Telligen
Healthcare Intelligence

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External Quality Review: Optum Idaho

Report of Findings

2021 - 2022

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External Quality Review Organization:

Optum Idaho
Annual Review and Summary
2021 - 2022

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External Quality Review Summary

In accordance with the United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) rule, Telligen, Inc. conducts onsite evaluations of Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) under contract with the Idaho Department of Health and Welfare (IDHW). The purpose of the evaluation is to assure that each contracted entity is providing quality services for its Medicaid members in accordance with the CMS Protocols. The CMS 42 CFR §433.15 and §438; Medicaid Program, External Quality Review (EQR) of Medicaid Managed Care Organizations rule specifies the requirements for evaluation of Medicaid managed care programs.

In 2013 Idaho began providing Behavioral Health Medicaid benefits to eligible enrollees statewide through the Optum Idaho Behavioral Health PAHP. Optum Idaho is contracted with IDHW to implement, administer, and maintain the Idaho Behavioral Health Plan, an outpatient PAHP. This is the third year that IDHW has requested an EQR of Optum Idaho. This technical report involves Optum Idaho's (Optum) performance related to Medicaid managed care quality as evaluated during desk reviews of Optum's policies and procedures and a virtual review conducted on February 27, 2023.

During the time of this review (July 1, 2021 through June 30, 2022) Optum reported 393,741 eligible Medicaid lives for 2021-2022; this is an increase from the 364,564 eligible Medicaid lives reported in 2020-2021, the 351,120 eligible Medicaid lives reported in 2019-2020 and the 261,586 eligible Medicaid lives reported in 2018-2019. On January 1, 2020, the state of Idaho expanded Medicaid to provide coverage to individuals with an annual household income up to 138% of the Federal Poverty Level (FPL), previously the income limit for Idaho Medicaid was 100% of the FPL. Optum was the only PAHP under contract during the review period in the State of Idaho to provide Medicaid behavioral-health services. Therefore, this report will not include comparative analysis with any other plan's performance.

The Telligen External Quality Review (EQR) Evaluation Team (the Team) includes Telligen staff with extensive managed care experience. Team members are experienced in managed care peer-to-peer review, quality improvement principles, and outcomes measurement. The Team is supported by an independent writer with many years of experience in EQR analysis and validation. This writer analyzed the findings and wrote an independent summary of those findings.

Optum participants in the on-site review included:

Optum Idaho:

- Georganne Benjamin, Executive Director
- Liz Johnsen, Compliance Director
- Jim Meldrum
- Dennis Baughman, Clinical Operations Director
- Matt Johansen, Provider Relations Director
- Julie Wood, Medical Director
- Chris Smith, Strategic Communications Director
- Eric Rawlings, Finance Director
- Eric Ewing, Compliance Manager
- Karena Dreuren

The External Quality Review Team included:

Telligen, Inc.
Nancy Johnson, Quality Improvement Manager
Matthew Dubberke, Information Security Analyst
Randy Quillen, Sr. Information Security GRC Analyst
Amy McCurry Schwartz, EQRO Consultant

This EQR technical report analyzes and aggregates data from three mandatory EQR activities as described below:

CMS regulations require an annual review of Performance Improvement Projects and Performance Measures, and a Compliance review every three years. The regulations also require an annual follow-up review of any identified Quality Standards that did not meet expectations during the prior evaluation period. This is the second follow up review to the full compliance review from 2018-2019. Therefore, any areas of compliance that were rated below "Proficient" were fully validated during this review. The IDHW also requires an Information Systems Capabilities Assessment (ISCA) to be conducted every two years, the ISCA was conducted during this review year. Additionally, IDHW requested that the EQR Team collect information in preparation for CMS's addition of a mandatory Network Adequacy protocol.

1) Validation of Performance Improvement Projects

Optum conducted two Performance Improvement Projects (PIPs) during the 12 months preceding the audit, as required in 42 CFR 438.330 (b)(1). The PIP submissions were then validated by the Team:

- Care Coordination

and

- 1915i State Plan Amendment (SPA) Person-Centered Service Plan (PCSP) Compliance, Youth Empowerment Services (YES)

2) Validation of Performance Measures

Thirty Performance Measures (PMs) were underway the preceding 12 months, and all were validated by the Team as required by 42 CFR 438.330(b)(2).

3) Review of Compliance with Medicaid Managed Care Regulations

The Team conducted a follow-up to last two review years' evaluation of compliance with Quality Standards addressing access to care, structure and operations, and quality management and improvement per 42 CFR §438.

and

4) Validation of Network Adequacy

In preparation for the release of CMS EQR Protocol 4: Network Adequacy, the Team conducted a Secret Shopper review of Optum's current provider network at the request of IDHW. This section is not scored as there is not a corresponding CMS protocol validation tool currently. The Team conducted calls to providers within Optum's network to ascertain the accuracy of their provider listing, the availability of providers taking new patients, and the wait times for routine and urgent appointments. The results of that survey are contained in this report.

To clearly report findings, technical methods of data collection, description of the data, conclusions, and recommendations for improvement will be discussed separately for the requirements pertaining to Quality Standards as well as PIPs, PMs, and Network Adequacy.

Additionally, IDHW has identified goals and objectives in the Idaho State Quality Strategy that pertain to delivery system reforms planned for the new contract that IDHW will begin in 2023. These include:

- Expand access to appropriate and quality behavioral health services
- Capture and analyze outcomes and other relevant measures for determining behavioral health provider and program effectiveness
- Standardize access to quality care and services across the state

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Quality Strategy Findings and Recommendations

At the time of this report, IDHW had submitted a statewide Quality Strategy to CMS. The **Idaho Medicaid Managed Care Quality Strategy** was submitted to CMS on May 17, 2022. This Quality Strategy did not include statewide performance goals or objectives that relate to Optum's performance during the time of this review. However, the Quality Strategy did include targets for future delivery system reforms in behavioral health. EQR determined that the IDHW Quality Strategy future delivery system reforms closely corresponded to some of the current projects underway at Optum. The Quality Strategy was reviewed by Telligen and the following findings and recommendations should be considered by IDHW.

Information from the 2022 Quality Strategy – Future Delivery System Reforms				
EQR Finding	Associated Quality Strategy Objective	Statewide Performance Baseline	Statewide Performance Target	EQRO Suggestions for the State
Care Coordination PIP	Expand access to appropriate and quality behavioral health services	Not Provided – each Plan sets goal The goal of this PIP is to increase high-risk member referrals to Care Coordination. Optum identified two performance measures for this PIP: 1) identify high risk members and 2) Increase number of high-risk member referrals.	Not Provided IDHW and Plan did not state target	• Include this metric in the quality strategy and require plans to implement performance targets that align with this metrics. • Work with the Plan to remove barriers to success in this PIP.

Information from the 2022 Quality Strategy – Future Delivery System Reforms				
EQR Finding	Associated Quality Strategy Objective	Statewide Performance Baseline	Statewide Performance Target	EQRO Suggestions for the State
Performance Measures required for submissions to IDHW	Capture and analyze outcomes and other relevant measures for determining behavioral health provider and program effectiveness	Not Provided	Not Provided by IDHW and Plan did not state target	Modify the 34 performance measures submitted by Optum to include true measurement of program and provider effectiveness and not just process measures.

Information from the 2022 Quality Strategy – Future Delivery System Reforms				
EQR Finding	Associated Quality Strategy Objective	Statewide Performance Baseline	Statewide Performance Target	EQRO Suggestions for the State
EQRO agrees that access to quality care and services should be standardized across the state	Standardize access to quality care and services across the state	Not Provided	Not Provided by IDHW and Plan did not state target	EQRO agrees that access to quality care and services should be standardized across the state

Performance Improvement Projects

Optum, under the direction of IDHW, has compiled two Performance Improvement Projects (PIPs) which will be discussed during this review:

- Care Coordination
- 1915i State Plan Amendment (SPA) Person-Centered Service Plan (PCSP) Compliance, Youth Empowerment Services (YES)

Technical Methods of Data Collection:
The technical methods of data collection and analysis incorporated by Optum are developed internally. These methods incorporate information from existing Plan reporting programs and databases. Utilizing the Performance Improvement Project Validation Worksheet (Attachment 1), analysis of internal processes utilized to document and interpret data results was completed by the Team. Finally, an interpretation of the interventions and ensuing improvements was incorporated as a measure of the effectiveness of the improvement process.

Objectives:
The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. The objectives of Telligen's review were to determine if the PIP design was methodologically sound, to validate the PIP results, and to evaluate the overall validity and reliability of the methods and findings.

The reviewers incorporated document review, interview, and observation techniques to fully evaluate the components of each Performance Improvement Project.

Table 1 - Performance Improvement Project Ratings

Step	**Care Coordination**	**1915i Person Centered Service Plan Compliance**
Step 1: Identifying the PIP Topic	Proficient	Proficient
Step 2: Developing the Aim Statement	Proficient	Proficient
Step 3: Identifying the PIP Population	Proficient	Proficient
Step 4: Describing the Sampling Plan	N/A	N/A
Step 5: Selecting the PIP Variables and Performance Measures	Proficient	Proficient
Step 6: Data Collection Procedures	Proficient	Proficient
Step 7: Data Analysis and Interpretation of Study Results	Proficient	Developing
Step 8: Assess the Improvement Strategies	Developing	Developing
Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred	Developing	Developing
Overall Rating	Developing	Developing

The rating scale reflecting compliance with standards is as follows:

P = Proficient: Documentation supports that all components were implemented, reviewed, revised, and/or further developed.
D = Developing: Documentation supports some but not all components were present.
N = No Documentation: No documentation found to substantiate this component.
N/A = Not Applicable: Component is not applicable to the focus of the evaluation.

Worksheet 1: Summary of Information about Performance Improvement Projects (PIPs)

1. General PIP Information

Managed Care Plan (MCP): Optum
PIP Title: Care Coordination
PIP Aim Statement: Will enrolling high risk members in the Field Care Coordination (FCC) program increase member engagement in outpatient services and reduce admissions to higher levels of care over each remeasurement year?
Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply) ☐State-mandated (state required plans to conduct a PIP on this specific topic) ☐Collaborative (Plans worked together during the Planning or implementation phases) ☒MCP choice (state allowed the Plans to identify the PIP topic)
Target age group (check one): ☐ Children only (ages 0–17)* ☐Adults only (age 18 and over) ☒Both adults and children *If PIP uses different age threshold for children, specify age range here: Age ranges are 1-20 and 21 and over
This PIP focused on high-risk members who are enrolled in the Optum Idaho Field Care Coordination Program for at least 60 consecutive days. The plan has identified high-risk members as those who are enrolled in Optum Idaho's FCC program for at least 60 consecutive days who have had at least two outpatient treatment services on two different dates within 120 days of enrollment The goal of this PIP is to increase high-risk member referrals to Care Coordination. Optum identified two performance measures for this PIP: 1) identify high risk members and 2) Increase number of high-risk member referrals.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) Phase 2 (07/01/2021 – 06/30/2022) focused on mitigating the challenges and barriers identified in phase one by increasing education and outreach to providers and stakeholders to increase the number of members participating in the care coordination program. The second activity was to monitor and evaluate whether those members enrolled in the FCC program engaged in an appropriate array of services after transitioning out of crisis centers.
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) Phase 2 focused on mitigating the challenges and barriers identified in phase one by increasing education and outreach to providers and stakeholders to increase the number of members participating in the care coordination program.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) The interventions implemented for this year of the PIP were a targeted outreach to identified members to enroll in FCC program: 1) Presentation developed to educate members and providers on the FCC program and referral process 2) Development of a FCC tracking form for all FCCs to use in tracking their outreach efforts with members. was the development of a high-risk algorithm that would both identify high risk members and refer those members to the Field Care Coordination (FCC) team.

3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Members enrolled in Field Care Coordination (FCC) Program for at least 60 consecutive days who had at least 2 outpatient treatment services (2 different dates of service) within 120 days of enrollment.	July 1, 2020 – June 30, 2021	440/729 60.4%	Remeasurement 1: July 2021 – June 2022	332/589 56.4%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
Members enrolled in FCC program for at least 60 consecutive days who had at least 1 admission to a higher level of care within 30 days of FCC enrollment (continuous eligibility).	July 1, 2020 – June 30, 2021	127/729 17.4%	Remeasurement 1: July 2021 – June 2022	78/589 13.2%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐**High confidence** ☒**Moderate confidence** ☐ **Low confidence** ☐ **No confidence**

Optum was able to use the high-risk algorithm to identify those who should receive care coordination. Optum set up a baseline year where they identified those who were enrolled in the program and then had 2 outpatient treatment services within 120 days of enrollment or had at least 1 admission to a higher level of care within 30 days of enrollment. They implemented targeted outreach to enroll members in FCC and implemented a monitoring process to track members in FCC and their levels of care. However, they did not see any improvement between baseline and the first re-measurement year.

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement

EQRO recommendations for improvement of PIP:

- Although Optum was able to implement interventions over the review period, they did not find improvement in the metrics. The number of patients who were identified for the project decreased and the issues with obtaining the data on patients in real time occurred. They did improve partnerships in the community and with the last remeasurement year beginning in July 2022, improvements may be seen.

