IDAHO BEHAVIORAL HEALTH PLAN

QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT

April – June 2019

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). This QMUM report provides a quarterly view of performance and outcomes data, through Quarter 2, 2019.

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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 provided to IBHP members and contracted providers. Information outlined in this report highlights quarterly performance from Quarter 2, 2019.

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.

Executive Summary – Quarter 2 - 2019

Optum Idaho monitors performance measures on a continual basis to ensure the needs of IBHP members and providers are being met. Included in this report is an analysis of 10 Optum Idaho operational functions—these include outcomes analysis, member satisfaction surveys, provider satisfaction surveys, performance improvement projects, access and availability, member protections and safety, provider monitoring and safety, utilization management and care coordination, population analysis, and claims. Below is a preview of some of the successes and challenges from Q2, 2019.

Within the 10 operational functions of Optum Idaho, 32 key performance measures have been identified and are tracked on a monthly basis. Each measure has a performance target based on contractual, regulatory or operational standards. For this reporting period, Optum Idaho met or exceeded performance goals for 31 (97%) of the key measures.

Monitoring member satisfaction with behavioral health services is vital to establishing the voice of the member. Overall member satisfaction again met the goal of ≥85%. Over the past 6 quarters of data (Q3, 2017 – Q4, 2018), member satisfaction with *Counseling and Treatment* and *Accessibility, Availability, and Acceptability of the Clinician Network* consistently met the goal of ≥85%. Members have also indicated that they are consistently satisfied with the *time it takes to get an appointment* and with the ability to *find care that was respectful of their language, culture, and ethnic needs*.

Other areas in which Optum continued to meet and/or exceed performance standards are access standards to urgent, emergent and non-urgent appointment wait times, provider dispute resolutions, complaint resolutions, critical incident reviews, provider call standards, and claims paid within 30 and 90 days.

Meeting the performance measure of answering member calls within 30 seconds remained an area for improvement during Q2. While the performance goal was not met, the Q2 results were within 5% of the target. Optum Idaho continues to monitor member calls and implement strategies to exceed performance goals. Provider Customer Services calls continued to meet performance standards in all domains.

Optum will continue its focus on an outcomes driven, recovery-centered system of care for Idaho members.

Key Performance Measures

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 goals. Those highlighted in yellow fell within 5% of the performance goal. Those highlighted in red fell below the performance goal.

Measure	Goal	April - June 2018	July - September 2018	October - December 2018	January - March 2019	April - June 2019
Member Satisfaction Survey Results						
Optum Support for Obtaining Referrals or Authorizations	≥85.0%	100%	93%	92%	**Based on Member Satisfaction Survey sampling methodology, Q4, 2018, is the most current data available**	
Accessibility, Availability, and Acceptability of the Clinician Network	≥85.0%	99%	90%	92%		
Experience with Counseling or Treatment	≥85.0%	100%	93%	97%		
Overall Satisfaction	≥85.0%	100%	91%	98%		
Provider Satisfaction Survey Results						
Annual Overall Provider Satisfaction	≥85.0%	Survey Completed Annually	Survey Completed Annually	Survey Completed Annually	2018 Results 78.4%	Survey Completed Annually
Accessibility & Availability						
Idaho Behavioral Health Plan Membership						
Membership Numbers	NA	276,824	282,237	285,095	273,117	Due to claims lag, data is reported 1 quarter in arrears
Member Services Call Standards						
Total Number of Calls	NA	1,159	1,230	1,146	1,083	1,052
Percent Answered within 30 seconds	≥80.0%	80.7%	57.1%	62.6%	79%	75%
Abandonment Rate	≤3.5% internal ≤7.0 % contractual	2.1%	4.4%	4.2%	2.3%	3.5%
Daily Average Hold Time	≤120 Seconds	20	47	45	24	24
Customer Service (Provider Calls) Standards						
Total Number of Calls	NA	2,678	2,886	3,152	3,056	2,943
Percent Answered within 30 seconds	≥80.0%	99%	98%	98%	99%	97%
Abandonment Rate	≤3.5% internal ≤7.0% contractual	0.00%	0.31%	0.55%	0.31%	0.52%
Daily Average Hold Time	≤120 Seconds	2	3	4	2	4

Measure	Goal	April - June 2018	July - September 2018	October - December 2018	January - March 2019	April - June 2019
Urgent and Non-Urgent Access Standards						
Urgent Appointment Wait Time (hours)	48 hours	23.1	21.1	23.2	15.6	20.0
Non-Urgent Appointment Wait Time (days)	10 days	5.1	4.5	5.2	3.5	4.0
Critical Appointment Wait Time	Within 6 hours	5.1	4.5	5.2	2.4	2.0
Geographic Availability of Providers						
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100.0%	99.8%*	99.8%*	99.8%*	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%	99.7%*	99.8%*	99.7%*	99.8%*	99.8%*
Member Protections and Safety						
Notification of Adverse Benefit Determinations						
Number of Adverse Benefit Determinations (ABDs)	NA	320	221	280	209	225
Clinical ABDs	NA	195	72	155	45	23
Administrative ABDs	NA	125	149	125	164	202
Written Notification	100% within 14 calendar days	100%	98.2%*	99.6%*	100%	99%*
Member Appeals						
Number of Appeals	NA	21	4	5	11	1
Non-Urgent Appeals	NA	19	4	4	8	1
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	2	0	1	3	0
Determination Compliance	100% within 72 Hours	100.0%	NA	100.0%	66.7%	N/A
Complaint Resolution and Tracking						
Total Number of Complaints	NA	18	17	21	14	18
Percent of Complaints Acknowleged within Turnaround time	5 business days	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Quality of Service Complaints	NA	17	12	16	14	15
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 business days	100.0%	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints	NA	1	5	5	0	3
Percent Quality of Care Resolved within Turnaround time	≤30 calendar days	100.0%	100.0%	100.0%	N/A	100.0%

Measure	Goal	April - June 2018	July - September 2018	October - December 2018	January - March 2019	April - June 2019
Critical Incidents						
Number of Critical Incidents Received	NA	**11**	**10**	**14**	**14**	**9**
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	**159**	**165**	**119**	**147**	**123**
Percent of Audits that passed with score of ≥85%	NA	**71.0%**	**76.0%**	**72.0%**	**73.0%**	**80.0%**
Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)						
Percent PCP is documented in member record	NA	**95.4%**	**98.0%**	**96.2%**	**96.4%**	**98.0%**
Percent documentation in member record that communication/ collaboration occurred between behavioral health provider and primary care provider	NA	**71.0%**	**81.0%**	**70.0%**	**86.8%**	**76.0%**
Provider Disputes						
Number of Provider Disputes	NA	**13**	**22**	**21**	**33**	**19**
Percent Provider Dispute Determinations made within 30 calendar days from request	100% within 30 Calendar Days	**100%**	**100%**	**100%**	**100%**	**100%**
Average Number of Days to Resolve Provider Disputes	≤30 days	**6.08**	**7.8**	**12.9**	**6.5**	**5.0**
Utilization Management and Care Coordination						
Service Authorization Requests						
Percentage Determination Completed within 14 days	100%	**98.9%**	**98.9%**	**99.5%***	**100.0%**	**100.0%**
Field Care Coordination						
Total Referrals to FCCs	NA	**184**	**144**	**235**	**238**	**283**
Average Number of Days Case Open to FCC	NA	**44**	**65**	**45**	**39**	**54**
Discharge Coordination: Post Discharge Follow-Up						
Number of Inpatient Discharges	NA	**798**	**638**	**768**	**701**	**Data is reported 1 quarter in arrears**
Percent of Members with Follow-Up Appointment or Authorization within 7 Days after discharge	NA	**47.0%**	**50.2%**	**47.1%**	**50.1%**	
Percent of Members with Follow-Up Appointment or Authorization within 30 Days after discharge	NA	**67.3%**	**71.2%**	**67.5%**	**67.2%**	

Measure	Goal	April - June 2018	July - September 2018	October - December 2018	January - March 2019	April - June 2019
Readmissions						
Number of Members Disharged	NA	**798**	**638**	**768**	**701**	**Data is reported 1 quarter in arrears**
Percent of Members Readmitted within 30 days	NA	**7.9%**	**6.6%**	**8.5%**	**4.8%**	
Inter-Rater Reliability						
Inter-Rater Reliability	NA	**Reported Annually**				**99%**
Peer-Review Audits						
MD Peer Review Audit Results	≥ 88.0%	**100%**	**97%**	**90%**	**95%**	**Data is reported 1 quarter in arrears**
Claims						
Claims Paid within 30 Calendar Days	≥90%	**99.9%**	**99.9%**	**99.9%**	**99.8%**	**99.9%**
Claims Paid within 90 Calendar Days	≥99%	**100.0%**	**100.0%**	**99.9%**	**99.9%**	**100.0%**
Dollar Accuracy	≥99%	**99.3%**	**99.6%**	**99.5%**	**99.8%**	**99.8%**
Procedural Accuracy	≥97%	**99.3%**	**99.5%**	**99.5%**	**99.2%**	**99.3%**

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

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

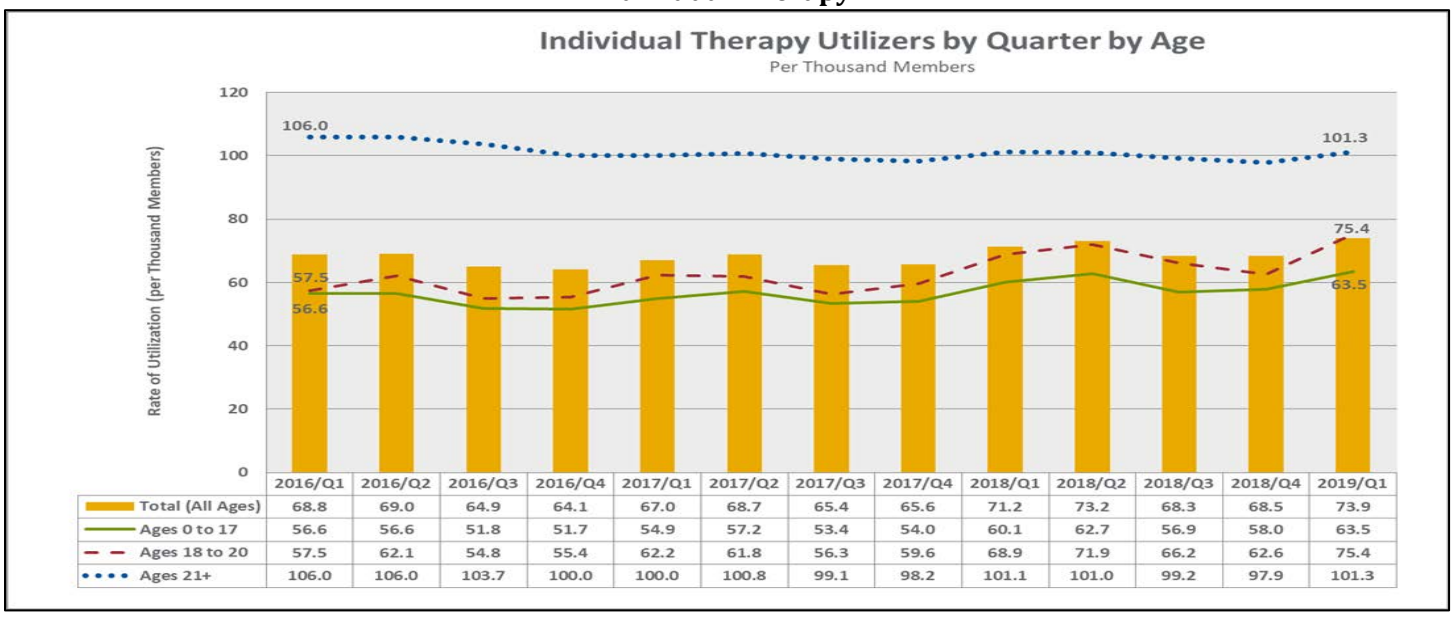
Outcomes Analysis

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

Utilization Rates

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

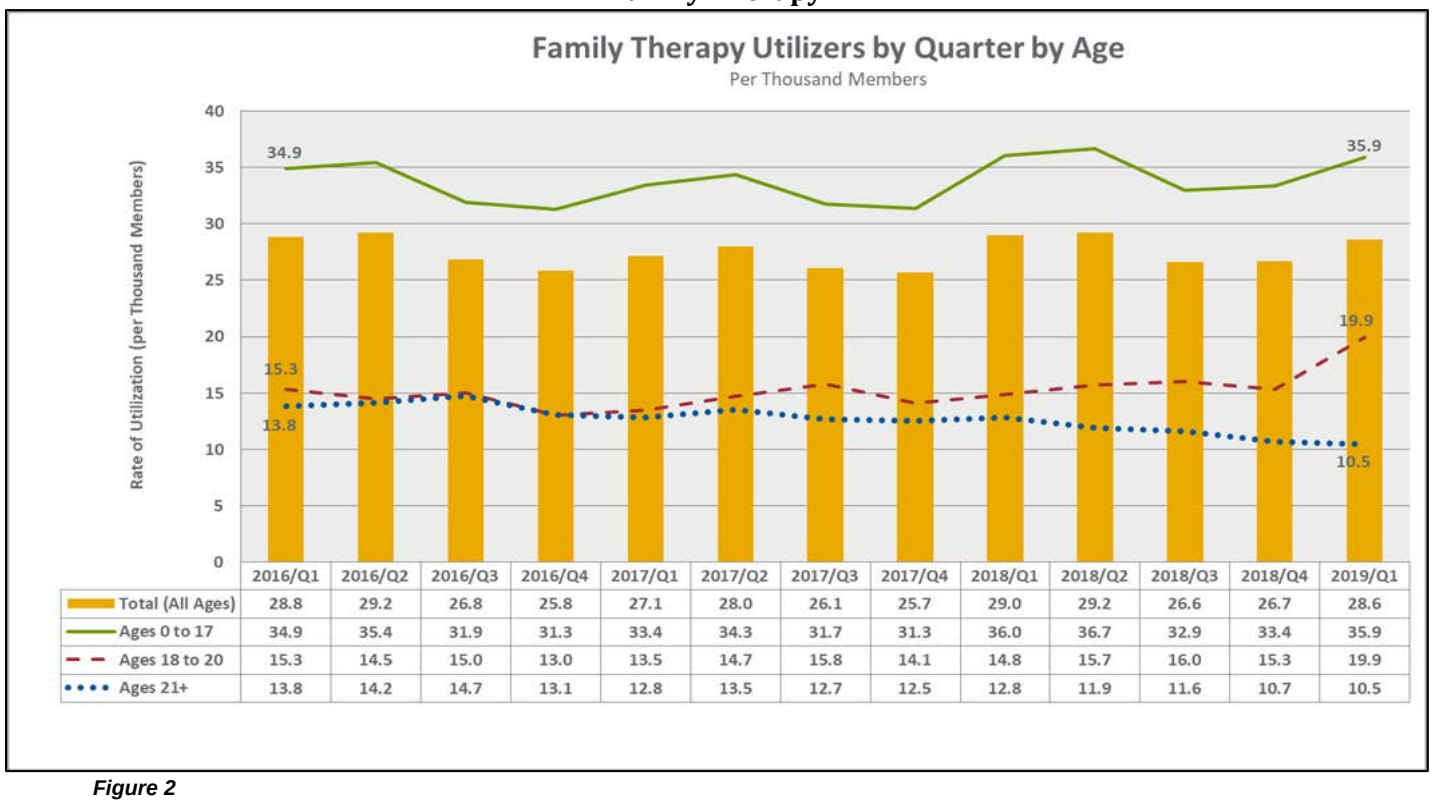
Individual Therapy



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Total (All Ages)	68.8	69.0	64.9	64.1	67.0	68.7	65.4	65.6	71.2	73.2	68.3	68.5	73.9
Ages 0 to 17	56.6	56.6	51.8	51.7	54.9	57.2	53.4	54.0	60.1	62.7	56.9	58.0	63.5
Ages 18 to 20	57.5	62.1	54.8	55.4	62.2	61.8	56.3	59.6	68.9	71.9	66.2	62.6	75.4
Ages 21+	106.0	106.0	103.7	100.0	100.0	100.8	99.1	98.2	101.1	101.0	99.2	97.9	101.3

Figure 1

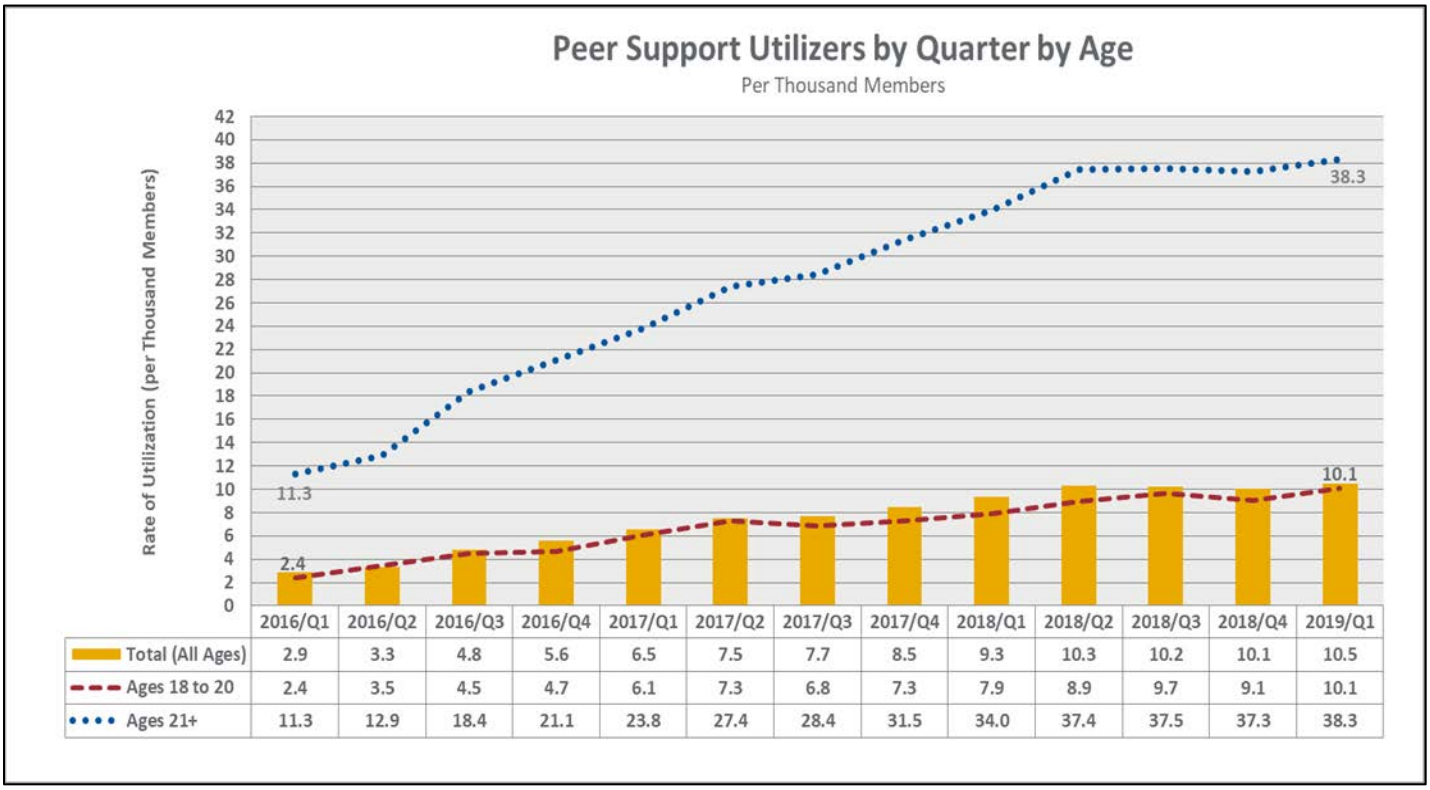
Family Therapy



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Total (All Ages)	28.8	29.2	26.8	25.8	27.1	28.0	26.1	25.7	29.0	29.2	26.6	26.7	28.6
Ages 0 to 17	34.9	35.4	31.9	31.3	33.4	34.3	31.7	31.3	36.0	36.7	32.9	33.4	35.9
Ages 18 to 20	15.3	14.5	15.0	13.0	13.5	14.7	15.8	14.1	14.8	15.7	16.0	15.3	19.9
Ages 21+	13.8	14.2	14.7	13.1	12.8	13.5	12.7	12.5	12.8	11.9	11.6	10.7	10.5

Figure 2

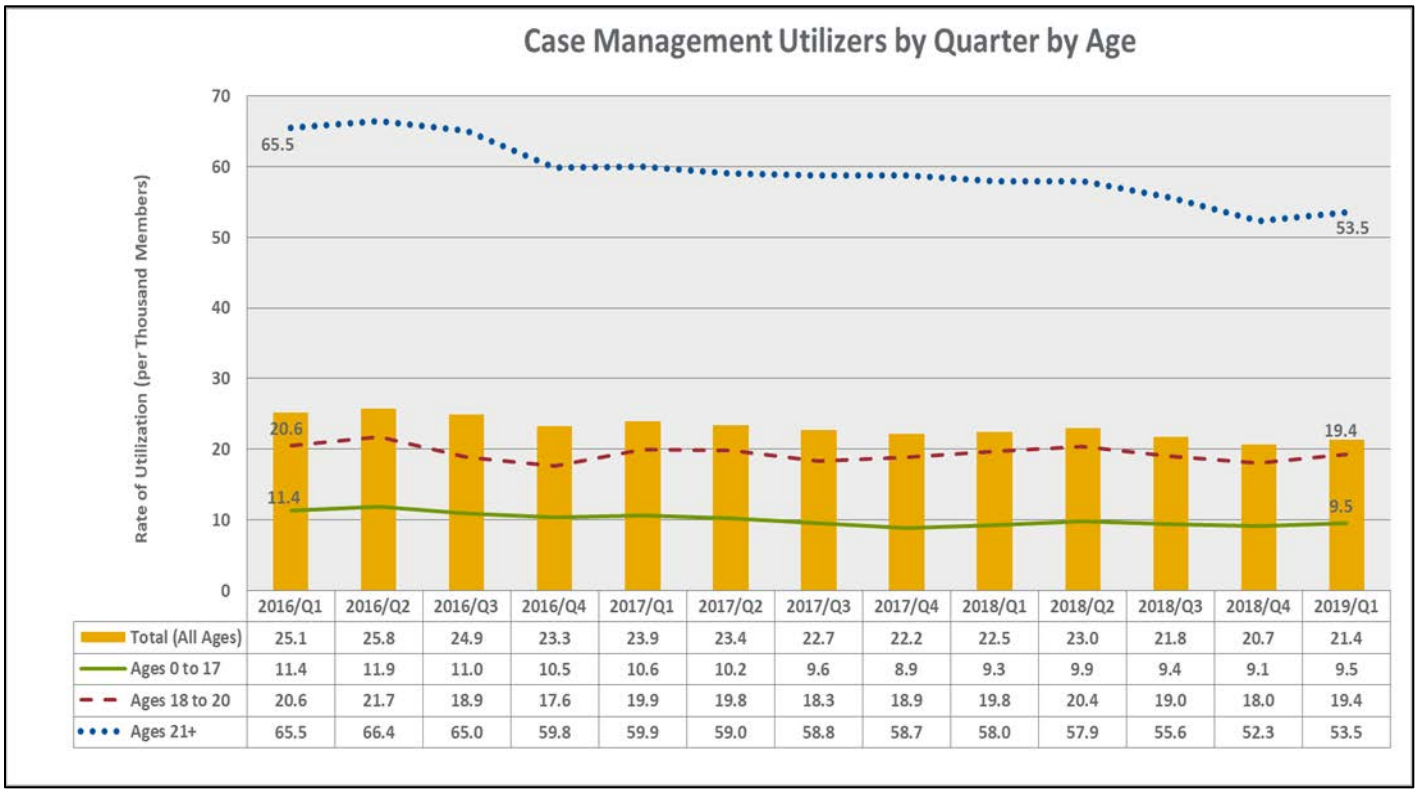
Peer Support



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Total (All Ages)	2.9	3.3	4.8	5.6	6.5	7.5	7.7	8.5	9.3	10.3	10.2	10.1	10.5
Ages 18 to 20	2.4	3.5	4.5	4.7	6.1	7.3	6.8	7.3	7.9	8.9	9.7	9.1	10.1
Ages 21+	11.3	12.9	18.4	21.1	23.8	27.4	28.4	31.5	34.0	37.4	37.5	37.3	38.3

