

IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT



OPTUM™

The Idaho Behavioral Health Plan (IBHP) Quality Management and Improvement (QMI) report summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) for Calendar Year 2016. It provides an overview of outcomes data, through Quarter 4, 2016, for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

*October -
December 2016*

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Executive Summary

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

The purpose of this document is to share with internal and external stakeholders Optum Idaho's performance, outcomes and improvement activities related to services we provide to IBHP members and contracted providers. Information outlined in this report highlights quarterly performance from Quarter 4, 2016, (October 1 – December 31, 2016), unless otherwise noted, and provides comparative performance from each quarter.

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

As noted in the outcomes analysis portion of this report, we are beginning to see a stabilization of the utilization of individual and family therapy services. While stabilization of these services is positive, we will continue to monitor these services through first quarter 2017 to determine if additional work can be focused on increasing usage of these evidence-based services. Additionally, we are realizing an increase in the usage of recovery-based Peer Support Services and will focus efforts in 2017 specific to education and information surrounding engagement and effective usage of this important service.

In addition, we continue to partner with the Idaho Department of Health and Welfare on the system design of the Idaho Behavioral Health Plan and opportunities that can better serve stakeholders and the members we serve. We are excited to announce that in October 2016 we awarded the first Community Health Initiatives Grant (CHI) to St. Luke's Health System and the REACH Institute. The goal of the \$420,000 grant is to improve behavioral health outcomes for child and adolescent Medicaid participants with serious emotional disturbance (SED).

In 2017, we will begin reimbursing providers a mileage reimbursement fee for psychotherapy services provided by licensed clinicians in a member's home. It is our goal by providing this additional option for providers and members that it will further assist members in receiving the right services at the right time for their individual needs. Additionally, we are working on developing new services that will further the continuum of care that members need and are currently scheduled to implement a new Intensive Outpatient Program in Summer 2017.

At Optum, we take pride in our commitment to engage in a meaningful way within the communities where we live and work. Together with community partners, we strive to make our communities better; one person, one family, one community at a time. Every individual and every family has a unique road to wellness, health, and hope; just as every community has its own ways to support and assist the people who live there.

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 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 32 (97.0%) of the total key measures. This high level of operational effectiveness further validates Optum Idaho's 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. Those highlighted in green met or exceeded overall performance. Those highlighted in yellow fell within 5% of the performance goal. Those highlighted in red fell below the performance goal.

Measure	Goal	January - March 2016	April - June 2016	July - September 2016	October - December 2016
Member Satisfaction Survey Results					
Experience with Optum Idaho Staff and Referral Process	≥85.0%	94.0%	86.3%	Based on the Member Satisfaction Survey sampling methodology, Q1, 2016, is the most recent data	
Experience with the Behavioral Health Provider Network	≥85.0%	94.0%	92.5%		
Experience with Counseling or Treatment	≥85.0%	93.6%	95.5%		
Overall Experience	≥85.0%	91.5%	97.0%		
Provider Satisfaction Survey Results					
Overall Provider Satisfaction	≥85.0%	75.0%	74.0%	Moved to Annual Survey. (Results will be presented in Q1, 2017, Report)	
Accessibility & Availability					
Idaho Behavioral Healthplan Membership					
Membership Numbers	NA	289,814	293,793	299,233	Due to claims lag, data is reported one quarter in arrears
Member Services Call Standards					
Total Number of Calls	NA	1,373	1,193	1,175	1,412
Percent Answered within 30 seconds	≥80.0%	94.3%	93.0%	82.0%	82.0%
Average Speed of Answer (seconds)	≤30 Seconds	11.2	12.0	18.0	18.5
Abandonment Rate	≤3.5%	1.1%	0.8%	3.4%	3.5%
Customer Service (Provider Calls) Standards					
Total Number of Calls	NA	3,284	3,032	2,818	3,086
Percent Answered within 30 seconds	≥80.0%	98.9%	91.1%	98.9%	98.6%
Average Speed of Answer (seconds)	≤30 Seconds	1.7	0.8	1.7	1.1
Abandonment Rate	≤3.5%	0.40%	0.20%	0.16%	0.41%
Urgent and Non-Urgent Access Standards					
Urgent Appointment Wait Time (hours)	48 hours	15.6	27.5	22.0	32.0
Non-Urgent Appointment Wait Time (days)	10 days	5.7	5.6	5.5	7.2

Measure	Goal	January - March 2016	April - June 2016	July - September 2016	October - December 2016
Geographic Availability of Providers					
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100.0%	99.9%*	99.9%*	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%*	99.9%*
Member Protections and Safety					
Notification of Adverse Benefit Determinations					
Number of Adverse Benefit Determinations	NA	621	508	540	470
Initial Verbal Notification on Same Day	100.0%	98.7%	99.6%*	99.6%*	98.9%
Written Notification Sent within 1 Business Day	100.0%	98.1%	99.0%	96.3%	92.9%
Grievances (appeal of adverse determination)					
Number of Grievances	NA	21	9	26	17
Member Grievance Turnaround time	≤30 days	18.2	14.4	16.2	13.8
Complaint Resolution and Tracking					
Total Number of Complaints	NA	14	18	18	11
Percent of Complaints Acknowledged within Turnaround time	5 days	100.0%	100.0%	100.0%	100.0%
Number of Quality of Service Complaints	NA	13	15	17	10
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints	NA	1	3	1	1
Percent Quality of Care Resolved within Turnaround time	≤30 days	100.0%	100.0%	100.0%	100.0%
Critical Incidents					
Number of Critical Incidents Received	NA	17	17	16	17
Percent Ad Hoc Reviews Completed within 5 business days from notification of incident	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%

Measure	Goal	January - March 2016	April - June 2016	July - September 2016	October - December 2016
Provider Monitoring and Relations					
Provider Quality Monitoring					
Number of Audits	NA	84	163	82	39
Initial Audit (Percent overall score)	≥ 85.0%	91.9%	96.3%	98.3%	95.9%
Recredentialing Audit (Percent overall score)	≥ 85.0%	96.1%	93.4%	92.2%	93.4%
Monitoring (Percent overall score)	≥ 85.0%	89.3%	58.3%**	NA***	85.0%
Quality (Percent overall score)	≥ 85.0%	92.4%	97.4%	96.5%	NA***
Percent of Audits that Required a Corrective Action Plan	NA	14.3%	8.6%	7.3%	7.6%
Coordination of Care Between Behavioral Health Provider and Primary Care Provider (PCP)					
Percent PCP is documented in member record	NA	95.9%	93.8%	97.1%	92.1%
Percent documentation in member record that communication/ collaboration occurred between behavioral health provider and primary care provider	NA	78.5%	87.0%	86.5%	87.2%
Provider Disputes					
Number of Provider Disputes	NA	4	19	14	15
Average Number of Days to Resolve Provider Disputes	≤30 days	13.5	17.4	9.9	12.9
Utilization Management and Care Coordination					
Service Authorization Requests					
Percentage Determination Completed within 14 days	100%	98.9%	99.2%	99.5%*	99.1%
Field Care Coordination					
Total Referrals to FCCs	NA	236	162	175	149
Average Number of Days Case Open to FCC	NA	119.1	53	97	46
Discharge Coordination: Post Discharge Follow-Up					
Number of Inpatient Discharges	NA	943	888	850	No data due to reporting lag
Percent of Members with Follow-Up Appointment within 7 Days	NA	52.5%	50.3%	50.1%	
Percent of Members with Follow-Up Appointment within 30 Days	NA	72.3%	69.1%	68.1%	
Readmissions					
Number of Members Discharged	NA	943	888	850	835
Percent of Members Readmitted within 30 days	NA	9.1%	9.8%	10.4%	9.7%
Inter-Rater Reliability					
Inter-Rater Reliability testing has been deferred until Q1 2016 due to role out of Clinical Model 2.1 in August, 2015.	NA	Results included in Q1 Report			
Peer-Review Audits					
PhD Peer Review Audit Results	≥ 88.0%	97.0%	100.0%	100.0%	****NA
MD Peer Review Audit Results	≥ 88.0%	98.0%	96.4%	98.1%	99.0%

Measure	Goal	January - March 2016	April - June 2016	July - September 2016	October - December 2016
Claims		Results included in Q1 Report			No data due
Claims Paid within 30 Calendar Days	90.0%	99.9%	99.9%	99.9%	to reporting lag 99.9%
Claims Paid within 90 Calendar Days	99.0%	100.0%	100.0%	100.0%	100.0%
Dollar Accuracy	99.0%	100.0%	100.0%	100.0%	99.7%
Procedural Accuracy	97.0%	99.5%	100.0%	100.0%	100.0%

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

*** there was only 1 monitoring audit during Q2*

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

****there were 0 monitoring audits during Q3 and 0 quality audits during Q4*

*****there were 0 peer review audits during Q4*

Outcomes Analysis

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

ALERT Outcomes

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

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

Wellness Assessments

Methodology: An important part assessment when engaging in population health is to monitor the severity of symptoms and functional problems among those being treated. One concept for

understanding population health as an outcome is to monitor whether utilizers as a group are getting healthier or sicker.

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

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

ADULT global distress scores are described as follows:

Total Score	Severity Level	Description
0-11	Low	Low level of distress (<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.

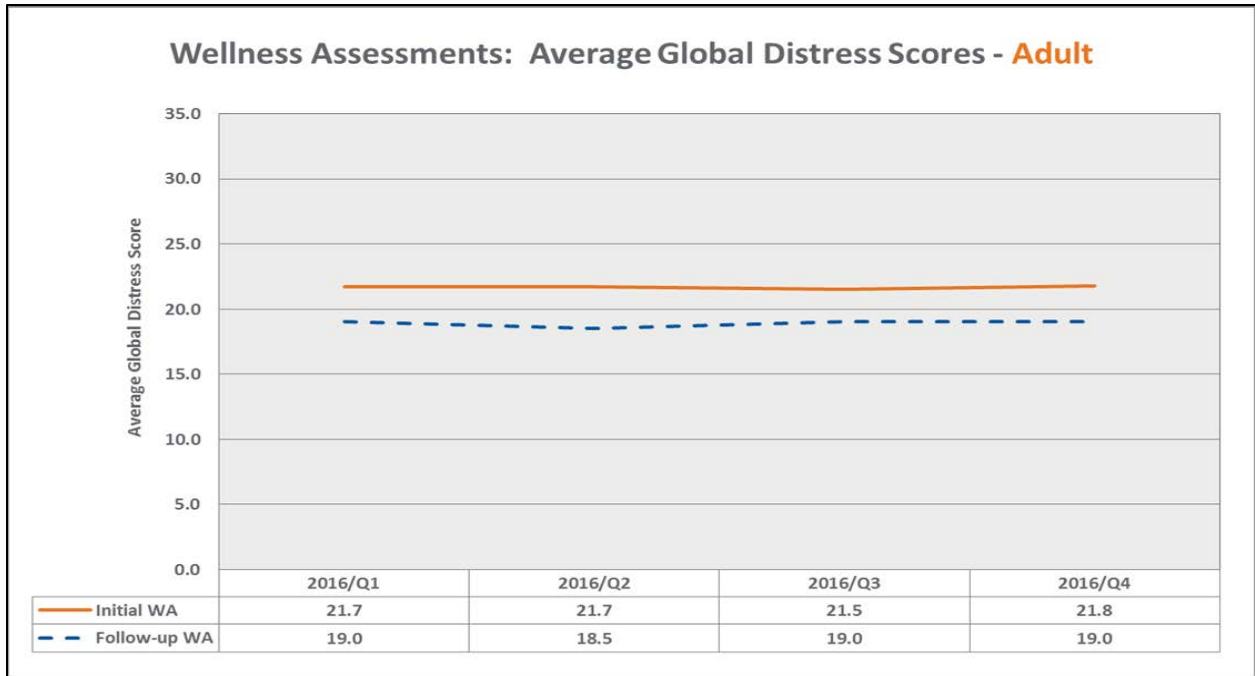


Figure 1: For adults, initial assessments display a flat curve over the 4 quarters from Q1 2016 through Q4 2016. Of note, there is a consistent reduction in follow-up adult Global Distress scores compared to initial scores for the population in treatment.

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.

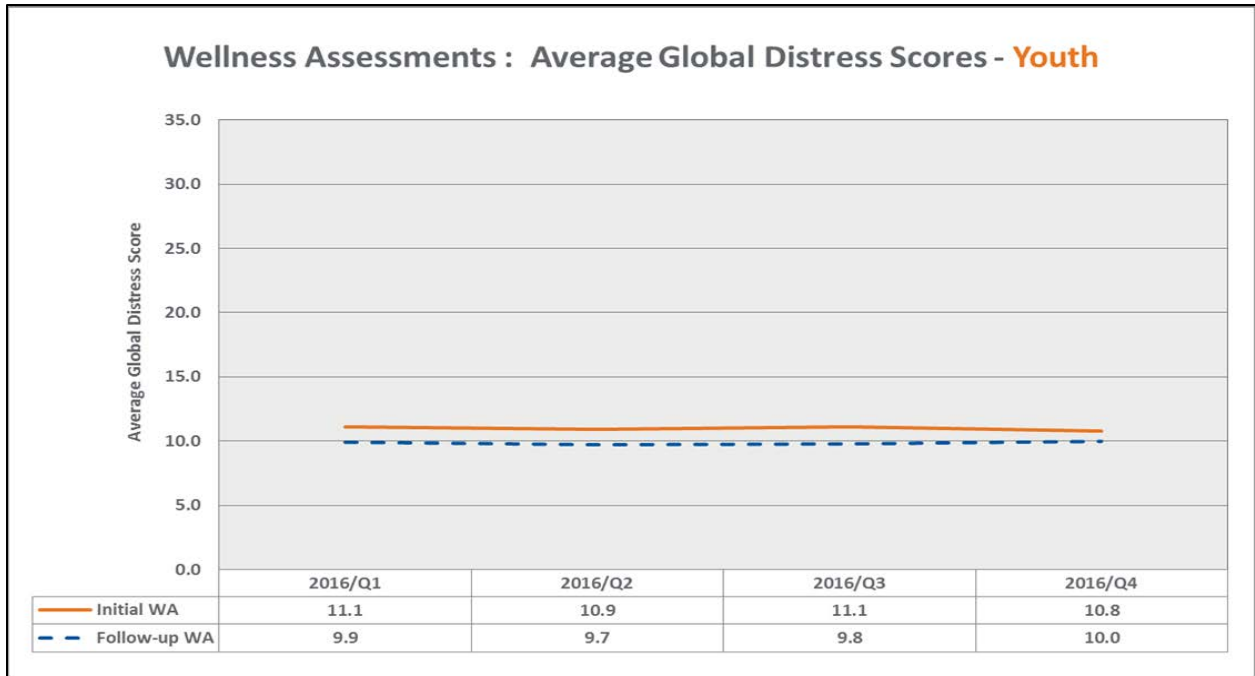


Figure 2: For children and youth, between Q1 2016 through Q4 2016, Global Distress scores have remained flat across time.

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.

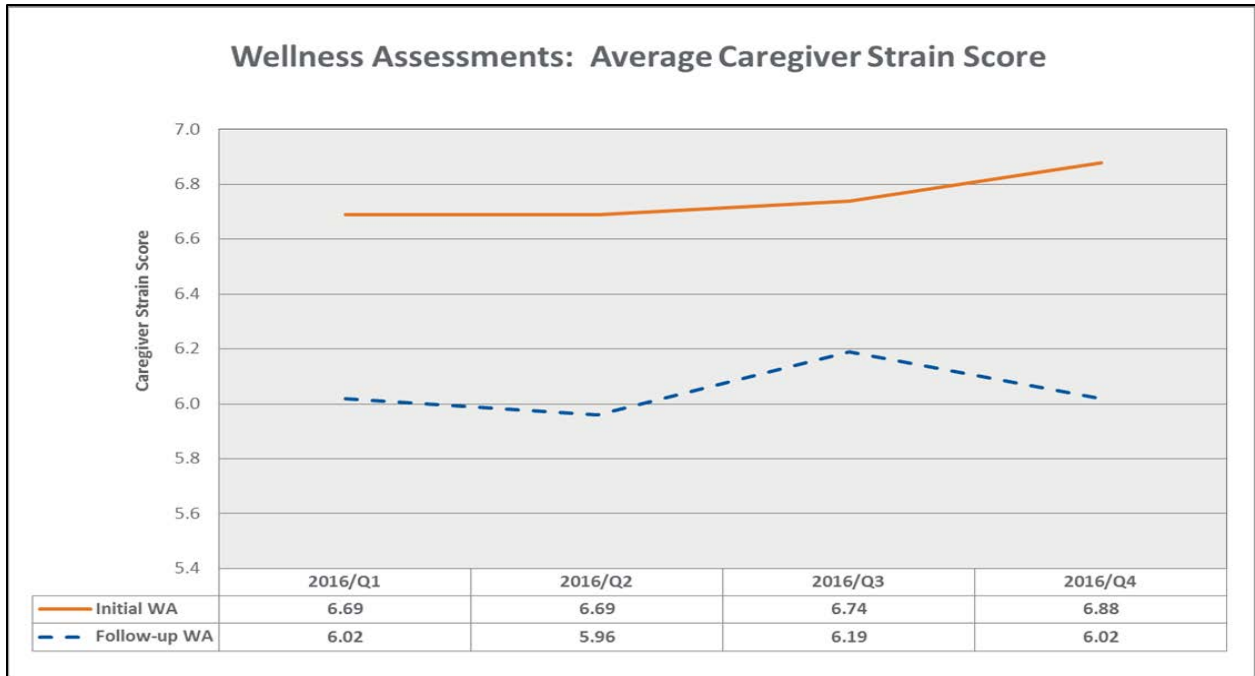


Figure 3: For children and youth, average initial Caregiver Strain scores have increased 2.8% over time. When follow-up scores in the population are reviewed, these have remained generally flat over time. Overall severity levels remained in the moderate range through the study period.

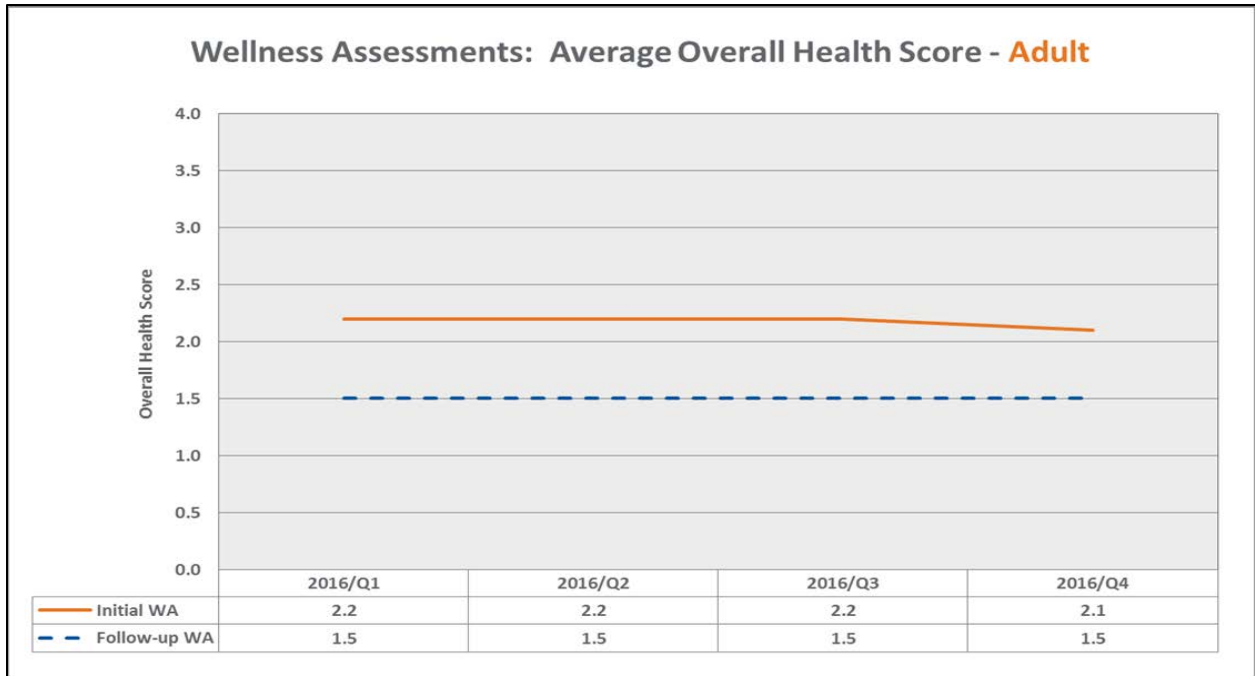


Figure 4: Adult Physical Health score values are as follows:

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

Overall physical health status is an important predictor of risk. Persons with coexisting physical health issues and behavioral health problems tend to do worse. Between Q1 2016 through Q4 2016, adults at baseline on initial assessment showed an unchanged occurrence of physical health issues that varied between “fair” and “good.” On follow-up assessment for the same period, adults showed lower scores in the range between “good” and “very good.” These lower scores for the population remained in the same approximate range throughout the study period

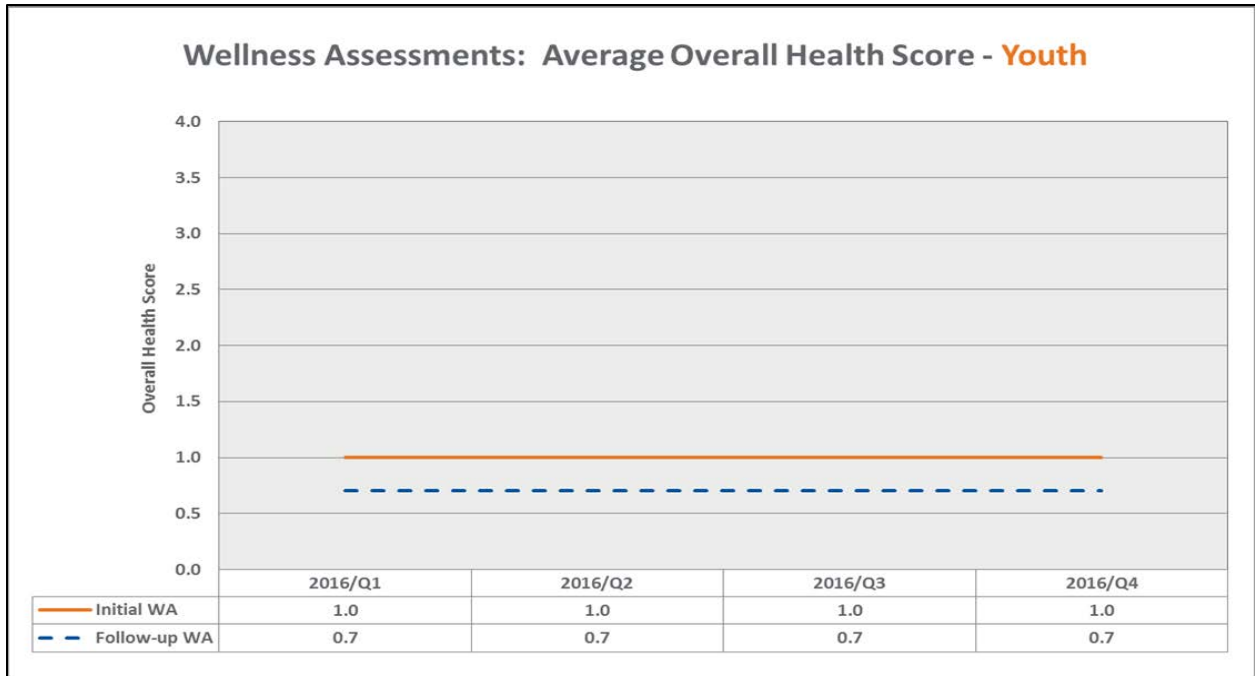


Figure 5: Child and Youth Physical Health score values are as follows:

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

Between Q1 2016 through Q4 2016, children and youth at baseline on initial assessment showed a flat occurrence of physical health issues that averaged “very good.” On follow-up assessment for the same period, children and youth showed lower scores in the range between “very good” and “excellent.” These lower scores for the population remained in the same approximate range throughout the study period.

Individual Therapy Utilization Rates

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

The rate of utilization is calculated as follows:

Numerator is the number of unique utilizers of Individual and Extended Therapy visits for a specific quarter.

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

Analysis: Individual Therapy is important for many behavioral health disorders. In general, according to the Treatment Guidelines of the American Psychiatric Association, Individual Therapy is an expected, evidence-based practice for adult mental disorders except for dementia. According to the Practice Parameters of the American Academy of Child and Adolescent Psychiatry, Individual Therapy is a central part of treatment in only some disorders,

such as Post-Traumatic Stress Disorder, and in limited respects for others. For some disorders, for instance, Individual Therapy is limited to Problem-Solving Skills Training only for children of school age. In contrast to adults, family-based interventions are the most important and the most commonly expected for children and youth. It is expected, therefore, that there should be more adult utilizers of Individual Therapy than what would be seen with children.

Examination of the data for the age groups 0-17 years, 18-20 years, and 21+ years, shows a clear predominance of utilizers of Individual Therapy in the adult group and many fewer for children and transitioning youth. Overall utilization of Individual Therapies decreased 6.1% between Q1 2016 and Q3 2016.

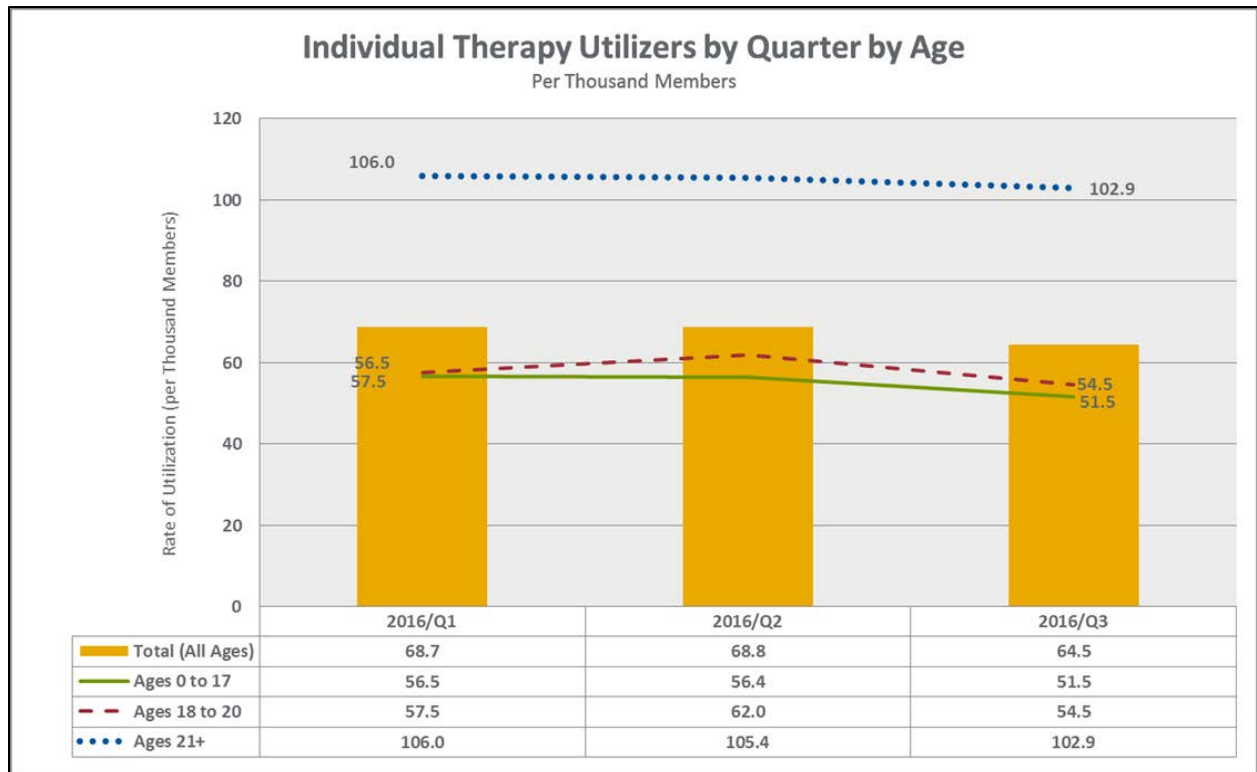


Figure 6:

Barriers: No identified barriers

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

Family Therapy Utilization Rates

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

The rate of utilization is calculated as follows:

Numerator is the number of unique utilizers of Family Therapy visits for a specific quarter. Denominator is the total number of IBHP members for the same quarter, in thousands.

Analysis: Over the past 3 quarters beginning Q1 2016 for which there are reliable claims data, there is overall a decrease of 7.3% in the utilizer rates for Family Therapy for all age groups combined. The 0-17 year group decreased 9.2%, the 18-20 year group decreased 2.0%, and the adult 21+ year group increased 5.8%.