Worksheet 1: Summary of Information about Performance Improvement Projects (PIPs)

1. General PIP Information

Managed Care Plan (MCP): Optum

PIP Title: 1915i State Plan Amendment (SPA) Person-Centered Service Plan (PCSP) Compliance, Youth Empowerment Services (YES)

PIP Aim Statement: Will implementing communication and education efforts to Youth Empowerment Services (YES) Program participants, families, and providers, while increasing Targeted Care Coordinator (TCC) workforce development efforts increase the percentage of individuals, timely completing their initial or renewal Person Centered Service Plans (PCSPs), year-over-year to the target of 86%, thereby, maintaining member eligibility and engagement in community-based services.

Was the PIP state-mandated, collaborative, statewide, or MHP/DMC-ODS choice? (check all that apply)

☒State-mandated (state required plans to conduct a PIP on this specific topic)

☐Collaborative (Plans worked together during the Planning or implementation phases)

☐MCP choice (state allowed the Plans to identify the PIP topic) This topic was suggested by IDHW but was not mandated.

Target age group (check one):

☒ Children only (ages 0–17)* ☐Adults only (age 18 and over) ☐Both adults and children

Idaho's 1915(i) Youth Empowerment Services (YES) Program serves children under eighteen with serious emotional disturbances (SED) in accordance with Section 16-2403, Idaho Code

*If PIP uses different age threshold for children, specify age range here: Age ranges are 1-20 and 21 and over

The PIP topic was directed by CMS following the 2021 Quality Reporting for the 1915i. At the request of the Idaho Department of Health and Welfare, the PIP addresses low compliance rates for individuals completing initial Person-Centered Service Plan (PCSP) as well as compliance rates for renewal of PCSPs prior to their previous plan expiration date.

The State has one Quality Reporting performance measure, 1-b of the 1915i State Plan Amendment (SPA) that reviews service plans prior to expiration of the current service plan but reported a very low compliance rate for CY2019 and CY2020 (19.3% for each year).

CMS determined that the compliance threshold for completion of service plans before plan expiration for the eligible 1915i population is 86%. This performance improvement project (PIP) is using that threshold as the improvement target.

The two primary goals this PIP will focus on to achieve the aim and target described above are:
Goal #1: Increase conversion rates for individuals completing their person-centered service plans (PCSP) prior to their previous plan expiration date by 10% year over calendar year.
Goal #1-A (added December 2022): Increase rates for individuals completing their initial person-centered service plans (PCSP) timely by 10% year over calendar year.

Goal #2: Increase the number of Targeted Care Coordinators (TCC) providers who can complete the PCSP by 5% within the Optum Provider Network year over calendar year.

2. Improvement Strategies or Interventions (Changes tested in the PIP)

Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) None provided.

1) Initial PCSP Letter and Call Outreach
2) Renewal PCSP Letter and Call Outreach

Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) None provided.

1) Provider Letter Outreach & Workforce Development Initiatives
2) Utilization of push notification generated from OSSM (Optum to Provider communication system) to alert providers status of plan and due dates

MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)

1) Recruit a mentor provider/agency to serve on the 1915i committee and participate in outreach/education/training activities.

3. Performance Measures and Results (Add rows as necessary)

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of members with PCSP renewals completed before the expiration of the active PCSP.	Baseline Measurement SFY 2020	56/356 1537%	Remeasurement 1 SFY 2021 53/570 9.3%	Remeasurement 2 7/1/2022 – 12/31/2022 35/664 5.3%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐<.05 Other (specify):
Number of members with initial PCSP completed within 90 days of enrollment.	Baseline Measurement SFY 2020	12/356 3.3%	Remeasurement 1 SFY 2021 36/570 6%	Remeasurement 2 7/1/2022 – 12/31/2022 25/664 3.7%	☒ Yes ☐ No Improvement over baseline, but not over Remeasurement 1	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐<.05 Other (specify):
CFTs billed by Providers with active TCCs (limited measure as a rolling count is the only view)	Baseline Measurement SFY 2020	528	920	7/1/2022 – 12/31/2022 85/1027 8.3%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐<.05 Other (specify):

Performance measures (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent remeasurement year (if applicable)	Most recent remeasurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Number of providers with active TCCs (limited measure as a rolling count is the only view)	Baseline Measurement SFY 2020	493	533	7/1/2022 – 12/31/2022 85/608 14.0%	☐ Yes ☒ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐<.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First remeasurement ☐ Second remeasurement ☐ Other (specify):

Validation rating: ☐ **High confidence** ☐ **Moderate confidence** ☒ **Low confidence** ☐ **No confidence**

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement

EQRO recommendations for improvement of PIP:

Optum identified many issues with getting the data from the correct sources to ensure accuracy in the calculation of the measures. They were able to calculate that the 1st outreach letter was somewhat successful, it had an aggregate success rate of 34%. However, the number of PCSP renewals that were completed prior to the expiration did not improve. EQRO recommends that Optum do some more analysis of the completion issue and provide more education to providers regarding completion of the PCSP renewals.

Optum also identified an issue with not enough Target Care Coordinators (TCC) to complete the requirements of the PIP…they have set a goal to improve the number of TCC by 2%.

Overall Evaluation and Recommendations for Improvement

Access to Care

Optum was clearly focused on the access to services delivered to the population in the Care Coordination PIP. The Care Coordination PIP is a project that should ensure members receive access to the care they require. The 1915i PIP is also a project that could ensure access to care for members. Both PIPs align with IDHW's Quality Strategy to expand access to appropriate and quality behavioral health services.

Quality of Care

The Care Coordination PIP is designed to increase high-risk member referrals, the purpose is to ensure that members receive the level and quality of care needed.

Timeliness of Care

By increasing referrals to the Field Care Coordination team in the Care Coordination PIP, Optum seeks to ensure that members receive care in a more timely manner than prior to the referral.

By providing the PCSP prior to the expiration date, it would ensure that members receive the appropriate care in a timely manner.

Recommendations:

1) Utilize the CMS Protocol, Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), to understand all project requirements.
2) Request technical assistance, as needed, when developing PIPs or implementing new interventions. This could help avoid the work that was done on the non-clinical project that was determined to not meet the PIP requirements.

Response to Prior Year Recommendations:

1) The EQRO recommended that Optum implement two PIPs. Optum was able to meet this recommendation with the addition of the 1915i PCSP PIP.
2) The EQRO recommended that Optum implement a PIP that focuses on member outcomes, Optum meet this recommendation with the two PIPs submitted for this year's review.

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Performance Measures

As a part of the EQR evaluation, Optum reported the results of thirty Performance Measures (PMs) for this evaluation period. The three PMs that were evaluated for this review included:

- Member Services Call Standards – Percentage of Calls Answered in 30 Seconds
- Member Services Call Standards – Abandonment Rate
- Member Services Call Standards – Daily Average Hold Time

Technical Methods of Data Collection:

The PMs are administrative indicators utilized by Optum to evaluate performance. The technical methods of data collection and analysis incorporated by Optum are internally defined utilizing available State and Plan data. Utilizing the PM Validation Worksheet (Attachment 2), a subsequent analysis of internal processes utilized to document and interpret data results was completed by the Team. The Team incorporated document review, interview, and observation techniques to fully evaluate the identified components of the PMs.

Objectives:

- Evaluate the policies, procedures, documentation, and methods Optum used to calculate the measures;
- Determine the extent to which reported rates were accurate, reliable, free of bias, and in accordance with standards for data collection and analysis;
- Verify measure specifications were consistent with the State's requirements; and
- Ensure re-measurement rates were produced with methods and source data that parallel the baseline rates.

The measures were derived from several sources, including claims/encounter systems, an enrollment/eligibility system, and calls to network providers regarding critical appointment wait times. All evaluation was calculated against the CMS Final Protocol, Validation of Performance Measures. The rating scale reflecting compliance with standards was as follows:

M = Met
Optum's measurement and reporting was fully compliant with State specifications.
PM = Partially Met
Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
NM = Not Met
Optum's measurement and reporting process was not compliant with State specifications.
NV = Not Valid
Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
n/a = Not Applicable
Measure was not reported. Optum did not have any enrollees that qualified for the denominator.

A summary of compliance for the evaluated PM is included in Table 2.

Table 2: Performance Measure Compliance Rating Summary Table

Step	Member Services: Percentage of Calls Answered within 30 Seconds	Member Services: Abandonment Rate	Member Services: Daily Average Hold Time
Documentation	Fully Compliant	Fully Compliant	Fully Compliant
Denominator: Data Source	Fully Compliant	Fully Compliant	Fully Compliant
Denominator: Calculation	Fully Compliant	Fully Compliant	Fully Compliant
Numerator: Data Source	Fully Compliant	Fully Compliant	Fully Compliant
Numerator: Calculation	Fully Compliant	Fully Compliant	Fully Compliant
Numerator: Integration	Fully Compliant	Fully Compliant	Fully Compliant
Numerator: Validation	Fully Compliant	Fully Compliant	Fully Compliant
Sampling: Unbiased	n/a	n/a	n/a
Sampling: Methodologies	n/a	n/a	n/a
Reporting	Fully Compliant	Fully Compliant	Fully Compliant
Overall Compliance Rating*	Fully Compliant	Fully Compliant	Fully Compliant

*The overall rating is one of the following:

FC = Fully Compliant (Measure was fully compliant with State Specifications.)

SC = Substantially Compliant (Measure was substantially compliant with State Specifications.)

NV = Not Valid (Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.)

Member Services Call Standards – Calls Answered within 30 Seconds, Abandonment Rate, Daily Average Hold Time

Optum Idaho contracts with ProtoCall services, a provider of specialty telephonic behavioral health services. Telephone access is provided 24 hours a day, seven days a week, 365 days a year through a toll-free Member Access and Crisis Line. ProtoCall uses Avaya's Communication System. The study denominator included all calls made to the Member Access and Crisis Lines during the timeframe. The time-period reported during this review was July 2021 – June 2022.

Calls Answered within 30 Seconds

The measure evaluated was:
1. The percentage of all calls received that were answered within 30 seconds.

The goal set by Optum for this measure was to answer 80% or more calls within 30 seconds. There is not an IDHW goal for this measure.

Optum reports the member and provider line metrics to IDHW. Optum accurately calculated this measure and therefore the measure is validated.

Optum did reach its goal for this performance measure during the review year.

Abandonment Rate

The measure evaluated was:
1. The percentage of calls that abandoned (hung-up or were disconnected) after waiting for 30 seconds or more.

The contracted goal for this measure is 7% or less, however Optum has set a goal of 3.5% or less.

Optum reports the member and provider line metrics to IDHW. Optum accurately calculated this measure and therefore the measure is validated.

Optum was able to reach this goal for most of the review year. In Q1 of 2022 they met the contracted goal and kept the rate below 7%, but in Q2 of 2022 they reported a rate above 8%. This was attributed to an issue with their contract provider who had staffing and training issues. Optum has since taken some of these calls in-house and improvements have been made.

Daily Average Hold Time

The measure evaluated was:
1. Total amount of hold time for each call during the measurement period.

The goal for this measure is 120 seconds or less.

Optum reports the member and provider line metrics to IDHW. Optum accurately calculated this measure and therefore the measure is validated.

Optum did reach its goal for this performance measure during the review year.

Evaluation of the Study and Recommendations for Improvement:

These Performance Measures are a measure of the access and availability of customer services for members.

Based on documentation supplied by Optum and on the Team's review, the process used to collect, integrate, and report these measures meets all standards. Telligen believes that the measures were calculated correctly as the same methodology is reported by Optum to be used each year. During the virtual on-site review, the Team and Optum discussed the possibility of new Performance Measures to be reviewed in the coming year. These performance measures have become part of Optum's day to day operation and have produced successful results, it would be beneficial to identify and target new issues to be improved.

The following discussion of evaluation and recommendations will clarify target areas for improvement.

Strengths:

1. Optum clearly defined the measurement period adding consistency in data measurement.
2. Optum identified performance measures that impact their day-to-day operations.
3. Optum has set its goal to achieve the State of Idaho's requirements.

Recommendations:

1. Reference the CMS Protocol, Validation of Performance Measures to ensure continued production of high-quality studies.
2. Continue to request technical assistance from CMS and/or the EQRO to enhance understanding of PM requirements and steps.
3. Continuing working with IDHW to propose new Performance Measures for the coming year.

Response to prior year's recommendations:

Prior Recommendations:

- "Reference the CMS Protocol, Validation of Performance Measures to ensure continued production of high-quality studies."
- Work with IDHW to propose new Performance Measures for the coming year.

Response to Recommendations:

- Optum supplied a narrative explanation for all 34 PMs. Additionally, they supplied supporting documentation of the calculations and source codes for all PMs.
- Optum approached IDHW about new Performance Measures that were more in-line with the CMS Protocols and is continuing to work to meet this recommendation.

Overall Evaluation and Recommendations for Improvement

There was evidence of understanding of the PMs as data measurement studies or projects.

Timeliness

Optum's choice to focus on the Call Center Standards was an effort to impact the timing of care received by its enrollees. This was to be accomplished by ensuring members received responses to their inquiries quickly.