Figure 3

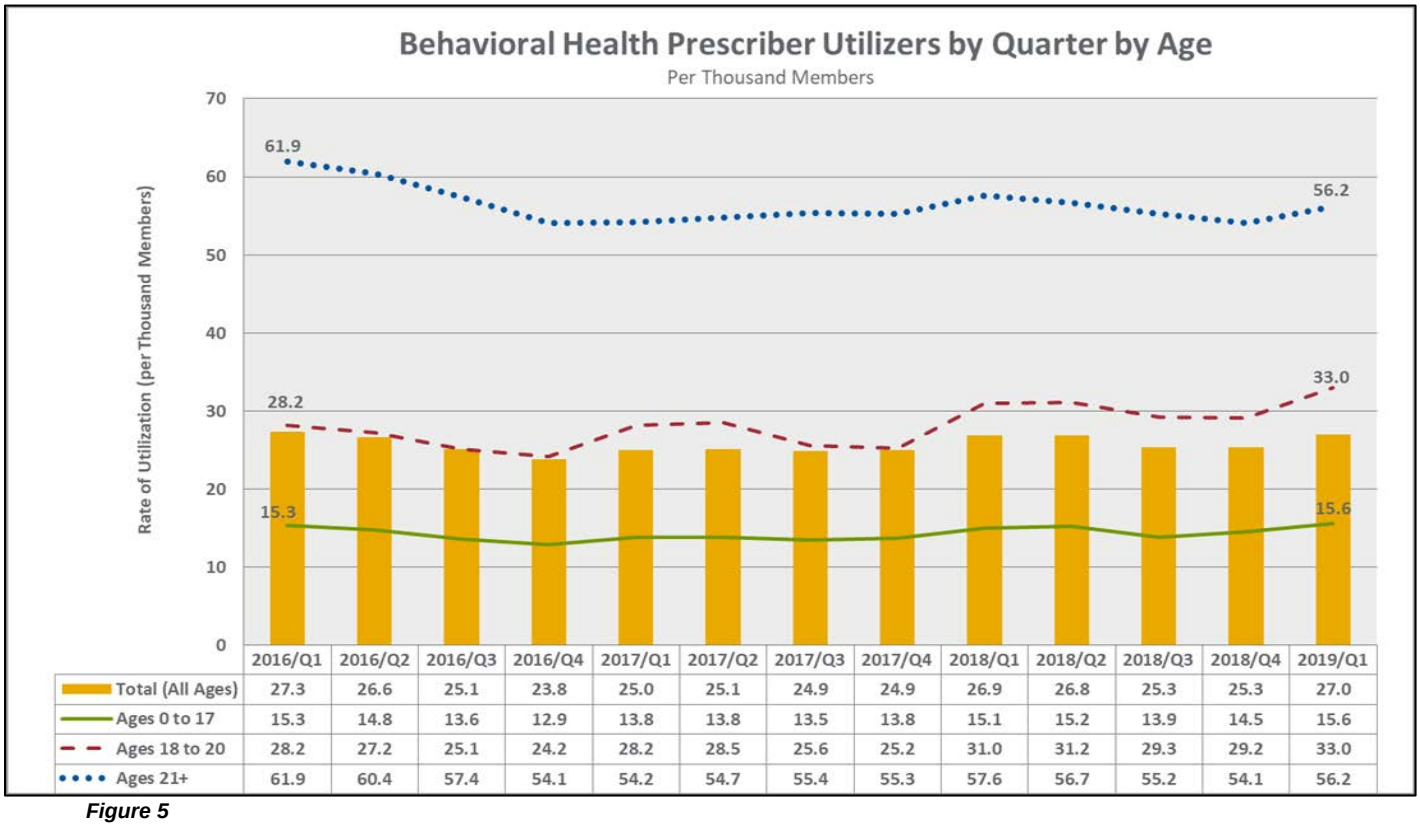
Case Management



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Total (All Ages)	25.1	25.8	24.9	23.3	23.9	23.4	22.7	22.2	22.5	23.0	21.8	20.7	21.4
Ages 0 to 17	11.4	11.9	11.0	10.5	10.6	10.2	9.6	8.9	9.3	9.9	9.4	9.1	9.5
Ages 18 to 20	20.6	21.7	18.9	17.6	19.9	19.8	18.3	18.9	19.8	20.4	19.0	18.0	19.4
Ages 21+	65.5	66.4	65.0	59.8	59.9	59.0	58.8	58.7	58.0	57.9	55.6	52.3	53.5

Figure 4

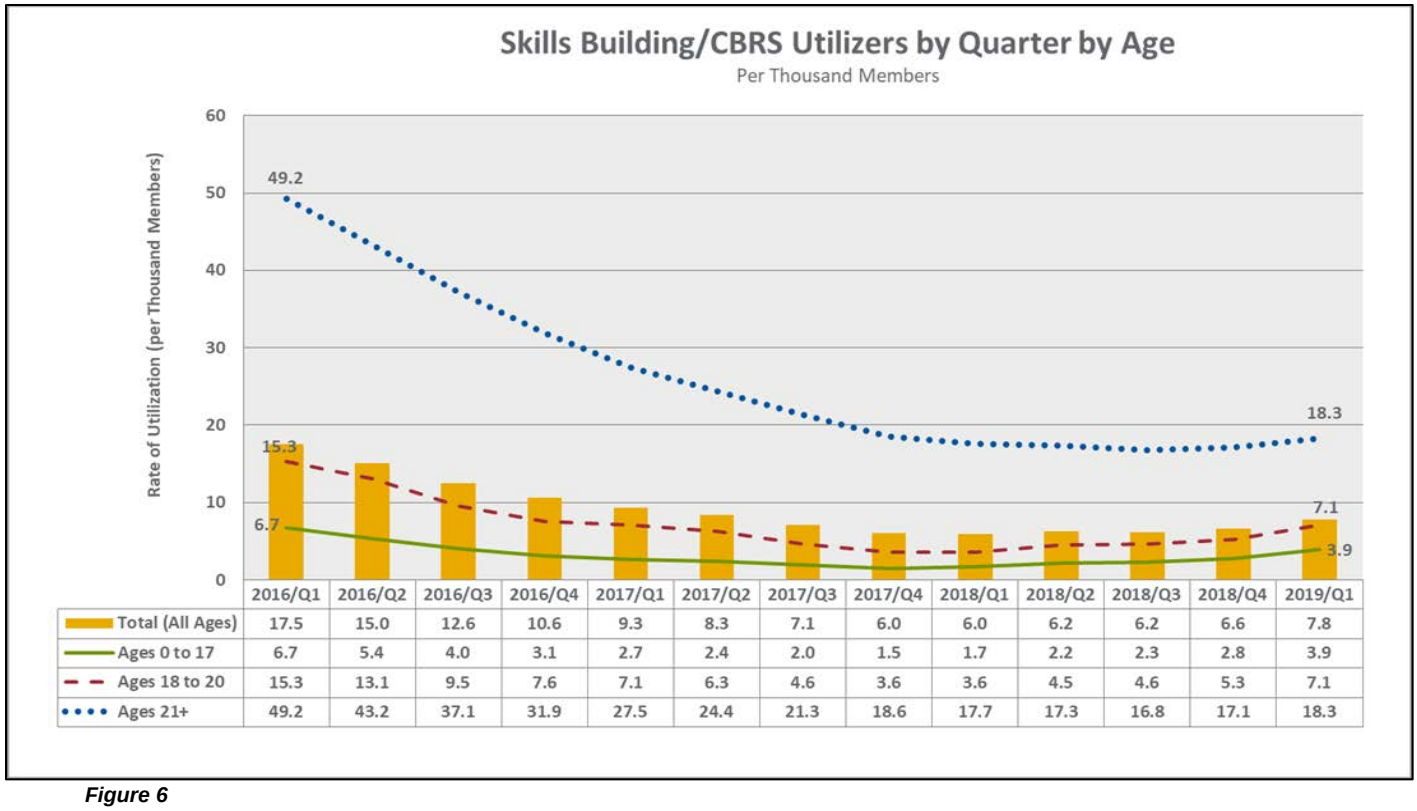
Prescriber Visits



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Total (All Ages)	27.3	26.6	25.1	23.8	25.0	25.1	24.9	24.9	26.9	26.8	25.3	25.3	27.0
Ages 0 to 17	15.3	14.8	13.6	12.9	13.8	13.8	13.5	13.8	15.1	15.2	13.9	14.5	15.6
Ages 18 to 20	28.2	27.2	25.1	24.2	28.2	28.5	25.6	25.2	31.0	31.2	29.3	29.2	33.0
Ages 21+	61.9	60.4	57.4	54.1	54.2	54.7	55.4	55.3	57.6	56.7	55.2	54.1	56.2

Figure 5

Skills Building/Community Based Rehabilitation Services (CBRS)



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Total (All Ages)	17.5	15.0	12.6	10.6	9.3	8.3	7.1	6.0	6.0	6.2	6.2	6.6	7.8
Ages 0 to 17	6.7	5.4	4.0	3.1	2.7	2.4	2.0	1.5	1.7	2.2	2.3	2.8	3.9
Ages 18 to 20	15.3	13.1	9.5	7.6	7.1	6.3	4.6	3.6	3.6	4.5	4.6	5.3	7.1
Ages 21+	49.2	43.2	37.1	31.9	27.5	24.4	21.3	18.6	17.7	17.3	16.8	17.1	18.3

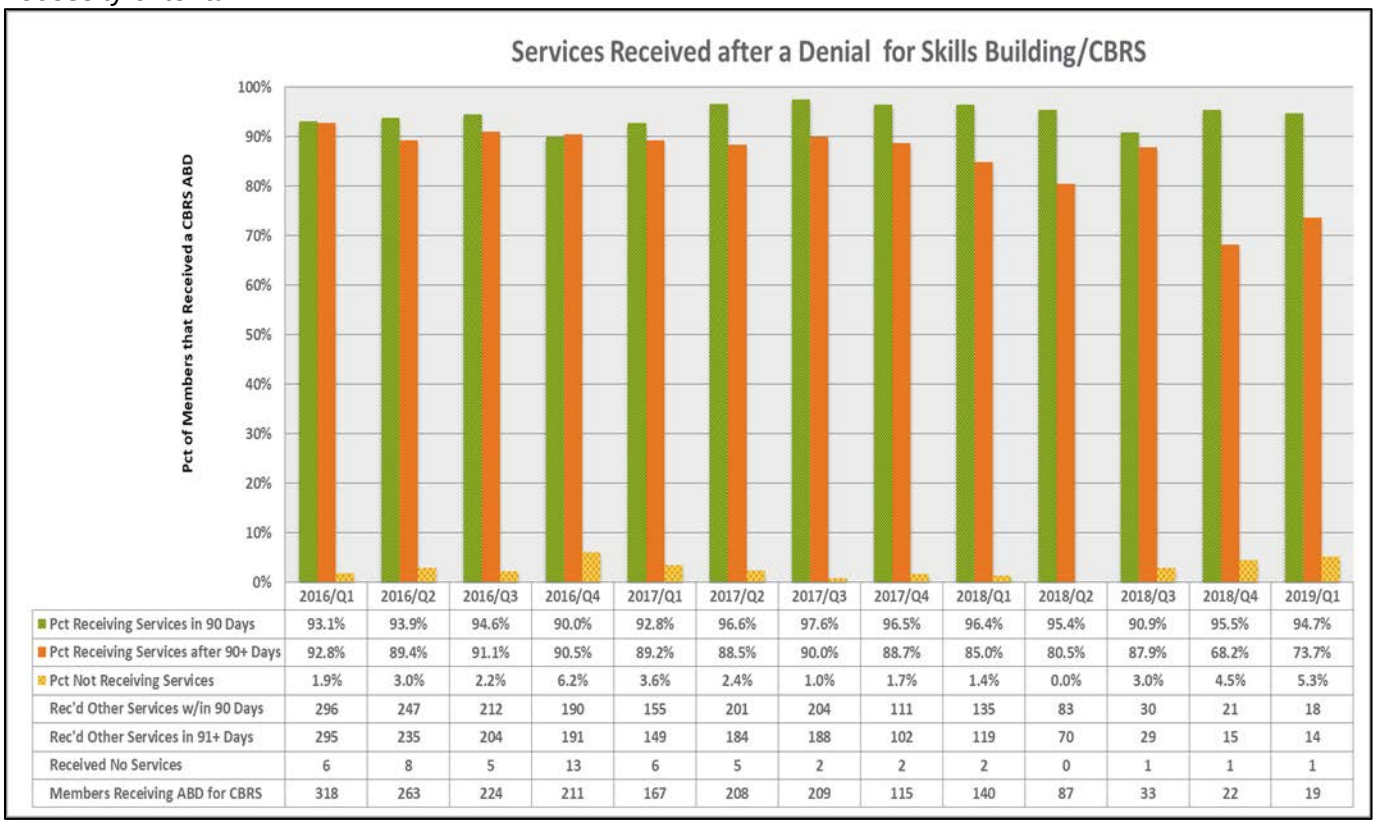
Figure 6

Analysis: Utilization rates fell within Optum Idaho expectations for Q1. Individual and Family Therapy utilization increased, as is the historical trend for the first quarter of each year. Peer Support rates have plateaued for the past four quarters. Skills Building/CBRS utilization rates saw a significant 15% increase. Starting in Q3 2018, this service was transformed from CBRS 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.

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: No opportunities for improvement were identified.

Services Received Post Skills Building/CBRS Denial

Methodology: Based on Denial and Claims data, the graph below identifies members that received evidence-based service(s) after a Skills Building/CBRS request was found not to meet administrative and/or medical necessity criteria.



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Pct Receiving Services in 90 Days	93.1%	93.9%	94.6%	90.0%	92.8%	96.6%	97.6%	96.5%	96.4%	95.4%	90.9%	95.5%	94.7%
Pct Receiving Services after 90+ Days	92.8%	89.4%	91.1%	90.5%	89.2%	88.5%	90.0%	88.7%	85.0%	80.5%	87.9%	68.2%	73.7%
Pct Not Receiving Services	1.9%	3.0%	2.2%	6.2%	3.6%	2.4%	1.0%	1.7%	1.4%	0.0%	3.0%	4.5%	5.3%
Rec'd Other Services w/in 90 Days	296	247	212	190	155	201	204	111	135	83	30	21	18
Rec'd Other Services in 91+ Days	295	235	204	191	149	184	188	102	119	70	29	15	14
Received No Services	6	8	5	13	6	5	2	2	2	0	1	1	1
Members Receiving ABD for CBRS	318	263	224	211	167	208	209	115	140	87	33	22	19

Figure 7

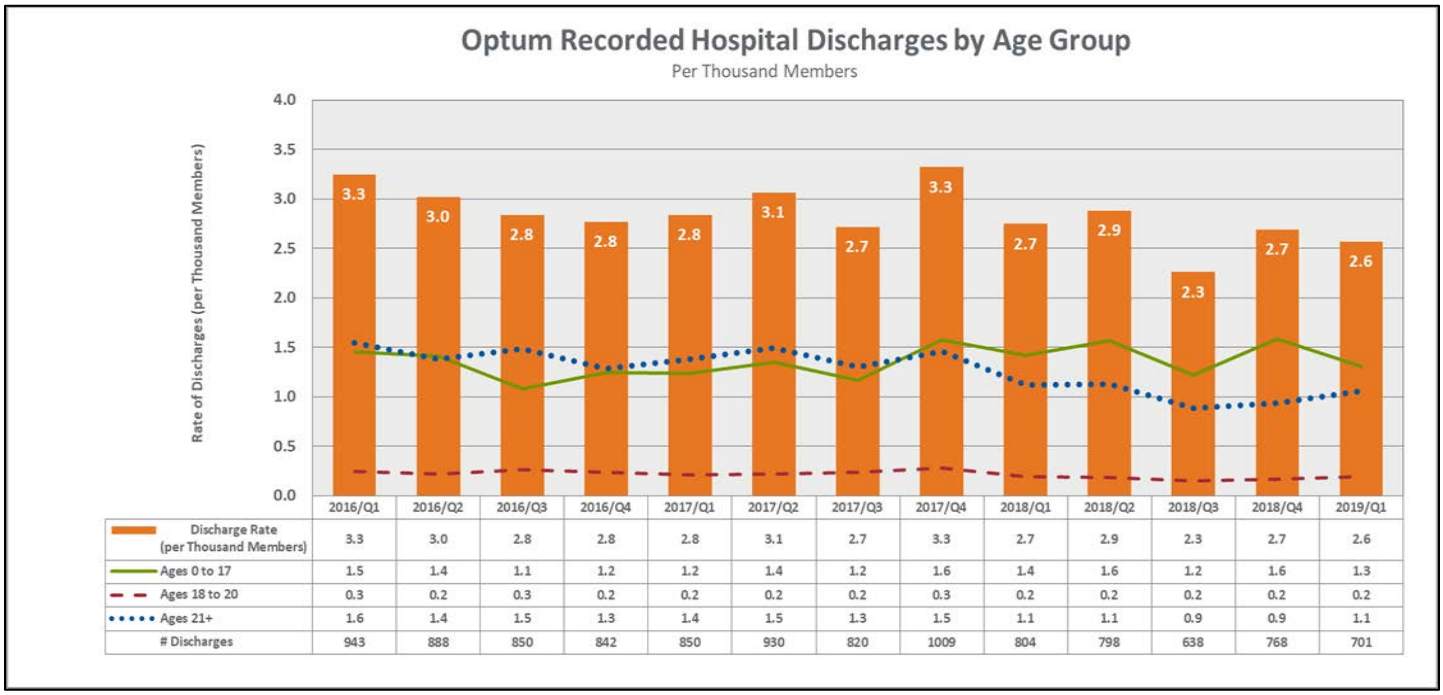
Analysis: Nearly 95% of members received evidenced-based therapeutic services within 90 days of a Skills Building/CBRS denial, which has been more or less the trend over the study period. An unknown percentage of these members receiving "no services" may in fact be receiving medication services from non-network prescribers that would not be reportable from Optum's claims database.

Barriers: No identified barriers***.***
Opportunities and Interventions: No opportunities for improvement were identified.

Psychiatric Inpatient Utilization

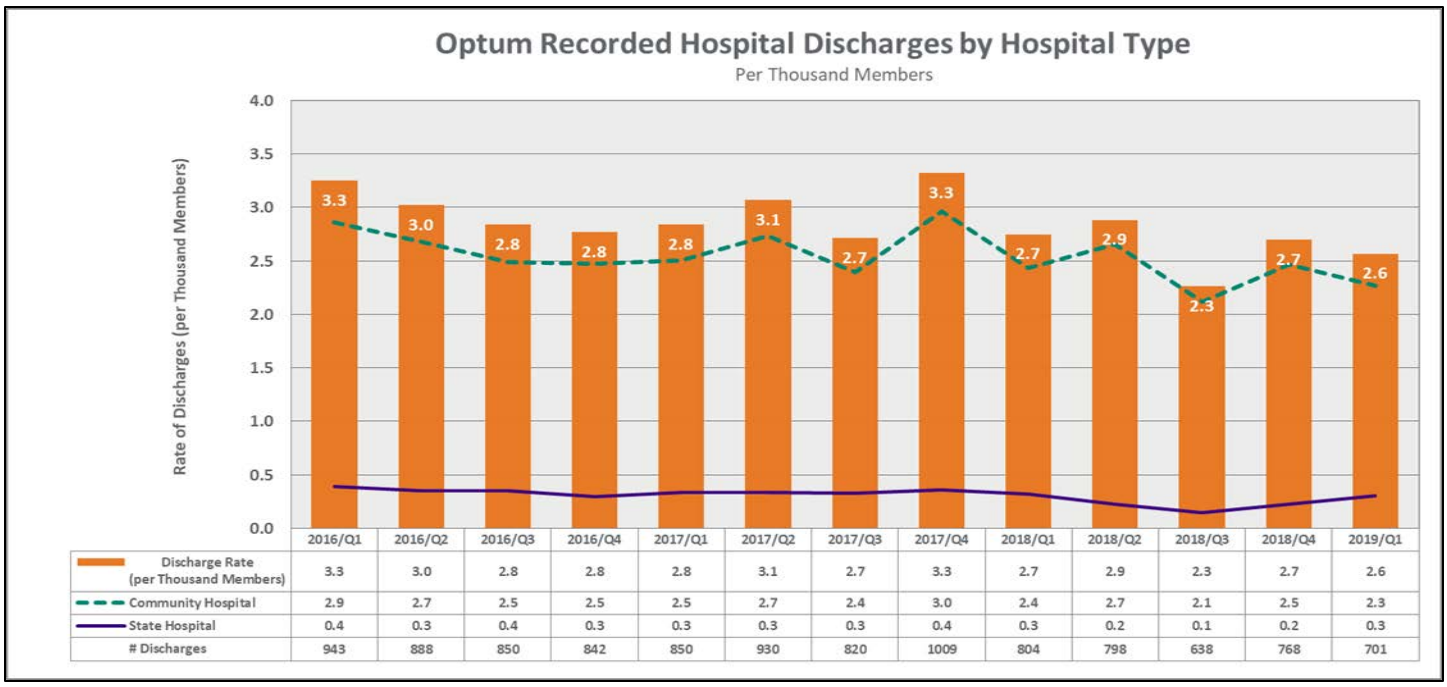
Methodology: Information is obtained from IDHW and other community resources using psychiatric hospital discharge data. A hospital stay is considered a readmission if the admission date occurred within 30 days of discharge. The data displayed indicates the rate of hospital discharges per quarter. To 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.



