1,159	1,230
Percent Answered within 30 seconds	≥80.0%	83.0%	86.0%	82.1%	80.7%	57.1%
Average Speed of Answer (seconds)	≤30 Seconds	2.7	1.5	4.0	2.8	31.2
Abandonment Rate	≤3.5% internal ≤7.0 % contractual	1.7%	1.4%	1.5%	2.1%	4.4%

Measure	Goal	July - September 2017	October - December 2017	January - March 2018	April - June 2018	July - September 2018
Customer Service (Provider Calls) Standards						
Total Number of Calls	NA	4,103	3,135	3,320	2,678	2,886
Percent Answered within 30 seconds	≥80.0%	97.1%	99.3%	98.0%	99.1%	98.1%
Average Speed of Answer (seconds)	≤30 Seconds	6.2	2.3	3.9	3.9	3.2
Abandonment Rate	≤3.5% internal ≤7.0% contractual	0.64%	0.00%	0.00%	0.00%	0.31%
Urgent and Non-Urgent Access Standards						
Urgent Appointment Wait Time (hours)	48 hours	20.0	21.4	22.2	23.1	21.1
Non-Urgent Appointment Wait Time (days)	10 days	6.0	5.4	4.3	5.1	4.5
Geographic Availability of Providers						
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100.0%	100.0%	99.8%*	99.8%*	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%*	99.8%*	99.8%*	99.7%*	99.8%*
Member Protections and Safety						
Notification of Adverse Benefit Determinations						
Number of Adverse Benefit Determinations (ABD's)	NA	756	492	504	320	221
Clinical ABD's (<i>began tracking Q3, 2017</i>)	NA	578	352	351	195	72
Administrative ABD's (<i>began tracking Q3, 2017</i>)	NA	178	140	153	125	149
Written Notification (<i>14 calendar days from request for services - implemented 7/1/17</i>)	100% within 14 calendar days	100.0% (756/756)	99.8% (491/492)	100.0% (504/504)	100.0% (320/320)	98.2% (217/221)
Member Appeals (formerly Grievances)						
Number of Appeals	NA	51	30	23	21	4
Non-Urgent Appeals	NA	36	26	17	19	4
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	15	4	6	2	0
Determination Compliance	100% within 30 Calendar Days	100.0%	100.0%	100.0%	100.0%	NA

Measure	Goal	July - September 2017	October - December 2017	January - March 2018	April - June 2018	July - September 2018
Complaint Resolution and Tracking						
Total Number of Complaints	NA	16	11	11	18	17
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	14	10	9	17	12
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints	NA	2	1	2	1	5
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	11	12	14	11	10
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	148	79	275	159	164
Initial Audit (Percent overall score)	≥ 85.0%	98.0%	92.3%	92.2%	93.0%	95.0%
Recredentialing Audit (Percent overall score)	≥ 85.0%	92.8%	89.1%	89.6%	93.9%	95.8%
Monitoring (Percent overall score)	≥ 85.0%	93.7%	93.9%	90.0%	87.7%	88.3%
Quality (Percent overall score)	≥ 85.0%	86.1%	NA**	NA**	NA**	88.1%
Percent of Audits that Required a Corrective Action Plan	NA	11.5%	8.9%	24.0%	28.9%	23.8%
Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)						
Percent PCP is documented in member record	NA	96.1%	96.2%	94.8%	95.4%	98.0%
Percent documentation in member record that communication/ collaboration occurred between behavioral health provider and primary care provider	NA	79.0%	72.0%	75.0%	71.0%	81.0%
Provider Disputes						
Number of Provider Disputes	NA	45	24	55	13	22
Percent Provider Dispute Determinations made within 30 calendar days from request	100% within 30 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%
Average Number of Days to Resolve Provider Disputes	≤30 days	6.1	4.6	7.1	6.08	7.8
Utilization Management and Care Coordination						
Service Authorization Requests						
Percentage Determination Completed within 14 days	100%	99.1%	99.5%*	99.1%	98.9%	98.9%

Measure	Goal	July - September 2017	October - December 2017	January - March 2018	April - June 2018	July - September 2018
Field Care Coordination						
Total Referrals to FCCs	NA	209	264	136	184	144
Average Number of Days Case Open to FCC	NA	41	32	46	44	65
Discharge Coordination: Post Discharge Follow-Up						
Number of Inpatient Discharges	NA	819 [^]	1009	804	798	Data is reported 1 quarter in arrears
Percent of Members with Follow-Up Appointment or Authorization within 7 Days after discharge	NA	50.4% [^]	47.0%	46.5%	47.0%	
Percent of Members with Follow-Up Appointment or Authorization within 30 Days after discharge	NA	69.5% [^]	67.9%	67.0%	67.3%	
Readmissions						
Number of Members Discharged	NA	820 [^]	1009	804	804	Data is reported 1 quarter in arrears
Percent of Members Readmitted within 30 days	NA	10.2% [^]	9.2%	6.1%	7.9%	
Inter-Rater Reliability						
Inter-Rater Reliability completed annually. Results presented during Q2, 2017	NA	Completed annually in November				
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%	98.1%	94.0%	93.4%	100.0%	
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%	99.9%	99.4%	99.7%	99.3%	99.6%
Procedural Accuracy	97.0%	100.0%	99.5%	100.0%	99.3%	99.5%

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

***there were 0 quality audits*

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

[^]numbers changed to reflect additional claims updates

within 5% of goal did not meet goal

Outcomes Analysis

There are multiple outcomes that Optum analyzes 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 Q3 2017 through Q3 2018.

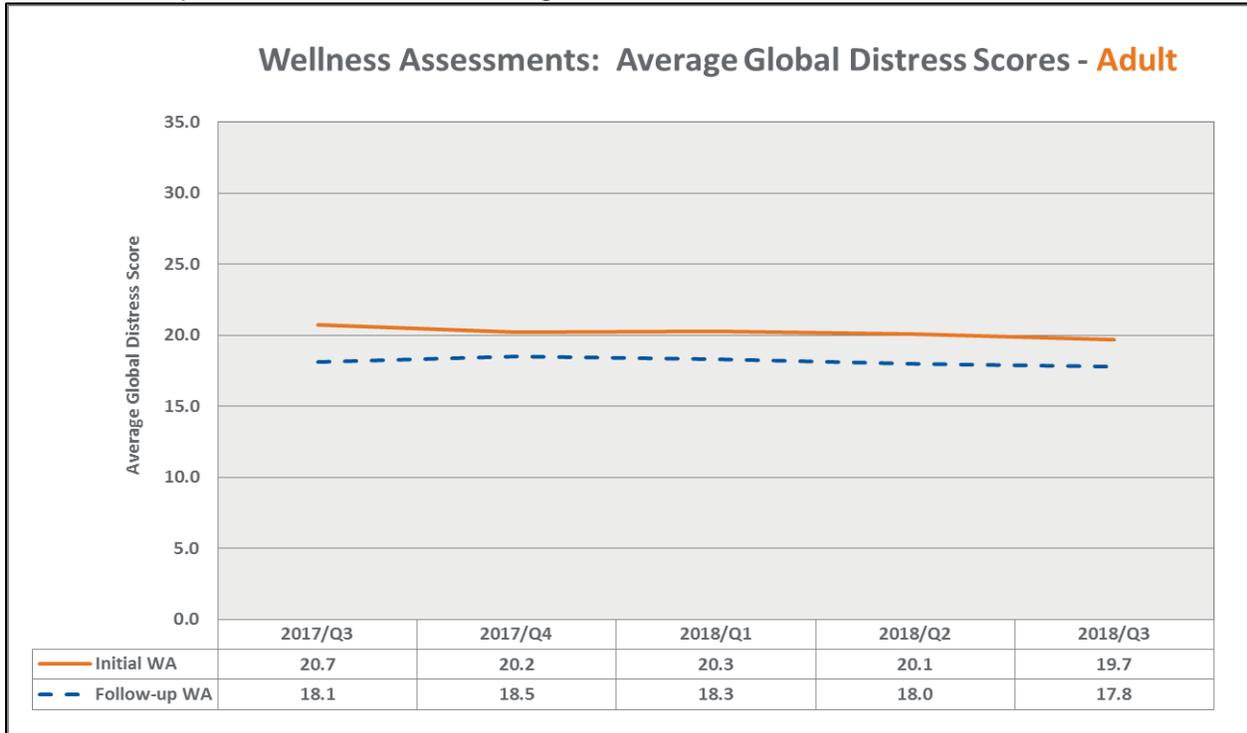


Figure 1

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 Q3 2017 through Q3 2018.

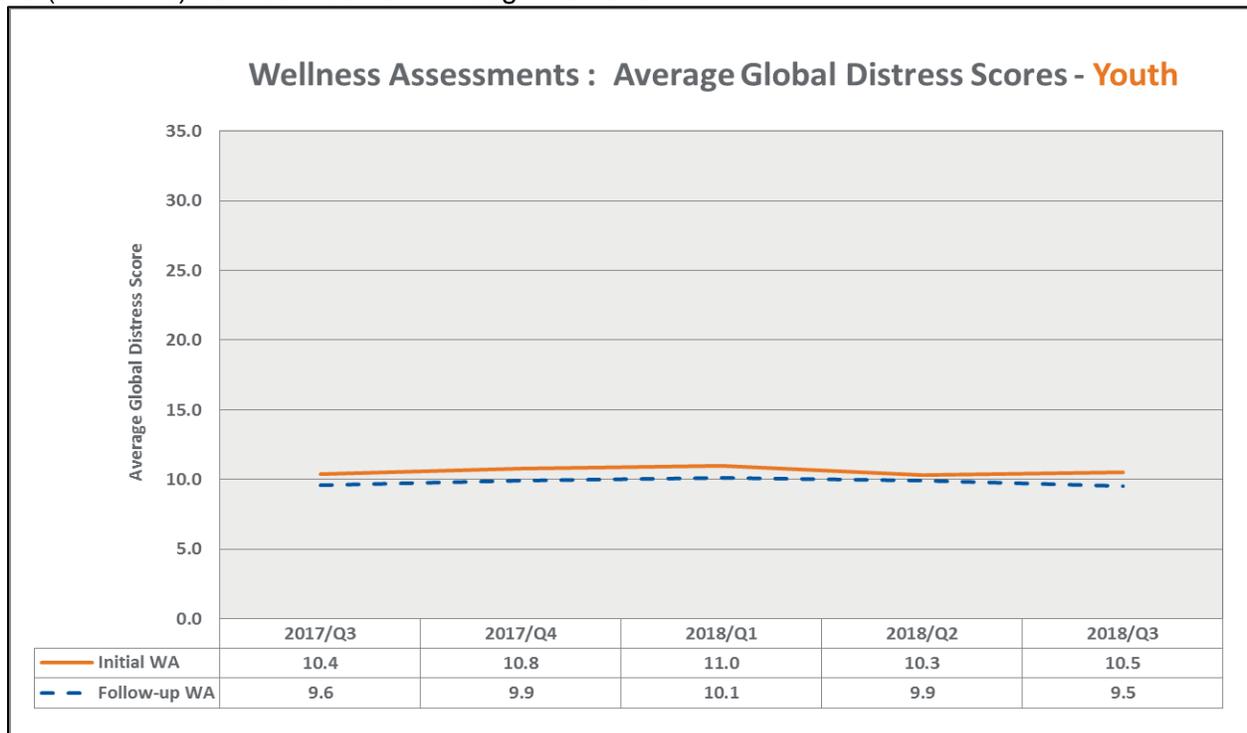


Figure 2

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: Average caregiver strain measured at the lower end of Moderate levels during the study period, and on average improved 10% between initial and follow-up assessments.

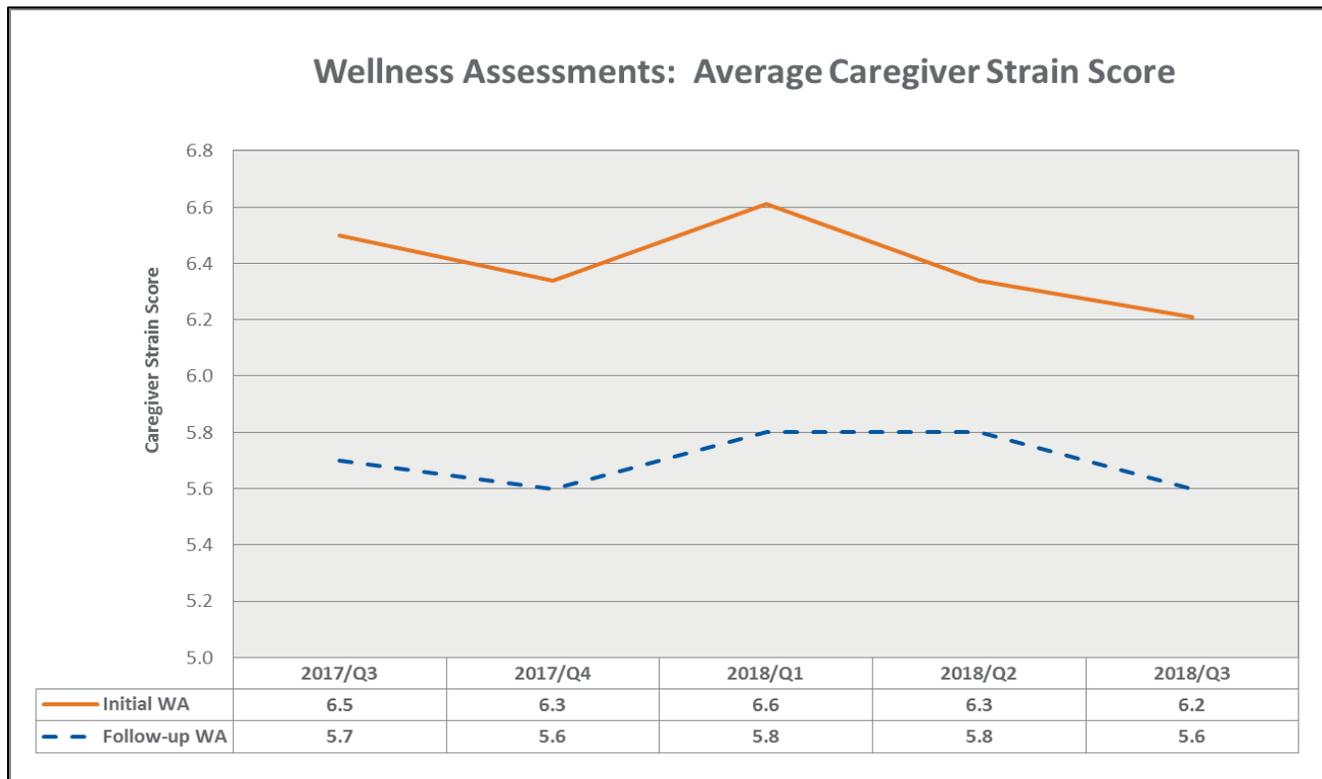


Figure 3

Adult Physical Health Score:

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.

Analysis Figure 4: 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.

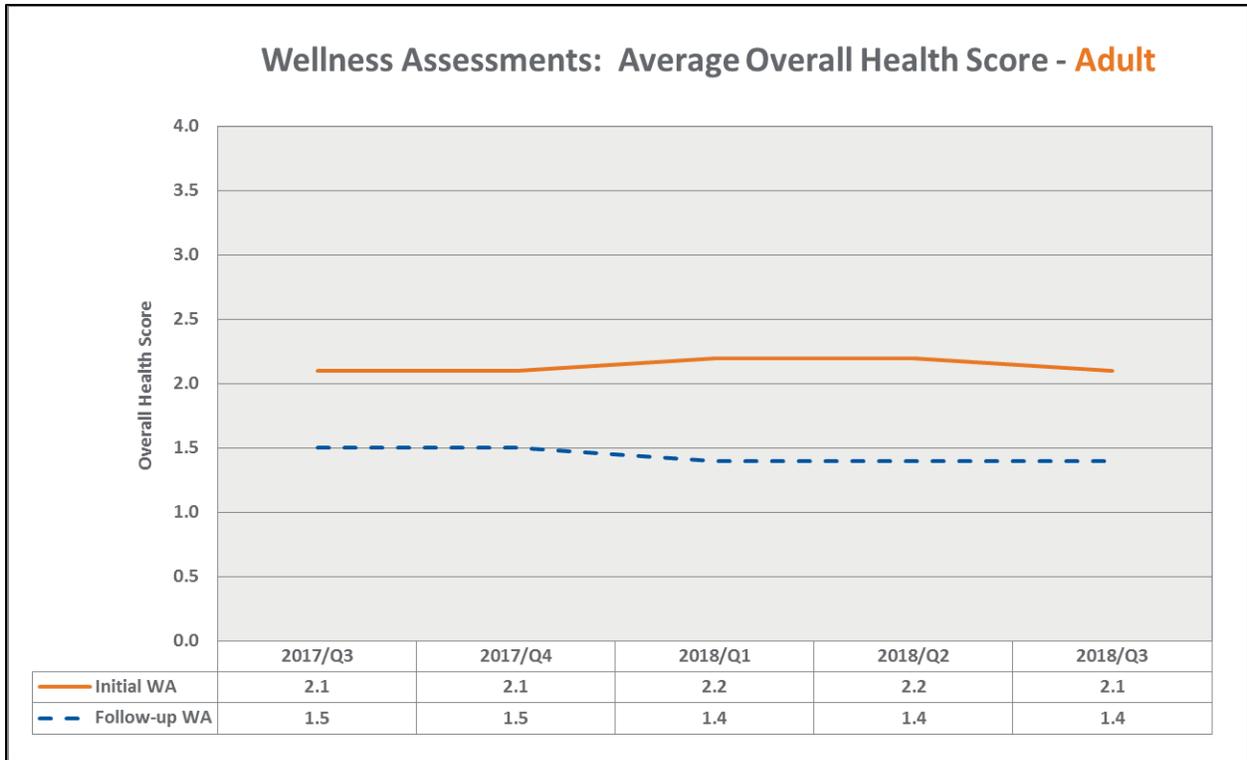


Figure 4

Child and Youth Physical Health Score:

Child and Youth Physical Health score values are as follows:

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

Analysis Figure 5: Between Q3 2017 through Q3 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.

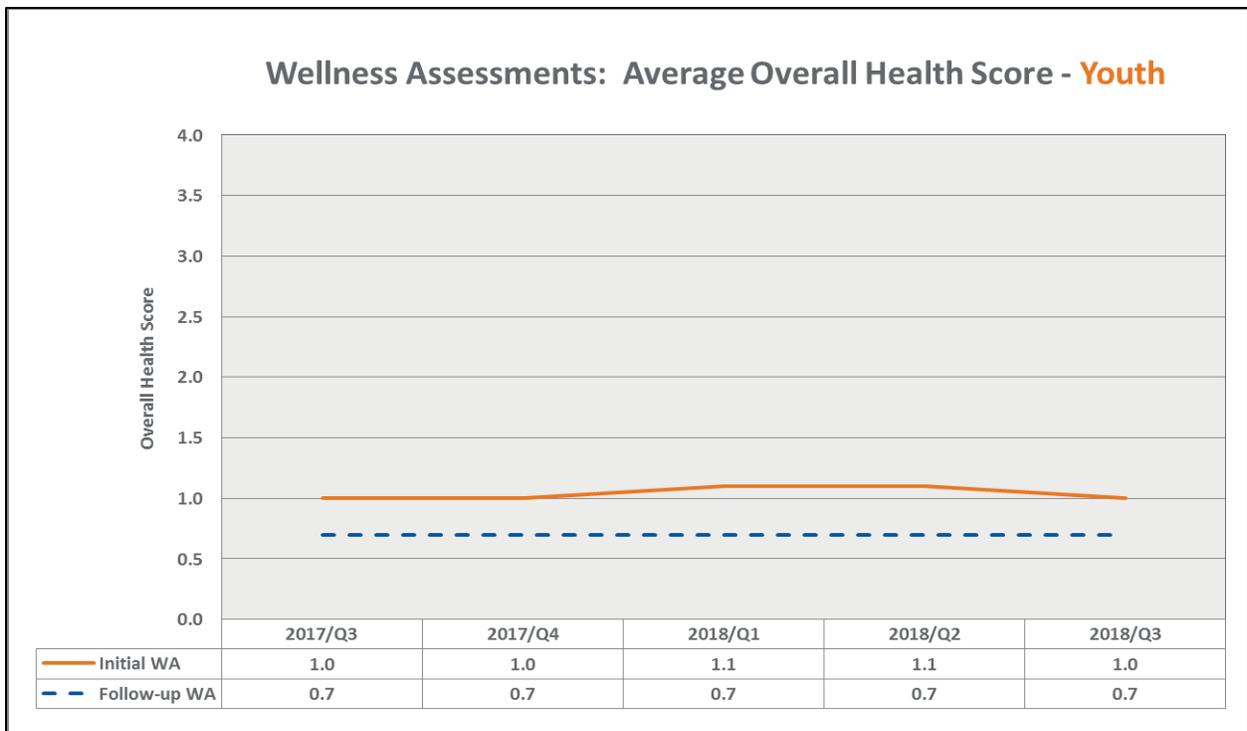


Figure 5

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 Figure 6: 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 fewer for children

and transitioning youth. Overall utilization of Individual Therapy increased 6.0% from Q2 2017 to Q2 2018, driven by youth and young adults; rates for ages 21+ were flat over the study period.

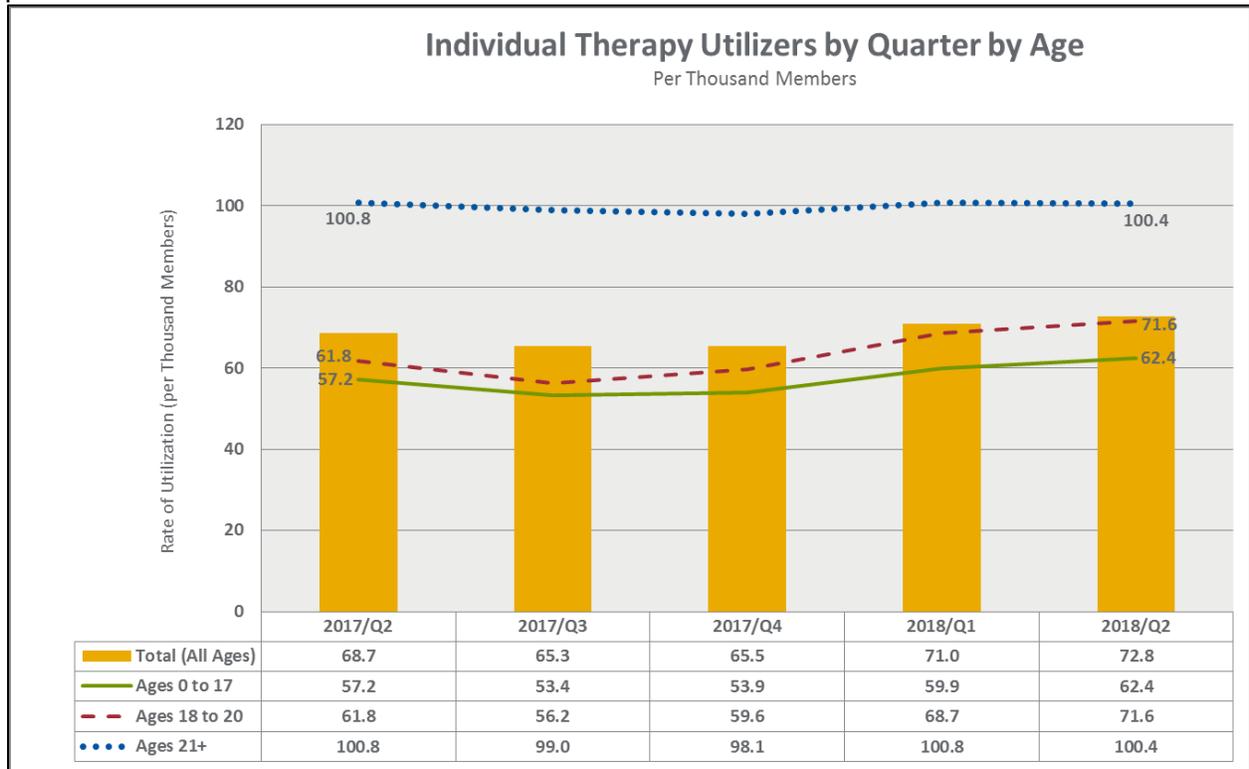


Figure 6

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 Figure 7: On average, the utilization rate of Family Therapy is consistent from Q2 2017 to Q2 2018, notwithstanding a slight decrease in the second half of 2017.

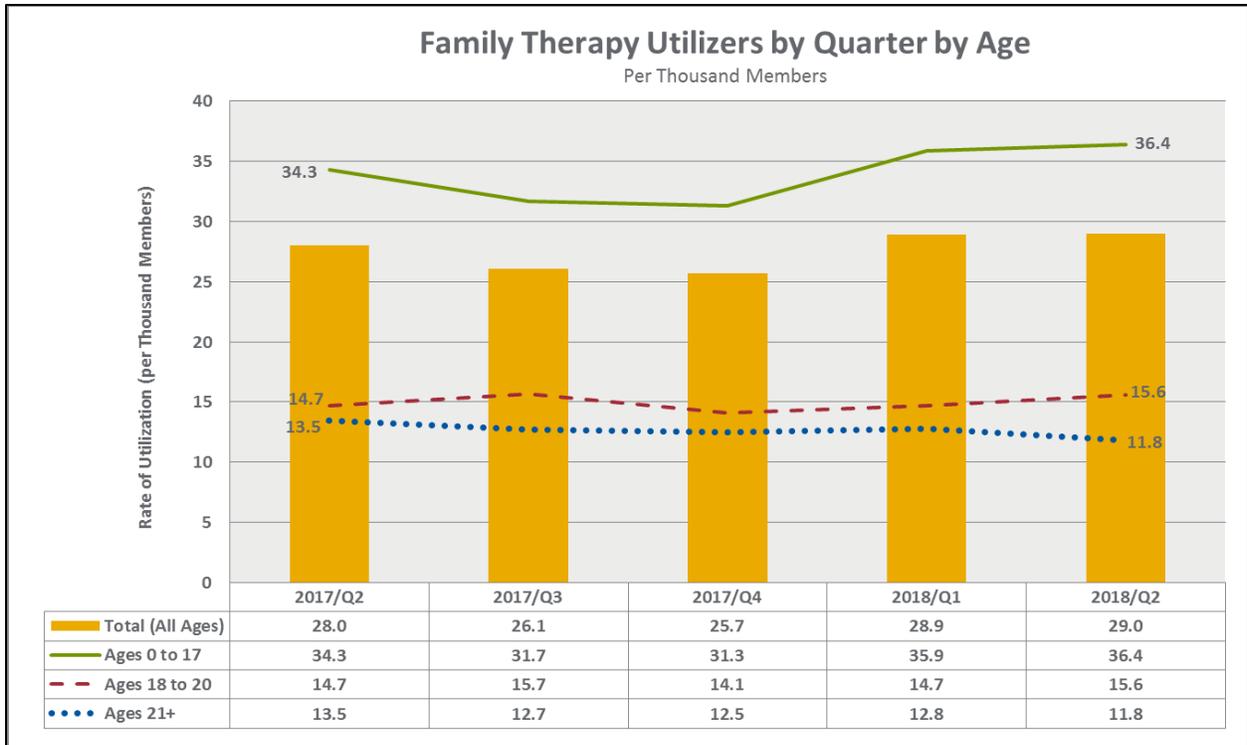


Figure 7

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 Figure 8: 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 Q2 2018 utilization for Peer Support increased 22% and 36% respectively from Q2 2017. This positive trend correlates with Optum’s changes in Peer Support utilization management and with increased community and provider training and awareness efforts.