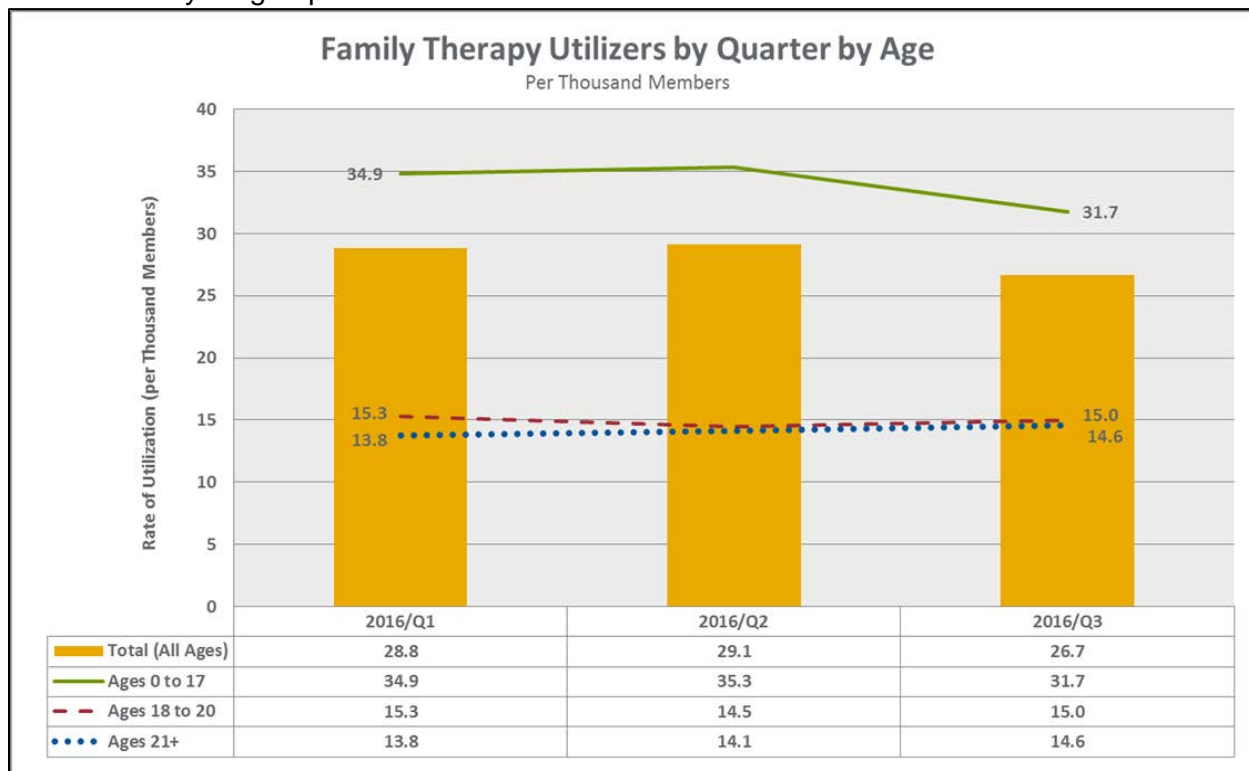


Figure 7:

Barriers: No identified barriers

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

Peer Support Utilization Rates

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

The rate of utilization is calculated as follows:

The numerator is the number of unique utilizers of Peer Support visits for a specific quarter.

The denominator is the total number of members 18 and over for the same quarter, in thousands.

Analysis: Per Optum Idaho’s Level of Care Guidelines, only members 18 years and over meet criteria for Peer Support Services. When all members 18 and over are examined, the utilization rate for Peer Support has increased by 66% between Q1 2016 and Q3 2016.

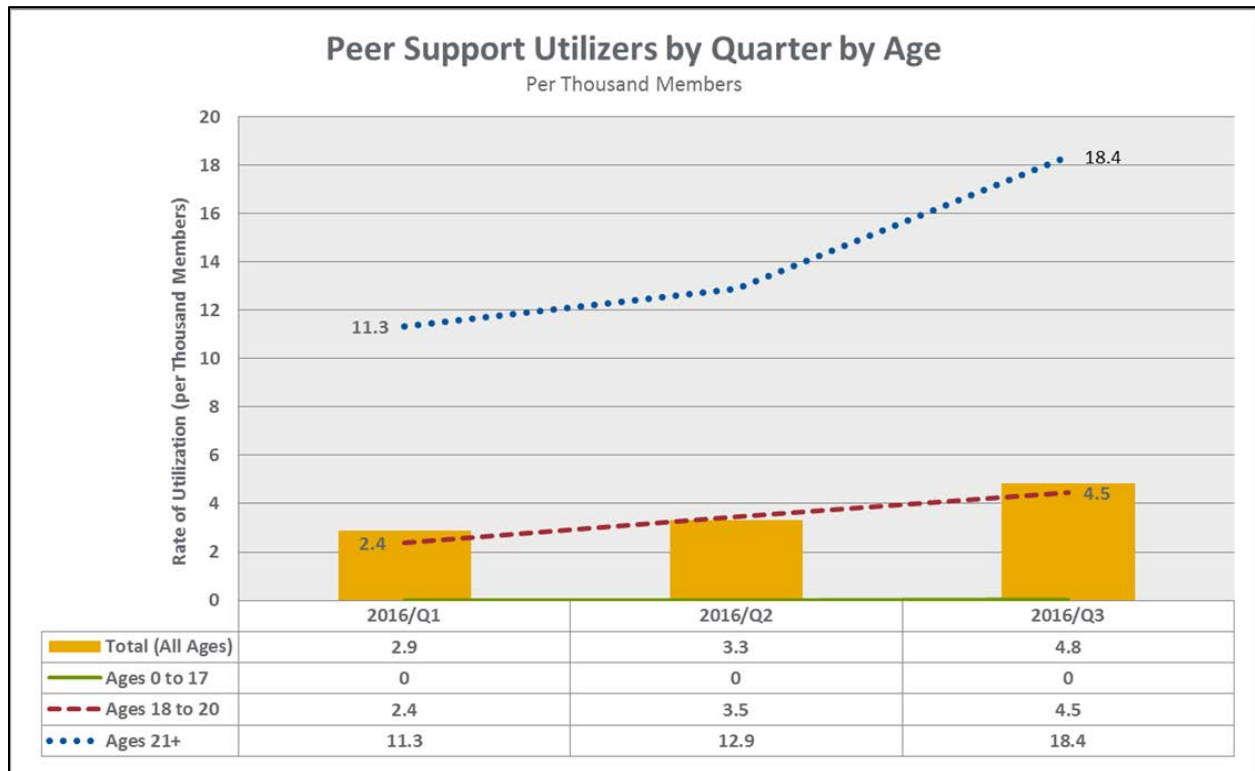


Figure 8:

Barriers: The chief barrier to utilization of Peer Support Services has been the limited number of certified specialists. A separate barrier has been variation of provider agencies across the state offering this service. The lack of extensive historical experience with Peer Support for providers in the State of Idaho is also a likely factor, as the benefits of using Peer Support are unfamiliar to some providers.

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

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

Case Management Utilization Rates

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

The rate of utilization is calculated as follows:

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

Analysis: Between Q1 2016 and Q3 2016, the last quarter for which reliable claims data is available, utilization rate of Case Management Services decreased 0.8%.

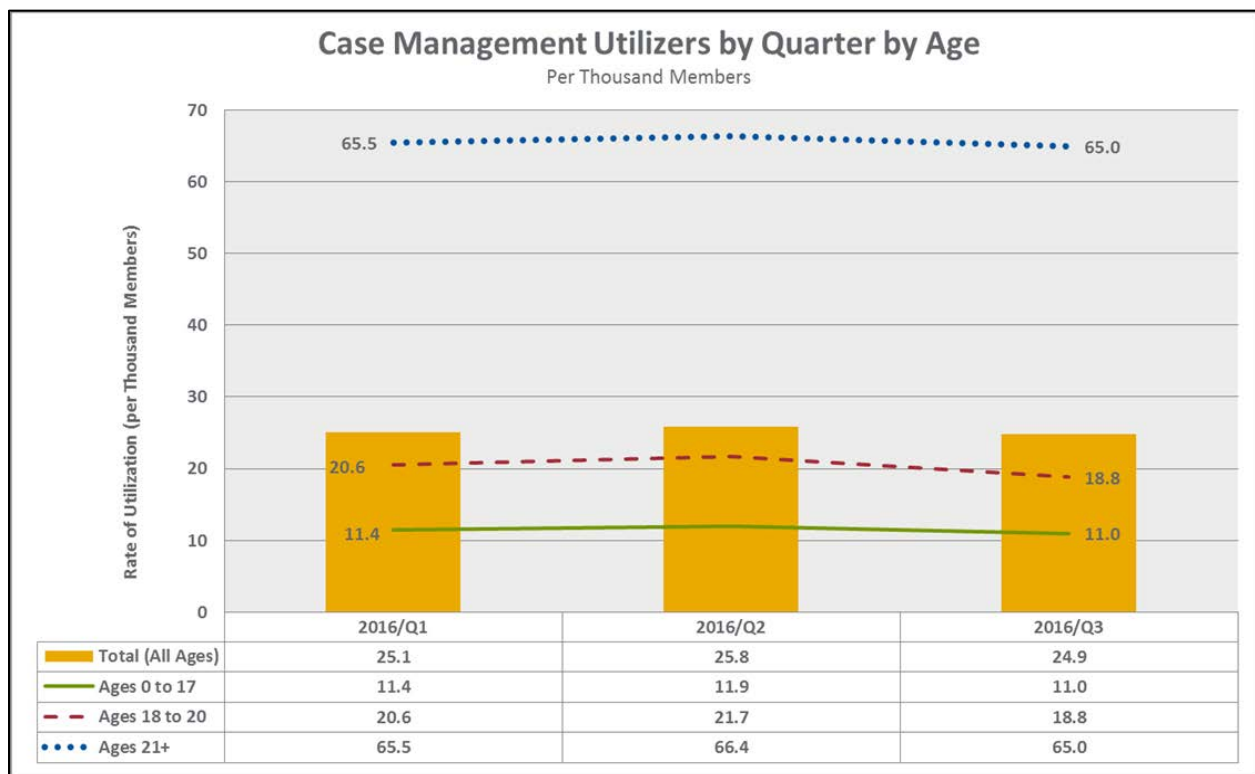


Figure 9:

Barriers: No barriers were identified.

Opportunities and Interventions: Case Management Services were changed in mid-August 2015 to a status that allows a predetermined number of case management hours before requiring clinical review. Further monitoring is needed to see whether Case Management services should be returned to a Category 3 status that would require prior review before authorization of service requests. We will continue to work with educating our Provider network concerning appropriate use of Case Management services.

Prescriber Visit Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed, since reliable data requires waiting for the 90-day claims lag allowed 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: Overall, the utilization rate for behavioral health prescription visits decreased 10.2% between Q1 2016 and Q3 2016.

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

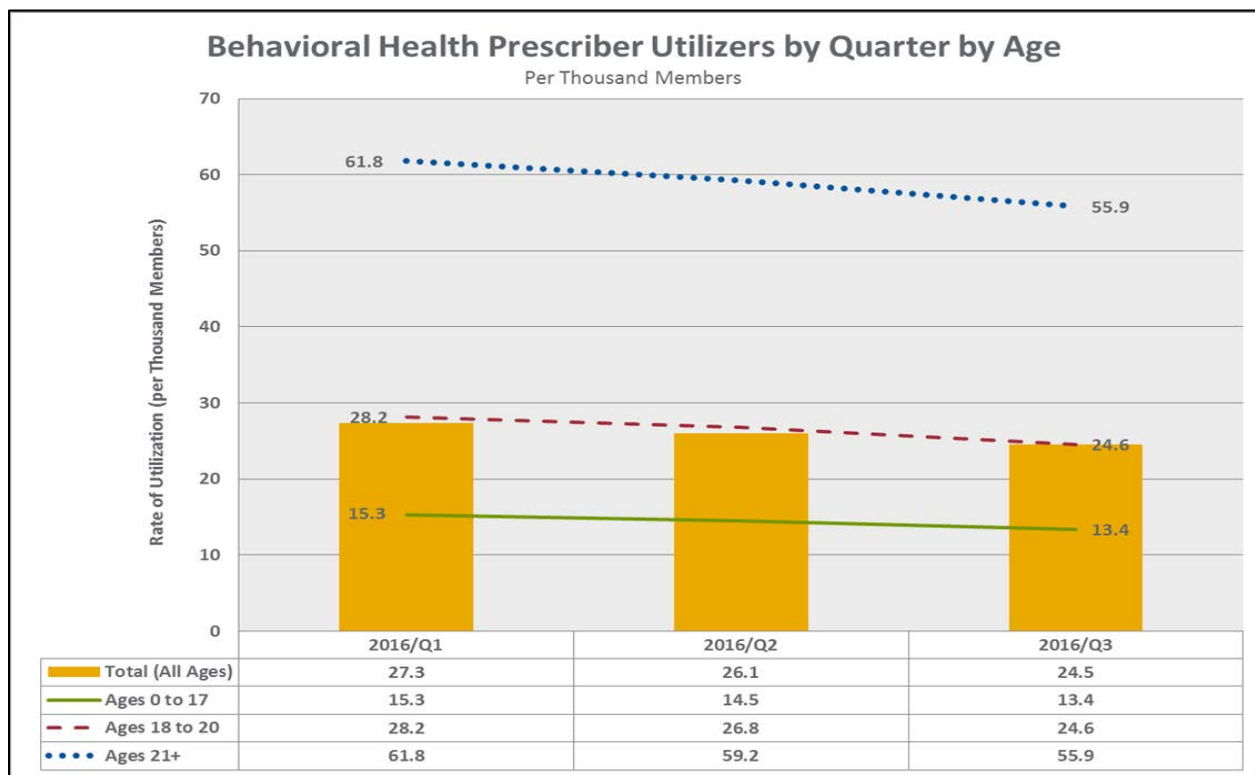


Figure 10:

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

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

CBRS Utilization Rates

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

The rate of utilization is calculated as follows:

Numerator is the number of unique utilizers of CBRS visits for a specific quarter.

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

Analysis: Community-Based Rehabilitative Services, CBRS, is a set of rehabilitation services originally developed to support adults diagnosed with Schizophrenia and severe and persistent Bipolar Disorder. Those two diagnoses are the only two diagnostic groupings for which the Treatment Guidelines of the American Psychiatric Association recognize psychosocial rehabilitation as appropriate.

Between Q1 2016 and Q3 2016, the reduction in CBRS for all age groups combined was 28%. 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 40.3%, 37.9%, and 24.6% respectively within the study period of Q1 2016 and Q3 2016. These changes have sustained a more clinically appropriate use of CBRS for different age groups.

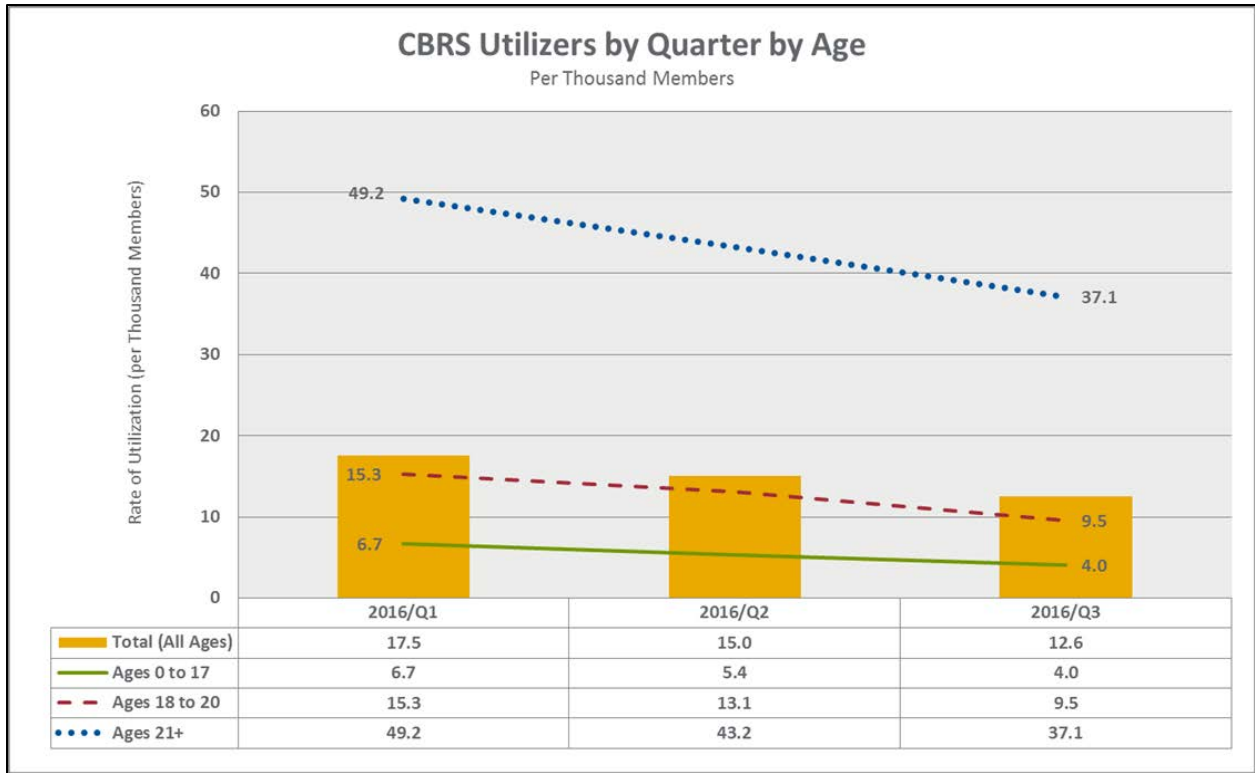


Figure 11:

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

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

Services Received Post CBRS Adverse Benefit Determination

Methodology: Based on Adverse Benefit Determination and Claims data, the graph below identifies members that received evidence based service(s) after receiving an ABD letter.

Analysis: Between Q1 2016 and Q3 2016, the use of medically necessary services has increased following denials of authorization for CBRS. Over the three quarters of this study, in the first 90 days following the ABD, approximately 93-94% of members have received therapeutic services. The overall pattern has been one of sustained openness to acceptance of alternative services to CBRS over the study period. An unknown percentage of these members receiving “no services” may in fact be receiving medication services from non-network prescribers that would not be reportable from Optum’s claims database.

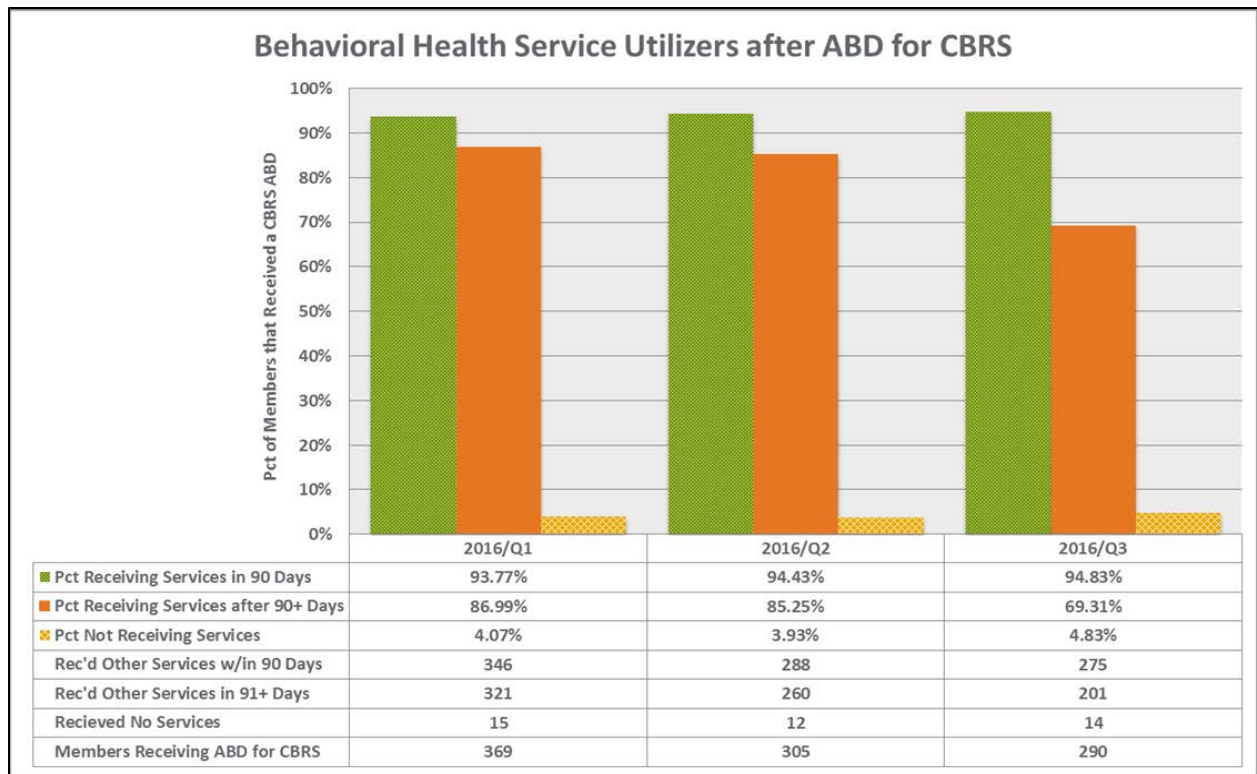


Figure 12:

Barriers: Although progressively changing, 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, we anticipate the increased use of these value-added Recovery and Resiliency services for the benefit of children and their families.

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

Psychiatric Inpatient Utilization

Methodology: Information is obtained from IDHW and other community resources using hospital discharge data. A hospital stay is considered a readmission if the admission date occurred within 30-days of discharge. The data displayed indicates the rate of hospital discharges per 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: In general, a well performing outpatient behavioral health system is 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 operation as a whole.

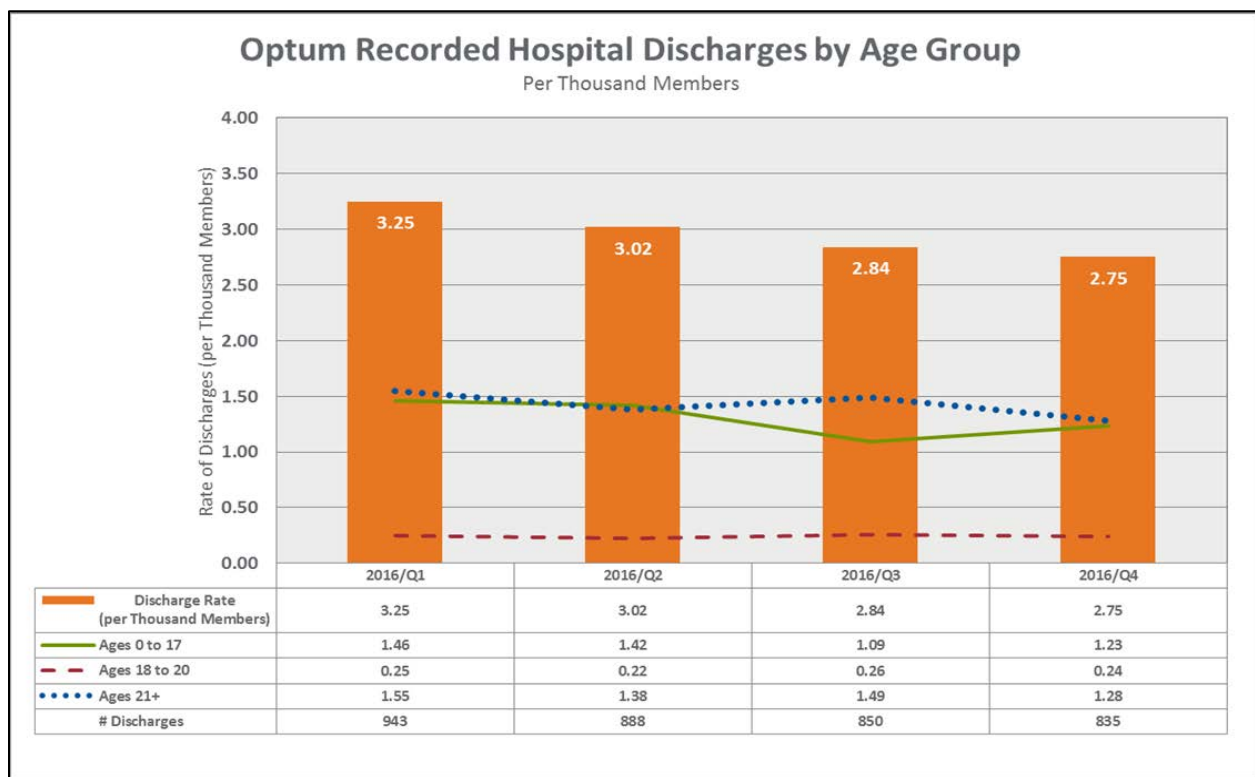


Figure 13: The overall rate of discharges, decreased from 3.25 to 2.75 per 1,000 members. This change represents a 15.4% reduction in hospitalizations.

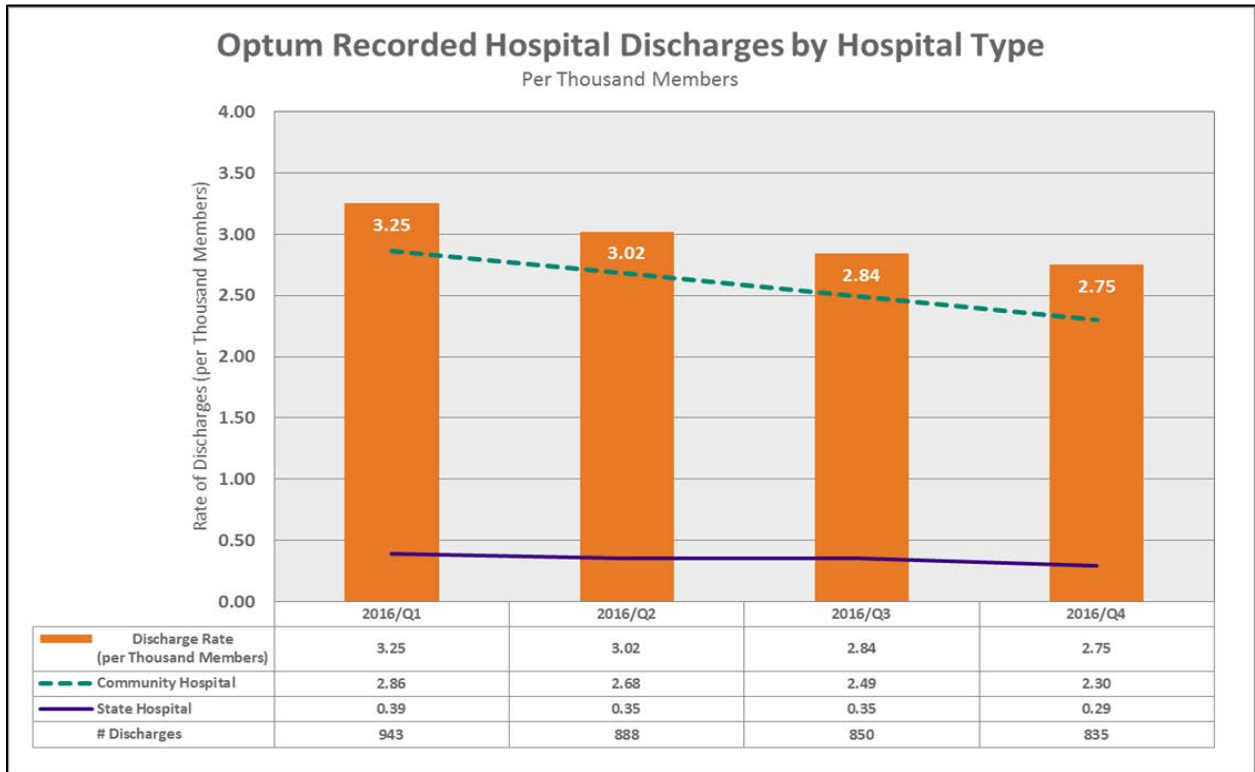


Figure 14: During the study period from Q1 2016 through Q4 2016, discharges from the state decreased 15.6% and decreasing 19.6% in 2016 for community hospitals.

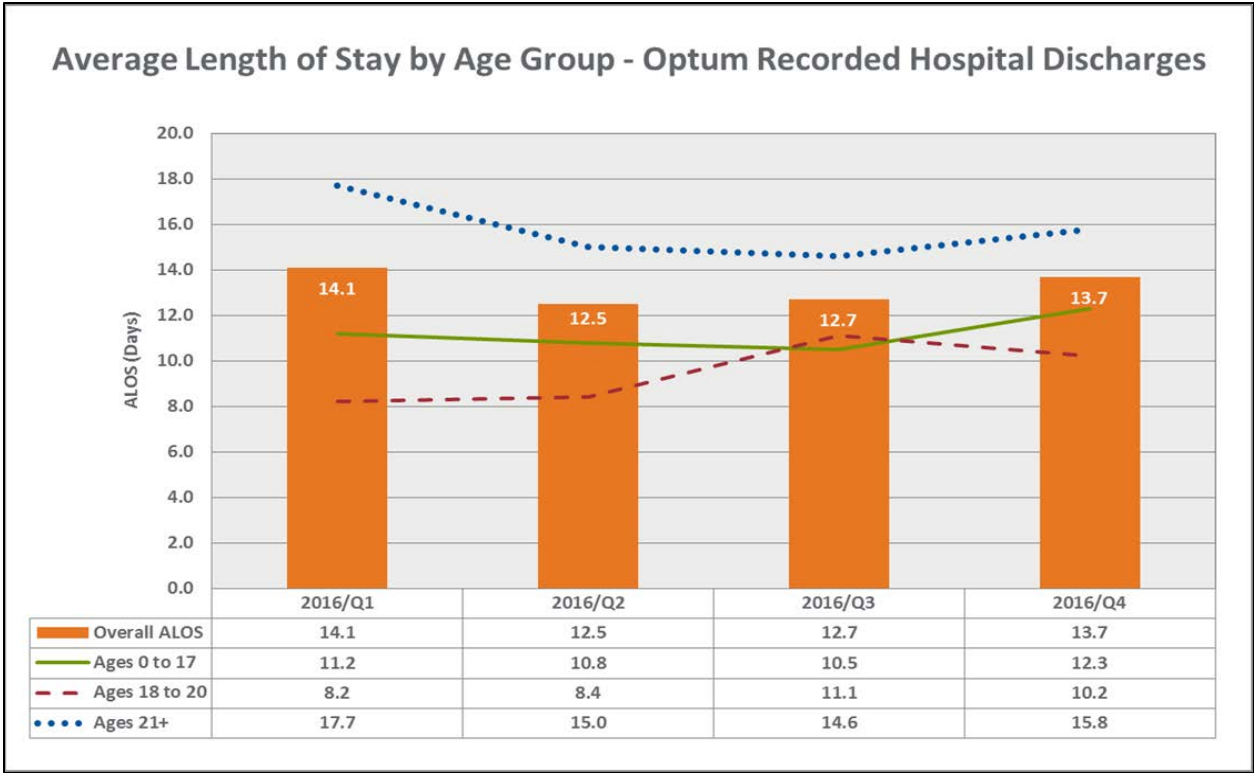


Figure 15: From Q1 2016 through Q4 2016, based on information reported to Optum Idaho from hospitals, the overall average length of stay returned to near Q1 level.