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Discharge Rate (per Thousand Members)	3.3	3.0	2.8	2.8	2.8	3.1	2.7	3.3	2.7	2.9	2.3	2.7	2.6
Ages 0 to 17	1.5	1.4	1.1	1.2	1.2	1.4	1.2	1.6	1.4	1.6	1.2	1.6	1.3
Ages 18 to 20	0.3	0.2	0.3	0.2	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2
Ages 21+	1.6	1.4	1.5	1.3	1.4	1.5	1.3	1.5	1.1	1.1	0.9	0.9	1.1
# Discharges	943	888	850	842	850	930	820	1009	804	798	638	768	701

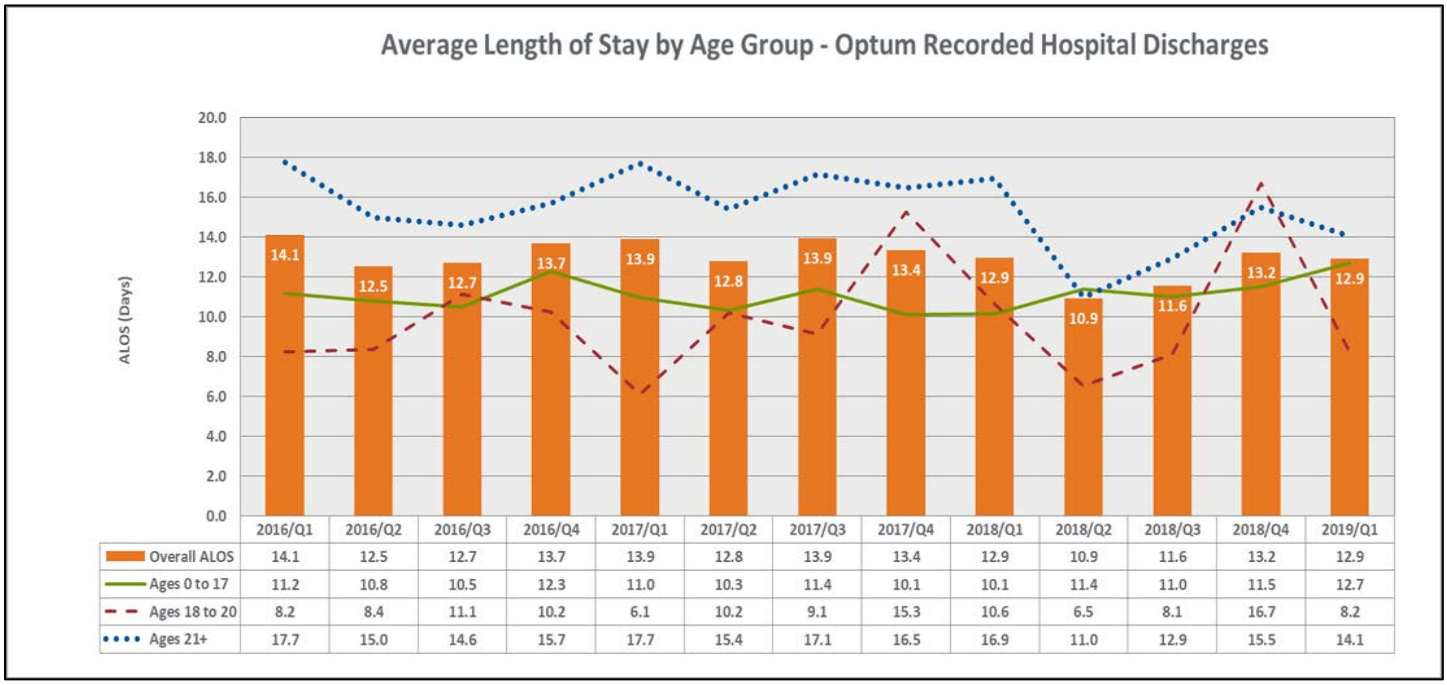
Figure 8



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Discharge Rate (per Thousand Members)	3.3	3.0	2.8	2.8	2.8	3.1	2.7	3.3	2.7	2.9	2.3	2.7	2.6
Community Hospital	2.9	2.7	2.5	2.5	2.5	2.7	2.4	3.0	2.4	2.7	2.1	2.5	2.3
State Hospital	0.4	0.3	0.4	0.3	0.3	0.3	0.3	0.4	0.3	0.2	0.1	0.2	0.3
# Discharges	943	888	850	842	850	930	820	1009	804	798	638	768	701

Figure 9

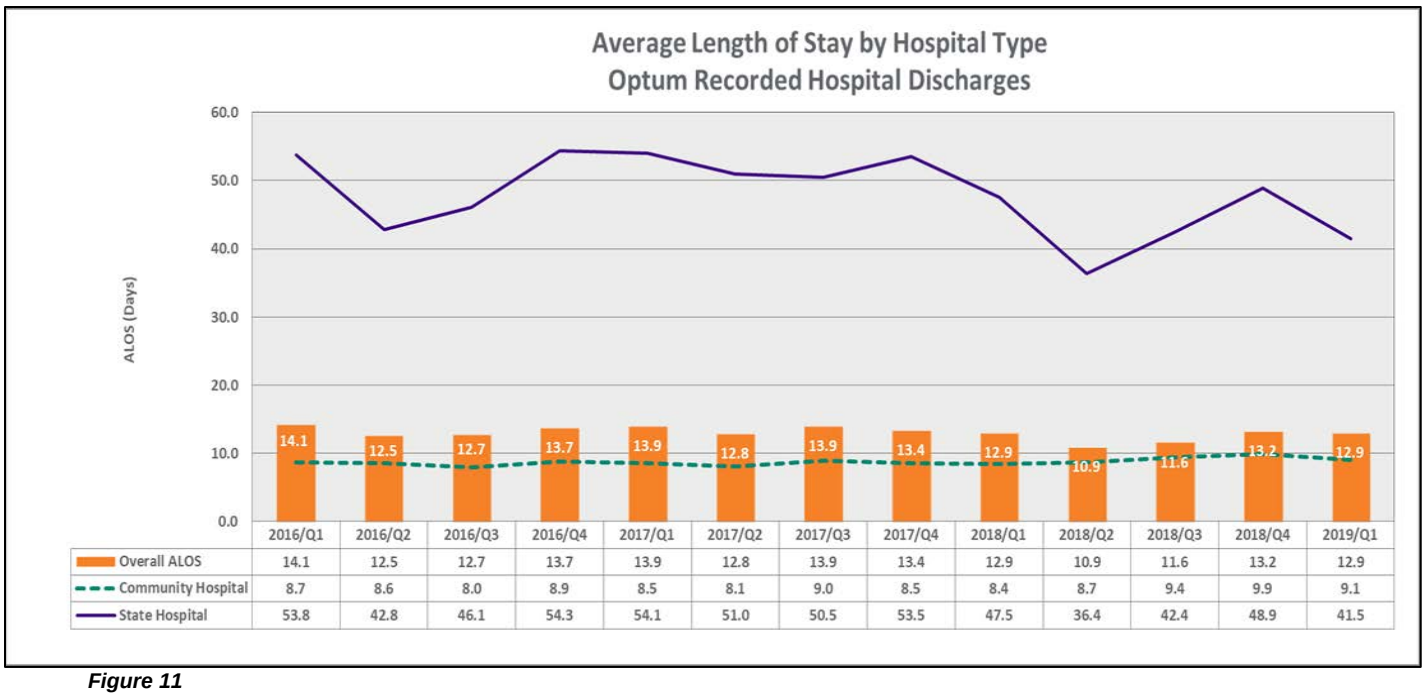
Figures 8 and 9 show the overall rate of discharges slightly decreased year-over-year from 2.7 to 2.6 per 1,000 members.



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Overall ALOS	14.1	12.5	12.7	13.7	13.9	12.8	13.9	13.4	12.9	10.9	11.6	13.2	12.9
Ages 0 to 17	11.2	10.8	10.5	12.3	11.0	10.3	11.4	10.1	10.1	11.4	11.0	11.5	12.7
Ages 18 to 20	8.2	8.4	11.1	10.2	6.1	10.2	9.1	15.3	10.6	6.5	8.1	16.7	8.2
Ages 21+	17.7	15.0	14.6	15.7	17.7	15.4	17.1	16.5	16.9	11.0	12.9	15.5	14.1

Figure 10

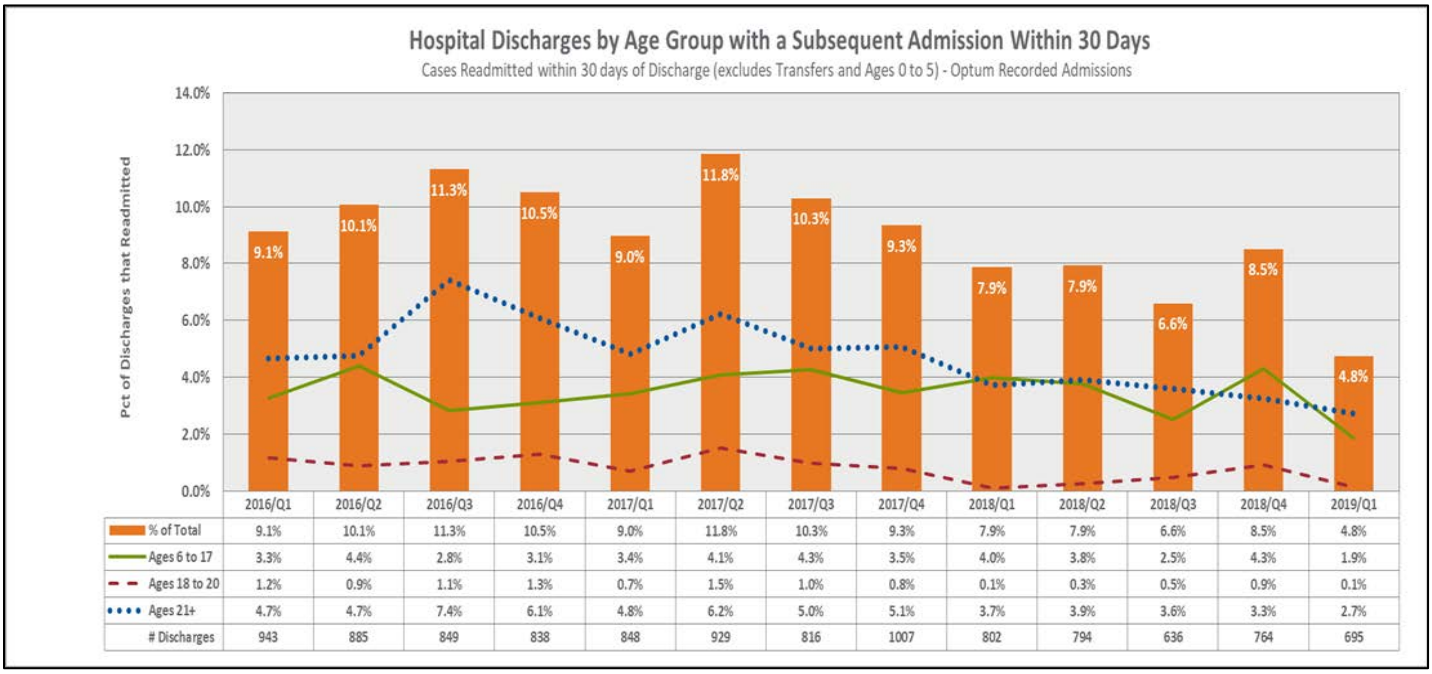
Figure 10 indicates that from Q1 2018 through Q1 2019, based on information reported to Optum Idaho, the overall average length of stay remained consistent, notwithstanding temporary decreases in average lengths of stay in Q2 and Q3 of 2018.



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Overall ALOS	14.1	12.5	12.7	13.7	13.9	12.8	13.9	13.4	12.9	10.9	11.6	13.2	12.9
Community Hospital	8.7	8.6	8.0	8.9	8.5	8.1	9.0	8.5	8.4	8.7	9.4	9.9	9.1
State Hospital	53.8	42.8	46.1	54.3	54.1	51.0	50.5	53.5	47.5	36.4	42.4	48.9	41.5

Figure 11

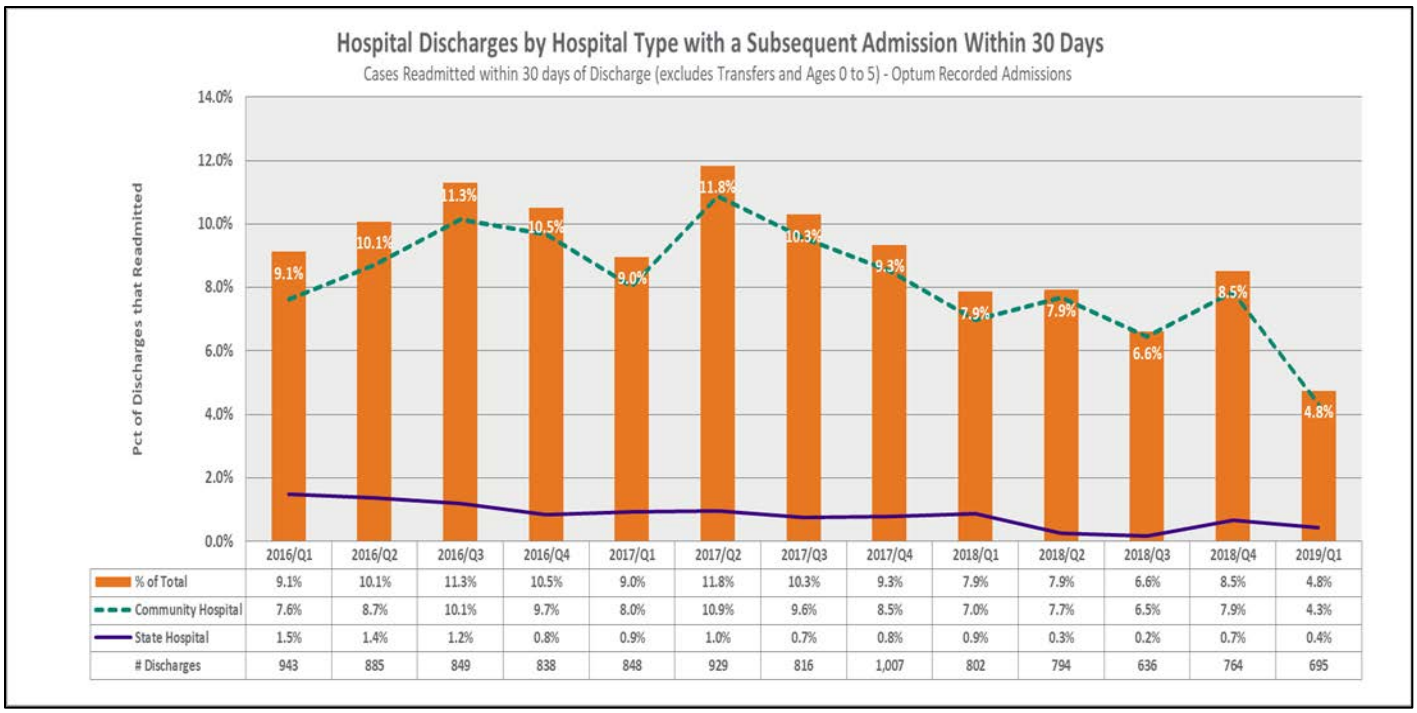
Figure 11 shows the average length of stay by hospital type. Year-over-year, the State Hospital length of stay has declined. Community hospital rates slightly decreased from the previous quarter.



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
% of Total	9.1%	10.1%	11.3%	10.5%	9.0%	11.8%	10.3%	9.3%	7.9%	7.9%	6.6%	8.5%	4.8%
Ages 6 to 17	3.3%	4.4%	2.8%	3.1%	3.4%	4.1%	4.3%	3.5%	4.0%	3.8%	2.5%	4.3%	1.9%
Ages 18 to 20	1.2%	0.9%	1.1%	1.3%	0.7%	1.5%	1.0%	0.8%	0.1%	0.3%	0.5%	0.9%	0.1%
Ages 21+	4.7%	4.7%	7.4%	6.1%	4.8%	6.2%	5.0%	5.1%	3.7%	3.9%	3.6%	3.3%	2.7%
# Discharges	943	885	849	838	848	929	816	1007	802	794	636	764	695

Figure 12

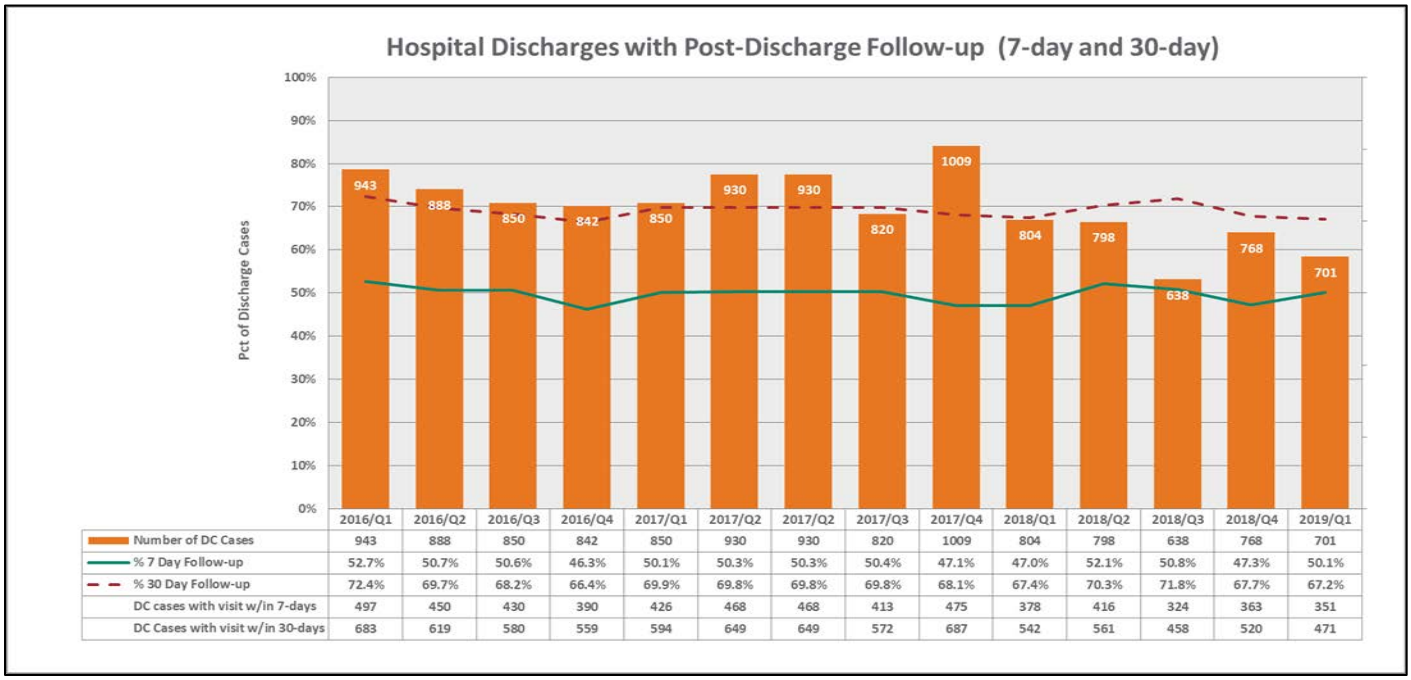
Figure 12 shows psychiatric hospital discharges by age group with a subsequent readmission within 30 days. According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals. Q1 shows a significant reduction in hospital readmissions, however, it is important to note that more readmissions are likely to be reported after publication of this report.



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
% of Total	9.1%	10.1%	11.3%	10.5%	9.0%	11.8%	10.3%	9.3%	7.9%	7.9%	6.6%	8.5%	4.8%
Community Hospital	7.6%	8.7%	10.1%	9.7%	8.0%	10.9%	9.6%	8.5%	7.0%	7.7%	6.5%	7.9%	4.3%
State Hospital	1.5%	1.4%	1.2%	0.8%	0.9%	1.0%	0.7%	0.8%	0.9%	0.3%	0.2%	0.7%	0.4%
# Discharges	943	885	849	838	848	929	816	1,007	802	794	636	764	695

Figure 13

Figure 13 shows readmission percentages by hospital type. During the study period from Q1 2018 through Q1 2019, the readmission rate for both state and community hospitals improved.



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Number of DC Cases	943	888	850	842	850	930	930	820	1009	804	798	638	768	701
% 7 Day Follow-up	52.7%	50.7%	50.6%	46.3%	50.1%	50.3%	50.3%	50.4%	47.1%	47.0%	52.1%	50.8%	47.3%	50.1%
% 30 Day Follow-up	72.4%	69.7%	68.2%	66.4%	69.9%	69.8%	69.8%	69.8%	68.1%	67.4%	70.3%	71.8%	67.7%	67.2%
DC cases with visit w/in 7-days	497	450	430	390	426	468	468	413	475	378	416	324	363	351
DC Cases with visit w/in 30-days	683	619	580	559	594	649	649	572	687	542	561	458	520	471

Figure 14

Figure 14 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 throughout the study period.

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

Opportunities and Interventions: Optum Idaho has implemented an Appointment Reminder Program to help members discharged from an inpatient psychiatric unit seek appropriate outpatient follow-up care. Optum data indicates that those members signed up for the program are more likely to attend a follow-up appointment following discharge than those who do not participate in the program. Optum continues to work with all Idaho psychiatric hospitals to engage in the program.

Algorithms for Effective Reporting and Treatment (ALERT)

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, tracks utilization patterns for psychotherapeutic services, and measures improvement of Member well-being. ALERT Online is an interactive dashboard that is available to network providers. Information from the Idaho Standardized Assessment completed by the provider's patients is available in ALERT Online both as a provider group summary and also individual Member detail.

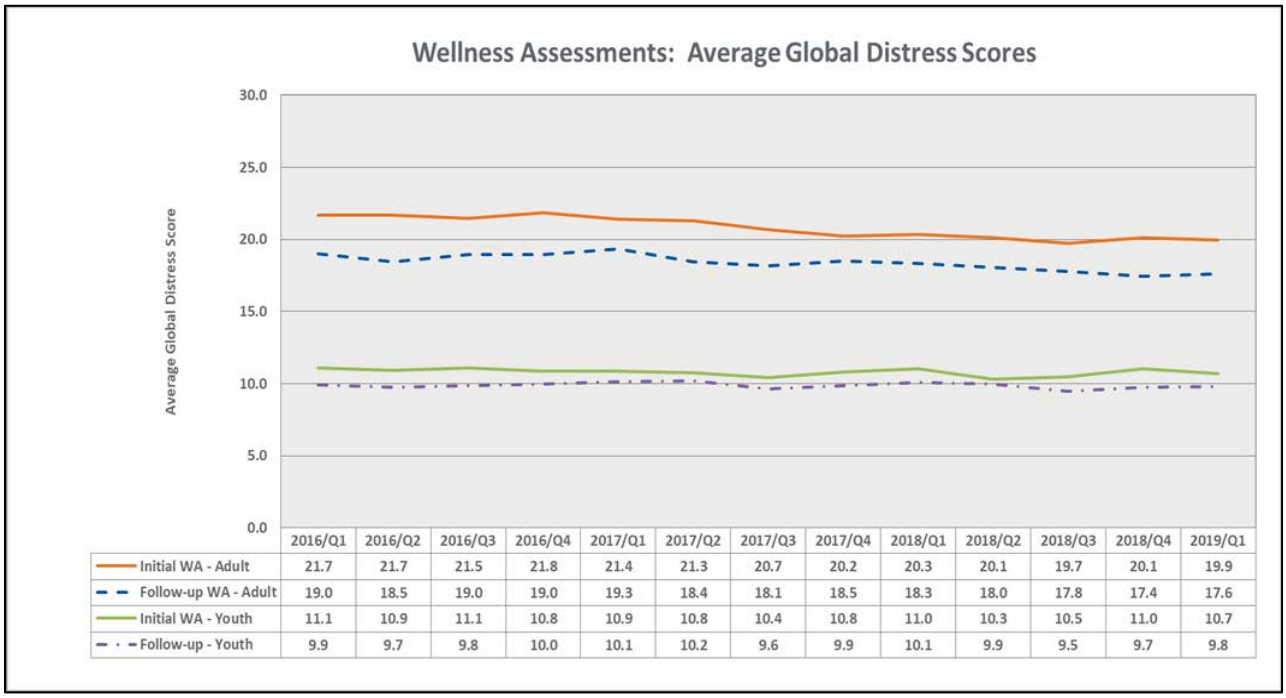
Methodology: The Idaho Standardized Assessment is a key component of the Idaho ALERT program—providers are required to ask Members to complete the Wellness Assessment at the initiation of treatment and to monitor treatment progress whenever the provider requests authorization to continue treatment. An 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.

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.

Global Distress Scores

Total Score	Severity Level	ADULT Global Distress Score Descriptions
0-11	Low	Low level of distress (*below clinical cut-off score of 12*).
12-24	Moderate	The most common range of scores for members 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.

Total Score	Severity Level	YOUTH Global Distress Score Descriptions
0-6	Low	Low level of distress *(below clinical cut-off score of 7)*
7-12	Moderate	The most common range of scores for members 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.