Access to Care

Optum placed a great deal of emphasis on their enrollees' access to care. Optum stated in the virtual review that they are "shaping outreach projects and additional enrollee interventions that will further improve the rates for the PMs and may lead to the development of PIPs." These PMs should align with IDHW's Quality Strategy goal to capture and analyze outcomes and other relevant measures for determining behavioral health provider and program effectiveness.

Quality of Care

Optum was fully committed to their members' quality of care. In addition, to the Member Services Call Standards that were validated in this report, the PAHP submits the following Performance Measures to IDHW:

- Claims
- Complaints
- Critical Incidents
- Customer Service (Provider Calls) Standards
- Critical Appointment Wait Times
- Geographic Availability of Providers
- Inter-Rater Reliability
- Member Appeals
- Member Satisfaction Survey
- Member Services Call Standards
- Notification of Adverse Benefits Determinations
- Provider Disputes
- Provider Satisfaction Survey
- Response to Written Inquiry
- Service Authorization Requests

Each of these PMs contained a quality-of-care element. Optum was committed to ensuring quality care was received by their members and they have used the data available to them to make informed policy and practice decisions that will further impact members' quality of care in the future.

It is the opinion of the Team that the studies presented for review during this measurement year be considered: Fully Compliant. It is also the opinion of the Team that these studies have become a part of Optum's day-to-day operation and no longer require validation by the EQR. The EQR would like to see IDHW and Optum work together to come up with two new Performance Measures that could be evaluated by the EQR during the next review year.

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Compliance
Review of Quality Standards

Technical Methods of Data Collection and Analysis:

Optum was subject to a full compliance audit during the 2021-22 audit. Therefore, the 2021-22 audit included a review of the Quality Standards: Plan Standards, Including Enrollee Rights and Protections; Quality Assessment and Performance Improvement Program; and Grievance System as defined in 42 CFR 438, 440 and 441 (as applicable). Evaluation of these components included review of:

- Defined organizational structure with corresponding committee minutes
- Policies and Procedures
- Organizational protocols
- Print materials available to members and providers
- Report results
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations (Compliance Protocol). See Attachment 3. Utilizing this tool, Optum was evaluated on the timeliness, access, and quality of care provided. This report incorporates a discussion of Plan strengths and areas for improvement with recommendations to enhance overall performance and compliance with standards.

Objectives:

To determine Optum's compliance with the Quality Standards as detailed in the EQR Compliance Protocol. Documentation that supports the implementation of each standard were reviewed and evaluated by the EQR.

The Telligen rating scale is as follows:

P = Proficient
Documentation supports that all components were implemented, reviewed, revised, and/or further developed and PAHP staff provided responses to reviewers that are consistent with the standard and with the documentation.
D = Developing
All documentation listed under a component was present, however PAHP staff are unable to consistently articulate evidence of compliance, or
PAHP staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.
N = No Documentation
No documentation found to substantiate this component.
N/A = Not Applicable.
Component is not applicable to the focus of the evaluation.

A summary of compliance with all evaluated Quality Standards is included in Table 3.

Table 3. Compliance Ratings

Measure	2021-2022 Rate
Plan Standards, Including Enrollee Rights and Protections	
Availability of Services	Proficient
Furnishing of Services and Timely Access	Proficient
Access and Cultural Considerations	Proficient
Assurance of Adequate Capacity and Services	Proficient
Coordination and Continuity of Care for All Enrollees	Proficient
Additional Coordination and Continuity of Care Requirements: Long-Term Services and Support (LTSS)	Proficient
Additional Coordination and Continuity of Care Requirements: Special Health Care Needs (SHCN)	Proficient
Enrollment and Disenrollment	Proficient
Coverage and Authorization of Services	Proficient
Information Requirement for all Enrollees	Proficient
Enrollee Right to Receive Information on Available Treatment Options	Proficient
Enrollee Right to Participate in Decisions Regarding His or Her Care and Be Free from any form of Restraint	Proficient
Compliance with Other Federal and State Laws	Proficient
Provider Selection	Proficient
Sub-Contractual Relationships and Delegation	Proficient
Practice Guidelines	Proficient
Health Information Systems	Proficient
Quality Assessment and Performance Improvement Program	
Quality Assessment and Performance Improvement Program General Rules	n/a
Basic Elements of Quality Assessment and Performance Improvement Program	Developing
Performance Measurement	Proficient
Performance Improvement Projects	Developing
QAPI Evaluations Review	Proficient
Grievance System	
Grievance System	Proficient
General Requirements	Proficient
Timely and Adequate Notice of Adverse Benefit Determination	Proficient
Handling of Grievances and Appeals	Proficient
Resolution and Notification: Grievances and Appeals	Proficient
Expedited Resolution of Appeals	Proficient
Information About the Grievance System and Subcontractors	Proficient
Recordkeeping Requirements	Proficient
Continuation of Benefits While Optum Appeal and IDHW Fair Hearing are Pending	Proficient
Effectuation of Reversed Appeal Resolutions	Proficient
Overall Rating	Developing

Description of the Data:

The review of Quality Standards was completed using Attachment 3, BBA Quality Standards Review Tool, adapted from 42 CFR 438. All areas of review, except one (Quality Assessment and Performance Improvement Program) were found to be "Proficient". The following is a description of the findings by performance category identified in the tool/regulations.

Quality Assessment and Performance Improvement Program

For the 2021 – 2022 review year, Optum was rated as proficient in three standards and developing in two standards. The standards that received the rating of developing pertained to Optum's Performance Improvement Projects. Although Optum has demonstrated improvement in their PIP development and they provided extensive data analysis and PIP results, they have not been able to produce improvement in the goals of either PIP.

Enrollment and Disenrollment

Although enrollment and disenrollment is largely managed by IDHW, this areas is rated as "Proficient" as the EQR has reviewed the requirements and limitations and found them sufficient to meet the requirements of 42 CFR 438.56.

Overall Evaluation and Recommendations for Improvement

This plan is committed to providing a high level of care to its members. Optum has a commitment to timeliness, access, and quality of care.

Timeliness

Optum provides reminders to all members regarding gaps in care and the timely need for services. Additionally, all Grievance and Appeals files were found to be completed in a timely manner.

Access To Care

Neither the Team nor Optum have identified any areas of concern regarding access in their network, but Optum continues to monitor the network for access issues.

Quality of Care

All Optum providers are credentialed and monitored according to required policies and procedures. Optum would benefit from some technical assistance regarding the design and implementation of performance improvement projects. The area of PIP design has improved, however the PIPs have not produced favorable results.

Recommendations for Improvement:

1. The EQRO recommends that Optum receive technical assistance in order to revise performance improvement projects and improve the results of the PIPs.
2. The EQRO recommends that Optum work with IDHW to determine additional performance measures that can be used to measure successful delivery of services to Idaho Medicaid members.

Prior Year's Recommendations:

- The EQRO recommends that Optum begin developing new performance improvement projects that will meet the standards of the CMS Protocol 1 "Validation of Performance Improvement Projects".
- The EQRO recommends ongoing evaluation of projects throughout the organization that can be fostered into performance improvement projects.
- The EQRO recommends that Optum work with IDHW to determine additional performance measures that can be used to measure successful delivery of services to Idaho Medicaid members.

Response to Prior Year's Recommendations:

- Optum developed a new project that they submitted as a PIP; this project met the requirements of a PIP, but did not produce improvement to date.
- Optum approached IDHW about new Performance Measures that were more in-line with the CMS Protocols and is continuing to work to meet this recommendation.

Network Adequacy

To prepare for the upcoming Mandatory EQR Protocol: Network Adequacy, IDHW and the Team met to discuss the need to gather data regarding the current network of Optum providers. The Team reviewed the network requirements detailed in Optum's contract with IDHW and then determined that a "Secret Shopper" type survey would help to analyze the availability of providers in the Optum network.

The ability of Idaho Behavioral Health Plan members to schedule and receive services is dependent upon the member having access to accurate information on the health plan provider network, and upon those providers having adequate accommodations for new and returning patients when appointments are requested. To this end, the Idaho Behavioral Health Plan (IBHP) is contractually obligated to have up-to-date provider information on their website and to have providers available to accept new patients.

To determine the degree to which the Plan follows these contractual requirements, IDHW asked the EQRO to develop and conduct a "Secret Shopper" survey. Between January 1, 2023 and February 16, 2023, associates at Telligen called a statistically significant random sample of behavioral health providers from the "November 2021 - Provider Roster Report" (Report) additionally a search of the Optum website was completed the week in which the calls were made to ensure the provider still indicated that they were accepting new patients.

Of the 2,244 providers who were accepting new patients based on the Report, a total of 313 calls were completed. The goal of each call was to replicate the experience of someone new to the Idaho Behavioral Health Plan. Surveyors were trained to act as if they needed a provider and were seeking to choose a provider through Optum's website provider listings. A script was provided to guide each caller in obtaining answers to the following questions:

- Did the provider phone number on the website reach the office location of the listed provider?
- Was the provider currently taking new patients?
- How long was the wait for a specified appointment type:
    - Routine Appointment
    - Urgent Appointment

According to the contract requirements a Routine Appointment should be available within 10 business days of a request and an Urgent Appointment should be available within 48 hours of a request.

Seventy-nine percent of providers were accepting new patients

Although all the providers surveyed were designated as accepting new patients, the results indicate that IBHP members would be able to make an appointment with seventy-nine percent of providers listed on Optum's website. Of the 313 calls that were completed, 247 providers indicated that they were accepting new patients.

To complete 313 calls, the Telligen surveyors made 487 calls. Of the 487 calls made, 33 calls (7%) reached a wrong number or had no answer, and 141 calls (29%) went to voicemail.

Forty-three percent of providers offered a Routine Appointment within 10 business days

The average number of routine care appointments that met the expected standard ranged from a regional high of 61% (Region 1) to a low of 25% (Region 2). The statewide average of providers who offered a routine appointment within ten business days was 43%. Thereby indicating that 56% of all providers in the Optum network are unable to offer a routine appointment in the contractually required timeframe.

Fifty-three percent of providers offered an Urgent Appointment within 48 hours

The average number of urgent appointments that met the expected standard ranged from a regional high of 60% (Region 4) to a low of 37% (Region 3). The statewide average of providers who offered an urgent appointment within 48 hours of the call was 53%. Thereby indicating that 46% of all providers in the Optum network are unable to offer an urgent appointment in the contractually required timeframe.

Board Certified Behavioral Analyst and Specialty Nurse providers: 100% likely to offer timely Routine and Urgent Appointments

When analyzing the provider types that were most likely to meet the contract requirements, surveyors found that Board Certified Behavioral Analysts and Specialty Nurses were 100% likely to offer routine appointments within 10 business days. In fact, the Board-Certified Behavioral Analyst and Specialty Nurse provider types were able to offer that routine appointment within five business days. The provider types with prescriptive authority (Psychiatrist, Nurse with Prescriptive Authority, Psychologist with Prescriptive Authority) were found to be the least likely to meet the appointment standards.

Routine Appointments

Provider Type	Percentage who meets Routine Appointment Standard
Nurse with Prescriptive Authority	26%
Psychiatrist	22%
Psychologist with Prescriptive Authority	0%

Urgent Appointments

Provider Type	Percentage who meets Urgent Appointment Standard
Nurse with Prescriptive Authority	42%
Psychiatrist	17%
Psychologist with Prescriptive Authority	0%

Conclusion

The EQR's survey of Idaho Behavioral Health Plan provider network Survey offers a snapshot of the difficulties a new member would face when attempting to find a provider on the health plan's website. The website listings accurately reflected which providers were accepting patients in 79% of the completed calls.

When a member was able to contact a provider who was accepting new patients, the type of provider with whom the member was attempting to schedule greatly influenced the level of success in scheduling a timely appointment. The likelihood of a member successfully seeing a provider with prescriptive authority for a routine appointment in a timely manner ranged from 0% to 26%. Whereas the likelihood of a member successfully seeing a provider with prescriptive authority for an urgent appointment in a timely manner ranged from 0% to 42%.

This reinforces a known issue in behavioral health, that the number of available providers with prescriptive authority for the Idaho Behavioral Health Plan members may not be sufficient to meet the demand for services.

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Information Systems Capabilities Assessment (ISCA)

Objectives
Telligen examined Optum's information systems and data processing and reporting procedures to determine the extent to which those systems and procedures support the production of valid and reliable State performance measures and the capacity to manage care of enrollees.

Methodology
The ISCA procedures are based on the CMS protocol Appendix V, as adapted for Optum. For each ISCA review area, reviewers used the information collected in the ISCA data collection tool, responses to interview questions, and results of the security walkthroughs to rate the PAHP's performance for seven review areas. Scores are based on the following: fully meeting, partially meeting, or not meeting standards.

The ISCA review process consists of two activities (Previously, there was 4 different activities, but since this evaluation was done over teams and not in person, no on-sight reviews were done):

Activity 1: Standard information about the PAHP's information systems is collected. The PAHP completed the ISCA data collection tool before the onsite review.

Activity 2: The completed ISCA data collection tools and accompanying documents are reviewed. Follow-up is conducted as needed.