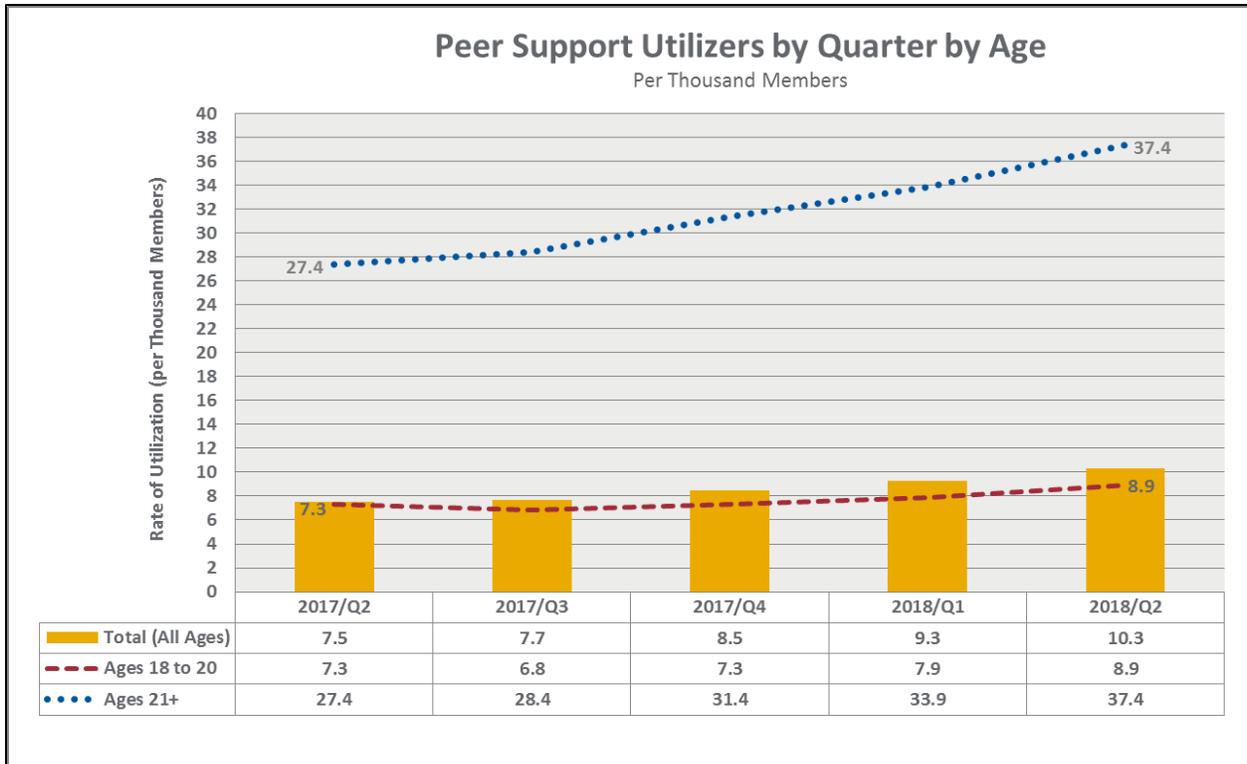


Figure 8

Barriers: No barriers were identified.

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 the 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 Figure 9: Case Management Services utilization rates for young adults 18-20 are flat over the study period but are down 3% for Children & Youth and down 2% for adults over 21.

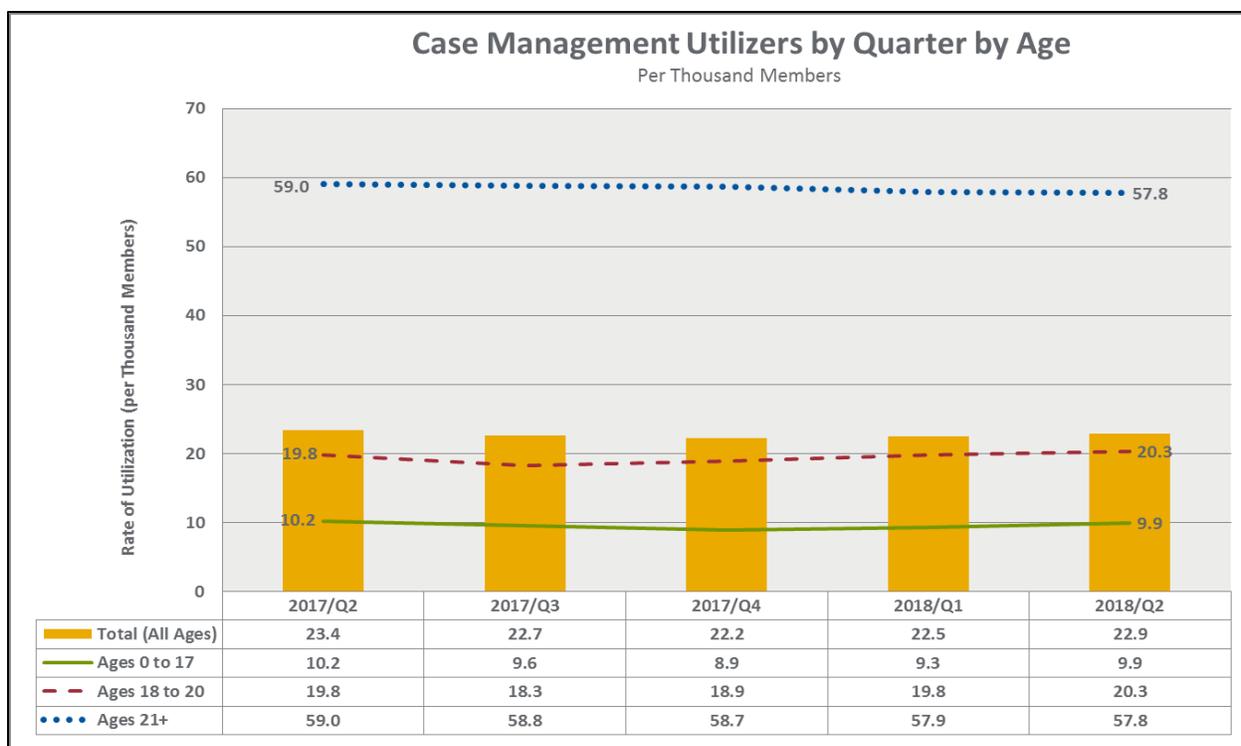


Figure 9

Barriers: No barriers were identified.

Opportunities and Interventions: No opportunities for improvement were identified.

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 Figure 10: The utilization rate for total behavioral health prescription visits are up for all age groups from Q2 2017 to Q2 2018, with largest increase coming from the 0-17 and 18-20 populations (approximately 9% year over year).

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.

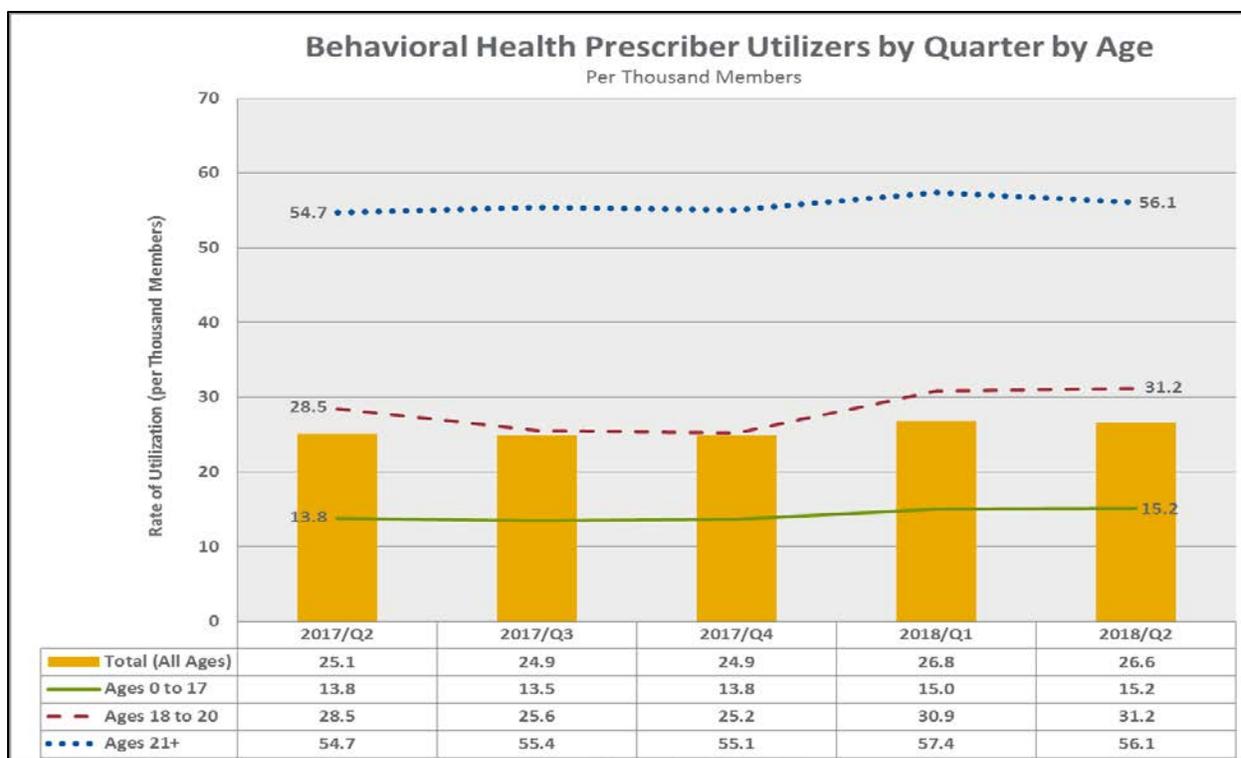


Figure 10

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.

Skills Building/Community Based Rehabilitation Services (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 Figure 11: CBRS was a set of rehabilitation services originally developed to support adults diagnosed with Schizophrenia and severe and persistent Bipolar Disorder. Starting in Q3 2018, this service was transformed to Skills Building/CBRS for both adults and youth. This enhanced service focuses on competency in social, communication, and behavioral skills, and

allows providers to deliver a structured process for addressing members' functional deficits in a timelier manner.

Between Q2 2017 and Q2 2018, the reduction in CBRS for all age groups combined was 25%. 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 8%, 26%, and 29% respectively within the study period. These changes have sustained a more clinically appropriate use of Skills Building/CBRS for members. Utilization will be closely monitored in subsequent quarters with the Skills Building enhancement added in Q3 2018.

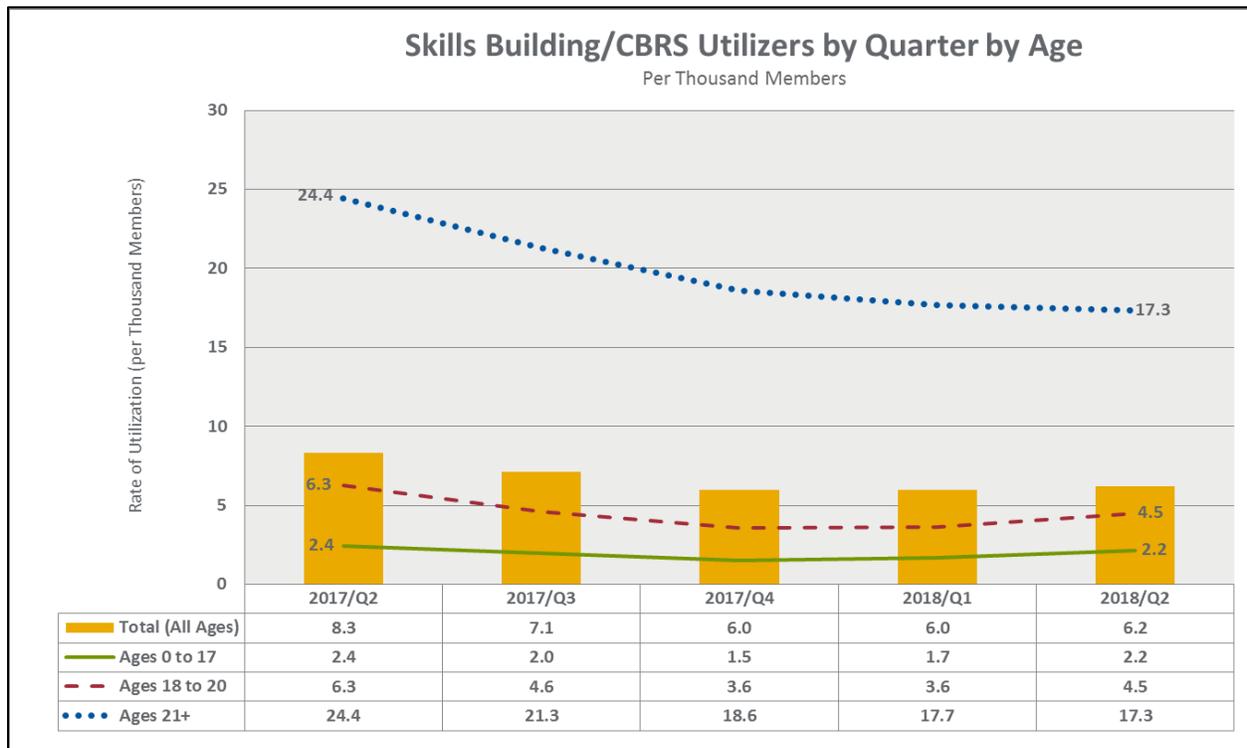


Figure 11

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

Opportunities and Interventions: Optum will continue utilization management of Skills Building/CBRS services and recommend 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 Figure 12: 96% of members who received an ABD for CBRS services in Q2 2018 received evidenced-based therapeutic services within 90 days of the ABD, which has been more or less the trend over the 5-quarter study period. Q1 and Q2 2018 observed a decline in service utilization after 90 days and an increase in the number receiving no services. 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.

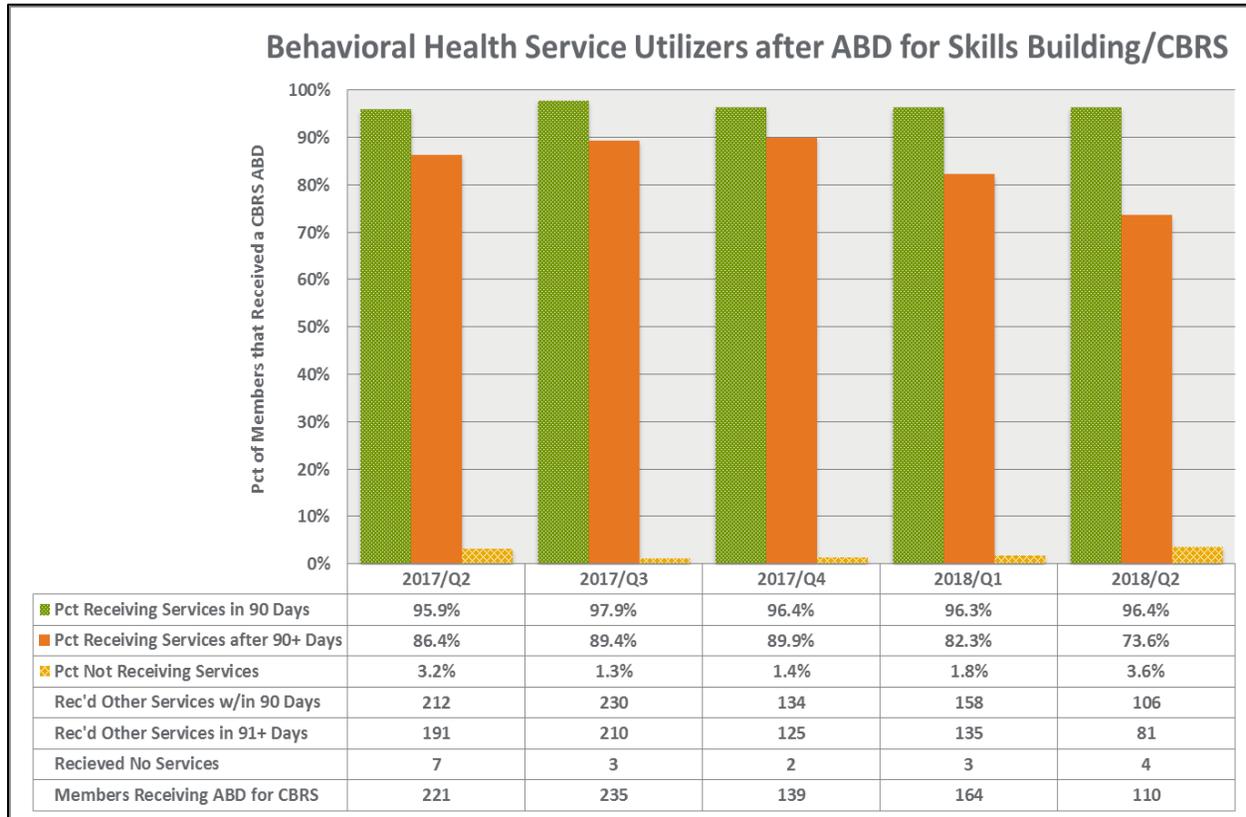


Figure 12

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 also 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 shows the overall rate of discharges decreased year-over-year from 2.72 to 2.20 per 1,000 members, which represents a 19% decrease in hospitalizations, notwithstanding temporary rises in the discharge rate in Q4 2017.

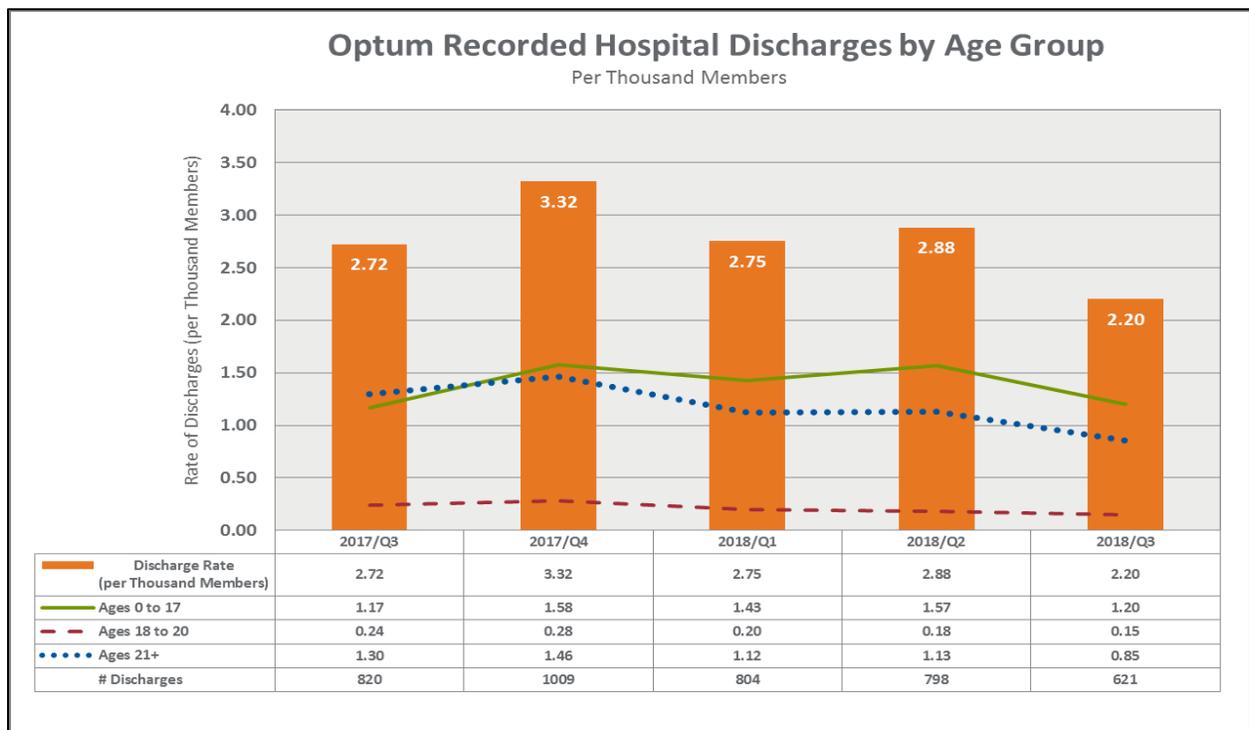


Figure 13

Figure 14 shows that during the study period from Q3 2017 through Q3 2018, discharges were trended downward for both the State and Community hospitals, notwithstanding a one quarter increase in Q4 2017 in the latter.

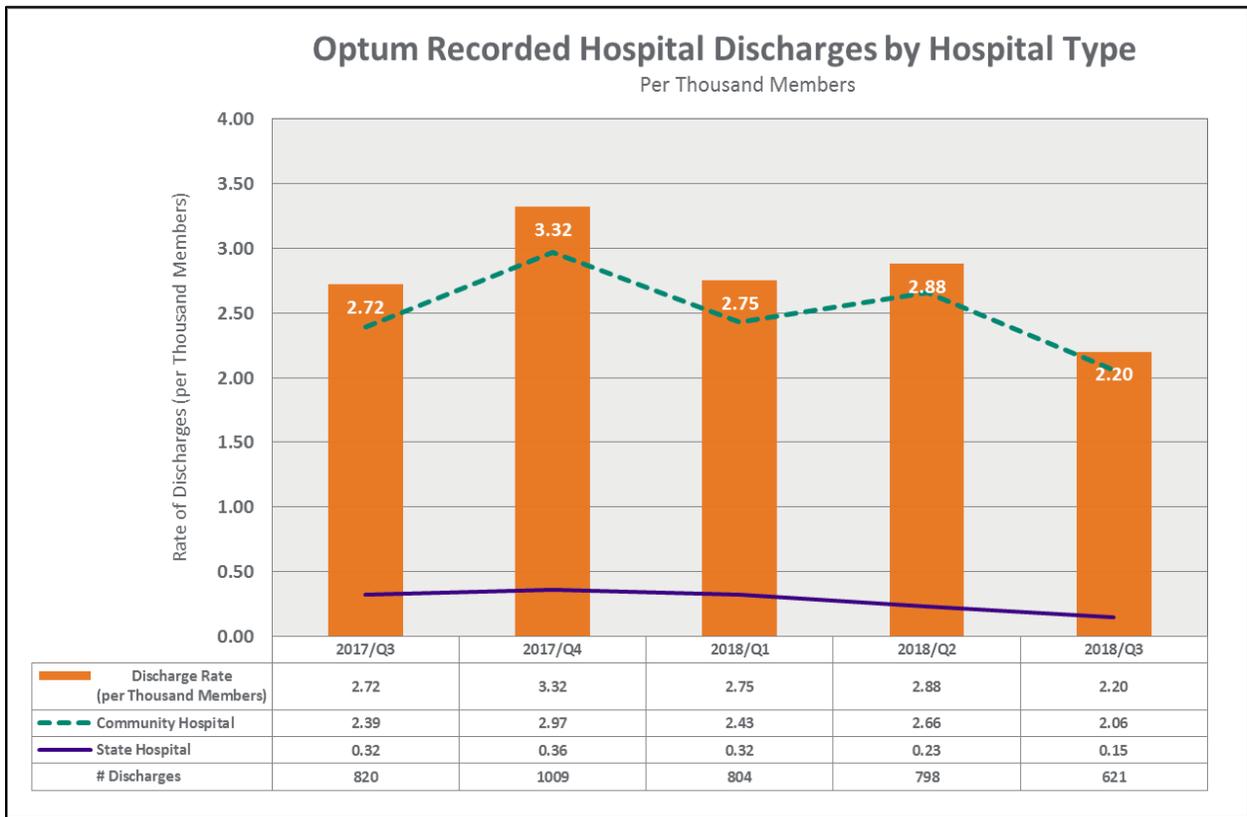


Figure 14

Figure 15 indicates that from Q3 2017 through Q3 2018, based on information reported to Optum Idaho from hospitals, the overall average length of stay was down by 17%. The 0-17 age group experienced an offsetting trend, and has 4% longer stays than a year ago.