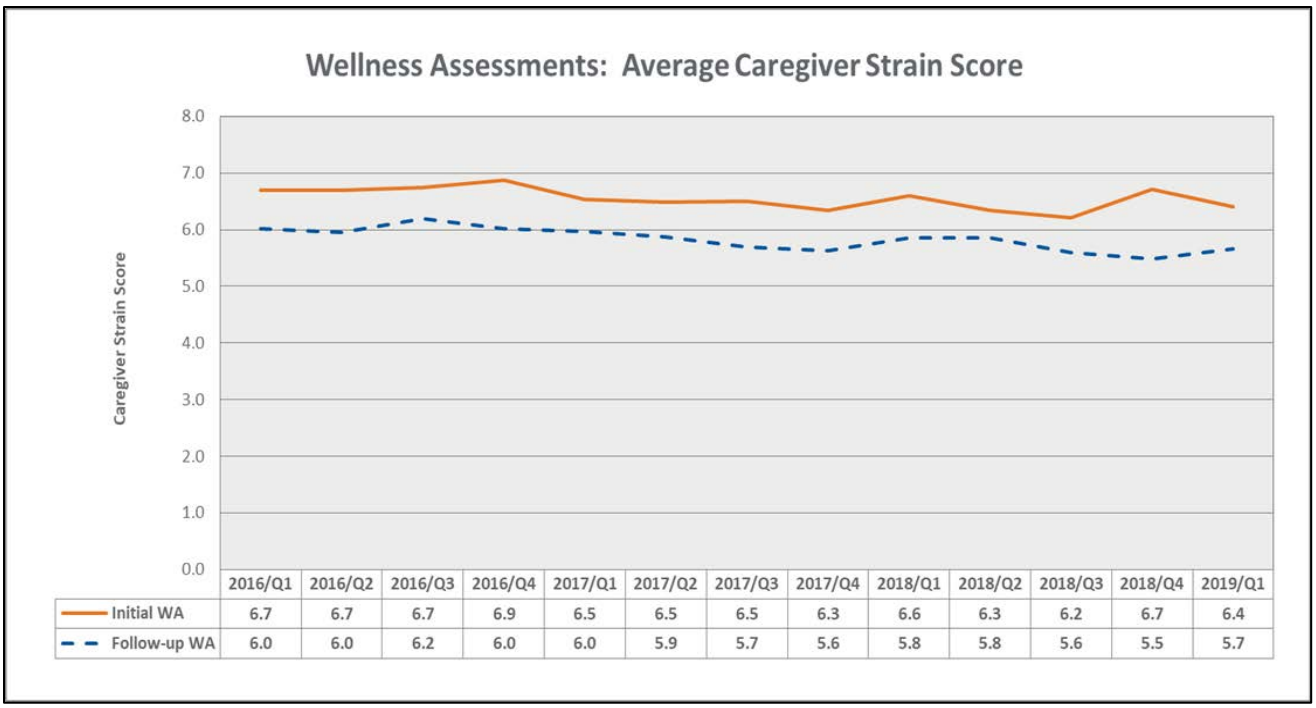


	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Initial WA - Adult	21.7	21.7	21.5	21.8	21.4	21.3	20.7	20.2	20.3	20.1	19.7	20.1	19.9
Follow-up WA - Adult	19.0	18.5	19.0	19.0	19.3	18.4	18.1	18.5	18.3	18.0	17.8	17.4	17.6
Initial WA - Youth	11.1	10.9	11.1	10.8	10.9	10.8	10.4	10.8	11.0	10.3	10.5	11.0	10.7
Follow-up - Youth	9.9	9.7	9.8	10.0	10.1	10.2	9.6	9.9	10.1	9.9	9.5	9.7	9.8

Figure 15

Caregiver Strain Scores

Score	Severity Level	Caregiver Strain Level Description
0-4	Low	No or mild strain *(below clinical cut-off score of 4.7)*
5-14	Moderate	The most common range of scores for caregivers with a child initiating outpatient psychotherapy.
15+	Severe	This level represents serious caregiver strain. Fewer than 10% of caregivers of children initiating outpatient psychotherapy report this level of strain.



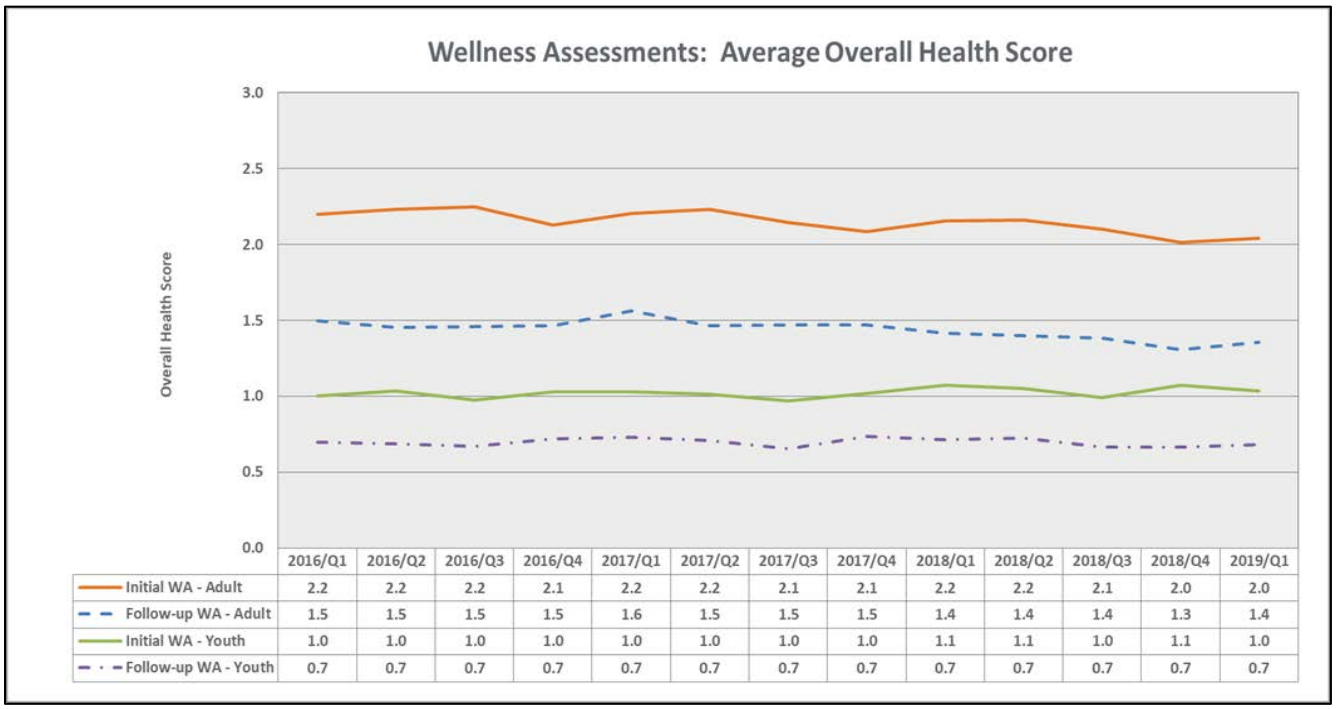
	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Initial WA	6.7	6.7	6.7	6.9	6.5	6.5	6.5	6.3	6.6	6.3	6.2	6.7	6.4
Follow-up WA	6.0	6.0	6.2	6.0	6.0	5.9	5.7	5.6	5.8	5.8	5.6	5.5	5.7

Figure 16

Average Overall Health Scores

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.

Physical Health score values: 0 = Excellent 1 = Very Good 2 = Good 3 = Fair 4 = Poor



	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Initial WA - Adult	2.2	2.2	2.2	2.1	2.2	2.2	2.1	2.1	2.2	2.2	2.1	2.0	2.0
Follow-up WA - Adult	1.5	1.5	1.5	1.5	1.6	1.5	1.5	1.5	1.4	1.4	1.4	1.3	1.4
Initial WA - Youth	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.1	1.1	1.0	1.1	1.0
Follow-up WA - Youth	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7

Figure 17

Analysis: Throughout the study period, Average Global Distress scores for adults and youth (Figure 15), initial and follow-up assessment scores remained consistent. Average Caregiver Strain (Figure 16) measured within Moderate levels during the same period, and on average improved more than 10% between initial and follow-up assessments. For the Average Overall Health Score (Figure 17), adults scored on average between "fair" and "good" on the initial assessments. On follow-up assessments conducted over the same period, adults scored on average between "good" and "very good." These scores have remained consistent. Children and youth at baseline on initial assessment (Figure 17) 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.

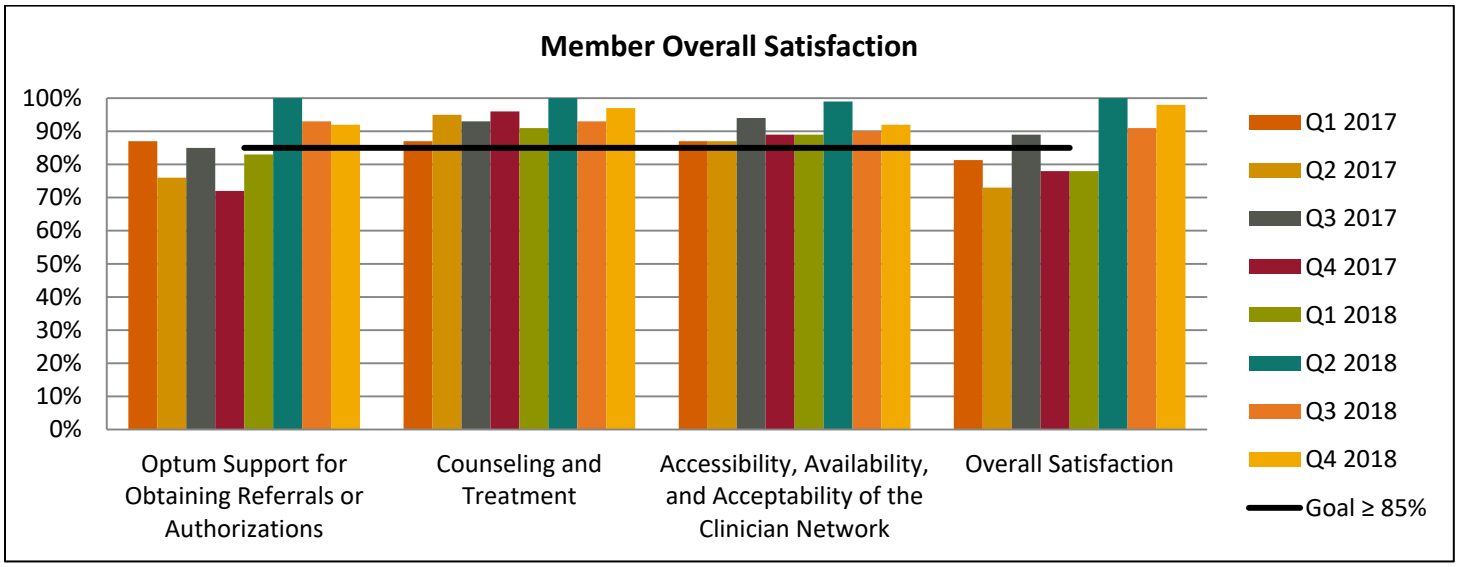
Barriers: No identified barriers.
Opportunities and Interventions: No opportunities for improvement were identified.

Member Satisfaction Survey Results

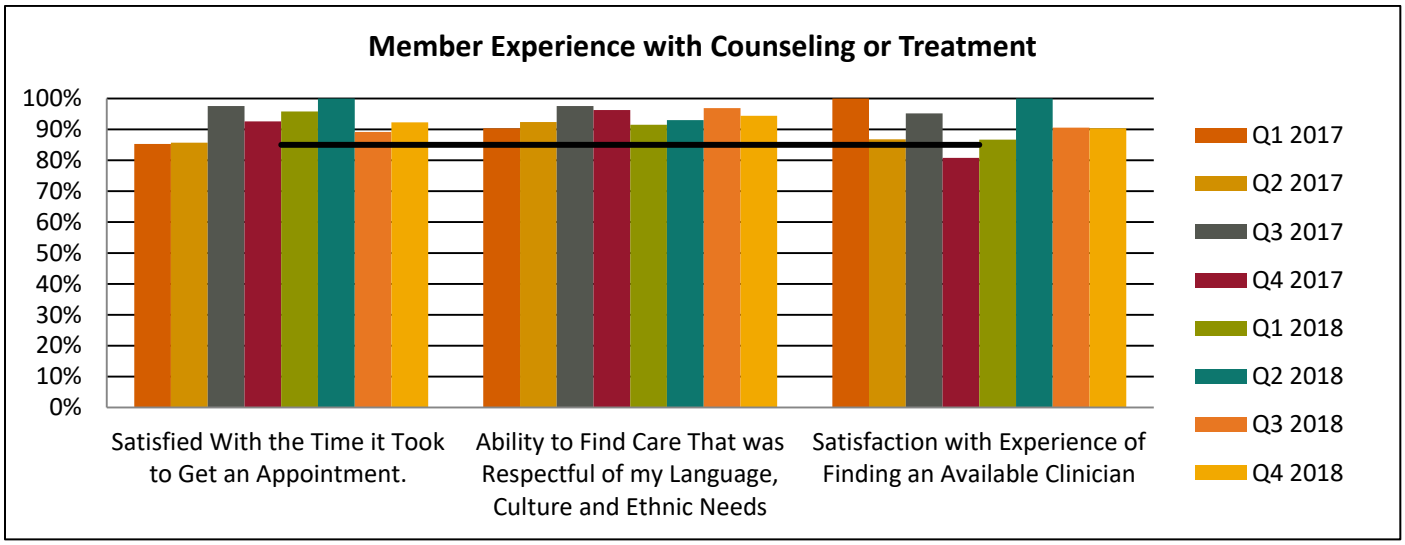
Methodology: Optum surveys Optum Idaho Behavioral Health Plan adults 18 years of age and older and parents of children aged 11 years and younger. The survey is administered through a live telephone interview. Translation services are available to members upon request. Due to various Privacy Regulations, members between the ages of 12 and 17 are not surveyed.

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 the services were rendered.

Analysis: The Quarter 4, 2018, results for Optum Idaho included surveys conducted from January 1, 2019, through March 31, 2019. The total number of members who responded to the survey was 54; a response rate of 8%. Of the total interviews conducted, none resulted in a request for translation services; all (100%) of the surveys completed were conducted in English. The goal of ≥85% was met again in all domains.



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. The goal of ≥85% was met again in all domains.



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

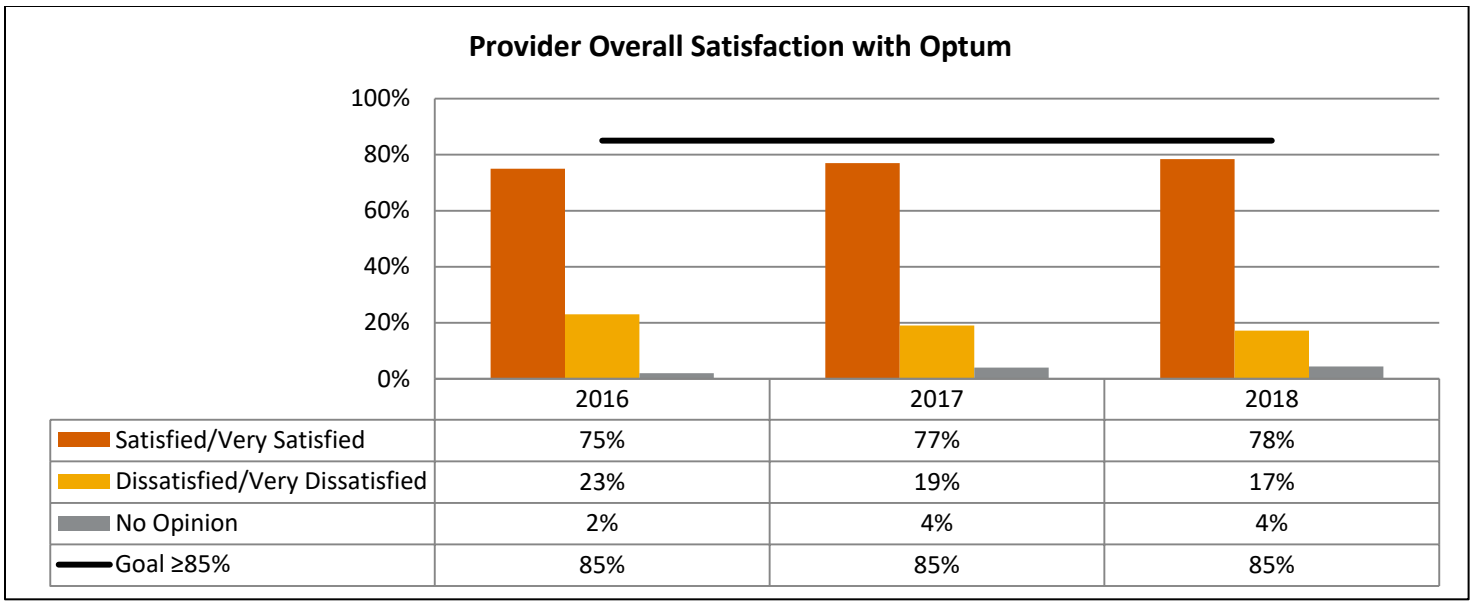
The goal of the research design of the Provider Satisfaction Survey is to provide representative and reliable measurement of providers' experiences with, attitudes toward, and suggestions for Optum Idaho.

Methodology: Optum Idaho's Provider Satisfaction Survey is conducted annually and is designed to connect with all Optum Idaho network providers to give them an opportunity to participate in the research.

There are 3 modes for providers to complete the survey:

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

Analysis: Provider Satisfaction Survey results are initially reported in Quarter 1. The following data is the same data reported on the Q1 report. The 2018 Provider Satisfaction Survey Overall Satisfaction was 78.4%. Overall satisfaction has continued to increase since 2016.



	2016	2017	2018
Satisfied/Very Satisfied	75%	77%	78%
Dissatisfied/Very Dissatisfied	23%	19%	17%
No Opinion	2%	4%	4%
Goal ≥85%	85%	85%	85%

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

Opportunities and Interventions: Action plans for 2019 include:

- Continue process for regular piloting initiatives with providers and seeking input.
- Create subcommittees of the Provider Advisory Committee for special topics.
- Increase visits and meetings with provider associations and offices.
- Educate providers on the use of the Net Promotor Score.
- Create trainings/webinars on specific issues identified within survey.

Performance Improvement Project(s)

Performance Improvement Projects (PIPs) are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

Appointment Reminder Program (ARP)

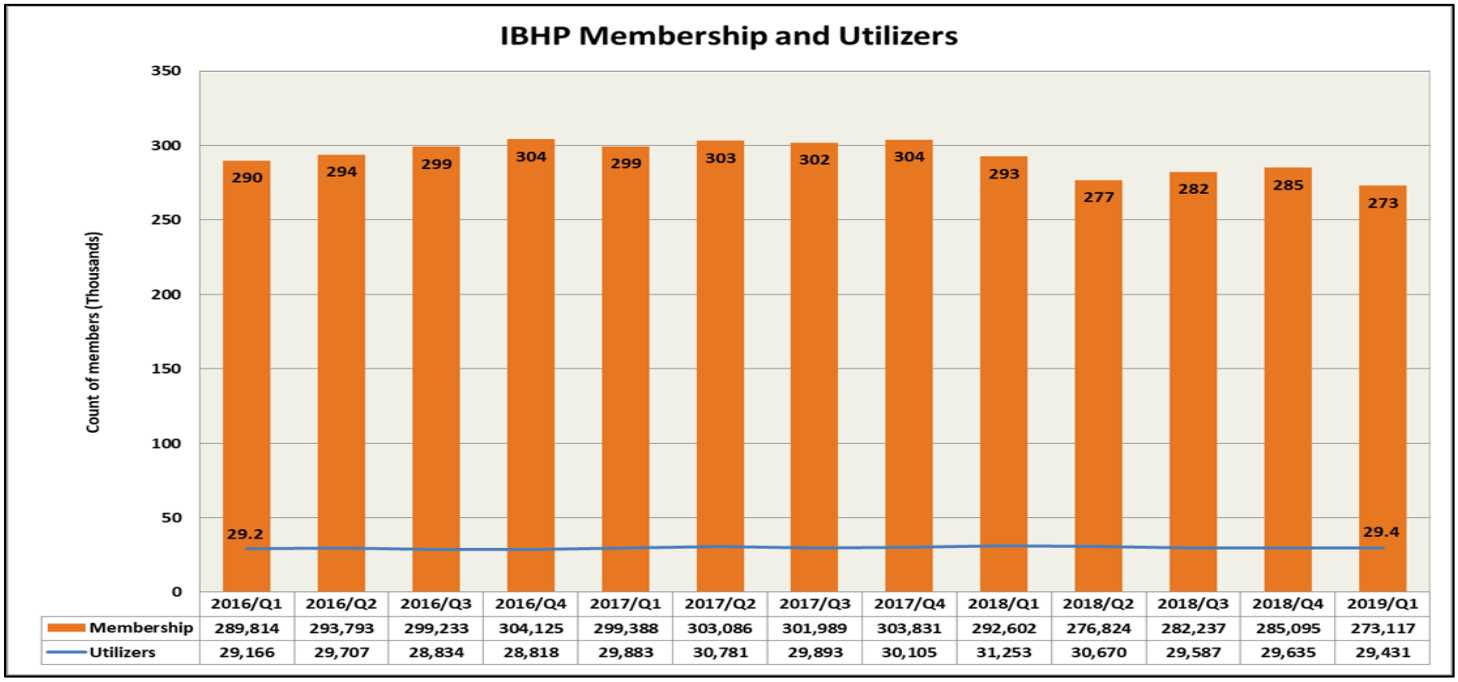
***Analysis*:** The purpose of this project is to improve outcomes for Members who have been hospitalized to ensure they have a behavioral health appointment within 30 days of inpatient discharge. Research indicates that individuals who receive a follow-up appointment within 7 and 30 days of discharge are less likely to be admitted in the future. Out of 945 total discharges received by Optum Idaho from January through April 2019, 203 members participated in ARP. Data reflects information received from 6 participating Idaho hospitals. Five hospitals did not submit data. Field Care Coordinators (FCCs) are currently working on a strategy to connect with these hospitals, trying to assist them with discharge paperwork so the information can be gleaned from that paperwork that is sent to Optum. Feedback has been positive. All hospitals will have an FCC associated with them and reviewing discharge paperwork. One of the hospitals, Intermountain, had close to 100% participation in the program.

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

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

Analysis: Membership and Utilizers decreased during the quarter. No identified trends year-over-year.