The following sections discuss the specific criteria for assessing compliance in each of the five ISCA review areas.
Section A: Information Systems
Section B: Hardware Systems
Section C: Information Security
Section D: Data Acquisition Capabilities
Section E: Provider Data

Scoring
All evaluation was calculated against the CMS Final Protocol, Validation of Performance Measures Reported by the PAHP: A Mandatory Protocol for External Quality Review (EQR). The rating scale reflecting compliance with standards was as follows:

M = Met
Optum's measurement and reporting was fully compliant with State specifications.
PM= Partially Met
Substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
NM = Not Met
Optum's measurement and reporting process was not compliant with State specifications.

NV = Not Valid
Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
n/a = Not Applicable
Measure was not reported because PAHP did not have any Medicaid enrollees that qualified for the denominator.

Table 3. ISCA scoring

ISCA Section	Description	Score
A. Information Systems	This section assesses the PAHP's information systems for collecting, storing, analyzing and reporting medical, member, provider and vendor data.	**Met**
B. Hardware Systems	This section assesses the PAHP's hardware systems and network infrastructure.	**Met**
C. Information Security	This section assesses the security of the PAHP's information systems.	**Met**
D. Data Acquisition Capabilities	This section assesses the PAHP's ability to capture and report accurate medical services data and the PAHP's ability to capture and report accurate Medicaid enrollment data.	**Met**
E. Provider Data	This section assesses the PAHP's ability to capture and report accurate provider information.	**Met**

Summary of ISCA Review
Telligen examined Optum's information systems and data processing and reporting procedures to determine the extent to which they support the production of valid and reliable State performance measures and the capacity to manage care of PAHP enrollees.

The determination of Medicaid eligibility, initial assessment and enrollment is handled by IDHW.

Information Systems
This section assesses the PAHP's information systems for collecting, storing, analyzing, and reporting medical data by member, provider, and vendor. Information systems that facilitate valid and reliable performance measurement have the following characteristics:

- flexible data structures
- no degradation of processing with increased data volume
- adequate programming staff
- reasonable processing and coding time
- ease of interoperability with other database systems
- data security via user authentication and permission levels
- data locking capability
- proactive response to changes in encounter and enrollment criteria
- adherence to the Federally required format for electronic submission of claims/encounter data.

Strengths, areas for improvement, and recommendations are based on the Optum ISCA submission, onsite interviews, and facility review.

Strengths:
1. Optum's Attribute-based Access Control (ABAC) can be utilized to support separation of duties and least privilege principles for logical data segmentation when a role-based mechanism is insufficient. Additionally, when extended access is needed, it requires a documented business reason and requires approval by management.

2. Optum encrypts data at rest without regard to its content or type at the storage media level on both disk and tape.

3. Always on virtual private network is utilized for remote access, this ensures that anytime a device is connected to a non-corporate network it must connect to the enterprise protected network. Two-factor authentication is required for remote access connections.
4. The existence of 3 data centers allows for data to be moved to accommodate increased data volume.
5. Optum programming employees are trained and capable of using the necessary tools to work with Optum's data systems. These employees also receive regular training throughout the year.

Areas for Improvement:
None identified.
Recommendations:
None identified.

Hardware Systems

This section assesses the PAHP's hardware systems and network infrastructure. Appropriate protocol for sustaining quality hardware systems include:

- Infrastructural support that includes maintenance and timely replacement of computer equipment and software, disaster recovery procedures, adequate training of support staff and a secure computing environment.
- Redundancy or duplication of critical components of a hardware system with the intention of increasing reliability of the system, usually in the case of a backup or fail-safe.

Strengths, areas for improvement, and recommendations are based on the Optum ISCA submission, 2022 findings validation, onsite interviews, and facility review.

Strengths
1. Business Impact Assessment for Business Continuity Plan is conducted annually
2. Optum has a well-developed Event Management Plan that defines the process, roles, and responsibilities for carrying out specific actions at projected times and places in a disaster.
3. Systems and databases are backed up daily and a thorough review of backup and standard operating procedures is performed on an annual basis during Sarbanes Oxley testing.
4. Redundancy is provided by the existence of 3 technology centers that are geographically distanced.
5. Vulnerabilities and patches are reviewed on a weekly basis and are assigned a severity score. Critical vulnerabilities are required to be addressed immediately, High risk 30 days if they are on the external boundary, 60 days for end user devices, and 90 days for internal systems.
6. In both the Mainframe and distributed environments, Optum's backup policy maintains two copies of operational data at its secured technology center. The primary data center features a virtual tape library that allows for daily operational recovery, this data is than transmitted the other datacenters for storage.

Areas for Improvement
None Identified.

Recommendations
None Identified.

Information Security
This section assesses the security of the PAHP's information systems. Appropriate practices for securing data include:

- Maintaining a well-run security management program that includes IT governance, risk assessment, policy development, policy dissemination and monitoring.
- Protecting computer systems and terminals from unauthorized access through use of a password system and security screens. Passwords should be changed frequently and reset whenever an employee terminates.
- Securing paper-based claims and encounters in locked storage facilities when not in use. Data transferred between systems/locations should be encrypted.
- Utilizing a comprehensive backup plan that includes scheduling, rotation, verification, retention, and storage of backups to provide additional security in the event of a system crash or compromised integrity of the data. Managers responsible for processing claims and encounter data must be knowledgeable of their backup schedules and of retention of backups to ensure data integrity.
- Verifying integrity of backups periodically by performing a "restore" and comparing the results. Ideally, annual backups would be kept for seven years or more in an offsite, climate-controlled facility.
- Ensuring databases and database updates include transaction management, commits and rollbacks. Transaction management is useful when making multiple changes in the database to ensure that all changes work without errors before finalizing the changes. A database commit is a command for committing a permanent change or update to the database. A rollback is a method for tracking changes before they have been physically committed to disk. This prevents corruption of the database during a sudden crash or some other unintentional intervention.
- Employing formal controls in the form of batch control sheets or assignment of a batch control number to ensure a full accounting of all claims received.

Strengths, areas for improvement, and recommendations are based on the Optum ISCA submission, 2022 findings validation, onsite interviews, and facility review.

Strengths:
1. Critical computing areas are monitored
2. Offices require badges for physical access. A clean desk policy is followed, and there are locked cabinets available for the storage of physical PHI. Cable locks and other tools are used to prevent the theft of hardware.
3. Verbose internal and external Information Security and Privacy Assessments program
    a. External

i. AICPA Service Organization Control (SOC) 2

ii. Sarbanes Oxley testing

b. Internal self-assessments

i. HITRUST Self assessments are completed.

ii. Nessus Vulnerability Scans – Run at least weekly. These scans are both internal and external. They also run credentialed and non-credentials scans.

4. 24 x 7 Security Monitoring of Information Systems and Applications.
5. Security awareness training is reviewed regularly. New Hire orientation features security awareness training, which is then reviewed on a periodic basis.

Areas for Improvement:
None identified.

Recommendations:
None identified.

Data Acquisition Capabilities

This section assesses the PAHP's ability to capture and report accurate medical services and Medicaid enrollment data. To ensure the validity and timeliness of the encounter and claims data used in calculating performance measures, it is important to have documented standards, a formal quality assurance of input data sources and transactional systems, and readily available historical data. Timely and accurate eligibility data are paramount in providing high-quality care and for monitoring services reported in utilization reports.

Strengths, areas for improvement, and recommendations are based on the Optum ISCA submission, 2022 findings validation, onsite interviews, and facility review.

Strengths:

1. All of Optum's member level transactions are submitted in real time except claim entry which are batched and processed once per day.
2. Optum handles mental health claims via standard claims or encounter forms CMS 1500 and UB-04.
3. Claims are submitted electronically or through a web-based direct claims entry system. Claims without required fields completed are rejected, sent back to the provider, and are not accepted into the claims processing system.
4. Optum Idaho monitors provider adherence to quality standards via site visits. The Optum Idaho Provider Quality Specialists complete treatment record reviews and site audits to provide a standardized review of practitioners and facilities on access, clinical record keeping, quality, and administrative efficiency in their delivery of behavioral health services.
5. Data is also verified through a service validation process in which a random sampling of members are selected on a monthly basis to verify the claims received on their behalf were the services provided (per 42 CFR 438.608(a)(5)).

Areas for Improvement:
None identified.

Recommendations:
None Identified.

Provider Data

This section assesses the PAHP's ability to capture and report accurate provider information. PAHPs need to ensure accuracy in capturing, rendering provider type as well as provider service location. PAHPs also need to be able to uniquely identify each provider. PAHPs must also present accurate provider information within the PAHP provider directory.

Strengths:

1. Providers are uniquely identified by provider ID's for each provider.
2. Medicaid provider directories updated daily on the Live and Work Well (LAWW) website. Optum's National Network Team carries out the changes requested by the Provider Relations Director.
3. Provider information is provided on Live and Work Well (Provider Search) Information includes: name, credentials, a provider, preferred provider, area of expertise, name of facility, address, phone number, distance based on zip code entered for the search, taking new patients, National Provider Identifier (NPI), license type, license #, education, gender, and language.

Areas for Improvement:
None observed.

Recommendations:
None Identified.

ATTACHMENTS

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ATTACHMENT 1

Performance Improvement Projects:

Care Coordination

1915i State Plan Amendment (SPA) Person-Centered Service Plan (PCSP) Compliance, Youth Empowerment Services (YES)

WORKSHEETS FOR PROTOCOL 1:
PIP VALIDATION TOOLS AND REPORTING FRAMEWORK

Instructions. Use these or similar worksheets to assist in validating Performance Improvement Projects (PIPs) conducted by the Managed Care Plan (MCP). These worksheets provide templates for validating PIPs and a framework for reporting on validated PIPs in the external quality review (EQR) technical report. This tool includes the following worksheets crosswalked to the applicable Activity and Step:

Worksheet name	Protocol activity and step
Worksheet 1.1. Review the PIP Topic	Activity 1. Step 1. Review the Selected PIP Topic
Worksheet 1.2. Review the PIP Aim Statement	Activity 1. Step. 2. Review the PIP Aim Statement
Worksheet 1.3. Review the Identified PIP Population	Activity 1. Step 3. Review the Identified PIP Population
Worksheet 1.4. Review the Sampling Method	Activity 1. Step 4. Review the Sampling Method
Worksheet 1.5. Review the Selected PIP Variables	Activity 1. Step 5. Review the Selected PIP Variables
Worksheet 1.6. Review the Data Collection Procedures	Activity 1. Step 6. Review the Data Collection Procedures
Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results	Activity 1. Step 7. Review Data Analysis and Interpretation of PIP Results
Worksheet 1.8. Assess the Improvement Strategies	Activity 1. Step 8. Assess the Improvement Strategies
Worksheet 1.9. Assess the Likelihood that Significant and Sustained Improvement Occurred	Activity 1. Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred
Worksheet 1.10. Perform Overall Validation of PIP Results	Activity 2. Perform Overall Validation and Reporting of PIP Results
Worksheet 1.11. Framework for Summarizing Information about Performance Improvement Projects (PIPs)	Activity 2. Perform Overall Validation and Reporting of PIP Results

For each PIP, please complete the following information:

MCP name	Optum Idaho
MCP contact name and title	Sherry Johnson, Quality Manager Judy Gimble, Project Lead
Mailing address	
Contact email address	sherryjohnson@optum.com judy.gimble@optum.com
EQRO interview date	2/27/2023
Performance Improvement Project (PIP) name	Care Coordination
PIP start and end date	7/1/2021-6/30/2022

Worksheet 1.1. Review the Selected PIP Topic

PIP Care Coordination

Assess the appropriateness of the selected PIP topic by answering the following questions about the MCP and PIP. Insert comments to explain "No" and "Not applicable (NA)" responses.

Question	Yes	No	NA	Comments
1.1 Was the PIP topic selected through a comprehensive analysis of beneficiary needs, care, and services (e.g., consistent with demographic characteristics and health risks, prevalence of conditions, or the need for a specific service by beneficiaries)? (If the PIP topic was required by the state, please check "not applicable" and note in comments.)	X			
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?	X			
1.3 Did the selection of the PIP topic consider input from beneficiaries or providers who are users of, or concerned with, specific service areas? • To the extent feasible, input from beneficiaries who are users of, or concerned with, specific services areas should be obtained.		X		No input from beneficiaries was obtained.
1.4 Did the PIP topic address care of special populations or high priority services, such as: • Children with special health care needs • Adults with physical disabilities • Children or adults with behavioral health issues • People with intellectual and developmental disabilities • Preventive care • Acute and chronic care • High-volume or high-risk services • Continuity or coordination of care from multiple providers and over multiple episodes • Appeals and grievances • Access to and availability of care	X			
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	X			
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				

Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement Will enrolling high risk members in the Field Care Coordination (FCC) program increase member engagement in outpatient services and reduce admissions to higher levels of care over each remeasurement year beginning with baseline year, 7/1/2020 – 6/30/2021.

Assess the appropriateness of the selected PIP topic by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
2.1 Did the PIP aim statement clearly specify the improvement strategy, population, and time period for the PIP?	X			
2.2 Did the PIP aim statement clearly specify the population for the PIP?	X			Because this applies to all members, the identification of PIP population was not necessary.
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	X			
2.4 Was the PIP aim statement concise?	X			
2.5 Was the PIP aim statement answerable?	X			The aim statement was not in the form of a question but was answerable.
2.6 Was the PIP aim statement measurable?	X			
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				

Worksheet 1.3. Review the Identified PIP Population

PIP Population All high-risk members enrolled in the Optum Idaho Field Care Coordination Program for at least 60 consecutive days.

