IDAHO BEHAVIORAL HEALTH PLAN QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT QUARTERLY REPORT

July - September 2017
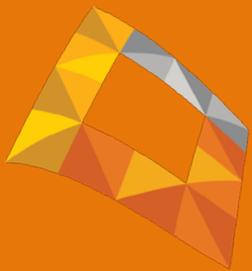
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The Idaho Behavioral Health Plan (IBHP) Quality Management and Improvement (QMI) report summarizes Optum Idaho's Quality Management and Utilization Management (QMUM) for Calendar Year 2017. It provides an overview of outcomes data, through Quarter 3, 2017, for Medicaid outpatient mental health and substance use disorder services managed by IBHP in the state of Idaho.

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Executive Summary – Quarter 3 - 2017

As noted in the outcomes analysis portion of this report, the overall trend for hospital re-admissions within 30 days has improved over time, and declined almost 40% year-over-year, which is a positive indicator that members are seeking outpatient services when appropriate. One of those services is Peer Support, which more than doubled from Q3 2016 when measured by the number of unique utilizers per 1,000 members. Optum's Field Care Coordinators continue to work with our highest need members and their providers upon inpatient discharge to help ensure the appropriate outpatient services are received within the reported seven-day requirement.

As part of our investment in program and service development, we have partnered with the Altarum Institute, to conduct a second Readiness Assessment to identify Providers for Phase Two of the Intensive Outpatient Program (IOP) implementation. It is our goal to provide this intermediate level of care for our members so that they will have an additional option for receiving more intensive therapy to support their individual needs.

During Recovery Month in September, Optum partnered with regional peer support specialists in our network on a proactive statewide media outreach campaign to promote the important work these individuals provide as part of the recovery process. Media interviews were conducted in areas where peers were available to speak about their role helping people reach recovery and highlighted specific recovery support programs and services that Optum is helping bring to the communities we serve. Efforts also included the placement of byline articles by local Optum behavioral health experts and a partnership with the Idaho Department of Health and Welfare to create TV and radio Public Service Announcements, in both English and Spanish raising awareness about mental health issues and promoting local recovery support resources. Over 175,000 total impressions through TV, print and radio messages were received across Idaho.

Collaboration continued in the third quarter with stakeholders across the state to host additional screenings of the documentary, *Resilience – The Biology of Stress and the Science of Hope* throughout Idaho. The film and panel discussions offered an opportunity for all community partners to continue the conversation about bringing to light the science behind the effects of toxic stress from a traumatic childhood and the effect it has in adulthood. Additional statewide community outreach activities included provider trainings, informational media coverage and organized events.

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

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About This Report

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

The purpose of this document is to share with internal and external stakeholders Optum Idaho's performance, outcomes and improvement activities related to services we provide to IBHP members and contracted providers. Information outlined in this report highlights quarterly performance from Quarter 3, 2017, (July through September 2017), unless otherwise noted, and provides comparative performance from each quarter.

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

Overall Effectiveness and Highlights

Optum Idaho monitors performance measures as part of our Outcomes Management and Quality Improvement Work Plan. In this report, thirty-four (34) key performance measures with performance goals were highlighted based on performance targets that are based on contractual, regulatory or operational standards. For this reporting period, Optum Idaho met or exceeded performance for 32 (94.0%) of the key measures. Optum Idaho's continues its commitment to IBHP members and families in transforming the behavioral health care system in the State of Idaho.

Quality Performance Measures and Outcomes

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

Measure	Goal	July - September 2016	October - December 2016	January - March 2017	April - June 2017	July - September 2017
Member Satisfaction Survey Results						
Optum Support for Obtaining Referrals or Authorizations	≥85.0%	NA	NA	87.0%	**Based on Member Satisfaction Survey sampling methodology, Q1, 2017, is the most current data available.**	
Accessibility, Availability, and Acceptability of the Clinician Network	≥85.0%	NA	NA	87.0%		
Experience with Counseling or Treatment	≥85.0%	NA	NA	87.0%		
Overall Satisfaction	≥85.0%	NA	NA	81.3%		
Provider Satisfaction Survey Results						
Overall Provider Satisfaction	≥85.0%	**Changed to Annual Survey. (2017 Results will be presented in Q1, 2018, Report)**				
Accessibility & Availability						
Idaho Behavioral Healthplan Membership						
Membership Numbers	NA	299,233	304,125	299,388	303,086	**Due to claims lag, data is reported 1 quarter in arrears**
Member Services Call Standards						
Total Number of Calls	NA	1,175	1,412	1,290	1,345	1,362
Percent Answered within 30 seconds	≥80.0%	82.0%	82.0%	80.0%	85.4%	83.0%
Average Speed of Answer (seconds)	≤30 Seconds	18.0	18.5	21.5	12.3	2.7
Abandonment Rate	≤3.5% internal ≤7.0 % contractual	3.4%	3.5%	4.1%	2.1%	1.7%

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Measure	Goal	July - September 2016	October - December 2016	January - March 2017	April - June 2017	July - September 2017
Customer Service (Provider Calls) Standards						
Total Number of Calls	NA	**2,818**	**3,086**	**2,917**	**2,861**	**4,103**
Percent Answered within 30 seconds	≥80.0%	**98.9%**	**98.6%**	**98.4%**	**98.4%**	**97.1%**
Average Speed of Answer (seconds)	≤30 Seconds	**1.7**	**1.1**	**2.8**	**1.8**	**6.2**
Abandonment Rate	≤3.5% internal ≤7.0% contractual	**0.16%**	**0.41%**	**0.56%**	**0.44%**	**0.64%**
Urgent and Non-Urgent Access Standards						
Urgent Appointment Wait Time (hours)	48 hours	**22.0**	**32.0**	**24.0**	**27.0**	**20.0**
Non-Urgent Appointment Wait Time (days)	10 days	**5.5**	**7.2**	**7.3**	**6.0**	**6.0**
Geographic Availability of Providers						
Area 1 - requires one provider within 30 miles for Ada, Canyon, Twin Falls, Nez Perce, Kootenai, Bannock and Bonneville counties.	100.0%	**99.8%***	**99.8%***	**99.8%***	**99.8%***	**100.0%**
Area 2 - requires one provider within 45 miles for the remaining 41 counties not included in Area 1 (37 remaining within the state of Idaho and 4 neighboring state counties)	100.0%	**99.8%***	**99.9%***	**99.8%***	**99.9%***	**99.8%***
Member Protections and Safety						
Notification of Adverse Benefit Determinations						
Number of Adverse Benefit Determinations (ABD's)	NA	**540**	**470**	**416**	**500**	**756**
Clinical ABD's *(began tracking Q3, 2017)*	NA	**NA**	**NA**	**NA**	**NA**	**578**
Administrative ABD's *(began tracking Q3, 2017)*	NA	**NA**	**NA**	**NA**	**NA**	**178**
Written Notification *(14 business days from request for services - implemented 7/1/17)*	100% within 14 business days	**NA**	**NA**	**NA**	**NA**	**100.0% (756/756)**
Initial Verbal Notification on Same Day	100.0%	**99.6%***	**98.9%***	**99.8%***	**99.6%***	**No longer tracking**
Written Notification Sent within 1 Business Day	100.0%	**96.3%**	**92.9%**	**98.3%**	**99.8%***	**New 14-day requirement tracked above**
Member Appeals (formerly Grievances)						
Number of Appeals	NA	**26**	**17**	**15**	**17**	**51**
Non-Urgent Appeals	NA	**26**	**17**	**15**	**17**	**36**
Acknowledgement Compliance	100% within 5 Calendar Days	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Determination Compliance	100% within 30 Calendar Days	**92.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Urgent Appeals	NA	**0**	**0**	**0**	**0**	**15**
Determination Compliance	100% within 30 Calendar Days	**NA**	**NA**	**NA**	**NA**	**100.0%**

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Measure	Goal	July - September 2016	October - December 2016	January - March 2017	April - June 2017	July - September 2017
Complaint Resolution and Tracking						
Total Number of Complaints	NA	**18**	**11**	**13**	**23**	**16**
Percent of Complaints Acknowleged within Turnaround time	5 days	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Number of Quality of Service Complaints	NA	**17**	**10**	**12**	**20**	**14**
Percent Quality of Service Resolved within Turnaround time	100% within ≤10 days	**100.0%**	**100.0%**	**83.3%**	**100.0%**	**100.0%**
Number of Quality of Care Complaints	NA	**1**	**1**	**1**	**3**	**2**
Percent Quality of Care Resolved within Turnaround time	≤30 days	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Critical Incidents						
Number of Critical Incidents Received	NA	**16**	**17**	**19**	**19**	**11**
Percent Ad Hoc Reviews Completed within 5 business days from notification of incident	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Response to Written Inquiries						
Percent Acknowledged ≤2 business days	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Provider Monitoring and Relations						
Provider Quality Monitoring						
Number of Audits	NA	**82**	**39**	**128**	**164**	**148**
Initial Audit (Percent overall score)	≥ 85.0%	**98.3%**	**95.9%**	**92.1%**	**93.6%**	**98.0%**
Recredentialing Audit (Percent overall score)	≥ 85.0%	**92.2%**	**93.4%**	**91.2%**	**94.3%**	**92.8%**
Monitoring (Percent overall score)	≥ 85.0%	**NA*****	**85.0%**	**94.9%**	**95.2%**	**93.7%**
Quality (Percent overall score)	≥ 85.0%	**96.5%**	**NA*****	**82.5%**	**NA*****	**86.1%**
Percent of Audits that Required a Corrective Action Plan	NA	**7.3%**	**7.6%**	**16.4%**	**6.1%**	**11.5%**
Behavioral Health Provider and						
Percent PCP is documented in member record	NA	**97.1%**	**92.1%**	**94.5%**	**96.0%**	**96.1%**
Percent documentation in member record that communication/ collaboration occurred betweem behavioral health provider and primary care provider	NA	**86.5%**	**87.2%**	**73.0%**	**87.0%**	**79.0%**
Provider Disputes						
Number of Provider Disputes	NA	**14**	**15**	**13**	**6**	**45**
Average Number of Days to Resolve Provider Disputes	≤30 days	**9.9**	**12.9**	**17.9**	**2.5**	**17.9**
Utilization Management and Care Coordination						
Service Authorization Requests						
Percentage Determination Completed within 14 days	100%	**99.5%***	**99.1%**	**99.1%**	**99.4%**	**99.1%**
Field Care Coordination						
Total Referrals to FCCs	NA	**175**	**149**	**123**	**204**	**209**
Average Number of Days Case Open to FCC	NA	**97**	**46**	**65**	**53.6**	**41**

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Measure	Goal	July - September 2016	October - December 2016	January - March 2017	April - June 2017	July - September 2017
Discharge Coordination: Post Discharge Follow-Up						
Number of Inpatient Discharges	NA	735^	837^	850^	930	Data is reported 1 Quarter in arrears
Percent of Members with Follow-Up Appointment or Authorization within 7 Days after discharge	NA	29.0%^	47.0%^	39.0%^	35.0%	
Percent of Members with Follow-Up Appointment or Authorization within 30 Days after discharge	NA	34.4%^	24.0%^	21.0%^	19.6%	
Readmissions						
Number of Members Disharged	NA	735^	837^	850^	930	Data is reported 1 Quarter in arrears
Percent of Members Readmitted within 30 days	NA	16.6%^	10.4%^	9.2%^	12.0%	
Inter-Rater Reliability						
Inter-Rater Reliabililty completed annually. Results presented during Q2, 2017	NA	NA	NA	NA	62.0%	Completed annually
Peer-Review Audits						
PhD Peer Review Audit Results	≥ 88.0%	100.0%	****NA	****NA	****NA	Data is reported 1 Quarter in arrears
MD Peer Review Audit Results	≥ 88.0%	98.1%	99.0%	99.4%	96.5%	
Claims						
Claims Paid within 30 Calendar Days	90.0%	99.9%	99.9%	99.9%	99.9%	99.9%
Claims Paid within 90 Calendar Days	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dollar Accuracy	99.0%	100.0%	99.7%	99.4%	99.9%	99.9%
Procedural Accuracy	97.0%	100.0%	100.0%	99.8%	99.8%	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, 2017   within 5% of goal   did not meet goal

***there were 0 audits during Q3, Q4, 2016 and Q1, 2017

****there were 0 peer review audits

^numbers changed to reflect accurate reporting

Outcomes Analysis

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

Beginning with Q3 2017's report, charts with quarterly data now display five quarters, whereas prior reports displayed four. The purpose of adding one quarter is to show year-over-year trends.

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ALERT Outcomes

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

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

Wellness Assessments

Methodology: An important part of assessment when engaging in population health is to monitor the severity of symptoms and functional problems among those being treated. One concept for understanding population health as an outcome is to monitor whether utilizers as a group are getting healthier or sicker.

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

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

ADULT global distress scores are described as follows:

Total Score	Severity Level	Description
0-11	Low	Low level of distress (*below clinical cut-off score of 12*).
12-24	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
25-38	Severe	Approximately one in four clients has scores in this elevated range of distress.
39+	Very Severe	This level represents extremely high distress. Only 2% of clients typically present with scores in this range.

Analysis Figure 1: For adults, initial assessments remained consistent over the five quarters from Q3 2016 through Q3 2017. There was a reduction in follow-up adult Global Distress scores compared to initial scores for the population in treatment for Q3.

Wellness Assessments: Average Global Distress Scores - Adult

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
Initial WA	21.5	21.8	21.4	21.3	20.6
Follow-up WA	19.0	19.0	19.3	18.4	18.2
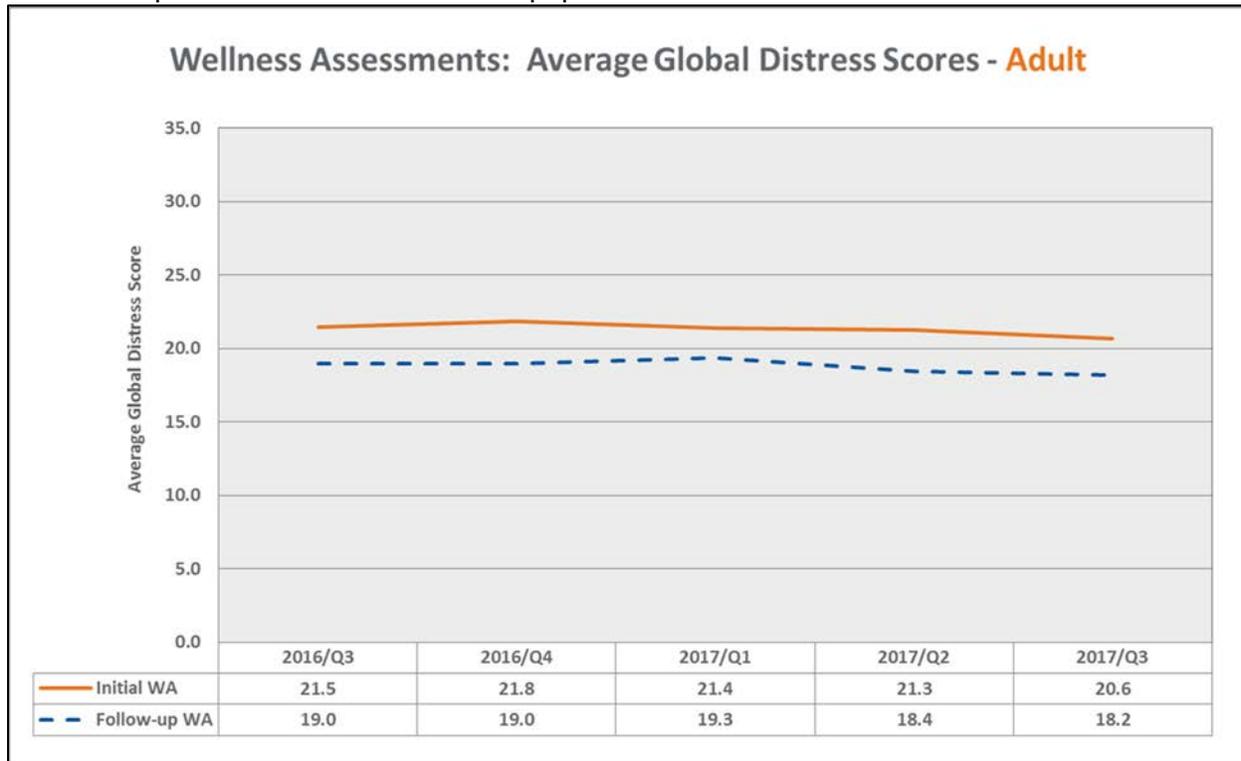
Figure 1

YOUTH global distress scores are described as follows:

Total Score	Severity Level	Description
0-6	Low	Low level of distress *(below clinical cut-off score of 7)*
7-12	Moderate	The most common range of scores for clients initiating standard outpatient psychotherapy.
13-20	Severe	Approximately one in four clients has an initial score in this elevated range of distress.
21+	Very Severe	This level represents extremely high distress. Only 2% of clients typically present with scores in this range.

Analysis Figure 2: Global Distress scores for children and youth consistently measured near 10 (Moderate) between Q3 2016 through Q3 2017.

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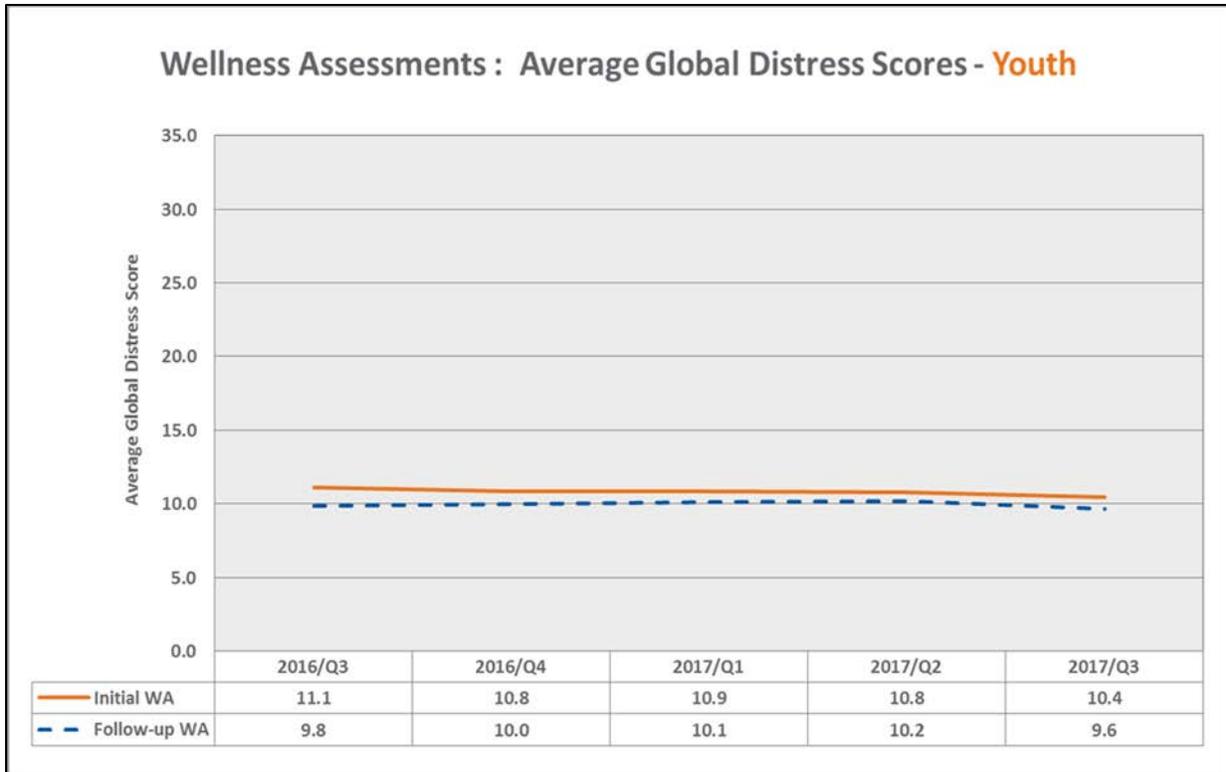
Figure 2

Caregiver Strain Level Descriptions:

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

Analysis Figure 3: Average initial Caregiver Strain scores over the past two quarters remained below Q3 2016 levels, with follow-up scores in the population showing slight, but steady, improvement over the five quarter study period. Overall severity levels are at the lower end of the moderate score range.

Wellness Assessments: Average Caregiver Strain Score

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
Initial WA	6.74	6.87	6.53	6.49	6.50
Follow-up WA	6.19	6.02	5.96	5.87	5.68
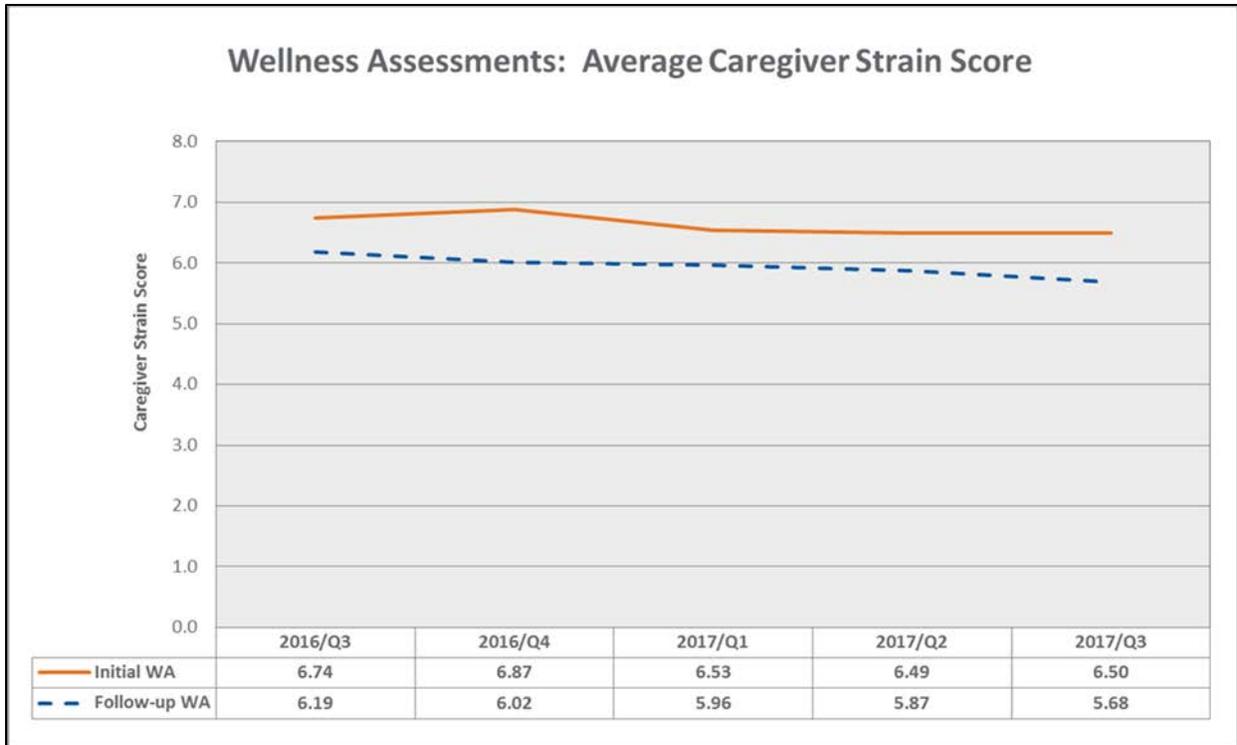
Figure 3

Adult Physical Health Score:

Figure 4: Adult Physical Health score values are as follows:
0 = Excellent   1 = Very Good   2 = Good   3 = Fair   4 = Poor

Overall physical health status is an important predictor of risk. Persons with coexisting physical and behavioral health problems tend to do worse than people with only behavioral health conditions. Adults scored on average between "fair" and "good" on the initial assessments during the five quarter study period. On follow-up assessments conducted over the same period, adults scored on average between "good" and "very good." These scores have remained consistent throughout the study period.