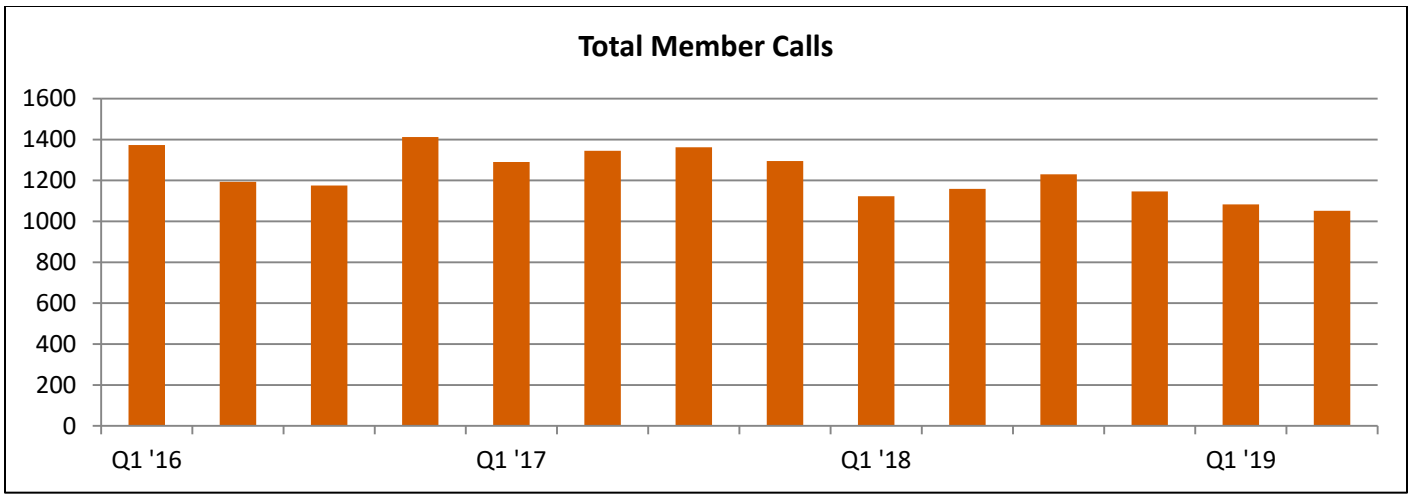
	2016/Q1	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3	2017/Q4	2018/Q1	2018/Q2	2018/Q3	2018/Q4	2019/Q1
Membership	289,814	293,793	299,233	304,125	299,388	303,086	301,989	303,831	292,602	276,824	282,237	285,095	273,117
Utilizers	29,166	29,707	28,834	28,818	29,883	30,781	29,893	30,105	31,253	30,670	29,587	29,635	29,431

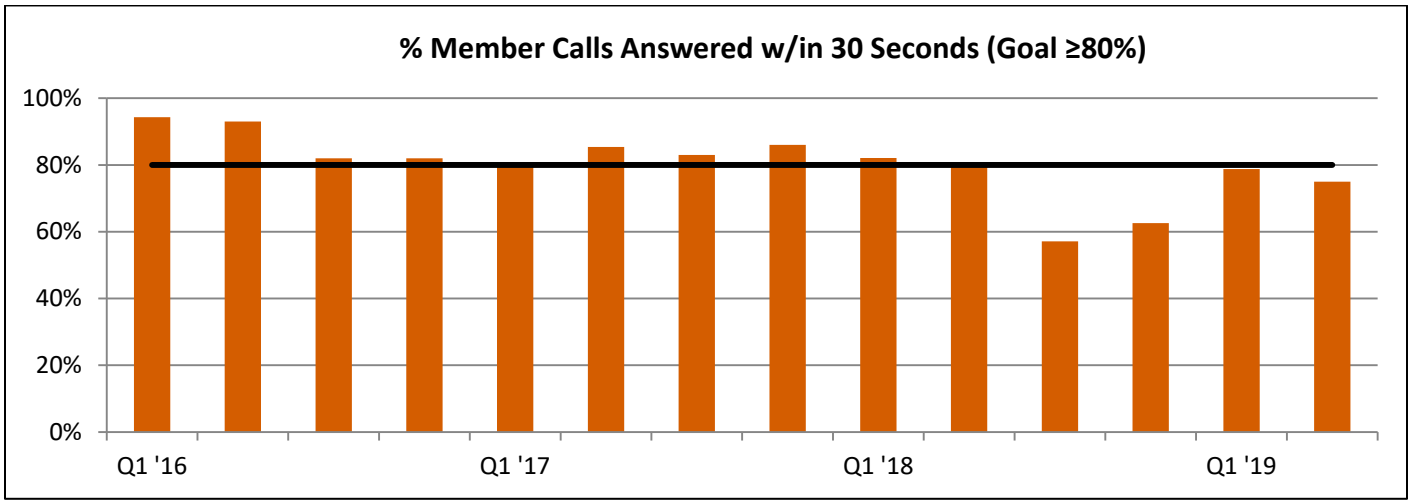
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

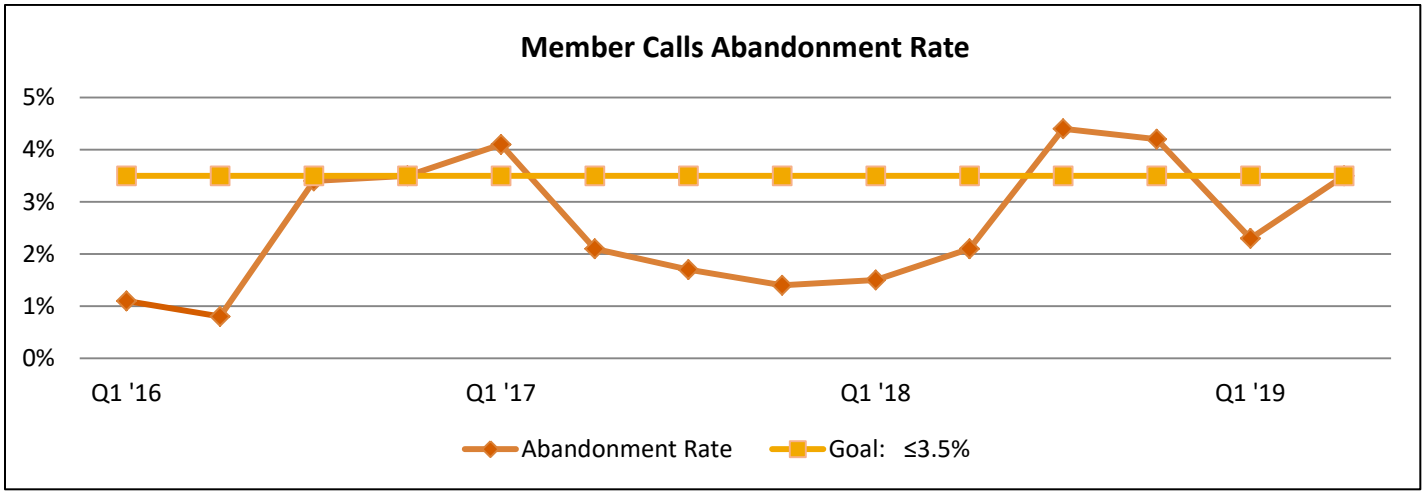
Member Services Call Standards

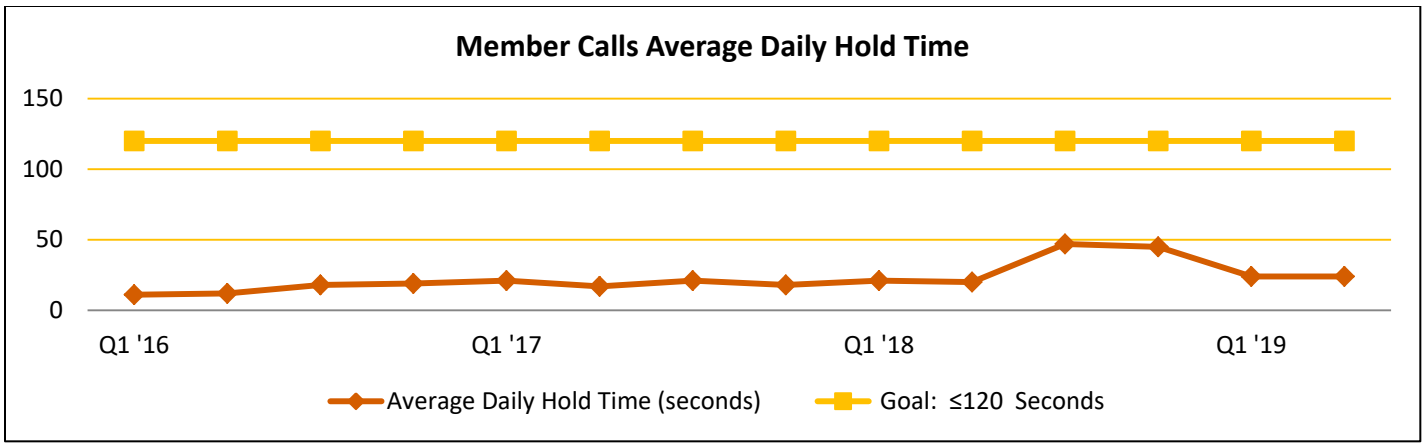
Methodology: Optum Idaho telephone access is provided 24 hours a day, seven days a week, 365 days a year through our toll-free Member Access and Crisis Line. Optum Idaho is contractually obligated to track the percent of member calls answered within 30 seconds, call abandonment rate, and daily average hold time.

Analysis: During Q2, the Member Services and Crisis Line received a total of 1,052 calls. Calls answered within 30 seconds fell below the goal of ≥80% at 75%. The call abandonment rate was 3.5% which met both the internal Optum Idaho Standards goal of ≤3.5% and the IBHP Contractual Standards goal of ≤7.0%. Average Daily Hold Time continued to meet the goal.


Total Member Calls
1600
1400
1200
1000
800
600
400
200
0
Q1 '16
Q1 '17
Q1 '18
Q1 '19


% Member Calls Answered w/in 30 Seconds (Goal ≥80%)
100%
80%
60%
40%
20%
0%
Q1 '16
Q1 '17
Q1 '18
Q1 '19


Member Calls Abandonment Rate
5%
4%
3%
2%
1%
0%
Q1 '16
Q1 '17
Q1 '18
Q1 '19
Abandonment Rate
Goal: ≤3.5%

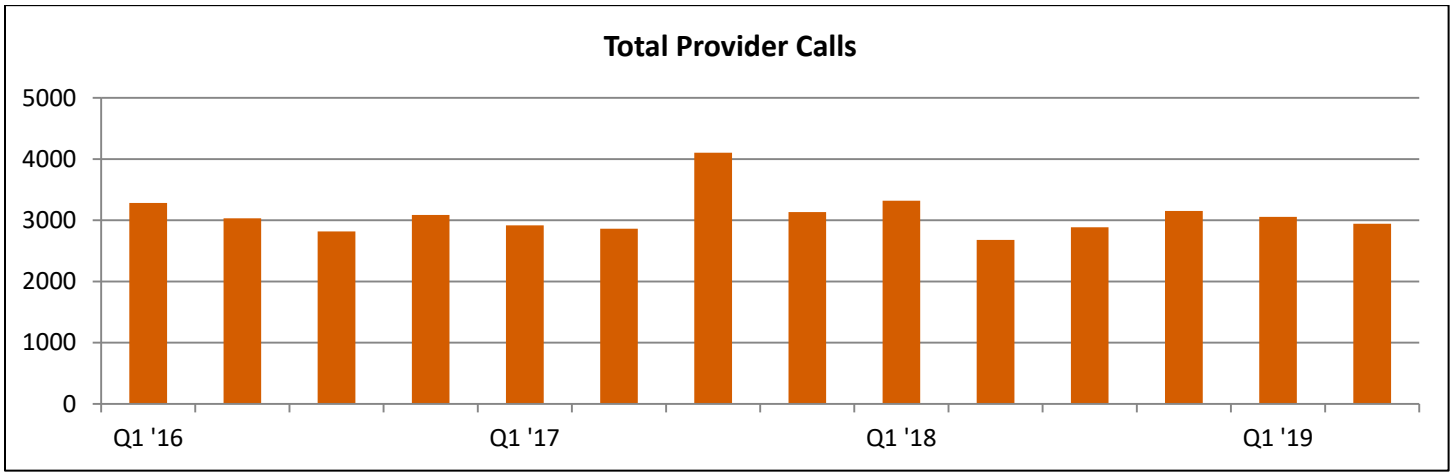


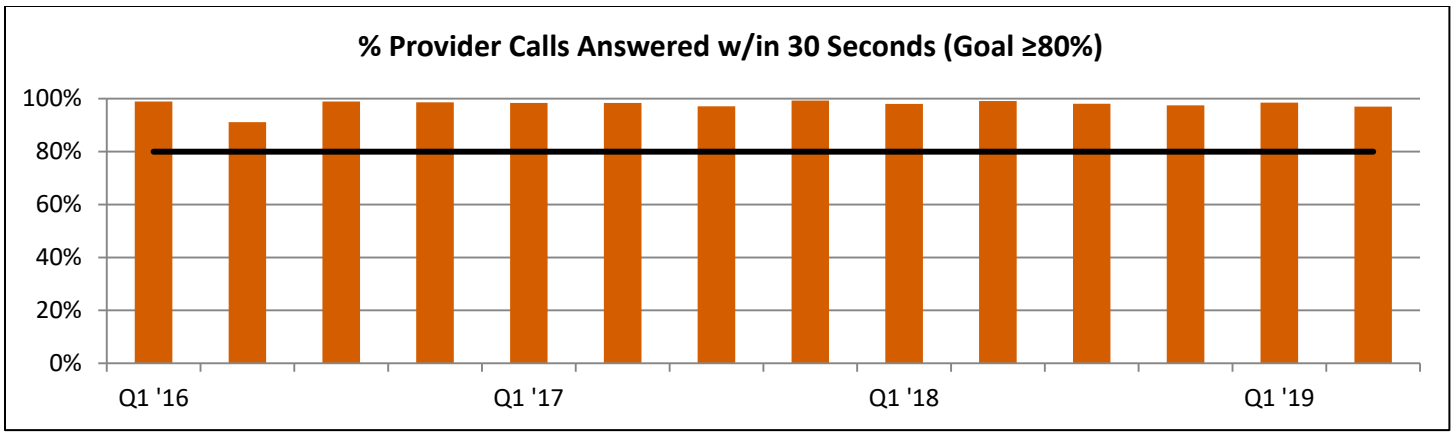
Barriers: Performance goal was not met for Percent of Calls Answered within 30 Seconds.
Opportunities and Interventions: An Improvement Action Plan (IAP) has been implemented to improve performance standards. The performance standards and improvement strategies are monitored on a weekly basis.

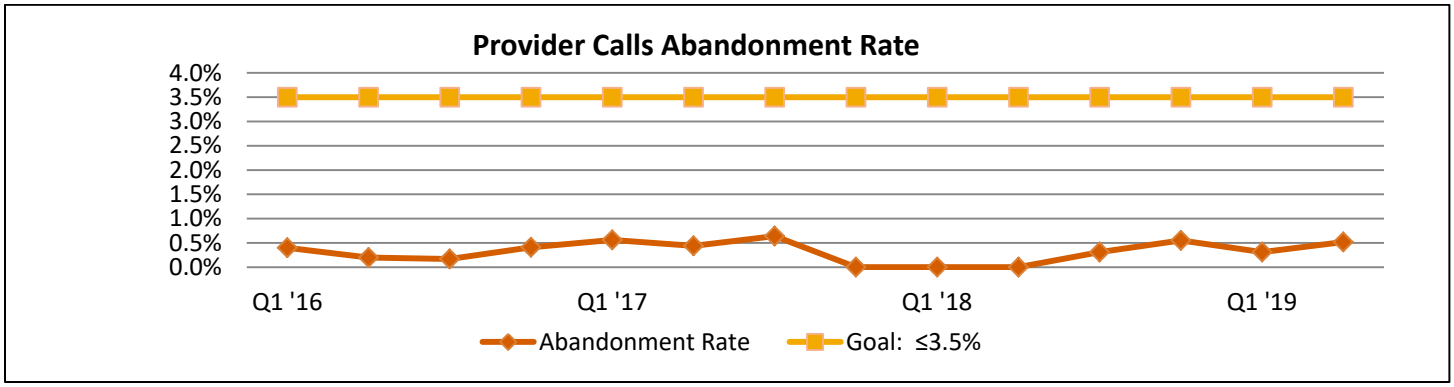
Customer Service (Provider Calls) Standards

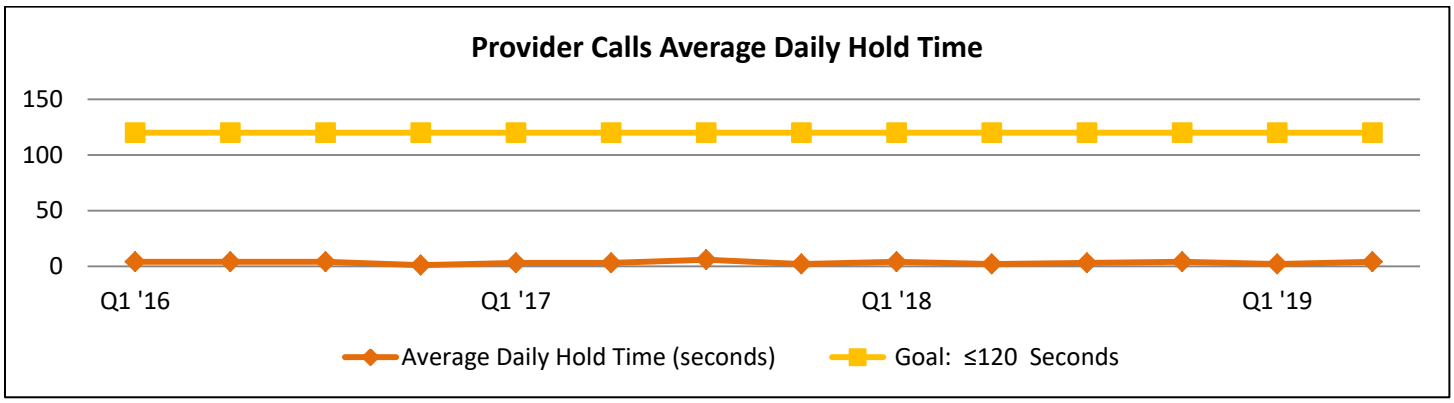
Methodology: Optum Idaho is contractually obligated to track the percent of provider calls answered within 30 seconds, call abandonment rate, and daily average hold time. The Customer Service Line is primarily used by providers, IDHW personnel and any other stakeholders to contact Optum Idaho to ensure the needs of our providers and stakeholders are met in a timely and efficient manner.

Analysis: The total number of Customer Service provider calls during Q2 was 2,943. Customer Service call standards met performance goals for all three customer service line measures again during Q2. The percent of calls answered within 30 seconds was at 97%, remaining above the goal of ≥80%. The call abandonment rate was 0.52% continuing to meet both the Optum Idaho Standards goal of ≤3.5% and the IBHP Contractual Standards goal of ≤ 7%. Average Daily Hold time continued to meet the goal.







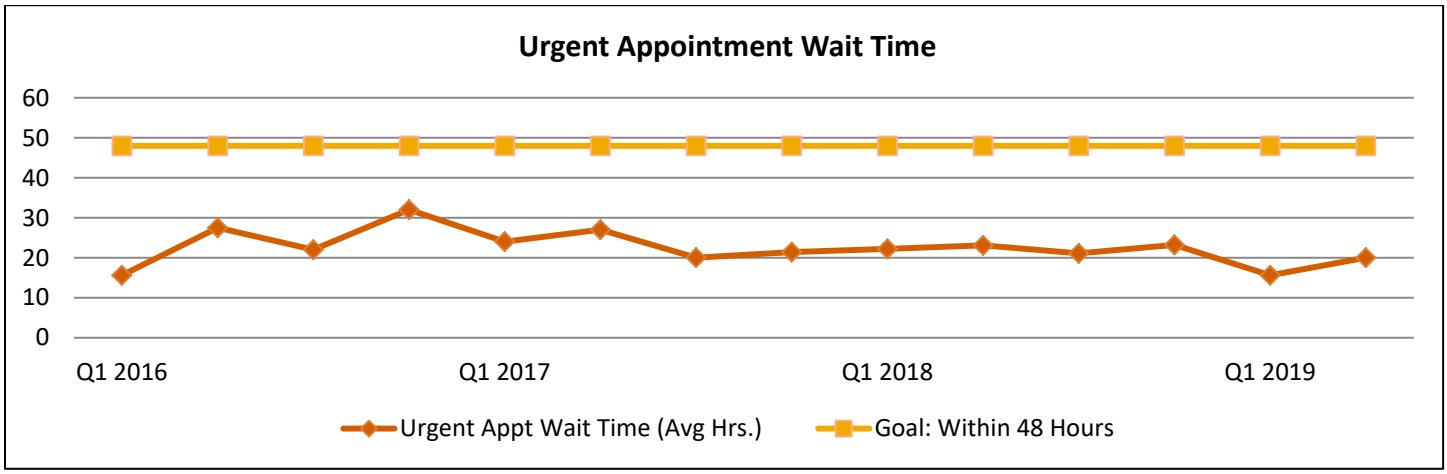


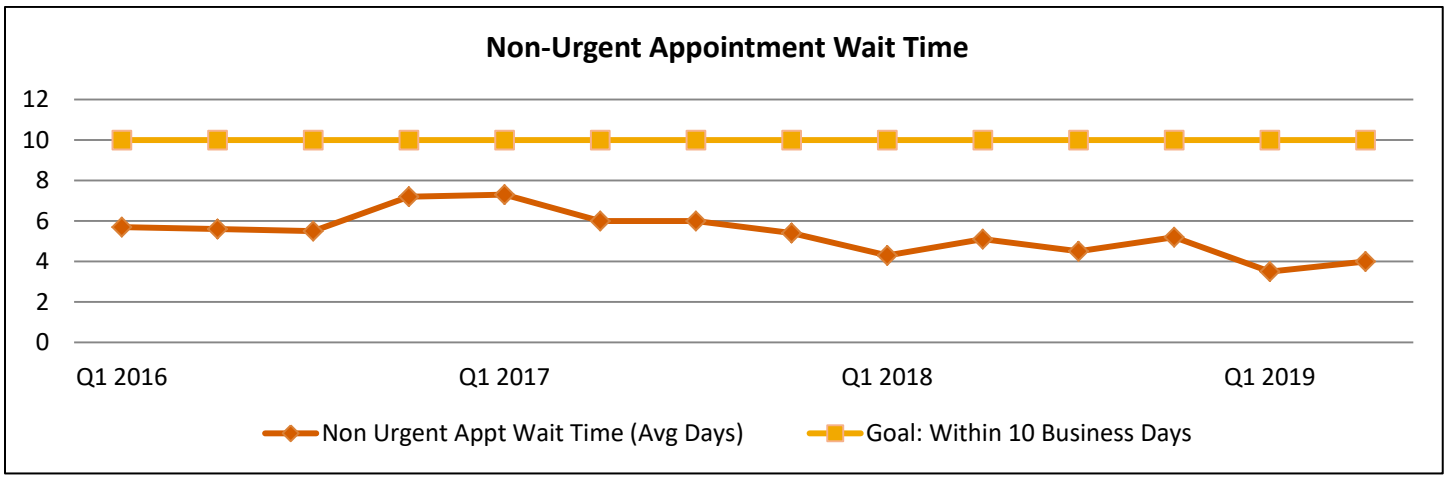
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

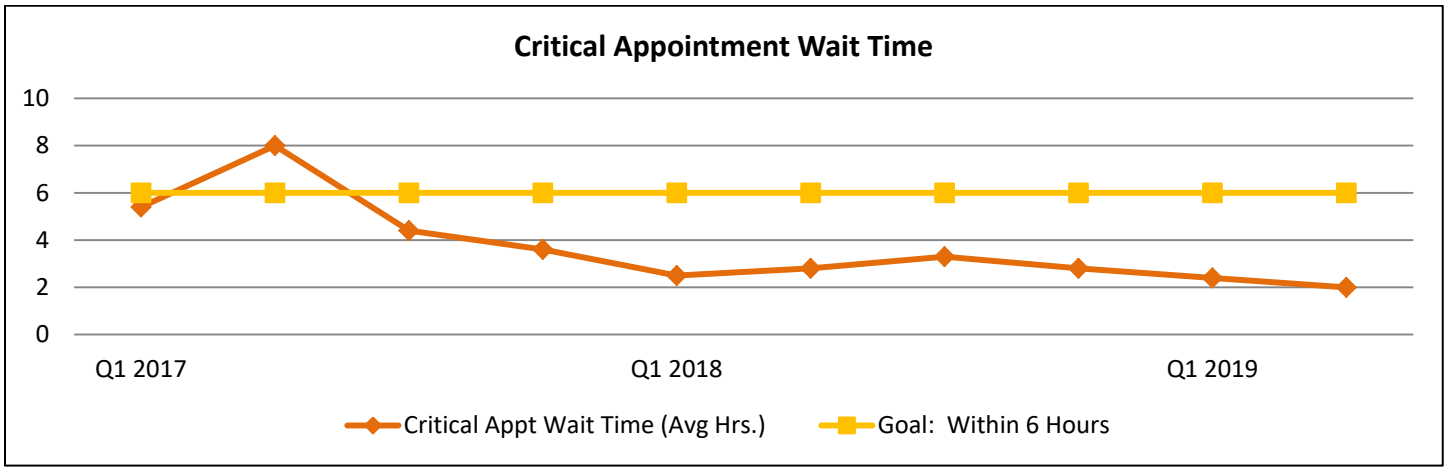
Urgent and Non-Urgent Access Standards

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, *Non-urgent Appointments* being offered within 10 business days of request, and *Critical Appointments* being offered within 6 hours. Access to care is monitored via monthly provider telephone polling by the Network team.