Assess whether the PIP population was clearly identified by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
3.1 Was the project population clearly defined in terms of the identified PIP question (e.g., age, length of the PIP population's participation, diagnoses, procedures, other characteristics)? • The required length of time will vary depending on the PIP topic and performance measures	X			
3.2 Was the entire MCP population included in the PIP?	X			
3.3 If the entire population was included in the PIP, did the data collection approach capture all beneficiaries to whom the PIP question applied? • If data can be collected and analyzed through an administrative data system, it may be possible to study the whole population. For more guidance on administrative data collection, see Worksheet 1.6.	X			
3.4 Was a sample used? (If yes, use Worksheet 1.4 to review sampling method • If the data will be collected manually (such as through medical record review), sampling may be necessary		X		
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				

Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method N/A

If no sampling is used or HEDIS® sampling is used, check here, and skip the rest of this worksheet. ☒

Assess whether the sampling method was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses. Refer to Appendix B for an overview of sampling approaches for EQR data collection activities.

Question	Yes	No	NA	Comments
4.1 Did the sampling frame contain a complete, recent, and accurate list of the target PIP population? • A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are key to the representativeness of the sample				
4.2 Did the sampling method consider and specify the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error?				
4.3 Did the sample contain a sufficient number of beneficiaries taking into account non-response?				
4.4 Did the method assess the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status?				
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.				
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				

Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

List Selected PIP Variables and Performance Measures:

Members enrolled in FCC Program who were engaged in outpatient (op) services within 60 days of enrollment; Members admitted to a higher level of care (PHP, IOP, IP, or Crisis) after FCC enrollment.

Assess whether the selected PIP variables were appropriate for measuring performance and tracking improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Recall that CMS encourages MCPs to choose variables for PIPs that reflect health outcomes. Performance measures are then used to measure these health outcomes. When selecting variables, the MCP should consider existing performance measures.

Question	Yes	No	NA	Comments
PIP variables				
5.1 Were the variables adequate to answer the PIP question? • Did the PIP use objective, clearly defined, time-specific variables (e.g., an event or status that can be measured)? • Were the variables available to measure performance and track improvement over time? (MCPs are encouraged to select variables that can be examined on at least a quarterly basis.)	X			• Number of ED visits • Documented count of reminder calls per outpatient appointment • Number of outpatient visits within 45 days of ED dx. • Members enrolled in FCC program for at least 60 consecutive days. • Members enrolled in FCC program for at least 60 consecutive days who had at least 1 admission to higher level of care within 30 days of FCC enrollment.
Performance measures				
5.2 Did the performance measure assess an important aspect of care that will make a difference to beneficiaries' health or functional status? In the comments for this question, list what health or functional status was assessed.	X			Engagement in treatment; involvement in recovery; increased knowledge of available resources.
5.3 Were the performance measures appropriate based on the availability of data and resources to collect the data (administrative data, medical records, or other sources)?	X			
5.4 Were the measures based on current clinical knowledge or health services research? • Examples may include: ○ Recommended procedures ○ Appropriate utilization (hospital admissions, emergency department visits) ○ Adverse incidents (such as death, avoidable readmission) ○ Referral patterns ○ Authorization requests	X			
5.5 Did the performance measures: • Monitor the performance of MCPs at a point in time? • Track MCP performance over time? • Compare performance among MCPs over time? • Inform the selection and evaluation of quality improvement activities?	X			

Question	Yes	No	NA	Comments
5.6 Did the MCP consider existing measures, such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures?	X			
5.7 If there were gaps in existing measures, did the MCP consider the following when developing new measures based on current clinical practice guidelines or health services research? • Did the measure address accepted clinical guidelines relevant to the PIP question? • Did the measure address an important aspect of care or operations that was meaningful to MCP beneficiaries? • Did available data sources allow the MCP to reliably and accurately calculate the measure? • Were all criteria used in the measure defined clearly (such as time periods, characteristics of eligible beneficiaries, services to be assessed, and exclusion criteria)?			X	
5.8 Did the measures capture changes in enrollee satisfaction or experience of care? • Although enrollee satisfaction/experience is an important outcome of care in clinical areas, improvement in satisfaction should not be the only measured outcome of a clinical project. Some improvement in health or functional status should also be addressed • For projects in nonclinical areas (such as addressing access or availability of services), measurement of health or functional status is preferred	X			
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?			X	
5.9 If process measures were used, is there strong clinical evidence indicating that the process being measured is meaningfully associated with outcomes? • This determination should be based on published guidelines, including citations from randomized clinical trials, case control studies, or cohort studies • At a minimum, the PIP should be able to demonstrate a consensus among relevant practitioners with expertise in the defined area who attest to the importance of a given process	X			
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				

Worksheet 1.6. Review the Data Collection Procedures

Assess whether the data collection procedures were valid and reliable by answering the following questions. This worksheet includes three sections: (1) overall data collection procedures, (2) data collection procedures for administrative data sources, and (3) data collection procedures for medical record review. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Section 1: Assessment of Overall Data Collection Procedures

Question	Yes	No	NA	Comments
6.1 Did the PIP design specify a systematic method for collecting valid and reliable data that represents the population in the PIP?	X			
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	X			Data is collected weekly, monthly, and sometimes daily.
6.3 Did the PIP design clearly specify the data sources? • Data sources may include: ○ Encounter and claims systems ○ Medical records ○ Case management or electronic visit verification systems ○ Tracking logs ○ Surveys ○ Provider and/or enrollee interviews	X			
6.4 Did the PIP design clearly define the data elements to be collected? • Accurate measurement depends on clear and concise definitions of data elements (including numerical definitions and units of measure)	X			
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?	X			
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	X			
6.7 If qualitative data collection methods were used (such as interviews or focus groups), were the methods well-defined and designed to collect meaningful and useful information from respondents?			X	
6.8 Overall assessment: In the comments section, note any recommendations for improving the data collection procedures. **Note:** Include assessment of data collection procedures for administrative data sources and medical record review noted below.				

Section 2: Assessment of Data Collection Procedures for Administrative Data Sources

Question	Yes	No	NA	Comments
6.9 If inpatient data was used, did the data system capture all inpatient admissions/discharges?			X	
6.10 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			X	
6.11 If EHR data was used, were patient, clinical, service, or quality metrics validated for accuracy and completeness as well as comparability across systems?			X	

Section 3: Assessment of Data Collection Procedures for Medical Record Review

Question	Yes	No	NA	Comments
6.15 Was a list of data collection personnel and their relevant qualifications provided? • Data collection personnel require the conceptual and organizational skills to abstract data. These skills will vary depending on the nature of the data and the degree of professional judgment required. For example, trained medical assistants or medical records clerks may collect data if the abstraction involves verifying the presence of a diagnostic test report. However, experienced clinical staff (such as registered nurses) should be used to extract data to support a judgment about whether clinical criteria are met	X			
6.16 For medical record review, was inter-rater and intra-rater reliability described? • The PIP should also consider and address intra-rater reliability (i.e., reproducibility of judgments by the same abstractor at a different time)			X	
6.17 For medical record review, were guidelines for obtaining and recording the data developed? • A glossary of terms for each project should be developed before data collection begins to ensure consistent interpretation among and between data collection staff • Data collection staff should have clear, written instructions, including an overview of the PIP, how to complete each section of the form or instrument, and general guidance on how to handle situations not covered by the instructions. This is particularly important when multiple reviewers are collecting data			X	

Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results

Assess whether the data analysis and interpretation was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable" responses.

Question	Yes	No	NA	Comments
7.1 Was the analysis conducted in accordance with the data analysis plan?	X			
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	X			
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?	X			
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	X			
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	X			
7.6 Did the PIP compare the results across multiple entities, such as different patient subgroups, provider sites, or MCPs? • Comparing the performance across multiple entities involves greater statistical design and analytical considerations than those required for a project assessing performance of a single entity, such as an MCP, over time		X		This information was not provided in the PIP write – up. Although information was collected for all patient subgroups, it was reported as a whole.
7.7 Were PIP results and findings presented in a concise and easily understood manner?	X			
7.8 To foster continuous quality improvement, did the analysis and interpretation of the PIP data include lessons learned about less-than-optimal performance? • Analysis and interpretation of the PIP data should be based on a continuous improvement philosophy and reflect on lessons learned and opportunities for improvement			X	
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results.				

Worksheet 1.8. Assess the Improvement Strategies

Assess whether the selected improvement strategies were appropriate for achieving improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
8.1 Was the selected improvement strategy evidence-based, that is, was there existing evidence (published or unpublished) suggesting that the test of change (performance measure) would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables)?	X			
8.2 Was the strategy designed to address root causes or barriers identified through data analysis and quality improvement processes? • Interventions that might have a short-term effect, but that are unlikely to generate long-term change (such as a one-time reminder letter to beneficiaries or providers) are insufficient • It is expected that interventions associated with significant improvement will be system interventions (such as educational efforts, policy changes, or targeting of additional resources) • It is expected that interventions should be measurable on an ongoing basis (e.g., quarterly, monthly) to monitor intervention progress	X			
8.3 Was the rapid-cycle PDSA approach used to test the selected improvement strategy? • The steps in the PDSA cycle[41] are to: ○ **Plan.** Plan the test or observation, including a Plan collecting data, and interpreting the results ○ **Do.** Try out the test on a small scale ○ **Study.** Set aside time to analyze the data and assess the results ○ **Act.** Refine the change, based on what was learned from the test. Determine how to sustain the intervention, if successful • If tests of change were not successful (i.e., did not achieve significant improvement), a process to identify possible causes and implement solutions should be identified			X	
8.4 Was the strategy culturally and linguistically appropriate?[42]			X	No information was provided on this aspect of the PIP.
8.5 Was the implementation of the strategy designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices)?	X			

[41] Institute for Healthcare Improvement: Science of Improvement, Testing Changes. Available at http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx.

[42] More information on culturally and linguistically appropriate services may be found at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

Question	Yes	No	NA	Comments
8.6 Building on the findings from the data analysis and interpretation of PIP results, did the PIP assess the extent to which the improvement strategy was successful and identify potential follow- up activities?	X			
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				

Worksheet 1.9. Assess the Likelihood that Significant and Sustained Improvement Occurred

Assess the likelihood that significant and sustained improvement occurred by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
9.1 Was the same methodology used for baseline and repeat measurements?	X			
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?		X		Improvement was not seen.
9.3 Was the reported improvement in performance likely to be a result of the selected intervention? • It is not necessary to demonstrate conclusively (e.g., through controlled studies) that a change is an effect of the intervention; it is sufficient to show that the change might reasonably be expected to result from the intervention • It is not necessary to undertake data analysis to correct for secular trends (e.g., changes that reflect continuing growth or decline in a measure because of external forces over an extended period). The measured improvement should reasonably be determined to have resulted from the intervention			X	
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?		X		
9.5 Was sustained improvement demonstrated through repeated measurements over time?		X		
9.6 Overall assessment: In the comments section, note any recommendations for improving the significance and sustainability of improvement as a result of the PIP.				

Worksheet 1.10. Perform Overall Validation of PIP Results

Provide an overall validation rating of the PIP results. The "validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement. Insert comments to explain the rating.

PIP Validation Rating (check one box)	Comments
☐High confidence ☒Moderate confidence ☐Low confidence ☐No confidence	Although Optum was able to implement interventions over the review period, they did not find improvement in the metrics. The number of patients who were identified for the project decreased and the issues with obtaining the data on patients in real time occurred. They did improve partnerships in the community and with the last remeasurement year beginning in July 2022, improvements may be seen.

WORKSHEETS FOR PROTOCOL 1:
PIP VALIDATION TOOLS AND REPORTING FRAMEWORK

Instructions. Use these or similar worksheets to assist in validating Performance Improvement Projects (PIPs) conducted by the Managed Care Plan (MCP). These worksheets provide templates for validating PIPs and a framework for reporting on validated PIPs in the external quality review (EQR) technical report. This tool includes the following worksheets crosswalked to the applicable Activity and Step:

Worksheet name	Protocol activity and step
Worksheet 1.1. Review the PIP Topic	Activity 1. Step 1. Review the Selected PIP Topic
Worksheet 1.2. Review the PIP Aim Statement	Activity 1. Step. 2. Review the PIP Aim Statement
Worksheet 1.3. Review the Identified PIP Population	Activity 1. Step 3. Review the Identified PIP Population
Worksheet 1.4. Review the Sampling Method	Activity 1. Step 4. Review the Sampling Method
Worksheet 1.5. Review the Selected PIP Variables	Activity 1. Step 5. Review the Selected PIP Variables
Worksheet 1.6. Review the Data Collection Procedures	Activity 1. Step 6. Review the Data Collection Procedures
Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results	Activity 1. Step 7. Review Data Analysis and Interpretation of PIP Results
Worksheet 1.8. Assess the Improvement Strategies	Activity 1. Step 8. Assess the Improvement Strategies
Worksheet 1.9. Assess the Likelihood that Significant and Sustained Improvement Occurred	Activity 1. Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred
Worksheet 1.10. Perform Overall Validation of PIP Results	Activity 2. Perform Overall Validation and Reporting of PIP Results
Worksheet 1.11. Framework for Summarizing Information about Performance Improvement Projects (PIPs)	Activity 2. Perform Overall Validation and Reporting of PIP Results

For each PIP, please complete the following information:

MCP name	Optum Idaho
MCP contact name and title	Jim Meldrum, Project Lead Karena Drewien, Clinical Quality Director
Mailing address	
Contact email address	jim.meldrum@optum.com karena.drewien@optum.com
EQRO interview date	2/27/2023
Performance Improvement Project (PIP) name	1915i State Plan Amendment (SPA) Person-Centered Service Plan (PCSP) Compliance, Youth Empowerment Services (YES)
PIP start and end date	July 1, 2021 – June 30, 2023

Worksheet 1.1. Review the Selected PIP Topic

PIP 1915i State Plan Amendment (SPA) Person-Centered Service Plan (PCSP) Compliance, Youth Empowerment Services (YES)

Assess the appropriateness of the selected PIP topic by answering the following questions about the MCP and PIP. Insert comments to explain "No" and "Not applicable (NA)" responses.