Wellness Assessments: Average Overall Health Score - Adult

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
Initial WA	2.2	2.1	2.2	2.2	2.1
Follow-up WA	1.5	1.5	1.6	1.5	1.5
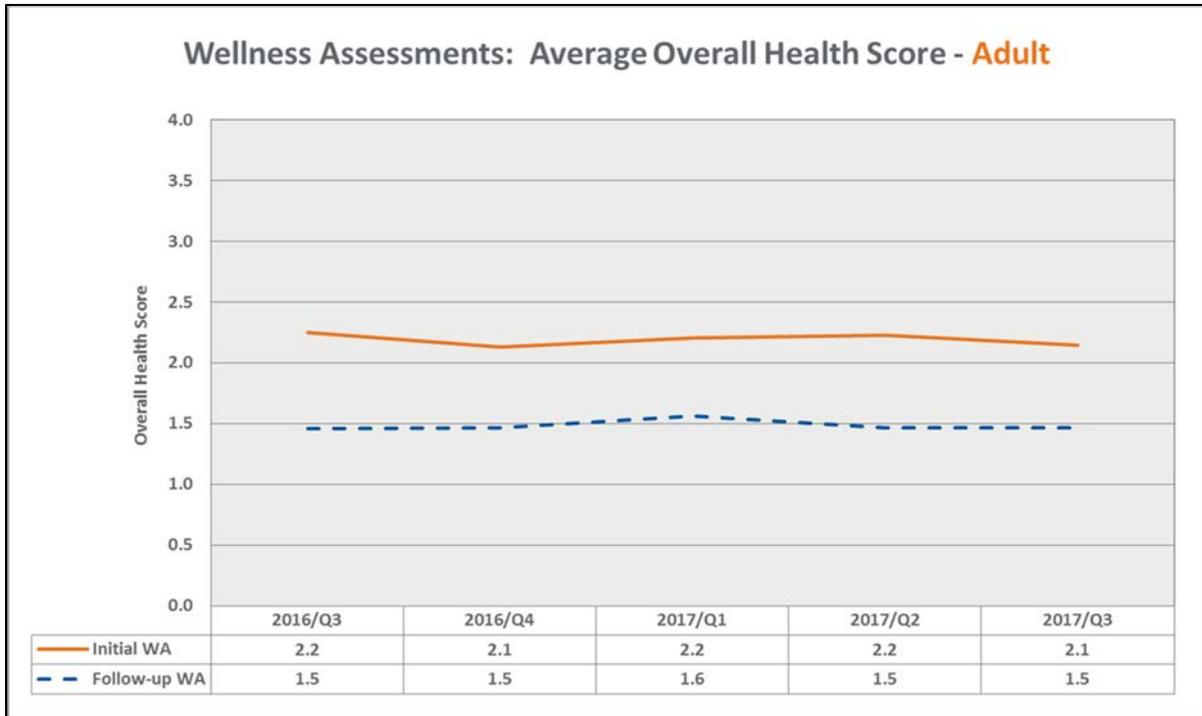
Figure 4

Child and Youth Physical Health Score:

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

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

Between Q3 2016 through Q3 2017, children and youth at baseline on initial assessment showed a consistent occurrence of physical health issues that averaged "very good." On follow-up assessment for the same period, children and youth showed improved scores in the range between "very good" and "excellent." These improved scores have remained consistent throughout the study period.

Wellness Assessments: Average Overall Health Score - Youth

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
Initial WA	1.0	1.0	1.0	1.0	1.0
Follow-up WA	0.7	0.7	0.7	0.7	0.7
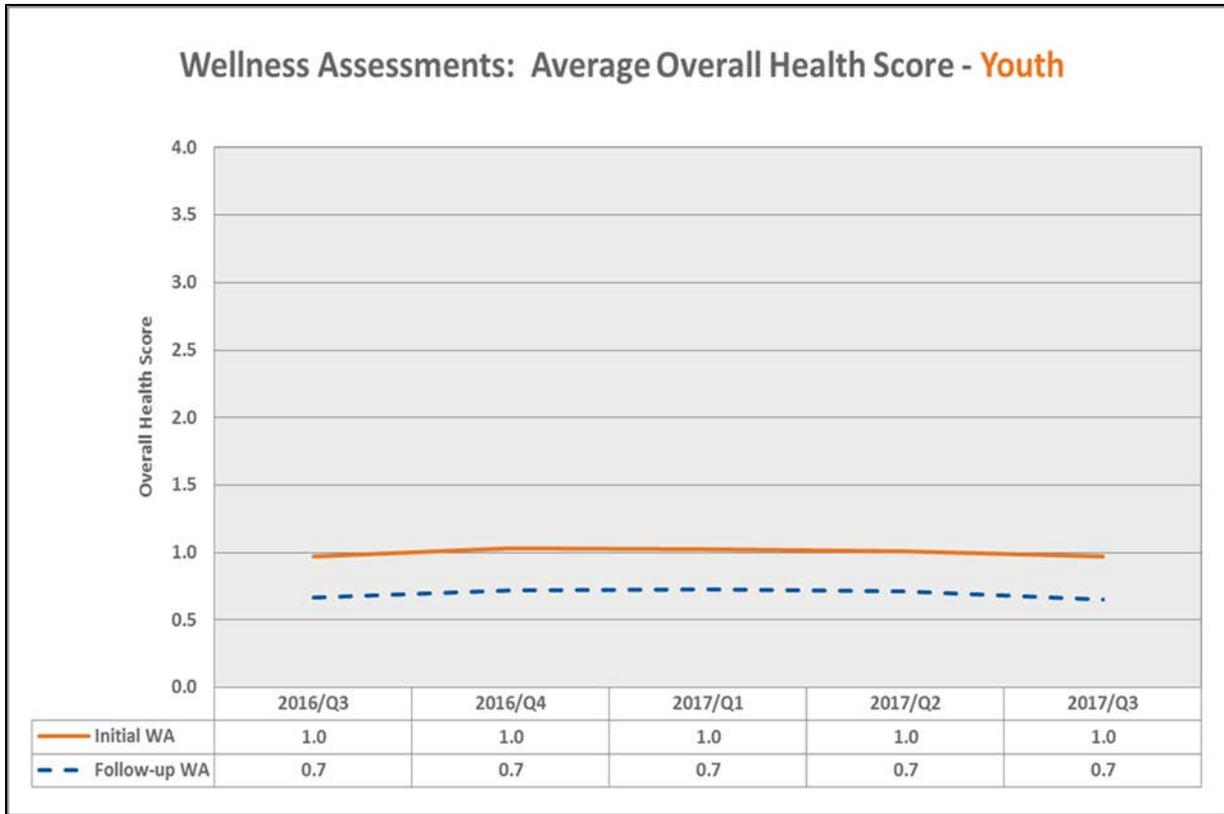
Figure 5

Barriers: No identified barriers.

Opportunities and Interventions: No opportunities for improvement were identified.

Individual Therapy Utilization Rates

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

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

Examination of the data for the age groups 0-17 years, 18-20 years, and 21+ years, shows a clear predominance of utilizers of Individual Therapy in the adult group and many fewer for children and transitioning youth. Overall utilization of Individual Therapy increased 2.0% from Q1 2017 to Q2 2017. Year-over-year there was a slight decline of 1.2%, primarily due to lower utilization in the 21+ age population.

Individual Therapy Utilizers by Quarter by Age
Per Thousand Members

	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2
Total (All Ages)	68.9	64.9	64.0	66.7	68.1
Ages 0 to 17	56.5	51.8	51.6	54.7	56.6
Ages 18 to 20	62.1	54.8	55.4	62.2	61.4
Ages 21+	105.9	103.6	99.9	99.6	99.7
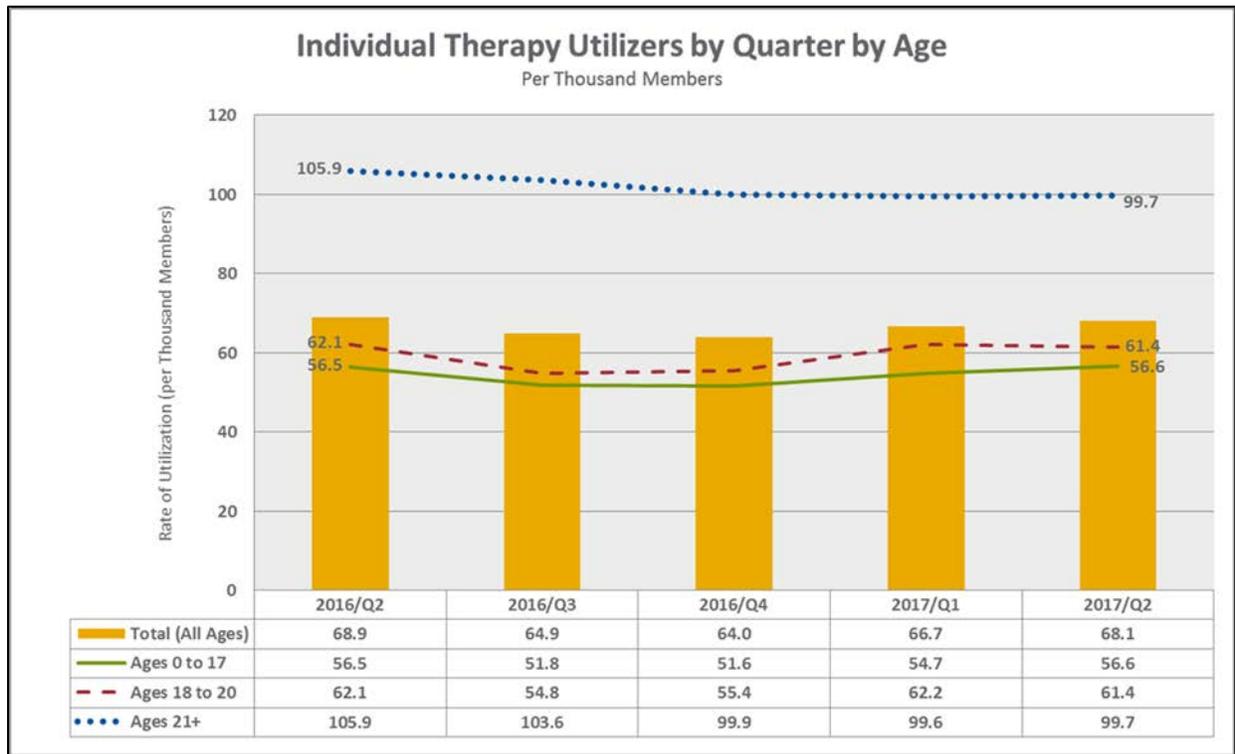
Figure 6

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 of claims data, beginning Q4 2016, an upward trend in the utilizer rates for Family Therapy is exhibited for all age groups: The 0-17 year group increased 9.0%, the 18-20 year group increased 13.1%, and the adult 21+ year group increased 1.5%.

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Year over year total utilizers in Q2 decreased 5.1%. Seasonal data indicates that the first half of each year typically has the highest utilization rates for Family Therapy.
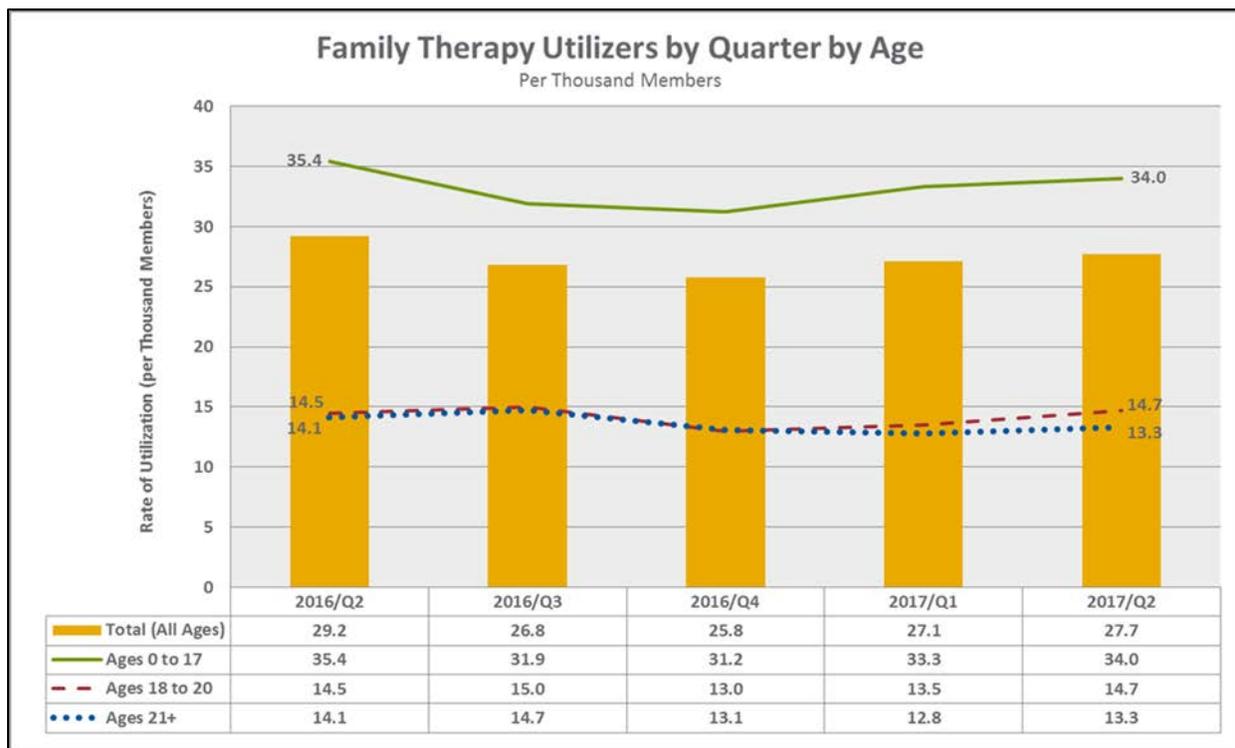
Figure 7

Barriers: No identified barriers.

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

Peer Support Utilization Rates

Methodology: Utilization rates are based on claims data, thereby limiting the number of quarters that can be displayed, since reliable data requires waiting for the 90-day period allowed for providers to file claims. The rate of utilization is calculated as follows:
The numerator is the number of unique utilizers of Peer Support visits for a specific quarter.
The denominator is the total number of members 18 and over for the same quarter, in thousands.

Analysis: Per Optum Idaho's Level of Care Guidelines, only members 18 years and over meet criteria for Peer Support Services. When all members 18 and over are examined, the Q2 2017 utilization for Peer Support has increased 15.4% and 127% year-over-year. This positive trend correlates with Optum's changes in Peer Support utilization management and with increased community and provider training and awareness efforts.

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Peer Support Utilizers by Quarter by Age
Per Thousand Members

	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2
Total (All Ages)	3.3	4.8	5.6	6.5	7.5
Ages 18 to 20	3.5	4.5	4.7	6.1	7.3
Ages 21+	12.9	18.4	21.1	23.8	27.4
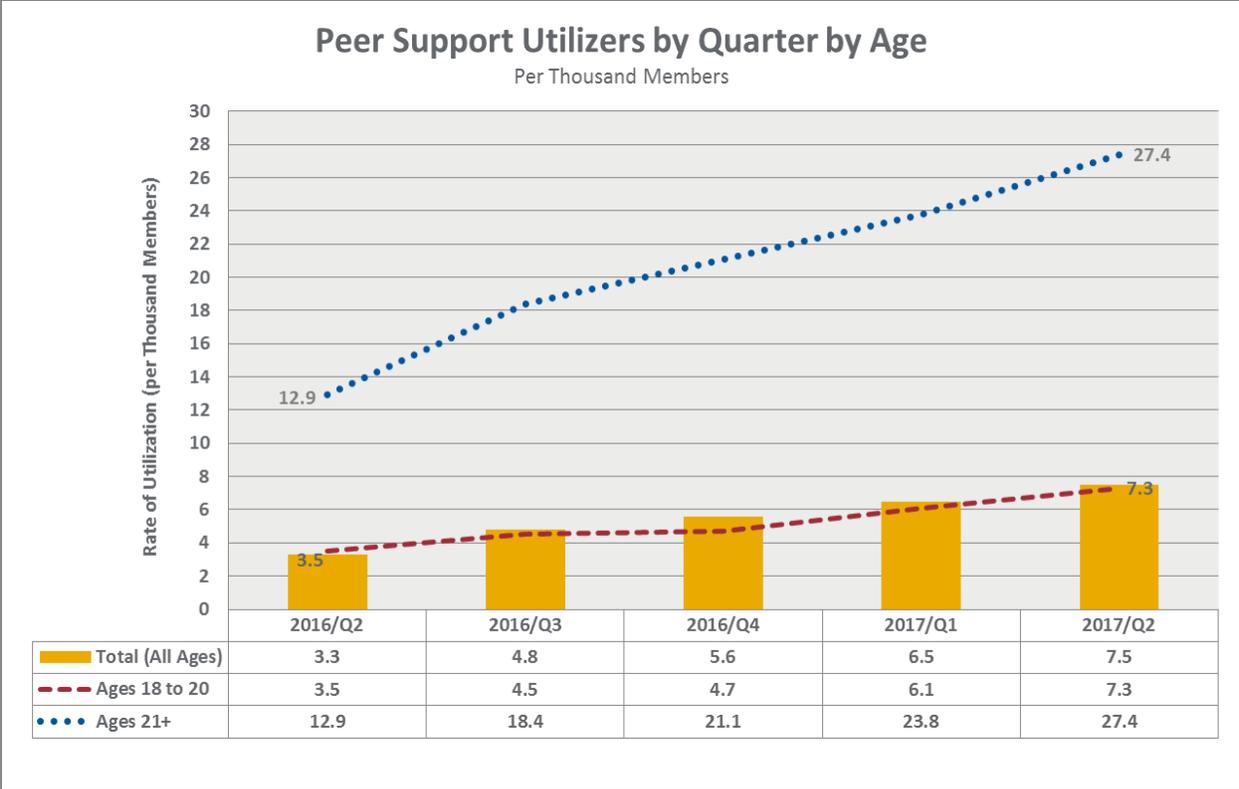
Figure 8

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

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

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

Case Management Utilization Rates

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

The rate of utilization is calculated as follows:
Numerator is the number of unique utilizers of case management services for a specific quarter.
Denominator is the total number of IBHP members for the same quarter, in thousands.

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Analysis: After utilization decreased from Q2 2016 to Q4 2016, Case Management Services utilization rates have flattened and remained steady for all age groups in the three quarters ending Q2 2017.

Case Management Utilizers by Quarter by Age
Per Thousand Members

	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2
Total (All Ages)	25.8	24.9	23.3	23.9	23.4
Ages 0 to 17	11.9	11.0	10.5	10.6	10.2
Ages 18 to 20	21.7	18.9	17.6	19.9	19.8
Ages 21+	66.4	65.0	59.8	59.8	59.0
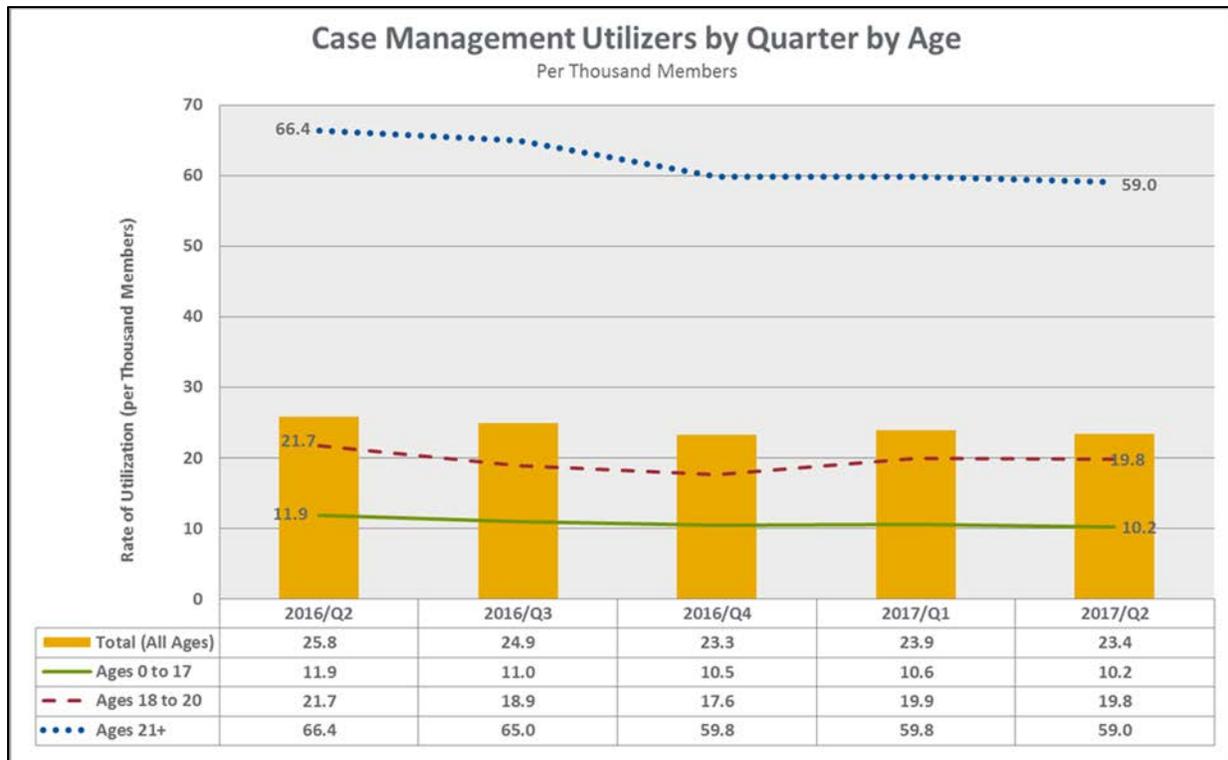
Figure 9

Barriers: No barriers were identified.