Analysis: During Q2, access standards were met in all areas: Urgent, Non-Urgent, and Critical appointment wait times.







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 is 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.

Geographic Availability of Providers		Performance Goal	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019
Area 1	(within 30 miles)	100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%
Area 2	(within 45 miles)	100.0%	99.8%	99.7%	99.8%	99.7%	99.8%	99.8%

Analysis: Optum Idaho continued to meet contract availability standards. During Q2, Area 1 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). Of note, not all members outside of the geographic area are utilizers of behavioral health services.

Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: The implementation of telehealth under the IBHP has allowed for more intervention opportunities for members living outside of the designated geographic areas. Optum is analyzing ways in which telehealth can better serve those members.

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 the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC).

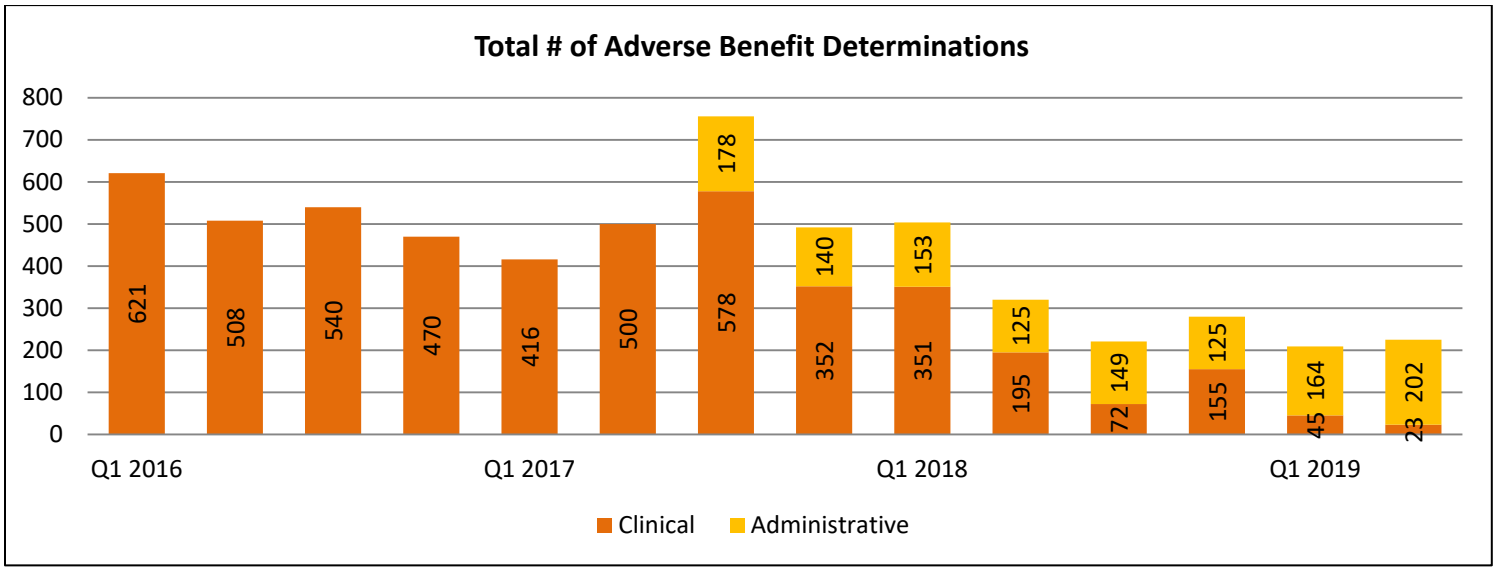
Case reviews are conducted in response to requests for coverage for treatment services. They may occur prior to a member receiving services (pre-service), or subsequent to a member receiving services (post-service or retrospective). Case reviews are conducted in a focused and time-limited manner to ensure 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 service plan, including advance directives.

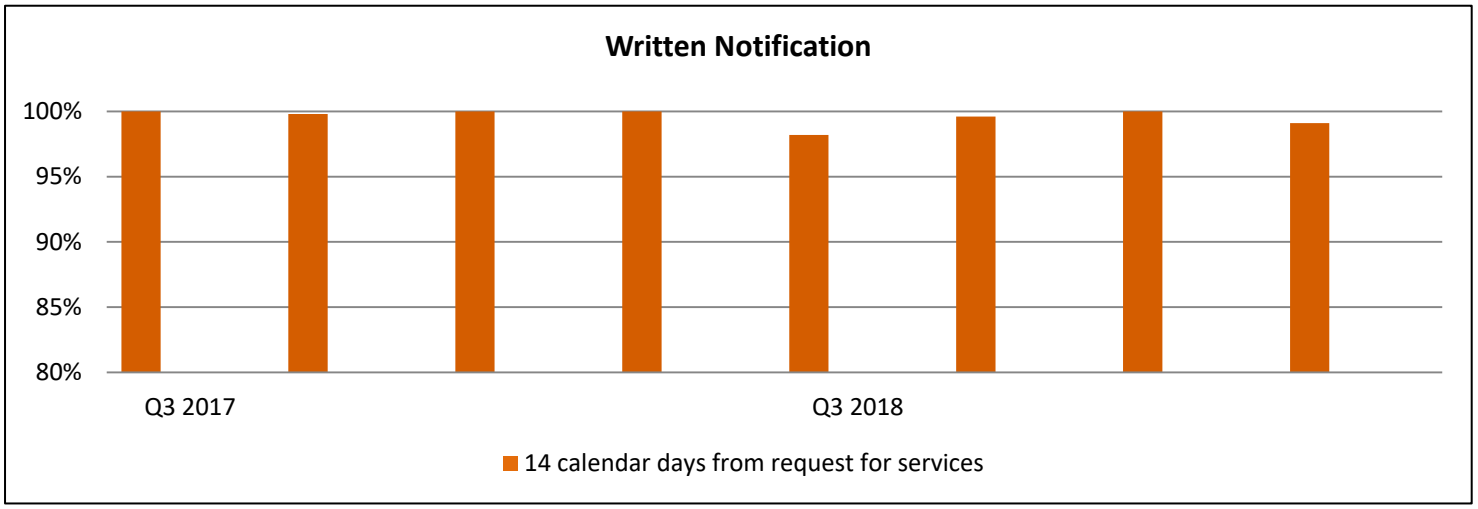
As part of Optum's ongoing assessment of the overall network, Optum Idaho evaluates, audits, and reviews the performance of existing contracted providers, programs, and facilities.

Notification of Adverse Benefit Determination

Methodology: An Adverse Benefit Determination (ABD) is defined as the denial or limited authorization of a requested service. When a request for services is received, Optum has 14 calendar days to review the case, make a determination to authorize or deny services in total or in part, and mail the ABD notification letter—if applicable. An ABD can be based on Clinical or Administrative guidelines.

Analysis: In Q2, Optum issued 225 ABDs – 23 Clinical and 202 Administrative. Two ABDs fell out of written notification compliance. Optum continues to see a decrease in clinical ABDs. This can be attributed to two factors: 1) Optum has reduced the number of services requiring pre-service authorizations and 2) Network Providers are more cognizant of what's required to get an authorization and less likely to submit a request that could potentially get denied.





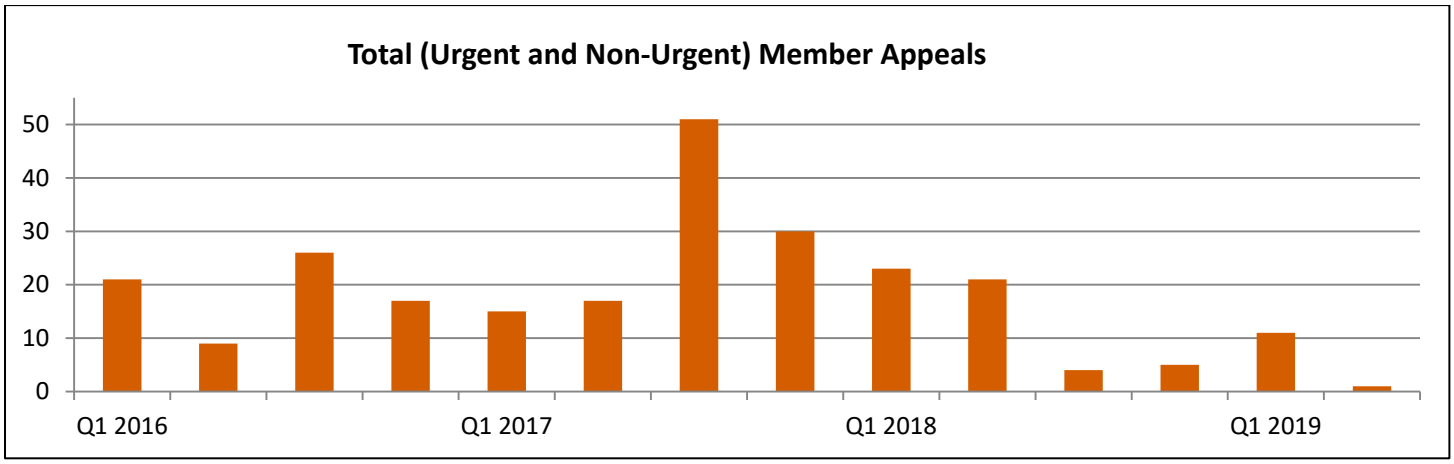
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

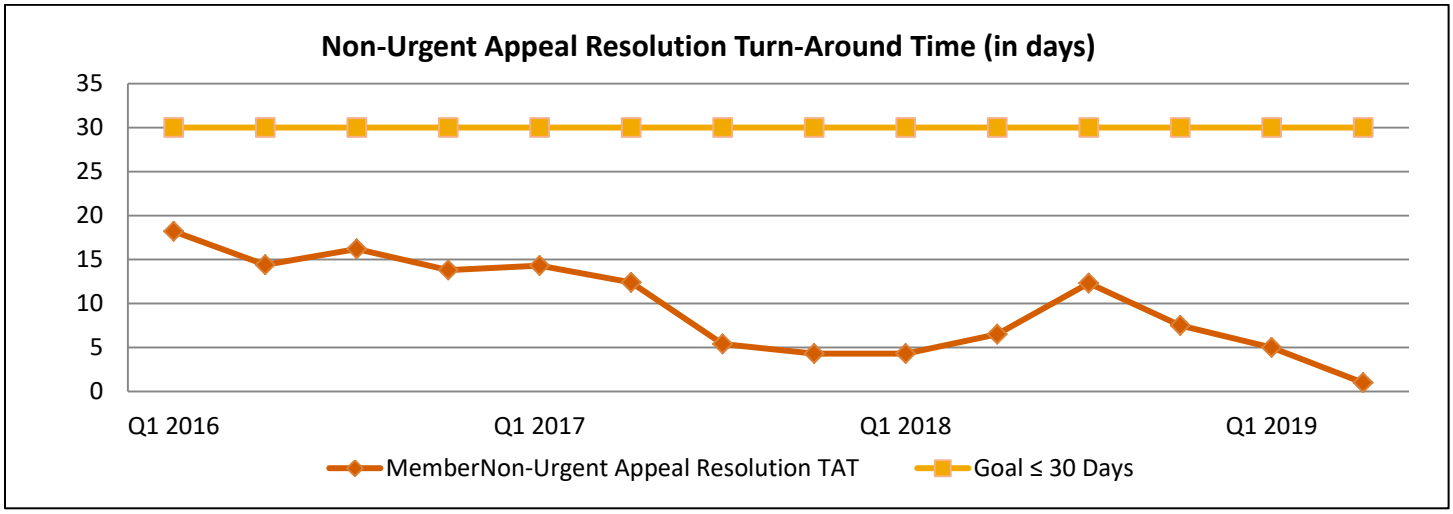
Member Appeals

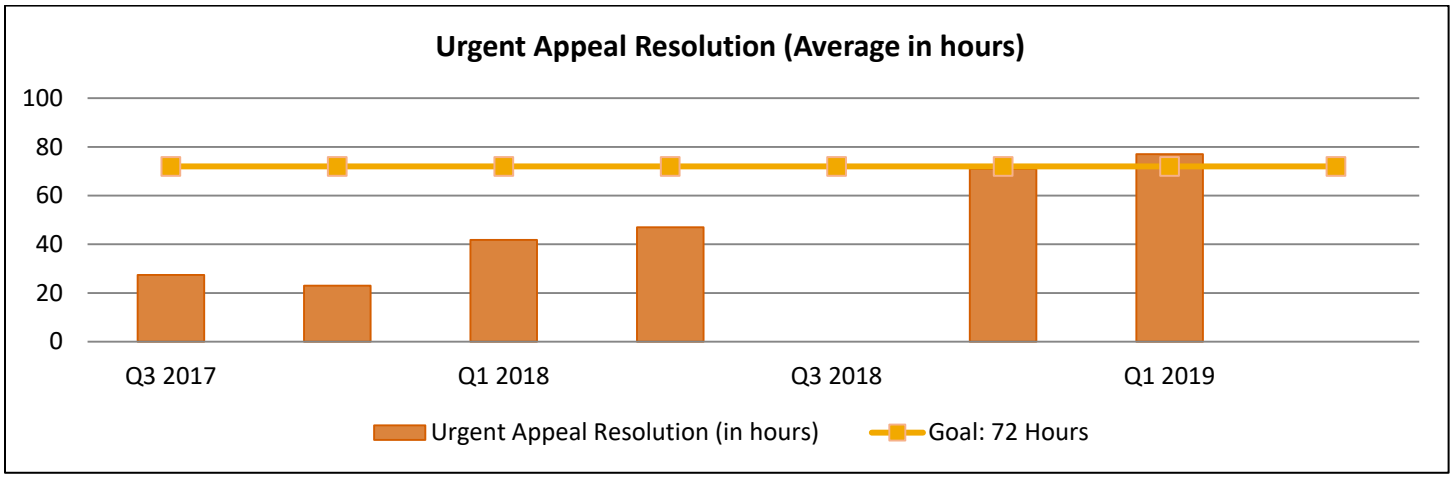
Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an adverse benefit determination that resulted in member financial liability or denied services. All non-urgent appeals are required to be reviewed and resolved within 30 calendar days. Urgent appeals are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

Analysis: In Q2, Optum Idaho received 1 non-urgent appeal and 0 urgent appeal requests. The non-urgent appeal met the performance goal.







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

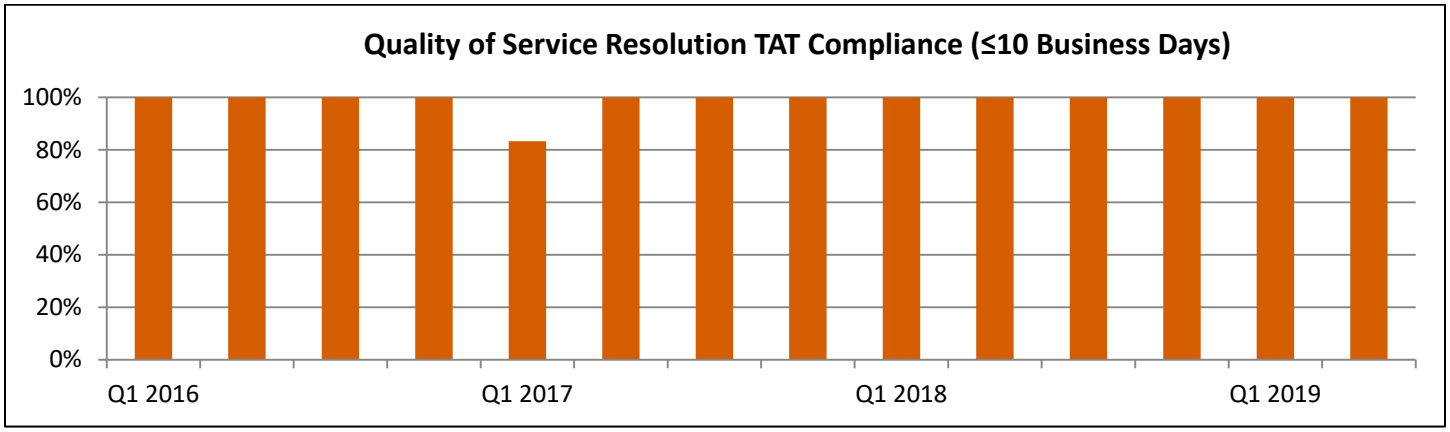
Complaint Resolution and Tracking

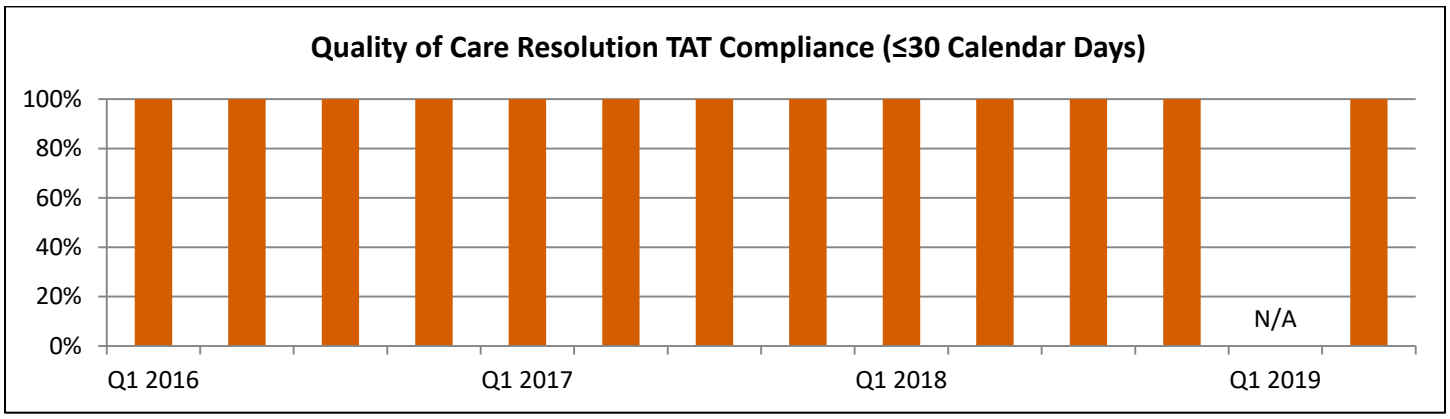
Methodology: A complaint is an expression of dissatisfaction logged by a member, a member's authorized representative or a provider concerning the administration of the plan and/or services received. This is also known as a Quality of Service (QOS) complaint. A complaint that relates to the quality of clinical treatment 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, Access, 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. Both QOS Complaints and QOC Concerns are to be acknowledged within 5 business days. QOS Complaints are to be resolved within 10 business days and QOC Concerns are to be resolved within 30 calendar days.

Analysis: During Q2, there were 18 total complaints processed. Fifteen (15) were QOS complaints and 3 were QOC Concerns. Optum Idaho was at 100% compliance for all acknowledgement and resolution turnaround times.





Complaints by Type

Quarter	Benefit	Service	Access	Billing & Financial	Clinical Quality of Care	Privacy Incident	Quality of Practitioner Office
Q1 2016	4	9	0	0	1	0	0
Q2 2016	4	9	1	0	3	0	1
Q3 2016	2	14	0	1	1	0	0
Q4 2016	1	9	0	0	1	0	0
Q1 2017	2	8	1	1	1	0	0
Q2 2017	2	16	1	1	3	0	0
Q3 2017	4	9	0	0	2	0	1
Q4 2017	3	5	0	1	1	0	1
Q1 2018	0	6	3	0	2	0	0
Q2 2018	1	10	1	5	1	0	0
Q3 2018	0	8	4	0	5	0	0
Q4 2018	0	11	3	2	5	0	0
Q1 2019	3	6	3	2	0	0	0
Q2 2019	0	8	4	3	3	0	0
Total	**26**	**128**	**21**	**16**	**29**	**0**	**3**

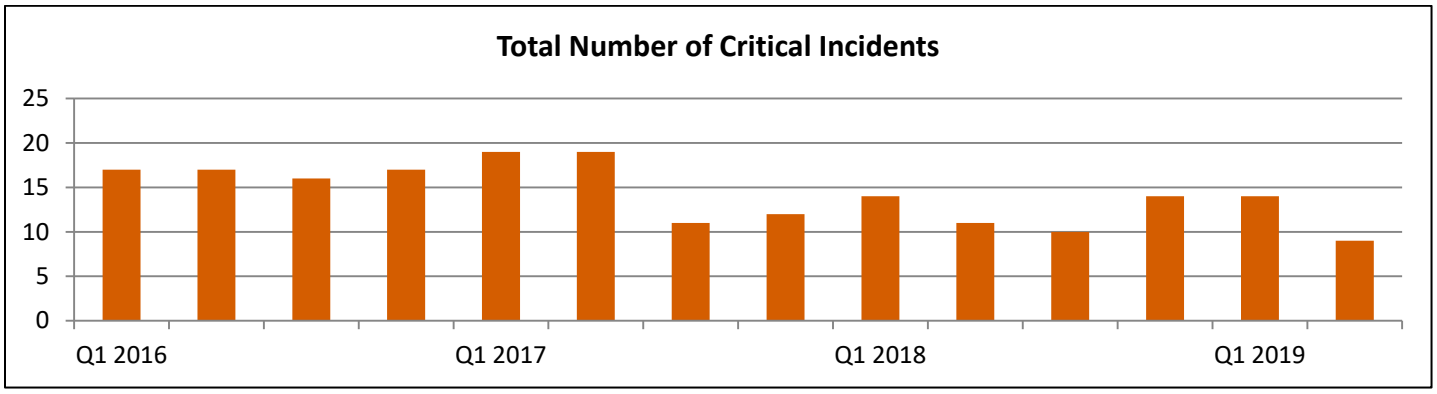
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

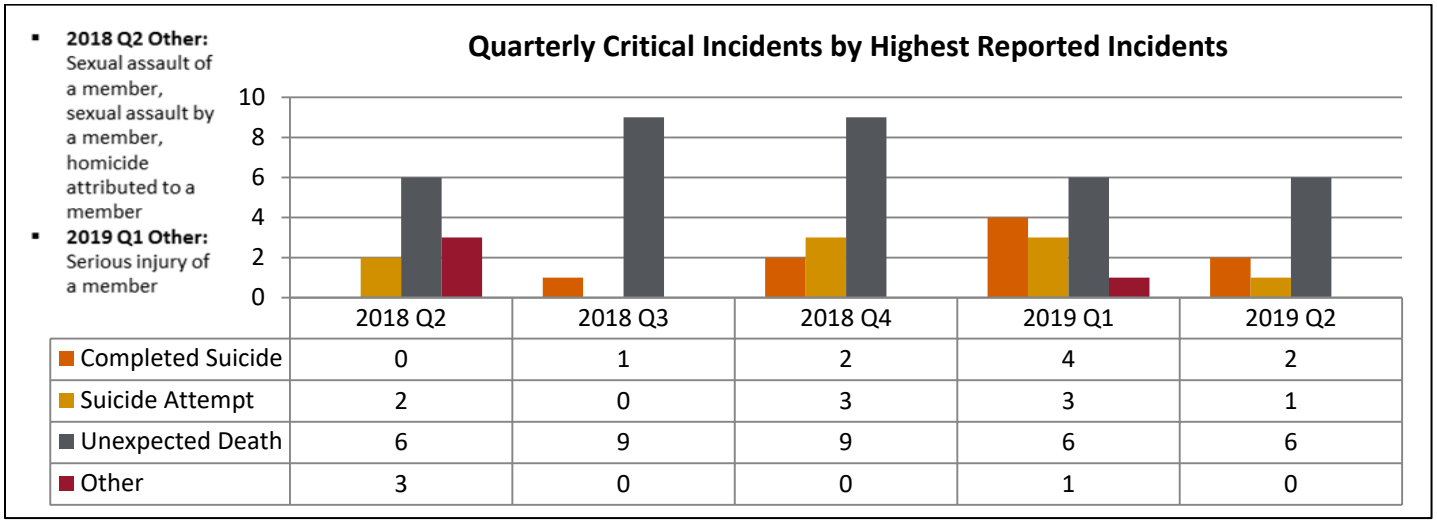
Critical Incidents

Methodology: To improve the overall quality of care provided to our members, Optum Idaho utilizes peer reviews for occurrences related to members that have been identified as Critical Incidents (CIs). Providers are required to report CIs to Optum Idaho within 24 hours of being made aware of the incident. A CI 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 has a Sentinel Events Committee (SEC) to review CIs identified as having a Quality of Care Concern and that meet Optum's definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review CIs identified as having a Quality of Care Concern and 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 CI. An internal CI Ad-Hoc Committee review is completed within 5 business days from notification of incident.