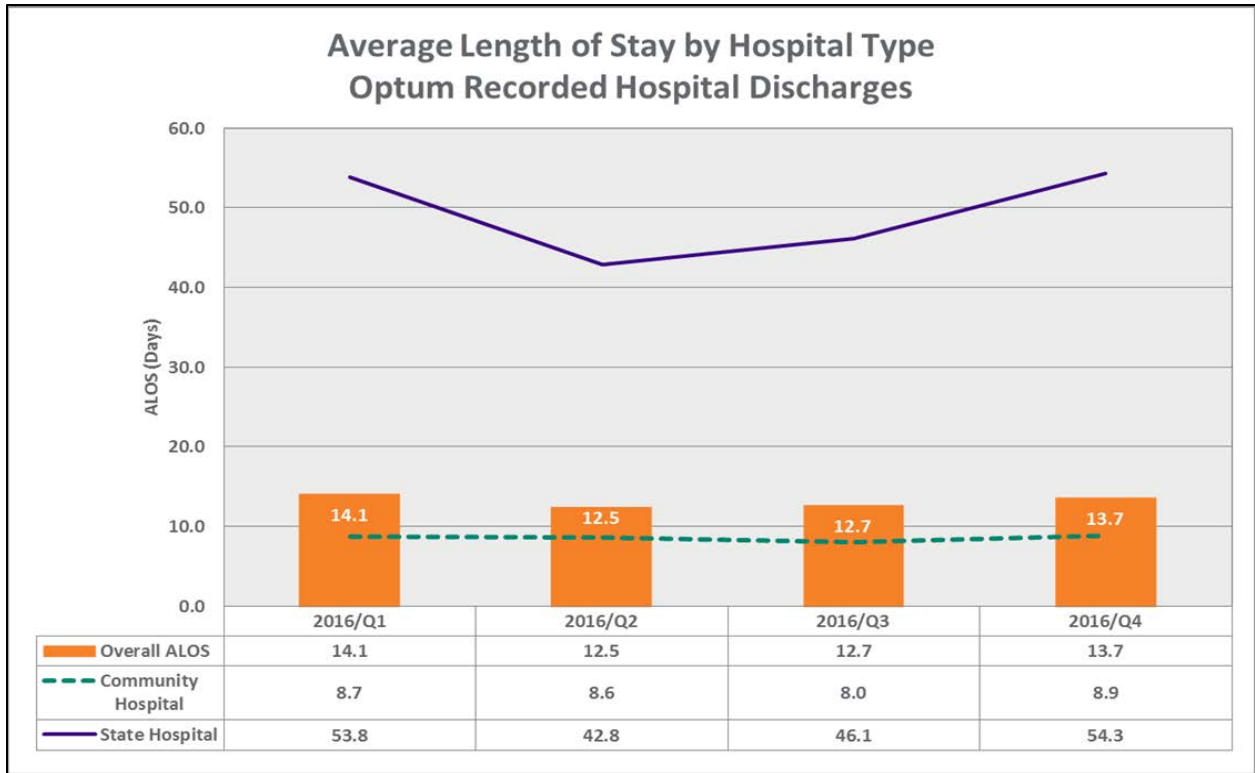


Figure 16: Average length of stay was examined by hospital type.

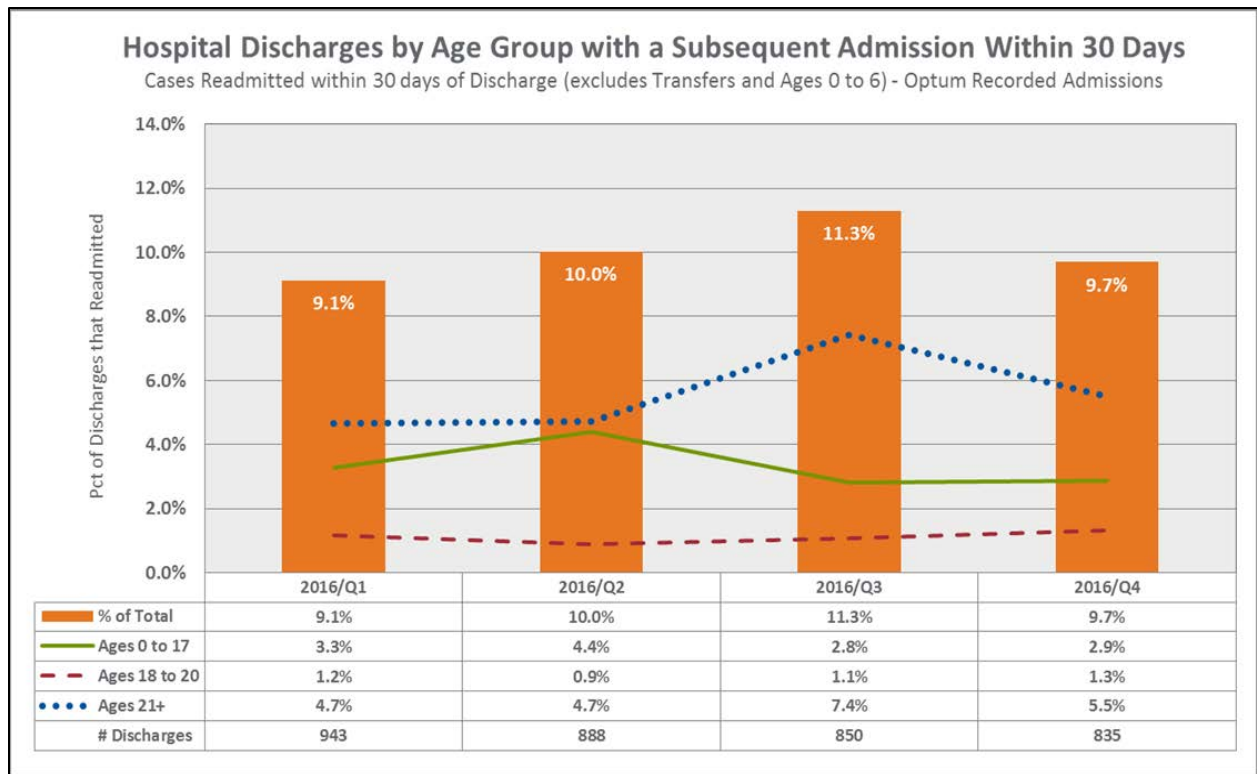


Figure 17: According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals.

Because of possible seasonal fluctuations in hospital readmissions, the year-over-year changes between Q4 2015 and Q4 2016 were examined. For Q4 2015, readmission rates were 10.8%. In comparison with Q4 2016, readmission rates decreased 10.2% year over year.

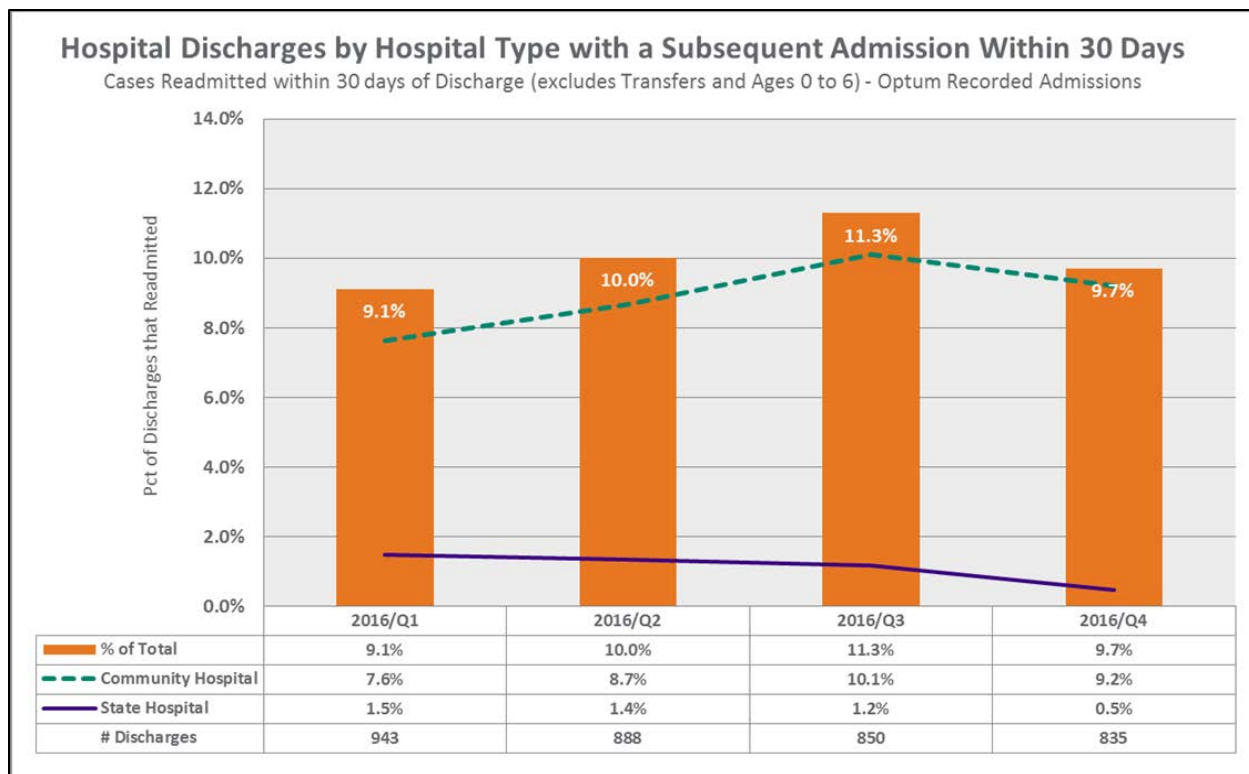


Figure 18: Readmissions broken out by hospital type.

Psychiatric Emergency Room Utilization Rates

Methodology: Data is provided by IDHW and is for May 2016 to August 2016. Utilization is given as visits per 1,000 members in the IBHP for each month.

Analysis: This graph displays the utilization of Idaho Emergency Room visits for psychiatric care. Over the 4 month period, for the period for which data is available, emergency room utilization remains consistent.

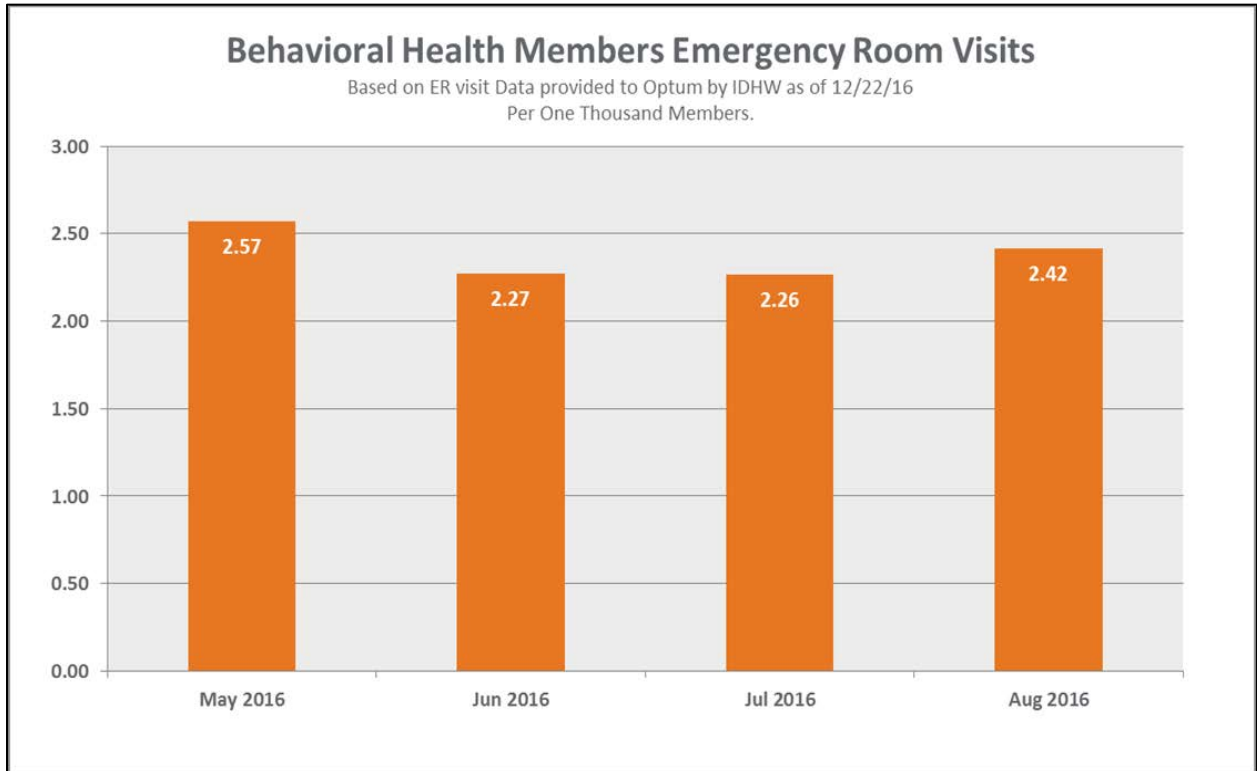


Figure 19

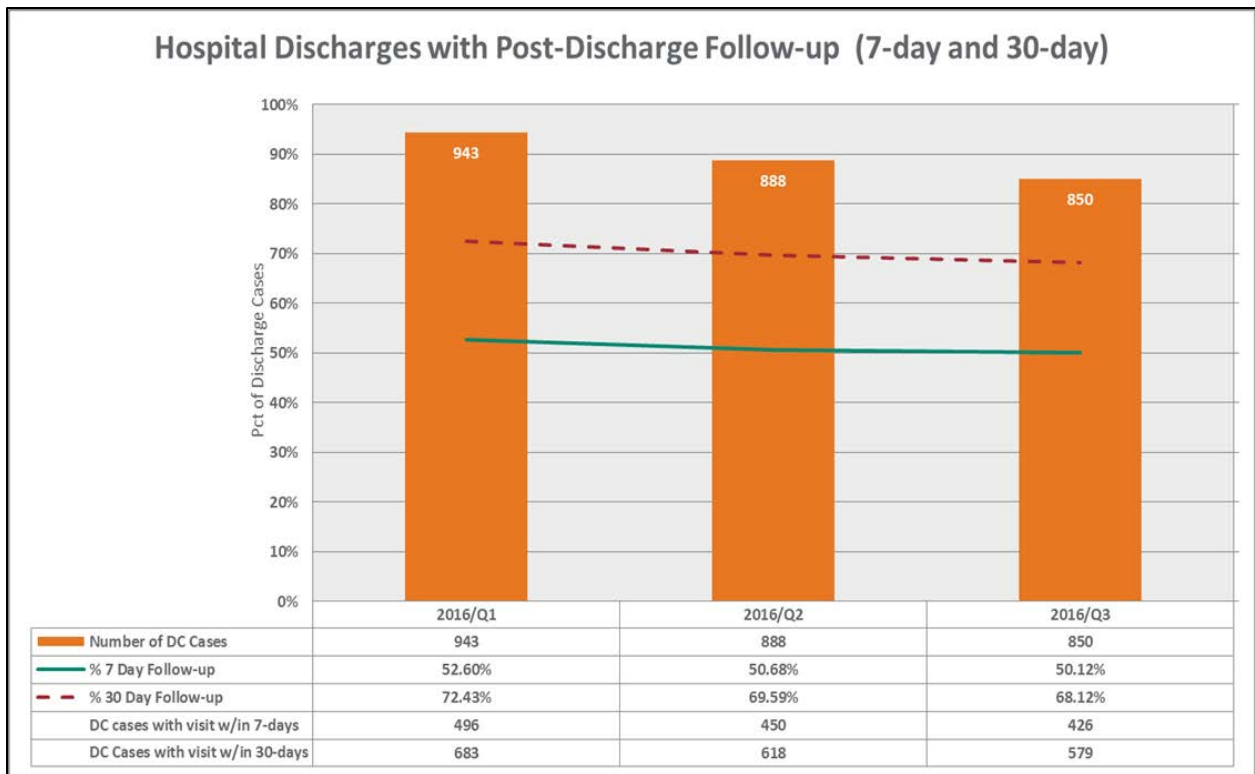


Figure 20: One of the goals for care coordination is improvement in the transition of members from inpatient to outpatient care, to support improved continuity of care. One of the measures for this is a HEDIS measure that examines the percentage of discharged members who are seen for an outpatient behavioral health visit within 7 days. Examination of 30 day outpatient visit attendance rates is also common.

Note: DC is an abbreviation for discharge.

Barriers: The historical responsibility for arranging post-discharge outpatient appointments for behavioral health services has rested with hospital discharge planners. Optum has an outpatient-only contract that results in our not managing hospitals or their staff or discharge planning.

Within the Optum Idaho care coordination system, discharge coordinators check to see whether a member has kept scheduled appointments but do not ensure and often are unable to ensure that there are scheduled appointments to keep due to hospitals' not releasing discharge information in a timely way.

Opportunities and Interventions: There were favorable outcomes for hospital discharge rates and readmission rates for all age groups.

There are two main opportunities for further change remains to strengthen the capacity of outpatient services to keep members in community-based care. The first is an on-going pilot program first with the state hospitals and then community hospitals to use an Appointment Reminder Program based on information about scheduled aftercare appointments that Optum will use to electronically notify members or their families of an upcoming appointment visit. The second is a resetting of the Community Transition Support Service to help with post-discharge timeliness and overall treatment adherence. These programs are in preparation, so data are currently unavailable to report.

Member Satisfaction Survey Results

Methodology: Optum monitors Idaho Medicaid enrollees' satisfaction with behavioral health services using the online and mailed versions of the Optum Idaho Member Satisfaction Survey. The surveys were designed in collaboration with IDHW. The mailed version is fielded quarterly, while the online version is accessible to members 24 hours a day on the Optum Idaho and Optum Idaho Live and Work Well websites.

The member survey is outsourced to the Center for the Study of Services (CSS), which is a NCQA-certified vendor. Mailed surveys are administered quarterly in English with Spanish translation available. The mailed survey is administered via two mailings, with second mailing being sent as a reminder to non-respondents.

Members who have received outpatient or medication services within the Optum network in the last 90 days are eligible to participate. As of the survey mail date, members 18 years of age and older and members 15 years of age and younger are eligible to be surveyed (please note that for members 15 years of age and younger, the survey packet is addressed to the parent of the member not to the youth directly). Members must be eligible for services at the time of the survey and have granted permission to mail to their address on record. Members who have accessed services in multiple quarters are eligible for the survey only once every 12 months.

A random sample of individuals eligible for the survey is then selected. Only mailed survey responses are used in our annual data analysis due to the limitations in validating the members who respond to our online survey methods. However, all responses submitted from our online portal are reviewed.

The member survey tool includes 26 items. Survey questions represent the following experience domains.

- *Experience with Optum Idaho staff and referral process* (composite score of qsts 2-7)
- *Experience with provider network* (composite score of qsts 10-14)
- *Experience with counseling and treatment* (composite score of qsts 15-23)
- *Overall experience* (qst 25, % respondents selected 'Excellent', 'Very Good', or 'Good')

Quarterly Performance Results:

Member Overall	Performance	Q3 2015	Q4 2015	Q1 2016	Q2 2016*
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Satisfaction Survey	Goal	(n=83)	(n=120)	(n=121)	(n=99)
Experience w/Optum ID Staff and Referral Process	≥85.0%	77.4%	90.1%	94.0%	86.3%
Experience with the Behavioral Health Provider Network	≥85.0%	88.8%	93.1%	94.0%	92.5%
Experience with Counseling or Treatment	≥85.0%	90.9%	95.3%	93.6%	95.5%
Overall Experience	≥85.0%	86.3%	94.8%	91.5%	97.0%

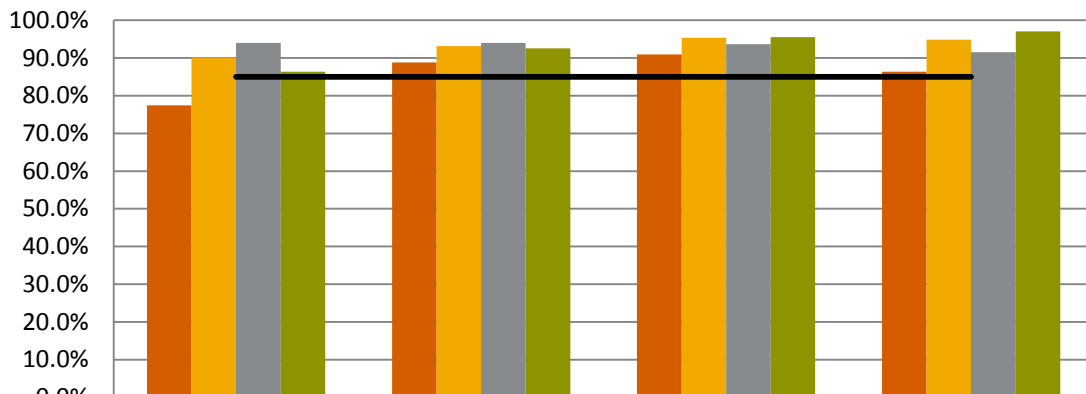
*Based on the Member Satisfaction Survey sampling methodology, Q2, 2016 data is the most recent set of results available.

Analysis: The survey was offered in English and Spanish. The survey was initially mailed on August 17, 2016 to 987 enrollees. Non-respondents were sent a second request and survey on September 14, 2016. The results presented in this report represent responses received before October 21, 2016. All mailings included a cover letter, survey, and postage-paid business reply envelope. Of the surveys mailed, 137 surveys (13.9%) were returned to Optum Idaho as undeliverable; and 14 surveys (1.4%) were returned as refused. Of the surveys mailed, 99 responses were received from the 987 surveys that were delivered, resulting in an 11.8% response rate.

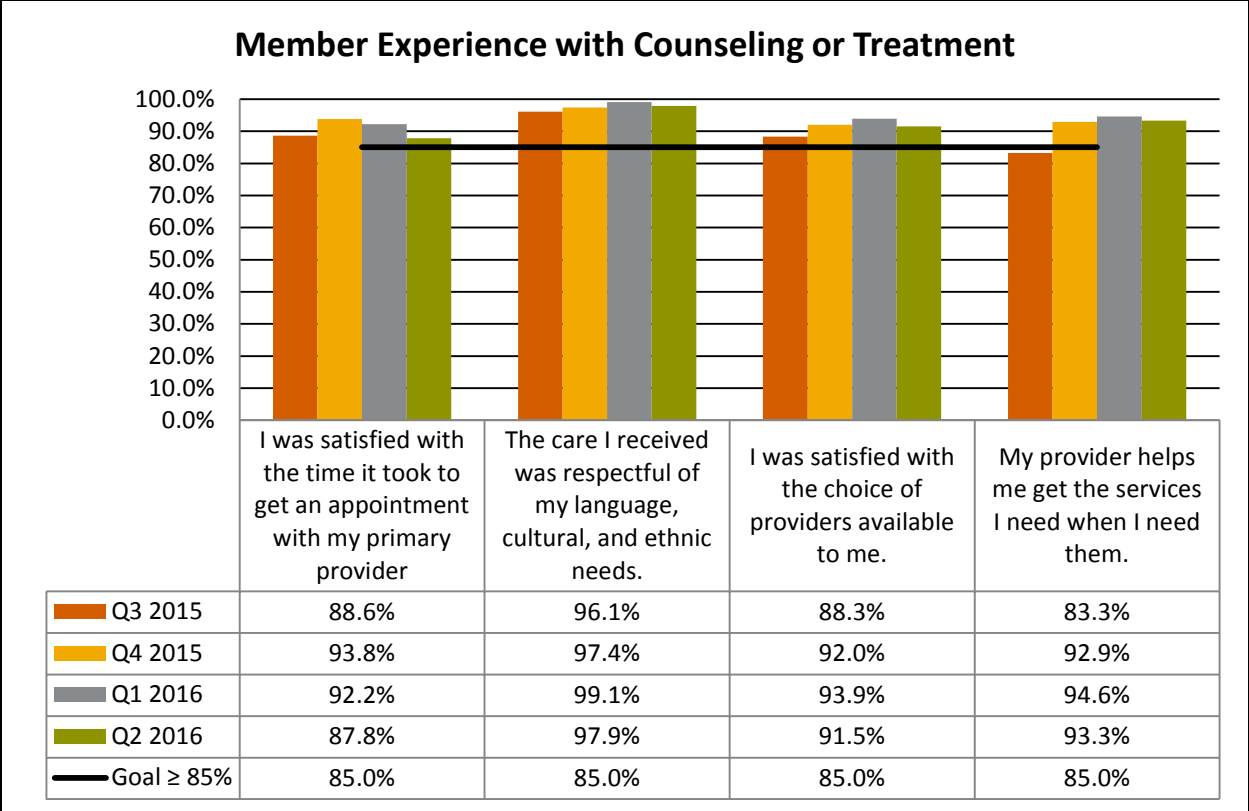
Of note, the rate of member’s Overall Experience with Optum Idaho increased from 91.5% during Q1 to 97.0% during Q3. All areas remained above the performance goal of ≥85.0%.

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.

Overall Member Satisfaction Survey Results



	Experience w/ Optum ID Staff and Referral Process	Experience with the Behavioral Health Provider Network	Experience with Counseling or Treatment	Overall Experience
Q3 2015	77.4%	88.8%	90.9%	86.3%
Q4 2015	90.1%	93.1%	95.3%	94.8%
Q1 2016	94.0%	94.0%	93.6%	91.5%
Q2 2016	86.3%	92.5%	95.5%	97.0%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%



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

Opportunities and Interventions: No opportunities for improvement were identified

Provider Satisfaction Survey Results

Optum Idaho moved to a provider satisfaction surveying method that includes a Net Promoter Score (NPS) function. The NPS is a standard measurement approach that allows Optum Idaho to identify key factors that are most impactful on a provider’s level of satisfaction in our network so we are better able to take the necessary steps to improve. The new survey was executed during the 4th Quarter of 2016. Survey results will be reported in the Q1, 2017, report.

What is changing?

- **The questionnaire will take less time to complete.** Optum Idaho values our provider’s input and wants to make sure a provider’s participation in the survey is not adversely impacting their operations.
- **The questions will be more focused** on Optum Idaho processes and related provider experiences with measurable satisfaction rating scales.
- **The survey will be conducted annually.** For those providers who recently participated in the past quarter’s survey, this may seem duplicative, however, the provider will notice the questions have changed and we encourage the provider’s participation.

What remains the same?

- **Optum’s commitment to use provider feedback to improve** our processes and to improve the provider’s experience participating in the Optum Idaho Medicaid Network.
- **Multiple options to participate and complete the survey** will remain; on the phone at the time of the call, reschedule a call at a time more convenient, complete an emailed survey or a paper survey.