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

Prescriber Visit Utilization Rates

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

Analysis: The utilization rate for behavioral health prescription visits have remained flat over the three most recent quarters ending Q2 2017 for the Adult 21+ and Youth 0-17 populations. After utilization declines from Q2 2016 to Q4 2016, the population aged 18-20 increased 16.5% from Q4 2016 to Q2 2017.

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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.

Behavioral Health Prescriber Utilizers by Quarter by Age
Per Thousand Members

	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2
Total (All Ages)	26.6	25.1	23.8	24.9	24.8
Ages 0 to 17	14.8	13.6	12.9	13.8	13.7
Ages 18 to 20	27.2	25.2	24.2	28.0	28.2
Ages 21+	60.4	57.4	54.0	54.1	53.7
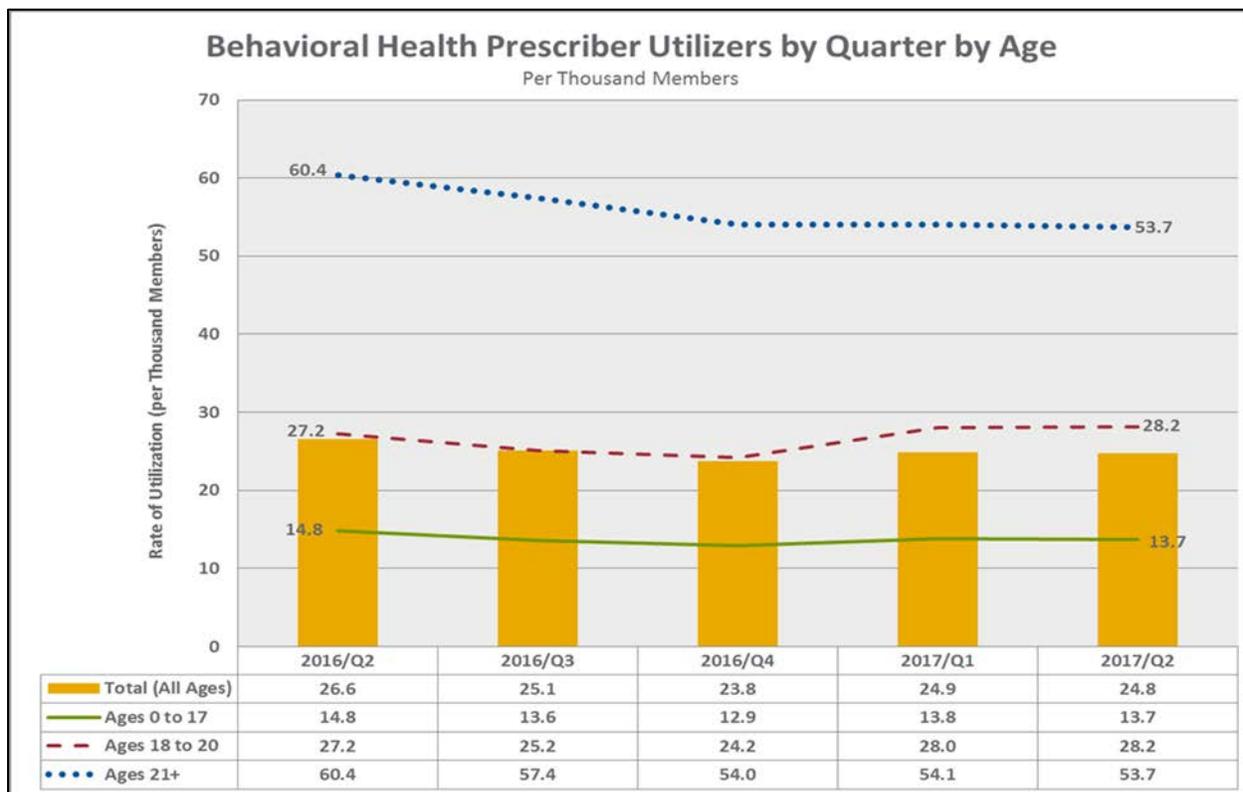
Figure 10

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.

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

Analysis: Community-Based Rehabilitative Services, CBRS, is a set of rehabilitation services originally developed to support adults diagnosed with Schizophrenia and severe and persistent Bipolar Disorder. Between Q2 2016 and Q2 2017, the reduction in CBRS for all age groups combined was 44.7%. All three age groups demonstrated a reduction in utilizer rates, with the 0-17 year group, the 18-20 year group, and the 21+ year group showing reductions of 55.6%, 51.9%, and 43.5% respectively within the study period. These changes have sustained a more clinically appropriate use of CBRS for the different age groups.

CBRS Utilizers by Quarter by Age
Per Thousand Members

	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2
Total (All Ages)	15.0	12.6	10.6	9.3	8.3
Ages 0 to 17	5.4	4.0	3.1	2.7	2.4
Ages 18 to 20	13.1	9.5	7.6	7.1	6.3
Ages 21+	43.2	37.1	31.9	27.5	24.4
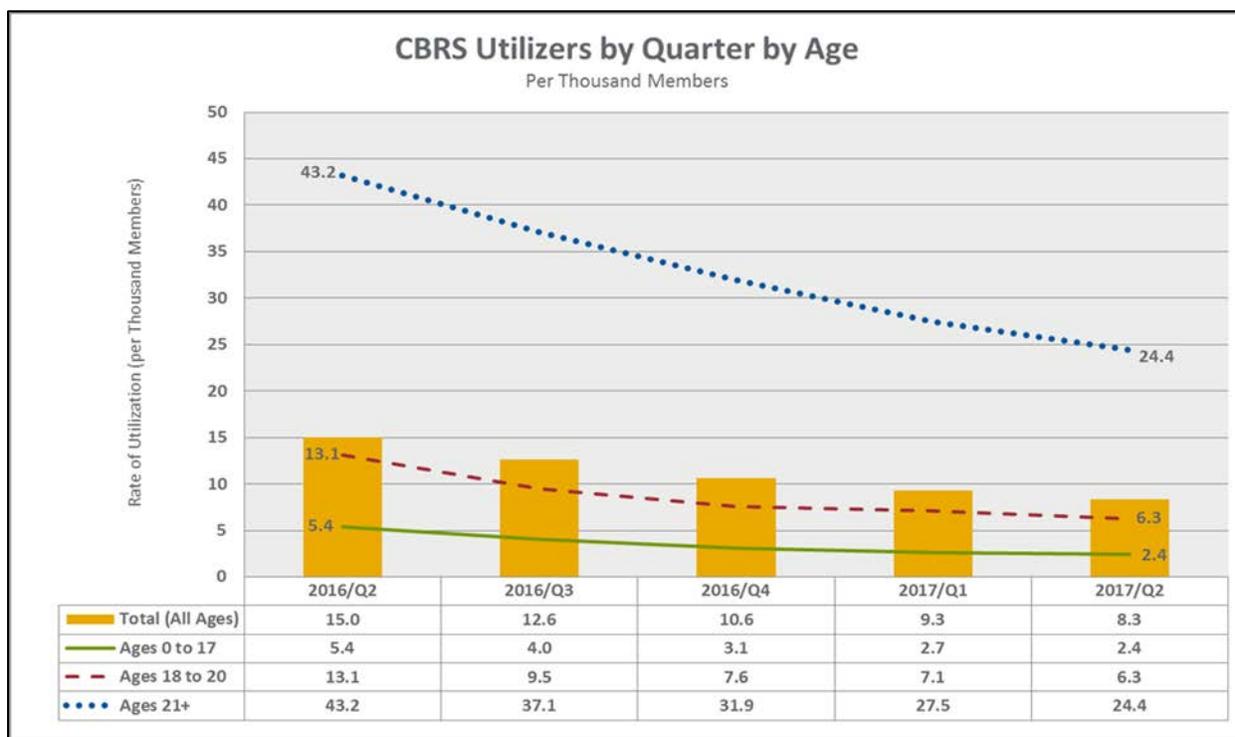
Figure 11

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

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

Services Received Post CBRS Adverse Benefit Determination

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

Analysis: Between Q2 2016 and Q2 2017, the use of medically necessary services has increased following denials of authorization for CBRS. Over the five quarters of this study, in

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the first 90 days following the ABD, approximately 90-96% 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.

Behavioral Health Service Utilizers after ABD for CBRS

	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2
Pct Receiving Services in 90 Days	94.3%	94.5%	90.6%	93.4%	95.1%
Pct Receiving Services after 90+ Days	87.9%	89.7%	87.5%	84.0%	66.3%
Pct Not Receiving Services	3.6%	3.2%	6.6%	5.7%	4.9%
Rec'd Other Services w/in 90 Days	265	239	232	198	254
Rec'd Other Services in 91+ Days	247	227	224	178	177
Recieved No Services	10	8	17	12	13
Members Receiving ABD for CBRS	281	253	256	212	267

Figure 12

Barriers: Although progressively changing, some limited provider familiarity with evidence-based therapies as well has historically underdeveloped Family Therapy workforce have constrained patterns of clinical practice consistent with national guidelines.

Opportunities and Interventions: The key to provider adoption of clinical practices consistent with national guidelines has been education and encouragement of the use of evidence based treatments. Provider trainings on medical necessity, promotion of use of national guidelines from the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry, care management contacts by Care Advocates, Field Care Coordinators, Medical Directors, and the Utilization Management have all shown a positive effect. Optum's use of its ACE program (Achievement in Clinical Excellence) also rewards providers who adopt use of treatments recommended in national clinical guidelines and use of the Wellness Assessment through the ALERT program. Providers recognized as high excellence in the ACE program receive a bonus for excellent performance and stars on the Provider Locator Tool to direct members and families to their agencies.

Optum promotes the continued increase in Peer Support Services in adults and transitioning youth. With Family Support Services, Optum anticipates the increased use of these value-added Recovery and Resiliency services for the benefit of children and their families.

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

Psychiatric Inpatient Utilization

Methodology: Information is obtained from IDHW and other community resources using hospital discharge data. A hospital stay is considered a readmission if the admission date occurred within 30-days of discharge. The data displayed indicates the rate of hospital discharges per quarter. To control for an increase in IBHP members over this time frame, the data has been standardized by displaying the numbers per 1,000 members.

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

Optum Recorded Hospital Discharges by Age Group
Per Thousand Members

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
Discharge Rate (per Thousand Members)	2.84	2.77	2.84	3.07	2.61
Ages 0 to 17	1.09	1.24	1.24	1.35	1.13
Ages 18 to 20	0.26	0.24	0.21	0.22	0.23
Ages 21+	1.49	1.29	1.38	1.49	1.26
# Discharges	850	842	850	930	789
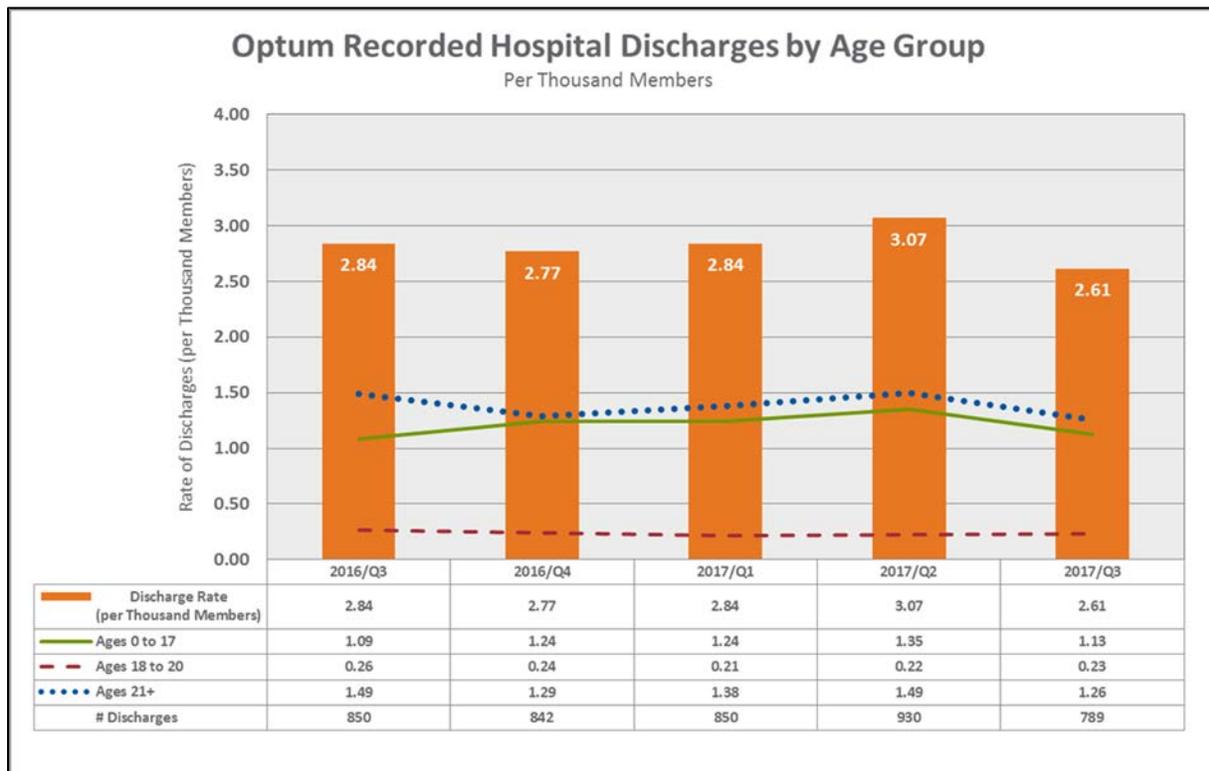
Figure 13

Figure 13 shows the overall rate of discharges decreased year-over-year from 2.84 to 2.61 per 1,000 members, which represents an 8.1% decrease in hospitalizations. The 2016 average discharge rate per 1,000 members was 2.97, which demonstrates that admissions are trending downward, notwithstanding the higher rate in Q2 2017.

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Optum Recorded Hospital Discharges by Hospital Type
Per Thousand Members

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
Discharge Rate (per Thousand Members)	2.84	2.77	2.84	3.07	2.61
Community Hospital	2.49	2.48	2.51	2.73	2.29
State Hospital	0.35	0.29	0.33	0.34	0.32
# Discharges	850	842	850	930	789

Figure 14

Figure 14 shows that during the study period from Q3 2016 through Q3 2017, discharges were consistent over time from the State Hospitals and decreased 8% from community hospitals.

Average Length of Stay by Age Group - Optum Recorded Hospital Discharges

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
Overall ALOS	12.7	13.7	13.9	12.8	14.3
Ages 0 to 17	10.5	12.3	11.0	10.3	11.6
Ages 18 to 20	11.1	10.2	6.1	10.2	9.3
Ages 21+	14.6	15.7	17.7	15.4	17.6

Figure 15

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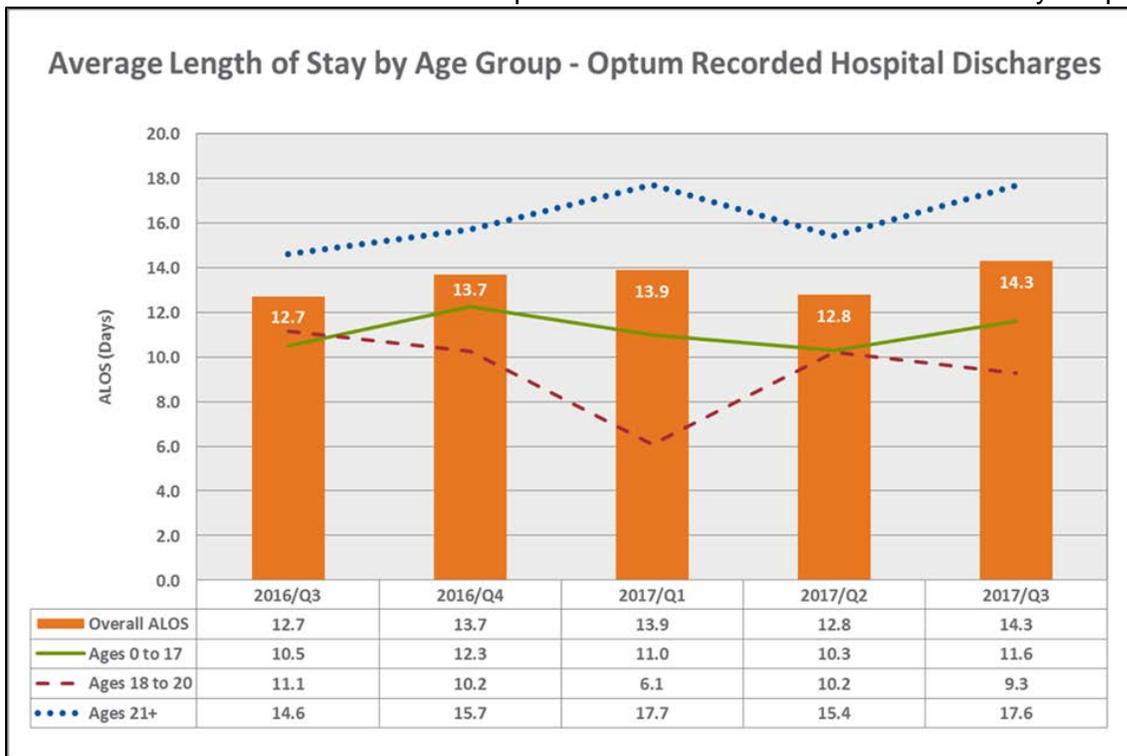
Figure 15 indicates that from Q3 2016 through Q3 2017, based on information reported to Optum Idaho from hospitals, the overall average length of stay increased 12.6%.

Average Length of Stay by Hospital Type
Optum Recorded Hospital Discharges

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
Overall ALOS	12.7	13.7	13.9	12.8	14.3
Community Hospital	8.0	8.9	8.5	8.1	9.2
State Hospital	46.1	54.3	54.1	51.0	50.5
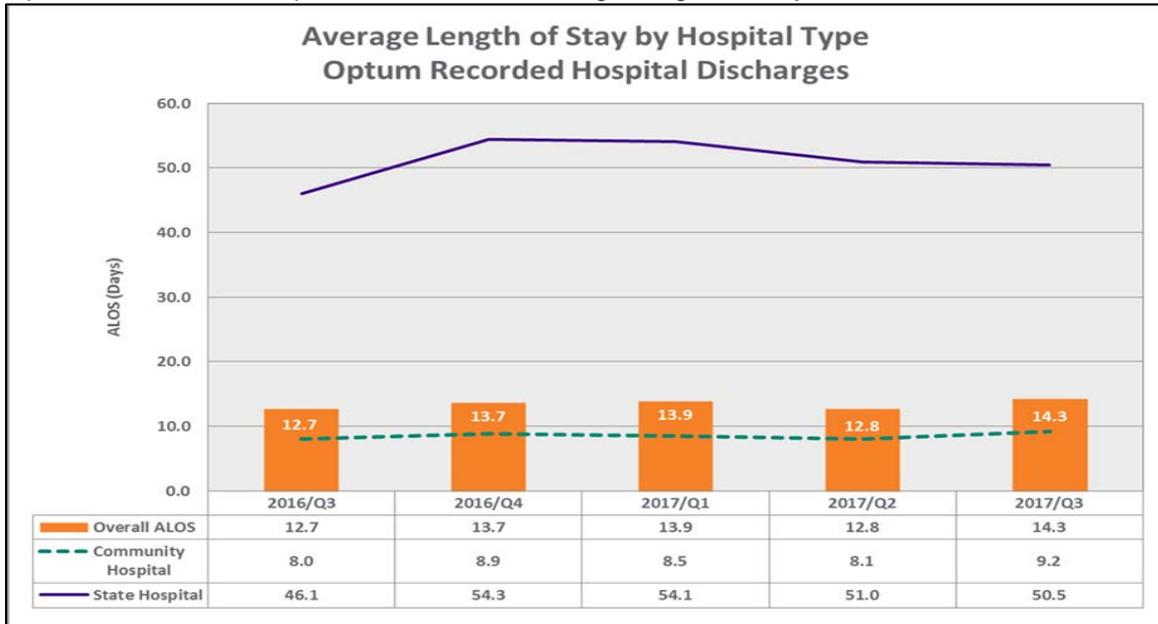
Figure 16

Figure 16 shows the average length of stay by hospital type. State hospital rates have demonstrated three quarters of sequential improvement; community hospitals had been trending down over the previous two quarters but increased 13.6% from Q2 to Q3 2017.

Hospital Discharges by Age Group with a Subsequent Admission Within 30 Days
Cases Readmitted within 30 days of Discharge (excludes Transfers and Ages 0 to 6) - Optum Recorded Admissions

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
% of Total	11.3%	10.5%	8.9%	11.8%	7.0%
Ages 0 to 17	2.8%	3.1%	3.4%	4.1%	2.4%
Ages 18 to 20	1.1%	1.3%	0.7%	1.5%	1.0%
Ages 21+	7.4%	6.1%	4.8%	6.2%	3.5%
# Discharges	850	842	850	930	789
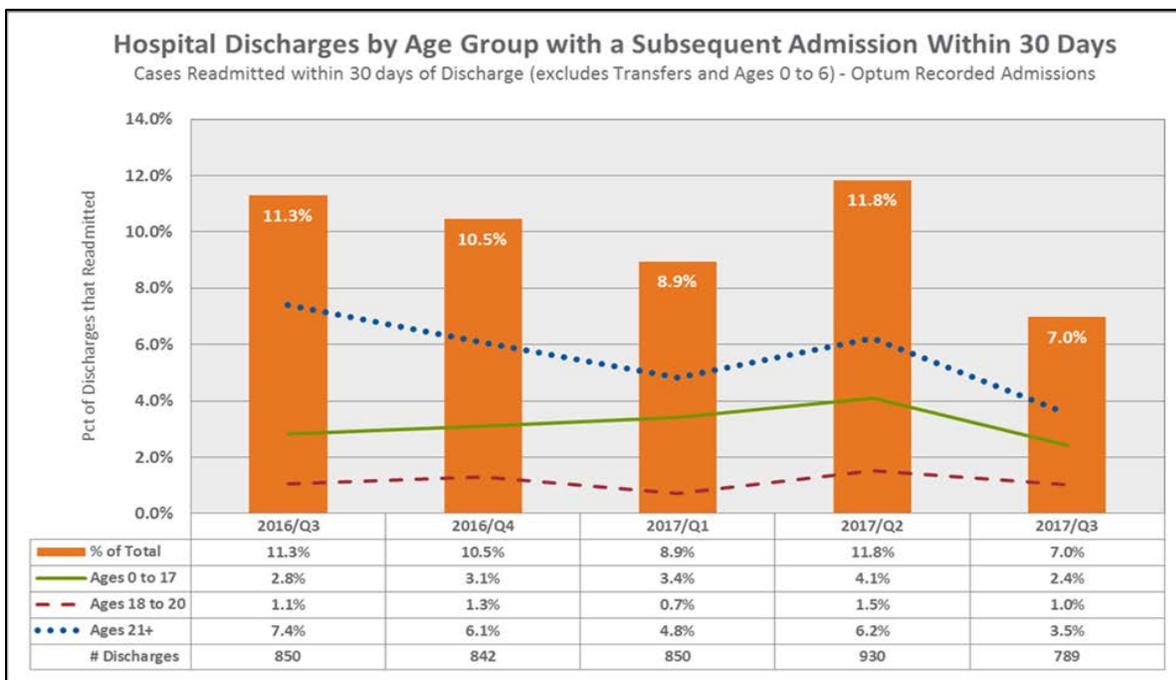
Figure 17

Figure 17 shows that during the study period from Q3 2016 through Q3 2017, readmissions decreased 38.1% year-over-year, and sequentially across all 5 quarters with the exception of Q2 2017. According to HEDIS definition, a readmission to a hospital is counted for all persons aged 6 years and over and excludes transfers between hospitals.