Analysis: There were 9 CIs reported during Q2. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. The highest number of CIs during Q2 fell in the category of unexpected deaths.





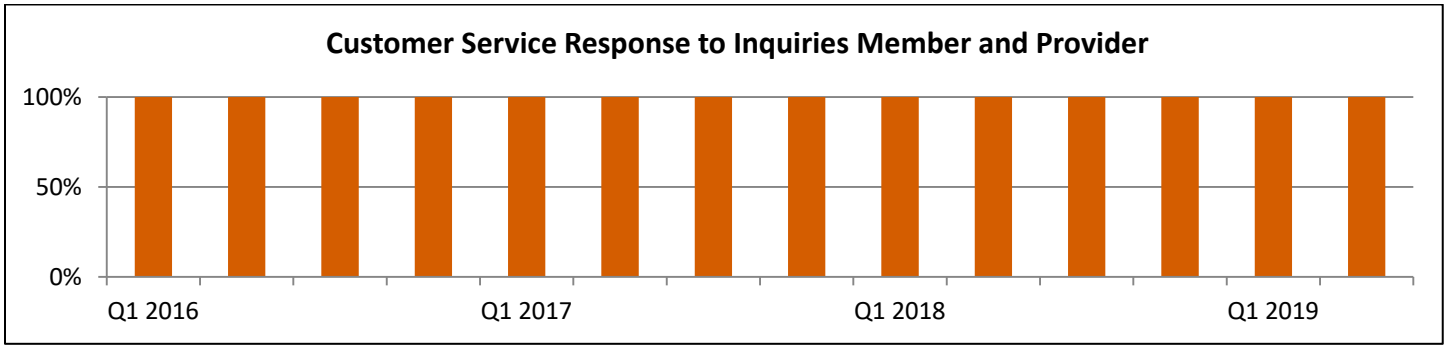
	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2
Completed Suicide	0	1	2	4	2
Suicide Attempt	2	0	3	3	1
Unexpected Death	6	9	9	6	6
Other	3	0	0	1	0

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

Response to Inquiries

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

Analysis: During Q2, the data indicated that the standard of 100% of inquiries 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.

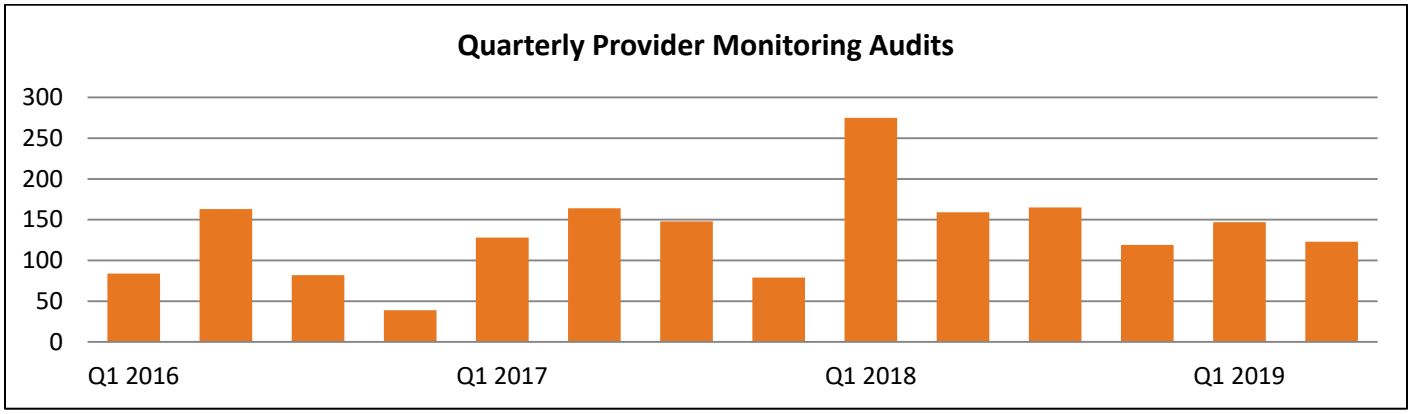
Provider Monitoring and Relations

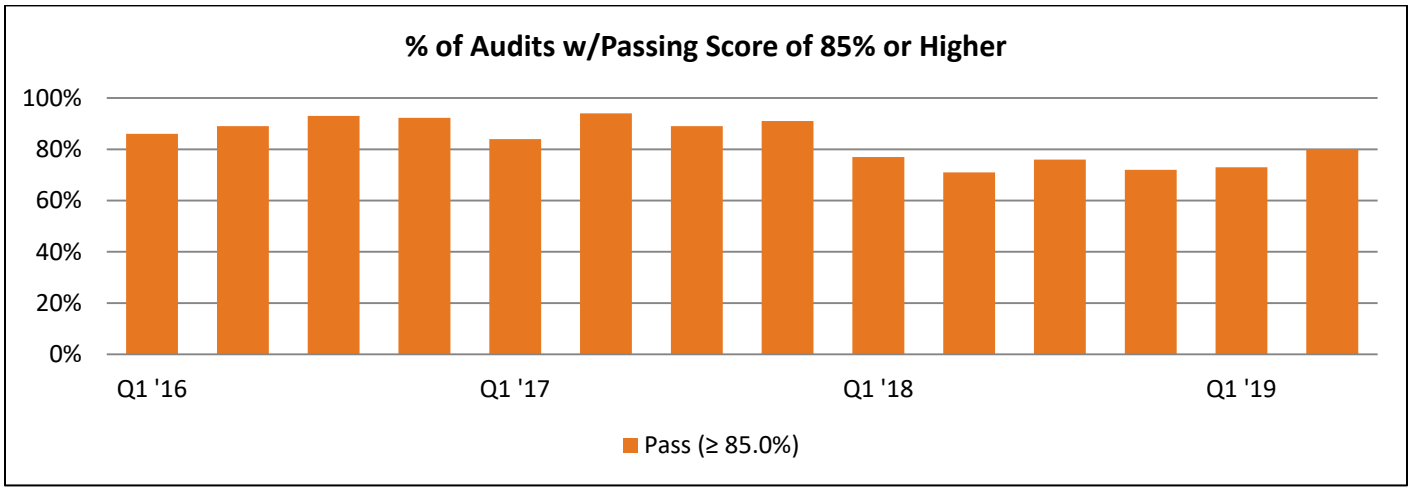
Provider Quality Monitoring

Optum Idaho monitors provider adherence to quality standards via site visits. The Optum Idaho Provider Quality Specialists complete treatment record reviews and site audits to facilitate communication and coordination and continuity of care, 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.

Methodology: Following an audit, the provider will receive initial verbal feedback 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.

Analysis: During Q2, there were 123 Provider Audits completed. Of the 123 audits completed, 80% received a passing score.





Coordination of Care

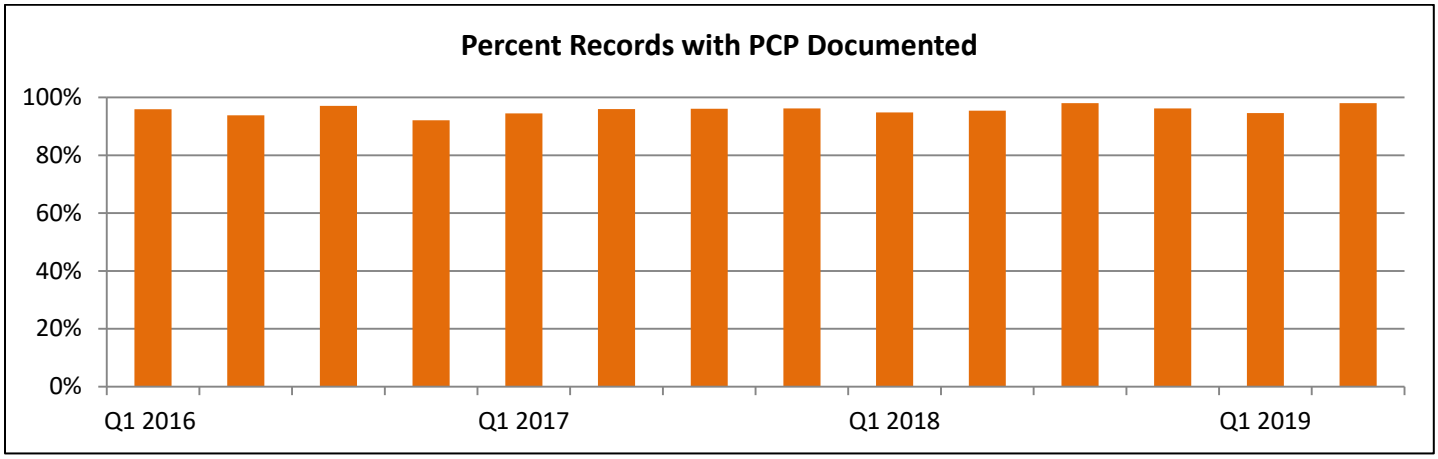
Methodology: To coordinate and manage care between behavioral health and medical professionals, Optum requires providers to obtain the member's consent to exchange appropriate treatment information with medical care professionals (e.g. primary care physicians, medical specialists). Optum requires that coordination and communication take place at the time of intake, during treatment, at 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:

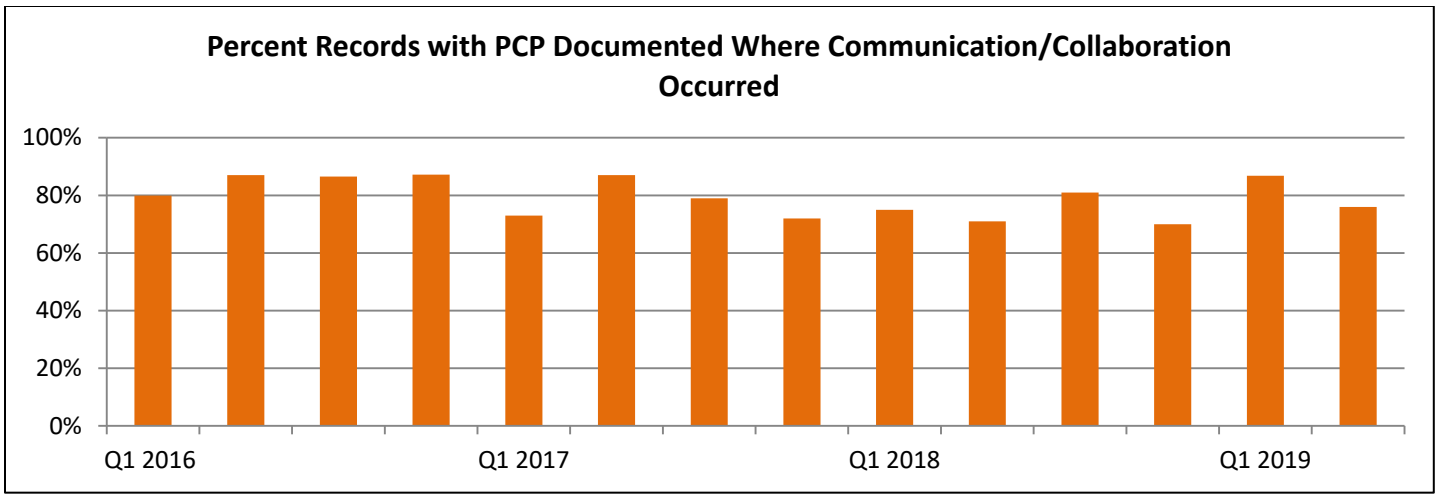
- It allows behavioral health and medical providers to create a comprehensive care plan
- It allows a primary care physician (PCP) to know that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for members who are being treated 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

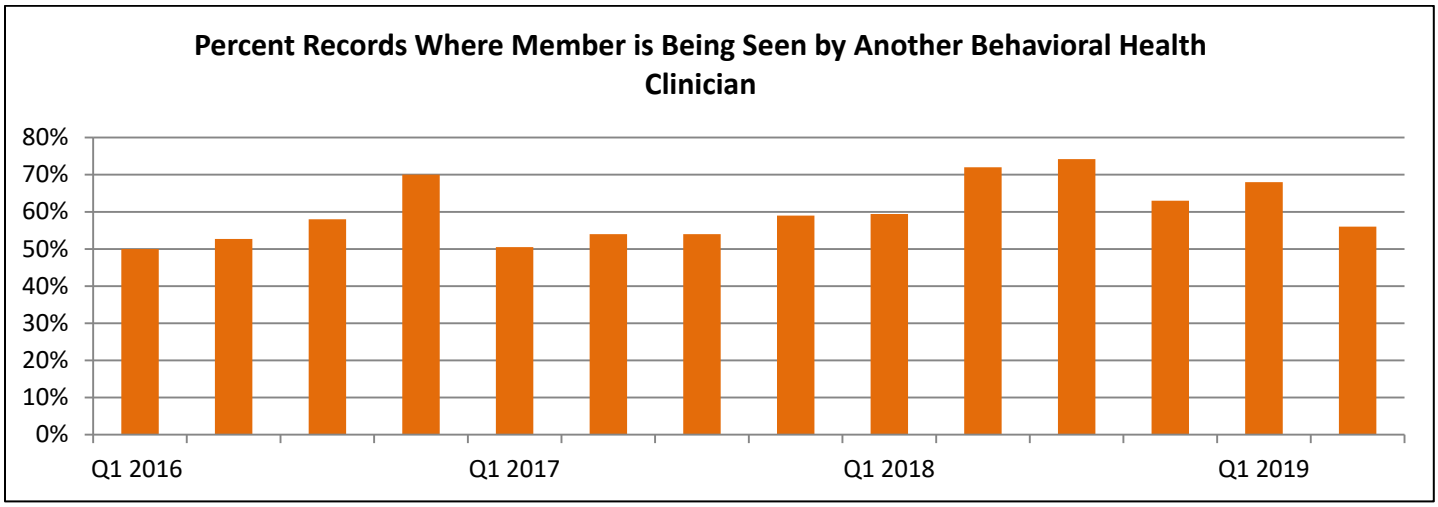
Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expect providers to make a "good faith" effort at communicating with other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

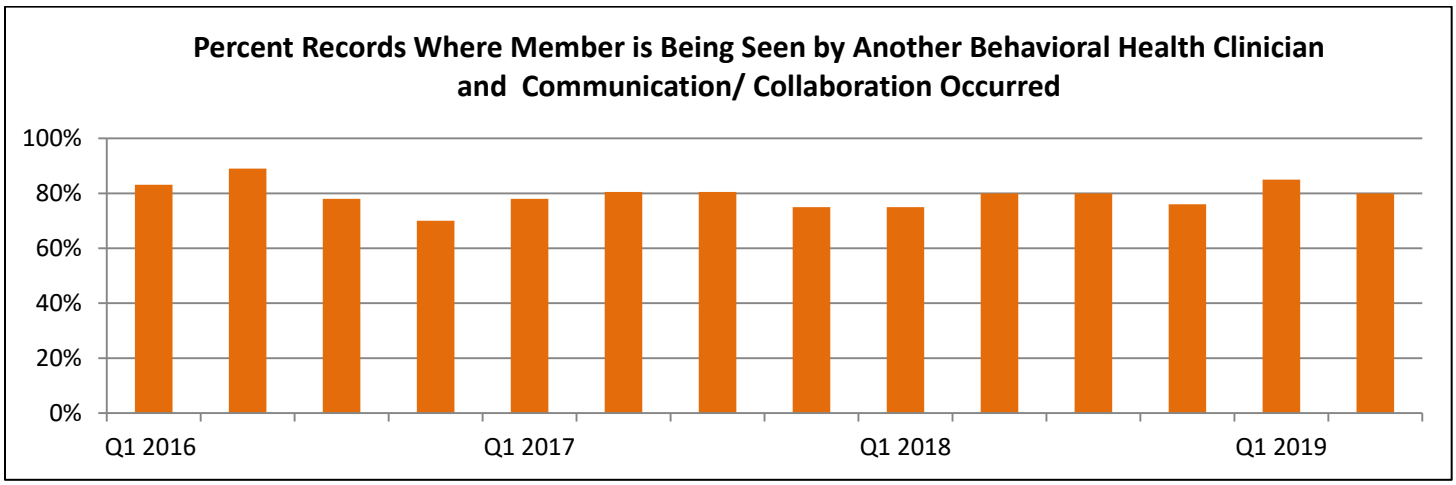
The Treatment Record Review Audit Tool includes questions related to Coordination of Care. These questions are completed during an audit by Optum Idaho Provider Quality Specialist (audit) staff.

Analysis: Coordination of Care audits completed during Q2 revealed that 98% of member records reviewed had documentation of the name of the member's PCP. Of those, 76% indicated that communication/collaboration had occurred between the behavioral health provider and the member's PCP. Audit results also showed that 56% 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% indicated that communication/collaboration had occurred.







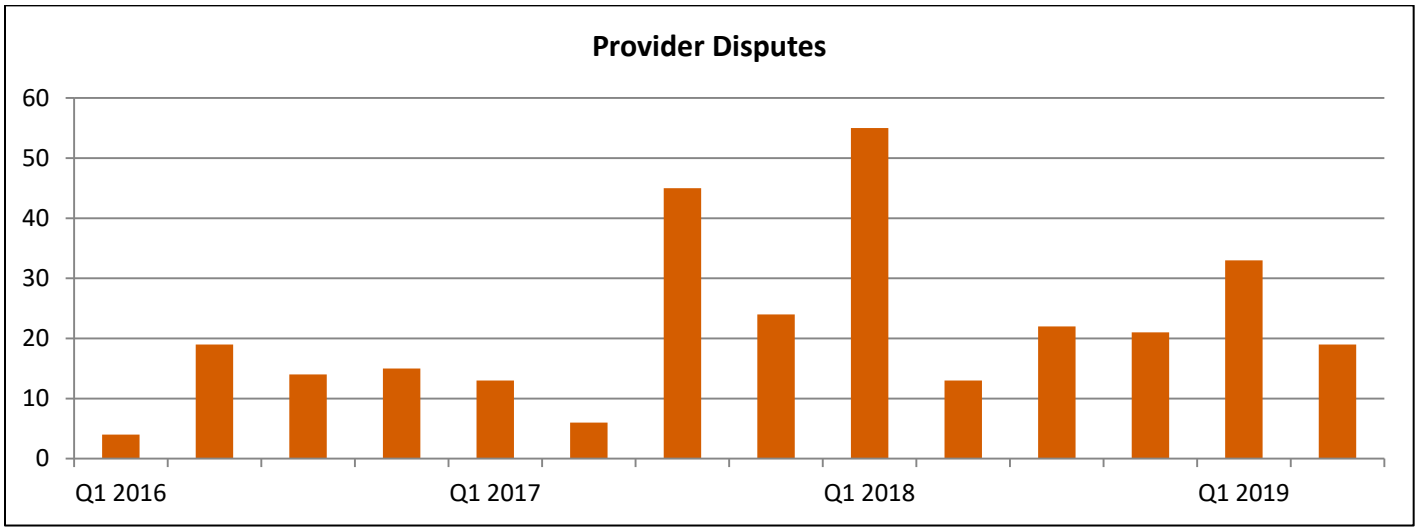


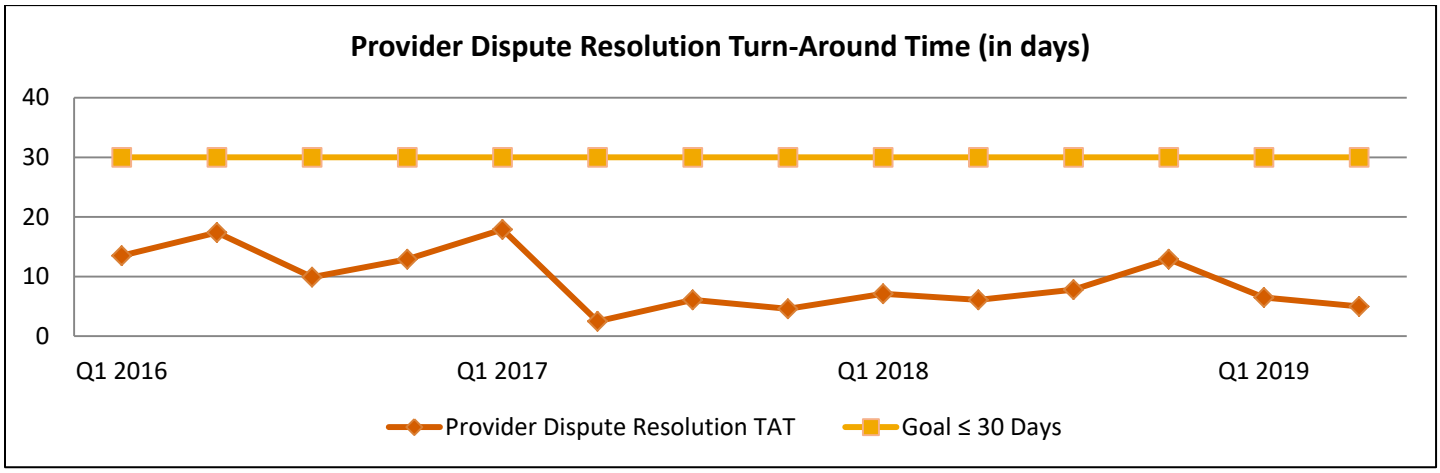
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

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 calendar days following the request for consideration.

Analysis: During Q2, there were 19 Provider Disputes. Of the 19 disputes, 11 were fully overturned. All disputes were resolved within the turnaround time. The average turnaround time was 5 calendar days.





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

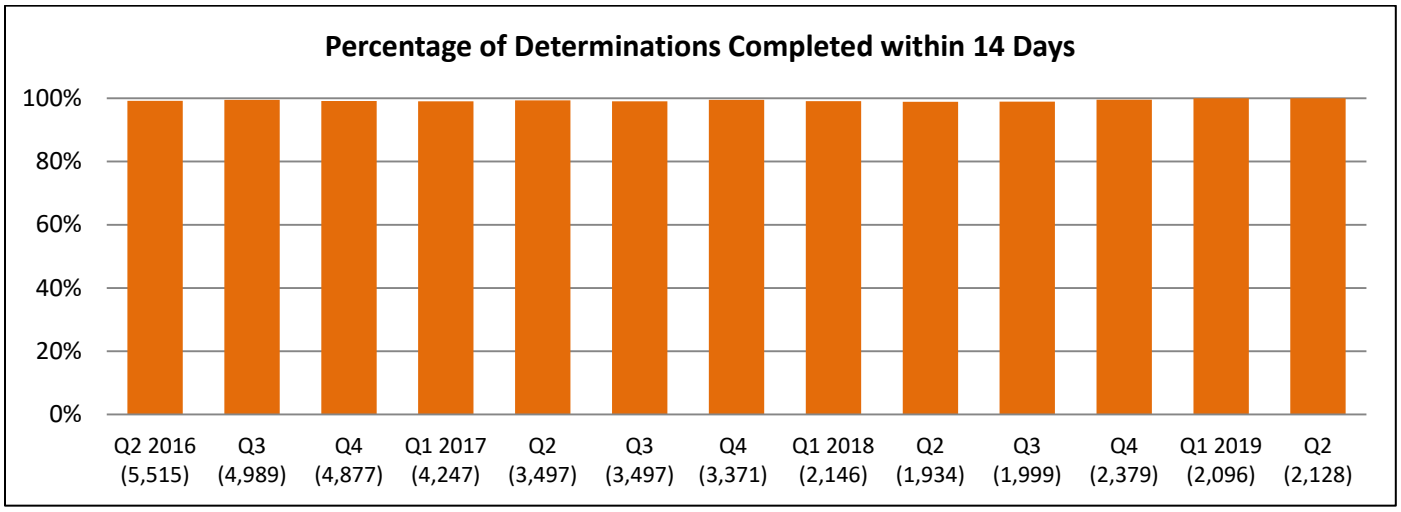
Utilization Management and Care Coordination

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 (INN) and out-of-network (OON)

providers and agencies. Optum Idaho adheres to a 14 calendar day turnaround time for processing requests for non-urgent, pre-service requests.