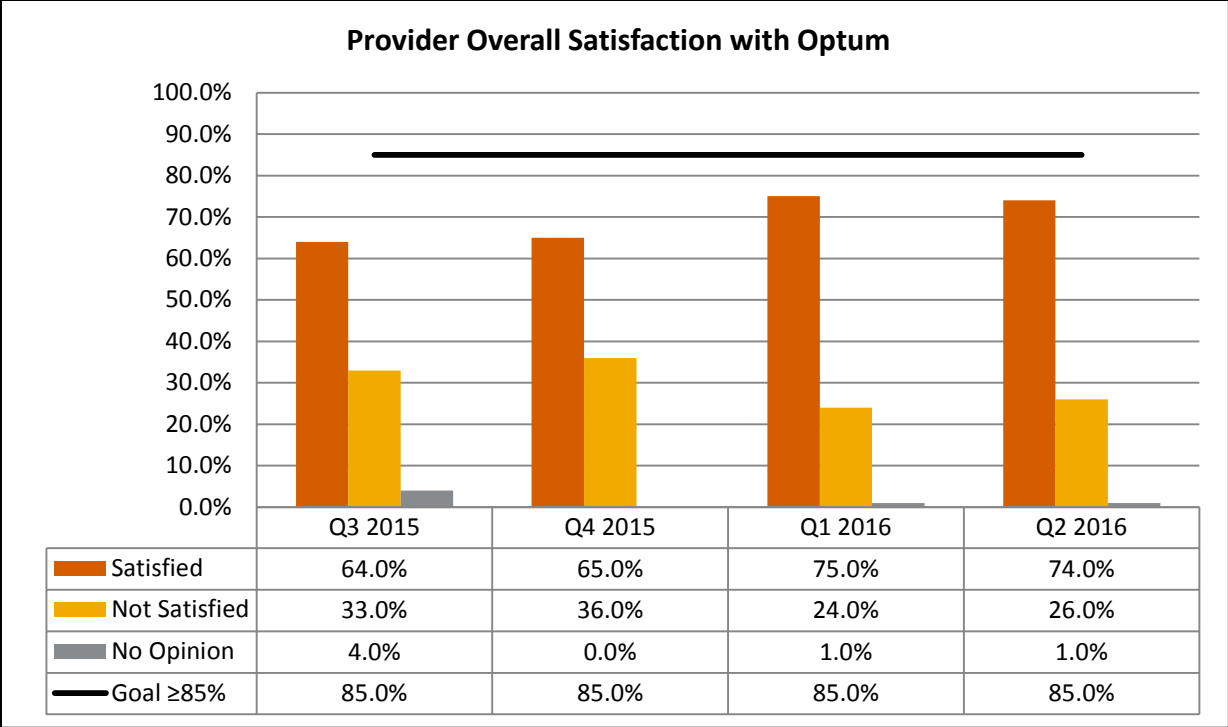
Results from previous provider satisfaction surveys are included in this report. The questionnaire used to survey Optum providers was developed to measure key indicators of satisfaction with Optum. These included:

<i>Overall Satisfaction</i>	<i>Customer Service Line</i>
<i>Authorizations</i>	<i>Peer Review</i>
<i>Field Care Coordinators</i>	<i>Alert Care Management</i>
<i>Claims</i>	<i>Optum Website</i>
<i>Training and Education</i>	<i>Electronic Health Records</i>
<i>Provider Monitoring Audits</i>	<i>Complaint Process</i>
<i>Suggestions for Improvement</i>	

Surveys were conducted over the phone between providers and a representative from Fact Finders, Inc. The representative from Fact Finders, Inc, placed an initial call to the provider agency to introduce the research and schedule an appointment to conduct the survey. Provider agencies were then called by an interviewer at the appointed date and time. Providers were given the option of calling Fact Finders’ toll-free telephone number to complete the interview at their convenience, as well. Providers were also given the option to request to complete the survey via fax.

Quarterly Performance Results:

Provider Satisfaction Survey	Performance Goal	Q3 2015	Q4 2015	Q1 2016	Q2 2016
Satisfied	≥85.0%	64.0%	65.0%	75.0%	74.0%
Not Satisfied	NA	33.0%	36.0%	24.0%	26.0%
No Opinion	NA	4.0%	0.0%	1.0%	1.0%



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 improvement initiatives and contractual Improvement Action Plans (IAP) until completion or closure.

In Quarter 4, Optum Idaho managed a total of five (5) open IAPs that carried over from the previous quarter. There were no “new” IAPs initiated during the quarter. No IAP’s were closed during Quarter 4.

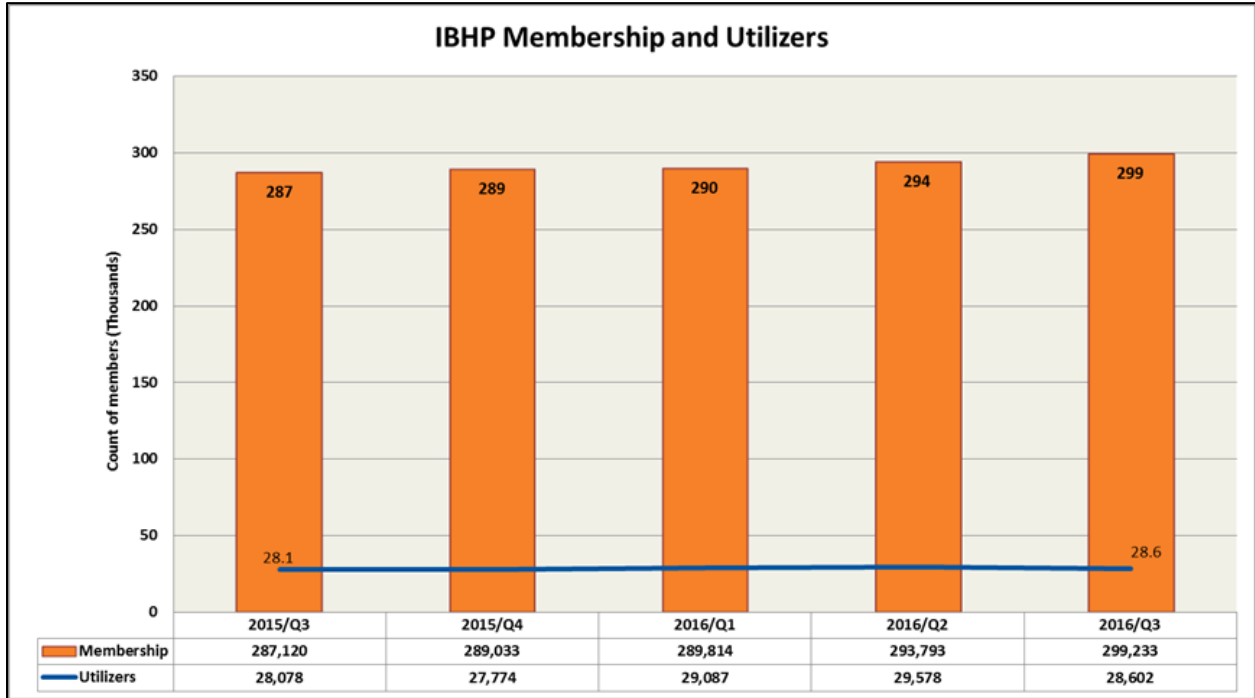
The following is a listing of the Improvement Action Plans, status, and key accomplishments that were achieved during Quarter 4.

Improvement Action Plan	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
ALERT Peer Review	10/2/2015	Quality Assurance Performance Improvement Committee and Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> •Case staffing with doctors and ALERT Care Advocate (CA) Staff scheduled on a monthly basis. •Dr. Hummel participated in staffing meetings to clarify ALERT CA questions. •ALERT CA's sent cases to Regional Network Managers when providers not responding to the ALERT CA's review calls. •Continued to refine internal process flows with Network Team.
Appointment Reminder	2/23/16	Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> • In cooperation with Clientell and the hospitals using this service, Field Care Coordination (FCC) lead Discharge Coordinator team continued to monitor the progress of this program and data was collected about its effectiveness. •FCC Team Assistant made regular presentations to CSAC on data results.
FCC Familiarity	3/22/16	Clinical and Services Advisory Committee and Provider Advisory Committee	Open	<ul style="list-style-type: none"> •Field Care Coordinators (FCC's) put together a webinar to talk about the FCC role and availability by region •FCC's made additional efforts to identify themselves by their titles and explanation of their roles and availability when communicating to providers, members, and stake holders. •FCC Training slides in development.
Communication Plan for Youth Transition	6/28/16	Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> •Letters were completed and tested for mail merge functionality. •Letters approved by customer. •First run of letters scheduled for January, 2017.
Task Force for Youth Transition	6/28/16	Clinical and Services Advisory Committee	Open	<ul style="list-style-type: none"> • Field Care Coordinator's (FCC) attended meetings to address Youth Transitions needs. •FCC's promoted the development of initiatives. •FCC's are captured their contacts and efforts in the form of reports. •Developed additional talking points.

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 numbers increased slightly and utilizers decreased slightly.

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.

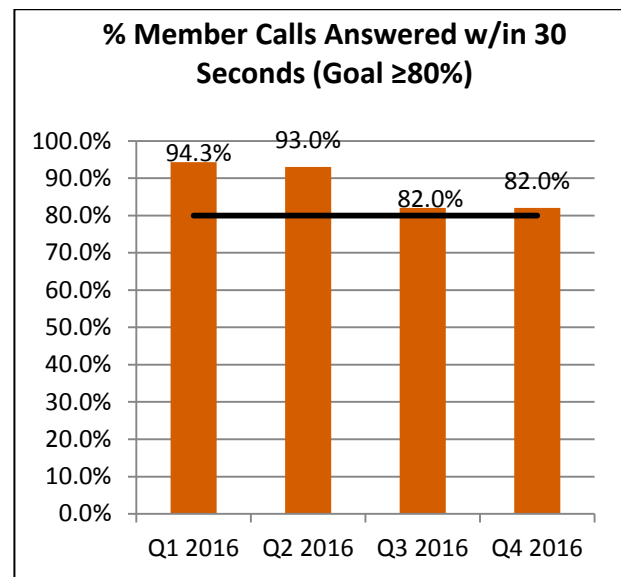
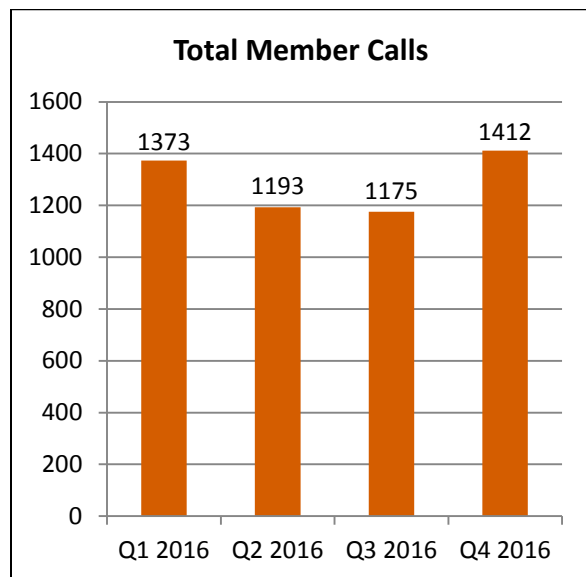
To ensure we meet our member’s needs in a timely and efficient manner, Optum Idaho established performance targets that exceeded IBHP contractual targets for average speed to

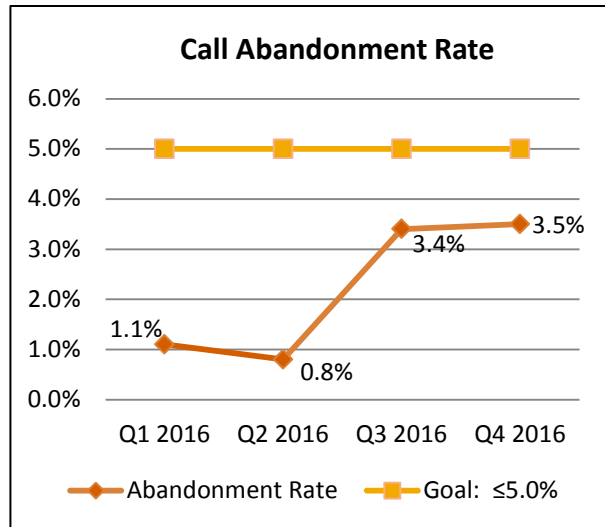
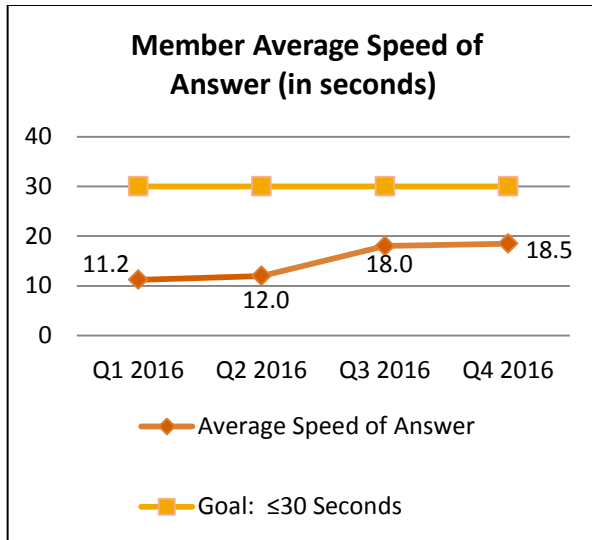
answer (120 seconds) and call abandoned rate ($\leq 7\%$). Data source is Avaya's Communication system (ProtoCall).

Quarterly Performance Results:

Member Service Line	Optum Idaho Standards	IBHP Contract Standards	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Total Number of Calls	NA	NA	1,373	1,193	1175	1412
Percent of Calls Answered Within 30 Sec	$\geq 80.0\%$	None	94.3%	93.0%	82.0%	82.0%
Average Speed of Answer	≤ 30 Seconds	120 seconds (2 minutes)	11.2 sec	12.0 sec	18.0 sec	18.5 sec
Abandonment Rate	$\leq 3.5\%$	$\leq 7\%$	1.1%	0.8%	3.4%	3.5%

Analysis: During Q4, the Member Services and Crisis Line received a total of 1,412 calls. During Q4, 82.0% of calls were answered within 30 seconds (goal $\geq 80\%$). The average speed to answer was met at 18.5 seconds (goal ≤ 30 seconds). The call abandoned rate was 3.5% which met both the Optum Idaho Standards goal of $\leq 3.5\%$ and the IBHP Contractual Standards goal of $\leq 7.0\%$. Optum Idaho will continue to monitor and identify trends.





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

Opportunities and Interventions: No opportunities for improvement were identified

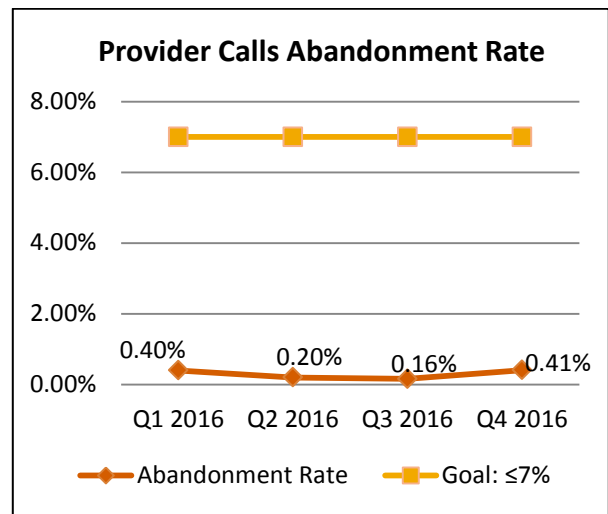
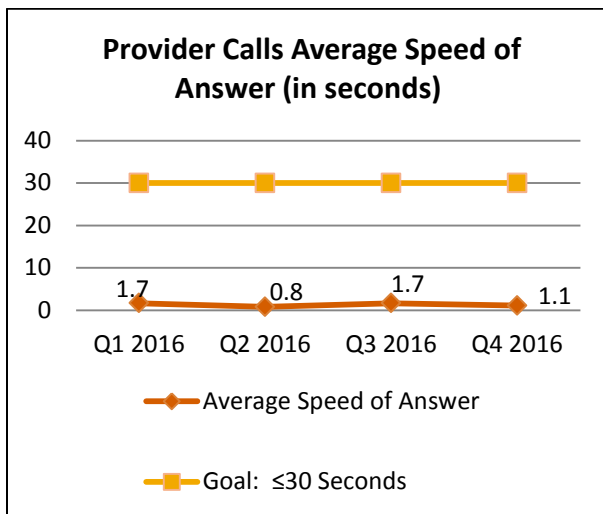
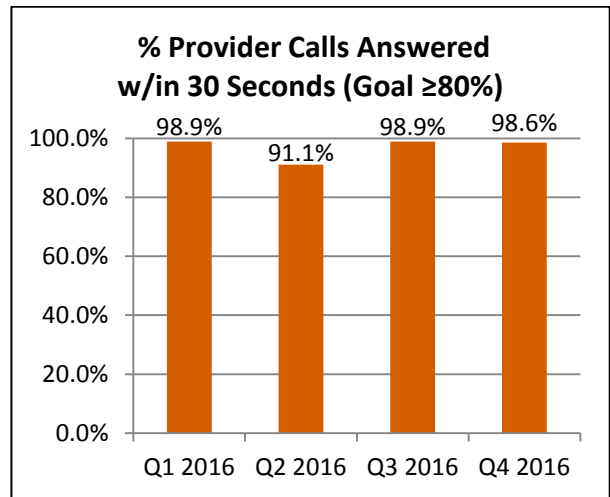
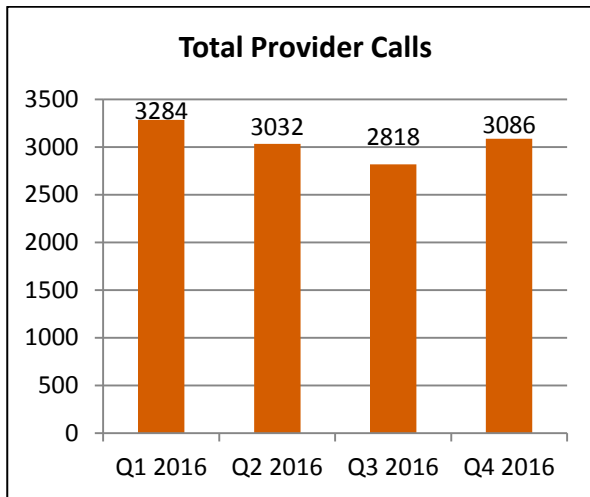
Customer Service (Provider Calls) Standards

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

Quarterly Performance Results:

Customer Service Line (Provider Calls)	Optum Idaho Standards	IBHP Contract Standards	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Total Number of Calls	NA	NA	3,284	3,032	2818	3086
Percent of Calls Answered Within 30 Seconds	≥80.0%	None	98.9%	91.1%	98.9%	98.6%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	1.7 sec	0.8 sec	1.7 sec	1.1 sec
Abandonment Rate	≤3.5%	≤7%	0.40%	0.20%	0.16%	0.41%

Analysis: The total number of Customer Service provider calls during Q4 was 3,086. Customer service call standards met performance goals for all three customer service line measures again during Q4. The percent of calls answered within 30 seconds was at 98.6%, remaining above the goal of ≥80%. The average speed of answer was at 1.1 seconds during Q4, again meeting the goal of ≤30 seconds. The call abandonment rate was 0.41% continuing to meet both the Optum Idaho internal goal of ≤3.5% and the IBHP Contract Standard of ≤7%.



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

Opportunities and Interventions: No opportunities for improvement were identified

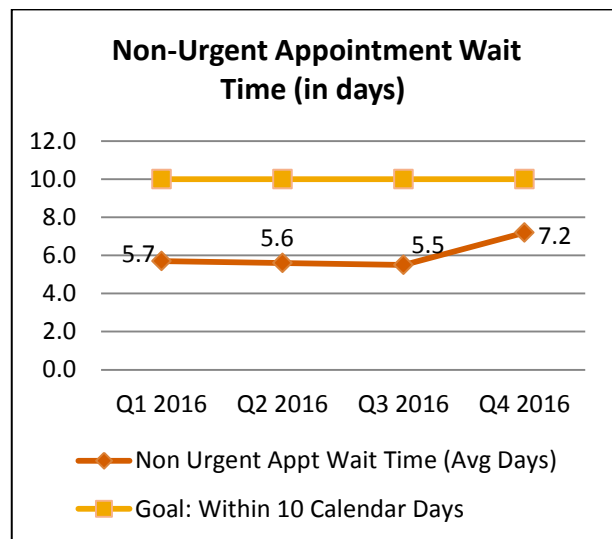
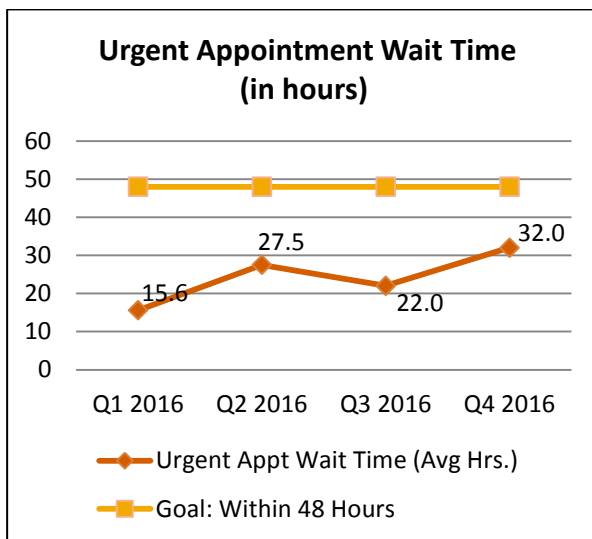
Urgent and Non-Urgent Access Standards

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

Quarterly Performance Results:

Urgent/Non-Urgent Appointment Wait Time	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Urgent Appointment Wait Time	Within 48 hours from request	15.6 hours	27.5 hours	22.0 hours	32.0 hours
Non-Urgent Appointment Wait Time	Within 10 days from request	5.7 days	5.6 days	5.5 days	7.2 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. During Q4, the Urgent Appointment Wait time was 32 hours. The performance goal for non-urgent appointment wait time is an appointment within 10 days. This goal was again met during Q4 at 7.2 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 in 45 miles.

Quarterly Performance Results:

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

Analysis: Optum Idaho continued to meet contract availability standards. During Q4, Area 1 availability standards were met at 99.8% and Area 2 availability standards were met at 99.9%. 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

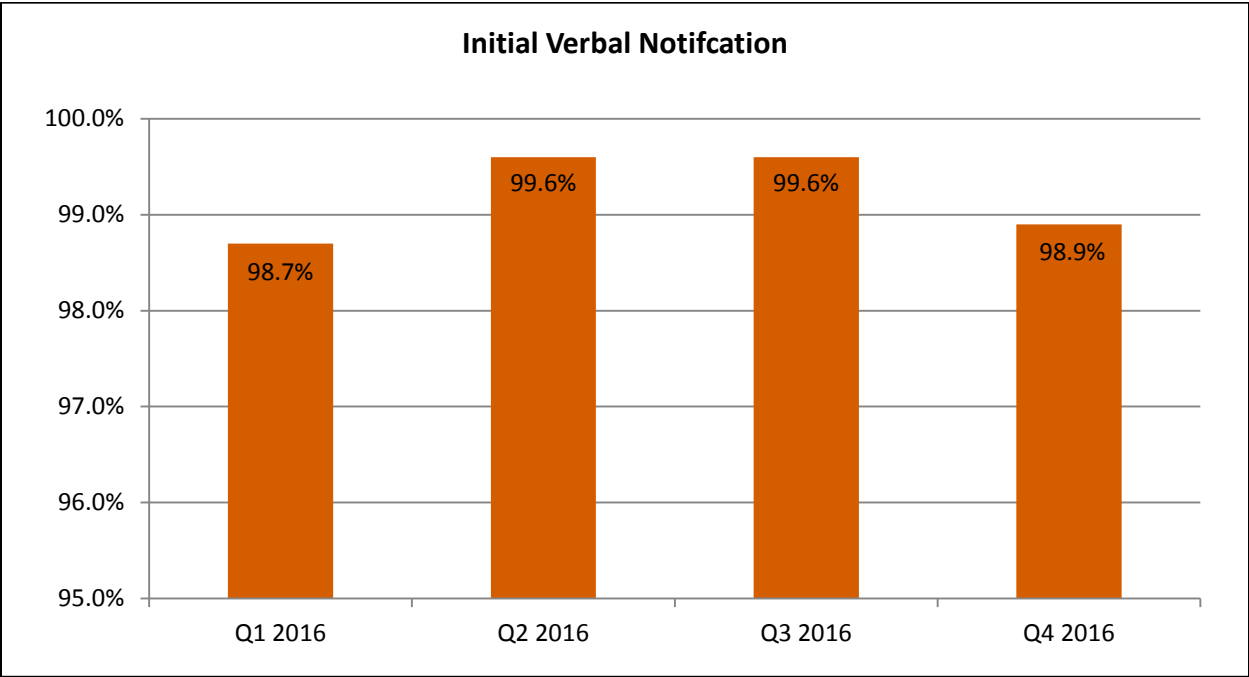
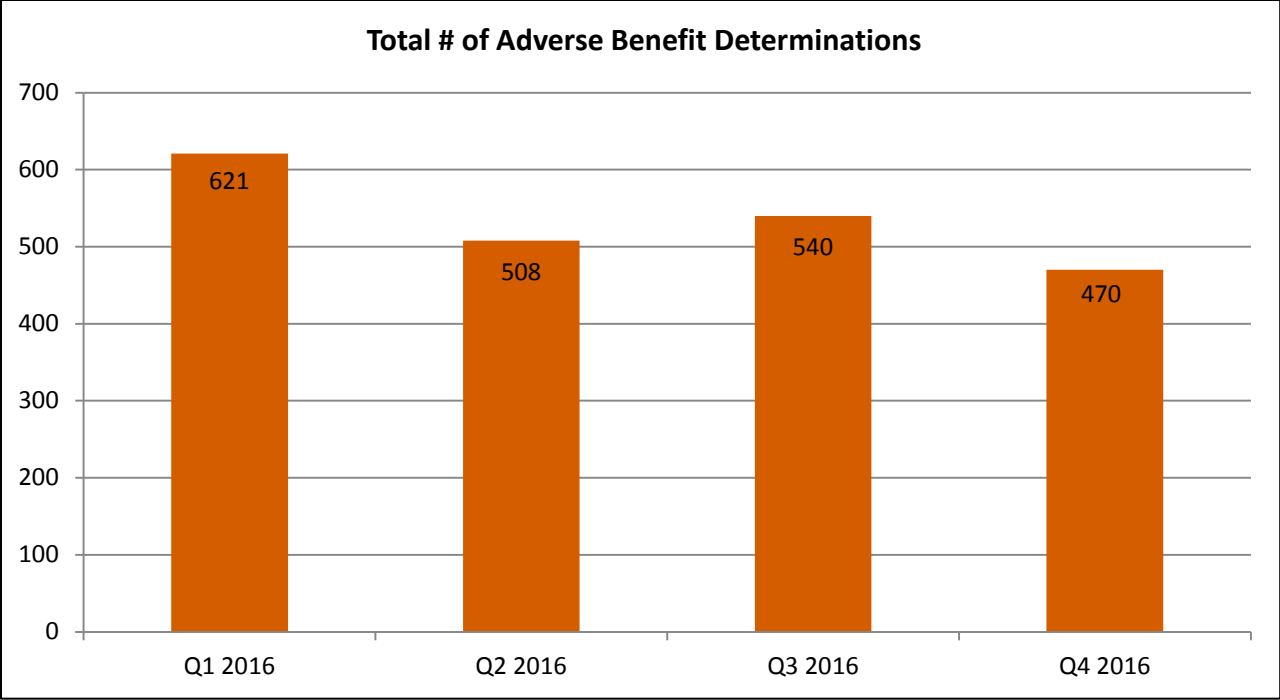
Methodology: Adverse Benefit Determinations (ABD's) are maintained in the Linx database. When a request for services is received, Optum has 14 days to review the case and make a determination to authorize services or deny services in total or in part. Once a determination is made to deny or reduce services, Optum has one (1) day following the verbal notification of the decision to mail a written notice informing the member and provider of the denial.

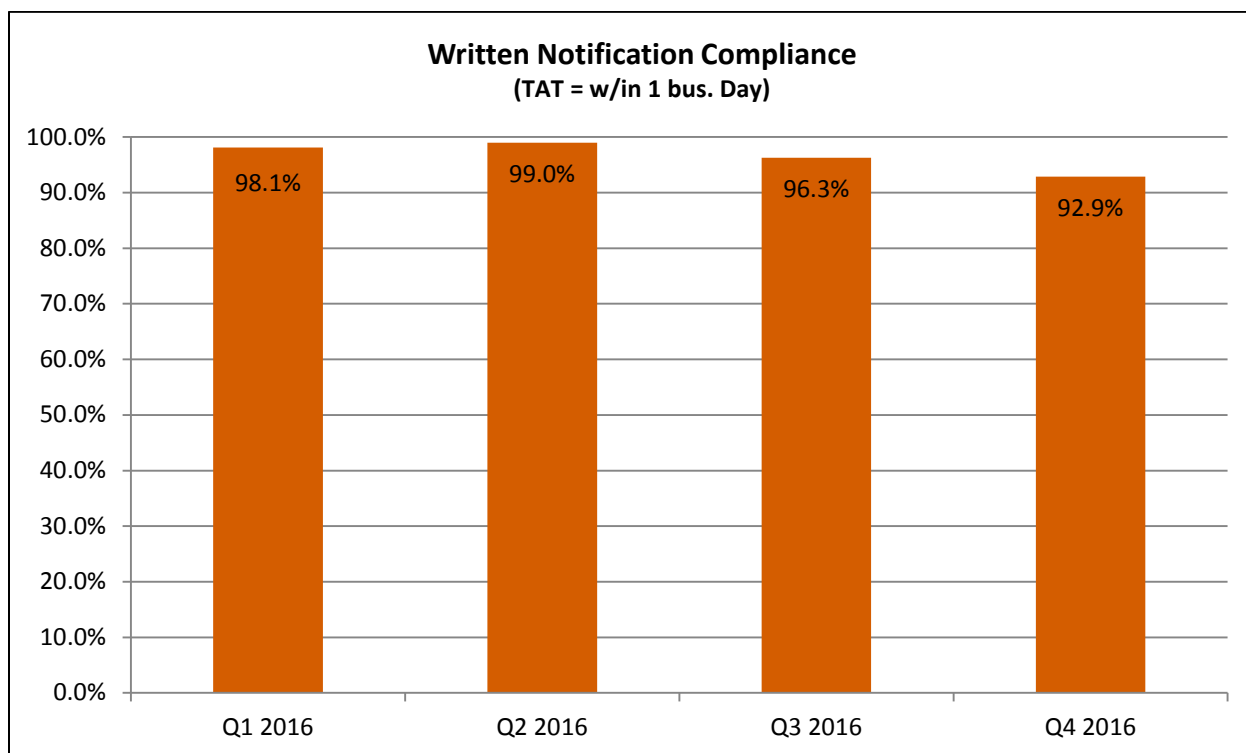
Quarterly Performance Results:

Notification of ABD	Performance Goal	Target	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Total # ABD's	NA	NA	621	508	540	470
Initial Verbal Notification to Provider	1 business day from determination date	100.0%	98.7%	99.6%	99.6%	98.9%
Written Notification	1 business day from verbal notification	100.0%	98.1% (609/621)	99.0% (503/508)	96.3% (520/540)	92.9% (437/470)

Analysis: During Q4, there were 470 ABDs. Verbal notification compliance was 98.9%, with 5 verbal notifications out of compliance. Written notification compliance dropped to 92.9%, with 33 written notifications out of compliance.