Hospital Discharges by Hospital Type with a Subsequent Admission Within 30 Days
Cases Readmitted within 30 days of Discharge (excludes Transfers and Ages 0 to 6) - Optum Recorded Admissions

	2016/Q3	2016/Q4	2017/Q1	2017/Q2	2017/Q3
% of Total	11.3%	10.5%	8.9%	11.8%	7.0%
Community Hospital	10.1%	9.6%	8.0%	10.9%	6.3%
State Hospital	1.2%	0.8%	0.9%	1.0%	0.6%
# Discharges	850	842	850	930	789
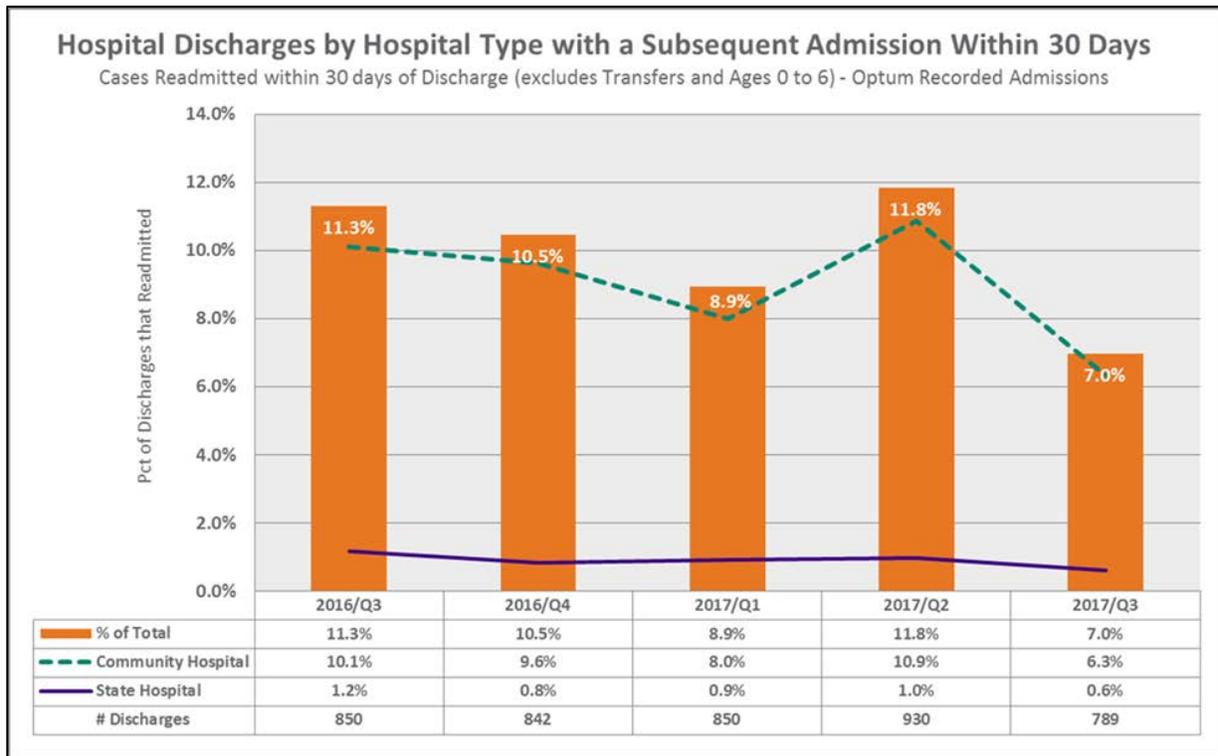
Figure 18

Figure 18 shows readmissions percentages by hospital type. During the study period from Q3 2016 through Q3 2017, readmissions decreased 50% for state hospitals and 37.6% for community hospitals, notwithstanding a Q2 2017 increase and subsequent improvement in the

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latter.
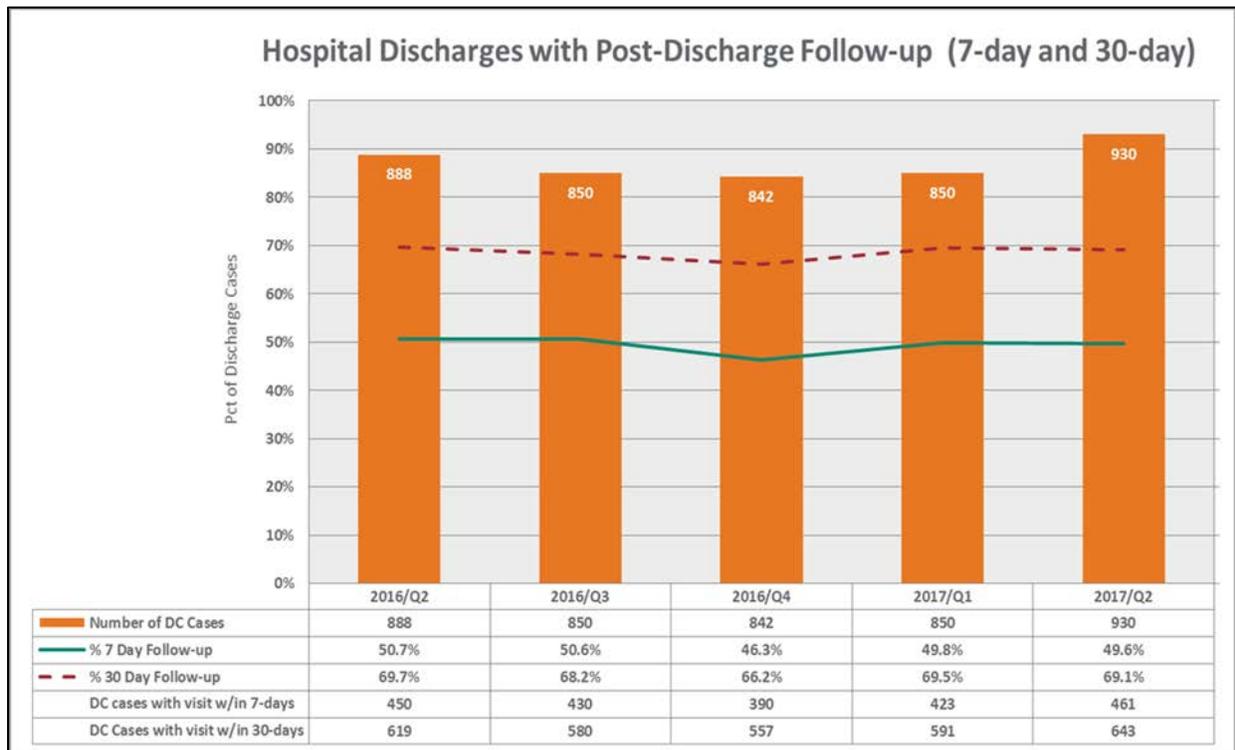
Figure 19

Figure 19 shows Hospital Discharges with Post-Discharge Follow-up. One of the goals of care coordination is the continuity of care and the successful transition of members from inpatient to outpatient care. One of the measures for this is a HEDIS metric that examines the percentage of members who are discharged from inpatient care and subsequently receive an outpatient behavioral health visit within 7 days and 30 days. The attendance rates have been consistent over the previous five quarters at approximately 50% for 7 days and 70% for 30 days post-discharge.

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

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

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Psychiatric Emergency Room Utilization Rates

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

Analysis: Figure 20 displays the utilization trends of Idaho Emergency Room visits for psychiatric care. Over the 5 month period ending May 2017—the most recent for which data is available—emergency room utilization trended upward, and increased 14.6% year-over-year.
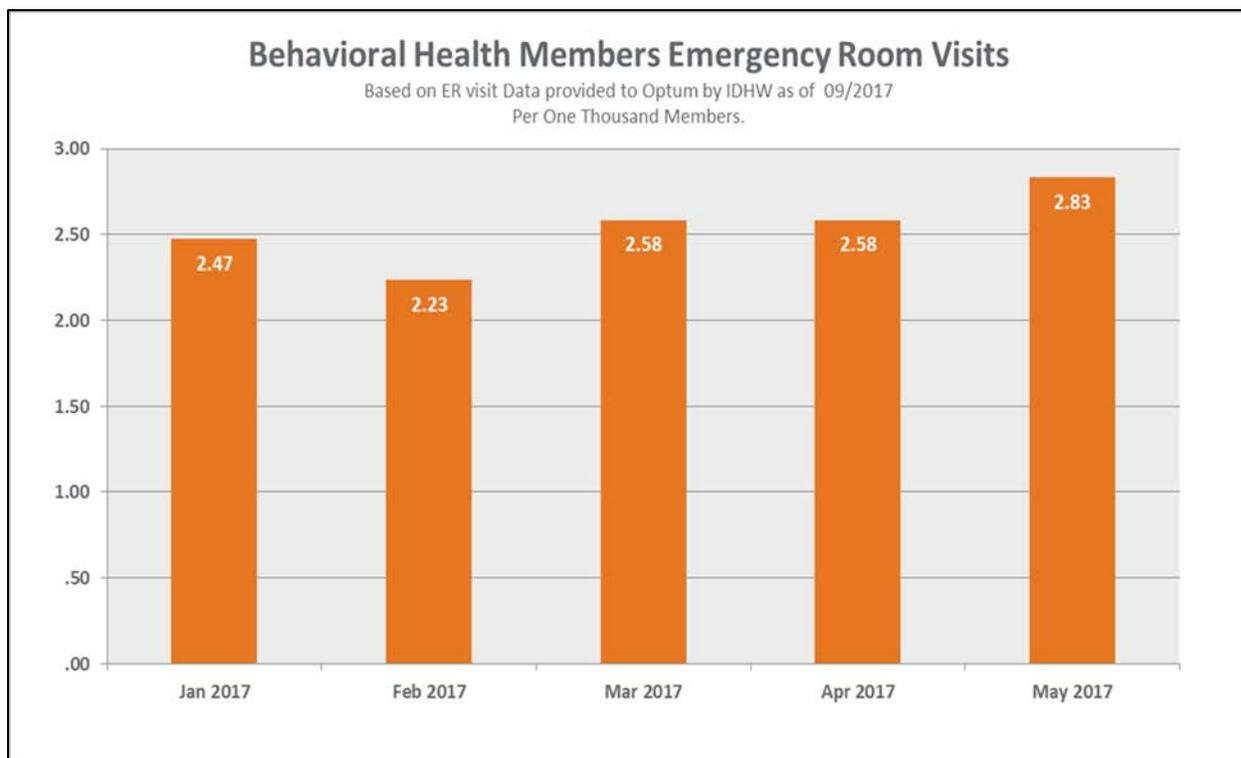
Figure 20

Barriers: No identified barriers.

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

Member Satisfaction Survey Results

Optum Behavioral Health monitors member satisfaction with behavioral health services. Beginning with Quarter 1, 2017, a new Member Satisfaction Survey, the *Optum Consumer Net Promoter Score Behavioral Health Survey* (CNPS BH Survey) was implemented. The Net Promoter Score, or NPS, is based on the fundamental perspective that every company's consumers can be divided into three categories: Promotors, Passives, and Detractors. By asking one question – *How likely it is that you would recommend [company] to a friend or*

colleague – companies can track these groups and get a measure of performance through consumers' eyes.

Consumers respond on a 0-to-10 point rating scale and are categorized as follows:
- Promoters (score 9-10) are loyal enthusiasts.
- Passives (score 7-8) are satisfied but unenthusiastic customers.
- Detractors (score 0-6) are unhappy customers.

The NPS item was scored on an 11-point scale ranging from 0 = 'Not at all Likely' to 10 = 'Extremely Likely'. The NPS score is calculated by subtracting the % of Detractors (those respondents that endorsed a score of 0-6) from the % of Promoters (those respondents that endorsed a score of 9-10).

Methodology: Optum surveys Optum Idaho Behavioral Health Plan adults 18 years of age and older and parents of children aged 11 years or younger. The survey is administered through a live telephone interview. Translation services are available to members upon request.

To be eligible for the survey, the member must have received services during the 90 days prior to the survey and have a valid telephone number on record. A random sample of individuals eligible for the survey is selected and called until the desired quota was met or the sample was exhausted. Members who have accessed services in multiple quarters are eligible for the survey only once every six months.

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

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

Quarterly Performance Results

The Quarter 1, 2017, results for Optum Idaho included surveys conducted from April 1, 2017, through June 30, 2017. Interviewers connected with a total of 395 members. Of the total connections, 75 members completed the survey, resulting in a response rate of 19%. Of the total interviews conducted, none (0%) resulted in a request for translation services. All (100%) of the surveys completed were conducted in English.

Key Consumer Measures	Q1 2017	YTD
Overall Satisfaction (Goal: ≥85.0%)	81.3%	81.3%
Optum support for obtaining referrals or authorizations	87.0%	87.0%
Accessibility, availability, and acceptability of the clinician network	87.0%	87.0%
Counseling and Treatment	87.0%	87.0%
Net Promoter Score (NPS):	4	4

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How likely it is that you would recommend Optum to a friend or colleague?		
Promoters	41%	41%
Passives	21%	21%
Detractors	37%	37%

Overall Member Satisfaction Survey Results

	Optum Support for Obtaining Referrals or Authorizations	Counseling and Treatment	Accessibility, Availability, and Acceptability of the Clinician Network	Overall Satisfaction
Q1 2017	87.0%	87.0%	87.0%	81.3%
Goal ≥ 85%	85.0%	85.0%	85.0%	85.0%
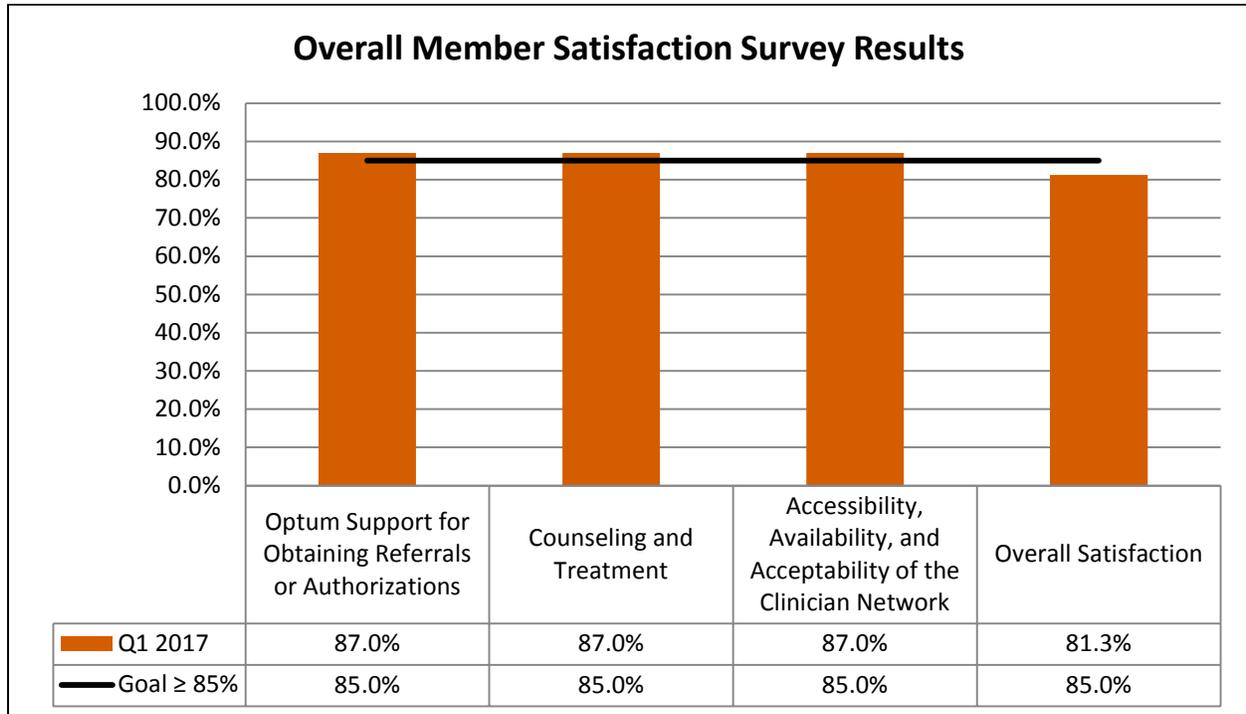
In addition, the Member Satisfaction Survey includes specific questions related to the member's experiences with counseling and treatment. The results are in the graph, "Member Experience with Counseling or Treatment", below.

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Member Experience with Counseling or Treatment

	Satisfied with the time it took to get an appointment.	Ability to Find Care That was Respectful of my Language, Culture and Ethnic Needs	Satisfaction with Experience of Finding an Available Clinician
Q1 2017	85.3%	90.4%	100.0%
Goal ≥ 85%	85.0%	85.0%	85.0%
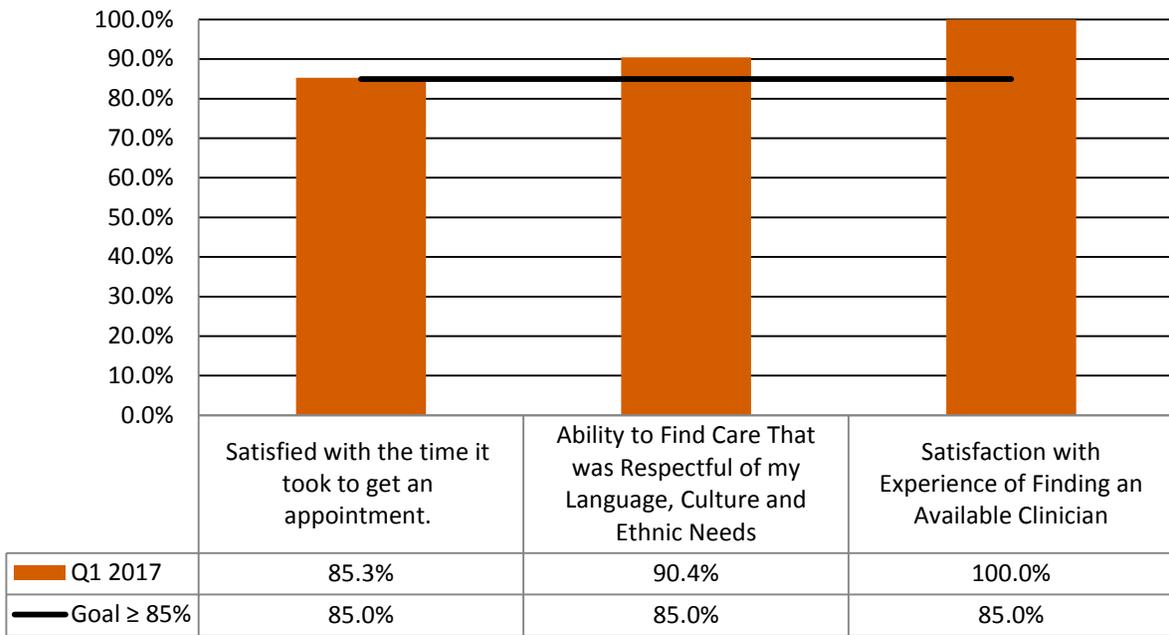
How likely would you be to recommend Optum to a friend or colleague? (scale 0 to 10 with 0 being not at all likely and 10 being extremely likely)
Net Promoter Score: 4

- Promoters [9, 10]: 41%
- Passives [7, 8]: 21%
- Detractors [0 - 6]: 37%

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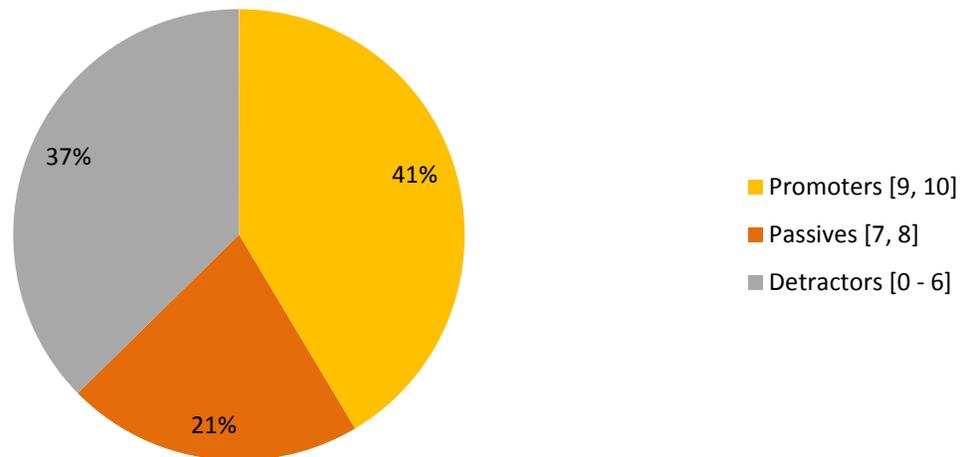
Analysis: Member Overall Satisfaction was 81.3% which is below the goal of ≥85.0%. All other domains were above the goal. The Net Promotor Score was 4; Promotors – 41%, Passives 21%, and Detractors, 37%.

Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: Since the result for Member Overall Satisfaction fell below the goal of≥85.0%, Optum Idaho will continue to monitor and identify trends.

Provider Satisfaction Survey Results

In 2016, Optum Idaho made the decision to change from a quarterly provider satisfaction survey to an annual survey to better align with national standards.   The new survey was executed during the 4th Quarter of 2016.