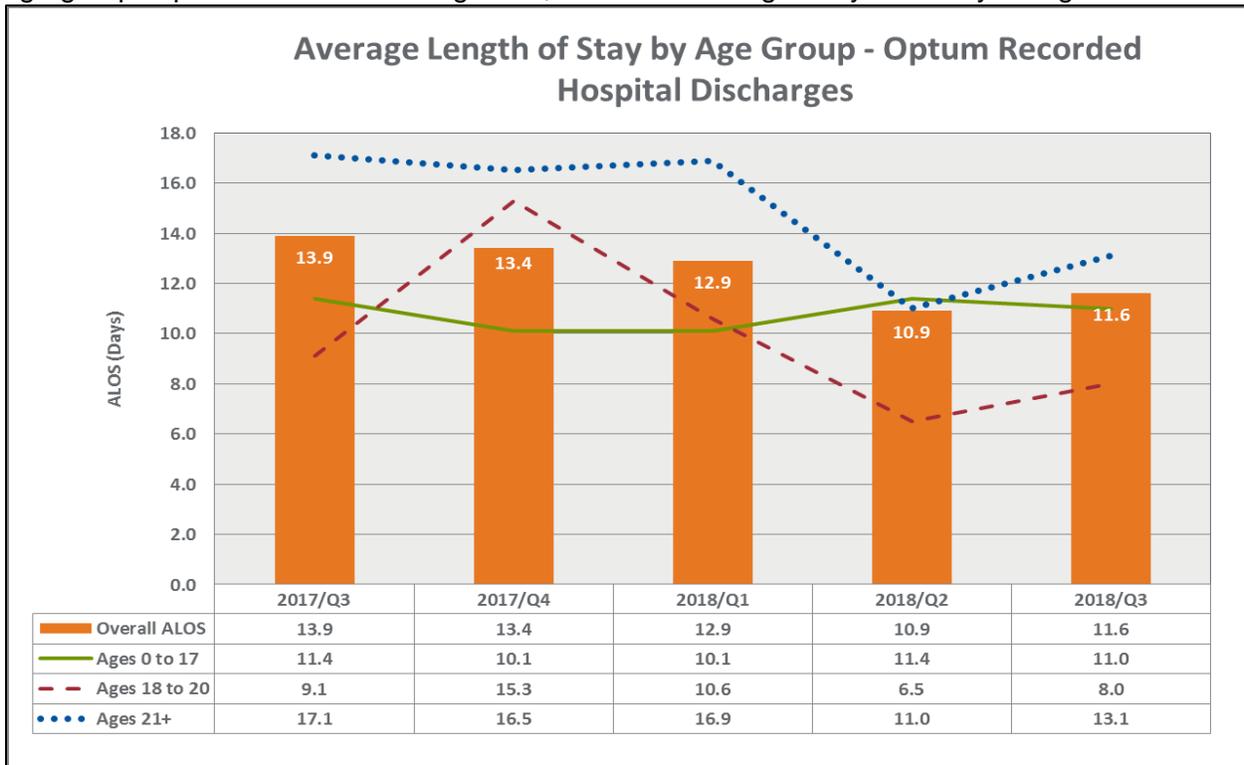


Figure 15

Figure 16 shows the average length of stay by hospital type. State hospitals experienced a marked decline in 2018, dropping 16% from Q3 2017 to Q3 2018. Community hospital rates had an opposite trend direction, though not to the degree experienced by State hospitals: Community hospital lengths of stay increased 6% over the five-quarter study period.

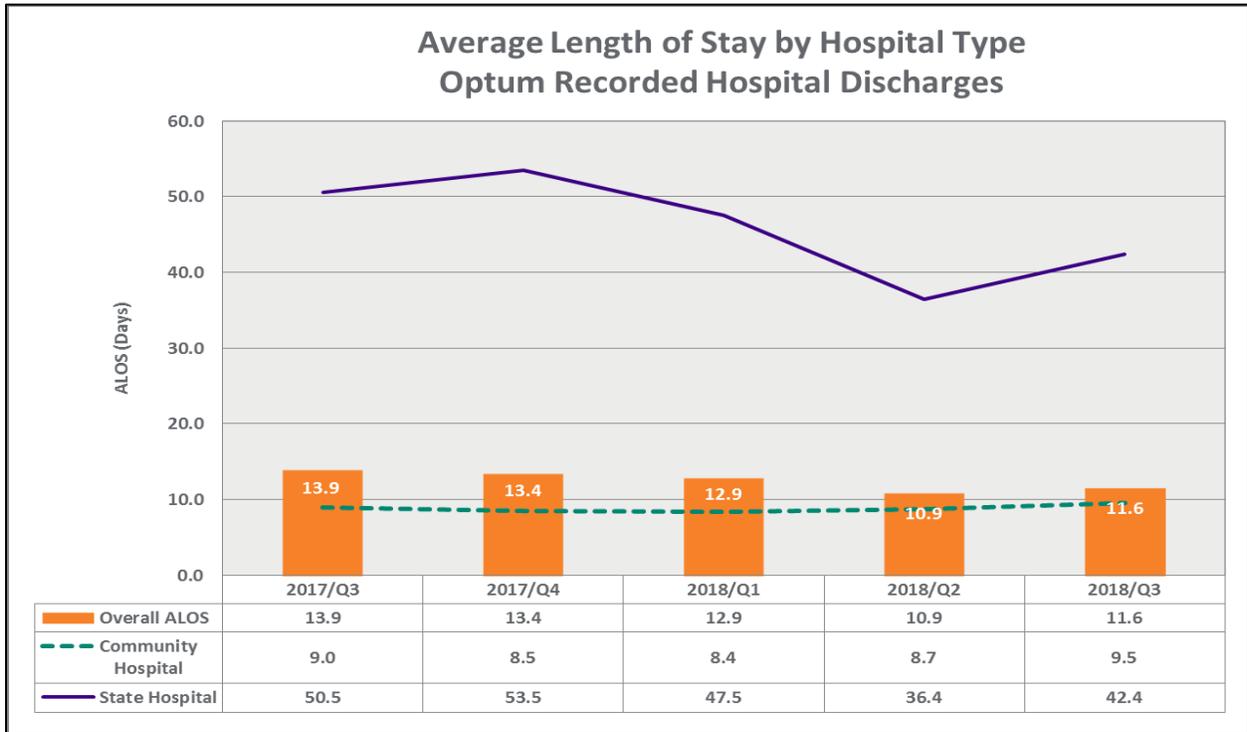


Figure 16

Figure 17 shows that during the study period from Q3 2017 through Q3 2018, readmissions decreased 6.3 percentage points (or by more than half) year-over-year. According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals.

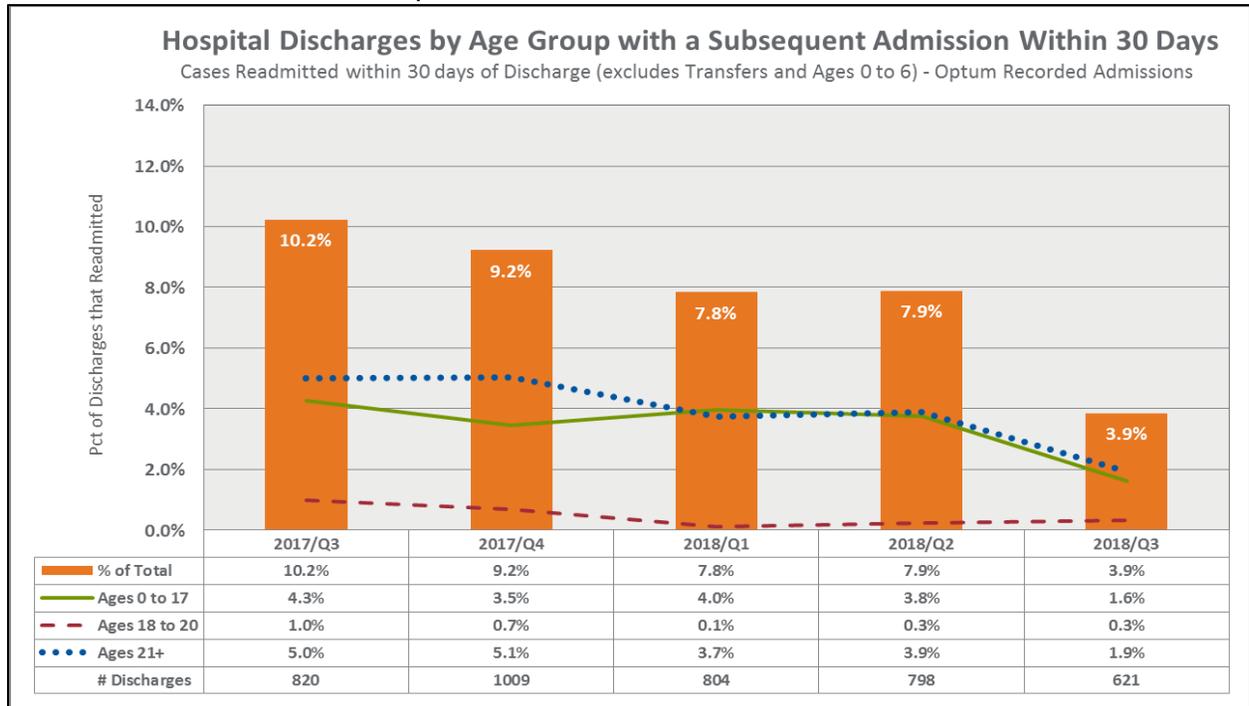


Figure 17

Figure 18 shows readmissions percentages by hospital type. During the study period from Q3 2017 through Q3 2018, the readmission rate for both state and community hospitals improved, with a community hospitals improving the most, at 61%.

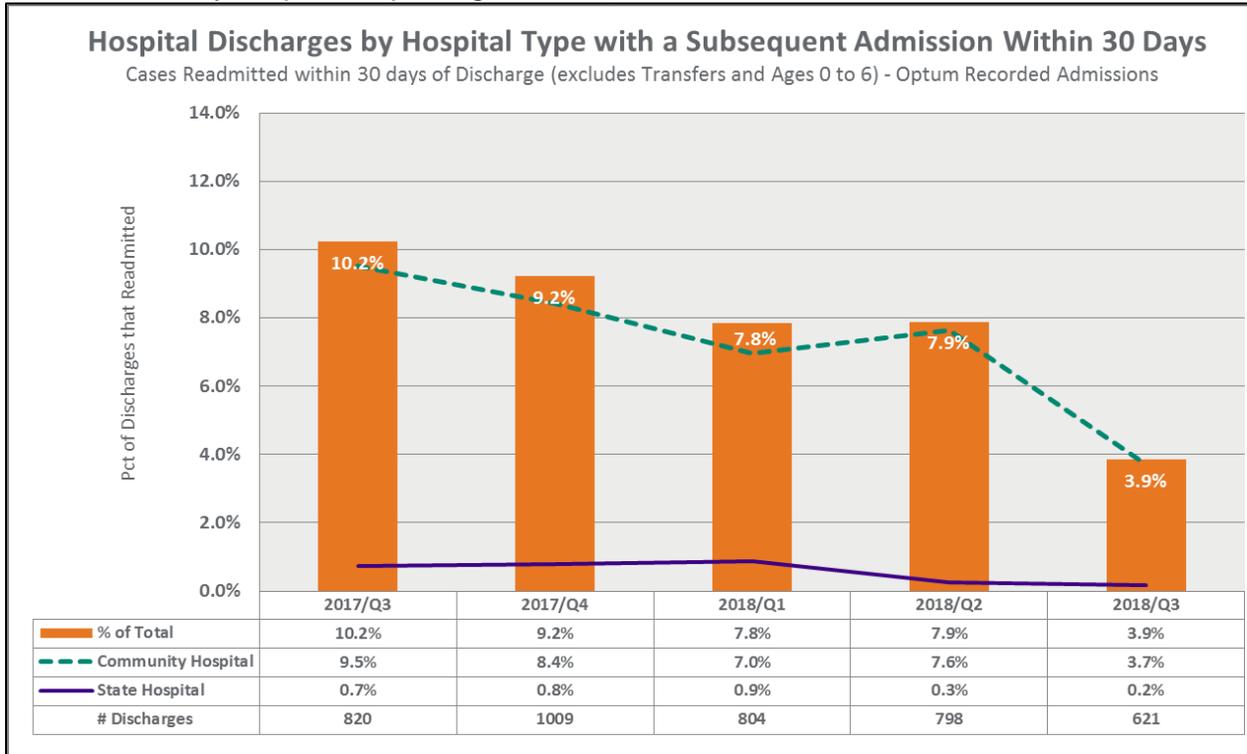


Figure 18

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.

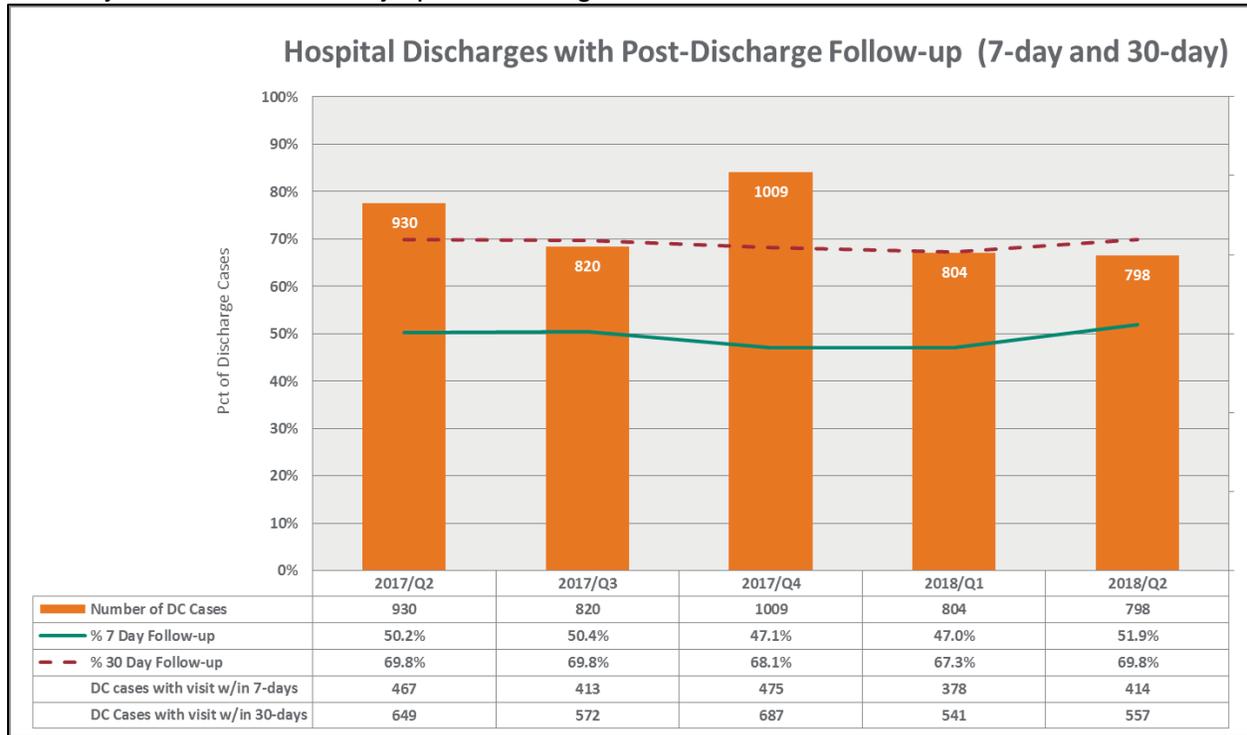


Figure 19

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 outpatient appointments are scheduled and kept, but, at times, are not able to verify that these appointments are kept due to timely hospital discharge information.

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

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:

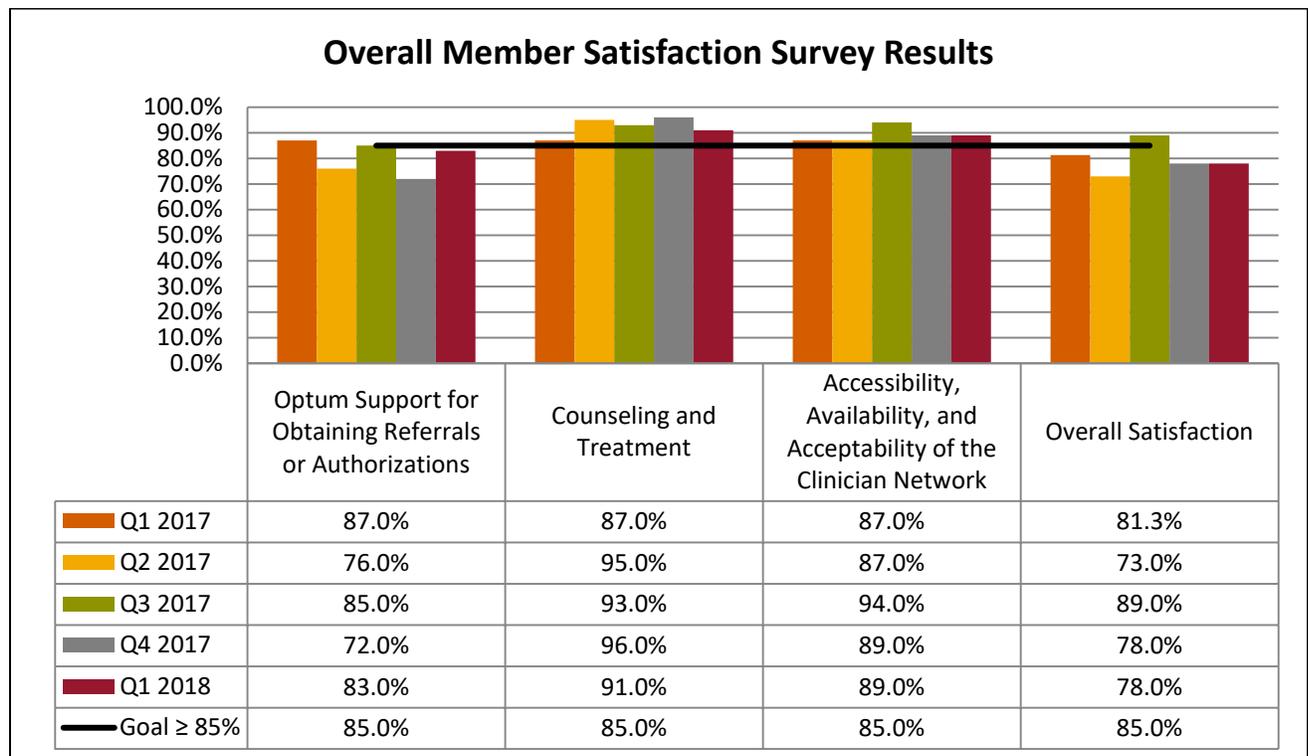
- Overall satisfaction
- Optum support for obtaining referrals or authorizations
- Accessibility, availability, and acceptability of the clinician network
- Claims customer service
- Counseling and treatment
- Net Promoter Score

Quarterly Performance Results

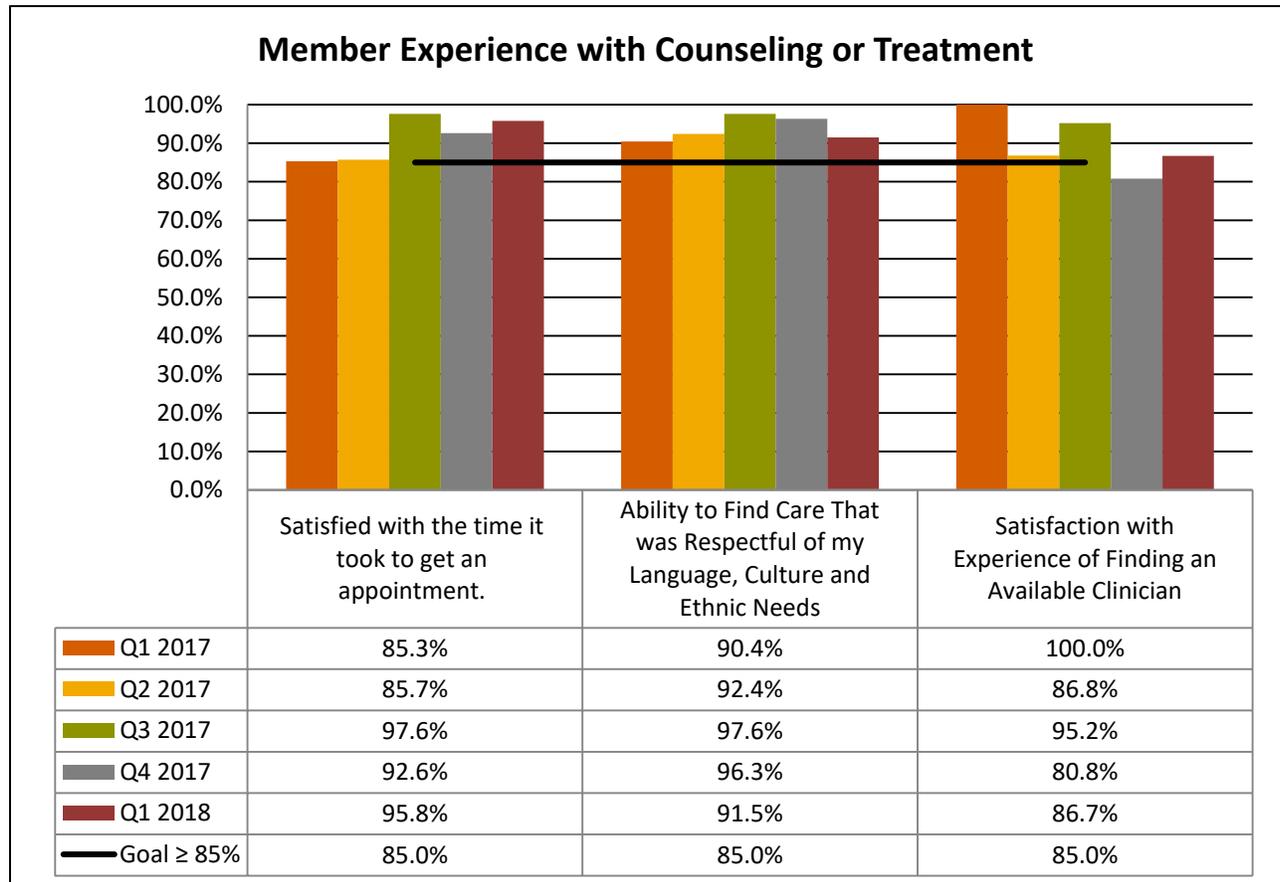
Key Consumer Measures	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018
Overall Satisfaction (Goal: ≥85.0%)	81.3%	73.0%	89.0%	78.0%	78.0%
Optum support for obtaining referrals or authorizations	87.0%	76.0%	85.0%	72.0%	83.0%
Accessibility, availability, and acceptability of the clinician network	87.0%	87.0%	94.0%	89.0%	89.0%
Counseling and Treatment	87.0%	95.0%	93.0%	96.0%	91.0%
Net Promoter Score (NPS): How likely it is that you would recommend Optum to a friend or colleague?	4	12	37	-18	12
Promoters	41%	45%	57%	26%	42%
Passives	21%	23%	23%	30%	28%
Detractors	37%	33%	20%	44%	30%

Analysis: The Quarter 1, 2018, results for Optum Idaho included surveys conducted from April 1, 2018, through June 30, 2018. The total number of members who responded to the survey was 50 which is up from 27 responses during Q4, 2017. The response rate was 11%. Of the total interviews conducted, none (0%) resulted in a request for translation services; all (100%) of the surveys completed were conducted in English.

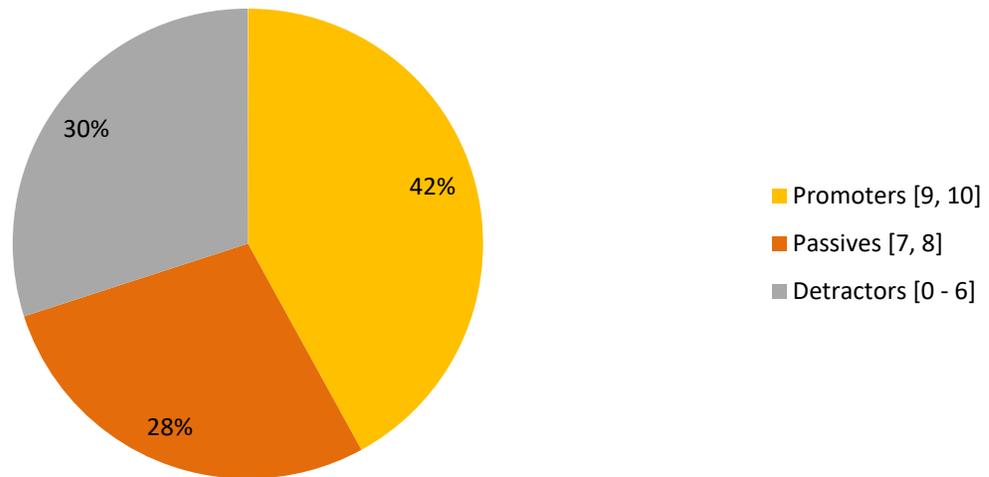
Member Overall Satisfaction was 78.0% during Q1. The Net Promotor Score indicated: Promoters – 42% which was up from 26% during Q4, 2017. Passives were 28%, and Detractors, 30%.



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.



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) Q1, 2018



Barriers: Scores have fluctuated with no identified trends at this time.

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

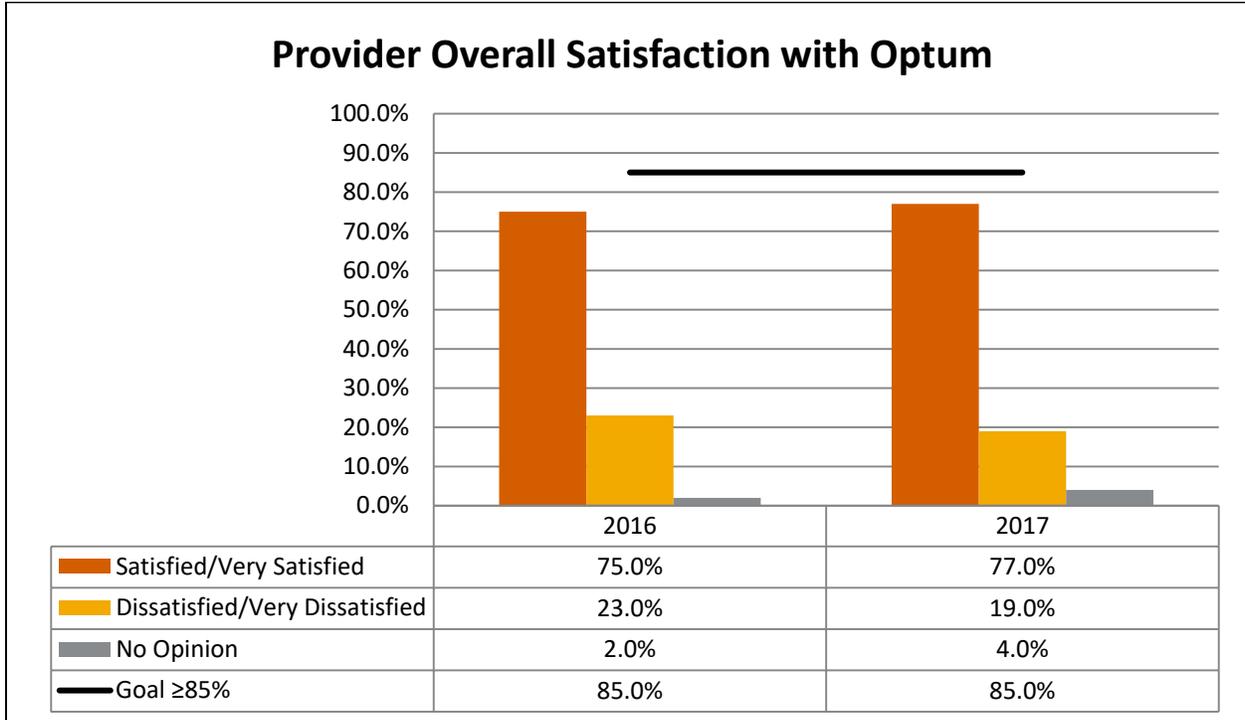
All of the data collection was conducted by Fact Finders. Fact Finders reached out to every provider. To accommodate the schedules of busy providers and include in the research as many of the providers as possible, a multi-stage, multi-mode coordinated data collection effort was employed. As soon as 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: As this is an annual satisfaction survey, the results presented here are the same as those presented in the Q3, 2018 report. They are presented for reference only with no additional information.