Question	Yes	No	NA	Comments
1.1 Was the PIP topic selected through a comprehensive analysis of beneficiary needs, care, and services (e.g., consistent with demographic characteristics and health risks, prevalence of conditions, or the need for a specific service by beneficiaries)? (If the PIP topic was required by the state, please check "not applicable" and note in comments.)	X			
1.2 Did selection of the PIP topic consider performance on the CMS Child and Adult Core Set measures?	X			
1.3 Did the selection of the PIP topic consider input from beneficiaries or providers who are users of, or concerned with, specific service areas? • To the extent feasible, input from beneficiaries who are users of, or concerned with, specific services areas should be obtained.	X			
1.4 Did the PIP topic address care of special populations or high priority services, such as: • Children with special health care needs • Adults with physical disabilities • Children or adults with behavioral health issues • People with intellectual and developmental disabilities • Preventive care • Acute and chronic care • High-volume or high-risk services • Continuity or coordination of care from multiple providers and over multiple episodes • Appeals and grievances • Access to and availability of care	X			
1.5 Did the PIP topic align with priority areas identified by HHS and/or CMS?	X			
1.6 Overall assessment: In the comments section, note any recommendations for improving the PIP topic.				

Worksheet 1.2. Review the PIP Aim Statement

PIP Aim Statement Will implementing communication and education efforts to Youth Empowerment Services (YES) Program participants, families, and providers, while increasing Targeted Care Coordinator (TCC) workforce development efforts increase the percentage of individuals, timely completing their initial or renewal Person Centered Service Plans (PCSPs), year-over-year to the target of 86%, thereby, maintaining member eligibility and engagement in community-based services.

Assess the appropriateness of the selected PIP topic by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
2.1 Did the PIP aim statement clearly specify the improvement strategy, population, and time period for the PIP?	X			
2.2 Did the PIP aim statement clearly specify the population for the PIP?	X			
2.3 Did the PIP aim statement clearly specify the time period for the PIP?	X			
2.4 Was the PIP aim statement concise?	X			
2.5 Was the PIP aim statement answerable?	X			
2.6 Was the PIP aim statement measurable?	X			
2.7 Overall assessment: In the comments section, note any recommendations for improving the PIP aim statement.				

Worksheet 1.3. Review the Identified PIP Population

PIP Population All eligible YES participants under the age of 18, who have not aged out, do not have a Developmental Disability waiver or is participating in Wraparound Intensive Services (WInS), and who received an assessment indicating the individual is 1915(i) eligible prior to receiving services.

Assess whether the PIP population was clearly identified by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
3.1 Was the project population clearly defined in terms of the identified PIP question (e.g., age, length of the PIP population's participation, diagnoses, procedures, other characteristics)? • The required length of time will vary depending on the PIP topic and performance measures	X			
3.2 Was the entire MCP population included in the PIP?	X			
3.3 If the entire population was included in the PIP, did the data collection approach capture all beneficiaries to whom the PIP question applied? • If data can be collected and analyzed through an administrative data system, it may be possible to study the whole population. For more guidance on administrative data collection, see Worksheet 1.6.	X			
3.4 Was a sample used? (If yes, use Worksheet 1.4 to review sampling method • If the data will be collected manually (such as through medical record review), sampling may be necessary		X		
3.5 Overall assessment: In the comments section, note any recommendations for identifying the project population.				

Worksheet 1.4. Review the Sampling Method

Overview of Sampling Method N/A

If no sampling is used or HEDIS® sampling is used, check here, and skip the rest of this worksheet. ☒

Assess whether the sampling method was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses. Refer to Appendix B for an overview of sampling approaches for EQR data collection activities.

Question	Yes	No	NA	Comments
4.1 Did the sampling frame contain a complete, recent, and accurate list of the target PIP population? • A sampling frame is the list from which the sample is drawn. It includes the universe of members of the target PIP population, such as individuals, caregivers, households, encounters, providers, or other population units that are eligible to be included in the PIP. The completeness, recency, and accuracy of the sampling frame are key to the representativeness of the sample				
4.2 Did the sampling method consider and specify the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error?				
4.3 Did the sample contain a sufficient number of beneficiaries taking into account non-response?				
4.4 Did the method assess the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status?				
4.5 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field.				
4.6 Overall assessment: In the comments section, note any recommendations for improving the sampling method.				

Worksheet 1.5. Review the Selected PIP Variables and Performance Measures

List Selected PIP Variables and Performance Measures:

A) Current Person-Centered Service Plan loaded into OSSM uploaded by Provider on behalf of a member in the preceding 18 months
B) Outpatient services members engage in: Billing codes for outpatient services: Child and Family Interdisciplinary Team Meetings (CFT) G9007
C) Documentation of TCC Training in RELIAS system

Assess whether the selected PIP variables were appropriate for measuring performance and tracking improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
PIP variables				
5.1 Were the variables adequate to answer the PIP question? • Did the PIP use objective, clearly defined, time-specific variables (e.g., an event or status that can be measured)? • Were the variables available to measure performance and track improvement over time? (MCPs are encouraged to select variables that can be examined on at least a quarterly basis.)	X			
Performance measures				
5.2 Did the performance measure assess an important aspect of care that will make a difference to beneficiaries' health or functional status? In the comments for this question, list what health or functional status was assessed.	X			
5.3 Were the performance measures appropriate based on the availability of data and resources to collect the data (administrative data, medical records, or other sources)?	X			
5.4 Were the measures based on current clinical knowledge or health services research? • Examples may include: ○ Recommended procedures ○ Appropriate utilization (hospital admissions, emergency department visits) ○ Adverse incidents (such as death, avoidable readmission) ○ Referral patterns ○ Authorization requests	X			
5.5 Did the performance measures: • Monitor the performance of MCPs at a point in time? • Track MCP performance over time? • Compare performance among MCPs over time? • Inform the selection and evaluation of quality improvement activities?	X			

Question	Yes	No	NA	Comments
5.6 Did the MCP consider existing measures, such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures?	X			This PIP was directed from a CMS initiative.
5.7 If there were gaps in existing measures, did the MCP consider the following when developing new measures based on current clinical practice guidelines or health services research? • Did the measure address accepted clinical guidelines relevant to the PIP question? • Did the measure address an important aspect of care or operations that was meaningful to MCP beneficiaries? • Did available data sources allow the MCP to reliably and accurately calculate the measure? • Were all criteria used in the measure defined clearly (such as time periods, characteristics of eligible beneficiaries, services to be assessed, and exclusion criteria)?			X	
5.8 Did the measures capture changes in enrollee satisfaction or experience of care? • Although enrollee satisfaction/experience is an important outcome of care in clinical areas, improvement in satisfaction should not be the only measured outcome of a clinical project. Some improvement in health or functional status should also be addressed • For projects in nonclinical areas (such as addressing access or availability of services), measurement of health or functional status is preferred		X		
5.9 Did the measures include a strategy to ensure inter-rater reliability (if applicable)?			X	
5.9 If process measures were used, is there strong clinical evidence indicating that the process being measured is meaningfully associated with outcomes? • This determination should be based on published guidelines, including citations from randomized clinical trials, case control studies, or cohort studies • At a minimum, the PIP should be able to demonstrate a consensus among relevant practitioners with expertise in the defined area who attest to the importance of a given process		X		
5.10 Overall assessment: In the comments section, note any recommendations for improving the selected PIP variables and performance measures.				

Worksheet 1.6. Review the Data Collection Procedures

Assess whether the data collection procedures were valid and reliable by answering the following questions. This worksheet includes three sections: (1) overall data collection procedures, (2) data collection procedures for administrative data sources, and (3) data collection procedures for medical record review. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Section 1: Assessment of Overall Data Collection Procedures

Question	Yes	No	NA	Comments
6.1 Did the PIP design specify a systematic method for collecting valid and reliable data that represents the population in the PIP?	X			
6.2 Did the PIP design specify the frequency of data collection? If yes, what was the frequency (for example, semi-annually)?	X			
6.3 Did the PIP design clearly specify the data sources? • Data sources may include: ○ Encounter and claims systems ○ Medical records ○ Case management or electronic visit verification systems ○ Tracking logs ○ Surveys ○ Provider and/or enrollee interviews	X			
6.4 Did the PIP design clearly define the data elements to be collected? • Accurate measurement depends on clear and concise definitions of data elements (including numerical definitions and units of measure)	X			
6.5 Did the data collection plan link to the data analysis plan to ensure that appropriate data would be available for the PIP?	X			
6.6 Did the data collection instruments allow for consistent and accurate data collection over the time periods studied?	X			
6.7 If qualitative data collection methods were used (such as interviews or focus groups), were the methods well-defined and designed to collect meaningful and useful information from respondents?			X	
6.8 Overall assessment: In the comments section, note any recommendations for improving the data collection procedures. **Note:** Include assessment of data collection procedures for administrative data sources and medical record review noted below.				

Section 2: Assessment of Data Collection Procedures for Administrative Data Sources

Question	Yes	No	NA	Comments
6.9 If inpatient data was used, did the data system capture all inpatient admissions/discharges?			X	
6.10 If ancillary data was used, did ancillary service providers submit encounter or utilization data for all services provided?			X	
6.11 If EHR data was used, were patient, clinical, service, or quality metrics validated for accuracy and completeness as well as comparability across systems?			X	

Section 3: Assessment of Data Collection Procedures for Medical Record Review

Question	Yes	No	NA	Comments
6.15 Was a list of data collection personnel and their relevant qualifications provided? • Data collection personnel require the conceptual and organizational skills to abstract data. These skills will vary depending on the nature of the data and the degree of professional judgment required. For example, trained medical assistants or medical records clerks may collect data if the abstraction involves verifying the presence of a diagnostic test report. However, experienced clinical staff (such as registered nurses) should be used to extract data to support a judgment about whether clinical criteria are met	X			Data collection was to be performed by a Data Analyst.
6.16 For medical record review, was inter-rater and intra-rater reliability described? • The PIP should also consider and address intra-rater reliability (i.e., reproducibility of judgments by the same abstractor at a different time)			X	
6.17 For medical record review, were guidelines for obtaining and recording the data developed? • A glossary of terms for each project should be developed before data collection begins to ensure consistent interpretation among and between data collection staff • Data collection staff should have clear, written instructions, including an overview of the PIP, how to complete each section of the form or instrument, and general guidance on how to handle situations not covered by the instructions. This is particularly important when multiple reviewers are collecting data			X	

Worksheet 1.7. Review Data Analysis and Interpretation of PIP Results

Assess whether the data analysis and interpretation was appropriate by answering the following questions. Insert comments to explain "No" and "Not Applicable" responses.

Question	Yes	No	NA	Comments
7.1 Was the analysis conducted in accordance with the data analysis plan?	X			
7.2 Did the analysis include baseline and repeat measurements of project outcomes?	X			
7.3 Did the analysis assess the statistical significance of any differences between the initial and repeat measurements?	X			
7.4 Did the analysis account for factors that may influence the comparability of initial and repeat measurements?	X			
7.5 Did the analysis account for factors that may threaten the internal or external validity of the findings?	X			
7.6 Did the PIP compare the results across multiple entities, such as different patient subgroups, provider sites, or MCPs? • Comparing the performance across multiple entities involves greater statistical design and analytical considerations than those required for a project assessing performance of a single entity, such as an MCP, over time	X			
7.7 Were PIP results and findings presented in a concise and easily understood manner?	X			
7.8 To foster continuous quality improvement, did the analysis and interpretation of the PIP data include lessons learned about less-than-optimal performance? • Analysis and interpretation of the PIP data should be based on a continuous improvement philosophy and reflect on lessons learned and opportunities for improvement		X		
7.9 Overall assessment: In the comments section, note any recommendations for improving the analysis and interpretation of PIP results.				