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

All of the data collection was conducted by Fact Finders. Fact Finders reached out to every provider. To accommodate the schedules of busy providers and include in the research as many of the providers as possible, a multi-stage, multi-mode coordinated data collection effort was employed. As soon as providers participated in the survey, they were removed from the active sample so there would be no further outreach to the practice.

There are 3 modes for providers to complete the survey:
1. Outbound Telephone Call from Fact Finders
2. Inbound Telephone from Provider to Fact Finders
3. Online Survey

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

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

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

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Overall Provider Satisfaction (goal ≥85%)

No Opinion
2%

Dissatisfied/Very
Dissatisfied
23%

Satisfied/Very
Satisfied
75%
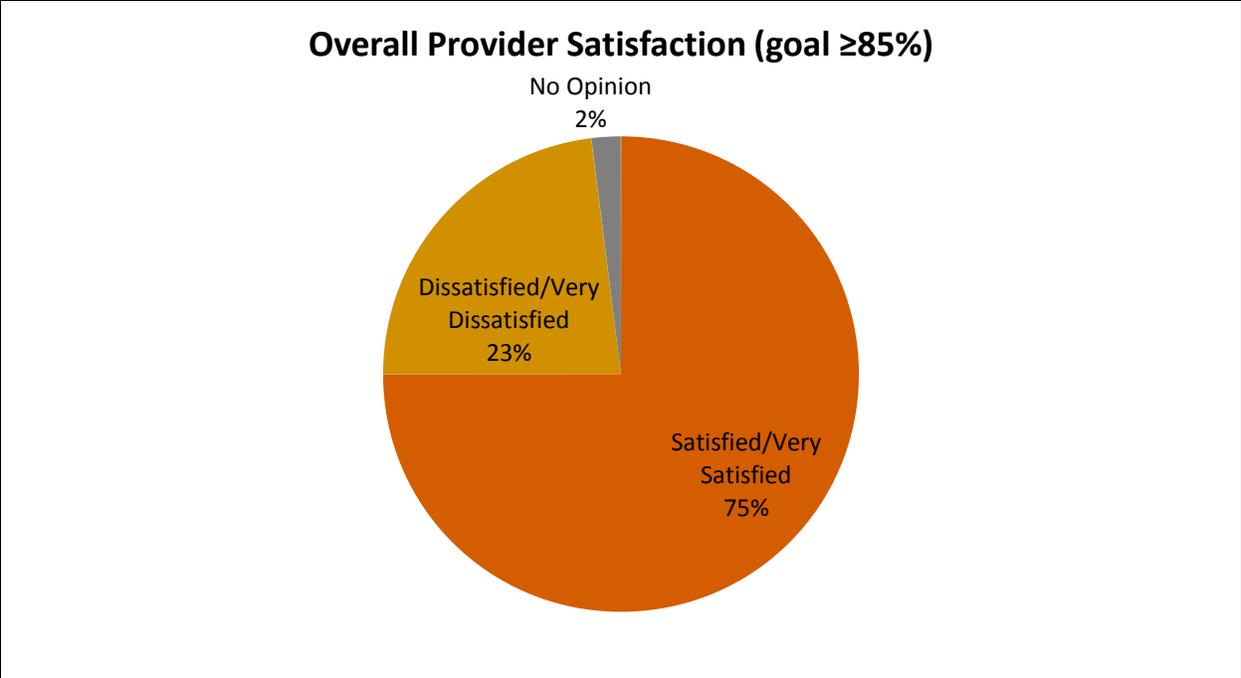
Barriers: The Optum Idaho performance goal for Overall Satisfaction is ≥85.0%. While the annual survey results fell below ≥85.0%, it was the first annual survey so results from future surveys will be monitored to identify trends. Optum Idaho will look at the areas within the survey that need improvement and identify interventions.

Opportunities and Interventions: The 2017 Annual Survey will be sent in November, 2017.

Performance Improvement

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

Performance Improvement Project (PIP)	Date Initiated	Quality Committee Oversight	Status	Key Accomplishments
No Current PIP's	NA	NA	NA	NA

During Quarter 3, there were 6 projects in progress. One (1) project was closed (A & G Mega Rule) and 2 new projects were added (IOP Phase II and Service Request Forms).

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Project	Description	Department Oversight	Status	Key Accomplishments
IOP-Phase 1 (Intensive Outpatient Program)	Develop and implement Intensive Outpatient Program (IOP), a new intermediate level of care treatment program for adult and child/adolescent members. The purpose of services is to monitor and maintain stability, decreasing moderate signs and symptoms, increase functioning, and assist members with integrating into community life.	Clinical-UM	Green	•Web-based Service Requests Form implementation
LEAN (UM Service Request Process Improvement)	Due to a new Center for Medicare Services (CMS) regulation, the Optum Idaho Utilization Management and Quality teams have a need to reduce turn-around time (TAT) on the Adverse Benefit Determination (ABD) process from the current =/>16 calendar days TAT to =/<14 calendar days by 7/1/2017, in order to meet the new regulatory requirements.	Clinical Ops, Med Dir, A & G	Green	•Linx upgrade approved and estimated to go live during Q4. •Meeting to discuss possible project closure.
Respite	Implement Respite for YES Class Members. Respite is a service that seeks to provide short-term, temporary care and supervision for a Class Member to relieve a stressful situation. The goal of the service is to prevent disruption of a Class Member's placement by providing relief to caregivers and Class Members.	Operations	Green	•Draft Level of Care Guidelines in review. •Draft Communication Plan developed.
IOP – Phase II	This project expands Optum Idaho's Intensive Outpatient Program (IOP) to include all Providers who are interested and able to provide IOP to Medicaid Members, as outlined by Optum's Level of Care Guidelines and national standards.	Clinical-UM	Green	•Readiness Assessment closed. •Training content completed.
Service Request Form	Ensure implementation questions/ concerns are addressed.	Clinical-UM	Green	•Forms for all services except IOP went live 7/1/17. All providers were required to start using on 8/1/17.

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Project	Description	Department Oversight	Status	Key Accomplishments
				•IOP forms went live 9/1/17.

During Quarter 3, one project was closed.

Project	Description	Department Oversight	Status	Key Accomplishments
A & G Mega Rule	Ensure Optum Idaho's A&G policies, procedures, Provider Manual, Member Handbook, Optum Idaho website, contract, and letter templates align with applicable CMS Mega Rule changes, effective July 1, 2017.	Quality	Closed	•Revised Monthly report (SR08). •Presented closure report to Executive committee. Closure report approved.

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.

IBHP Membership and Utilizers

	2016/Q2	2016/Q3	2016/Q4	2017/Q1	2017/Q2
Membership	293,793	299,233	304,125	299,388	303,086
Utilizers	29,694	28,822	28,790	29,811	30,605
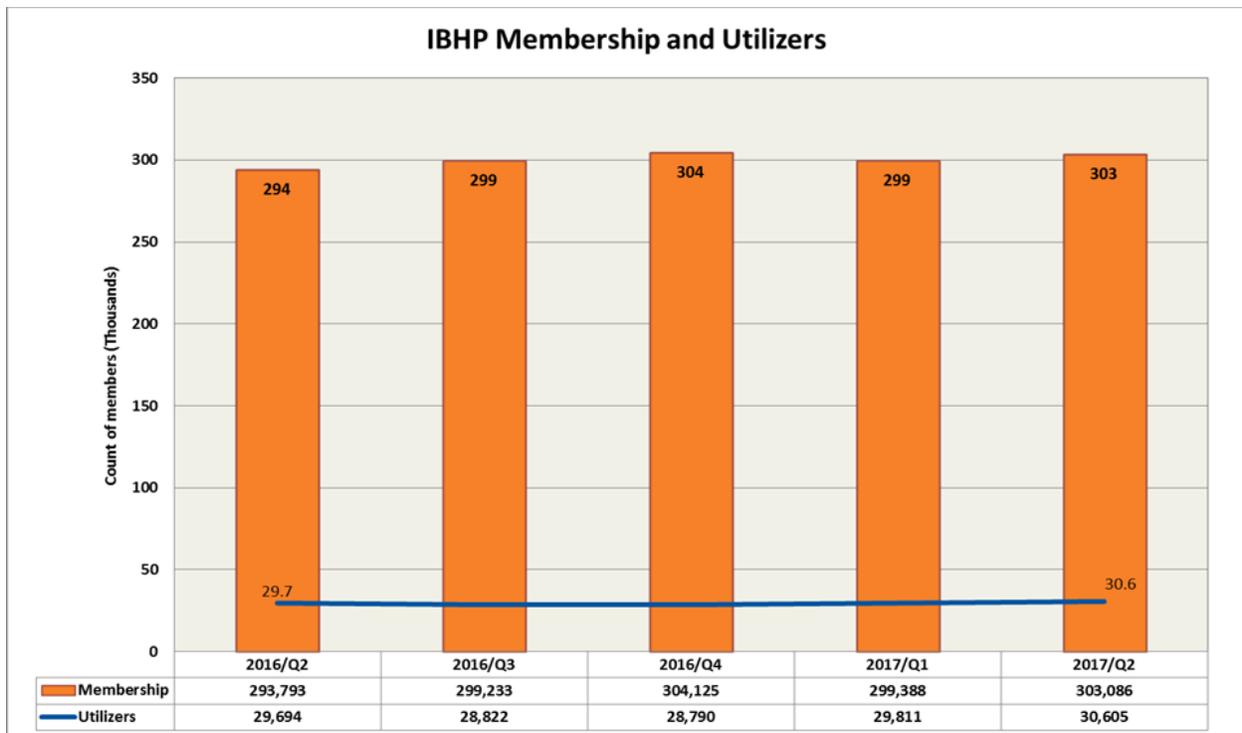
Analysis: Membership and utilizer numbers increased slightly during the quarter.

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

Member Services Call Standards

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

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

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Quarterly Performance Results

Member Service Line	Optum Idaho Standards	IBHP Contract Standards	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Total Number of Calls	NA	NA	1,175	1,412	1,290	1,345	1,362
Percent of Calls Answered Within 30 Sec	≥80.0%	None	82.0%	82.0%	80.0%	85.4%	83.0%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	18.0 sec	18.5 sec	21.5 sec	12.3 sec	2.7 sec
Abandonment Rate	≤3.5%	≤7%	3.4%	3.5%	4.1%	2.1%	1.7%

Analysis: During Q3, the Member Services and Crisis Line received a total of 1,362 calls. During Q3, 83.0% of calls were answered within 30 seconds (goal ≥80%). The average speed to answer was met at 2.7 seconds. The call abandoned rate was 1.7% which met the Optum Idaho Standards goal of ≤3.5% and the IBHP Contractual Standards goal of ≤7.0%. Optum Idaho will continue to monitor and identify trends.
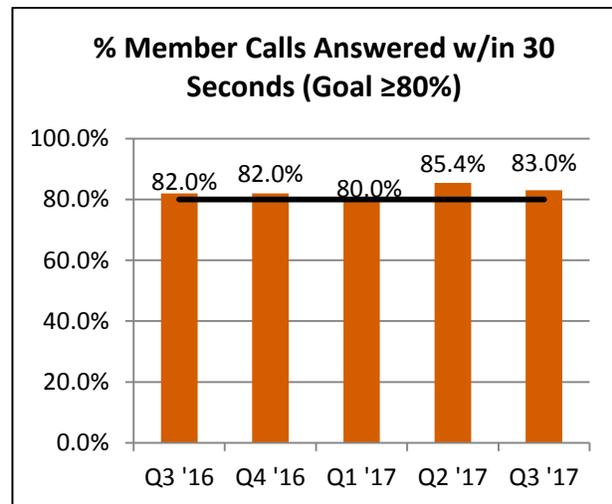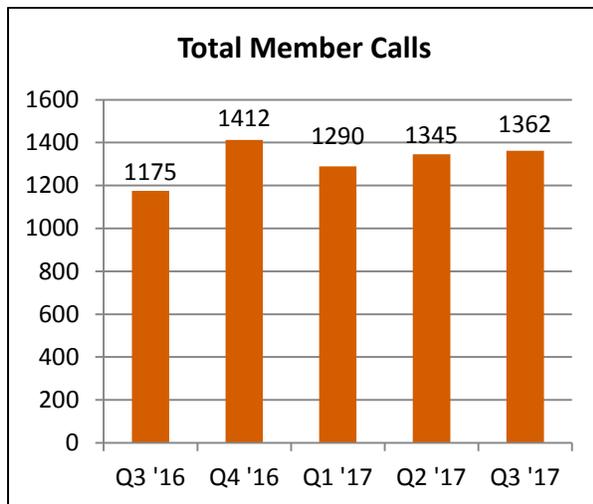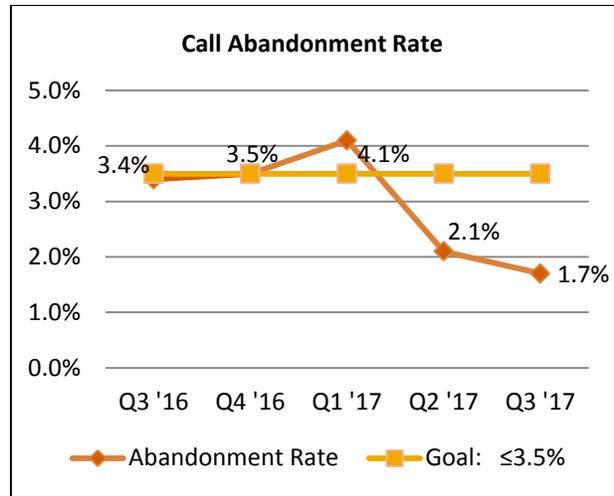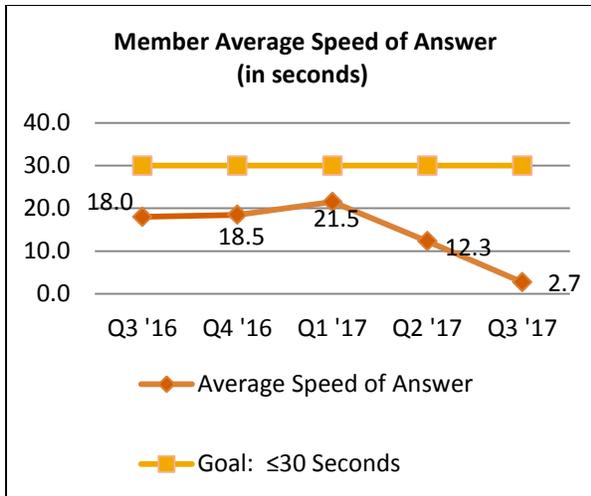
Total Member Calls

% Member Calls Answered w/in 30 Seconds (Goal ≥80%)

Member Average Speed of Answer (in seconds)

Quarter	Average Speed of Answer	Goal: ≤30 Seconds
Q3 '16	18.0	30.0
Q4 '16	18.5	30.0
Q1 '17	21.5	30.0
Q2 '17	12.3	30.0
Q3 '17	2.7	30.0

Call Abandonment Rate

Quarter	Abandonment Rate	Goal: ≤3.5%
Q3 '16	3.4%	3.5%
Q4 '16	3.5%	3.5%
Q1 '17	4.1%	3.5%
Q2 '17	2.1%	3.5%
Q3 '17	1.7%	3.5%

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	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Total Number of Calls	NA	NA	2,818	3,086	2,917	2,861	4,103
Percent of Calls Answered Within 30 Seconds	≥80.0%	None	98.9%	98.6%	98.4%	98.4%	97.1%
Average Speed of Answer	≤30 Seconds	120 seconds (2 minutes)	1.7 sec	1.1 sec	2.8 sec	1.8 sec	6.2 sec
Abandonment Rate	≤3.5%	≤7%	0.16%	0.41%	0.56%	0.44%	0.64%

Analysis: The total number of Customer Service provider calls during Q3 was 4,103. The increase in calls for the quarter stems from the implementation of the new Optum Idaho Clinical Services Service Request Form (SRF) and providers calling with questions. Customer service call standards met performance goals for all three customer service line measures again during Q3. The percent of calls answered within 30 seconds was at 97.1%, remaining above the goal

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of ≥80%. The average speed of answer was at 6.2 seconds during Q3, which was impacted as well, by the SRF implementation, but continued to meet the goal. The call abandonment rate was 0.64% continuing to meet both the Optum Idaho internal goal of ≤3.5% and the IBHP Contract Standard of ≤ 7%.
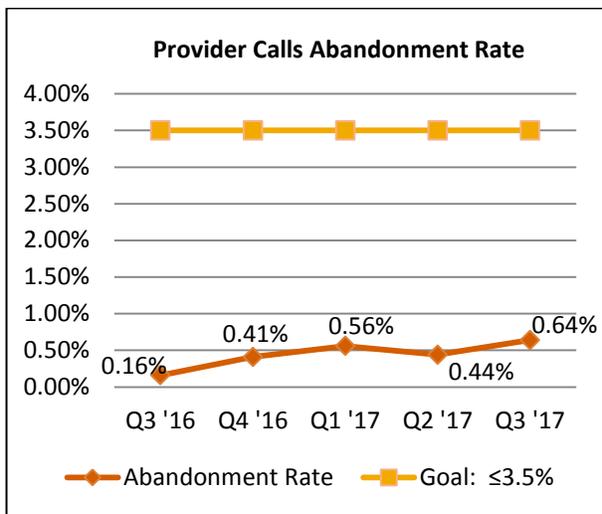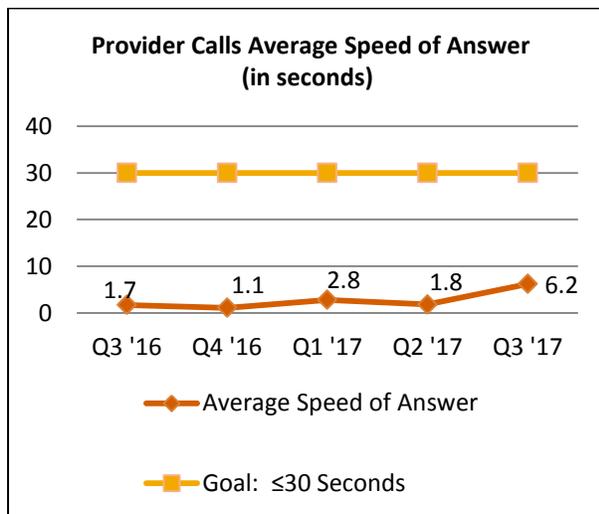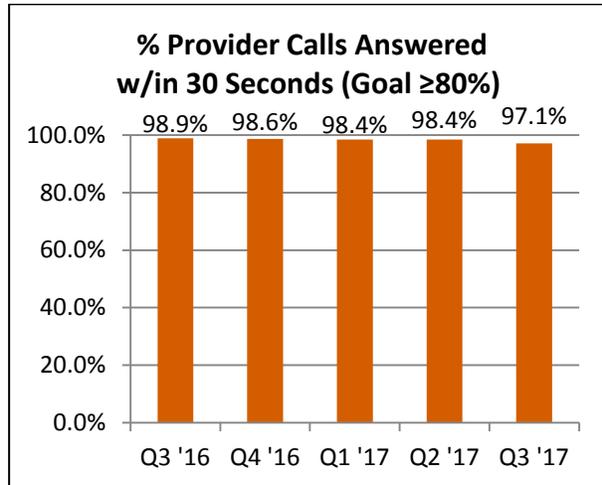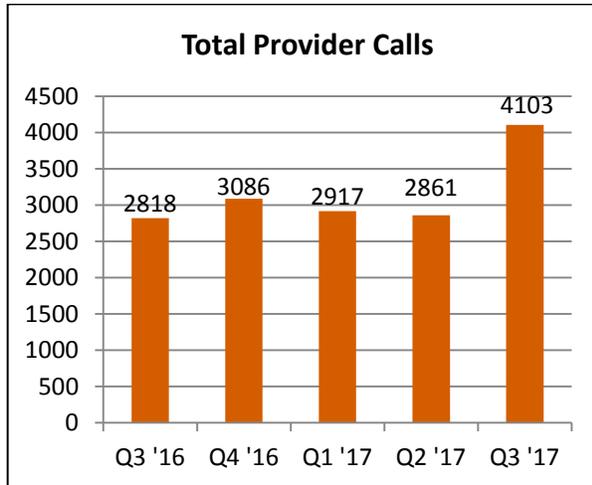
Total Provider Calls

% Provider Calls Answered w/in 30 Seconds (Goal ≥80%)

Provider Calls Average Speed of Answer (in seconds)

Provider Calls Abandonment Rate

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

Urgent and Non-Urgent Access Standards

Methodology: As part of Optum Idaho's Quality Improvement Program, and to ensure that all members have access to appropriate treatment as needed, Optum developed, maintains, and monitors a network with adequate numbers and types of clinicians and outpatient programs. Optum requires that network providers adhere to specific access standards for *Urgent Appointments* being offered within 48 hours and *Non-urgent Appointments* being offered within

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10 business days of request. Urgent and non-urgent access to care is monitored via monthly provider telephone polling by the Network team.

Quarterly Performance Results

Urgent/Non-Urgent Appointment Wait Time	Performance Goal	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Urgent Appointment Wait Time	Within 48 hours from request	22.0 hours	32.0 hours	24.0 hours	27.0 hours	20.0 hours
Non-Urgent Appointment Wait Time	Within 10 days from request	5.5 days	7.2 days	7.3 days	6 days	6 days

Analysis: The performance goal for Urgent Appointment wait time is 48 hours. During Q3, the average Urgent Appointment wait time was 20.0 hours. The performance goal for Non-Urgent Appointment wait time is an appointment within 10 days. This goal was again met during Q3 at an average of 6 days.
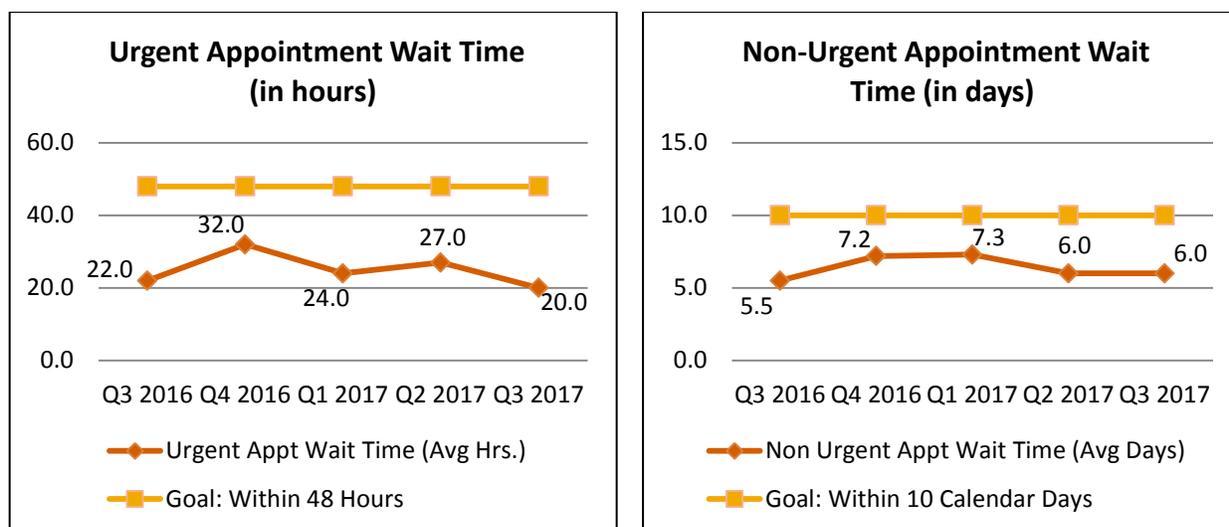
Urgent Appointment Wait Time (in hours)

Non-Urgent Appointment Wait Time (in 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

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

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

Quarterly Performance Results

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

Analysis: Optum Idaho continued to meet contract availability standards. During Q3, Area 1 availability standards were met at 100.0% and Area 2 availability standards were met at 99.8%. Our performance is viewed as meeting the goal due to established rounding methodology (rounding to the nearest whole number).