Analysis: During Q2, Optum Idaho met the 14-day turnaround time at 100%.



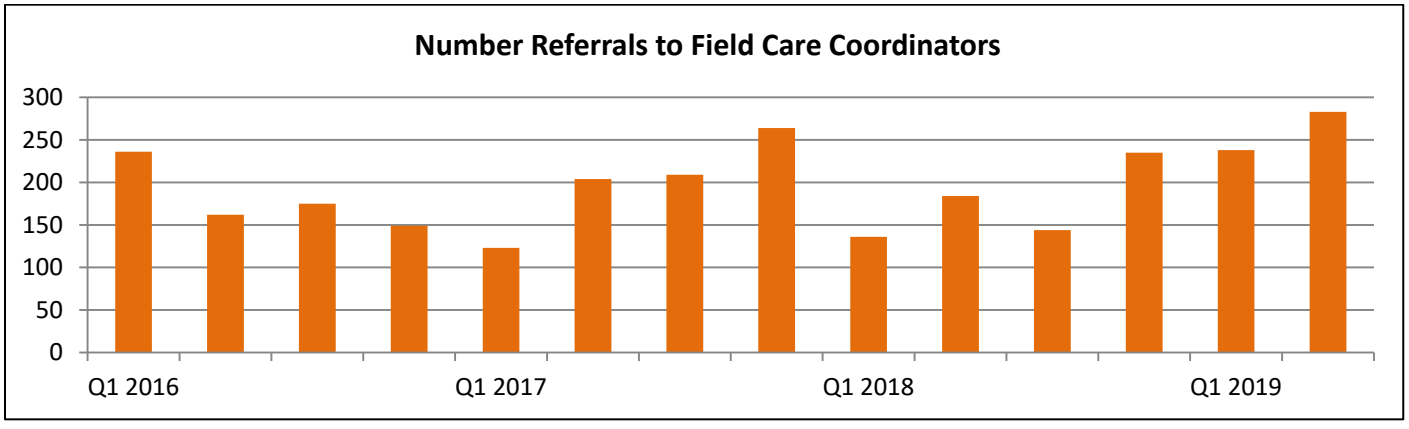
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

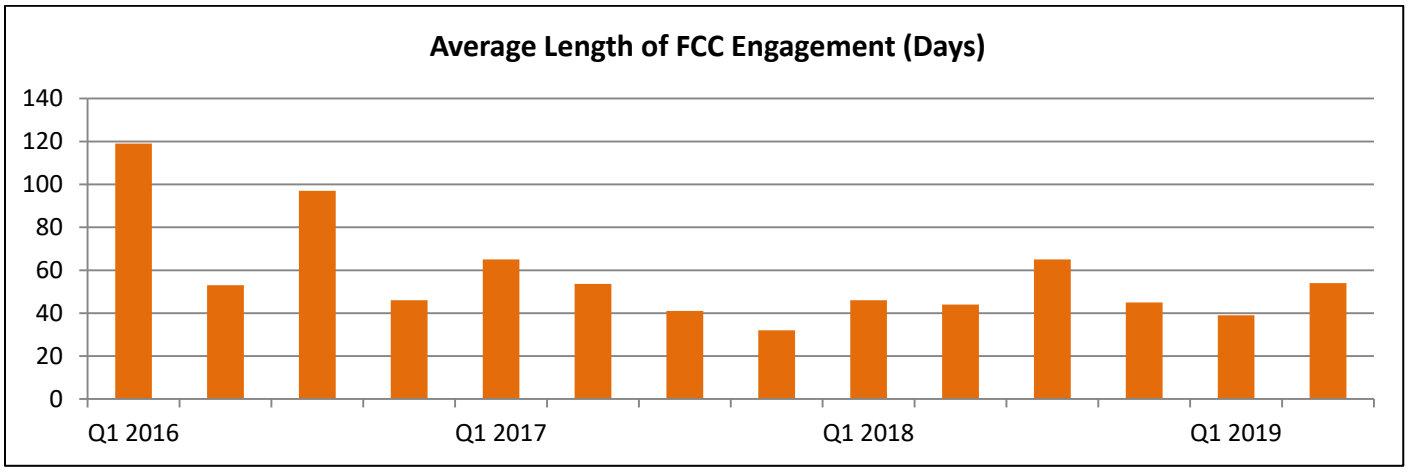
Field Care Coordination

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

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

Analysis: During Q2, Field Care Coordinators received 283 referrals. The average length of FCC engagement during Q2 was 54 days.



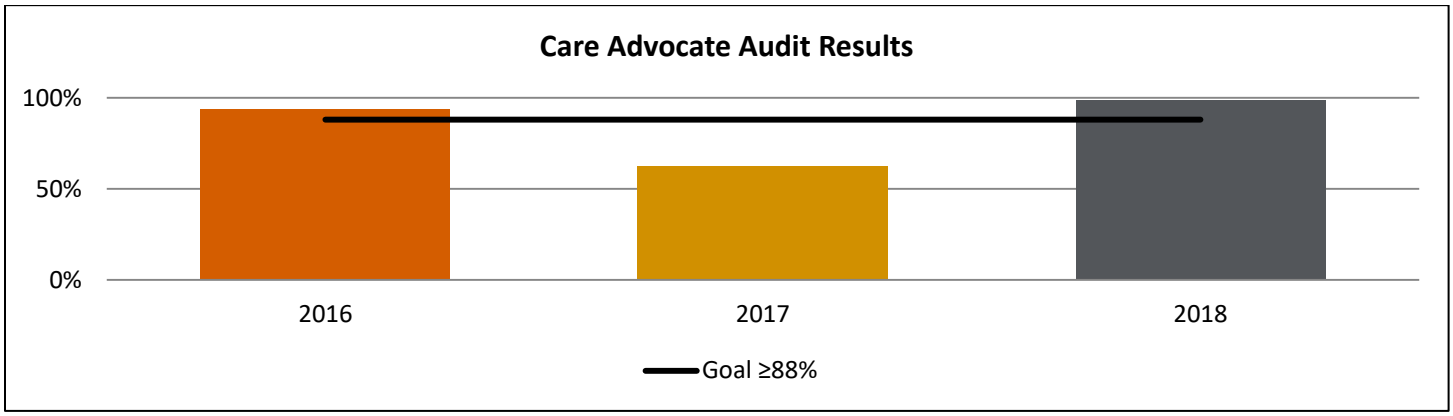


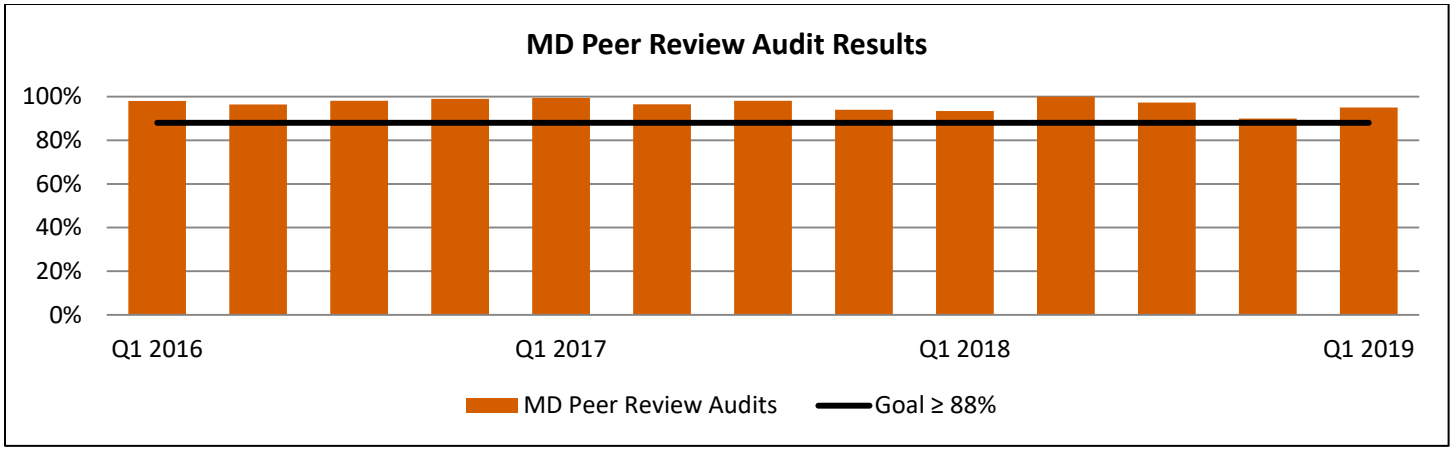
Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

Inter-Rater Reliability

Optum Idaho evaluates and promotes the consistent application of the Level of Care Guidelines (LOCG) 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 assessment of inter-rater reliability (IRR). Results are summarized and reviewed for trends. Optum Idaho also promotes a process for review and evaluation of the clinical documentation of adverse benefit determinations issued by Optum Peer Reviewers to ensure completeness, quality, and consistency in the use of medical necessity criteria, coverage determination guidelines and adherence to standard Care Advocacy policies.

Methodology: For the Care Advocate Audits, the Annual Assessment includes a question to determine IRR which states: Does Clinical Determination reflect correct application of LOCG or state specific criteria was met? For the Quarterly MD Peer Reviewer Audits, a random sample of adverse benefit determination cases are identified and assigned to a Regional Medical Director. The audits are conducted to review and evaluate the clinical documentation by Optum Physicians in their role as Peer Reviewers. The established goal is ≥88%.





Analysis: The Annual 2018 Care Advocate Audits Inter-Rater Reliability results were 99%.
The quarterly (reported one quarter in arrears) MD Peer Review Audit results for Q1, 2019 were 95%.

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

Population Analysis

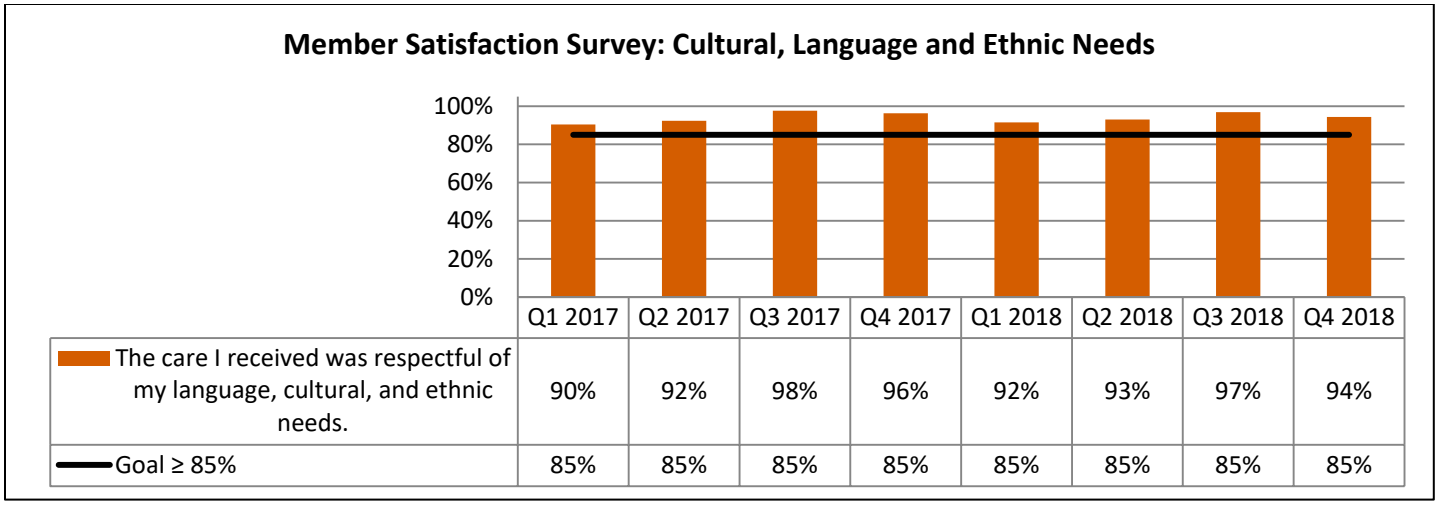
Language and Culture

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 accounted for 12.2% of the Idaho population, an increase from 11.2% from the 2015 Census results. This is the second highest population total, with White comprising 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 showed that 94% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q4 2018 data is the most current data available.



	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018
The care I received was respectful of my language, cultural, and ethnic needs.	90%	92%	98%	96%	92%	93%	97%	94%
Goal ≥ 85%	85%	85%	85%	85%	85%	85%	85%	85%

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 a year.

Language Assistance Requests by Type	# of Requests
Member Written Communication	1
Member Written Communication Formatted to Large Print	0
Language Service Associates	0
Languages Represented	0
Do Not Mail List	0

Analysis: During Q2, Optum Idaho responded to 1 request for language assistance for written communication.

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

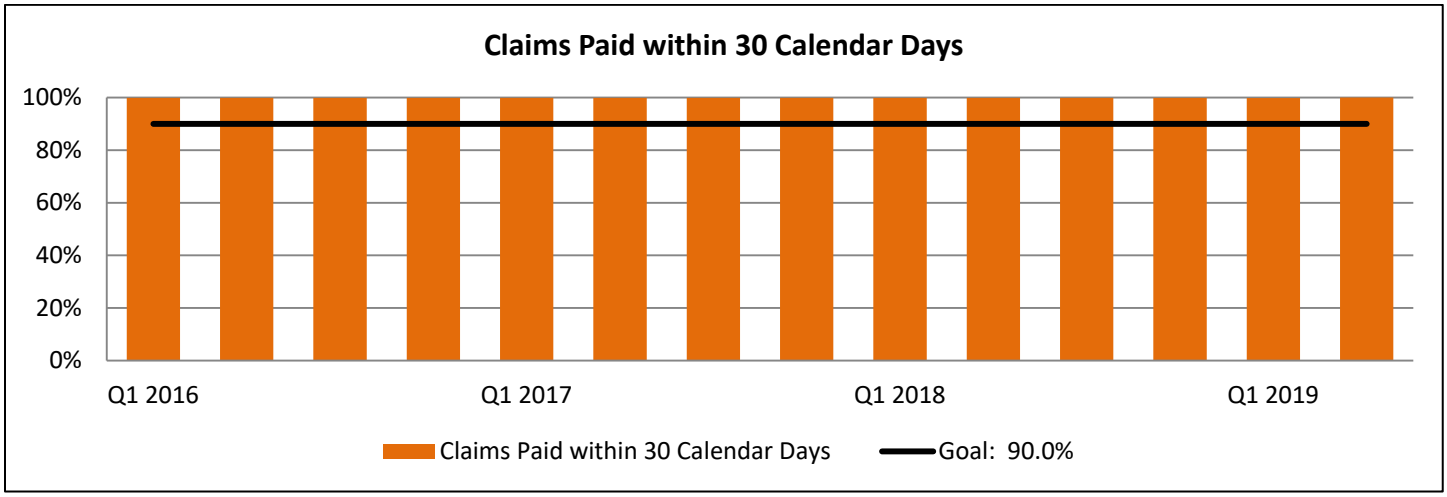
Claims

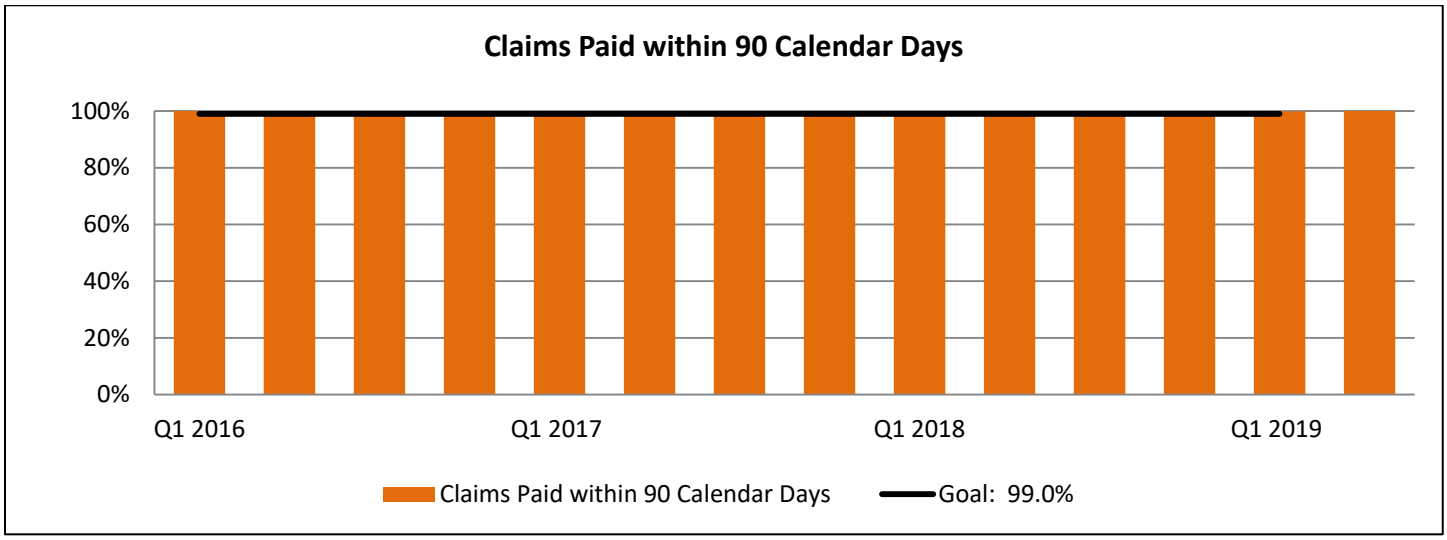
Methodology: The data source for claims is Cosmos via Webtrax. Data extraction is the number of "clean" claims paid within 30 and 90 calendar days. A clean claim excludes adjustments (any transaction that modifies (increases/decreases) the original claims payment), claims in which the original payment must have dollars applied to the deductible/copay/payment to provider or member, and/or resubmissions (a 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.

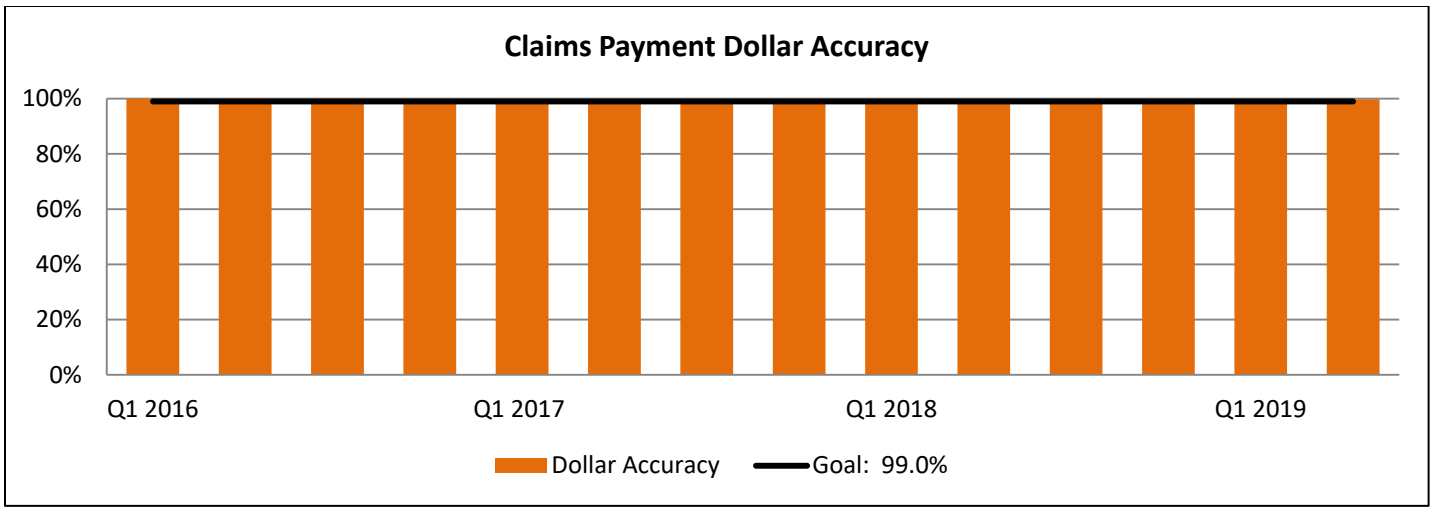
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid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

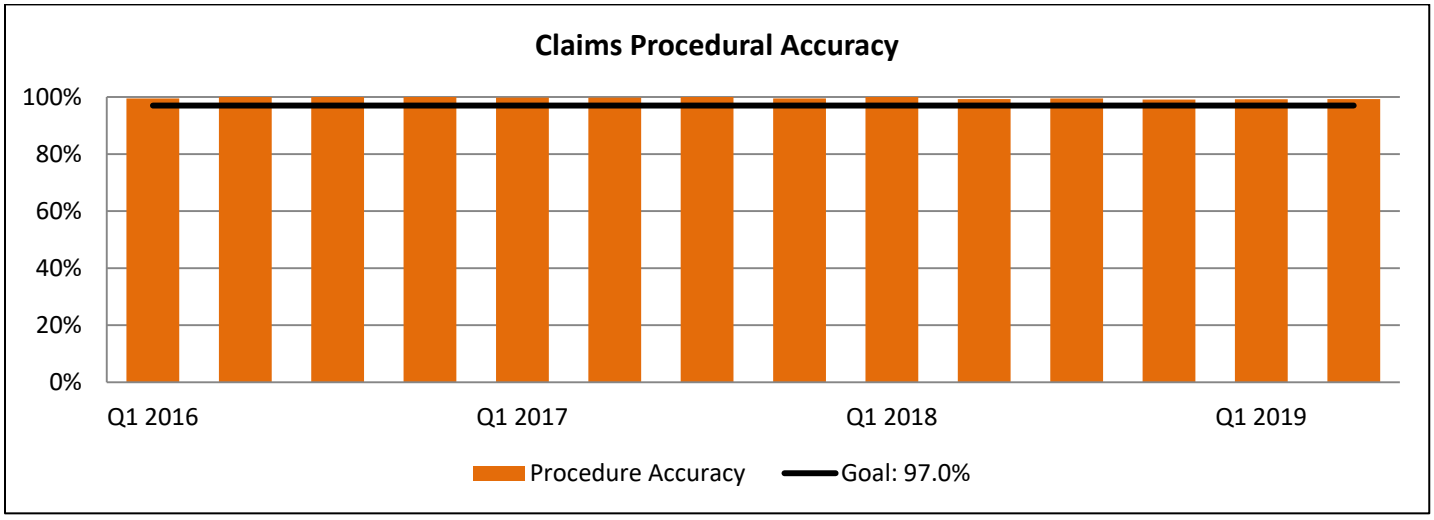
Procedural Accuracy Rate (PAR) is measured by collection of a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial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

Analysis: The data shows that all performance goals have been consistently met.









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