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
SA ASAM Expansion	Optum Idaho uses American Society of Addiction Medicine (ASAM) criteria related to SUDS services. However, due to a National project there is an opportunity to align with the broader effort within Optum, to better incorporate ASAM into key operations, policies and processes. The goal is to align with the efforts of the ASAM project within Optum, adapting to Idaho Behavioral Health Plan (IBHP) specific requirements, as needed. Project initiatives will be addressed through modification of key documents (policies, clinical documents, job aids, etc.), staff training, and provider materials (Provider Manual, alerts). The timeframe established for this project is January 31, 2019.	Compliance	Green	<ul style="list-style-type: none"> Finalizing Project Plan. Identified impacts which will determine project deliverables and tasks.
Appointment Reminder Program	This project to add additional hospitals to the program, beginning in September, 2017. The first step will be to gain all necessary formal approvals, as outlined in the milestones. 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 available to all stakeholders.	Clinical & Services Advisory Committee	Green	<ul style="list-style-type: none"> Received final training documents. Scheduled hospital trainings.

Performance Improvement Project (PIP)	Description	Department/Committee Oversight	Status	Key Accomplishments
UM Clinical Review Documentation	The goal of the project is to streamline the utilization management (UM) clinical review process. This project aims to improve communication and collaboration between the Care Advocates (CA) and Peer Reviewers and to improve member facing documentation.	Clinical & Services Advisory Committee	Green	<ul style="list-style-type: none"> • Adverse Benefit Determination (ABD) letter for Skills Building/CBRS created and approved. • Peer Review and Care Advocate review templates created and approved. • Education and training completed. • Began to incorporate all Utilization Management reviewed services into the new template.

Projects

Project	Description	Department/Committee Oversight	Status	Key Accomplishments
School-Based Behavioral Health Care	Optum is working with the Boise School District to implement behavioral health care services in 4 elementary and 1 high school setting, in order to increase access to mental health services and behavioral health counseling for students and families. Boise School District distributed an RFP for providers to participate in a pilot, in which providers would travel to the schools and offer behavioral health services on site. Students enrolled in the district's Community schools program are eligible for these services. Those students participating in the IBHP would receive services from an Optum Network provider. The contract for these services is between the Boise school district and providers. Optum is working with the school district to determine which candidates are network providers, is facilitating codes for travel to schools, and evaluating clinical results at the end of the school year.	Clinical-UM	Green	<ul style="list-style-type: none"> •Continued discussion with school districts about this model. •Transportation Code approved. •Forty kids currently in program with average age of 11; typically seen for depression or aggression. •Transportation Code now approved. •Additional school went live.

Project	Description	Department/Committee Oversight	Status	Key Accomplishments
Skills Building Phase II (formerly: Child & Youth Skills Building)	<p>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).</p>	Clinical-UM	Green	<ul style="list-style-type: none"> • Revised Level of Care Guidelines and Service Request Form and posted to website. • Evidence Based Practice library went live on website • Closed Phase I. Phase II began 7/16/18. • Draft of scope for Phase II complete. • Changed name to Skills Building Phase II.
Infant Toddler Behavioral Health	<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>	Clinical-UM	Green	<ul style="list-style-type: none"> • Provider alert sent. • Met with vendor to finalize legal discussions. • Contract with Vendor was signed. • Date for Informational Conference call for prospective providers scheduled.

Project	Description	Department/Committee Oversight	Status	Key Accomplishments
Tele mental Health	A project team will research TMH 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 stakeholders. The project will also provide education and visibility on current allowed services to expand utilization.	Network	Green	<ul style="list-style-type: none"> • Established which CPT codes with modifier will be impacted.
Crisis Services Phase 1 (Crisis Intervention) Phase 2 (Crisis Response) Phase 3 (Crisis Respite)	As part of the YES implementation, Crisis Services will need to be developed within the guidelines from the Jeff D settlement agreement. There will be 3 services implemented; Crisis Respite, Crisis Response, and Crisis Intervention.	Clinical-UM	Green	<ul style="list-style-type: none"> • Level of Care Guidelines finalized. • Pro forma completed. • Training strategy in process. • Provider Advisory and Clinical and Services Advisory Committee meetings scheduled. • Billing Codes determined. • Provider Alert announced services. • Member handbook definitions completed and ready to send to customer for review. • Fee Schedule loaded and ready for testing. • Revisions for Provider manual sent to customer for approval..
Family Psychoeducation & Training	To describe and define one of the services in the YES service array to be used with membership treatment plans. Family psychoeducation focuses on the illness as the object of treatment, not the family. Evidence indicates that family engagement in the treatment of mental illness helps lead to success by contributing to the prevention of relapse and re-hospitalizations. This approach has been shown repeatedly to achieve major advances in social	Clinical-UM	Green	<ul style="list-style-type: none"> • Level of Care guidelines finalized. • Pro forma completed. • Training strategy in process. • Provider Advisory and Clinical and Services Advisory Committee meetings scheduled. • Changed name to “Family Psychoeducation” • Billing codes determined. • Provider Alert announced services. • Fee scheduled loaded and ready for testing. • Revisions for provider manual

Project	Description	Department/Committee Oversight	Status	Key Accomplishments
	and role functioning, allowing over 80% of young people who participate to continue in school or work.			sent to customer for approval. <ul style="list-style-type: none"> Announcement for Training Kit on SAMHSA completed.
Claims Outlier Management	As part of the ALERT process, an algorithm is applied to identify high or frequent utilization of behavioral health services. Given the impending increase in services that do not require prior authorization, there is a mandate that requires a back-end review that uses concurrent or retrospective review. To ensure high quality member care and utilization, algorithms representing provider behavior are monitored. The algorithms are the starting point for clinical engagement with the provider.	Clinical-UM	Green	<ul style="list-style-type: none"> Business Case revisions in progress. Monitoring 6 months of services to determine outlier criteria.

New Projects implemented during Q3

Project	Description	Department Oversight	Status	Key Accomplishments
Opioid Awareness Phase I Phase II	A national epidemic of Opioid abuse, addiction and overdoses has been clearly identified. Opioid Use Disorder (OUD) is a chronic medical condition. Chances for recovery are better if the person receives evidence-based treatment and long-term support that is tailored to his or her needs. This will be a shared effort with coordination across Idaho's health care system. Addressing this complex opioid crisis will improve the awareness, access to and support of treatment for Idahoans with an Opioid Use Disorder. Opioid use in Idaho will be researched and investigated to design an awareness approach for our Idaho Behavioral Health	Clinical-UM	Green	<ul style="list-style-type: none"> Developing pilot for Opioid offenders who meet specific criteria. Pilot program will be implemented in the Treasure Valley of Idaho.

Project	Description	Department Oversight	Status	Key Accomplishments
	<p>Plan (IBHP) members, providers and internal staff.</p> <p>Phase 1 : Opioid Awareness</p> <p>Phase 2: Collaboration within the system of care to improve the coordination and/or access to appropriate treatment for our members with the goal of positive recovery outcomes.</p> <p>Project will begin end of 2nd quarter 2018 and will be complete by end of year 2019.</p>			
Behavior Modification & Consultation	<p>The Jeff D. Settlement Agreement stipulates that Behavioral Therapeutic Aide must be implemented as a new service for children and youth no later than June 30, 2019. This does not currently exist as a reimbursable service under Medicaid through the Idaho Behavioral Health Plan (IBHP). The team will work to implement as a new service on the fee schedule. The project team recommends requiring certification through the Behavioral Analyst Certification Board (BACB). A limited number of individuals throughout Idaho are currently certified through the BACB, but are most likely providing services to individuals with developmental disabilities and may not be in the IBHP network. Most certified individuals are Master's-level Board Certified Behavioral Analysts (BCBAs). High school-level Registered Behavioral Technicians (RBTs) are available in the state, though in fewer numbers. Optum will also allow certifications for doctoral and bachelor's level individuals.</p>	Clinical-UM	Green	<ul style="list-style-type: none"> • Developing Project Plan.
Cultural DASH Education	<p>This project aims to create educational resources for the Provider Network, internal staff, and community members to promote culturally and linguistically appropriate services. The online modules will focus on LGBTQ++, Refugee, Native American, and Hispanic populations.</p>	Clinical-UM	Green	<ul style="list-style-type: none"> • Charter approved by Executive Project Committee. Will be submitted to Clinical Services Advisory Committee. • Developing Project Plan.
CANS – Phase II	<p>The overall goal of this project is to ensure an adequate network of certified CANS Providers is in place for June 30, 2019. This means that Optum will facilitate</p>	Clinical-UM	Green	<ul style="list-style-type: none"> • Charter approved by Executive Project Committee. Will be submitted to Clinical Services Advisory Committee. • Developing Project Plan.

Project	Description	Department Oversight	Status	Key Accomplishments
	communication about the requirements and changes and offer training/education opportunities for the Provider Network.			
Youth – Family Support	The Jeff D settlement agreement states that Youth and Family Supports must be implemented for youth and children. By the agreed upon date of April 1, 2019, the project team must develop and implement Youth Support as a group reimbursable service. This includes updating the Fee Schedule to include a new reimbursement code, creating LOCGs and Provider Manual language, identifying audit and credentialing requirements and creating appropriate tools, and providing communication and education to the Network. For Family Support, the project team must assess all current clinical documentation, including the Provider Manual and LOCGs, and revise as necessary to ensure alignment with the settlement agreement.	Clinical-UM	Green	<ul style="list-style-type: none"> • Charter approved by Executive Project Committee. Will be submitted to Clinical Services Advisory Committee. • Developing Project Plan.

Project Closures

Project	Description	Department 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	Closed	<ul style="list-style-type: none"> •All tasks completed. •Closure Report Approved.
CANS-Phase I	The Child and Adolescent Needs and Strengths (CANS) assessment will be the only reimbursed assessment tool for children and adolescents served under the Idaho Behavioral Health Plan as of July 1, 2019. This project aims to support the Provider Network as it transitions from the current CAFAS, PECFAS, and CALOCUS assessment tools to the CANS.	Clinical-UM	Closed	<ul style="list-style-type: none"> •All tasks completed. •Closure Report Approved.

Project	Description	Department Oversight	Status	Key Accomplishments
	To render the CANS, Providers must receive an online certification. Optum Idaho will work with the Praed Foundation to offer supplemental in-person workshops throughout the state, as well as web-based training workshops for those unable to attend in person.			
SUD Rate	The SUD rates were adopted at implementation from the states active fee schedule at that time. Providers were advised not to bill psychotherapy codes when the SUD diagnosis was primary. Therefore, all licensure levels bill the H0001 – H0005 when treating clients with an addiction. The state customer asked that Optum consider paying master's level clinicians at a higher rate to treat these clients. As requested by EPC, the issue was discussed with the Provider Advisory Committee. The members asked that Optum review all SUD rates at the same time. The comparison conducted by Network Pricing does indicate that the Idaho reimbursement rate is low relative to the average paid in other Medicaid markets.	Network	Closed	<ul style="list-style-type: none"> •All tasks completed. •Closure Report Approved.
Case Consultation	A service defined in Appendix C of the Jeff D Settlement agreement as a new service and support to be implemented to Class Members. The intent is for Providers to communicate with other treatment Providers on a member's treatment and services.	Clinical-UM	Closed	<ul style="list-style-type: none"> •All tasks completed. •Closure Report Approved.
Community Funding for ACE's Survey	Collect the baseline data for the state of Idaho regarding scores on ACE's to understand if our prevention and intervention efforts are proving a positive momentum of ending childhood trauma through addition of 11 questions to the Behavioral Risk Factor Surveillance System (BRFSS) yearly survey.	Recovery & Resiliency	Closed	<ul style="list-style-type: none"> •All tasks completed. •Closure Report Approved.
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	Recovery & Resiliency	Closed	<ul style="list-style-type: none"> •All tasks completed. •Closure Report Approved.

Project	Description	Department Oversight	Status	Key Accomplishments
	communities. We want to promote a collaboration with them that will strengthen the recovery oriented system of care in Idaho.			
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	Closed	<ul style="list-style-type: none"> •All tasks completed. •Closure Report Approved.

Project(s) On Hold

Project	Description	Department Oversight	Status	Key Accomplishments
CAST (Children and Adolescent Stabilization Team)	At present, Idaho children who are determined to need residential care must be sent out of state to receive that care. Not only is this care expensive (the state is on track to spend \$6 million dollars, annually), but it is very difficult, if not impossible, for families to participate in their child's care, in a meaningful, effective manner. This is particularly problematic for children who have protracted placements and further hinders a successful transition/re-integration into the family on discharge. Optum Idaho's solution will help address this need and complements the YES services development that is currently underway. This project could also have a positive impact on inpatient utilization.	Clinical-UM	On Hold	Pending until Q4, 2019

Analysis: During Quarter 3, there were 23 projects in progress, 4 of which were Performance Improvement Projects (PIPs – one new PIP was added and one PIP was closed). Of the 23, six (6) new projects (which included 1 PIP) were implemented, 7 were closed and 1 was put on hold.

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

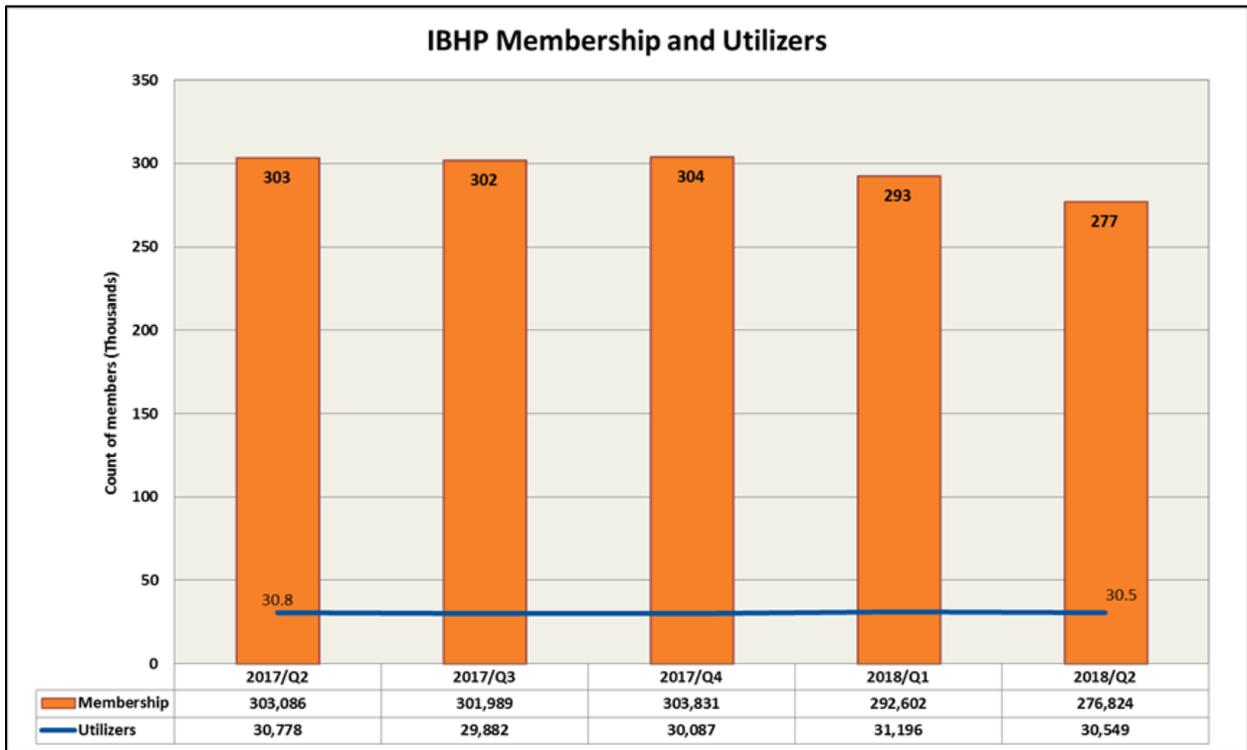
Opportunities and Interventions: No opportunities for improvement were identified.

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 utilizers decreased 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.

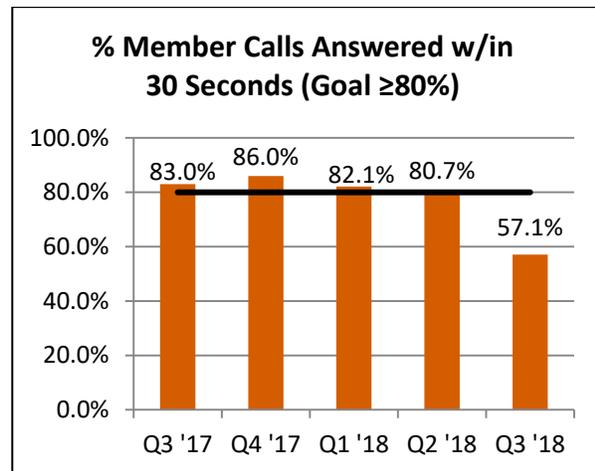
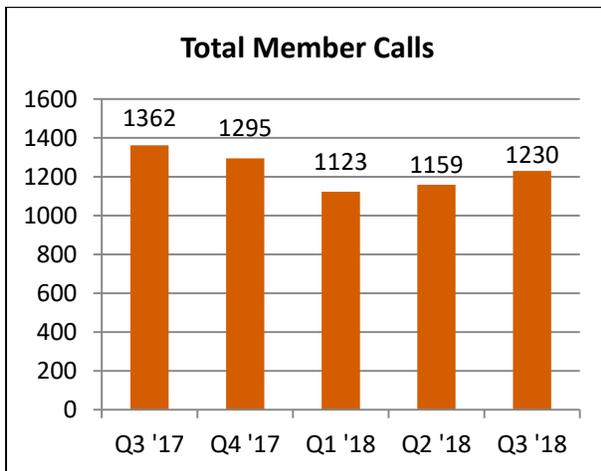
To ensure member’s needs are met in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to answer (120

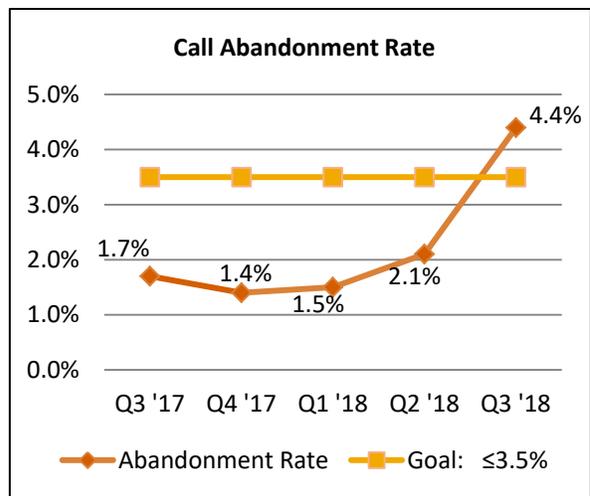
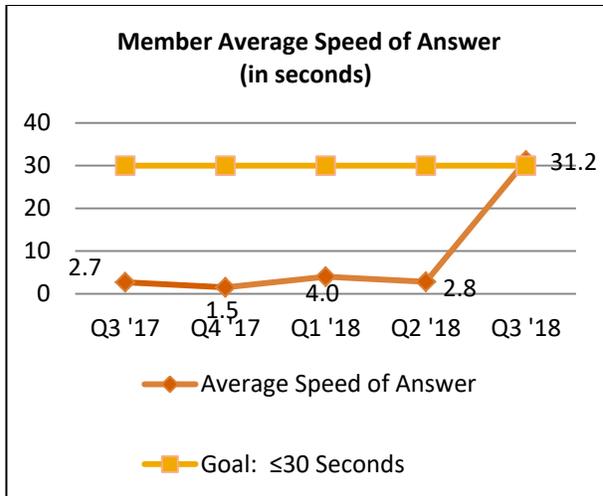
seconds) and call abandoned rate ($\leq 7\%$). Data source is Avaya's Communication system (ProtoCall).

Quarterly Performance Results

Member Service Line	Optum Idaho Standards	IBHP Contract Standards	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Total Number of Calls	NA	NA	1,362	1,295	1,123	1,159	1,230
Percent of Calls Answered Within 30 Sec	$\geq 80.0\%$	None	83.0%	86.0%	82.1%	80.7%	57.1%
Average Speed of Answer	≤ 30 Seconds	120 seconds (2 minutes)	2.7 sec	1.5 sec	4.0 sec	2.8 sec	31.2 sec
Abandonment Rate	$\leq 3.5\%$	$\leq 7\%$	1.7%	1.4%	1.5%	2.1%	4.4%

Analysis: During Q3, the Member Services and Crisis Line received a total of 1,230 calls. During the same period of time, 57.1% of calls were answered within 30 seconds (goal $\geq 80\%$). The average speed to answer did not meet Optum Idaho standards, but met IBHP contract standards at 31.2 seconds. The call abandoned rate was 4.4% which did not meet the Optum Idaho Standards goal of $\leq 3.5\%$ but continued to meet the IBHP Contractual Standards goal of $\leq 7.0\%$.





Barriers: Performance goal was not met for Percent of Calls Answered within 30 Seconds and Member Average Speed of Answer during Q3.

Opportunities and Interventions: An Improvement Action Plan (IAP) has been implemented with the Vendor, ProtoCall, to address not meeting the Percent of Calls Answered within 30 seconds and Member Average Speed of Answer during Q3. Optum Idaho will continue to work closely with the Vendor to address barriers and continue to monitor.

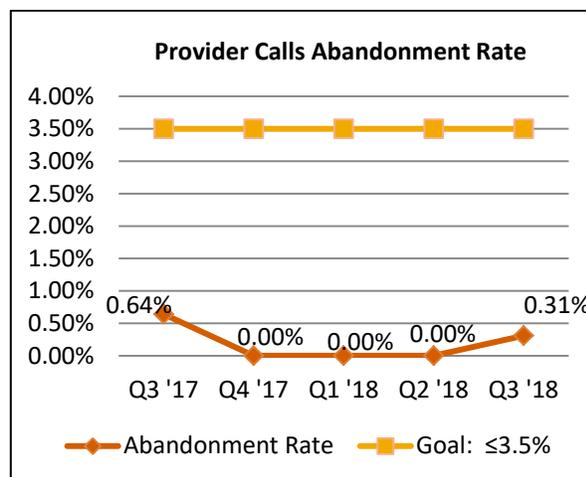
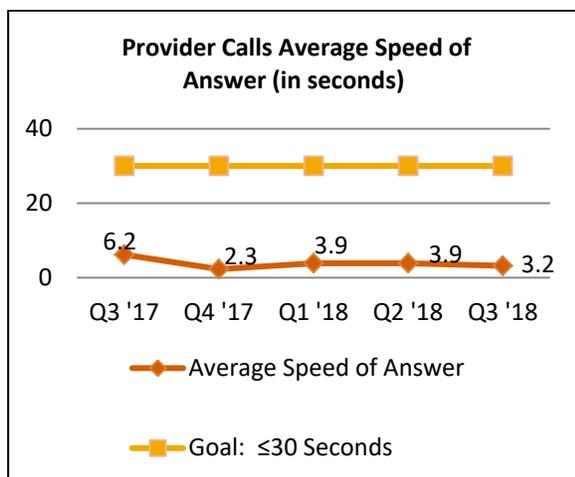
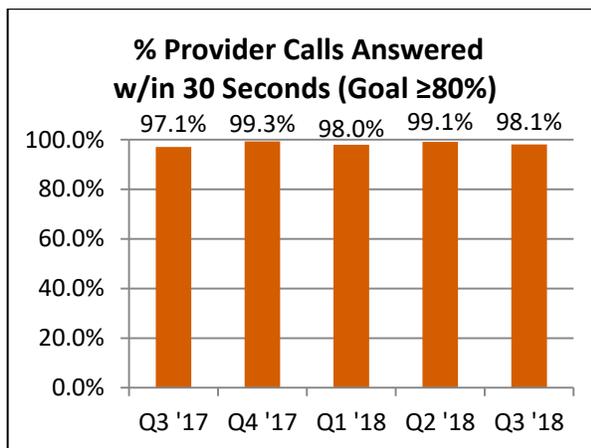
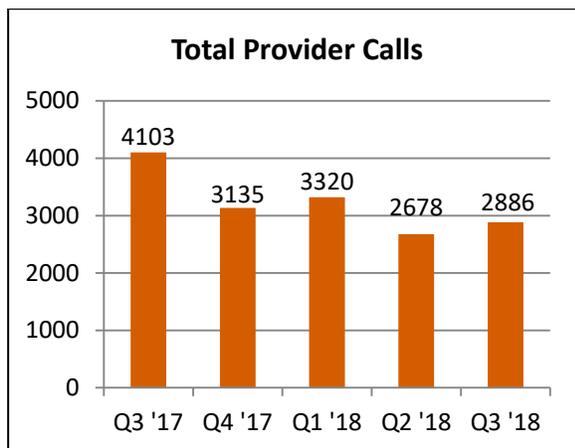
Customer Service (Provider Calls) Standards

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	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Total Number of Calls	NA	NA	4,103	3,135	3,320	2,678	2,886
Percent of Calls Answered Within 30 Seconds	≥80.0%	None	97.1%	99.3%	98.0%	99.1%	98.1%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	6.2 sec	2.3 sec	3.9 sec	3.9 sec	3.2 sec
Abandonment Rate	≤3.5%	≤7%	0.64%	0%	0%	0%	0.31%

Analysis: The total number of Customer Service provider calls during Q3 was 2,886. Customer service call standards met performance goals for all three customer service line measures again during Q3. The percent of calls answered within 30 seconds was at 98.1%, remaining above the goal of $\geq 80\%$. The average speed of answer was at 3.2 seconds during Q3, which continued to meet the goal. The call abandonment rate was 0.31% 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

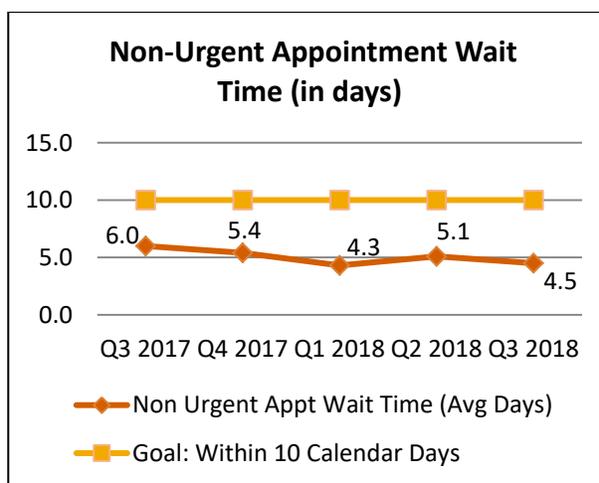
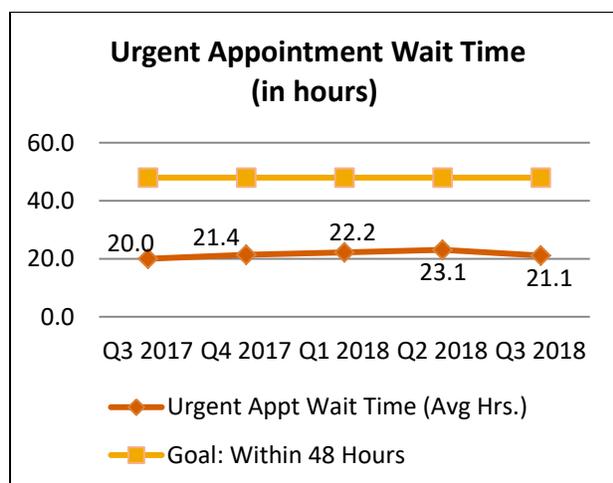
Methodology: As part of Optum Idaho's Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, Optum developed, maintains, and monitors a network with adequate numbers and types of clinicians and outpatient programs. Optum requires that network providers 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	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Urgent Appointment Wait Time	Within 48 hours from request	20.0 hours	21.4 hours	22.2 hours	23.1 hours	21.1 hours
Non-Urgent Appointment Wait Time	Within 10 days from request	6.0 days	5.4 days	4.3 days	5.1 days	4.5 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. During Q3, the average Urgent Appointment wait time was 21.1 hours. The performance goal for Non-Urgent Appointment wait time is an appointment within 10 days. This goal was again met during Q3 at an average of 4.5 days.