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

Member Protections and Safety

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

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

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

Notification of Adverse Benefit Determination

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

Quarterly Performance Results

Notification of ABD	Performance Goal	Target	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Total # ABD's	NA	NA	540	470	416	500	756
Clinical ABD's	NA	NA	NA	NA	NA	NA	578
Administrative ABD's	NA	NA	NA	NA	NA	NA	178
Written Notification	14 business days from request for services	NA	NA	NA	NA	NA	100.0% (756/756)
Initial Verbal Notification to Provider	1 business day from determination date	100.0%	99.6%	98.9%	99.8%	99.6%	No longer tracking
Written Notification	1 business day from verbal notification	100.0%	96.3% (520/540)	92.9% (437/470)	98.3% (409/416)	99.8% (499/500)	New 14 day requirement above

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

In Q3, Optum issued 756 ABDs – 578 Clinical and 178 Administrative. All 756 ABDs met the performance goal of being mailed within 14 days from receipt of the service request.
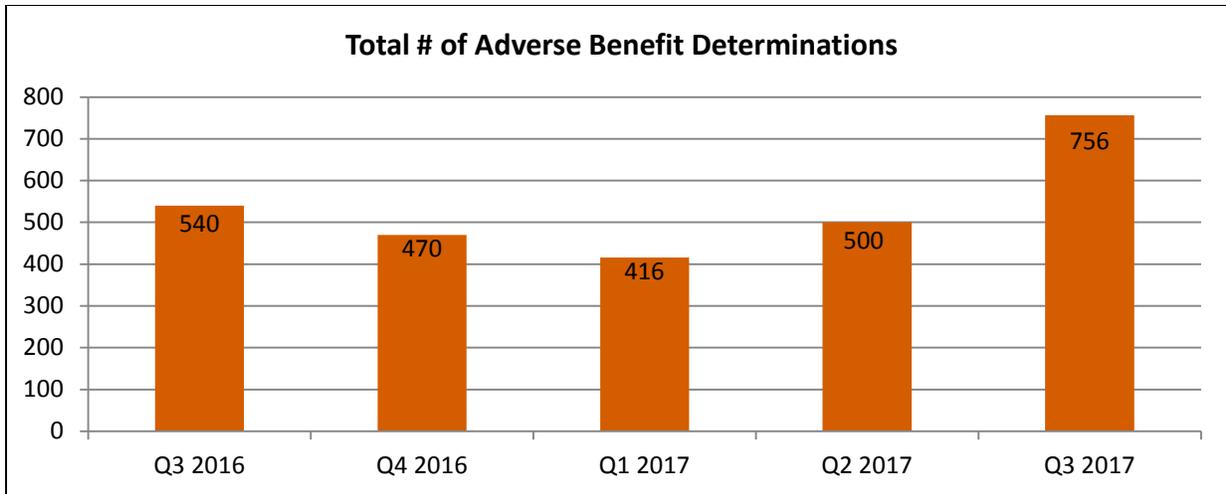
Total # of Adverse Benefit Determinations

Quarter	Value
Q3 2016	540
Q4 2016	470
Q1 2017	416
Q2 2017	500
Q3 2017	756

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

Member Appeals (formerly Grievances)

Methodology: Optum Idaho recognizes the right of a member or authorized representative to appeal an adverse benefit determination that resulted in member financial liability or denied services. All non-urgent appeals are required to be reviewed and resolved within 30 days. Urgent appeals are required to be reviewed and resolved within 72 hours. Additionally, all non-urgent appeals are required to be acknowledged within 5 calendar days from receipt of the complaint with an acknowledgement letter. Urgent appeal requests do not require an acknowledgement letter. All appeals are upheld, overturned, or partially overturned.

Quarterly Performance Results

Appeals	Performance Goal	Q3 2016	Q4 2016	Q1 2017	Q2 2017
Number of Member Appeals	NA	26	17	15	17
Average Number of Days to Resolution	30 Days	16.2	13.8	14.3	12.4
Number of Overturned Appeals	NA	4	1	1	1
Number of Partially Overturned Appeals	NA	0	2	2	0
% of Appeals Overturned or Partially Overturned	NA	15.4%	17.6%	20.0%	6.0%

Non-Urgent Appeals	Performance Goal	Q3 2017			
Total Appeal Determinations	NA	36			
Acknowledgement Compliance	5 Calendar Days	100.0%			
Determination Compliance	30 Calendar Days	100.0%			
Average Days to Resolve	NA	5.4			
Overturned Non-Urgent Appeals	NA	4			
Partially Overturned Non-Urgent Appeals	NA	5			

Urgent Appeals	Performance Goal	Q3 2017			
Total Appeal Determinations	NA	15			
Determination Compliance	72 Hours	100.0%			
Average Hours to Resolve	NA	27.4			
Overturned Urgent Appeals	NA	7			
Partially Overturned Urgent Appeals	NA	4			

Analysis: In Q3, Optum Idaho received 36 non-urgent appeals and 15 urgent appeal requests, for a total of 51 appeals. This is a significant increase in quarterly volume due in large part to the higher volume of ABDs. Additionally, new Federal Regulations provided additional member protections related to filing appeals.   All non-urgent and urgent appeals met the respective performance goals.
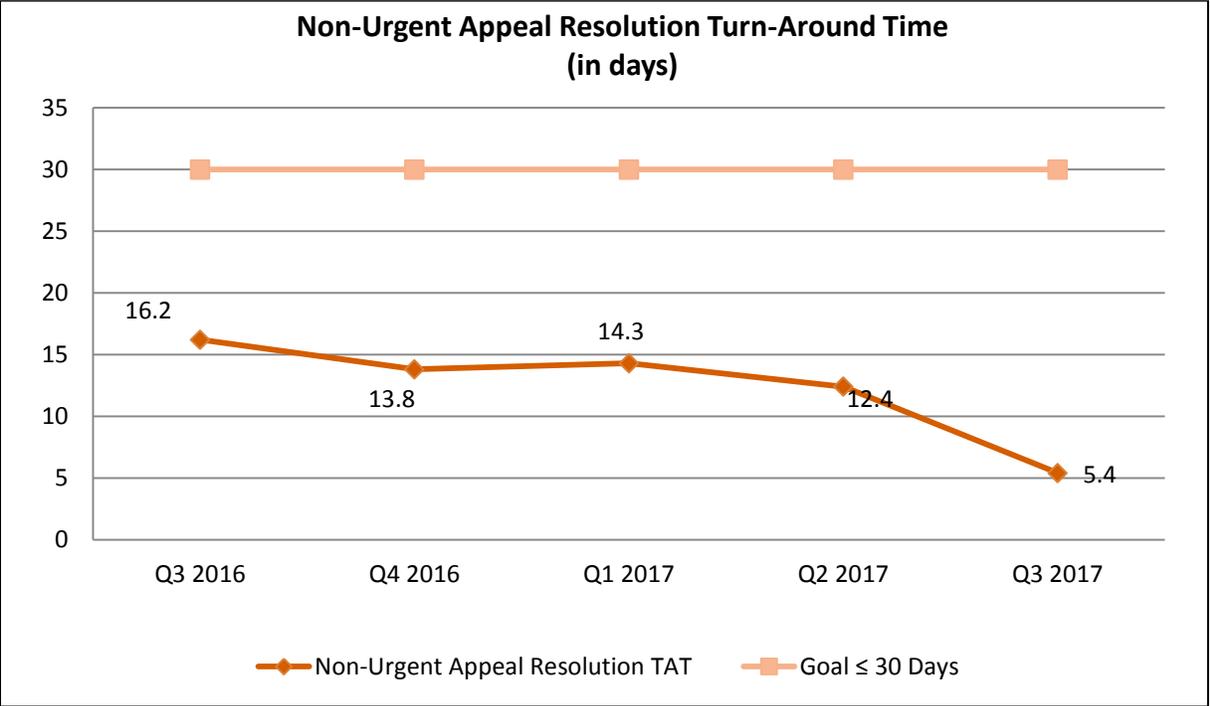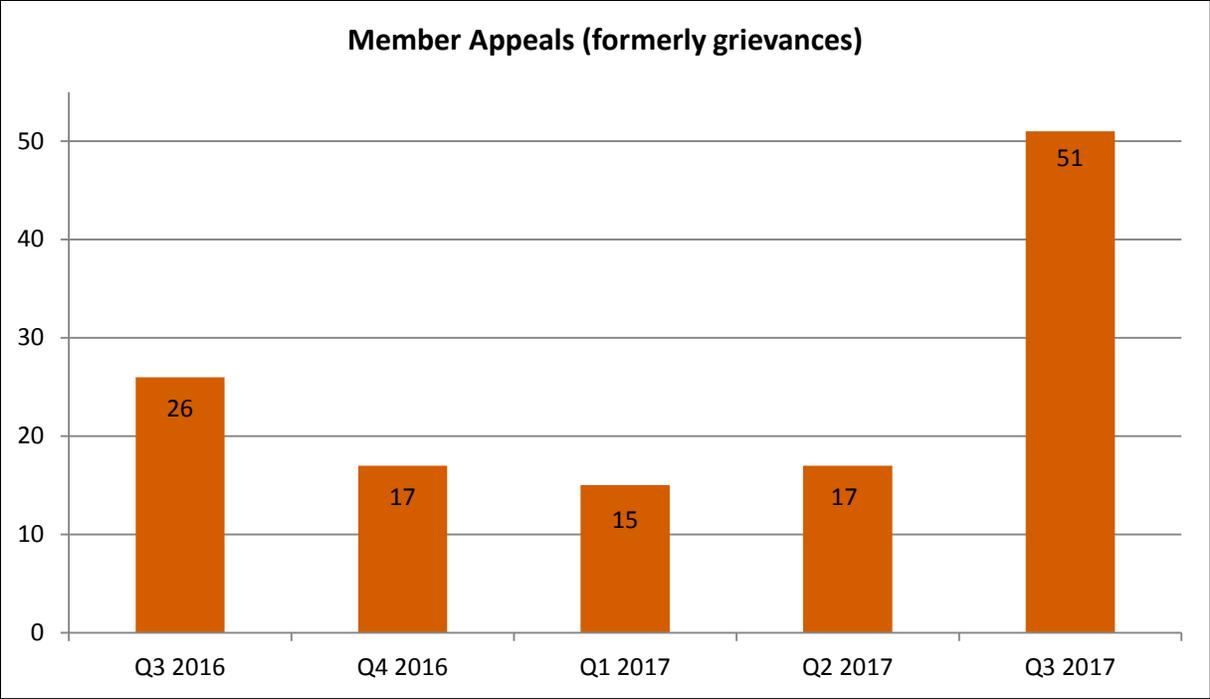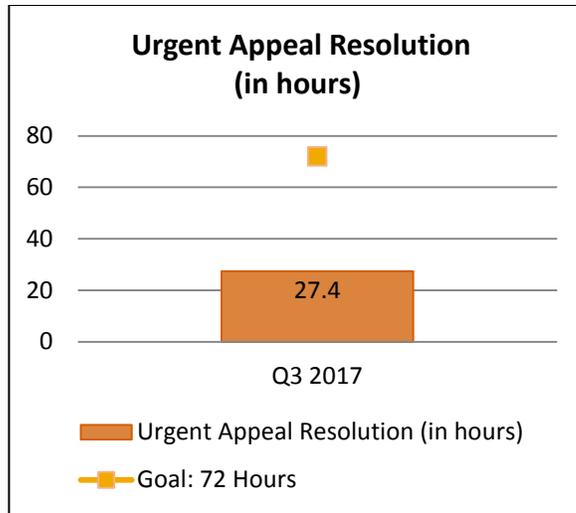
Member Appeals (formerly grievances)

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
	26	17	15	17	51

Non-Urgent Appeal Resolution Turn-Around Time (in days)

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Non-Urgent Appeal Resolution TAT	16.2	13.8	14.3	12.4	5.4
Goal ≤ 30 Days	30	30	30	30	30

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**Urgent Appeal Resolution
(in hours)**

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

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Quarterly Performance Results

Complaints	Performance Goal	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Number of Quality of Service (QOS) Complaints Received	NA	17	10	12	20	14
Percent QOS Complaints Resolved w/in TAT	10 Days	100.0%	100.0%	83.3%	100.0%	100.0%
Number of Quality of Care Complaints (QOC) Received	NA	1	1	1	3	2
Percent QOC Complaints Resolved w/in TAT	30 Days	100.0%	100.0%	100.0%	100.0%	100.0%

Analysis: During Q3, there were 16 total complaints processed. Fourteen (14) were Quality of Service complaints, and 2 were Quality of Care concerns. Optum Idaho was at 100% compliance for all acknowledgement and resolution turnaround times.

Number of Complaints Received Q1 2014 - Q3 2017

Data points: Q1 '14: 221, Q2 '14: 169, Q3 '14: 107, Q4 '14: 58, Q1 '15: 37, Q2 '15: 42, Q3 '15: 26, Q4 '15: 28, Q1 '16: 14, Q2 '16: 18, Q3 '16: 18, Q4 '16: 11, Q1 '17: 13, Q2 '17: 23, Q3 '17: 16

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Quality of Service Resolution TAT Compliance (≤10 Days)

Quarter	Value
Q3 2016	100.0%
Q4 2016	100.0%
Q1 2017	83.3%
Q2 2017	100.0%
Q3 2017	100.0%

Quality of Care Resoluation TAT Complaince (≤30 Days)

Quarter	Value
Q3 2016	100.0%
Q4 2016	100.0%
Q1 2017	100.0%
Q2 2017	100.0%
Q3 2017	100.0%

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Complaints by Type

	Benefit	Service	Access	Billing & Financial	Clinical Quality of Care	Privacy Incident	Quality of Practitioner Office Site
Q3 2016	2	14	0	1	1	0	0
Q4 2016	1	9	0	0	1	0	0
Q1 2017	2	8	1	1	1	0	0
Q2 2017	2	16	1	1	3	0	0
Q3 2017	4	9	0	0	2	0	1

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

Critical Incidents

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

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

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

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

Quarterly Performance Results

Critical Incidents	Performance Goal	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Number of CI's Received	NA	16	17	19	19	11
CI Ad-hoc Review: % completed within 5 business days from notification of incident	100%	100.0%	100%	100%	100%	100%

Analysis: There were 11 Critical Incidents reported during Q3. The turnaround time for Ad-Hoc Committee review within 5 business days from notification of incident was met. Again during Q3, the highest number of Critical Incidents fell in the category of unexpected deaths. Of the 11 Critical Incidents reported, 6 (54.5%) were from unexpected deaths. In addition, 4 (36.4%) were from suicide attempts, and 1 (9.1%) was from a completed suicide.

Further analysis showed that during Q3, Region 7 reported the highest number (4) of critical incidents at 36.4%, followed by Region 6 with 3 reported at 27.3%. Coordination of Care between the behavioral health provider and the Primary Care Provider (PCP) occurred in 7 (63.6%) of the total cases. Of the 11 reported Critical Incidents, 3 (27.3%) males and 8 (72.7%) females showed that member had a co-morbid health condition. Of the cases reported, all (100.0%) were adults (18+). The average age for males was 40 and females 57. Of the cases

reported, 3 (27.3%) were males and 8 (72.7%) were females. No providers were put on unavailable status due to a Critical Incident.

Total Number of Critical Incidents

Quarter	Total
Q3 2016	16
Q4 2016	17
Q1 2017	19
Q2 2017	19
Q3 2017	11

Quarterly Critical Incident by Type

	Completed Suicide	Suicide Attempt	Unexpected Death	Physical Assault by a Member	Sexual Assault of a Member	Sexual Assault by a Member	High Profile Incident
2016 Q3	0.0%	26.7%	66.7%	6.7%	0.0%	0.0%	0.0%
2016 Q4	11.8%	41.2%	47.1%	0.0%	0.0%	0.0%	0.0%
2017 Q1	10.5%	10.5%	73.7%	0.0%	0.0%	0.0%	5.3%
2017 Q2	5.3%	31.6%	52.6%	5.3%	0.0%	0.0%	5.3%
2017 Q3	9.1%	36.4%	54.5%	0.0%	0.0%	0.0%	0.0%

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Quarterly Critical Incident by Region
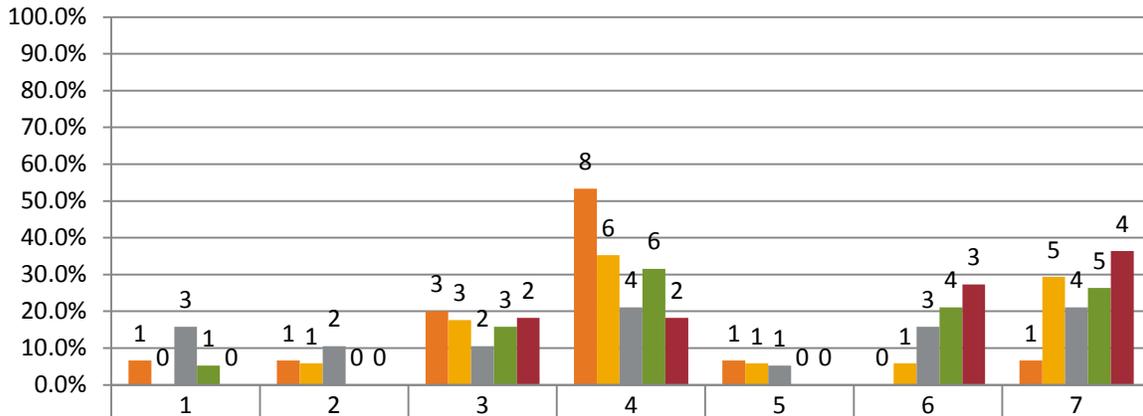
	1	2	3	4	5	6	7
2016 Q3	6.7%	6.7%	20.0%	53.3%	6.7%	0.0%	6.7%
2016 Q4	0.0%	5.9%	17.6%	35.3%	5.9%	5.9%	29.4%
2017 Q1	15.8%	10.5%	10.5%	21.1%	5.3%	15.8%	21.1%
2017 Q2	5.3%	0.0%	15.8%	31.6%	0.0%	21.1%	26.3%
2017 Q3	0.0%	0.0%	18.2%	18.2%	0.0%	27.3%	36.4%

Quarterly Critical Incidents-Coordination of Care Occurred
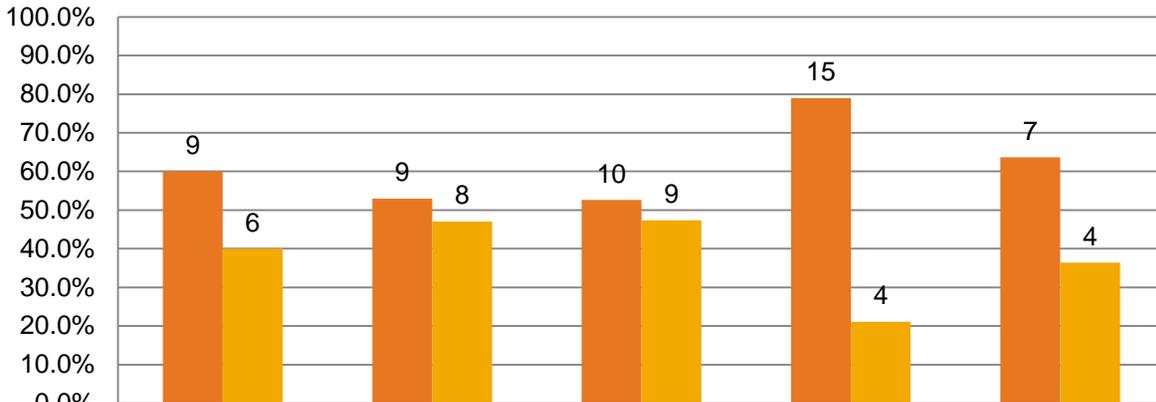
	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3
Yes	60.0%	52.9%	52.6%	78.9%	63.6%
No	40.0%	47.1%	47.4%	21.1%	36.4%

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

	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3
■ Male	40.0%	5.9%	21.1%	15.8%	27.3%
■ Female	46.7%	11.8%	63.2%	52.6%	72.7%
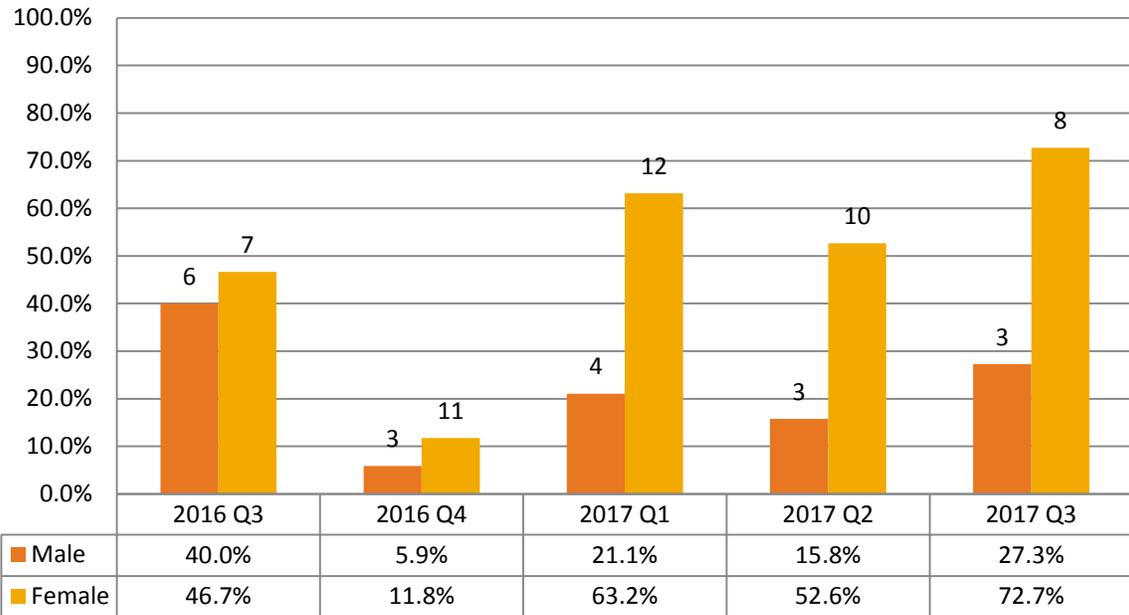
Quarterly Critical Incidents by Age
(Adults & Children/Adolescents)