The noncompliant written notifications were late by an average of 3.21 calendar days. 23 of the noncompliant written notifications were late by one (1) day. Notably, 23 of the 33 noncompliant written notifications were still sent within 14 days of receipt of the service request.





Barriers: The ABD process involves three different teams - the Optum Idaho Medical Directors conducting the peer reviews, the Clinical team processing those reviews, and the Quality team processing the written notifications. The multiple handoffs between departments create risks for ABDs to fall out of compliance. At the beginning of Q3, the Optum Idaho Medical Directors started doing their own verbal notifications (which were previously conducted by the Clinical team) during the peer review. This was an attempt to streamline the process. While having the Optum Idaho Medical Directors conduct and document the verbal ABD notification streamlined the process, it created another barrier for the written notification turn-around times. Medical Directors were sending in their review a day or two after it was completed. When the Quality team received these late reviews, the written notifications were already out of compliance.

Opportunities and Interventions: There was one Medical Director contributing to a large portion of noncompliant written notifications. This Medical Director has moved on from his duties at Optum Idaho, and thus it's anticipated the 2017 Q1 compliance rates will improve. The Quality team is closely monitoring the ABD process and working with the Optum Idaho Medical Directors to ensure peer reviews are sent to the Quality team the day the review was conducted. Optum Idaho is also currently conducting a LEAN study on the peer review process.

to increase efficiencies and compliance rates. If compliance rates do not increase for 2017 Q1, Optum Idaho will open an Improvement Action Plan for the ABD written notification process.

Grievances

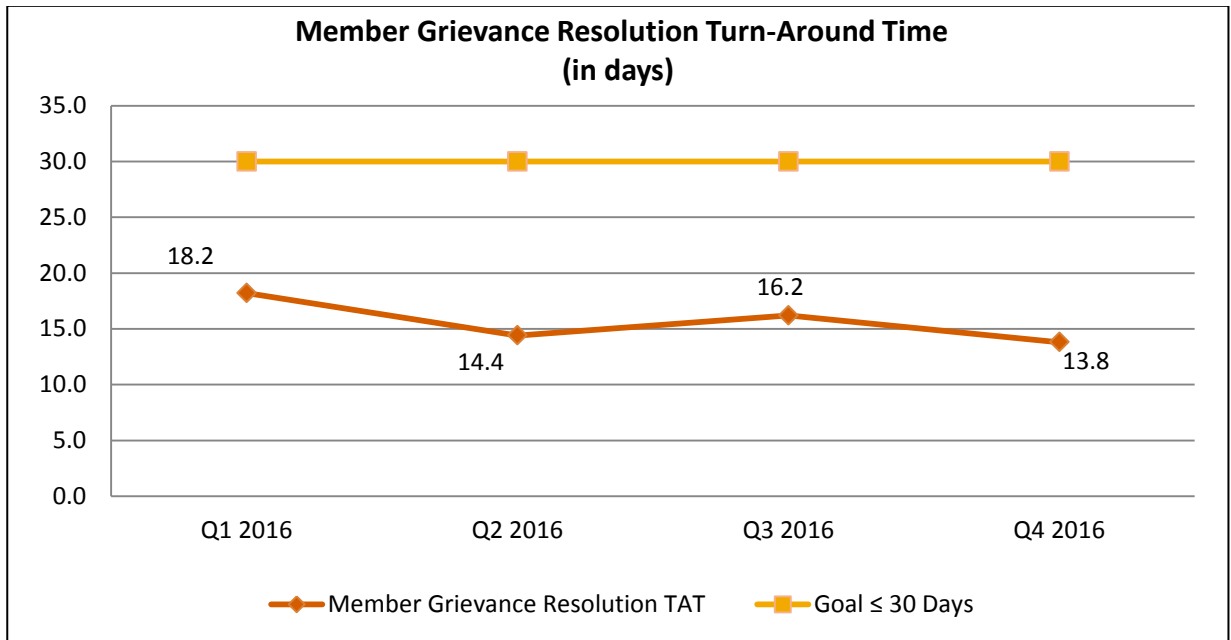
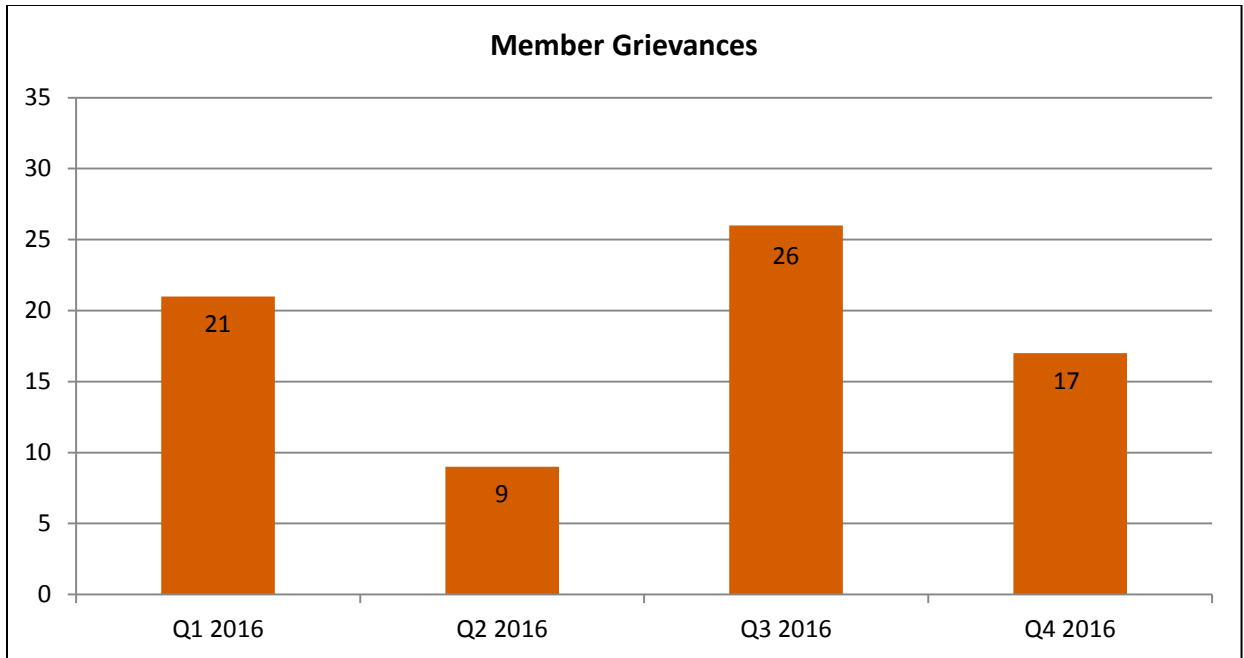
Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an adverse action that resulted in member financial liability or denied service, which is referred to within Optum as filing a grievance. All grievances are required to be reviewed and resolved within 30 days. Grievances are upheld, overturned, or partially overturned.

Quarterly Performance Results:

Grievances	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Number of Member Grievances	NA	21	9	26	17
Average Number of Days to Resolution	30 Days	18.2*	14.4	16.2	13.8
Number of Overturned Grievances	NA	1	0	4	1
Number of Partially Overturned Grievances	NA	0	2	0	2
% of Grievances Overturned or Partially Overturned	NA	4.8%	22.2%	15.4%	17.6%

**due to error in reporting, this was changed from 21 to 18.2.*

Analysis: During Q4 2016, there were 17 Grievances. One (1) grievance was completely overturned, and two (2) were partially overturned. Optum continued to exceed the 30 day turnaround time for resolutions with a 13.8 day average.



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

Opportunities and Interventions: No opportunities for improvement were identified.

Complaint Resolution and Tracking

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

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

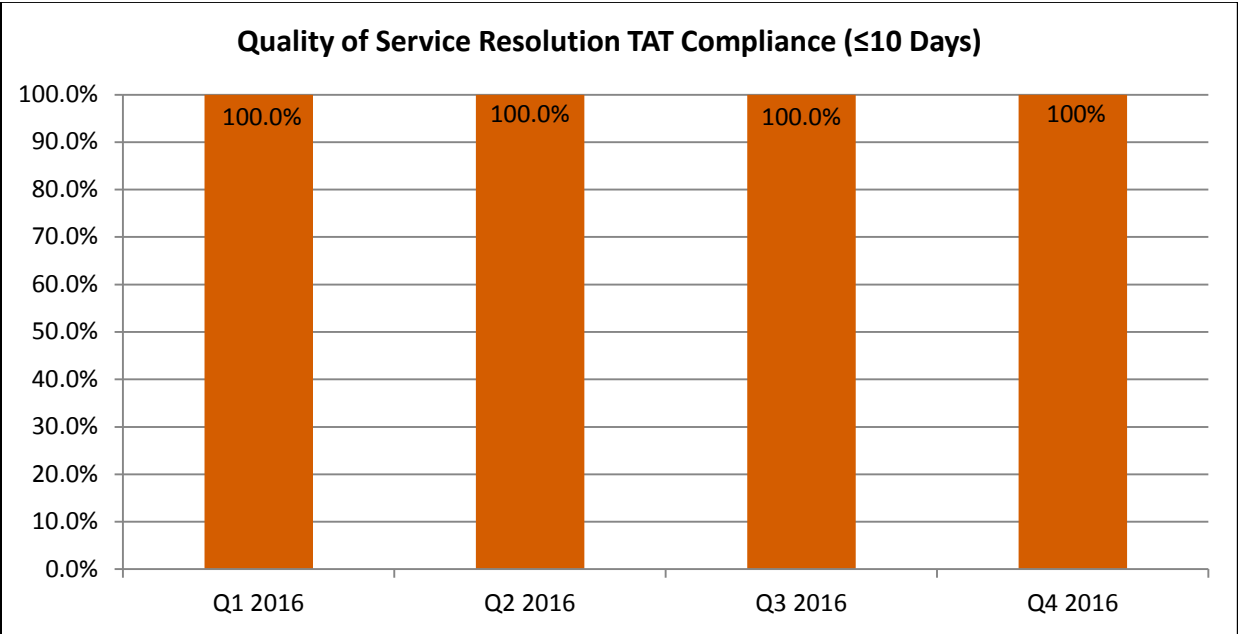
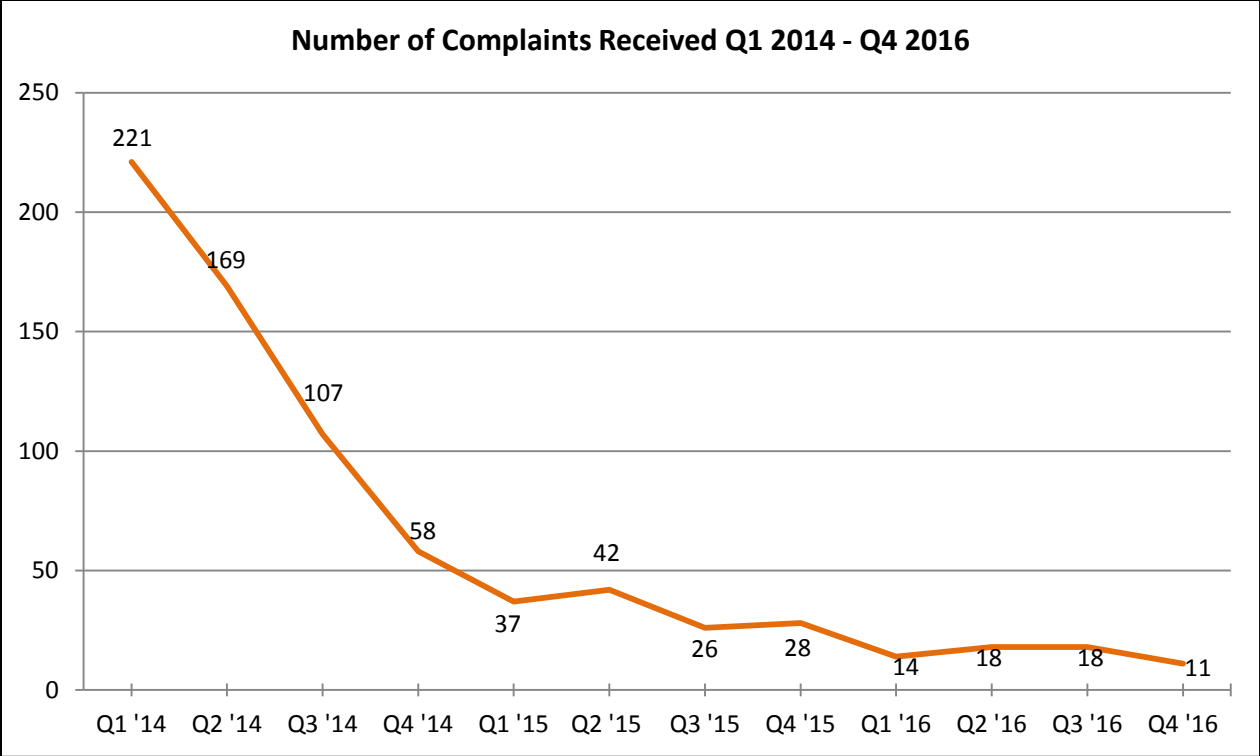
Optum Idaho maintains a process for recording and triaging Quality of Care (QOC) Concerns and Quality of Service (QOS) complaints, to ensure timely response and resolution in a manner that is consistent with contractual and operational standards. The timeframes for acknowledgement and resolution for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

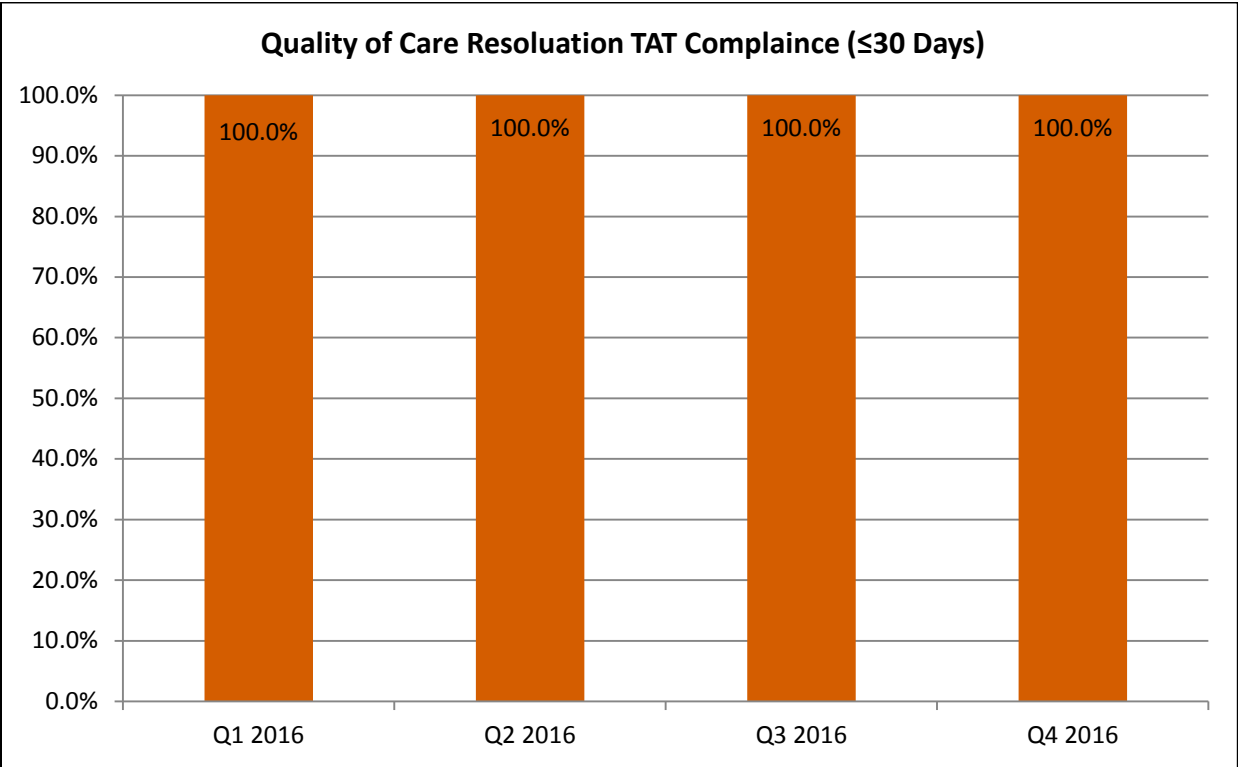
Complaint Resolution and Tracking Timeframes	Acknowledged	Resolved
Quality of Service (QOS) Complaints	5 Business Days	10 Business Days
Quality of Care (QOC) Concerns	5 Business Days	30 Calendar Days

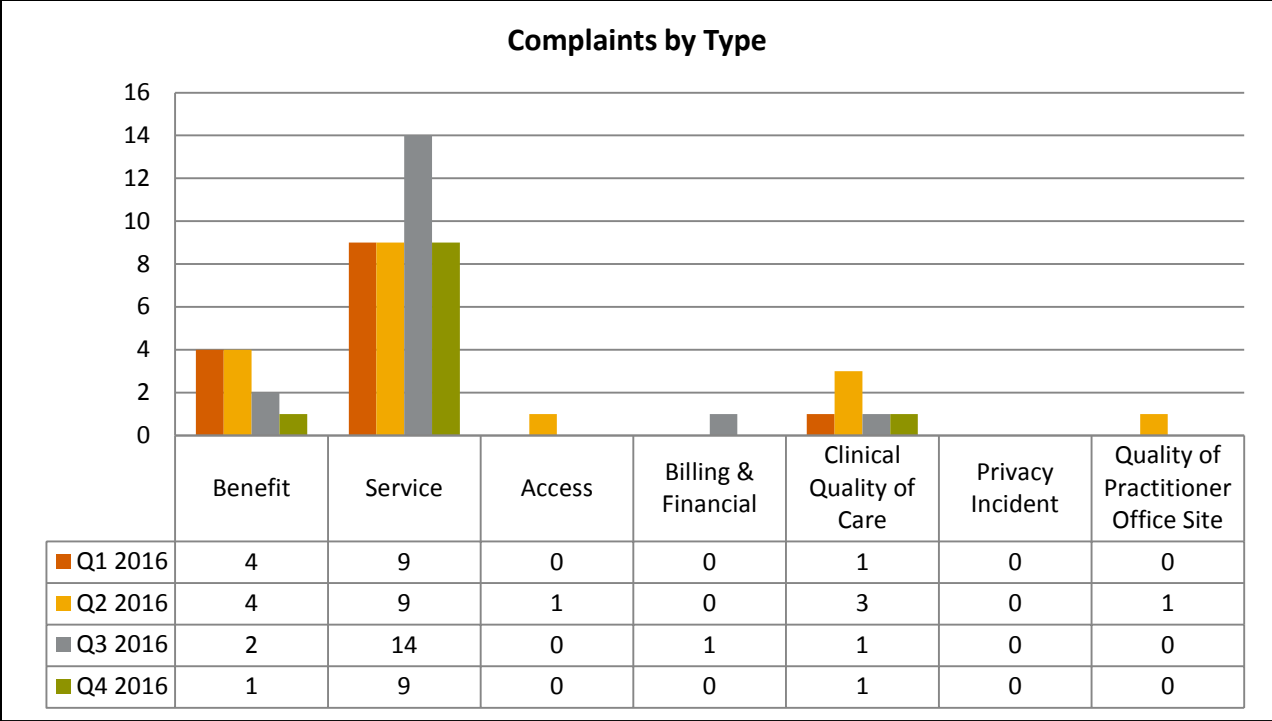
Quarterly Performance Results:

Complaints	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Number of Quality of Service (QOS) Complaints Received	NA	13	15	17	10
Percent QOS Complaints Resolved w/in TAT	10 Days	100.0%	100.0%	100.0%	100.0%
Number of Quality of Care Complaints (QOC) Received	NA	1	3	1	1
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%	100.0%

Analysis: During Q4, there were 11 total complaints. Ten (10) were Quality of Service complaints, and 1 was a Quality of Care concern. Optum Idaho met the resolution turnaround time at 100% for both QOS complaints (10 business days) and QOC concerns (30 days).







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, requiring an overnight admission to a hospital medical unit that occurred while the member was receiving treatment services.
- An unexpected death of a member that occurred while the member was receiving agency based treatment or within 12 months of a member having received MH/SA

treatment.

- A serious injury requiring an overnight admission to a hospital medical unit of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of a serious physical assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a sexual assault **of a member** occurring on an agency's premises while in agency-based treatment.
- A report of a serious physical assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A report of sexual assault **by a member** occurring on an agency's premises while the member was receiving agency-based treatment.
- A homicide that is attributed to a member who was engaged in treatment at any level of care at the time of the homicide, or within the previous 60 calendar days (also defined as a sentinel event).
- A report of an abduction of a member occurring on an agency's premises while the member was receiving agency-based treatment.
- An instance of care ordered or provided for a member by someone impersonating a physician, nurse or other health care professional (also defined as a sentinel event).
- High profile incidents identified by the IDHW as warranting investigation.

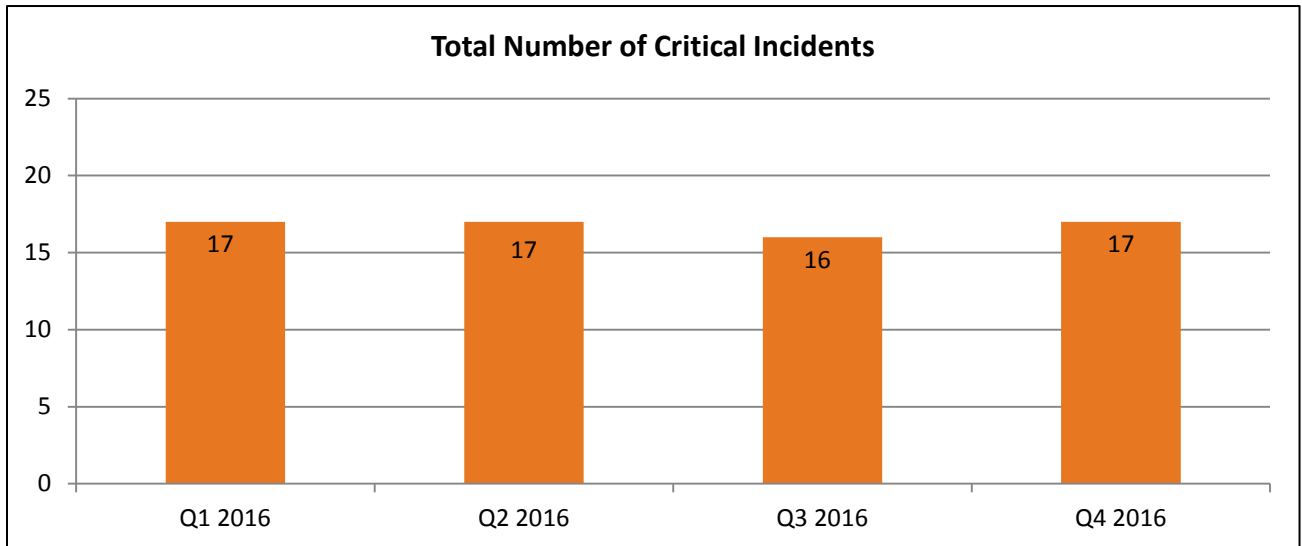
Optum has a Sentinel Events Committee (SEC) to review Critical Incidents that meet Optum's definition of sentinel events. Optum Idaho has a Peer Review Committee (PRC) to review Critical Incidents that do not meet Optum's definition of sentinel event. The SEC and PRC make recommendations for improving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

Quarterly Performance Results:

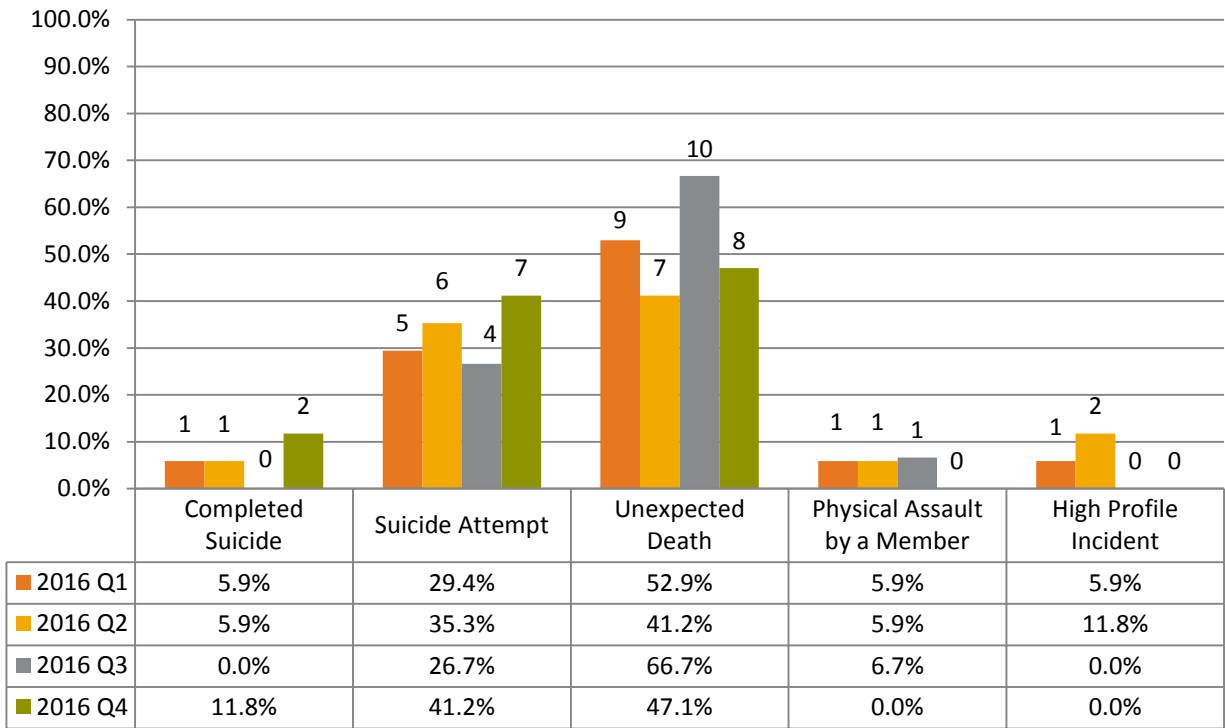
Critical Incidents	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Number of CI's Received	NA	17	17	16	17
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100.0%	100.0%	100.0%	100%

Analysis: There were 17 Critical Incidents reported during Q4. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. Of the 17 Critical Incidents reported, 8 (47.0%) were from unexpected deaths, 7 (41.0%) were from suicide attempts, and 2 (12.0%) were from completed suicides.

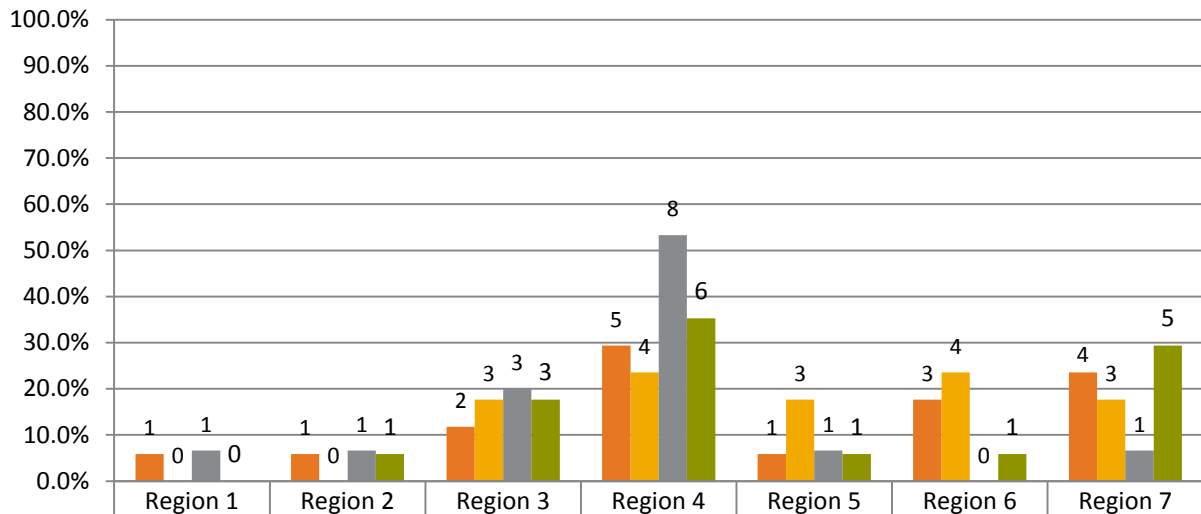
Further analysis showed that during Q4, 35.3% of the Critical Incidents reported occurred in Region 4. And, Coordination of Care between the behavioral health provider and the Primary Care Provider (PCP) occurred in 52.9% of the total cases. Of the 17 reported Critical Incidents, 40.0% of males and 11.8% of females showed that member had a co-morbid health condition. Of the cases reported during Q4, 100.0% were adults (18+). Further analysis showed that the average age for males was 40 and females 42. Of Critical Incidents reported during Q4, 23.5% were males and 76.5% were females. No providers were put on unavailable status due to a Critical Incident.