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

Opportunities and Interventions: No opportunities for improvement were identified.

Geographic Availability of Providers

Methodology: GeoAccess reporting enables the accessibility of health care networks to be accurately measured based on the geographic locations of health care providers relative to those of the members being served. On a quarterly basis, Optum Idaho runs a report using

GeoAccess™ software to calculate estimated drive distance, based on zip codes of unique members and providers/facilities. Performance against standards will be determined by calculating the percentage of unique members who have availability of each level of /service provider and type of provider/service within the established standards.

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

Quarterly Performance Results

Geographic Availability of Providers		Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Area 1	(within 30 miles)	100.0%	100.0%	99.8%	99.8%	99.8%	99.8%
Area 2	(within 45 miles)	100.0%	99.8%	99.8%	99.8%	99.7%	99.8%

Analysis: Optum Idaho continued to meet contract availability standards. During Q3, Area 1 availability standards were met at 99.8% and Area 2 availability standards were met at 99.8%. Our performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number).

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

Opportunities and Interventions: No opportunities for improvement were identified.

Member Protections and Safety

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

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

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

Notification of Adverse Benefit Determination

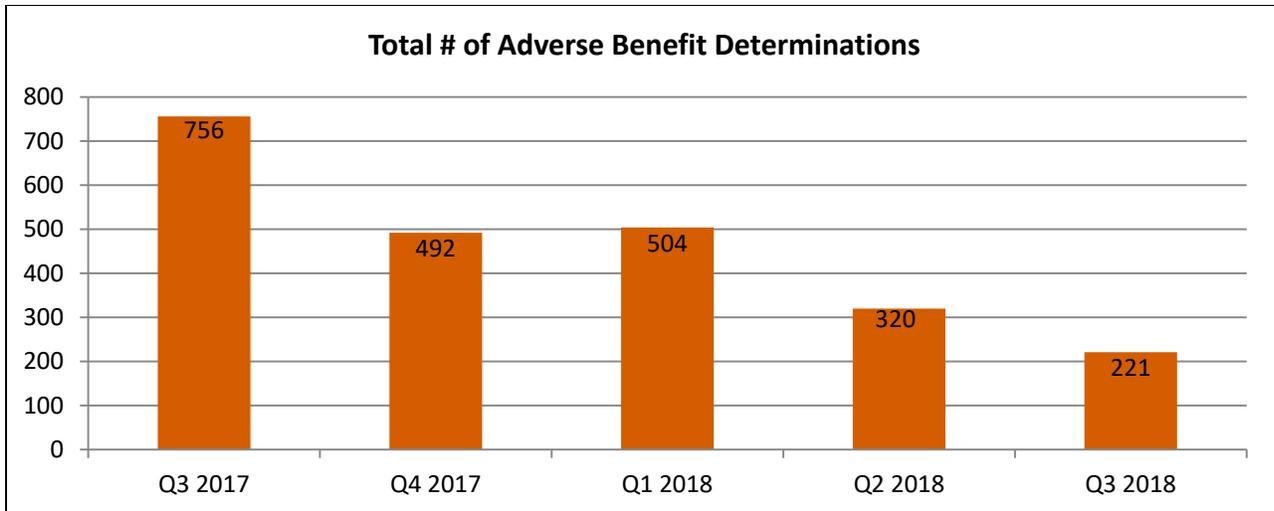
Methodology: Adverse Benefit Determinations (ABD's) are maintained in the Linx database. When a request for services is received, Optum has 14 days to review the case, make a determination to authorize services or deny services in total or in part, and mail the ABD notification if the decision was to 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	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Total # ABD's	NA	NA	756	492	504	320	221
Clinical ABD's	NA	NA	578	352	351	195	72
Administrative ABD's	NA	NA	178	140	153	125	149
Written Notification	14 calendar days from request for services	NA	100.0% (756/756)	99.8% (491/492)	100.0% (504/504)	100.0% (320/320)	98.2% (217/221)

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, 2017. Administrative denials are issued when service requests fall outside of administrative guidelines set by Optum Idaho.

In Q3, Optum issued 221 ABDs – 72 Clinical and 149 Administrative. Four (4) ABD's were out of compliance.



Barriers: As noted above, 4 ABD written notifications were out of compliance. This was due to a barrier in the clinical review process. Increased oversight efficiencies have been put into place.

Opportunities and Interventions: Continued monitoring will take place to ensure compliance.

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.

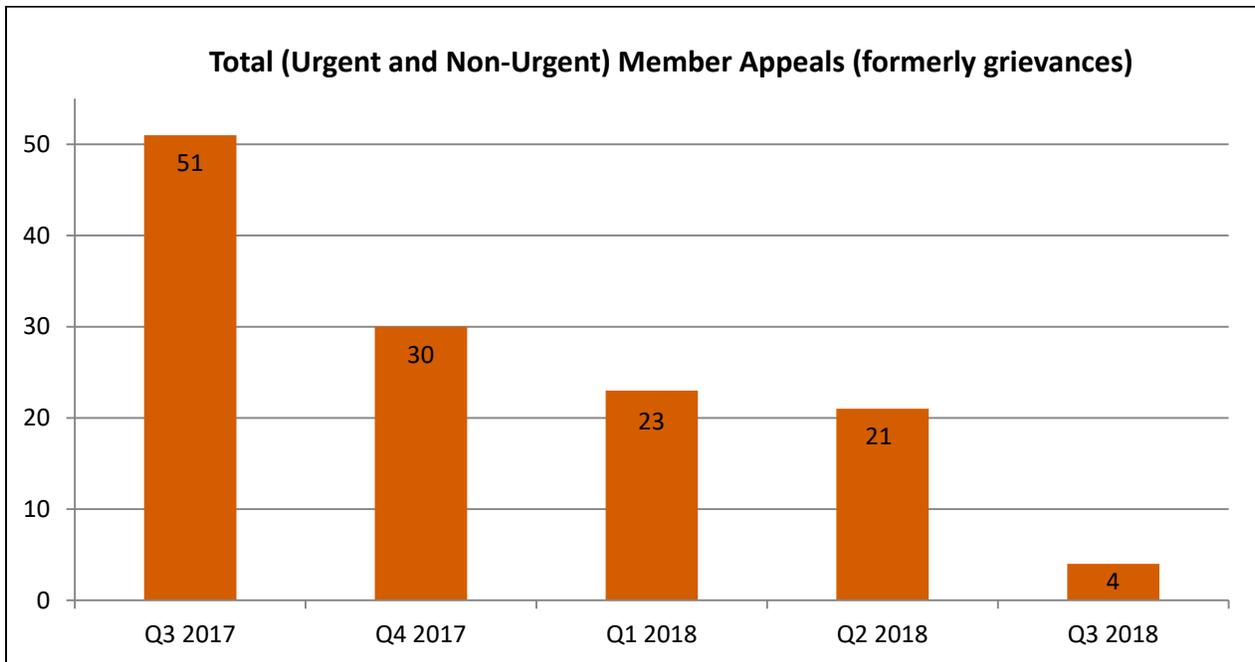
Quarterly Performance Results

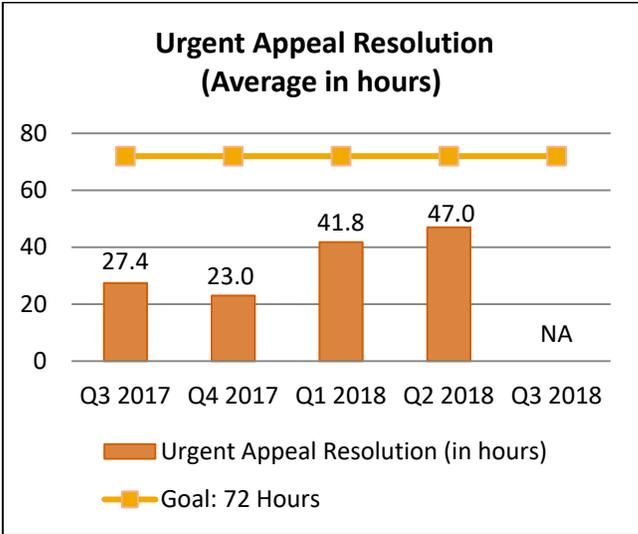
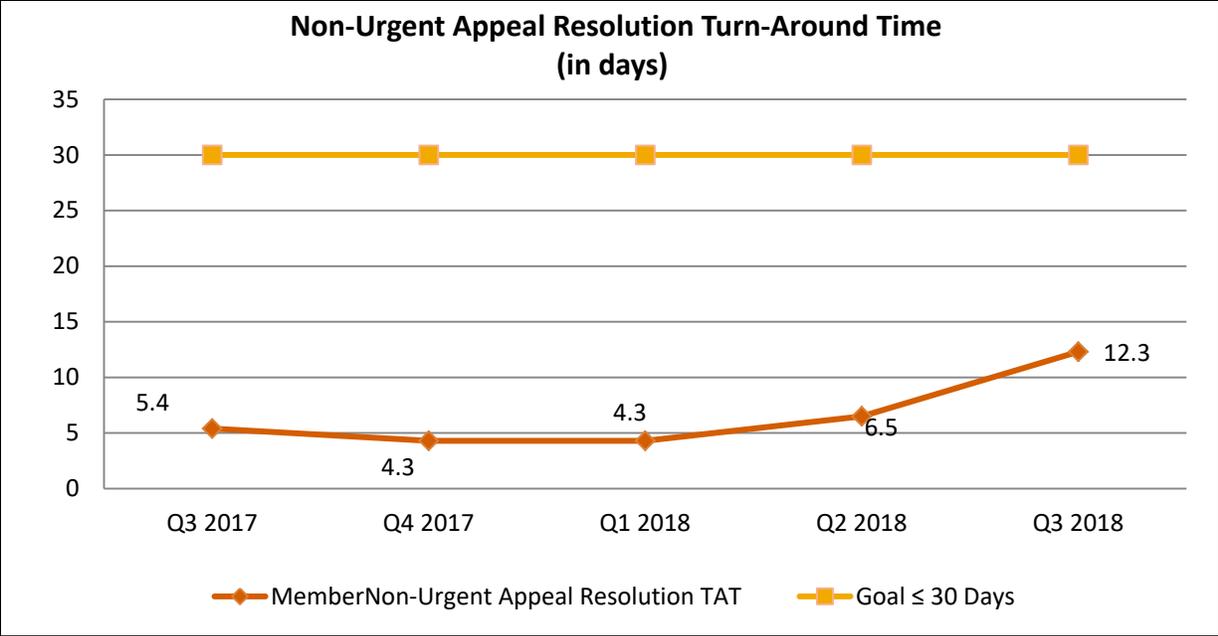
Non-Urgent Appeals	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Total Appeal Determinations	NA	36	26	17	19	4
Acknowledgement Compliance	5 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%
Determination Compliance	30 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%
Average Days to Resolve	NA	5.4	4.35	4.35	6.58	12.3
Overturned Non-Urgent Appeals	NA	4	1	2	3	0

Non-Urgent Appeals	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Partially Overturned Non-Urgent Appeals	NA	5	16	10	8	0

Urgent Appeals	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Total Appeal Determinations	NA	15	4	6	2	0
Determination Compliance	72 Hours	100.0%	100.0%	100.0%	100.0%	NA
Average Hours to Resolve	NA	27.4	23.0	41.8	47.0	NA
Overturned Urgent Appeals	NA	7	2	0	1	NA
Partially Overturned Urgent Appeals	NA	4	0	5	1	NA

Analysis: In Q3, Optum Idaho received 4 non-urgent appeals and 0 urgent appeal requests. All appeals met the 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.

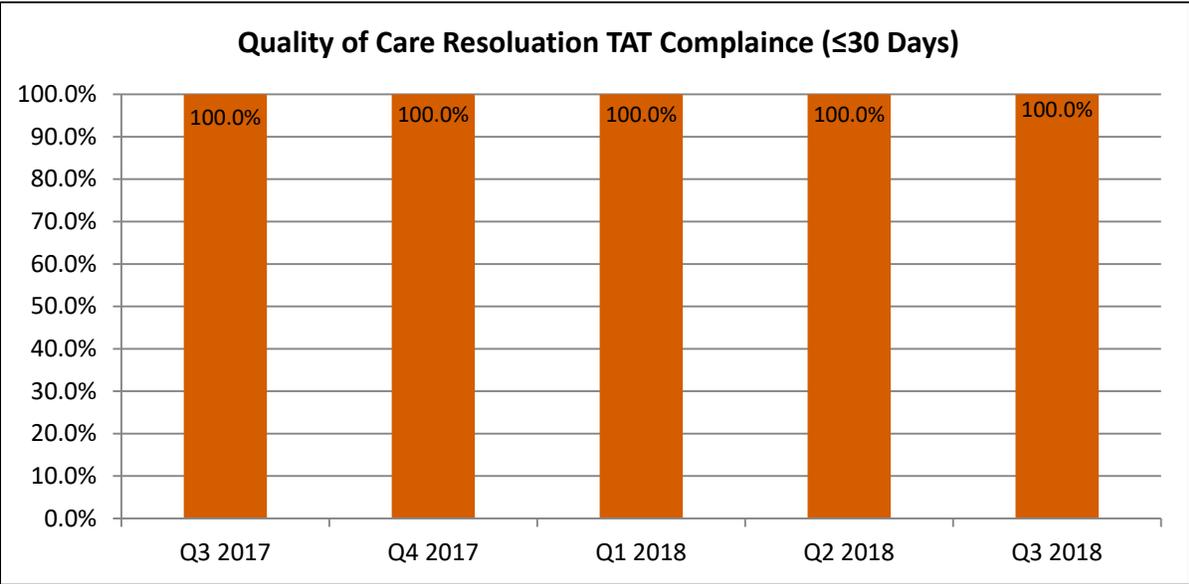
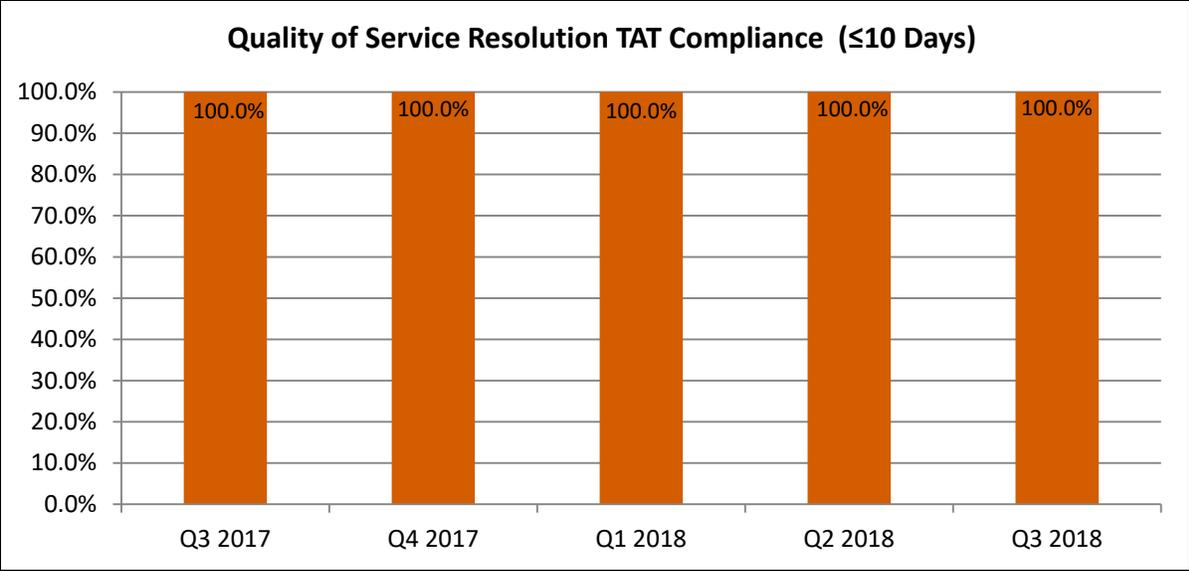
Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for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

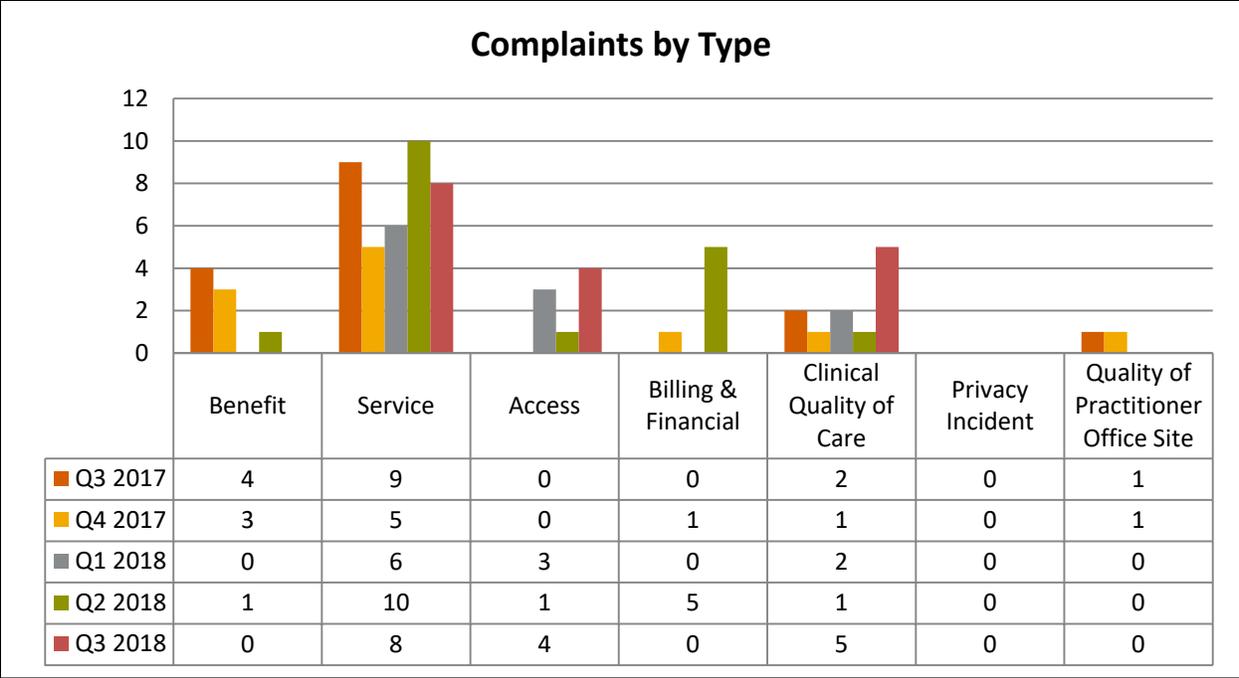
Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Calendar Days

Quarterly Performance Results

Complaints	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Number of Quality of Service (QOS) Complaints Received	NA	14	10	9	17	12
Percent QOS Complaints Resolved w/in TAT	10 Days	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints (QOC) Received	NA	2	1	2	1	5
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%	100.0%	100.0%

Analysis: During Q3, there were 17 total complaints processed. Twelve (12) were Quality of Service complaints, and 5 were 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.

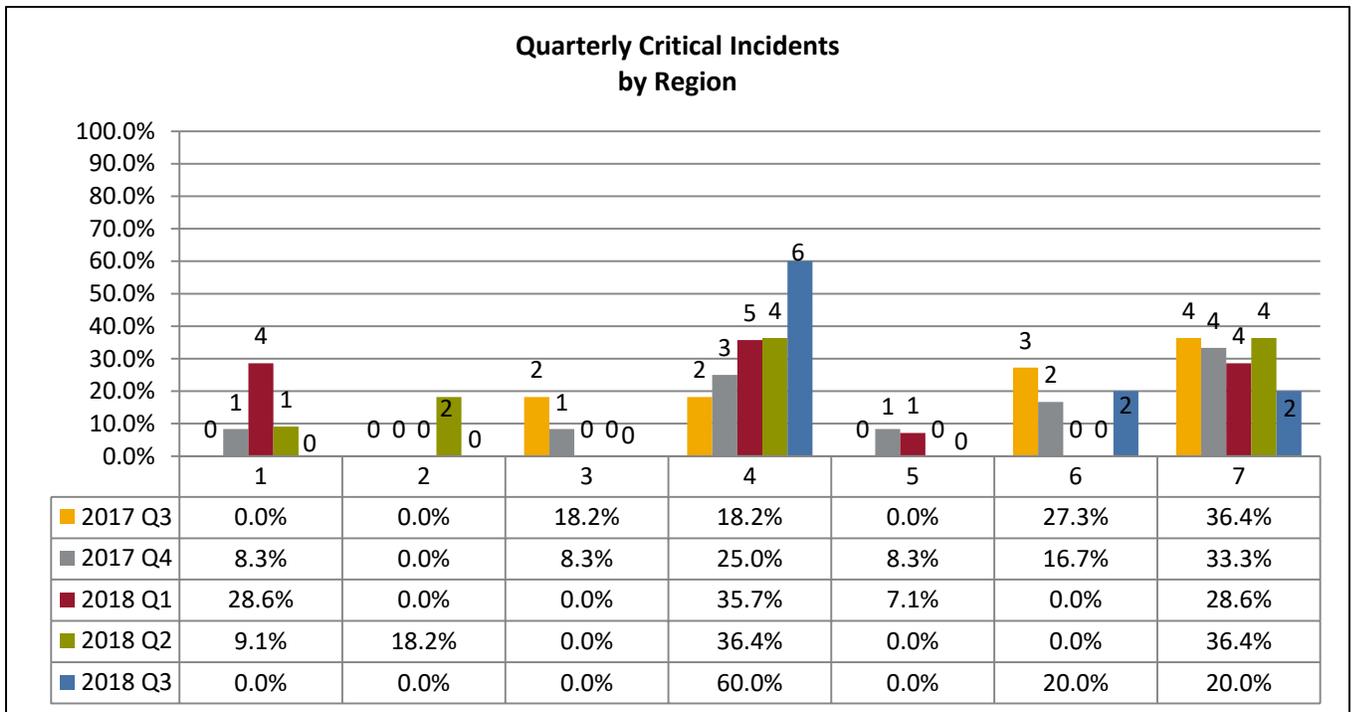
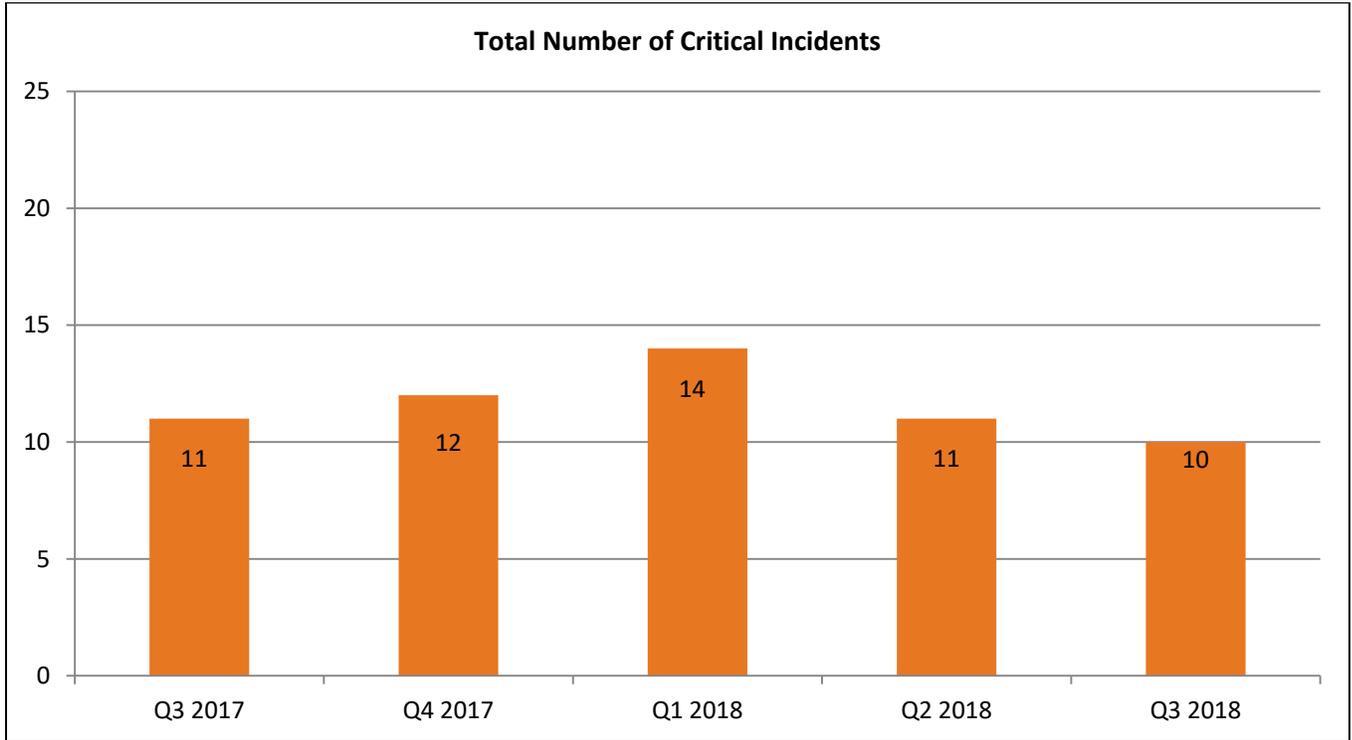
Quarterly Performance Results

Critical Incidents	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Number of CI's Received	NA	11	12	14	11	10
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100%	100%	100%	100%	100%

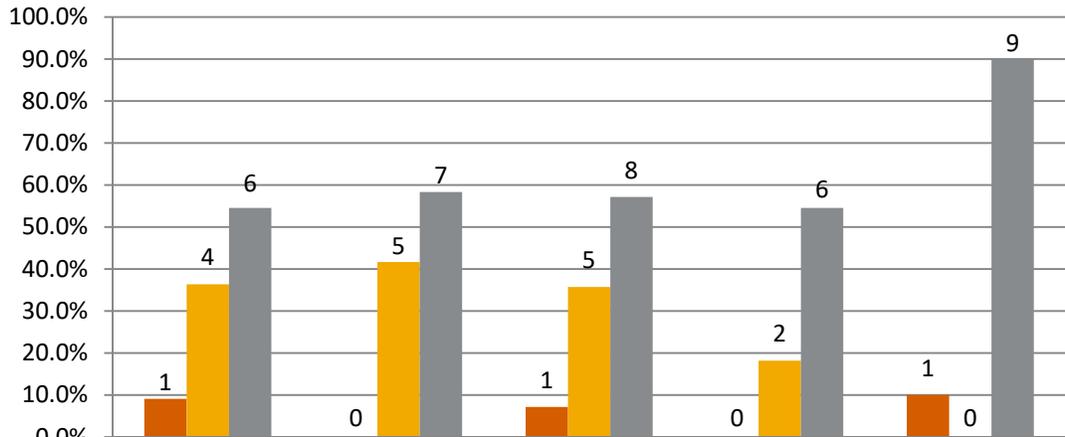
Analysis: There were 10 Critical Incidents reported during Q3. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. The highest number of Critical Incidents fell in the category of unexpected deaths. Of the 10 Critical Incidents reported, 9 (90.0%) were from unexpected deaths.