	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3
■ Adult (18+)	93.3%	94.1%	94.7%	89.5%	100.0%
■ Child/Adolescent (17 and under)	6.7%	5.9%	5.3%	10.5%	0.0%

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Quarterly Critical Incidents by Average Age

	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3
Male	42	40	36	34	40
Female	47	42	49	42	57

Quarterly Critical Incidents by Gender

	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3
Male	45.7%	23.5%	31.6%	36.8%	27.3%
Female	53.3%	76.5%	68.4%	63.2%	72.7%

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

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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	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Percent Acknowledged ≤ 2 business days	100%	100%	100%	100%	100%	100%

Analysis: The data summarizes Optum Idaho Customer Service responsiveness to written inquiries to both members and providers. The data indicated that the standard of 100% acknowledged within 2 business days was again met during Q3.
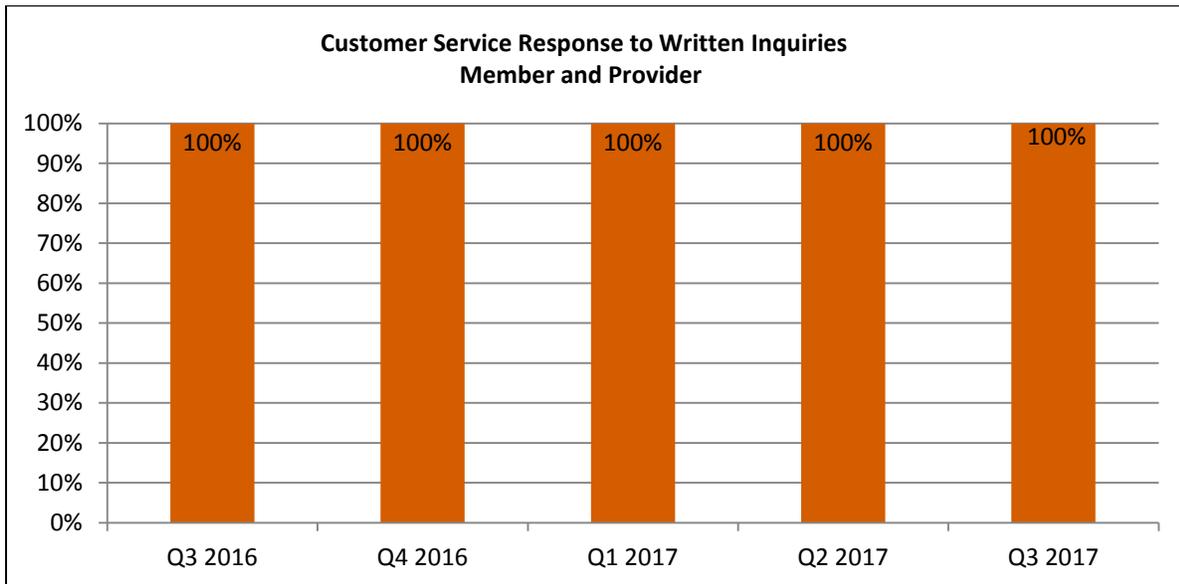

Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified.

## *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	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Number of Audits Conducted	NA	82	39	128	164	148
Initial Audit (Average overall score)	85.0%	98.3%	95.9%	92.1%	93.6%	98.0%
Recredentialing Audit (Average overall score)	85.0%	92.2%	93.4%	91.2%	94.3%	92.8%
Monitoring (Average overall score)	85.0%	NA*	85.0%	94.9%	95.2%	93.7%
Quality (Average overall score)	85.0%	96.5%	NA**	82.5%***	NA**	86.1%
Percent of Audits Requiring a Corrective Action Plan	NA	7.3%	7.6%	16.4%	6.1%	11.5%

*There were no monitoring audits during Q3, 2016. **There were no quality audits during Q4, 2016 and Q2 2017.
***There was only 1 Quality audit during Q1, 2017.

Analysis: During Q3, one-hundred and forty-eight (148) Provider Audits were completed on Optum Idaho network providers. Of the 148 audits completed, 88.5% received a passing score. Corrective action plans were implemented for 11.5% of the audits. Overall audit scores per region and per audit type are reflected in graphs below.

Also, network providers are given the opportunity to rate the Provider Quality Monitoring Audit process in a Satisfaction Survey. In Q1, 2016, Optum Idaho began using a new Satisfaction Survey for providers to complete once a monitoring audit is completed. The survey used to gather this information is through the Qualtrics Survey Application which was approved by United Health Group. The survey is sent to providers by email.   If an email address is not on file, the provider will not receive the survey. Surveys are emailed every other week to providers who were audited within the previous 2 weeks. Providers have 4 weeks to complete and return the survey. The results at the end of Q3 showed that 19 responses were received. Of those responses, 53.0% of providers stated that the overall value of the audit process was excellent, followed by 26.0% who stated it was very good and 10.5% who stated it was good and 10.5% stating it was fair. 73.6% indicated that the auditor was excellent. Sixty-three percent (63.1%) of respondents indicated that their overall experience with the audit was excellent.

Quarterly Provider Monitoring Audits

Q3 2016: 82
Q4 2016: 39
Q1 2017: 128
Q2 2017: 164
Q3 2017: 148

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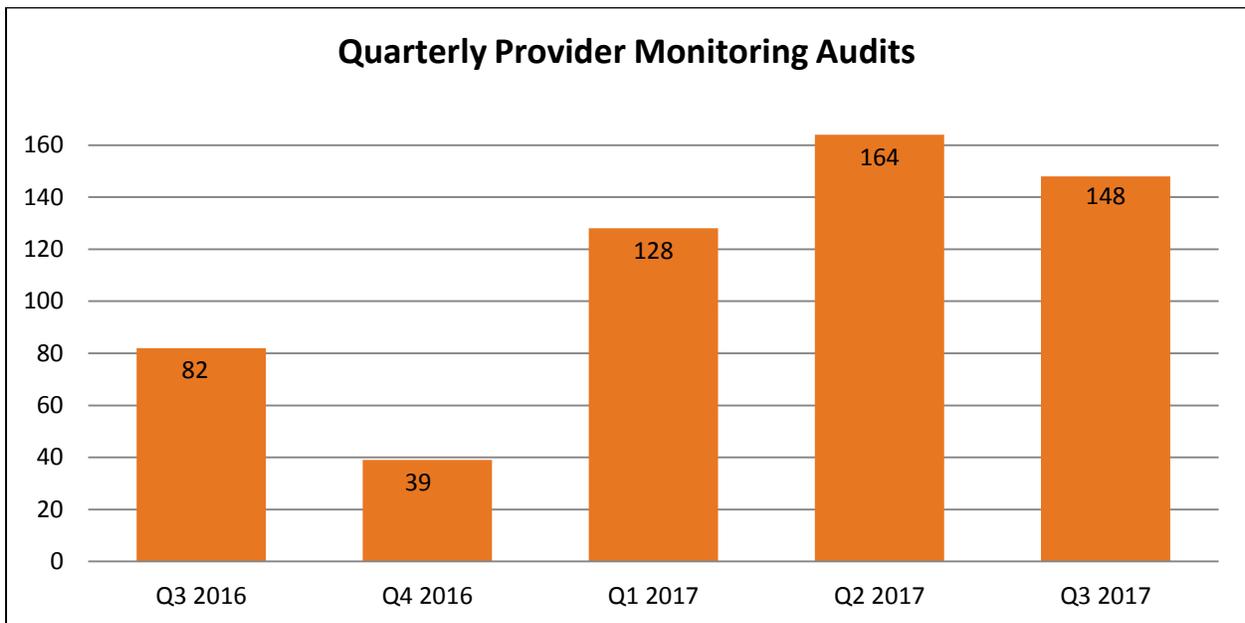
Overall Provider Monitoring Audit Score Per Region
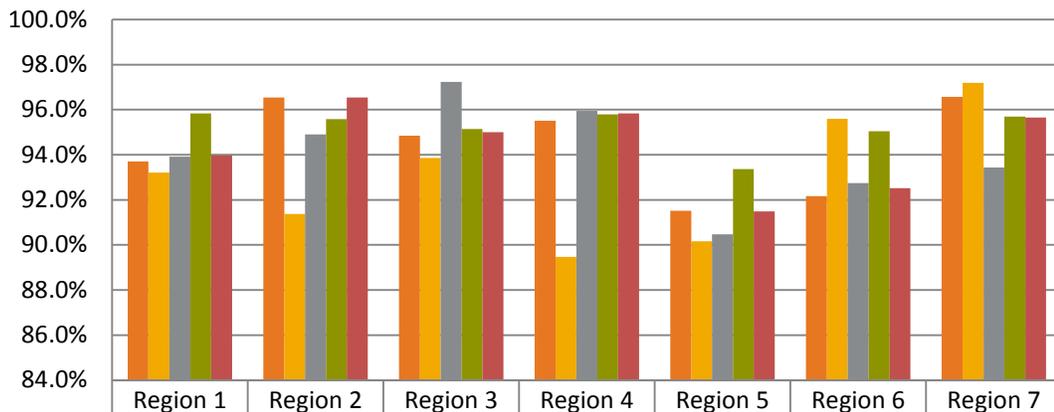
	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7
Q3 2016 (n=82)	93.7%	96.5%	94.8%	95.5%	91.5%	92.2%	96.6%
Q4 2016 (n=39)	93.2%	91.4%	93.9%	89.5%	90.2%	95.6%	97.2%
Q1 2017 (n=128)	93.9%	94.9%	97.2%	95.9%	90.5%	92.7%	93.4%
Q2 2017 (n=164)	95.8%	95.6%	95.1%	95.8%	93.4%	95.0%	95.7%
Q3 2017 (n=148)	94.0%	96.5%	95.0%	95.8%	91.5%	92.5%	95.7%

Total Number of Provider Monitoring Audits by Type
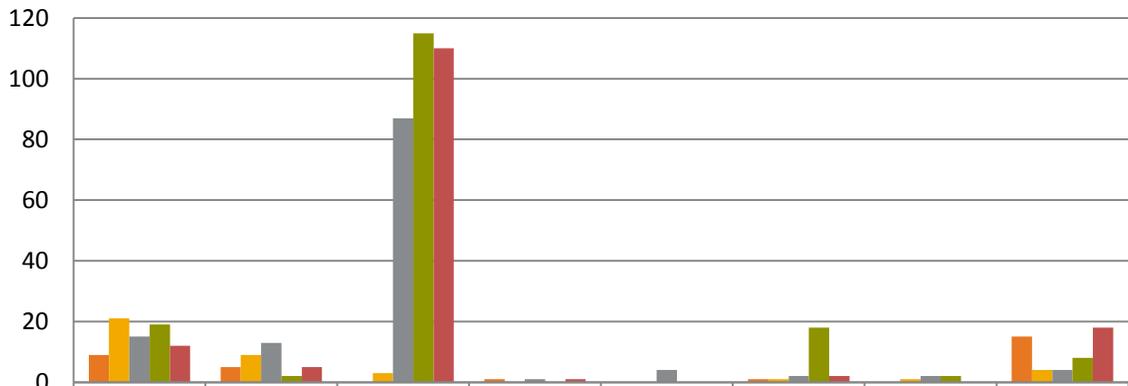
	Initial	Recredentialing	Monitoring	Quality	Change/New Location	New Program	Re-audit	Secondary Location
Q3 2016 (n=82)	9	5	0	1	0	1	0	15
Q4 2016 (n=39)	21	9	3	0	0	1	1	4
Q1 2017 (n=128)	15	13	87	1	4	2	2	4
Q2 2017 (n=164)	19	2	115	0	0	18	2	8
Q3 2017 (n=148)	12	5	110	1		2		18

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Overall Provider Audit Score by Type
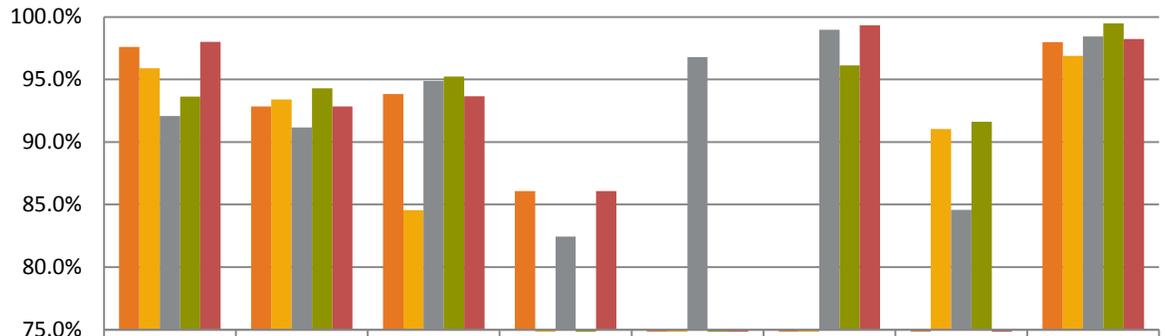
	Initial	Recredentialing	Monitoring	Quality	Change/New Location	New Program	Re-audit	Secondary Location
Q3 2016 (n=82)	97.6%	92.8%	93.8%	86.1%	0.0%	0.0%	0.0%	98.0%
Q4 2016 (n=39)	95.9%	93.4%	84.6%	0.0%	0.0%	68.3%	91.0%	96.9%
Q1 2017 (n=128)	92.1%	91.2%	94.9%	82.5%	96.8%	99.0%	84.6%	98.4%
Q2 2017 (n=164)	93.6%	94.3%	95.2%	0.0%	0.0%	96.1%	91.6%	99.5%
Q3 2017 (n=148)	98.0%	92.8%	93.7%	86.1%	0.0%	99.3%	0.0%	98.2%

% of Audits w/Passing Score of 85% or Higher

Q3 (n=82)	Q4 (n=39)	Q1 (n=128)	Q2 (n=164)	Q3 (n=148)
92.7%	92.3%	83.6%	93.9%	88.5%

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% of Audits Where Corrective Action Plan was Required

| Quarter	Percentage
Q3 (n=82)	7.3%
Q4 (n=39)	7.6%
Q1 (n=128)	16.4%
Q2 (n=164)	6.1%
Q3 (n=148)	11.5%
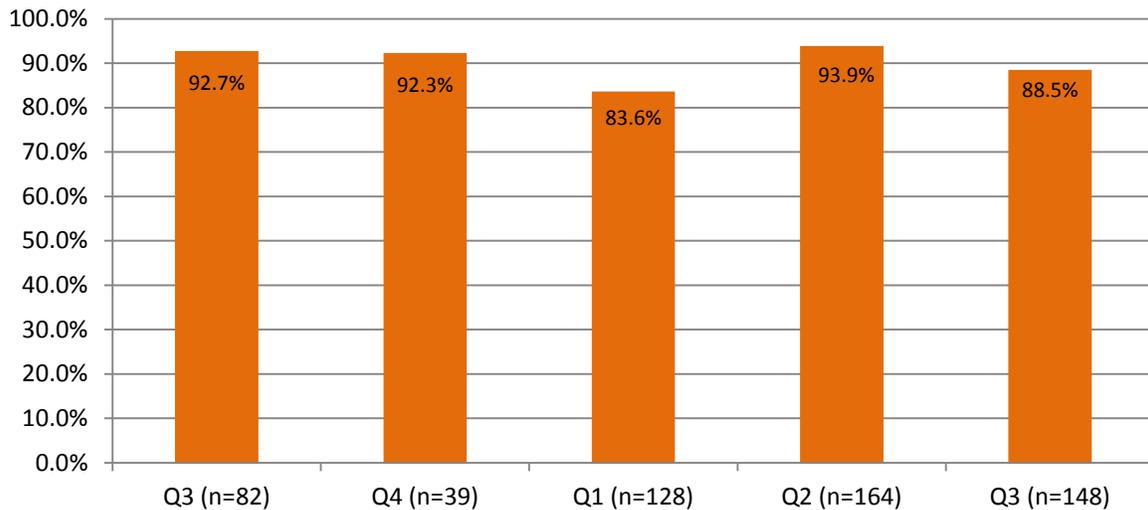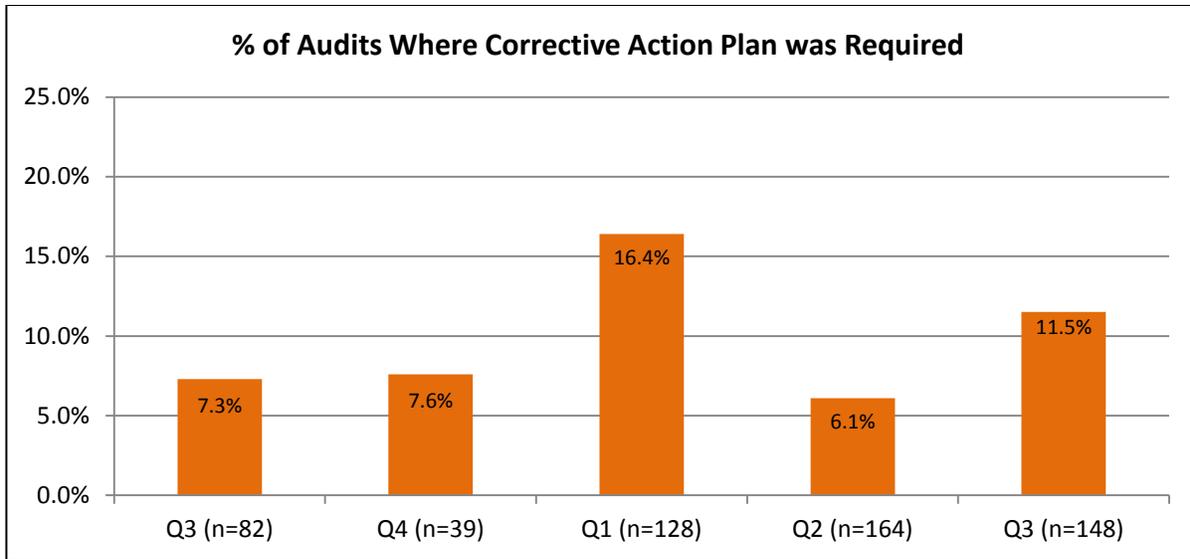
Below are the results of the surveys received back by the end of Q3 that were sent to providers regarding their rating of the Monitoring Audit Process.

Rating of Overall Value of Audit Process

	Excellent	Very Good	Good	Fair	Poor
Q3 2016 (Responses: 30)	50.0%	33.3%	3.3%	6.7%	6.7%
Q4 2016 (Responses: 8)	62.5%	25.0%	0.0%	12.5%	0.0%
Q1 2017 (Responses: 14)	57.0%	36.0%	7.0%	0.0%	0.0%
Q2 2017 (Responses: 23)	56.5%	26.1%	8.7%	8.7%	0.0%
Q3 2017 (Responses: 19)	53.0%	26.0%	10.5%	10.5%	0.0%

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Overall Rating of Auditor

	Excellent	Very Good	Good	Fair	Poor
Q3 2016 (Responses: 30)	57.0%	23.0%	7.0%	3.0%	10.0%
Q4 2016 (Responses: 8)	75.0%	25.0%	0.0%	0.0%	0.0%
Q1 2017 (Responses: 14)	57.0%	43.0%	0.0%	0.0%	0.0%
Q2 2017 (Responses: 23)	74.0%	13.0%	4.3%	8.7%	0.0%
Q3 2017 (Responses: 19)	73.6%	16.0%	10.5%	0.0%	0.0%

Overall Experience with Audit

	Excellent	Very Good	Good	Fair	Poor
Q3 2016 (Responses: 30)	50.0%	33.3%	3.3%	0.0%	13.3%
Q4 2016 (Responses: 8)	75.0%	25.0%	0.0%	0.0%	0.0%
Q1 2017 (Responses: 14)	57.1%	28.6%	14.3%	0.0%	0.0%
Q2 2017 (Responses: 23)	52.1%	23.0%	13.0%	9.0%	0.0%
Q3 2017 (Responses: 19)	63.1%	15.8%	15.8%	5.3%	0.0%

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

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Coordination of Care

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

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

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

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

Quarterly Performance Results

| Coordination of Care (% answered in the affirmative)	Performance Goal	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Is the name of the member's primary care physician (PCP) documented in the record?	NA	97.1%	92.1%	94.5%	96.0%	96.1%
If the Member has a PCP there is documentation that communication/collaboration occurred	NA	86.5%	87.2%	73.0%	87.0%	79.0%
Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor) and/or were they seen by another behavioral health clinician in the past? This is a non-scored question.	NA	58.0%	70.0%	50.5%	54.0%	59.0%

If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred.	NA	78.0%	70.0%	78.0%	80.5%	75.0%

Analysis: Coordination of Care audits completed during Q3 revealed that 96.1% of member records reviewed had documentation of the name of the member's PCP. Of those, 79.0% indicated that Communication/Collaboration had occurred between the behavioral health provider and the member's PCP. Audit results also showed that 59.0% of the records indicated the member was being seen (or had been seen in the past) by another behavioral health clinician (psychiatrist, social worker, psychologist, substance abuse counseling). Of those, 75.0% indicated that communication/collaboration had occurred.

Is the name of the member's primary care physician (PCP) documented in the record?

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
	97.1%	92.1%	94.5%	96.0%	96.1%

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

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
	86.5%	87.2%	73.0%	87.0%	79.0%

Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor) and/or were they seen by another behavioral health clinician in the past? (non-scored question)

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
	58.0%	70.0%	50.5%	54.0%	59.0%

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If the member is being seen by another behavioral health clinician, there is documentation that communication/ collaboration occurred.

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

Provider Disputes

Methodology: Provider Disputes are requests by a practitioner for review of a non-coverage determination when a service has already been provided to the member, and includes a clearly expressed desire for reconsideration and indication as to why the non-coverage determination is believed to have been incorrectly issued. A denied claim or an Administrative ABD are the two most common disputed items. Provider disputes require that a written resolution notice be sent within 30 days following the request for consideration.