Quarterly Critical Incident by Type

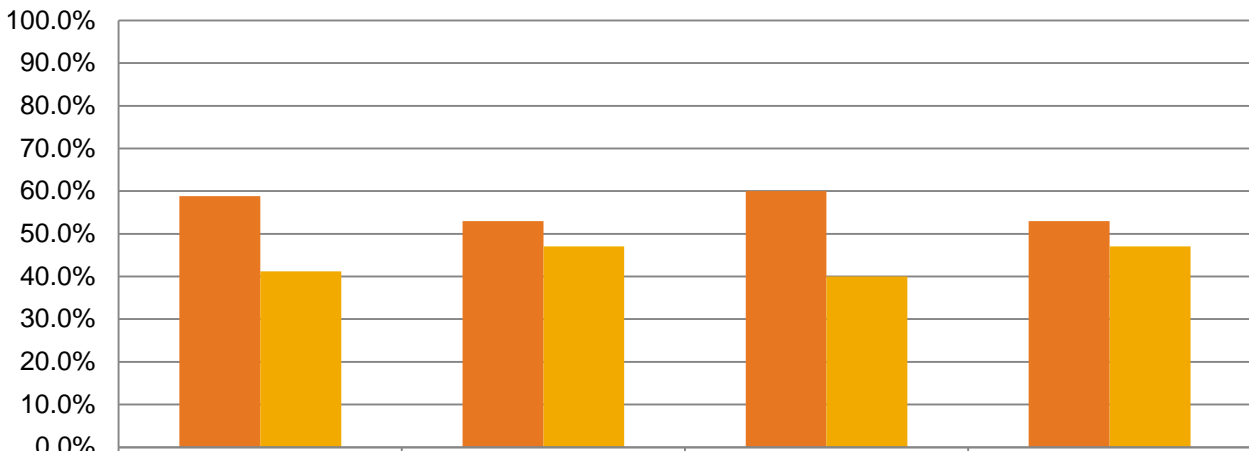


Quarterly Critical Incident by Region



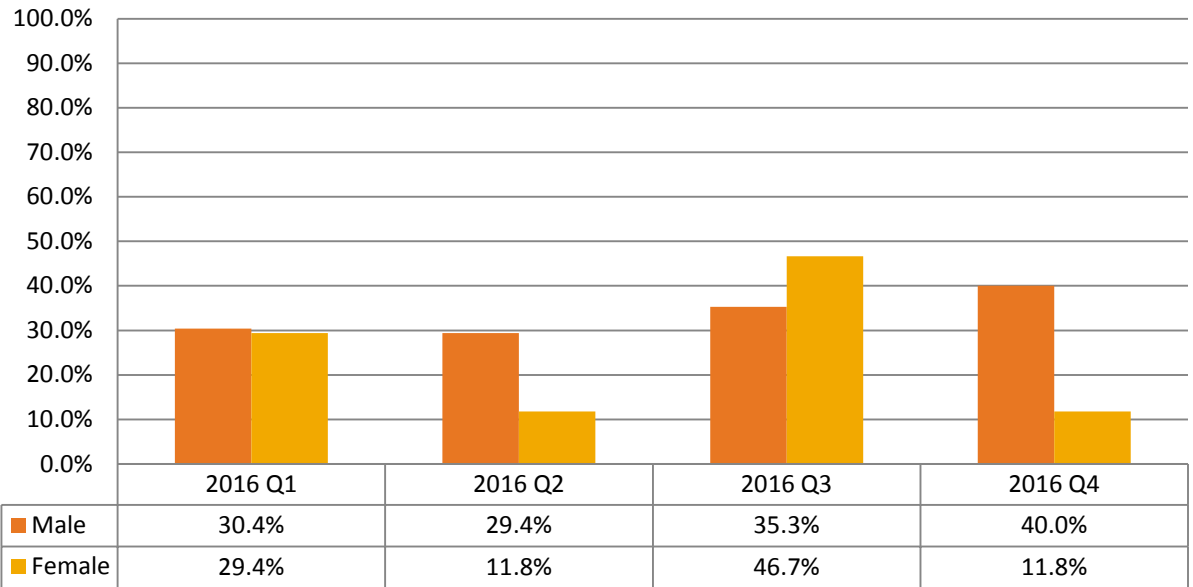
2016 Q1	5.9%	5.9%	11.8%	29.4%	5.9%	17.6%	23.5%
2016 Q2	0.0%	0.0%	17.6%	23.5%	17.6%	23.5%	17.6%
2016 Q3	6.7%	6.7%	20.0%	53.3%	6.7%	0.0%	6.7%
2016 Q4	0.0%	5.9%	17.6%	35.3%	5.9%	5.9%	29.4%

Quarterly Critical Incidents-Coordination of Care Occurred

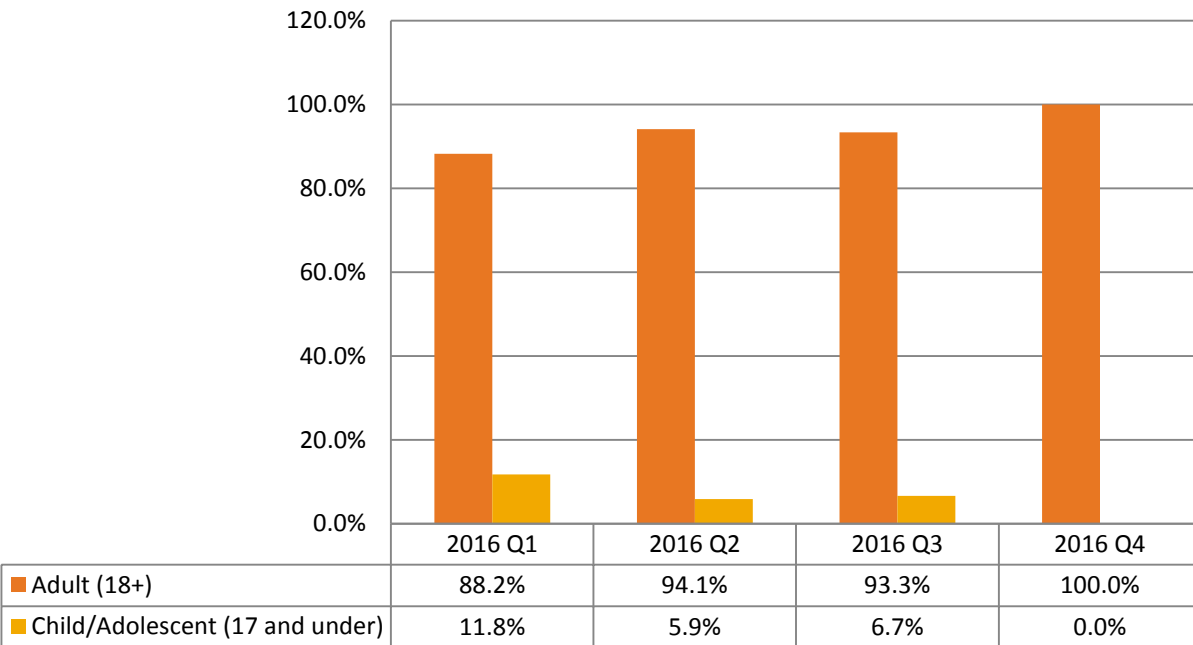


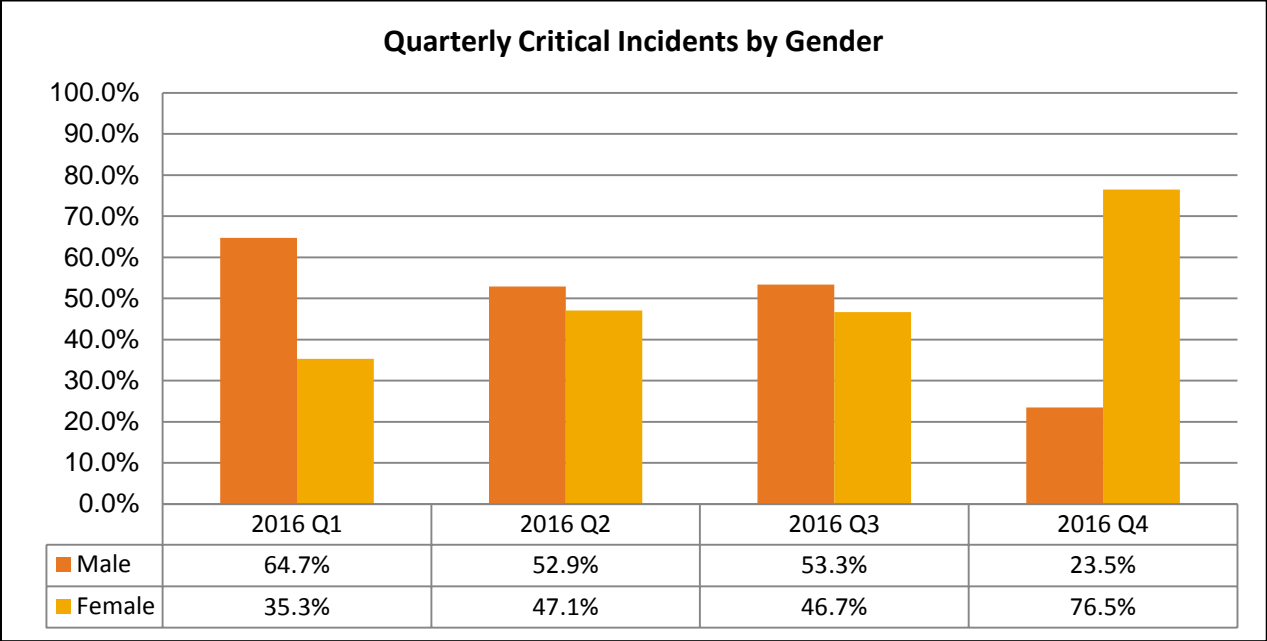
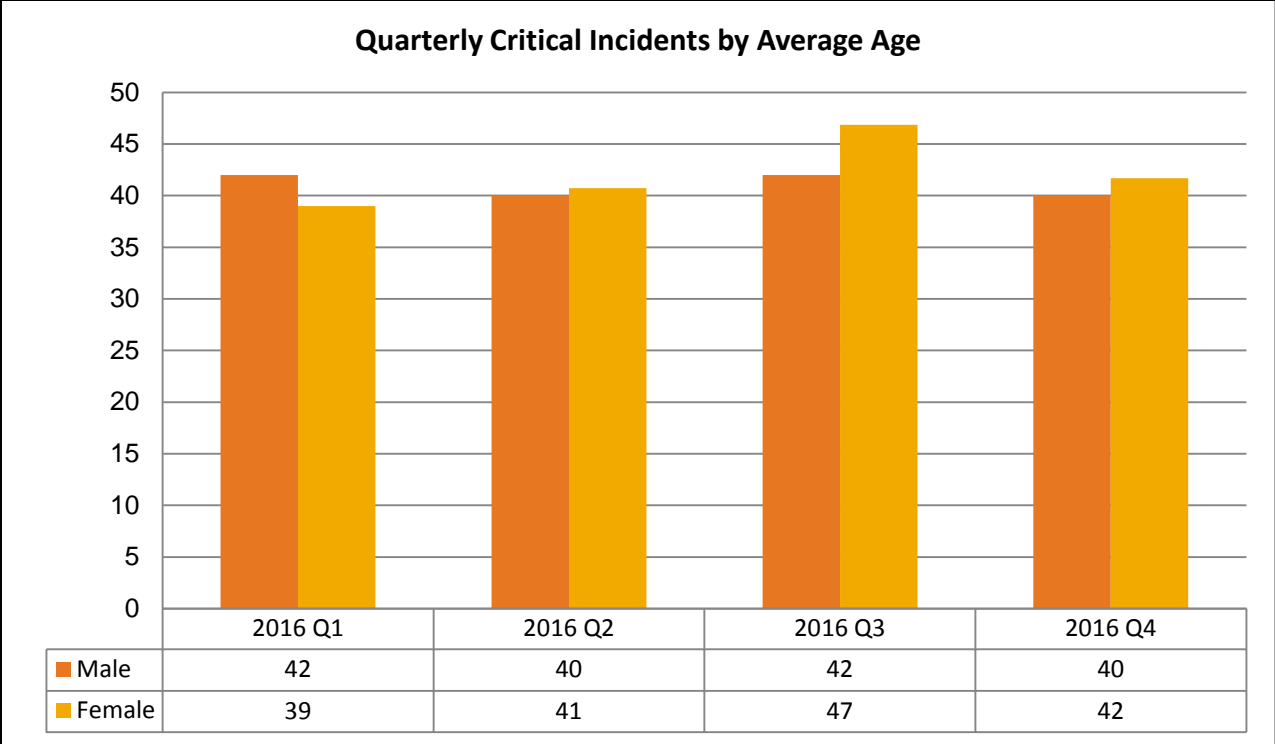
Yes	58.8%	52.9%	60.0%	52.9%
No	41.2%	47.1%	40.0%	47.1%

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



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





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

Opportunities and Interventions: No opportunities for improvement were identified.

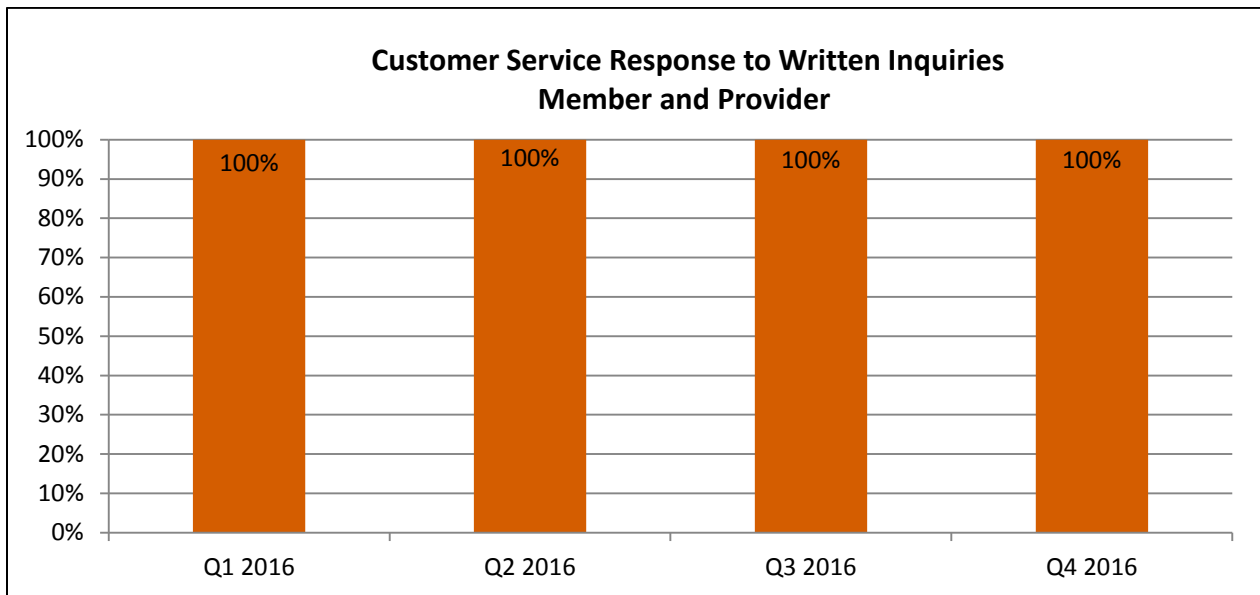
Response to Written Inquiries

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

Quarterly Performance Results:

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

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



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

Opportunities and Interventions: No opportunities for improvement were identified.

Provider Monitoring and Relations

Provider Quality Monitoring

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

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

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

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

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

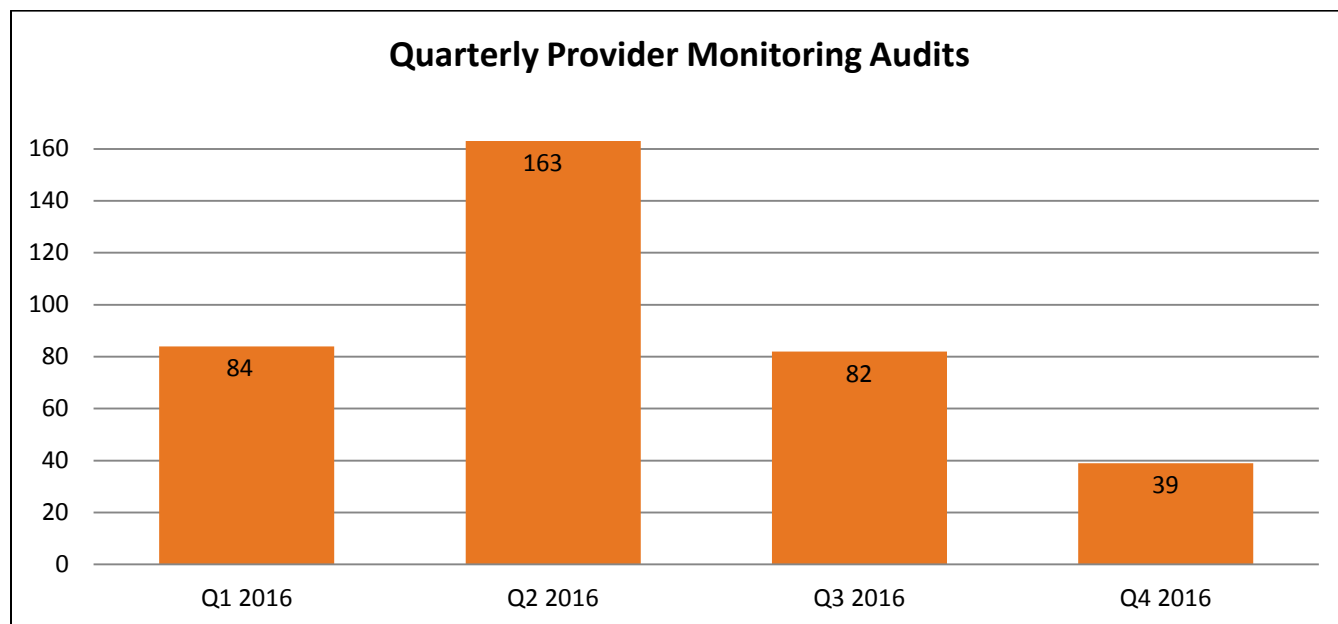
Quarterly Performance Results:

Treatment Record Audit	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Number of Audits Conducted	NA	84	163	82	39
Initial Audit (Average overall score)	85.0%	92.4%	96.3%	98.3%	95.9%
Recredentialing Audit (Average overall score)	85.0%	96.0%	93.4%	92.2%	93.4%
Monitoring (Average overall score)	85.0%	89.3%	58.3%*	NA**	85.0
Quality (Average overall score)	85.0%	92.4%	97.4%	96.5%	NA***
Percent of Audits Requiring a Corrective Action Plan	NA	14.3%	8.6%	7.3%	7.6%

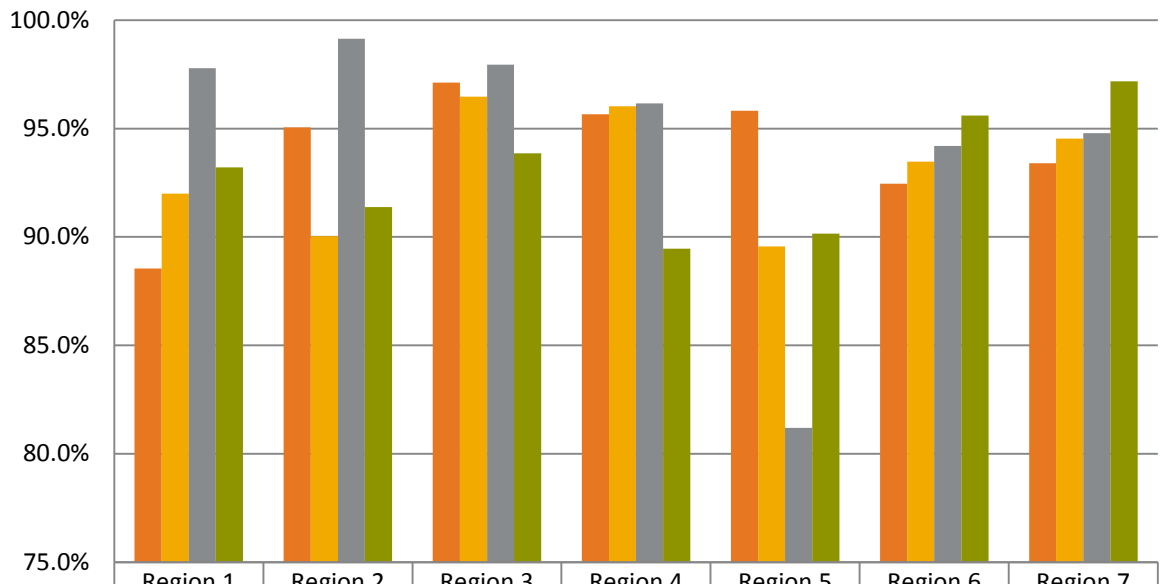
*there was only 1 monitoring audit during Q2. **there were no monitoring audits during Q3. ***there were no quality audits during Q4.

Analysis: During Q4, thirty-nine (39) Provider Monitoring Audits were completed. Of the 39 audits completed, 92.3% received a passing score. Corrective action plans were implemented for 7.6% of the audits. Overall audit scores per region and per audit type are reflected in graphs below.

Also, network providers are given the opportunity to rate the Provider Quality Monitoring Audit process in a Satisfaction Survey. Beginning in Q1, 2016, Optum Idaho began using a new Satisfaction Survey for providers to complete once a monitoring audit is completed. The survey used to gather this information is through the Qualtrics Survey Application which was approved by United Health Group. The survey is sent to providers by email. If an email address is not on file, the provider will not receive the survey. Surveys are emailed every other week to providers who were audited within the previous 2 weeks. Providers have 4 weeks to complete and return the survey. The results at the end of Q4 showed that 8 responses were received. Of those responses, 62.5% of providers stated that the overall value of the audit process was excellent, followed by 25.0% who stated it was very good. There were 12.5% of respondents that stated that the process was fair. Seventy-five percent (75.0%) indicated that the Auditor was excellent. Seventy-five percent (75.0%) of respondents indicated that their overall experience with the audit was excellent.

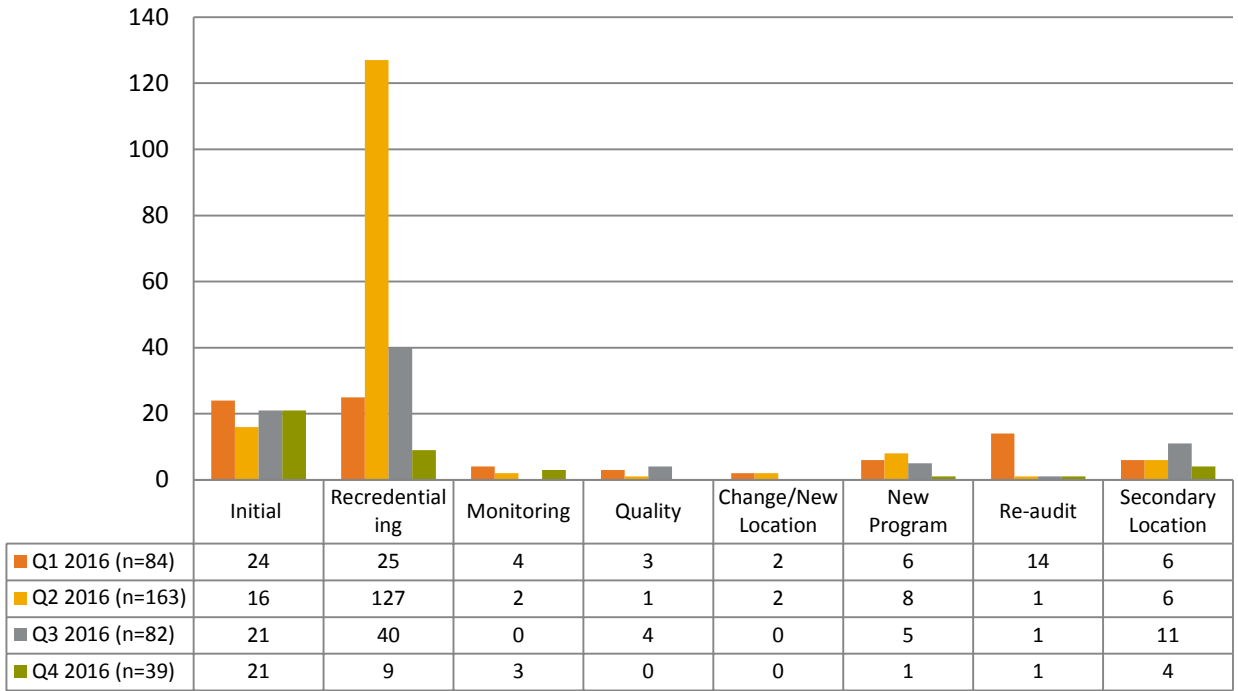


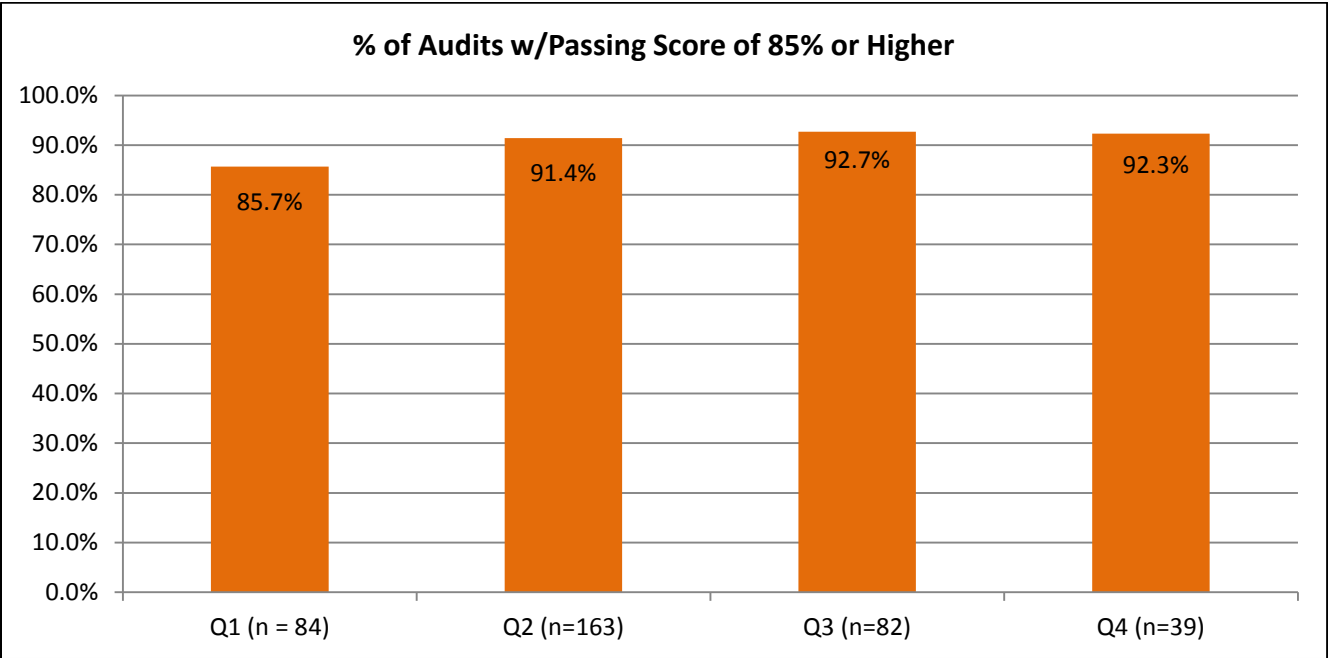
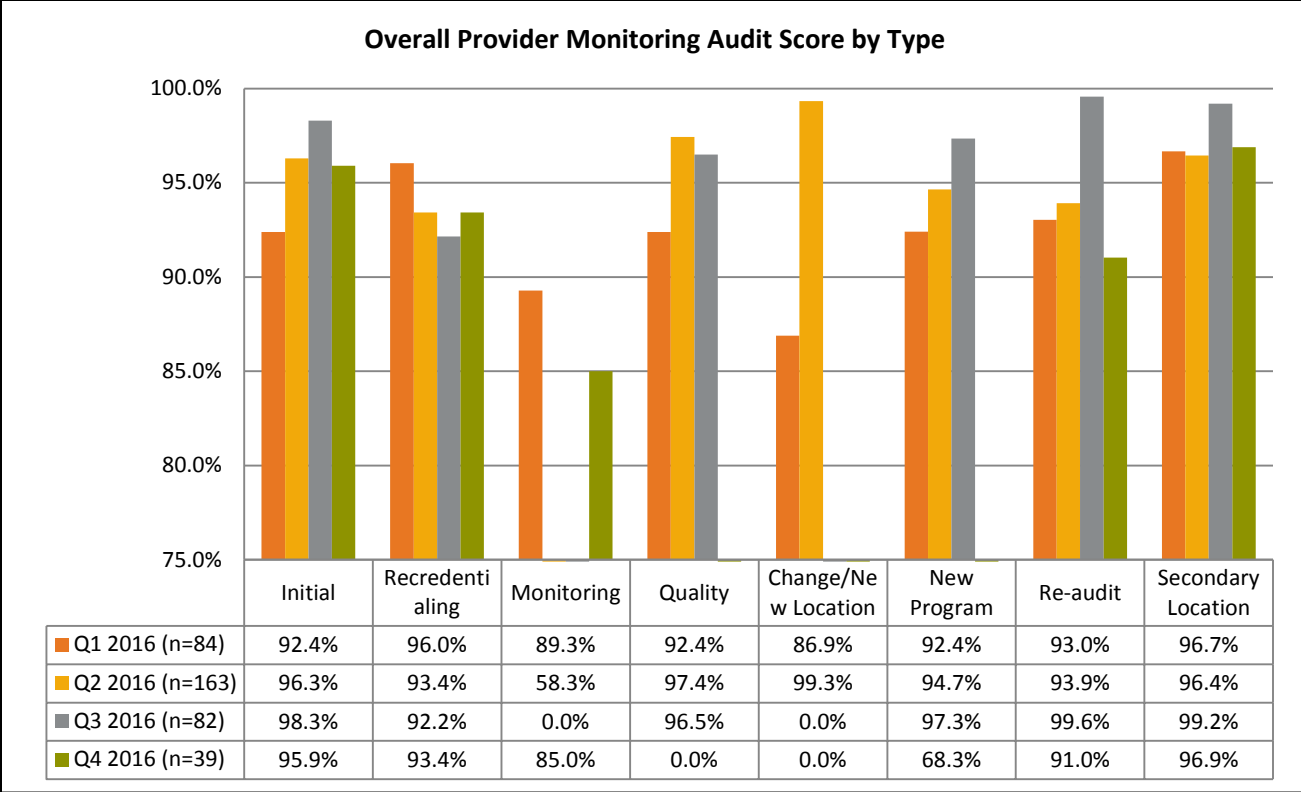
Overall Provider Monitoring Audit Score Per Region