Worksheet 1.8. Assess the Improvement Strategies

Assess whether the selected improvement strategies were appropriate for achieving improvement by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
8.1 Was the selected improvement strategy evidence-based, that is, was there existing evidence (published or unpublished) suggesting that the test of change (performance measure) would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables)?		X		Factors that may have impacted this study are Medicaid Expansion, accuracy of eligibility file, and COVID-19 PHE which limited enrollment eligibility enforcement.
8.2 Was the strategy designed to address root causes or barriers identified through data analysis and quality improvement processes? • Interventions that might have a short-term effect, but that are unlikely to generate long-term change (such as a one-time reminder letter to beneficiaries or providers) are insufficient • It is expected that interventions associated with significant improvement will be system interventions (such as educational efforts, policy changes, or targeting of additional resources) • It is expected that interventions should be measurable on an ongoing basis (e.g., quarterly, monthly) to monitor intervention progress		X		
8.3 Was the rapid-cycle PDSA approach used to test the selected improvement strategy? • The steps in the PDSA cycle[41] are to: ○ **Plan.** Plan the test or observation, including a Plan collecting data, and interpreting the results ○ **Do.** Try out the test on a small scale ○ **Study.** Set aside time to analyze the data and assess the results ○ **Act.** Refine the change, based on what was learned from the test. Determine how to sustain the intervention, if successful • If tests of change were not successful (i.e., did not achieve significant improvement), a process to identify possible causes and implement solutions should be identified		X		
8.4 Was the strategy culturally and linguistically appropriate?[42]			X	
8.5 Was the implementation of the strategy designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices)?		X		Factors that may have impacted this study are Medicaid Expansion, accuracy of eligibility file, and COVID-19 PHE which limited enrollment eligibility enforcement.

[41] Institute for Healthcare Improvement: Science of Improvement, Testing Changes. Available at http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx.

[42] More information on culturally and linguistically appropriate services may be found at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

Question	Yes	No	NA	Comments
8.6 Building on the findings from the data analysis and interpretation of PIP results, did the PIP assess the extent to which the improvement strategy was successful and identify potential follow- up activities?		X		The project write up indicates that the Plan is "Not able to determine at this time" whether the results are attributable to the PIP.
8.7 Overall assessment: In the comments section, note any recommendations for improving the implementation strategies.				

Worksheet 1.9. Assess the Likelihood that Significant and Sustained Improvement Occurred

Assess the likelihood that significant and sustained improvement occurred by answering the following questions. Insert comments to explain "No" and "Not Applicable (NA)" responses.

Question	Yes	No	NA	Comments
9.1 Was the same methodology used for baseline and repeat measurements?	X			
9.2 Was there any quantitative evidence of improvement in processes or outcomes of care?		X		None was presented.
9.3 Was the reported improvement in performance likely to be a result of the selected intervention? • It is not necessary to demonstrate conclusively (e.g., through controlled studies) that a change is an effect of the intervention; it is sufficient to show that the change might reasonably be expected to result from the intervention • It is not necessary to undertake data analysis to correct for secular trends (e.g., changes that reflect continuing growth or decline in a measure because of external forces over an extended period). The measured improvement should reasonably be determined to have resulted from the intervention		X		The project write up indicates that the Plan is "Not able to determine at this time" whether the results are attributable to the PIP.
9.4 Is there statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention?		X		No statistical testing performed.
9.5 Was sustained improvement demonstrated through repeated measurements over time?		X		
9.6 Overall assessment: In the comments section, note any recommendations for improving the significance and sustainability of improvement as a result of the PIP.				

Attachment 1

Worksheet 1.10. Perform Overall Validation of PIP Results

Provide an overall validation rating of the PIP results. The "validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of significant improvement. Insert comments to explain the rating.

PIP Validation Rating (check one box)	Comments
☐High confidence ☐ Moderate confidence ☒Low confidence ☐No confidence	Optum identified many issues with getting the data from the correct sources to ensure accuracy in the calculation of the measures. They were able to calculate that the 1st outreach letter was somewhat successful, it had an aggregate success rate of 34%. However, the number of PCSP renewals that were completed prior to the expiration did not improve. EQRO recommends that Optum do some more analysis of the completion issue and provide more education to providers regarding completion of the PCSP renewals. Optum also identified an issue with not enough Target Care Coordinators (TCC) to complete the requirements of the PIP…they have set a goal to improve the number of TCC by 2%.

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Attachment 2

PM Audit Tool

Member Services Call Standards – Percentage of Calls Answered in 30 Seconds

Member Services Call Standards – Abandonment Rate

Member Services Call Standards – Daily Average Hold Time

Attachment 2

Performance Measure Validation Worksheet

Performance Measure to be Validated: Member Services Call Standards: Percentage of Calls Answered in 30 Seconds; Abandonment Rate; Daily Average Hold Time

Methodology for Calculating Measure: ☐ Administrative ☐ Medical Record Review ■ Hybrid

Scoring: MET: Optum's measurement and reporting process was fully compliant with State specifications.
NOT MET: Optum's measurement and reporting process was not compliant with State specifications. (This designation should be used for any audit element that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All audit elements with this designation must include explanation of the deviation in the comments section.)
n/a: The audit element was not applicable to Optum's measurement and reporting process.

Audit Element	Specifications	Score	Comments
DENOMINATOR			
1. Population	• Medicaid population appropriately segregated from commercial/Medicare.	Met	
	• Population defined as effective Medicaid enrollment as of _____	n/a	
	• Dual Medicaid and Medicare beneficiaries are included.	n/a	
2. Geographic Area	• Includes only those Medicaid enrollees served in Optum's reporting area.	Met	
3. Age & Sex	• No specifications, all included	Met	
4. Enrollment Calculation	• Were members of Plan on _____	n/a	This is a measure of Member Call Center Operations.
	• Were continuously enrolled from _____to____with one break per year of up to 45 days allowed.	n/a	This is a measure of Member Call Center Operations.

Attachment 2

Audit Element	Specifications	Score	Comments
DENOMINATOR (continued)			
4. Enrollment Calculation (continued)	• Switches between populations (Medicare, Medicaid, and commercial) were not counted as breaks.	n/a	
5. Data Quality	• Based on the IS assessment findings, are any of the data sources for this denominator inaccurate?	Met	
6. Proper Exclusion Methodology in Administrative Data (If no exclusions were taken, score as n/a)	• Only members with contraindications or data errors were excluded.	n/a	
	• Contraindication exclusions were performed according to current State specifications.	n/a	
	• Only the codes listed in specifications as defined by State were counted as contraindications.	n/a	
NUMERATOR			
7. Administrative Data: Number of calls to dedicated MMCP phone lines	• Standard codes listed in State specifications or properly mapped internally developed codes were used. (Intended to reference appropriate specifications as defined by State.)	n/a	
	• Members were counted only once.	Met	Calls were only counted once.
8. Medical Record Review Documentation Standards	• Record abstraction tool required notation of the date that the element was performed.	n/a	
	• Record abstraction tool required notation of the element result or finding.	n/a	

Attachment 2

Audit Element	Specifications	Score	Comments
NUMERATOR (continued)			
9. Time Period	• Element performed on or between _____&_____.	Met	Daily, during call center hours.
10. Data Quality	• Properly identified enrollees.	Met	
	• Based on the IS assessment findings, were any of the data sources used for this numerator inaccurate?	Met	
SAMPLING (If administrative method was used, score as "n/a" for audit elements 11, 12, and 13)			
11. Unbiased Sample	• As specified in State specifications, systematic sampling method was utilized.	n/a	
12. Sample Size	• After exclusions, sample size is equal to i. ____n/a____ ii. the appropriately reduced sample size, which used the current year's administrative rate or preceding year's reported rate, or iii. the total population.	n/a	

Attachment 2

Audit Element	Specifications	Score	Comments
SAMPLING (If administrative method was used, score as "n/a" for audit elements 11, 12, and 13) (continued)			
13. Proper Substitution Methodology in Medical Record Review (If no exclusions were taken, score as n/a)	• Only excluded members for whom medical record review revealed 1) contraindications that correspond to the codes listed in appropriate specifications as defined by State, or 2) data errors.	n/a	
	• Substitutions were made for properly excluded records and the percentage of substituted records was documented.	n/a	

ADDITIONAL QUESTIONS	
Were members excluded for contraindications found in the administrative data?	n/a
Were members excluded for contraindications found during the medical record review?	n/a
Were internally developed codes used?	n/a

Attachment 2

VALIDATION FINDING	
The validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "NOT MET." Consequently, it is possible that an error for a single audit element may result in a designation of "NV" because the impact of the error biased the reported performance measure by more than "x" percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate and, thus the measure could be given a designation of "SC." The following is a list of the validation findings and their corresponding definitions:	
FC = Fully Compliant	Measure was fully compliant with State specifications.
SC = Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
NV = Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
n/a = Not Applicable	Measure was not reported because PAHP/PIHP did not have any Medicaid enrollees that qualified for the denominator.

Performance Measure Designation: **FC**

This Performance Measures were a measure of the Member Call Centers compliance with Standards .

Attachment 3

Compliance Audit Tool 2022

Compliance Review

Idaho EQR Tool – Optum Idaho (March 2022 onsite for timeframe July 1, 2021 – June 30, 2022)
* – State and Plan responsibility Numbering sequenced on master tool; individual State and Plan tools will not be sequential.
(MCO, PHIP, PAHP, PCCM) has been changed to Plan ****Individual Component Scoring:** (scoring present on each line of the administrative tool)
P = Proficient - Documentation supports that component was implemented, reviewed, revised, and/or further developed.
D = Developing - Documentation supports some but not full compliance was present.
N = No Documentation - No documentation was found to substantiate component compliance.
n/a = Not Applicable - Component is not applicable to the focus of the evaluation.