Quarterly Performance Results

Provider Disputes	Performance Goal	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Number of Provider Disputes	NA	14	15	13	6	45
Average # of Days Provider Disputes Resolved	≤30 Days	9.9	12.9	17.9	2.5	6.1
Number of Disputes Fully Overturned	NA	6	3	1	1	39
Number of Disputes Partially Overturned	NA	0	0	2	0	4
% of Appeals Overturned or Partially Overturned	NA	42.9%	20.0%	23.0%	1.6%	96.0%

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Analysis: During Q3, there were 45 Provider Disputes. The significant increase in Provider Disputes is a result of the Administrative Denials that Optum began issuing at the beginning of Q3. Of the 45 disputes, 43 were overturned – 39 were fully overturned and 4 were partially overturned.   All disputes were resolved within the turnaround time. The overall average turnaround time was 6.1 days.
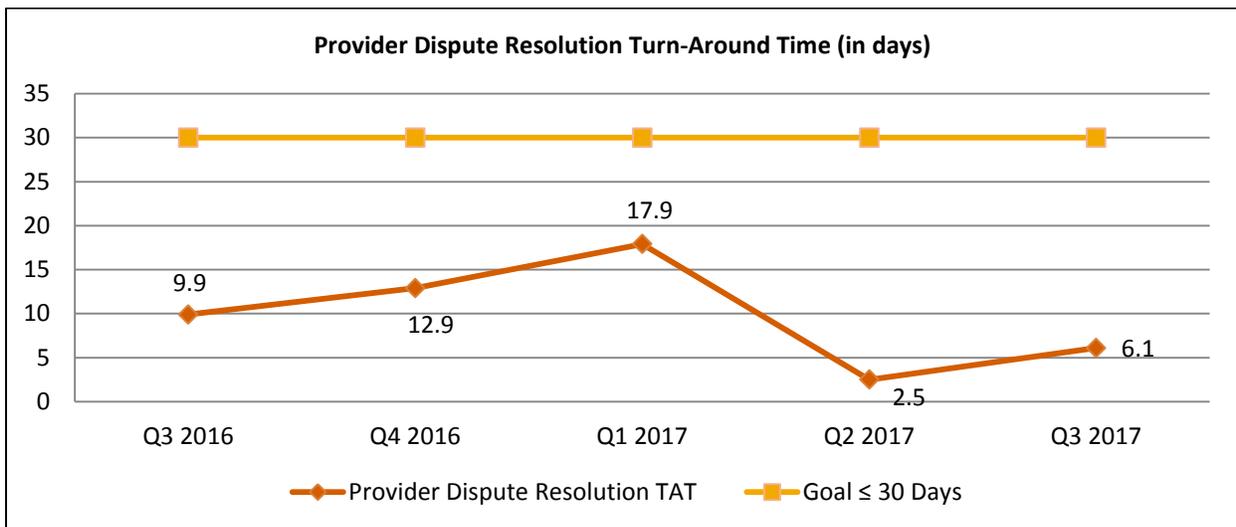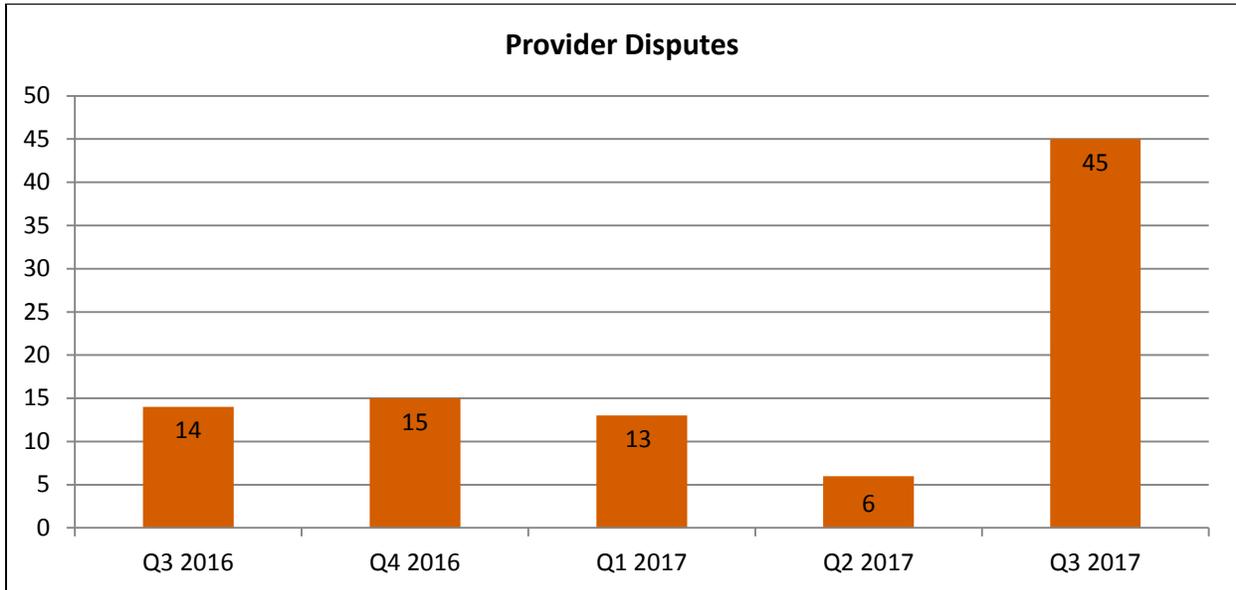
Provider Disputes

Quarter	Disputes
Q3 2016	14
Q4 2016	15
Q1 2017	13
Q2 2017	6
Q3 2017	45

Provider Dispute Resolution Turn-Around Time (in days)

Quarter	Provider Dispute Resolution TAT	Goal ≤ 30 Days
Q3 2016	9.9	30
Q4 2016	12.9	30
Q1 2017	17.9	30
Q2 2017	2.5	30
Q3 2017	6.1	30

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

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Opportunities and Interventions: There appears to be no root cause for the increase in Q3 Provider Dispute volume. Optum will continue to monitor the volume of Provider Disputes and any potential root causes.

Utilization Management and Care Coordination

Service Authorization Requests

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

Service Authorization Requests	Performance Goal	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Number of Service Authorization Requests	NA	4,991	4,878	4,247	3,948	3,498
Percent Determinations Completed within 14 days	100.0%	99.5%	99.1%	99.1%	99.4%	99.1%

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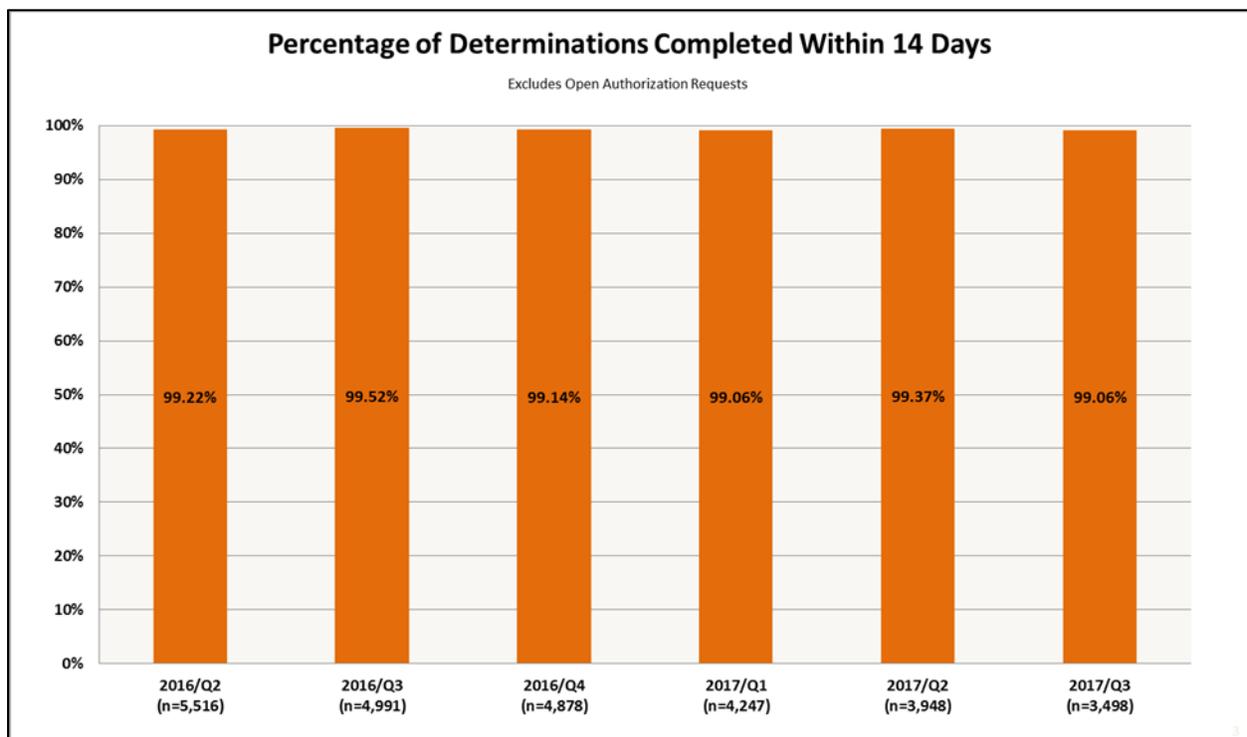
Field Care Coordination

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 Q3, 2016 through Q3, 2017.

Referral Sources	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Discharge Coordinator	151	112	83	161	145
Utilization Reviewers	12	8	13	14	10
Providers	6	5	4	6	14
Dept of Behavioral Health	2	6	6	6	16
Juvenile Justice	0	0	0	0	0
Provider Quality Specialist	2	3	2	0	0
Peer Review Committee	1	2	0	0	0
Hospitals	0	0	0	0	0
EPSDT	0	0	0	0	4
Family/Parent	0	0	0	0	4
Member Services/Crisis Line	1	0	0	0	0
Education	NA	6	10	4	2
FCC Manager Referral	NA	4	1	3	0
Outpatient Disposition	NA	3	4	10	4
Suicide Attempt	NA	NA	NA	NA	10
Total	175	149	123	204	209

Analysis: During Q3, Field Care Coordinators received 209 referrals. Of these referrals, 145 referrals were made by the Discharge Coordinator staff. The average length of FCC engagement during Q3 was 41 days.
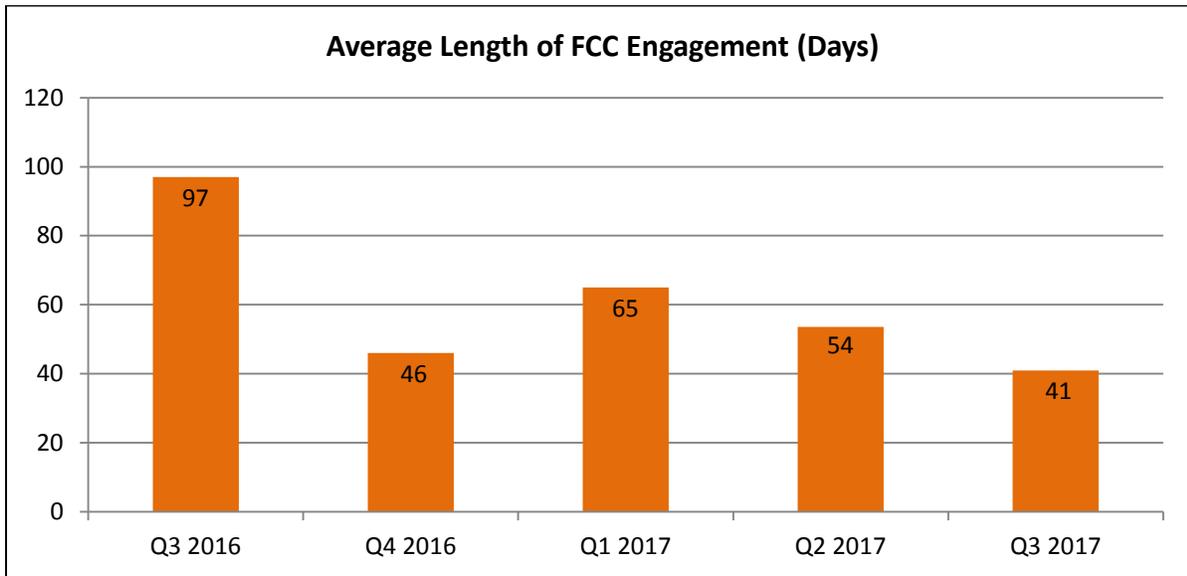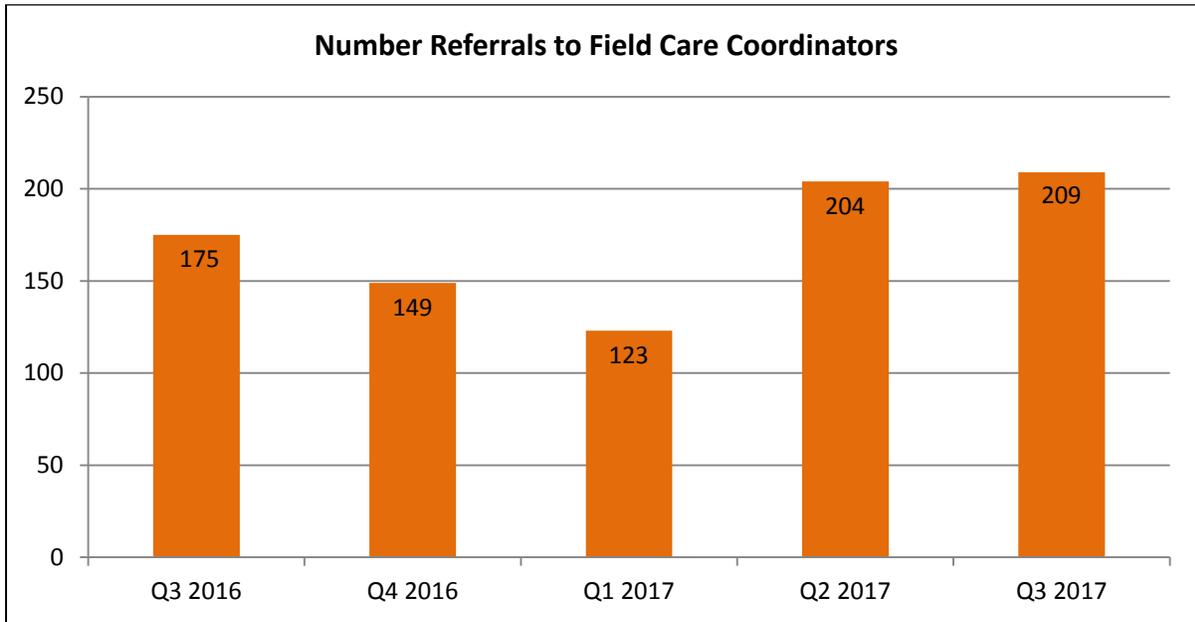
Number Referrals to Field Care Coordinators

Quarter	Value
Q3 2016	175
Q4 2016	149
Q1 2017	123
Q2 2017	204
Q3 2017	209

Average Length of FCC Engagement (Days)

Quarter	Value
Q3 2016	97
Q4 2016	46
Q1 2017	65
Q2 2017	54
Q3 2017	41

Barriers: Based on the above analysis, no barriers were identified.
Opportunities and Interventions: No opportunities for improvement were identified. The data will continue to be monitored to identify trends.

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Peer Reviewer Audits

Methodology: Optum Idaho promotes a process for review and evaluation of the clinical documentation of adverse benefit determinations and appeal reviews by Optum physicians 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 ≥ 88%.

Analysis: During Q3, there were no PhD denial decisions that required a Peer Review Audit. The MD Peer Review Audit result was at 96.5%.

MD Peer Review Audit Results

Quarter	MD Peer Review Audits
Q2 2016	96.4%
Q3 2016	98.1%
Q4 2016	99.0%
Q1 2017	99.4%
Q2 2017	96.5%

Legend: MD Peer Review Audits — Goal ≥ 88%
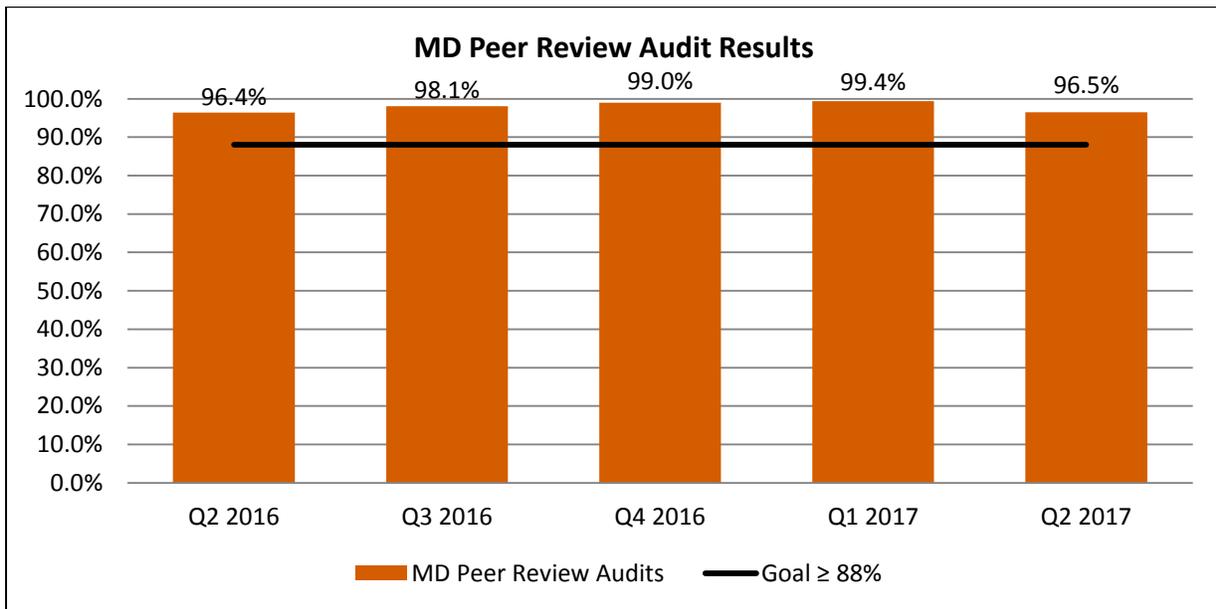
Inter-Rater Reliability

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

Population Analysis

Language and Culture

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

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

*most current data available

Analysis: Hispanic or Latino counted for 12.2 % of the Idaho population an increase from 11.2% from the 2010 Census results. This is the second highest population total, with White consisting of 93.4% (an increase from 89.1% from the 2010 Census results). Ethnic and racial backgrounds can overlap which explains for the percentage total > 100%. The Member Satisfaction Survey results show that 99.0% of members believe the care they received was respectful of their language, cultural, and ethnic needs. Based on the Member Satisfaction Survey sampling methodology, Q1 2017 data is the most current data available.
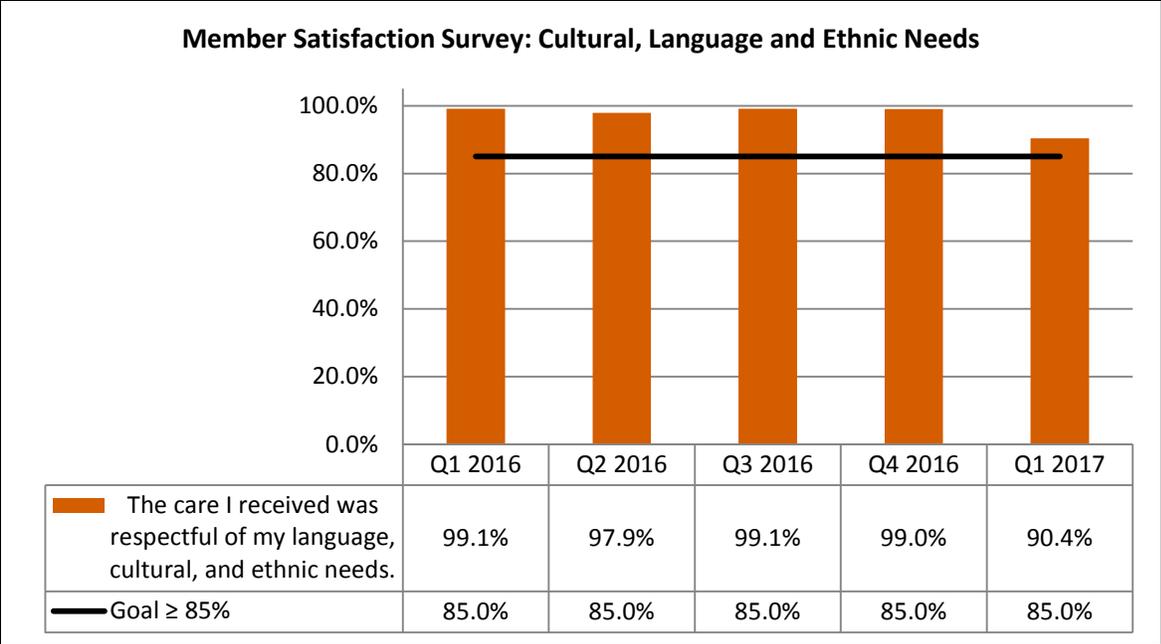
Member Satisfaction Survey: Cultural, Language and Ethnic Needs

	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017
The care I received was respectful of my language, cultural, and ethnic needs.	99.1%	97.9%	99.1%	99.0%	90.4%
Goal ≥ 85%	85.0%	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.

Results for Language and Culture

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

Quarterly Performance Results

Language Assistance Requests by Type	# of Requests
Member Written Communication	6
Member Written Communication Formatted to Large Print	1
Language Service Associates	18
Languages Represented	11
Do Not Mail List	2

Analysis: During Q3, Optum Idaho responded to 38 requests for language assistance. Predominant request was for Spanish followed by Farsi, and then Arabic.

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

Claims

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

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

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

Quarterly Performance Results:

Claims	Performance Goal	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017 (based on the September OR57 report)
Paid within 30 days	90.0%	99.9%	99.9%	99.9%	99.9%	99.9%
Paid within 90 days	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dollar Accuracy	99.0%	100.0%	99.7%	99.4%	99.9%	99.9%
Procedural Accuracy	97.0%	100.0%	100.0%	99.8%	99.8%	100.0%

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

Claims Paid within 30 Calendar Days

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Claims Paid within 30 Calendar Days	99.9%	99.9%	99.9%	99.9%	99.9%

Claims Paid within 30 Calendar Days — Goal: 90.0%

Claims Paid within 90 Calendar Days

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017 (YTD)
Claims Paid within 90 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%

Claims Paid within 90 Calendar Days — Goal: 99.0%

Claims Payment Dollar Accuracy

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Dollar Accuracy	100.0%	99.7%	99.4%	99.9%	99.9%

Dollar Accuracy — Goal: 99.0%

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Claims Procedural Accuracy

	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017
Procedure Accuracy	100.0%	100.0%	99.8%	99.8%	100.0%

Goal: 97.0%

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

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