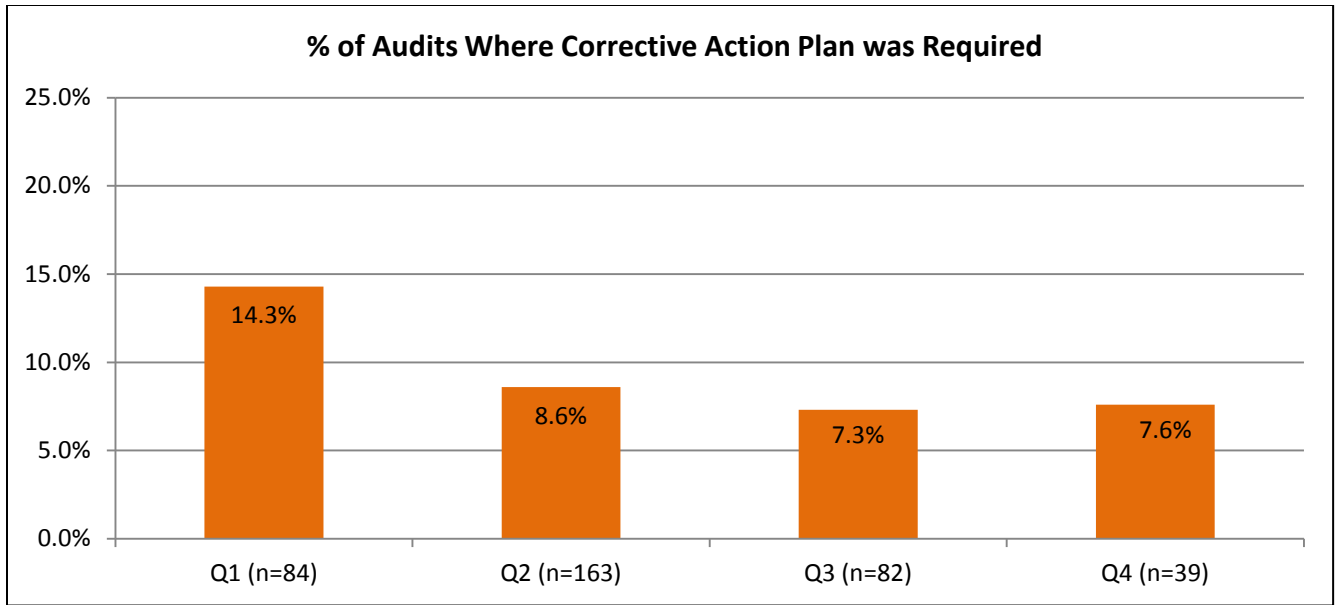


	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Q1 2016 (n=84)	88.5%	95.1%	97.1%	95.7%	95.8%	92.5%	93.4%
Q2 2016 (n=163)	92.0%	90.0%	96.5%	96.0%	89.6%	93.5%	94.5%
Q3 2016 (n=82)	97.8%	99.1%	97.9%	96.2%	81.2%	94.2%	94.8%
Q4 2016 (n=39)	93.2%	91.4%	93.9%	89.5%	90.2%	95.6%	97.2%

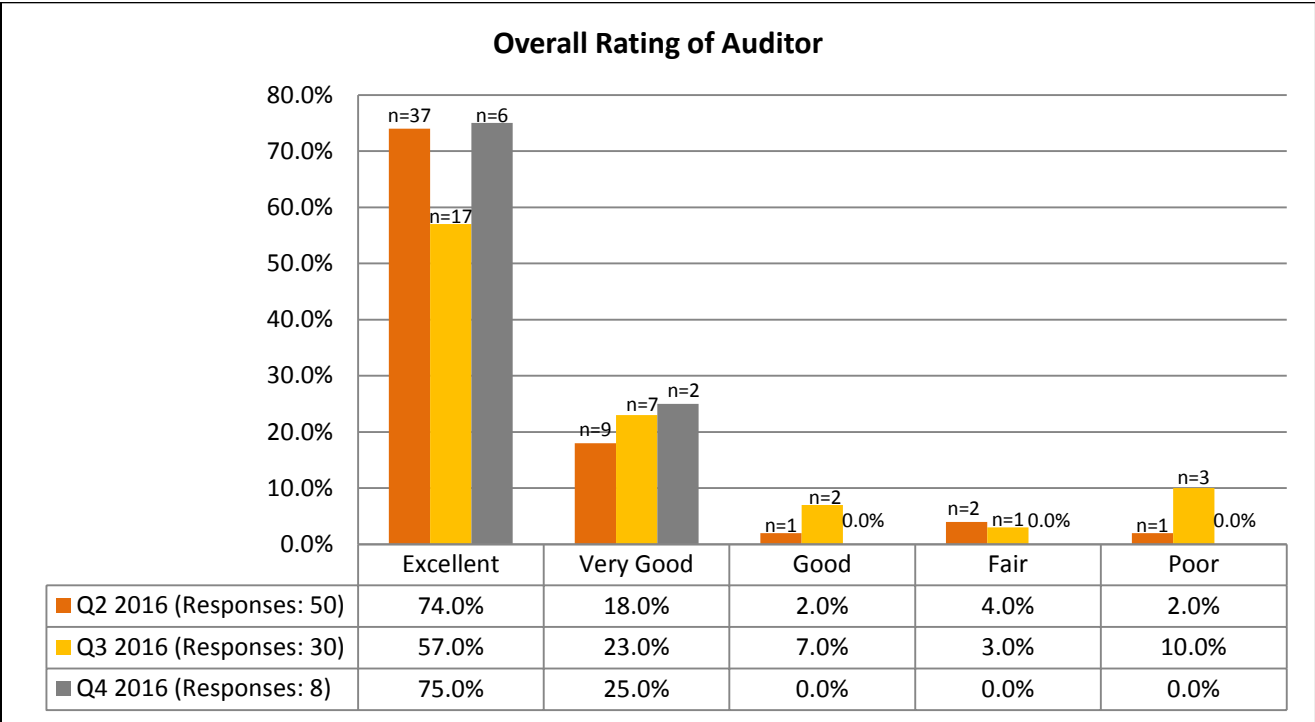
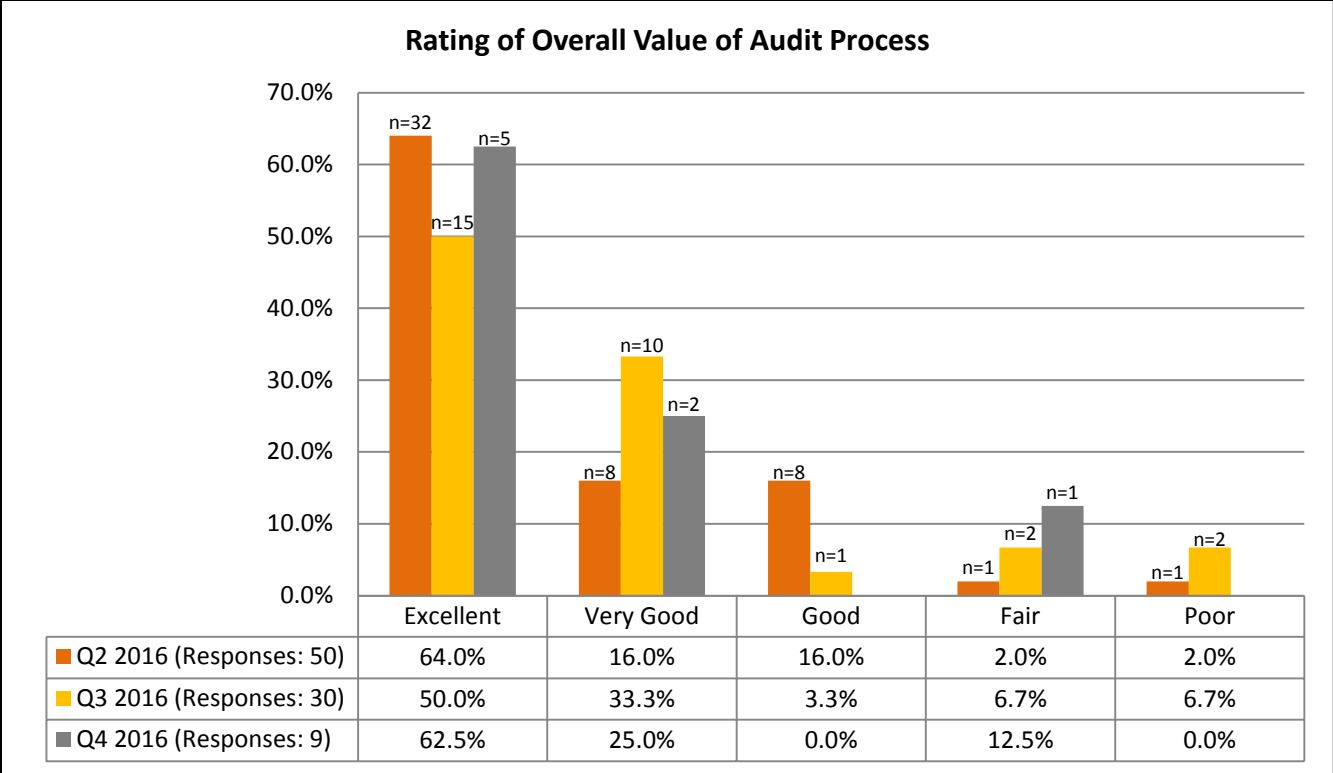
Total Number of Provider Monitoring Audits by Type

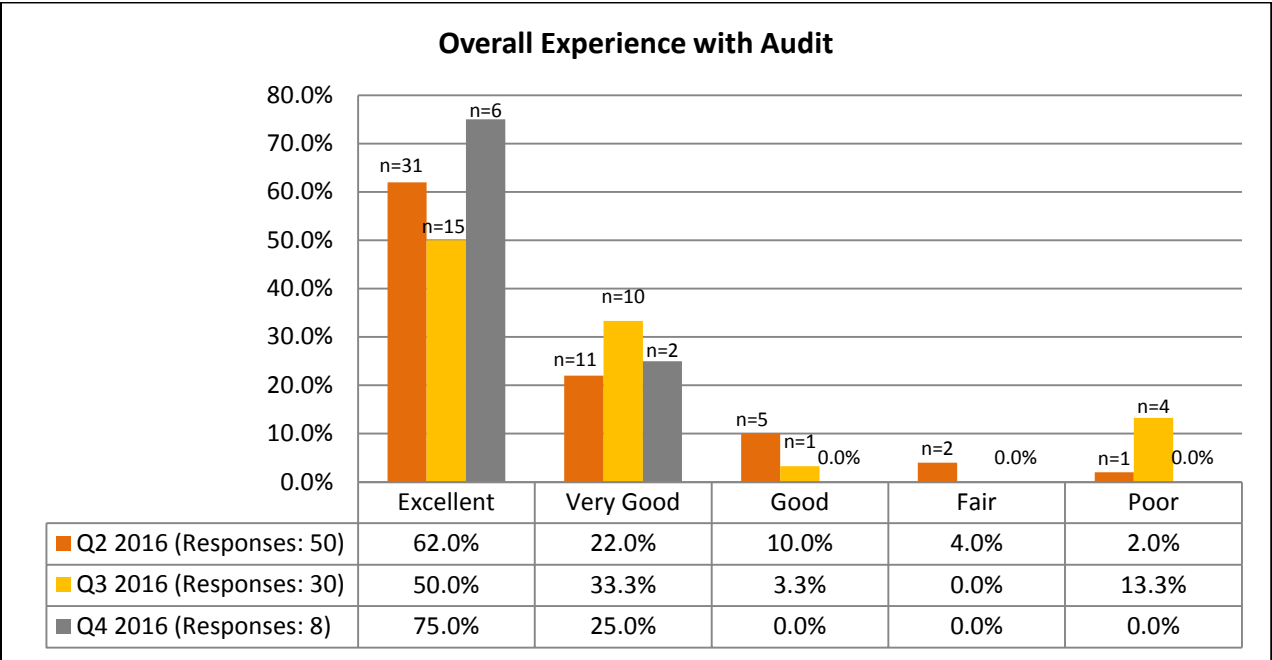






Below are the results of the surveys received back by the end of Q4 that were sent to providers regarding their rating of the Monitoring Audit Process.





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

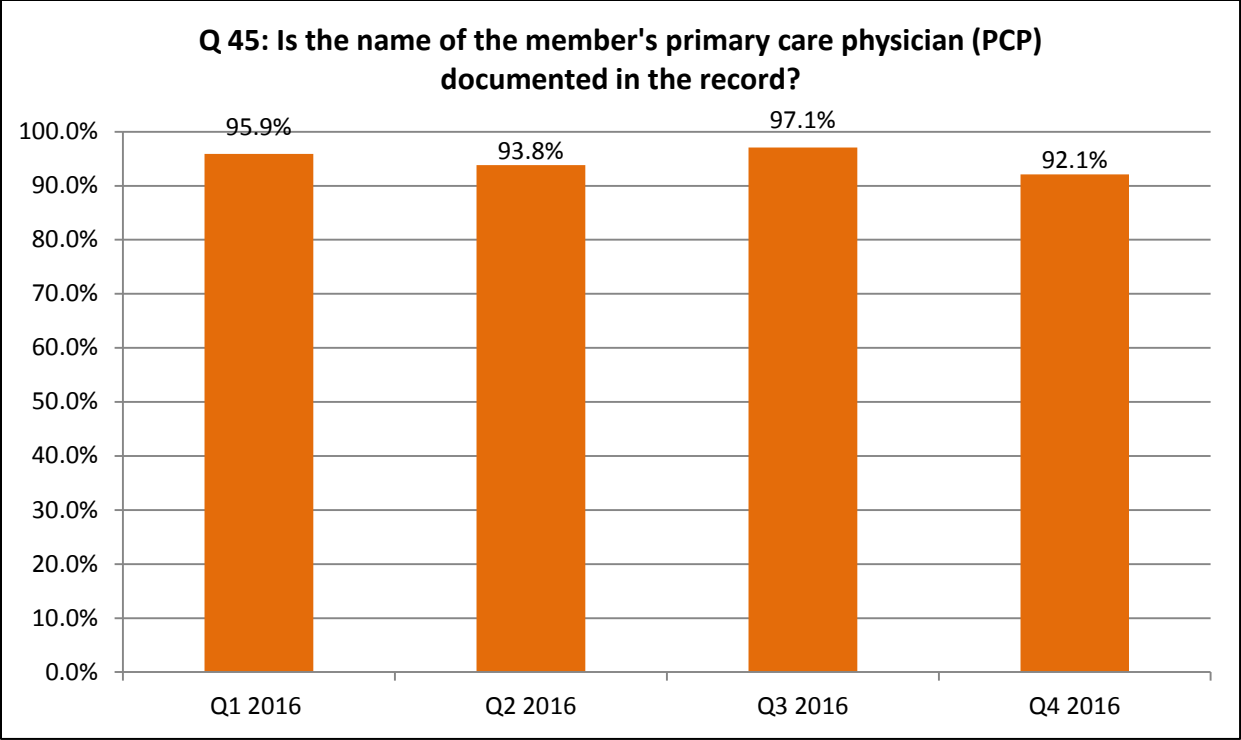
Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expect providers to make a “good faith” effort at communicating with other 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. The results are tabulated in an internal Excel spreadsheet.

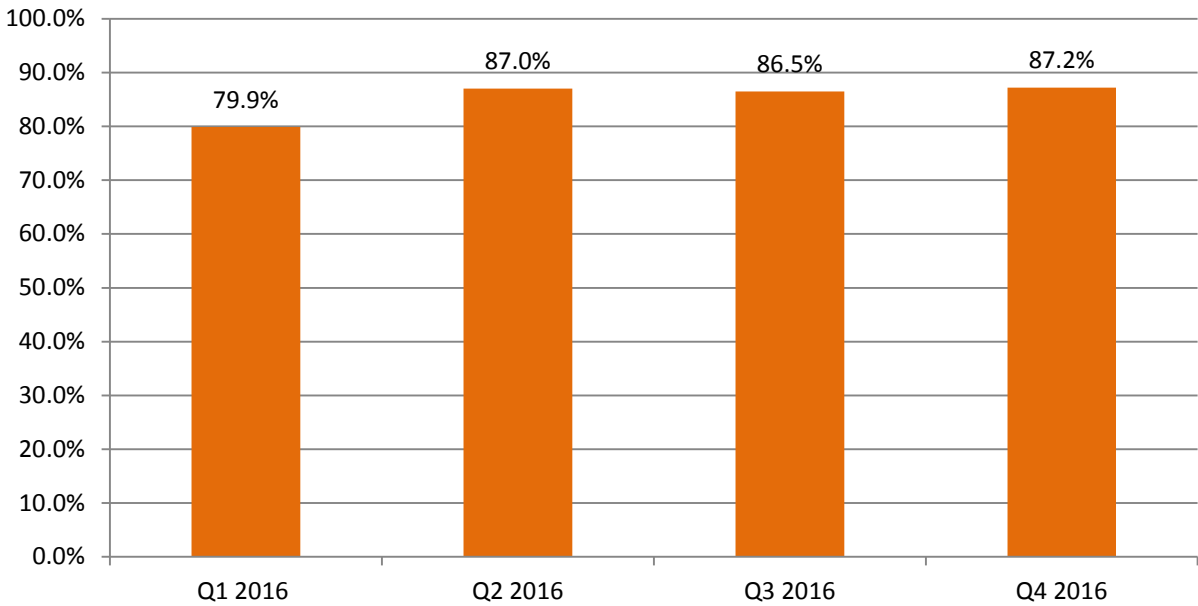
Quarterly Performance Results:

Coordination of Care (% answered in the affirmative)	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Q45: Is the name of the member’s primary care physician (PCP) documented in the record?	NA	95.8%	93.8%	97.1%	92.1%
Q 46: If the Member has a PCP there is documentation that communication/collaboration occurred	NA	79.9%	87.0%	86.5%	87.2%
Q48 Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor) and/or were they seen by another behavioral health clinician in the past? This is a non-scored question.	NA	50.0%	52.7%	58.0%	70.0%
Q49 If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred.	NA	83.1%	89.0%	78.0%	70.0%

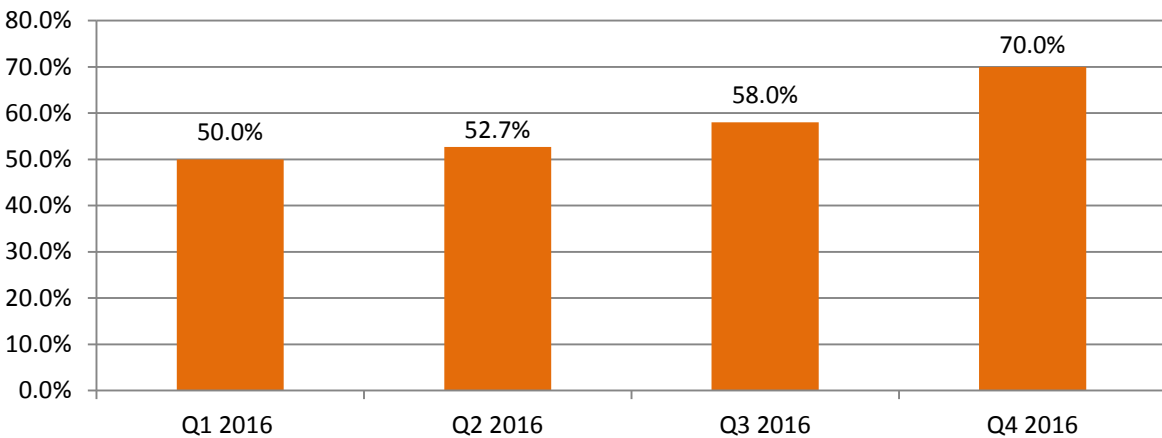
Analysis: Coordination of Care audits completed during Q4 revealed that 92.1% of member records reviewed had documentation of the name of the member’s PCP. Of those, 87.2% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member’s PCP. The results also indicated that that 70.0% of the records indicated that the member was being seen (or had been seen in the past) by another behavioral health clinician (psychiatrist, social worker, psychologist, substance abuse counseling). Of those, 70.0% indicated that communication/collaboration had occurred.

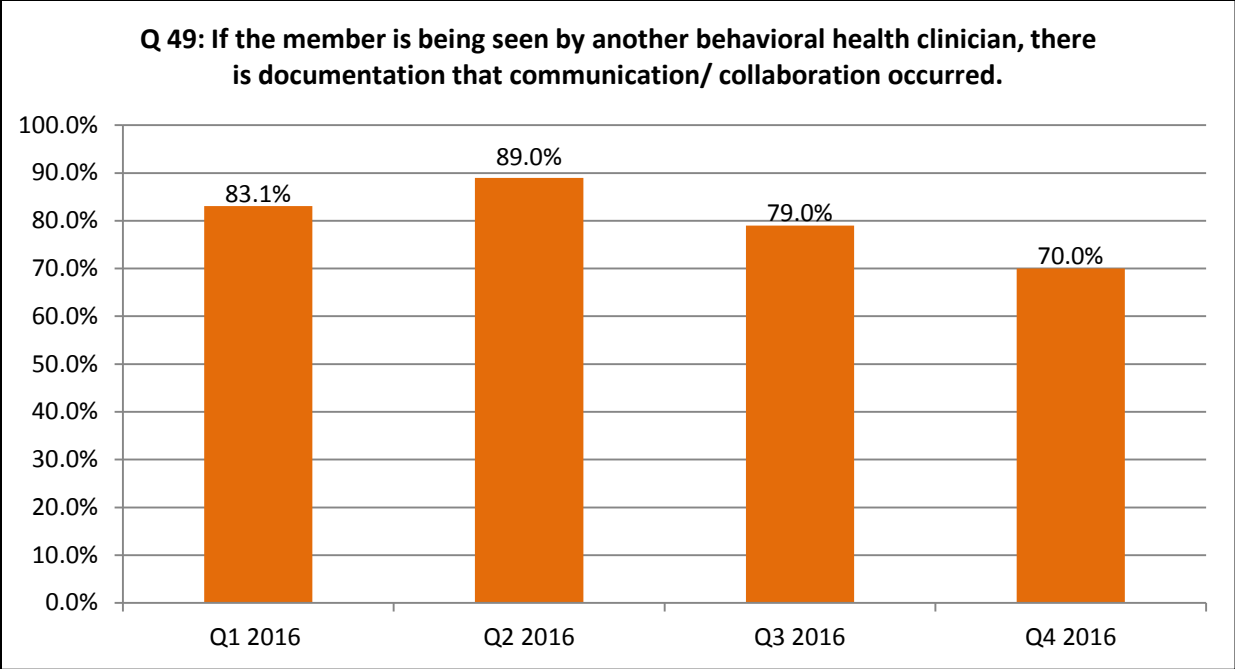


Q 46: If the member has a PCP there is documentation that communication/collaboration occurred.



Q 48: 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? (non-scored question)





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

Opportunities and Interventions: No opportunities for improvement were identified.

Provider Disputes

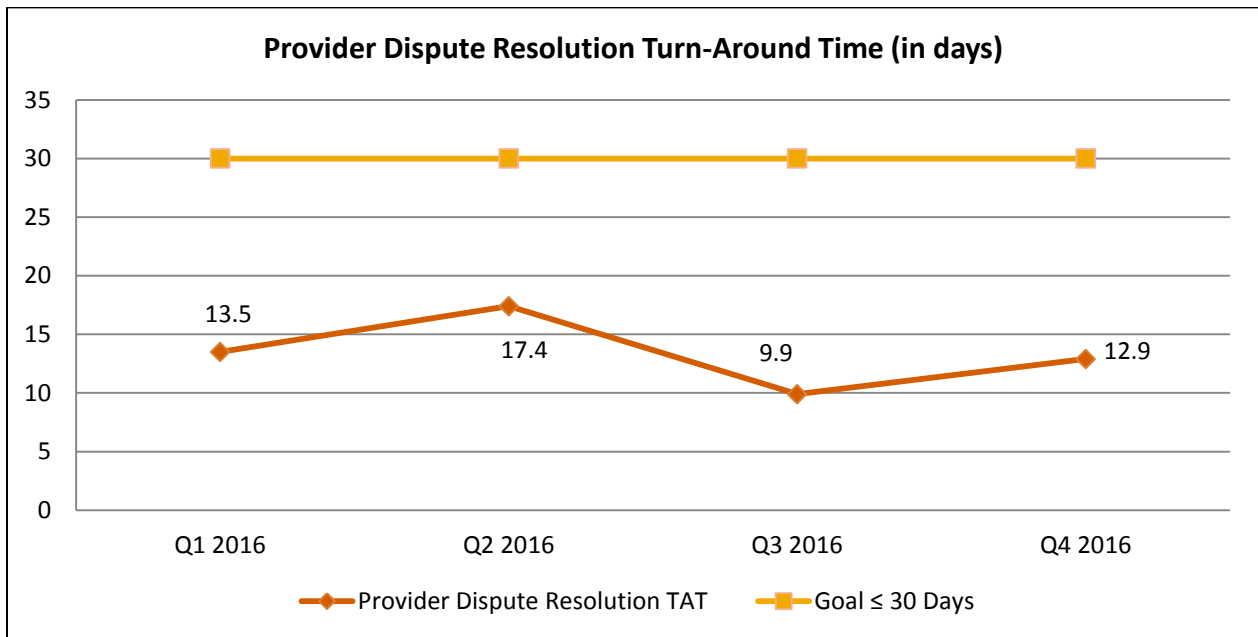
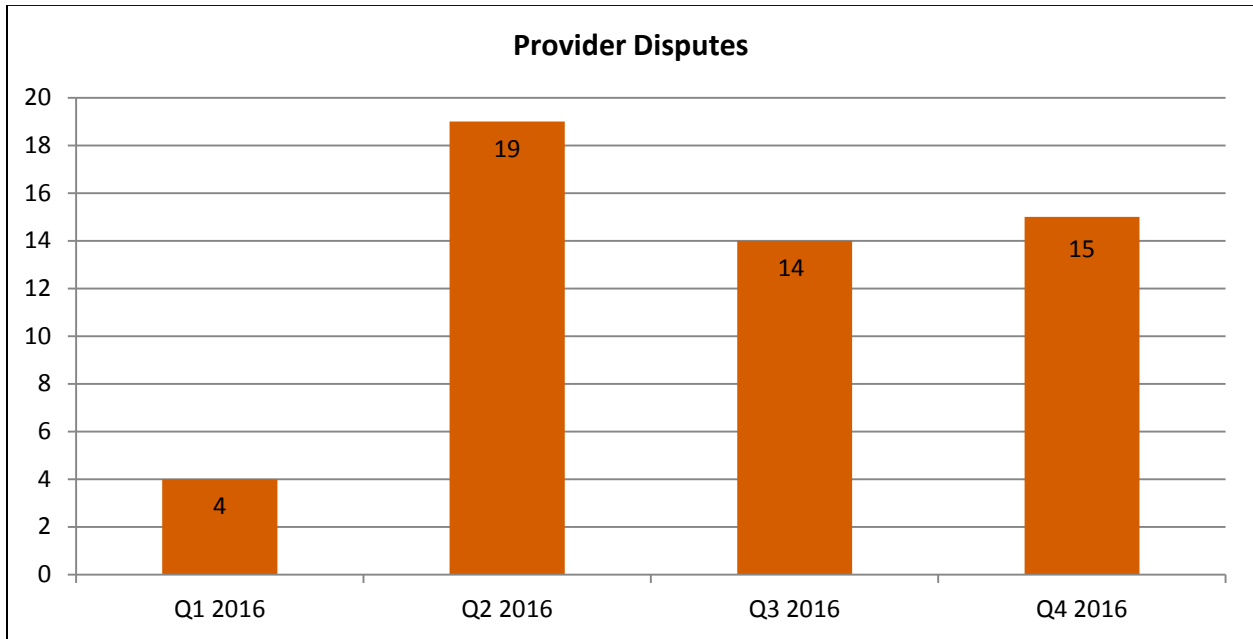
Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination (claims-based denials) when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is believed to have been incorrectly issued. Provider disputes require that a written resolution notice be sent within 30 days following the request for consideration.