Further analysis showed that during Q3, Region 4 reported the highest number (6) of critical incidents. Coordination of Care between the behavioral health provider and the Primary Care Provider (PCP) occurred in 9 (90.0%) of the total cases. Of the 10 reported Critical Incidents, 6 (60.0%) males and 1 (10.0%) females showed that member had a co-morbid health condition. No co-morbid health conditions were reported for 3 of the cases. Of the cases reported, 9 were adults (18+) and 1 was a child (17 and under). The average age for males was 42 and females

43. Of the cases reported, 7 (70.0%) were males and 3 (30.0%) were females. No providers were put on unavailable status due to a Critical Incident.



Quarterly Critical Incidents by Highest Reported Incidents

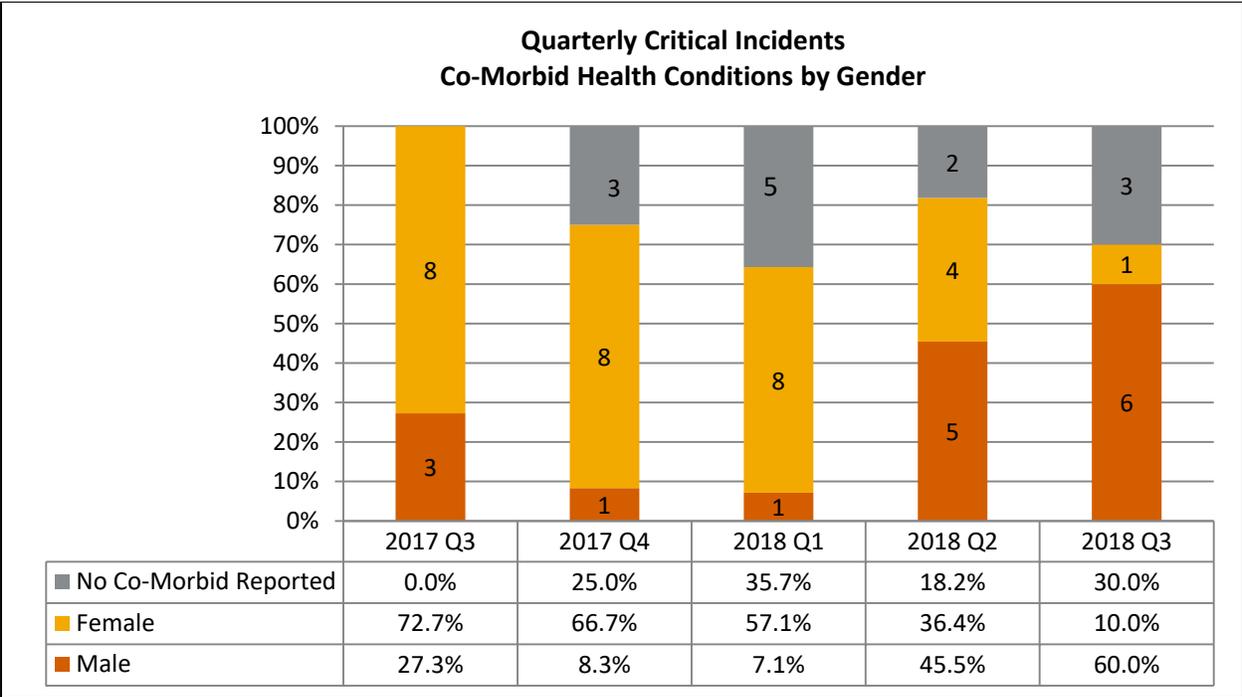
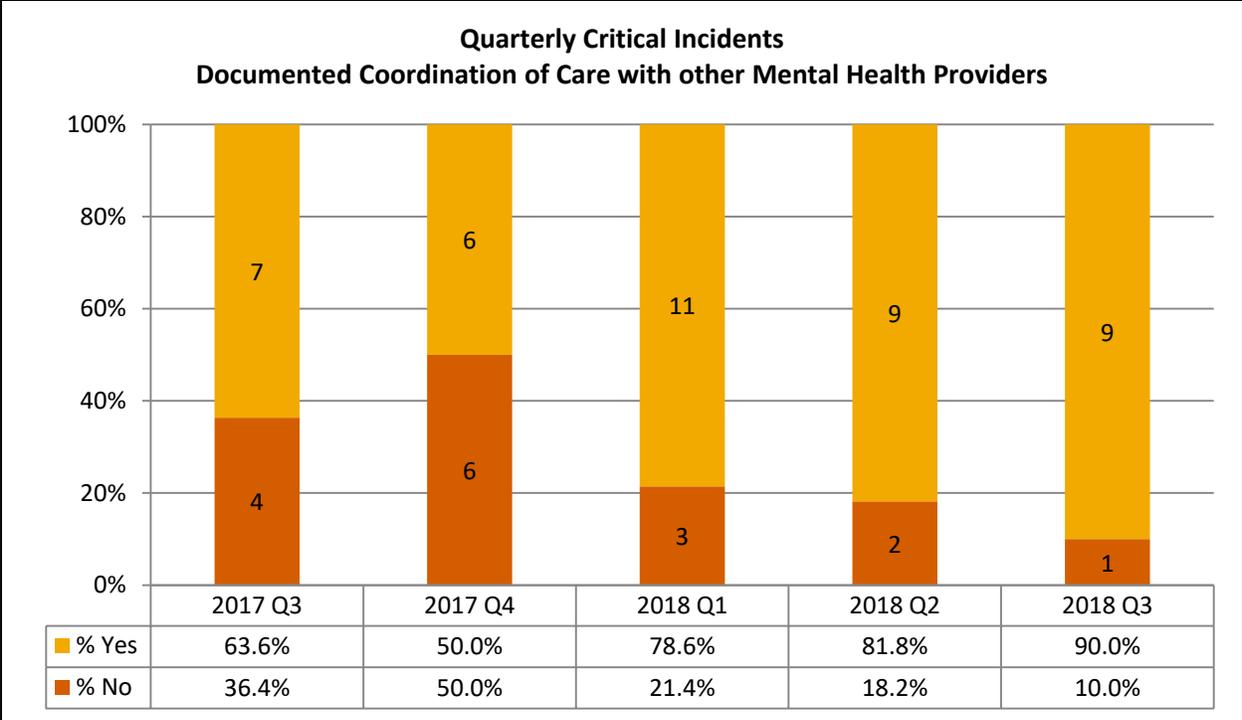


Completed Suicide	9.1%	0.0%	7.1%	0.0%	10.0%
Suicide Attempt	36.4%	41.7%	35.7%	18.2%	0.0%
Unexpected Death	54.5%	58.3%	57.1%	54.5%	90.0%

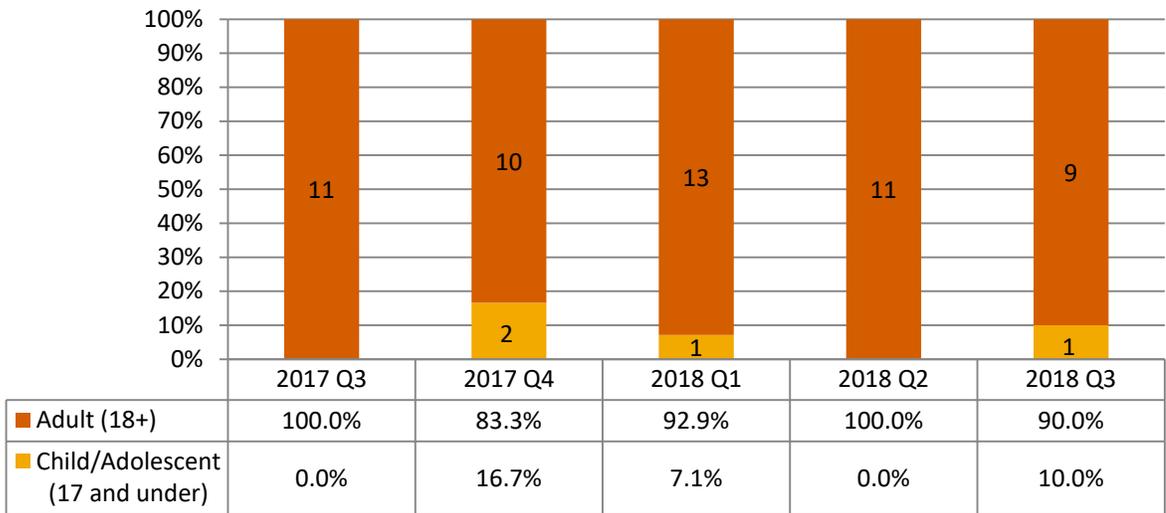
Quarterly Critical Incidents Documented Coordination of Care with Primary Care Provider



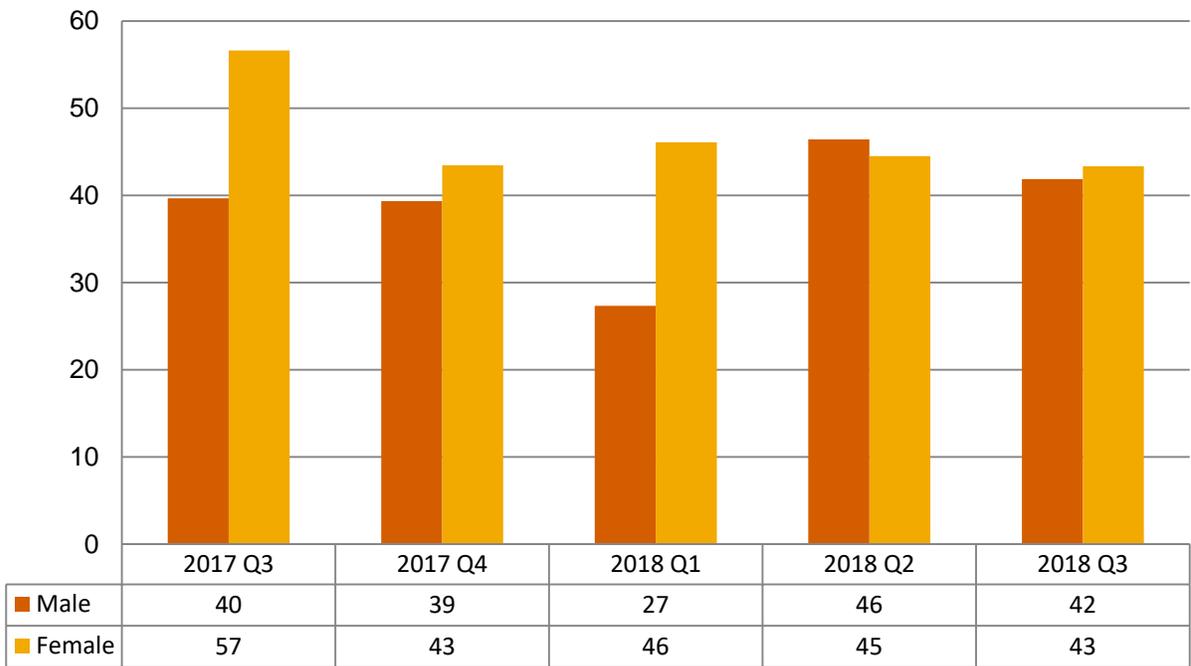
% Yes	63.6%	66.7%	85.7%	81.8%	90.0%
% No	36.4%	33.3%	14.3%	18.2%	10.0%

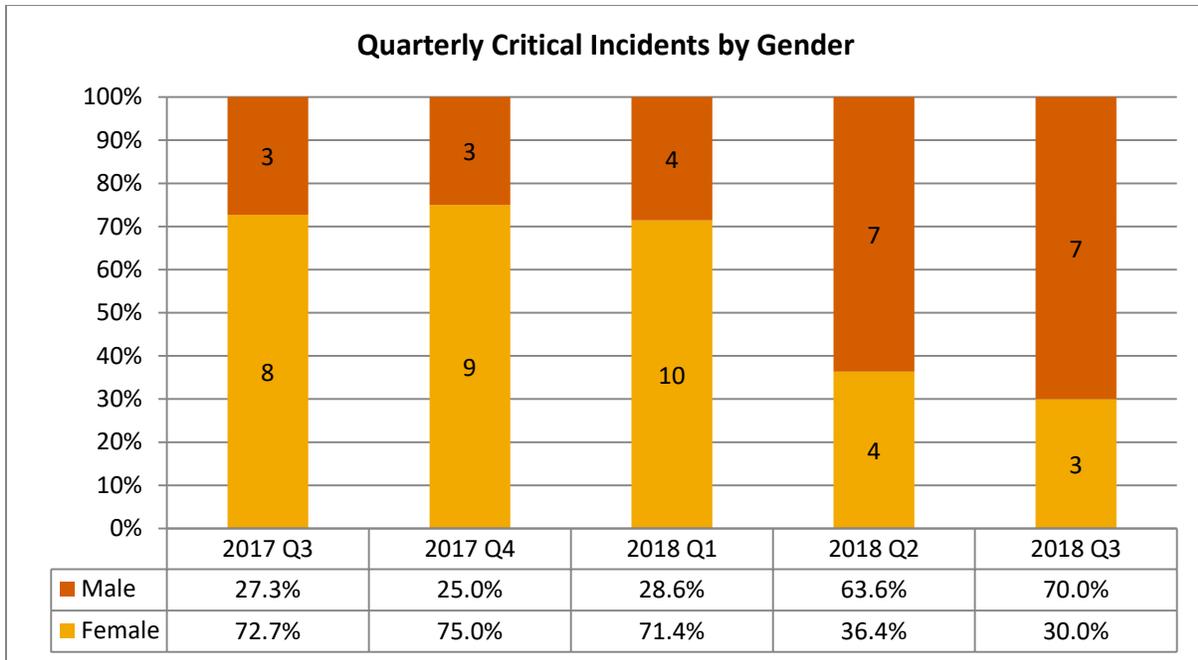


Quarterly Critical Incidents by Age Category



Quarterly Critical Incidents Average Age





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

Opportunities and Interventions: No opportunities for improvement were identified.

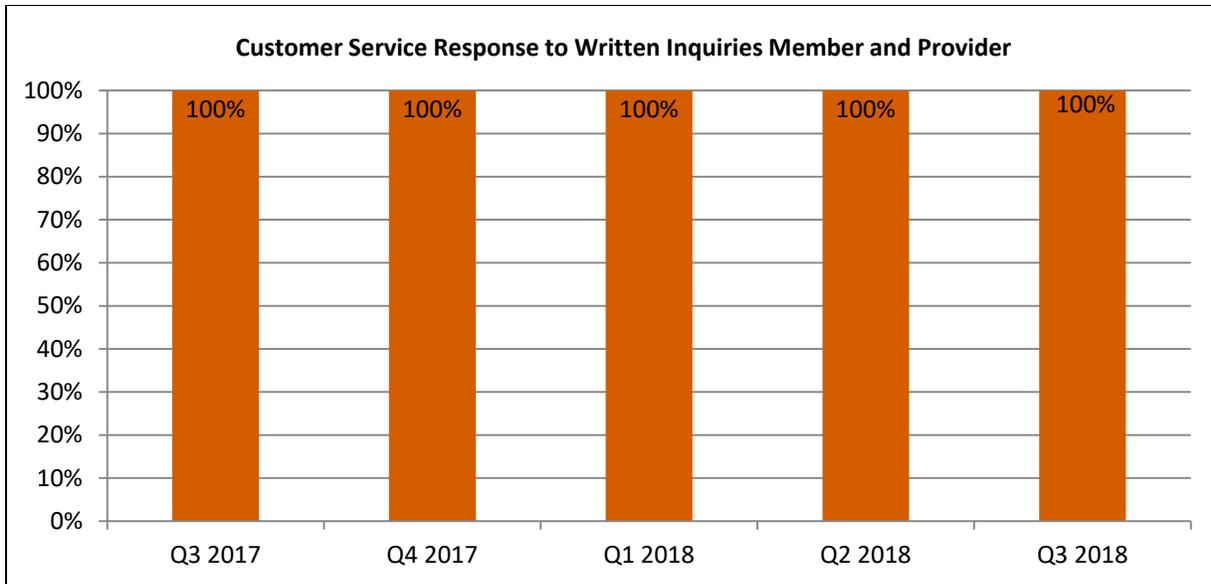
Response to Written Inquiries

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. The data summarizes Optum Idaho Customer Service responsiveness to written inquiries to both members and providers.

Quarterly Performance Results

Customer Service Response to Written Inquiries	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Percent Acknowledged ≤ 2 business days	100%	100%	100%	100%	100%	100%

Analysis: During Q3, the data indicated that the standard of 100% acknowledged within 2 business days was again met.



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.

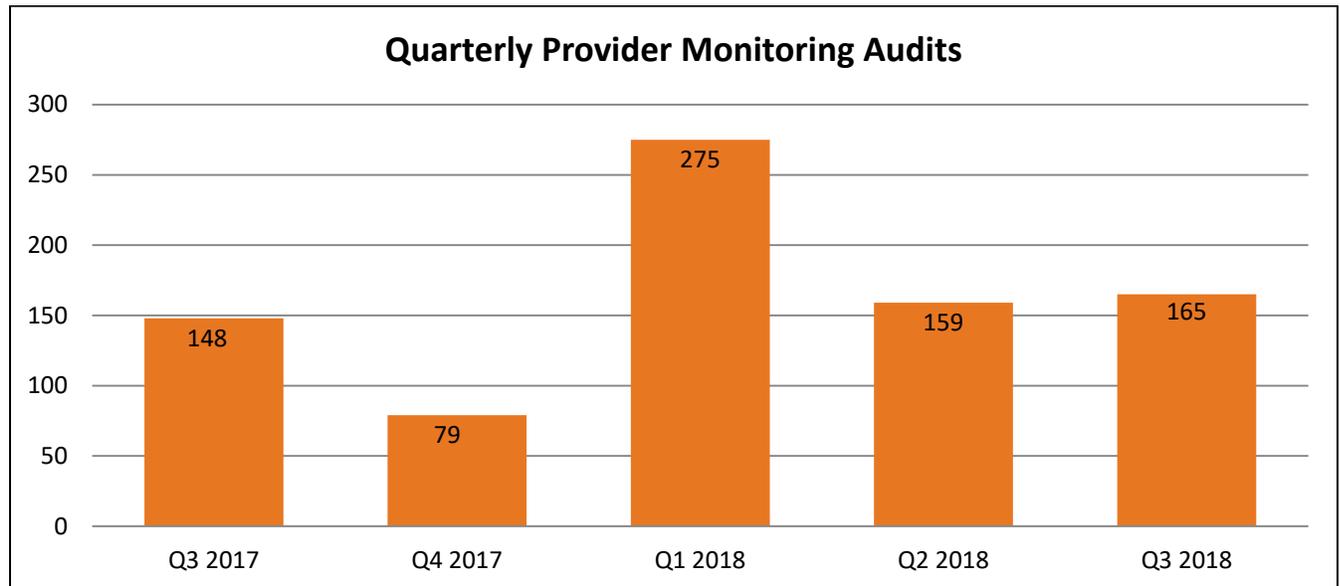
The provider will receive verbal feedback at the conclusion of the site visit and written feedback within 30 days of the site visit. Scores above 85% are considered passing. A score between 80-84% requires submission of a corrective action plan. A score of 79% or below requires submission of a corrective 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

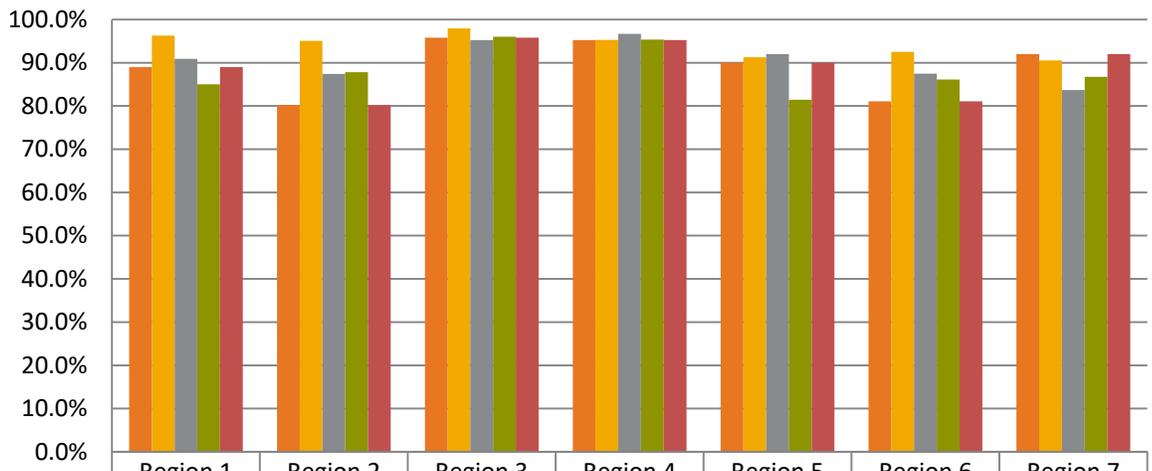
Treatment Record Audit	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Number of Audits Conducted	NA	148	79	275	159	164
Initial Audit (Average overall score)	85.0%	98.0%	92.3%	92.2%	93.0%	95.0%
Recredentialing Audit (Average overall score)	85.0%	92.8%	89.1%	89.6%	93.9%	95.8%
Monitoring (Average overall score)	85.0%	93.7%	93.9%	90.0%	87.7%	88.3%
Quality (Average overall score)	85.0%	86.1%	NA*	NA*	NA*	88.1%
Percent of Audits Requiring a Corrective Action Plan	NA	11.5%	8.9%	24.0%	28.9%	23.8%

*There were no quality audits.

Analysis: During Q3, there were 164 Provider Audits completed on Optum Idaho network providers. Of the 164 audits completed, 76.2% received a passing score, up from 71.1% during Q2. Corrective action plans were implemented for 23.8% of the audits. Overall audit scores per region and per audit type are reflected in graphs below.

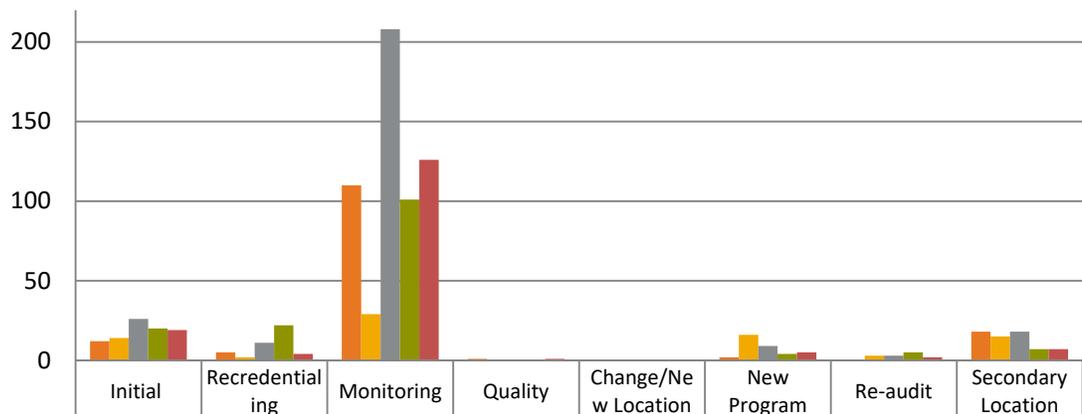


Overall Provider Audit Score Per Region

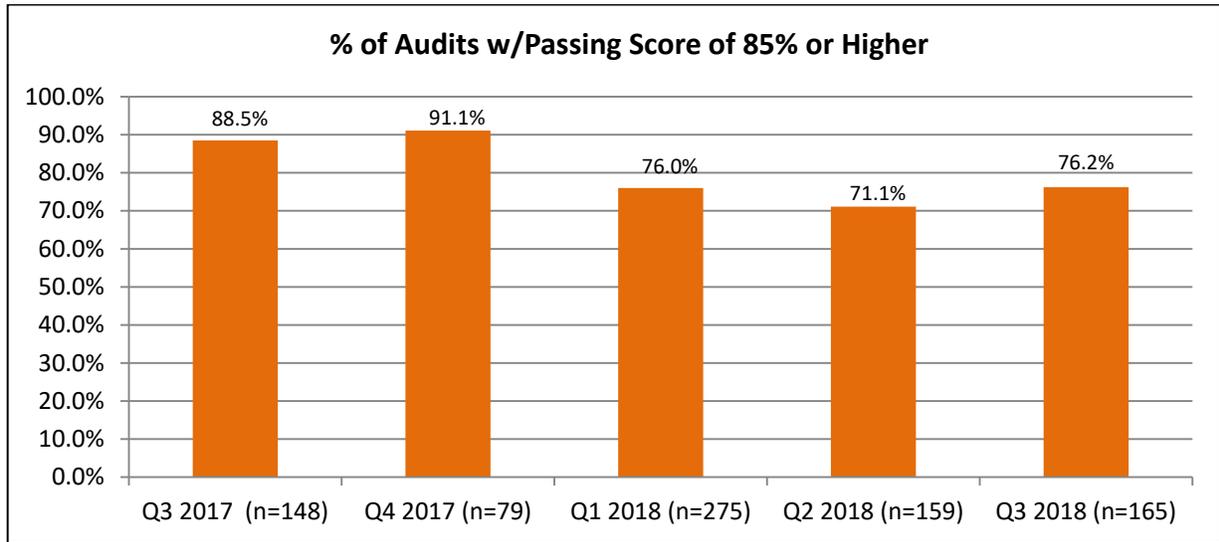
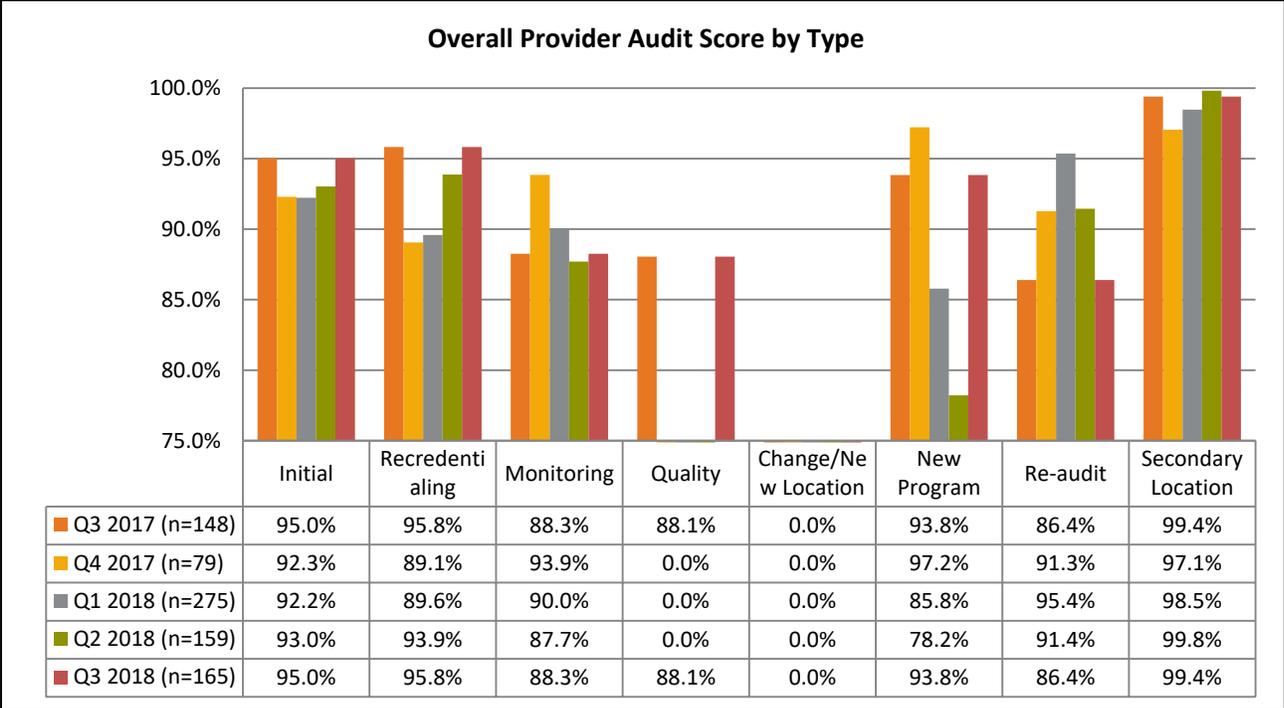


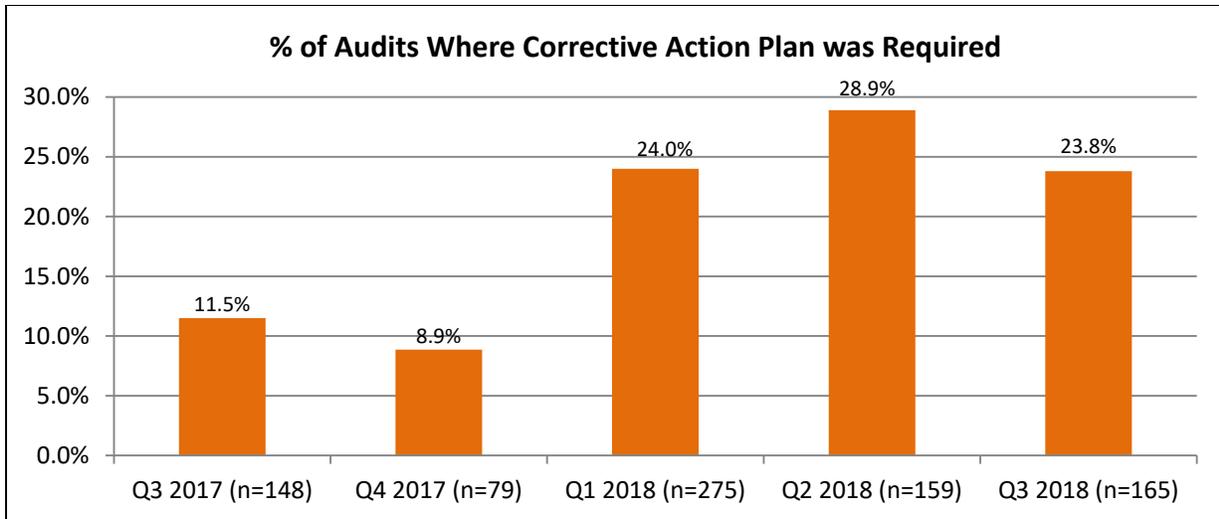
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Q3 2017 (n=148)	89.0%	80.2%	95.8%	95.2%	90.0%	81.1%	92.0%
Q4 2017 (n=79)	96.3%	95.0%	97.9%	95.3%	91.3%	92.5%	90.5%
Q1 2018 (n=275)	90.9%	87.4%	95.3%	96.7%	92.0%	87.5%	83.7%
Q2 2018 (n=159)	85.0%	87.8%	96.0%	95.3%	81.4%	86.1%	86.8%
Q3 2018 (n=165)	89.0%	80.2%	95.8%	95.2%	90.0%	81.1%	92.0%

Total Number of Provider Audits by Type

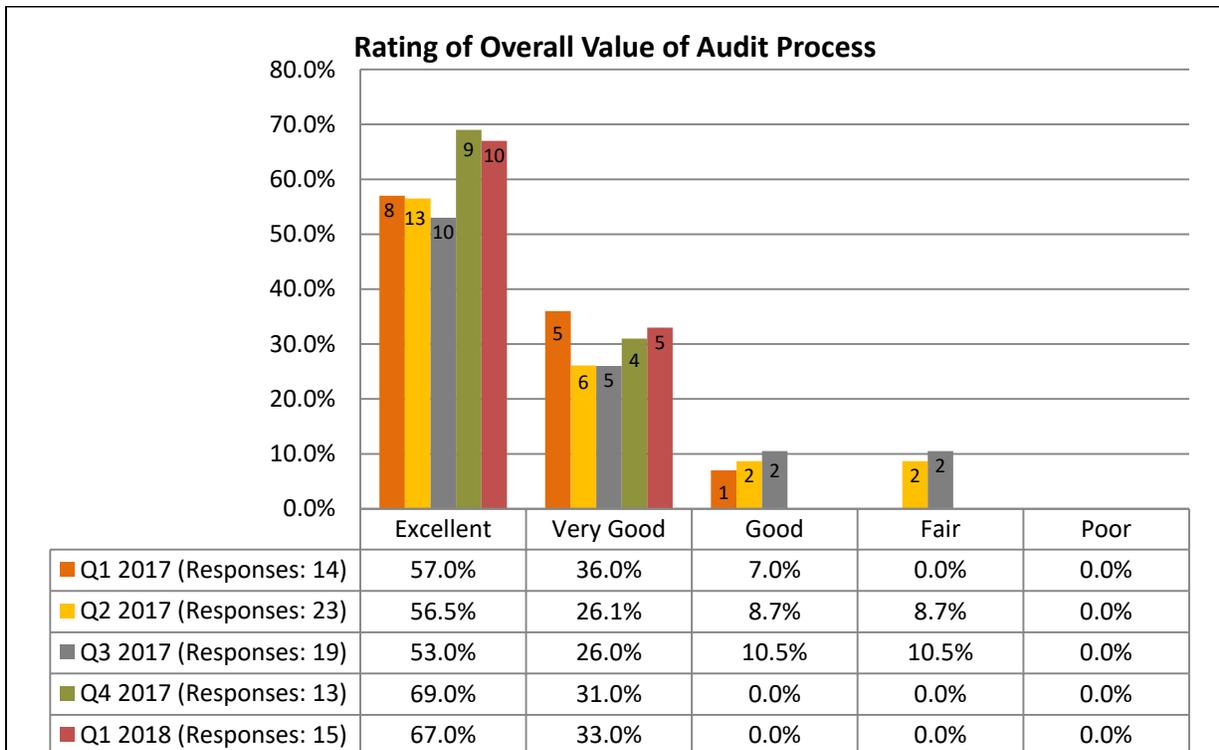


	Initial	Recredentialing	Monitoring	Quality	Change/New Location	New Program	Re-audit	Secondary Location
Q3 2017 (n=148)	12	5	110	1	0	2	0	18
Q4 2017 (n=79)	14	2	29	0	0	16	3	15
Q1 2018 (n=275)	26	11	208	0	0	9	3	18
Q2 2018 (n=159)	20	22	101	0	0	4	5	7
Q3 2018 (n=165)	19	4	126	1	0	5	2	7

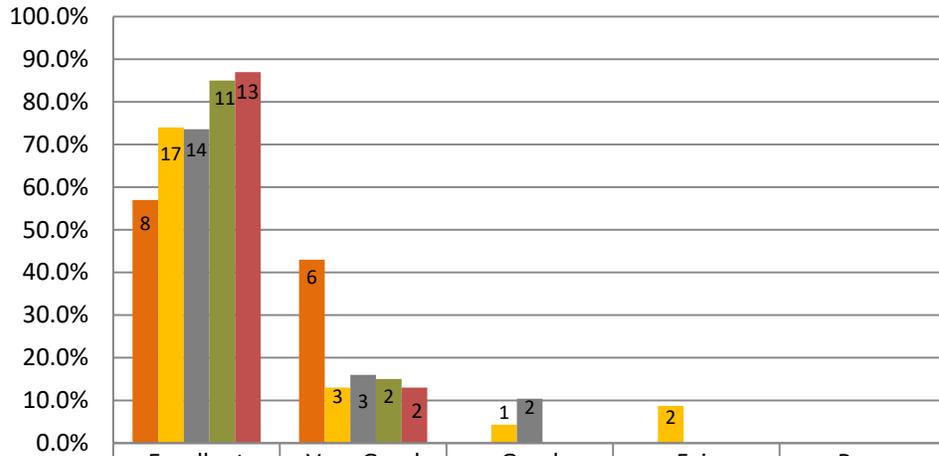




Network providers are given the opportunity to rate the Provider Quality Monitoring Audit process in a Satisfaction Survey. The survey is sent to providers by email. If an email address is not on file, the provider will not receive the survey. Surveys are emailed every other week to providers who were audited within the previous 2 weeks. Providers have 4 weeks to complete and return the survey. The results included in this report are from 2017 and Q1, 2018. Since there were minimal responses received during Q2 and Q3, results were not tabulated by the national audit team. Optum Idaho will continue to monitor.

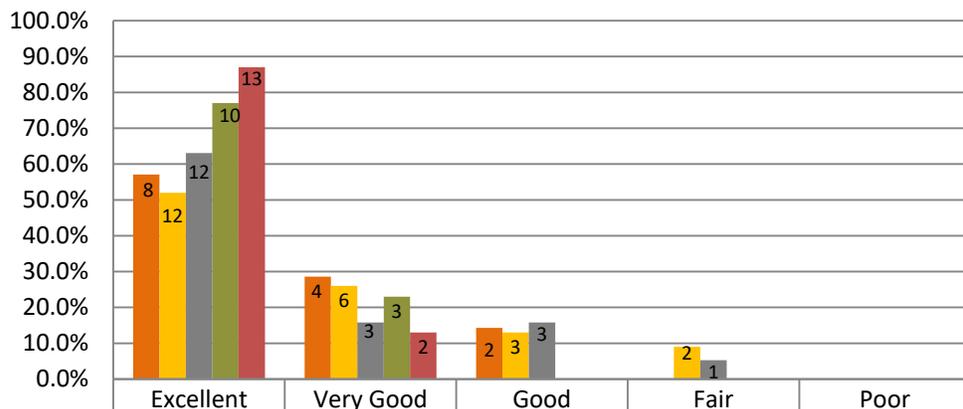


Overall Rating of Auditor



	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.

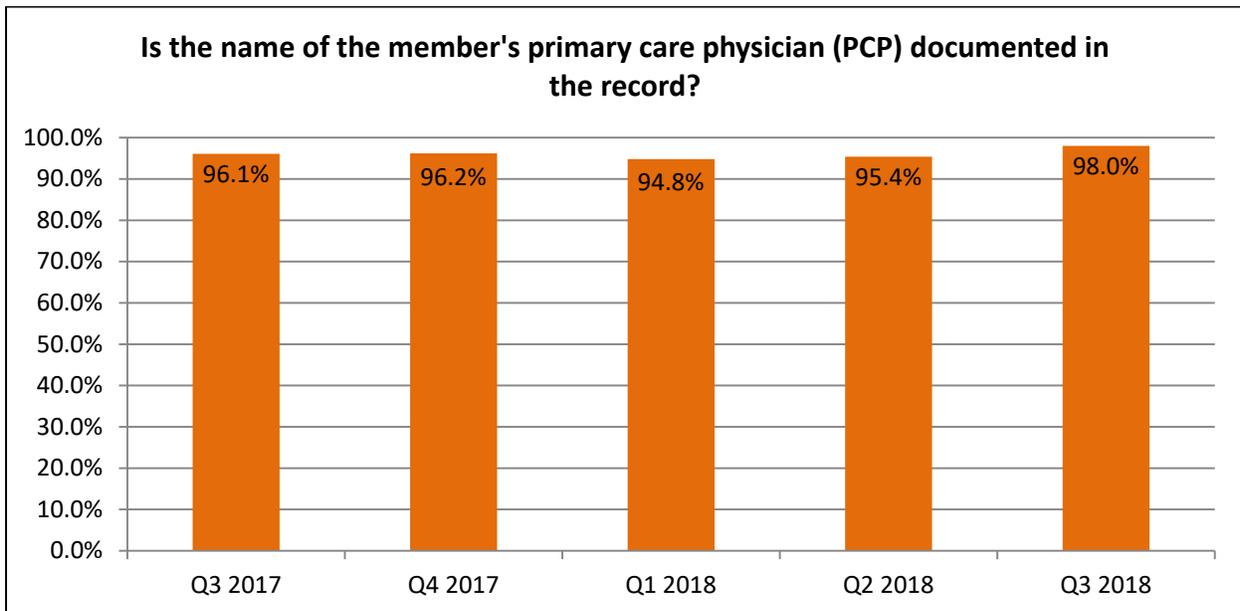
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff.

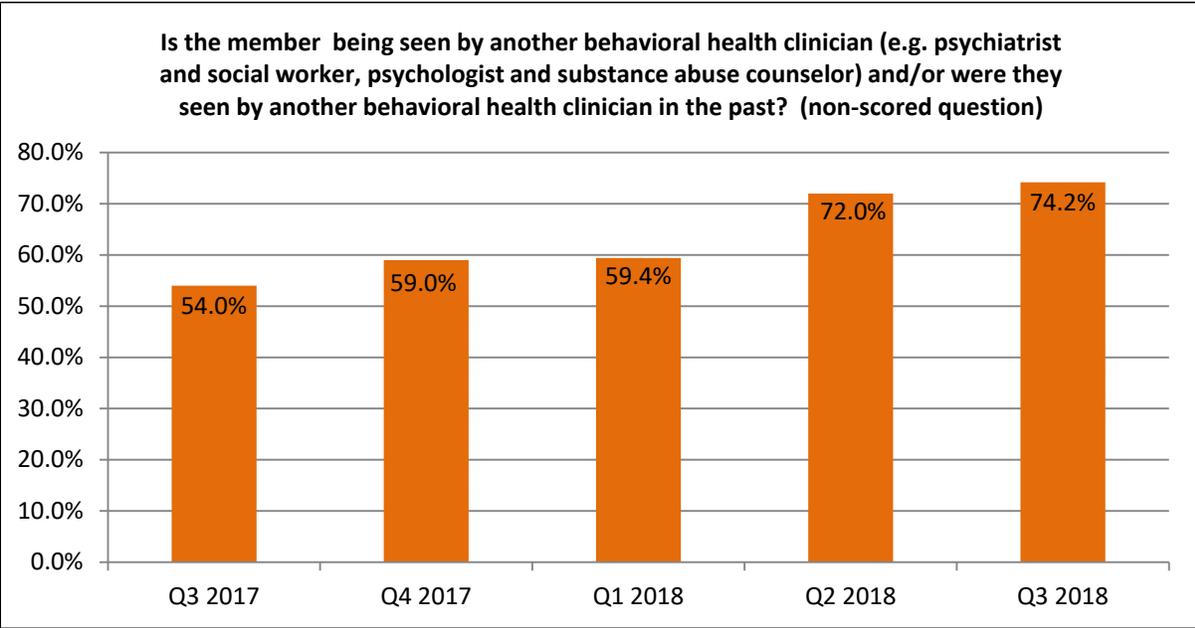
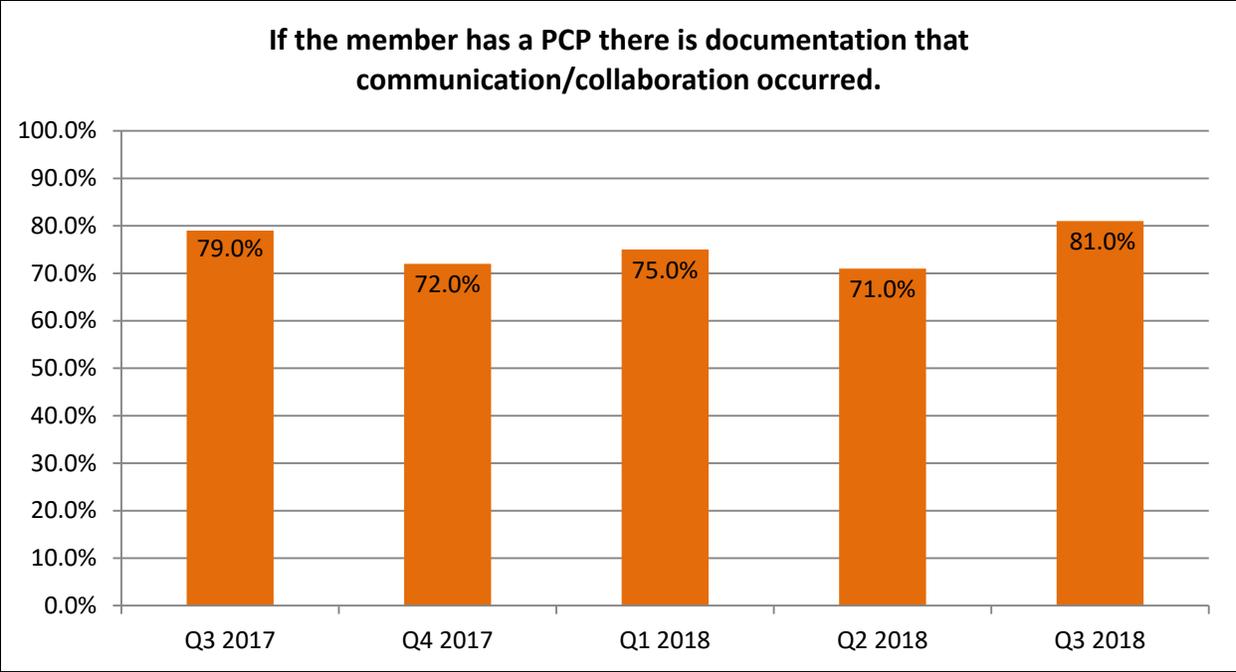
Quarterly Performance Results

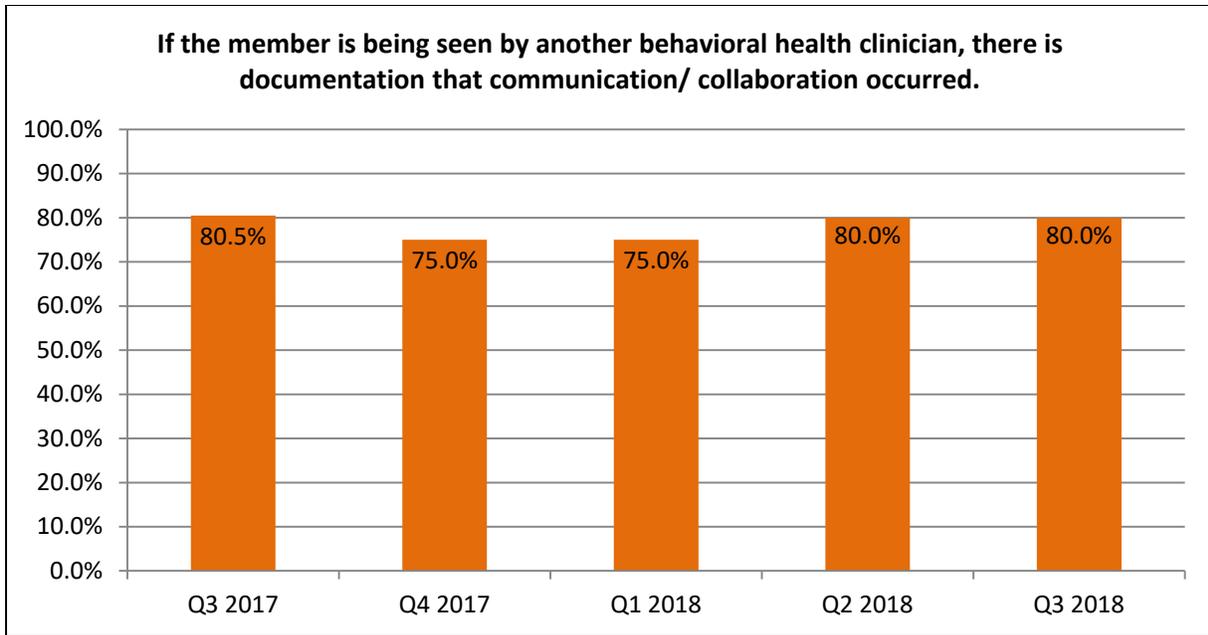
Coordination of Care (% answered in the affirmative)	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Is the name of the member’s primary care physician (PCP) documented in the record?	NA	96.1%	96.2%	94.8%	95.4%	98.0%
If the Member has a PCP there is documentation that communication/collaboration occurred	NA	79.0%	72.0%	75.0%	71.0%	81.0%

Coordination of Care (% answered in the affirmative)	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 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	54.0%	59.0%	59.4%	72.0%	74.2%
If the member is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.	NA	80.5%	75.0%	75.0%	80.0%	80.0%

Analysis: Coordination of Care audits completed during Q3 revealed that 98.0% of member records reviewed had documentation of the name of the member’s PCP. Of those, 81.0% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member’s PCP. Audit results also showed that 74.2% 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

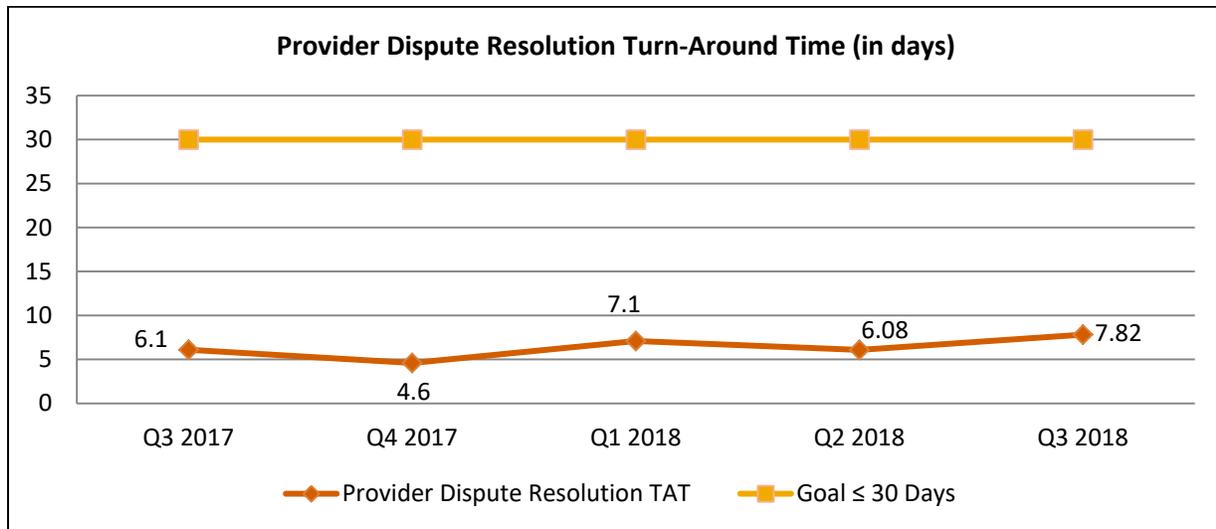
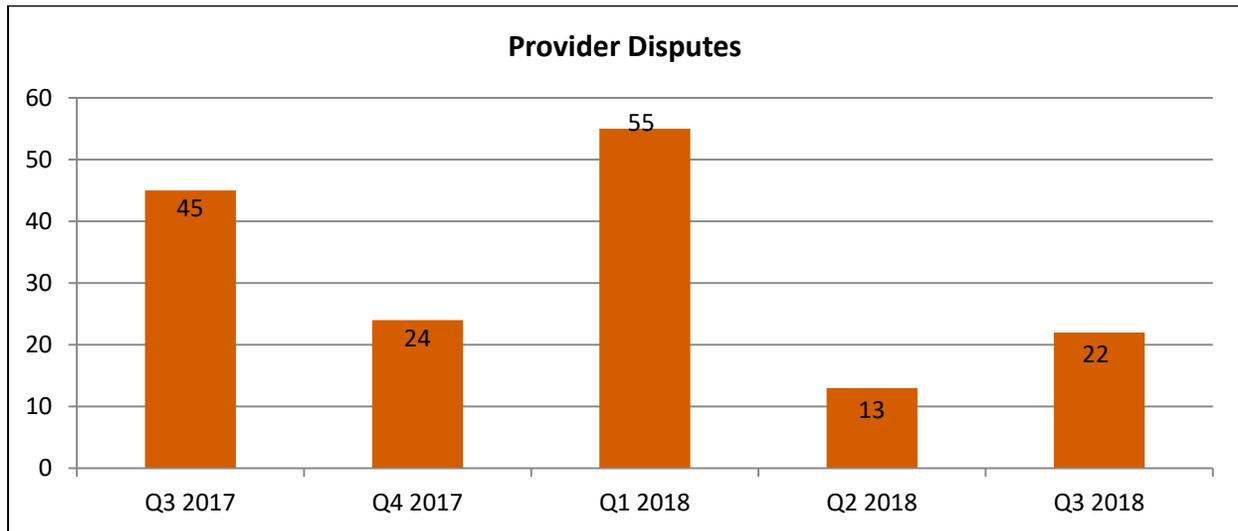
Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is believed to have been 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	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Number of Provider Disputes	NA	45	24	55	13	22
Percent Provider Dispute Determinations made within 30 calendar days from request	100% within 30 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%
Average # of Days Provider Disputes Resolved	≤30 Days	6.1	4.6	7.1	6.08	7.82
Number of Disputes Fully Overturned	NA	39	20	27	7	15
Number of Disputes Partially Overturned	NA	4	0	4	0	1
% of Disputes Overturned or	NA	95.5%	83.3%	56.4%	53.8%	73.0%

Provider Disputes	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Partially Overturned						

Analysis: During Q3, there were 22 Provider Disputes. Of the 22 disputes, 15 were fully overturned and 1 was partially overturned. All disputes were resolved within the turnaround time. The overall average turnaround time was 7.82 days.