Quarterly Performance Results:

Provider Disputes	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Number of Provider Disputes	NA	4	19	14	15
Average # of Days Provider Disputes Resolved	≤30 Days	13.5*	17.4	9.9	12.9
Number of Disputes Overturned	NA	4	16	6	3
% of Disputes Overturned	NA	100.0%	84.2%	42.9%	20.0%

*due to error in reporting, this was changed from 12 to 13.5.

Analysis: During Q4 2016, there were 15 Provider Disputes. Three (3) disputes were overturned. All were resolved within the goal of ≤30 days, with an average resolution time of 12.9 days.



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

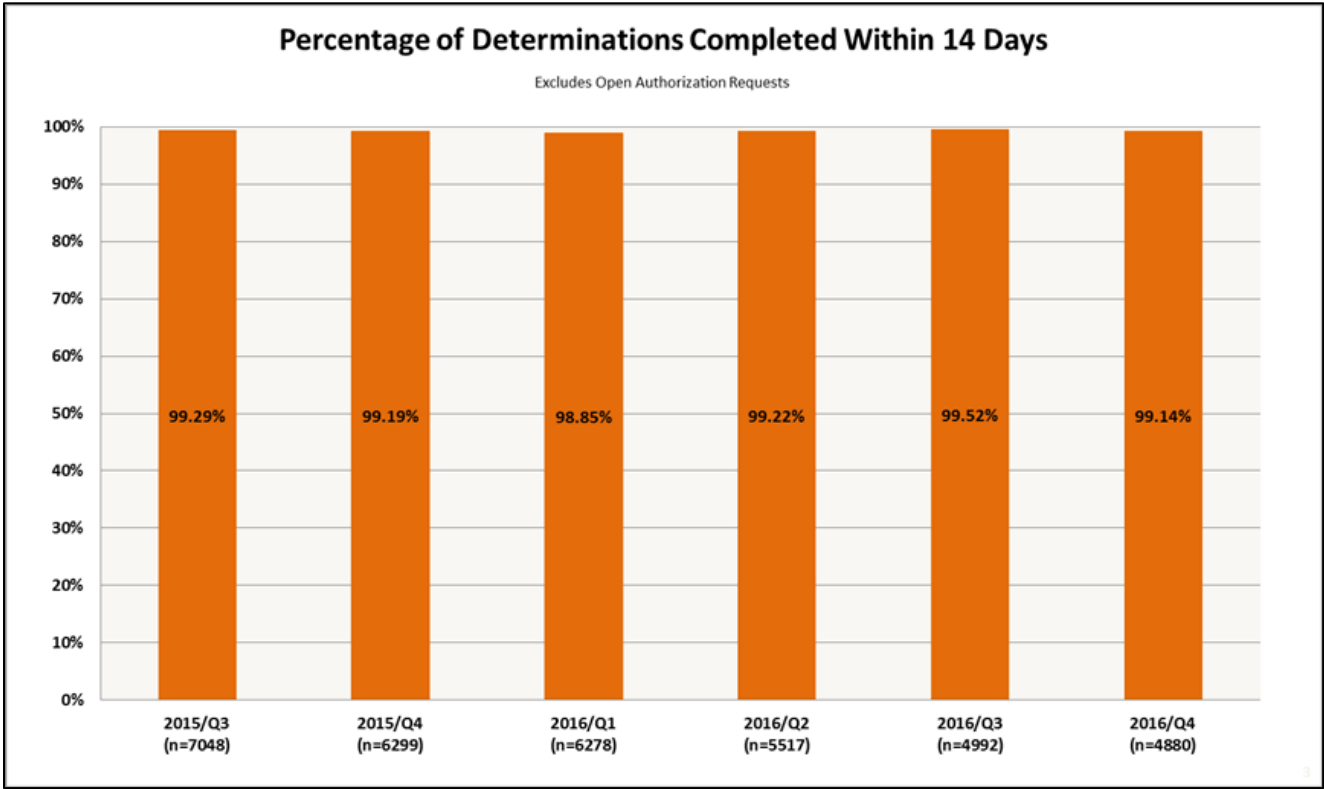
Opportunities and Interventions: No opportunities for improvement were identified.

Utilization Management and Care Coordination

Service Authorization Requests

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

Service Authorization Requests	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Number of Service Authorization Requests	NA	6,278	5,517	4,992	4880
Percent Determinations Completed within 14 days	100.0%	98.8%	99.2%	99.5%	99.1%



Analysis: During Q4, there were 4,880 service authorization requests. Of those, 99.1% of the requests were completed within the 14-day turnaround time.

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:

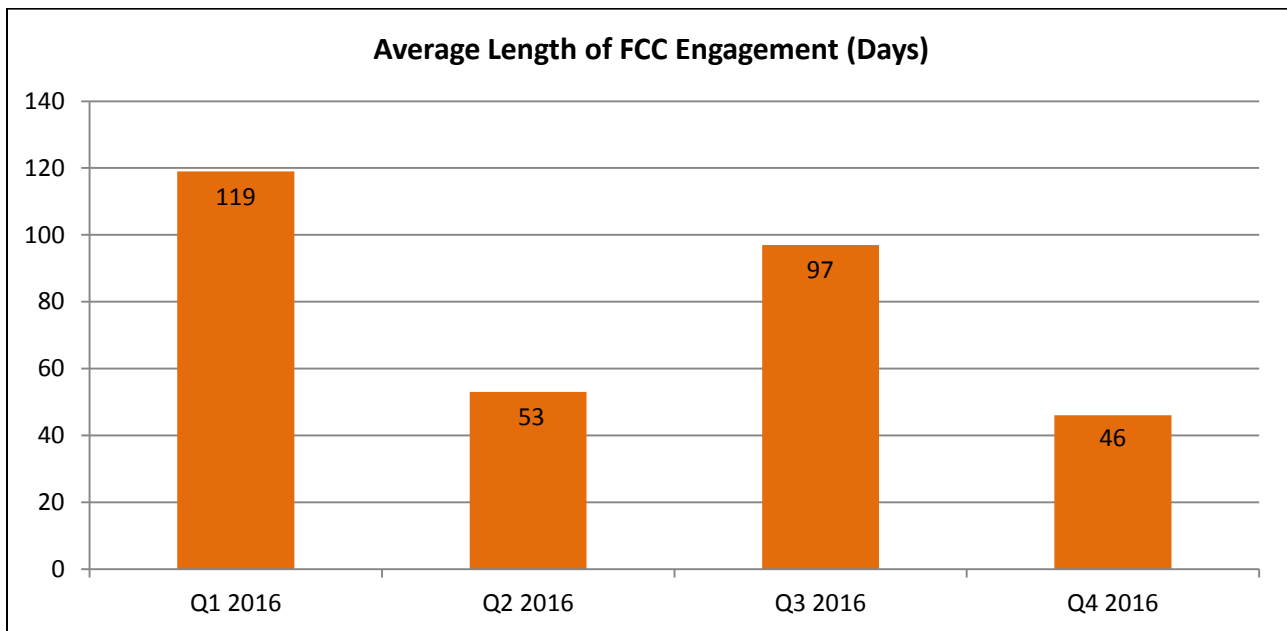
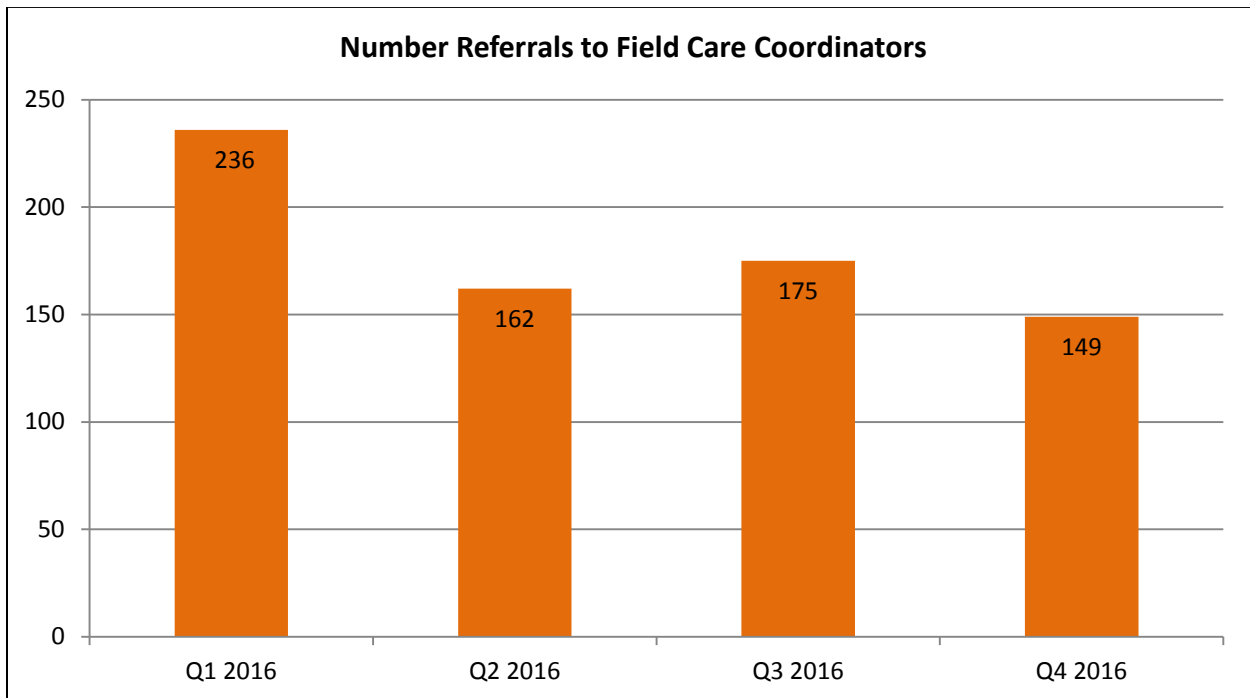
- Focusing on members and member families who are at greatest clinical risk
- Focusing on member’s wellness and the member’s responsibility for his/her own health and well-being.
- Improved care coordination for members moving between services, especially those being discharged from 24-hour care settings.

The Field Care Coordinators receive referrals from different sources. The below table identifies the referral sources and the number of referrals made to FCC staff during Q4, 2015 through Q3, 2016.

Referral Sources	Q1 2016	Q2 2016	Q3 2016	Q4 2016
Discharge Coordinator	191	136	151	112
Utilization Reviewers	11	10	12	8
Providers	22	6	6	5
Dept of Behavioral Health	7	3	2	6
Juvenile Justice	0	0	0	0
Provider Quality Specialist	1	2	2	3
Peer Review Committee	3	4	1	2
Hospitals	0	0	0	0
EPSDT	1	1	0	0
Family	0	0	0	0
Member Services/Crisis Line	0	0	1	0
Education	NA	NA	NA	6
FCC Manager Referral	NA	NA	NA	4
Outpatient Disposition	NA	NA	NA	3
Total	236	162	175	149

Analysis: Three new Referral Source categories were added during Q4. These include: Education, FCC Manager, and Outpatient Disposition. During Q4, Field Care Coordinators

received 149 referrals. Of these referrals, 112 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement during Q4 was 46 days.



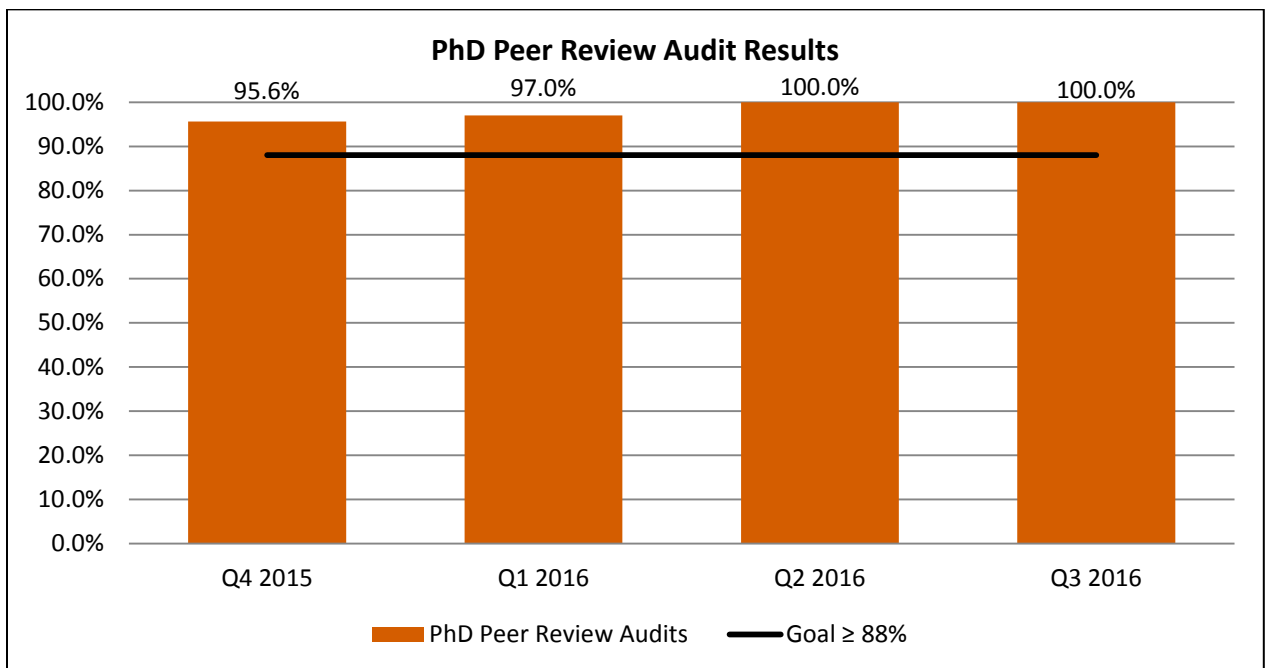
Barriers: Based on the above analysis, no barriers were identified.

Opportunities and Interventions: No opportunities for improvement were identified.

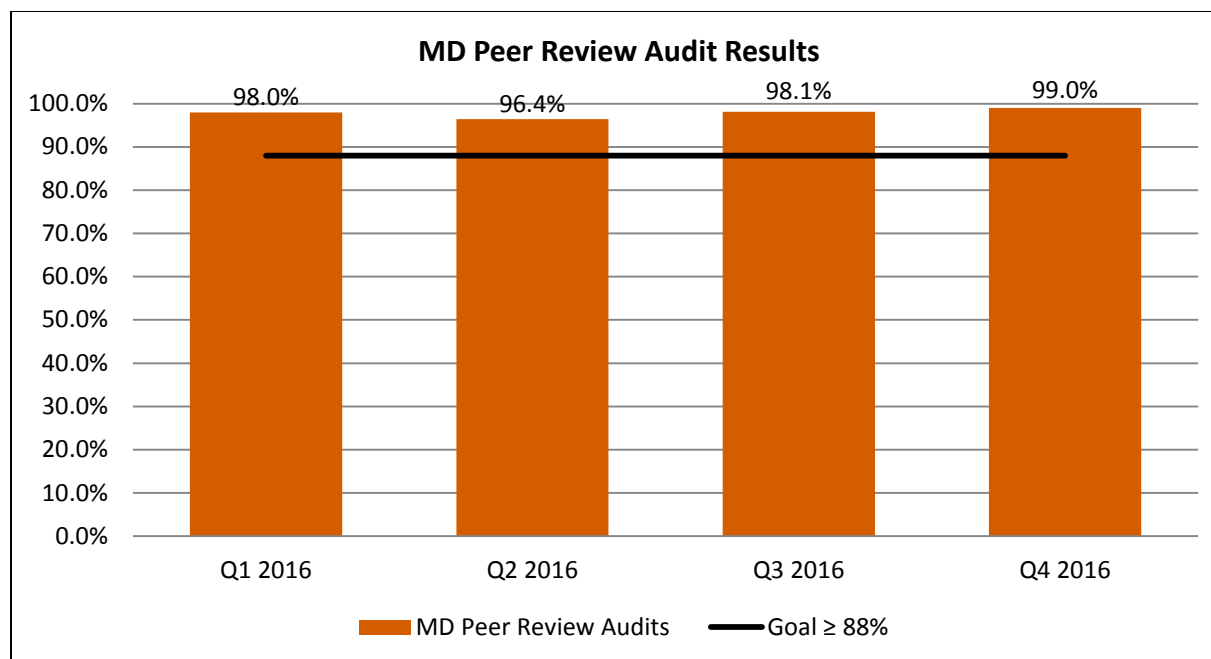
Peer Reviewer Audits

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

Analysis: During Q4, there were no PhD denial decisions that required a Peer Review Audit. MD audit score for Q4 was 99.0%. Based on the performance goal of $\geq 88\%$, audit results indicate the MD Peer Review Audits received passing scores.



**There were no PhD Peer Review Audits required during Q4*



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 Q1, 2016 Quarterly report. Inter-rater Reliability testing is completed annually.

Population Analysis

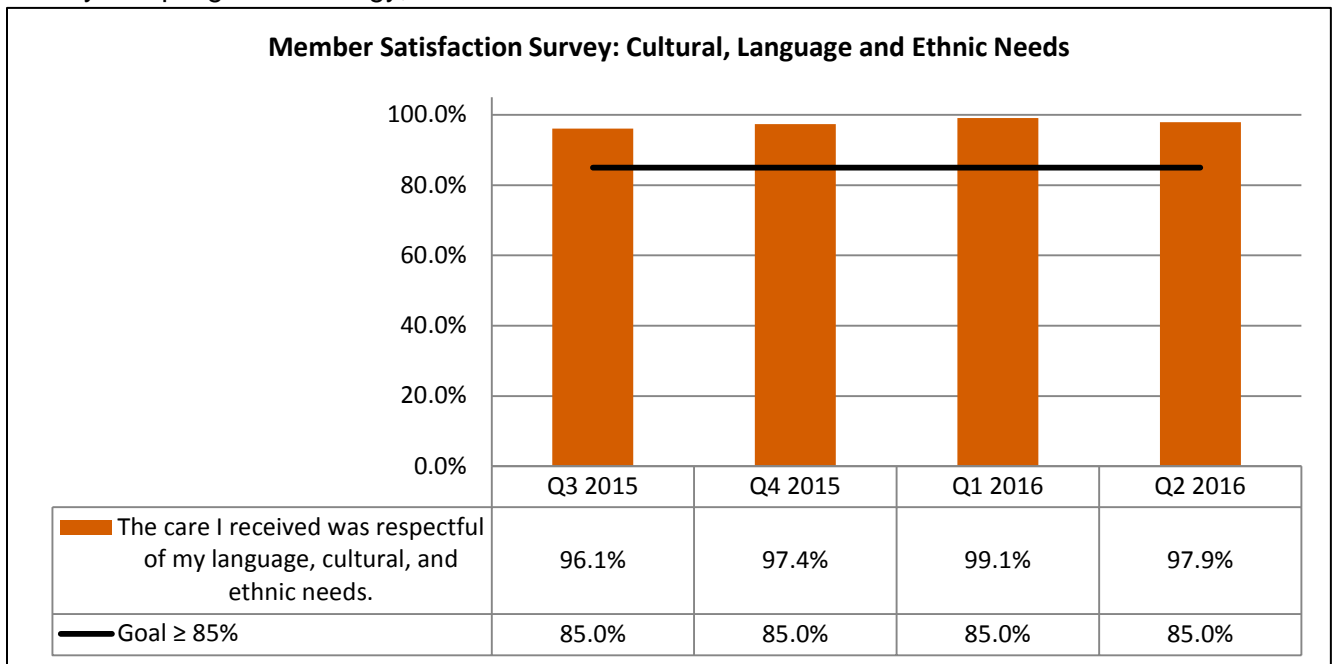
Language and Culture

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

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

*most current data available

Analysis: Hispanic or Latino counted for 12.2 % of the Idaho population an increase from 11.2% from the 2010 Census results. This is the second highest population total, with White consisting of 93.4% (an increase from 89.1% from the 2010 Census results). Ethnic and racial backgrounds can overlap which explains for the percentage total > 100%. The Member Satisfaction Survey results show that 97.9% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q2 2016 data is the most recent results 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 Translated to Spanish (Annual Member Mailing)	0
Member Written Communication Formatted to Large Print (Annual Member mailing)	1
Mental Health First Aid (MHFA) Training Materials Translated to Spanish	0
Interpreter Services – Language Service Associates (verbal translations by phone)	46

Analysis: During Q4, Optum Idaho responded to 47 requests for 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.

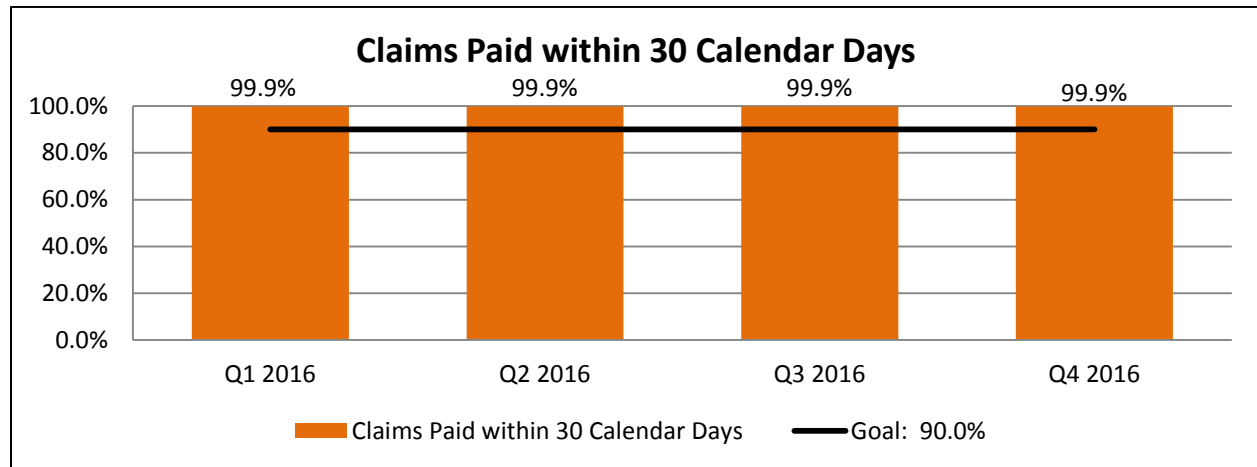
Dollar Accuracy Rate (DAR) is measured by collecting a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claim dollars paid correctly out of the total claim dollars paid. It is the percent of paid dollars processed correctly (total paid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

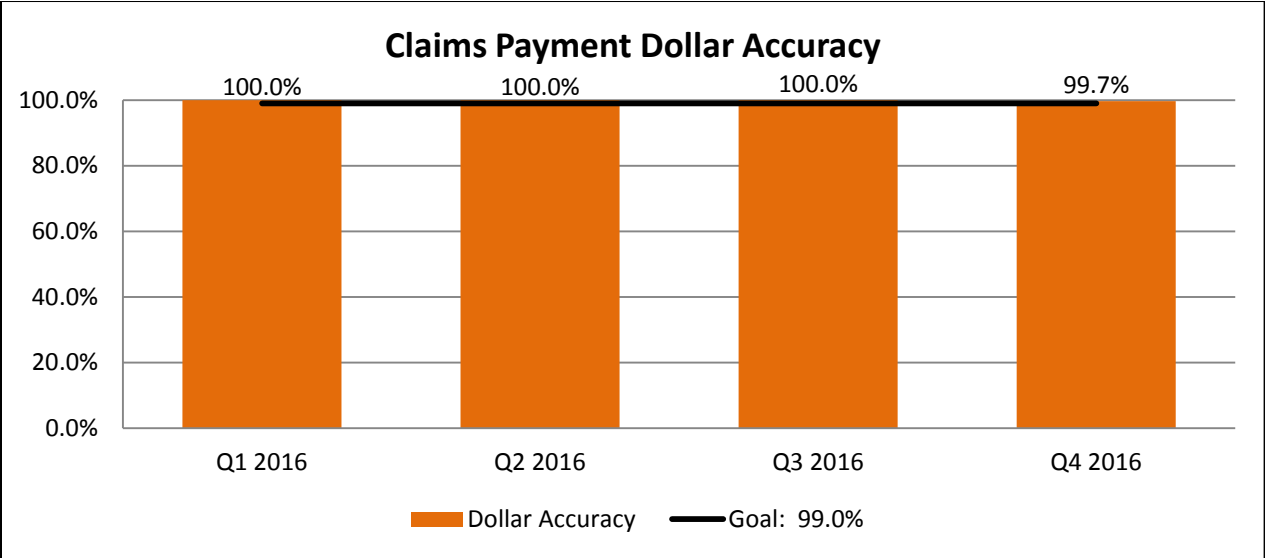
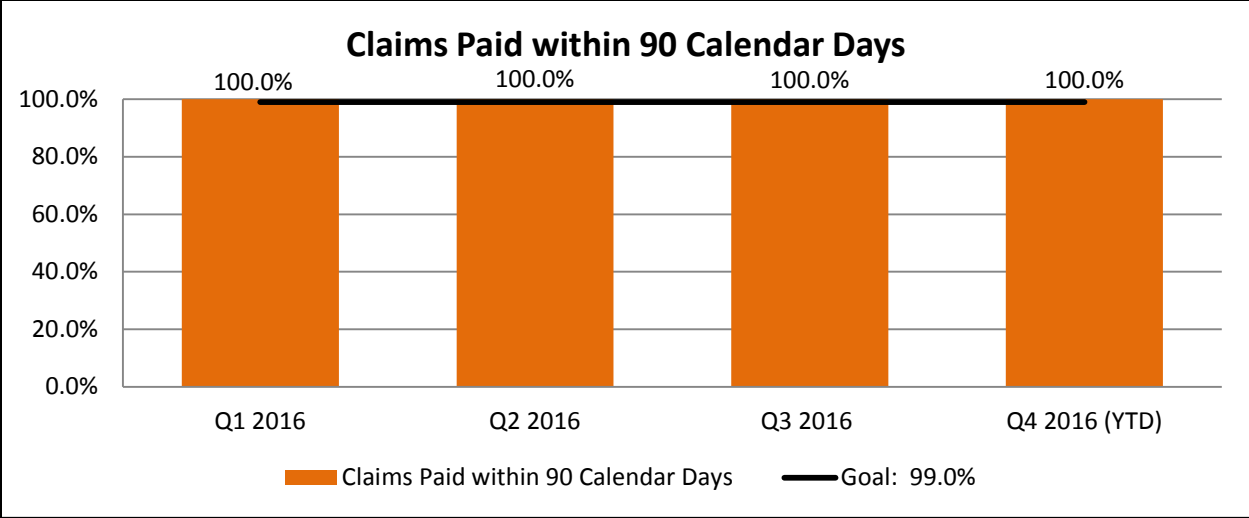
Procedural Accuracy Rate (PAR) is measured by collection a statistically significant random sample of claims processed. The sample is reviewed to determine the percentage of claims processed without procedural (i.e. non-financial) errors. It is the percentage of claims processed without non-financial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

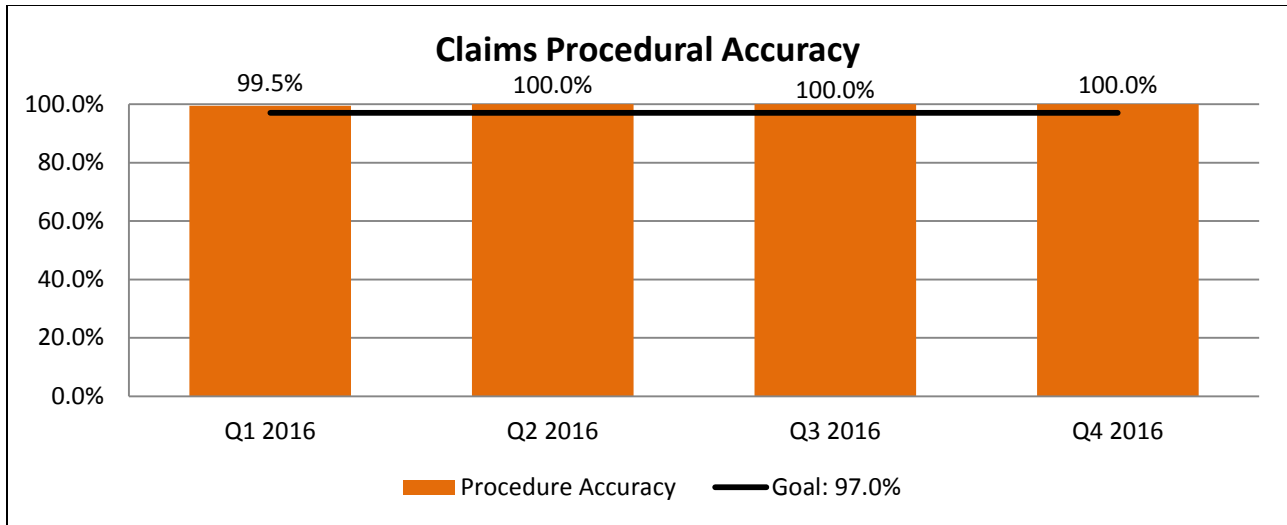
Quarterly Performance Results:

Claims	Performance Goal	Q1 2016	Q2 2016	Q3 2016	Q4 2016 (based on the Dec. OR57 report)
Paid within 30 days	90%	99.9%	99.9%	99.9%	99.9%
Paid within 90 days	99%	100.0%	100.0%	100.0%	100.0%
Dollar Accuracy	99%	100.0%	100.0%	100.0%	99.7%
Procedural Accuracy	97%	99.5%	100.0%	100.0%	100.0%

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







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

Opportunities and Interventions: No opportunities for improvement were identified.