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

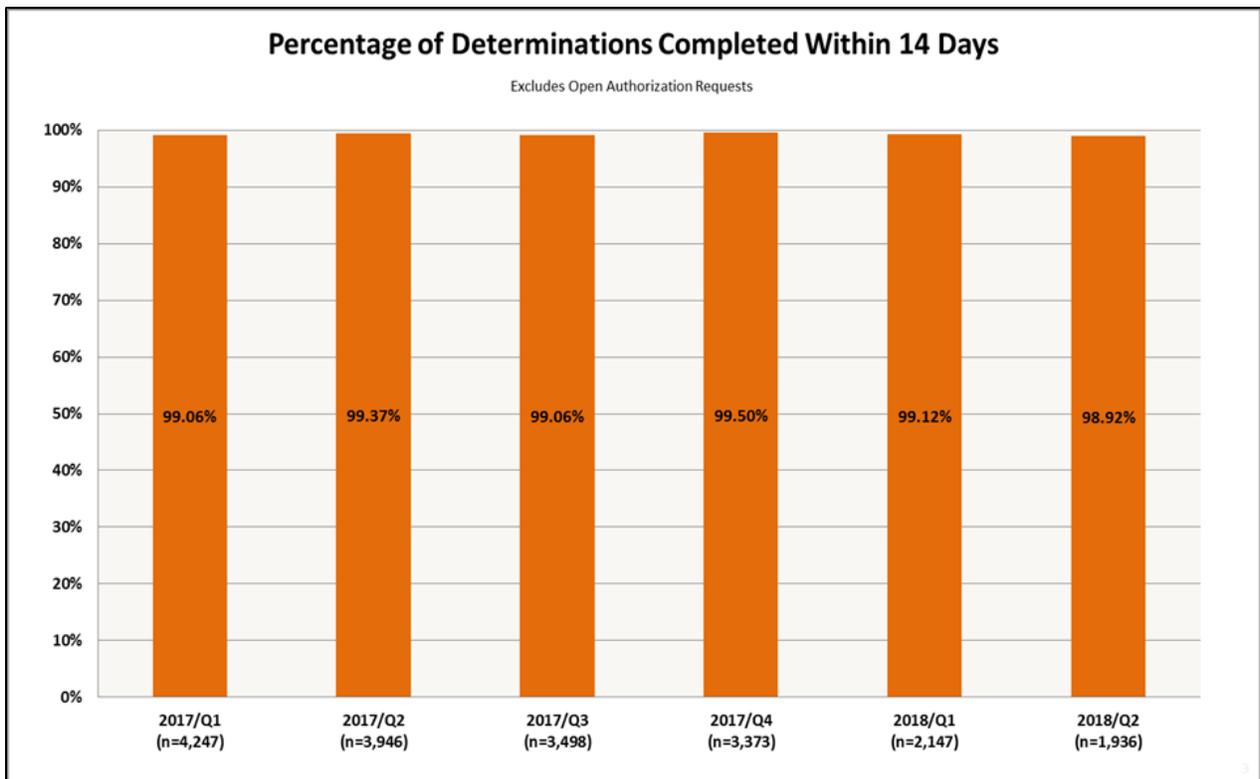
Opportunities and Interventions: No opportunities for improvement were identified.

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	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Number of Service Authorization Requests	NA	3,498	3,373	2,147	1,936	2,000
Percent Determinations Completed within 14 days	100.0%	99.1%	99.5%	99.1%	98.9%	98.9%



Barriers: Optum Idaho continues to monitor to determine process improvement.

Opportunities and Interventions: Continue to identify ways to improve process.

Field Care Coordination

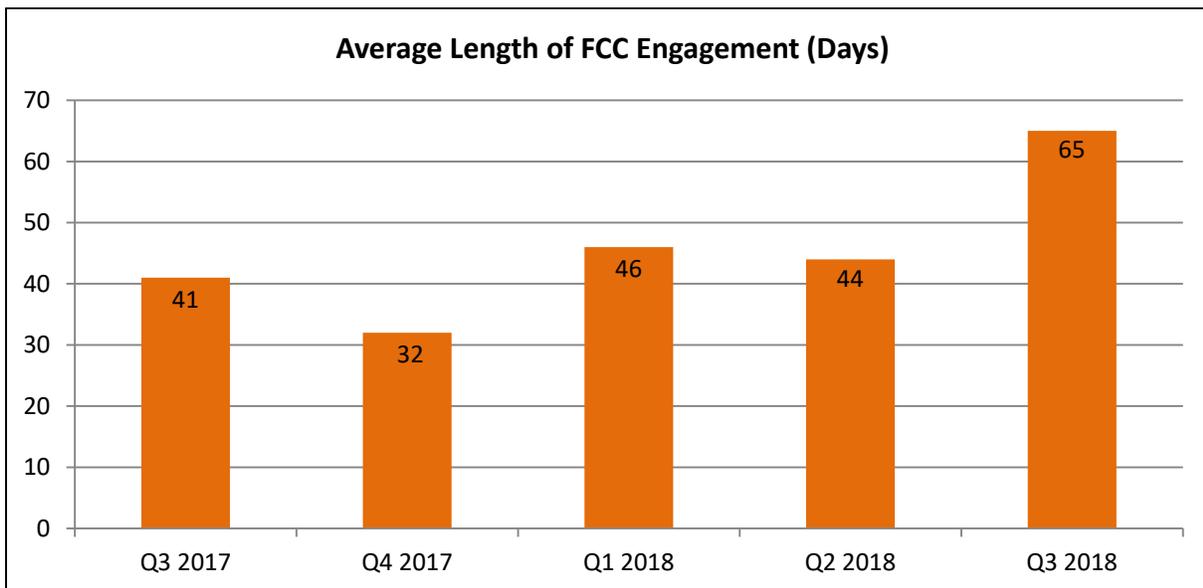
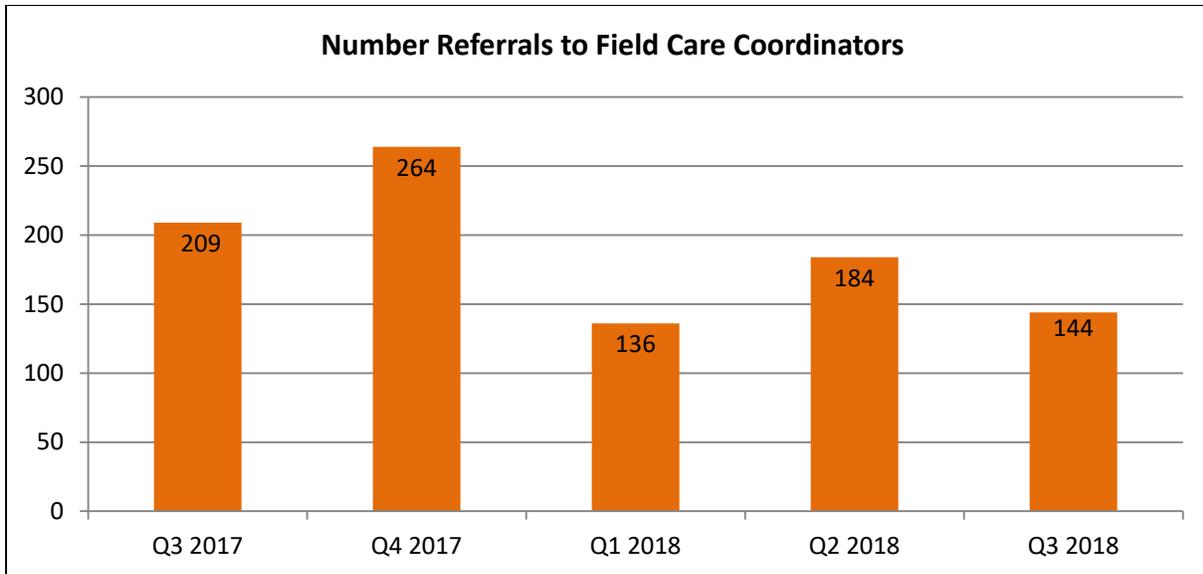
Methodology: The Field Care Coordination (FCC) program includes regionally based clinicians across the state of Idaho. They provide locally based care coordination and discharge planning support. Field Care Coordinators work with the provider to help members. The FCC team focuses on member wellness, 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	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
Discharge Coordinator	145	182	76	85	60
Utilization Reviewers	10	8	3	6	7
Providers	14	6	2	9	16
Dept of Behavioral Health	16	20	17	32	20
Juvenile Justice	0	0	0	0	0
Provider Quality Specialist	0	0	0	1	0
Peer Review Committee	0	0	0	0	0
Hospitals	0	3	0	0	0
EPSDT	4	9	4	10	0
Family/Parent	4	0	0	0	2
Member Services/Crisis Line	0	0	0	0	0
Education	2	1	1	0	0
FCC Manager Referral	0	1	2	1	1
Outpatient Disposition	4	0	0	0	0
Suicide Attempt	10	21	29	38	35
Adult Corrections	NA	13	0	0	0
Telligen	NA	NA	2	1	1
IDHW “PRTF” (member d/c from residential)	NA	NA	NA	NA	2
Total	209	264	136	184	144

Analysis: During Q3, Field Care Coordinators received 144 referrals. Of these referrals, 60 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement during Q3 was 65 days.



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

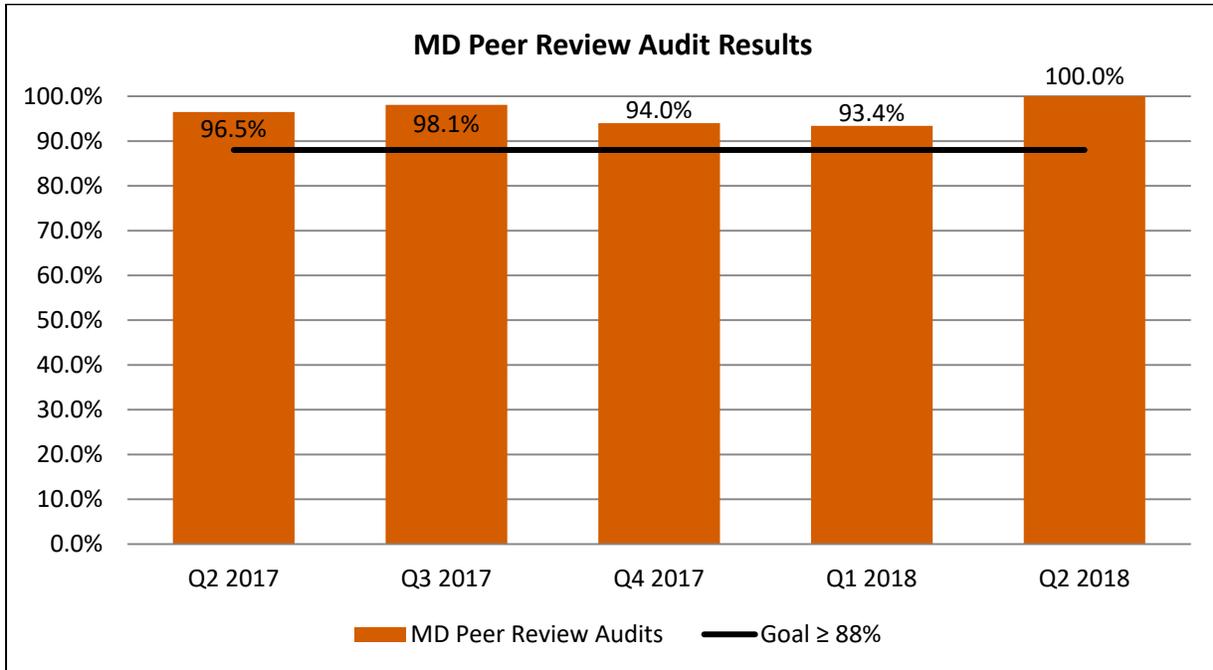
Opportunities and Interventions: No opportunities for improvement were identified.

Peer Reviewer Audits

Methodology: Optum Idaho promotes a process for review and evaluation of the clinical documentation of adverse benefit determinations 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 data is reported one quarter in arrears. The MD Peer Review Audit result for Q2, 2018, was 100.0%.



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

Opportunities and Interventions: No opportunities for improvement were identified.

Inter-Rater Reliability

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

Population Analysis

Language and Culture

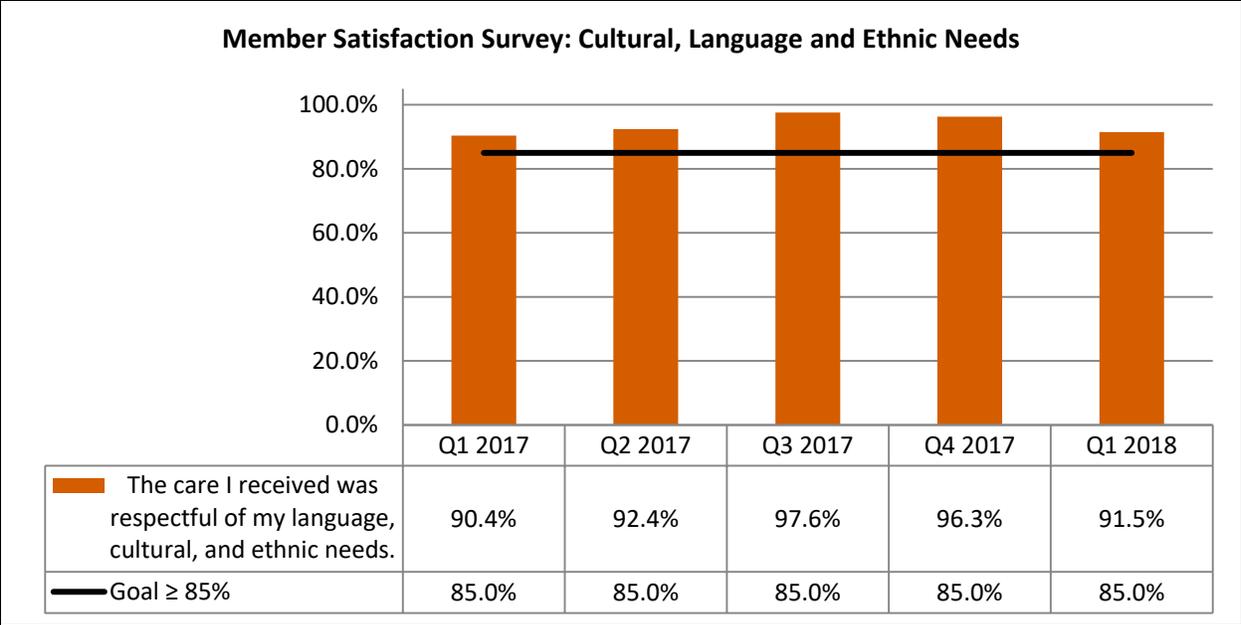
Methodology: Optum strives to provide culturally competent behavioral health services to its Members. Optum uses U. S. Census results to estimate the ethnic, racial, and cultural distribution of our membership. Below is a table listing the 2015 census results for ethnic, racial and cultural distribution 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 91.5% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q1 2018 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	4
Member Written Communication Formatted to Large Print	4
Language Service Associates	12
Languages Represented	5
Do Not Mail List	1

Analysis: During Q3, Optum Idaho responded to 26 requests for language assistance. The predominant request was for Spanish language assistance.

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

Opportunities and Interventions: No opportunities for improvement were identified.

Claims

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

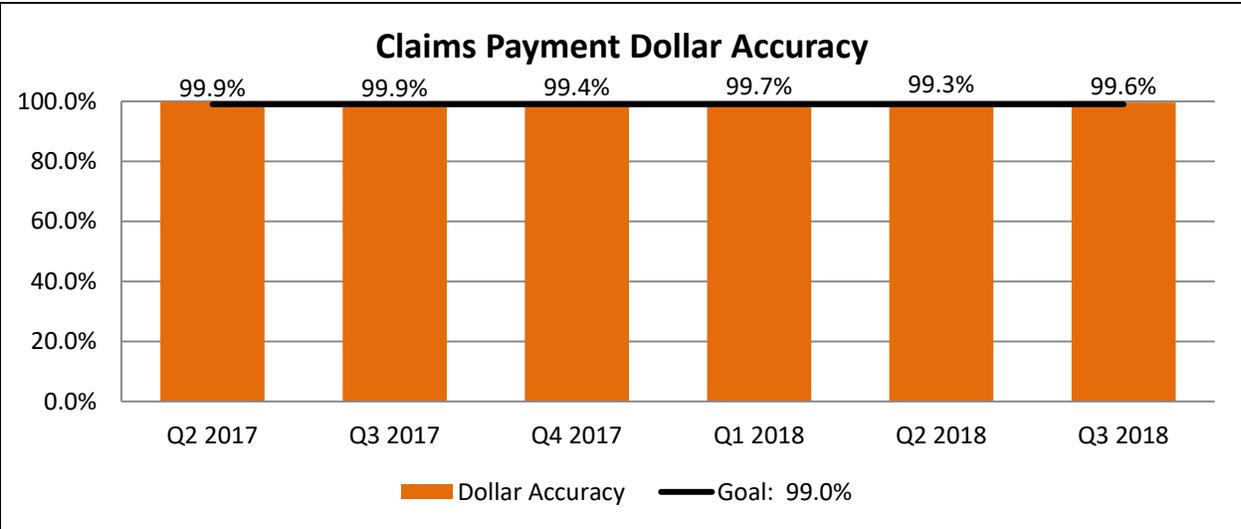
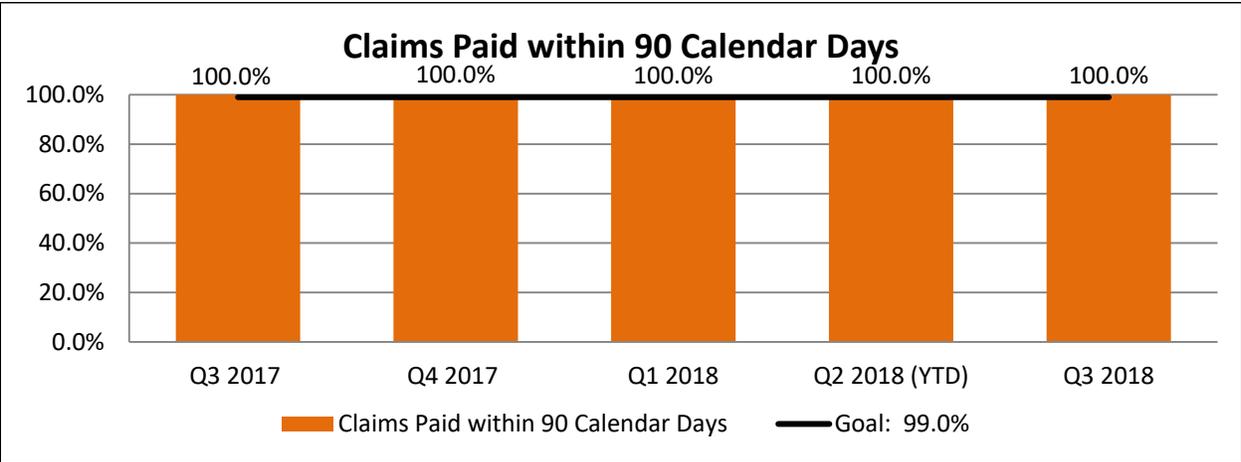
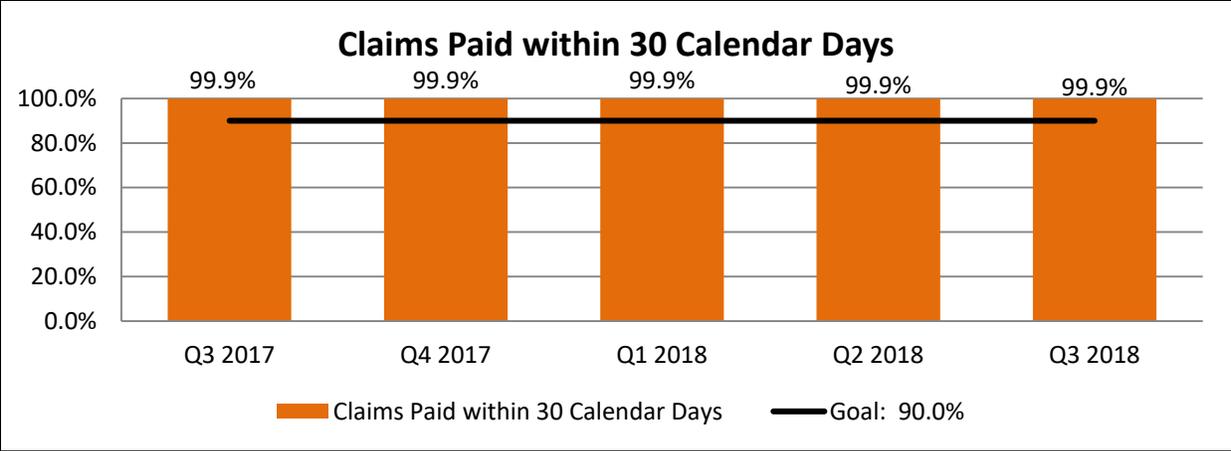
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid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

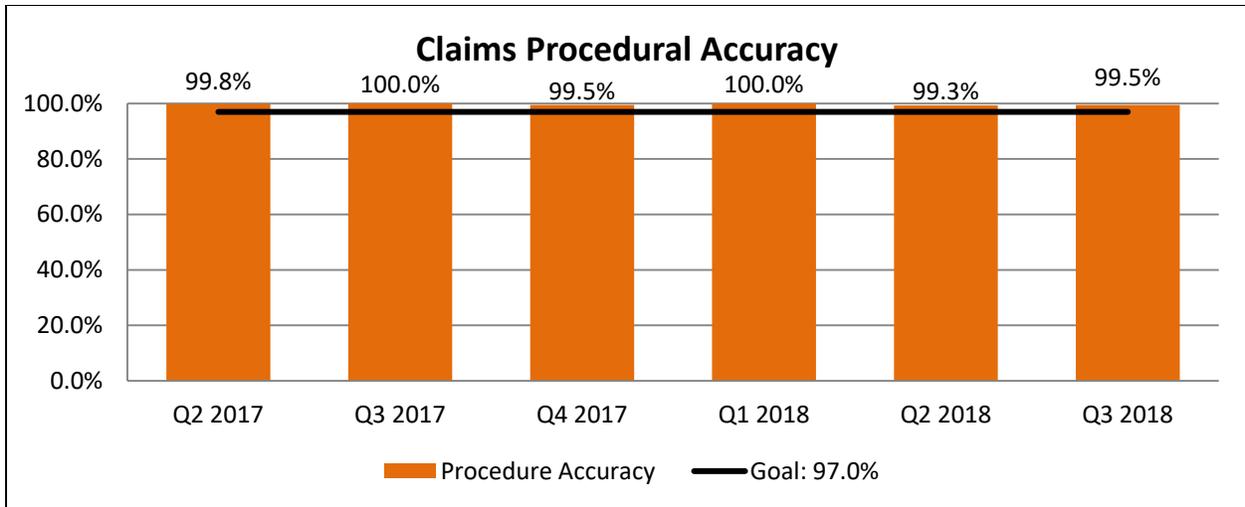
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial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

Quarterly Performance Results:

Claims	Performance Goal	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018
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%	99.9%	99.4%	99.7%	99.3%	99.6%
Procedural Accuracy	97.0%	100.0%	99.5%	100.0%	99.3%	99.5%

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





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

Opportunities and Interventions: No opportunities for improvement were identified.