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Availability of services **Medicaid:** 42 C.F.R. §§ 438.206 (availability of services) and 42 C.F.R. § 10(h) provider directory)	• IDHW's requirements for Optum provider directory • Information on the documentation that IDHW uses to support its certification that Optum complied with IDHW's requirements for availability and accessibility of services, including the adequacy of the provider network	• Service planning documents and provider network planning documents • Other performance standards and quality indicators established by Optum • Optum contract with IDHW • Provider Directory • Strategic plans • Administrative policies and procedures • Utilization management policies and procedures • Service authorization policies and procedures • Provider manuals • Provider oversight and evaluation policies and procedures, audit tools • Member services policies and procedures • Member Handbook • Provider directory • Grievance and appeals policies and procedures	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Furnishing of services and timely access **Medicaid**: 42 C.F.R. § 438.206(c)(1): Furnishing of services and timely access	• Obtain a copy of IDHW's standards for timely enrollee access to care and services required of Plans.	• Performance standards and quality indicators established by Optum • Provider directory • Organization strategic plans • Administrative policies and procedures • Utilization management policies and procedures • Service authorization policies and procedures • Provider manuals • Member Handbook • Provider directory • Grievance and appeals policies and procedures	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Access and cultural considerations Medicaid: 42 C.F.R. § 438.206(c)(2): Furnishing of services and cultural considerations.	• Descriptive information on IDHW's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. • The requirements IDHW has communicated to Optum with respect to how Optum is expected to participate in IDHW's efforts to promote the delivery of services in a culturally competent manner.	• Performance standards and quality indicators established by Optum • Provider directory • Organization strategic plans • Administrative policies and procedures • Utilization management policies and procedures • Provider contracts • Provider manual • Member Handbook • Grievance and appeals policies and procedures	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**IDHW policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Assurances of adequate capacity and services Medicaid: 42 C.F.R. § 438.207: Assurances of adequate capacity and services	• IDHW documentation and submission timing standards to assure that Optum has an appropriate range of preventive, primary care, specialty, and LTSS services that are adequate for the anticipated number of enrollees in Optum's service area. • IDHW documentation and submission timing standards to assure that Optum maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.	Plan 42 C.F.R. § 438.207(b) compliance documentation Plan 42 C.F.R. § 438.207(c) compliance documentation Plan 42 C.F.R. § 457.1230(b) compliance documentation Appointment Timeliness Policies and Procedures	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**IDHW policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Coordination and continuity of care for all enrollees **Medicaid**: 42 C.F.R. § 438.208: Coordination and continuity of care	IDHW's requirements regarding the obligation to and methods by which a Plan must: • a) Ensure enrollees have an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity • b) Coordinate the services Optum furnishes to enrollees (between settings, between Plans, between Plan and FFS, and with services provided by community and social supports) • c) Make a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees • d) Share with IDHW or other Plans serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities • e) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards • f) Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with applicable privacy requirements	• Practice guidelines adopted by Optum • Provider Services policies and procedures manuals • Provider manuals • Member Handbooks • Care coordination policies and procedures • Contract for services between IDHW and Optum	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**IDHW policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Additional coordination and continuity of care requirements: LTSS Medicaid: 42 C.F.R. § 438.208: Coordination and continuity of care	• Methods used by IDHW to identify to Optum enrollees who need LTSS. • Whether Optum is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries. • Any LTSS assessment mechanisms requirements, including the requirement to use appropriate providers or individuals meeting the LTSS service coordination requirements. • IDHW's quality assurance and utilization review standards.	• Practice guidelines adopted by Optum • Provider Services policies and procedures manuals • Provider manuals • Member Handbooks • Care coordination policies and procedures	Proficient
Additional coordination and continuity of care requirements: SHCN Medicaid: 42 C.F.R. § 438.208: Coordination and continuity of care	• Methods used by IDHW to identify to Optum individuals with special health care needs (SHCNs). • Whether Optum is required to implement mechanisms for identifying, assessing, and producing a treatment plan for persons with SHCNs using IDHW's definition of SHCNs. • Whether Optum is required to meet identification, assessment, and treatment planning requirements for dually-enrolled beneficiaries. • Any SHCN assessment mechanisms requirements, including the requirement to use appropriate providers or individuals meeting the LTSS service coordination requirements. • Whether IDHW requires Optum to produce a treatment or service plan for enrollees with SHCN that are determined through assessment to need a course of treatment or regular care monitoring. • IDHW's quality assurance and utilization review standards.	• Practice guidelines adopted by Optum • Provider Services policies and procedures manuals • Provider manuals • Member Handbooks • Care coordination policies and procedures	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Disenrollment **Medicaid:** 42 C.F.R. § 438.56: Disenrollment: Requirements and limitations	• Obtain from IDHW Information on: • Reasons for which Optum may request the disenrollment of an enrollee. • Methods by which Optum assures IDHW that it does not request disenrollment for reasons other than those permitted under the contract. • Whether IDHW chooses to limit disenrollment. • Medicaid/CHIP agency enrollee disenrollment request policies. • Whether DHW allows Optum to process enrollee requests for disenrollment. • Whether IDHW requires enrollees to seek redress through Optum's grievance system before IDHW makes a disenrollment determination on the enrollee's request.	• Enrollment and disenrollment policies and procedures	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Coverage and authorization of services **Medicaid:** 42 C.F.R. § 438.210(a–e)*: Coverage and authorization of services, including 42 C.F.R. § 440.230 Sufficiency of amount, duration, and scope; 42 C.F.R. § Part 441, Subpart B: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21;* and 42 C.F.R. § 438.114, Emergency and post-stabilization services	• Obtain from IDHW any amount, duration, and/or scope of service requirements that are greater than those set forth in 42 C.F.R. §440.230 or, for enrollees under the age of 21, as set forth in 42 C.F.R. § Part 441, Subpart B. • Obtain from IDHW any statutory, regulatory and policy definitions of "medical necessity", as well as any quantitative and non-quantitative treatment limitation limits set forth in those sources. • Obtain from IDHWIDHW IDHW- established standards for Plan processing of standard authorization decisions. • Any IDHW drug authorization requirements, including whether IDHW requires approval of outpatient drugs before its dispensing under Section 1927(d)(5)(A) of the Act.	• Completed evaluations of entities conducted before delegation is granted • Grievance and appeals data • Utilization management policies and procedures • Data on claims denials • Service authorization policies and procedures • Policies and procedures for notifying providers and enrollees of denials of service	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Information requirements for all enrollees **Medicaid:** 42 C.F.R. § 438.100(b)(2)(i) Enrollee right to receive information in accordance with 42 C.F.R. § 438.10: Information requirements	• Whether IDHW, the enrollment broker, or Plan must provide all required information to enrollees. • Medicaid/CHIP agency developed definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Medicaid/CHIP agency developed model enrollee handbooks and enrollee notices. • The language(s) that IDHW determines are prevalent in Optum's geographic service area, and all non-English languages that the Medicaid/CHIP identifies. • Policies relevant to written material language and format, for example, policies relevant to inclusion of taglines. • Any interpretation services that IDHW makes available to enrollees. • How IDHW defines 'reasonable time' for purposes of providing the enrollee handbook to enrollees. • Medicaid/CHIP agency developed or approved language describing grievance, appeal, and fair hearing	• Provider contracts • Enrollee services policies and procedures • Enrollee marketing materials • Marketing plans, policies and procedures • Member Handbook • Grievance and appeals policies and procedures • Provider directory • Plan website	Proficient

	procedures and timeframes, for inclusion in the enrollee handbook. • Medicaid/CHIP agency policy on whether enrollee are required to pay costs for services while an appeal or state fair hear is pending – and the final decision is adverse to the enrollee – for purposes of the enrollee handbook. • Any content required by IDHW for the enrollee handbook that is not covered in 42 CFR 438.10(g). • Information on how IDHW has defined a "significant change" in the information Plans are required to give enrollees pursuant to 42 C.F.R. § 438.10(g). • Any applicable Medicaid/CHIP laws on enrollee rights.		

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Enrollee right to receive information on available treatment options Medicaid: 42 C.F.R. § 438.100(b)(2)(iii) Enrollee right to receive information on available treatment options and alternatives including requirements of 42 C.F.R. § 38.102: Provider-enrollee communications	• Information on whether or not Optum has documented to IDHW any moral or religious objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a particular Medicaid/CHIP service or services.	• Provider contracts • Marketing materials • Marketing plans, policies and procedures • Enrollment and disenrollment policies and procedures • Member Handbook • Grievance and appeals policies and procedures	Proficient
Enrollee right to participate in decisions regarding his or her care and be free from any form of restraint Medicaid: 42 C.F.R. § 438.100(b)(2)(iv) and (v): Enrollee right to: - participate in decisions regarding his or her care, including the right to refuse treatment; - Be free from any form of restraint . . . as specified in other Federal regulations And related: 42 C.F.R. § 438.3(j): Advance directives	• A written description of any state law(s) concerning advance directives. The written description may include information from state statutes on advance directives, regulations that implement the statutory provisions, opinions rendered by state courts and other states administrative directives. • Information on whether or not Optum has documented to IDHW any moral or religious objection to fulfilling the regulatory provisions pertaining to advance directives	• Provider contracts • Enrollee services policies and procedures • Member Handbook • Marketing materials	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Compliance with other Federal and state laws **Medicaid:** 42 C.F.R. § 438.100(d): Compliance with other federal and state laws	• Obtain from IDHW the identification of all State laws that pertain to enrollee rights and with which IDHW Medicaid/CHIP Agency requires its Plans to comply.	• Provider contracts • Enrollee services policies and procedures • Member Handbook • Marketing materials	Proficient
Provider Selection **Medicaid**: 42 C.F.R. § 438.214: Provider selection	• Obtain from IDHW information on any credentialing, re-credentialing, or other provider selection and retention requirements established by IDHW that address acute, primary, behavioral, substance use disorder, and MLTSS providers, as appropriate.	• Contracts or written agreements with organizational subcontractors • Procedures and methodology for oversight, monitoring, and review of delegated activities • Completed evaluations of entities conducted before delegation is granted • Credentialing committee meeting minutes	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Sub-contractual relationships and delegation **Medicaid:** 42 C.F.R. § 438.230: Subcontractual relationships and delegation	• Obtain from IDHW the "periodic schedule" established by the State according to which Optum is to monitor and formally review on an ongoing basis all subcontractors' performance of any delegated activities.	• Procedures and methodology for oversight, monitoring, and review of delegated activities • Completed evaluations of entities conducted before delegation is granted • Ongoing evaluations of entities performing delegated activities	Proficient
Practice Guidelines **Medicaid:** 42 C.F.R. § 438.236: Practice guidelines	• Information on any state statutory, regulatory, or policy requirements concerning Plan practice guidelines.	• Provider contracts • Contracts or written agreements with organizational subcontractors • Practice guidelines • Provider Services policies and procedures manuals • Medicaid enrollee services policies and procedures	Proficient

Plan Standards, Including Enrollee Rights and Protections			
Federal regulation source(s)	**Medicaid/CHIP agency policy/ regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Health information systems Medicaid: 42 C.F.R. § 438.242	• Information on whether or not IDHW has required Optum to undergo, or has otherwise received, a recent assessment of Optum's health information system. If IDHW has required or received such an assessment, obtain a copy of the information system assessment from IDHW or Optum. Also obtain contact information about the person or entity that conducted the assessment and to whom follow- up questions may be addressed. • State specifications for data on enrollee and provider characteristics that must be collected by Optum. • Information on whether or not IDHW has conducted a recent review and validation of Optum's encounter data, or required Optum to undergo, or has otherwise received, a recent validation of Optum's encounter data. If IDHW has required or received such a validation review, obtain a copy of the review from IDHW or Optum. Also obtain contact information about the person or entity that conducted the validation and to whom follow- up questions may be addressed. • State specifications for how Plans are to (1) collect data elements necessary to enable the mechanized claims processing retrieval systems to provide for electronic transmission of claims data in the format consistent with the Transformed Medicaid Statistical Information System (T- MSIS); (2) collect and transmit data on enrollee and provider characteristics specified by IDHW, on all services furnished to enrollees through an encounter data system; and (3) Ensure that data received from providers is accurate and complete. • Specifications for submitting encounter data to IDHW in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format. • Make all collected data available to IDHW and upon request to CMS. • IDHW's procedures and quality assurance protocols to ensure that enrollee encounter data submitted by Optum is a complete and accurate representation of the services provided to its enrollees.	• QAPI project descriptions, including data sources and data audit results • Analytic reports of service utilization • Information systems capability assessment reports • Policies and procedures for auditing data or descriptions of other mechanisms used to check the accuracy and completeness of data (internally generated and externally generated data) information system • Completed audits of data or other evidence of data monitoring for accuracy and completeness both for Plan data and information system • Provider contracts	Proficient

Quality Assessment and Performance Improvement Program			
Federal regulation source(s)	**State policy/regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Quality Assessment and Performance Improvement: General rules Medicaid: 42 C.F.R. § 438.330(a): General rules	• In the event that CMS specifies national performance measures or PIP topics, whether or not IDHW has requested an exemption from the national performance measures or PIPs.	• Plan QAPI implementation documentation	No national PMs or PIPs specified.

Quality Assessment and Performance Improvement Program			
Federal regulation source(s)	**State policy/regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Basic elements of quality assessment and performance improvement program **Medicaid:** 42 C.F.R. § 438.330(b): Basic elements of quality assessment and performance improvement programs	• IDHW's specifications for performance improvement projects (PIPs) required per paragraph (d) of this section. • IDHW's specifications for how Optum should identify, measure and report performance measures required per paragraph (c) of this section. • IDHW's requirements for detection by Optum of over- and under-utilization. • IDHW's requirements for assessment by Optum of the quality and appropriateness of care furnished to enrollees with special health care needs, as defined in IDHW's quality strategy under 438.340 (as cross- referenced for CHIP in 457.1240(e)). • IDHW's requirements for assessment by Optum of the quality and appropriateness of care furnished using LTSS, if applicable, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan. • IDHW's requirements for Optum's participation in efforts by the State to prevent, detect, report, investigate and remediate critical incidents, that occur within the delivery of LTSS as well as to track and trend results in order to make systems improvements, if applicable	• Policies and procedures related to QAPI project metrics • QAPI project quality indicators, the selection or development criteria, and processes for selection or development • Performance standards and quality indicators established by Optum • Performance measure reports and data provided to IDHW • Utilization management policies and procedures • Policies and procedures related to data collection and data quality checks for QAPI projects • Policies and procedures for assisting IDHW in the prevention, detection and remediation of critical incidents that occur within the delivery of MMLTSS.	Developing

Quality Assessment and Performance Improvement Program			
Federal regulation source(s)	**State policy/regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
Performance measurement Medicaid: 42 C.F.R. § 438.330(c): Performance measurement	• Information on the standard performance measures identified by IDHW. • For a Plan providing long-term services and supports, the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports. • Information on whether Optum calculates the performance measure and reports to IDHW or whether Optum provides data to IDHW, which then calculates the PM.	• Performance measure reports and data provided to IDHW • Contract between IDHW and Optum	Proficient
Performance Improvement projects Medicaid: 42 C.F.R. § 438.330(d)	• Information on any PIP requirements specified by IDHW. • Information on how often IDHW requests that each Plan report the status and results of each project conducted per paragraph (d)(1) of this section. • Information on if IDHW permits a Plan exclusively serving dual eligibles to substitute an MA Organization quality improvement project conducted under § 422.152(d) of this chapter for one or more of the performance improvement projects otherwise required under this section.	• Reports and status documentation of Plan internal QAPI evaluations	Developing

Quality Assessment and Performance Improvement Program			
Federal regulation source(s)	**State policy/regulation information needed to determine Plan compliance**	**Applicable Plan documents**	**Reviewer determination**
QAPI evaluations review **Medicaid:** 42 C.F.R. § 438.330(e)(2): Program and review by IDHW	• Information on whether IDHW requires its Plans to develop a process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program. If so, information on the frequency with which that evaluation must be conducted, and on IDHW's requirements for how Plans conduct that process.	• Plan's Annual Quality Assessment	Proficient

Grievance System			
Federal Regulation Source(s)	**State Policy/Regulation Information Needed to Determine Plan Compliance**	**Applicable Plan Documents**	**Reviewer Determination**
Grievance Systems Medicaid: 42 C.F.R. § 438.228: Grievance and appeal systems	• Obtain information on: • Whether or not IDHW delegates responsibility to Optum for providing each enrollee (who has received an adverse decision with respect to a request for a covered service) notice that he or she has the right to a state fair hearing or review to reconsider their request for the covered service.	• Grievance and appeals policies and procedures • Grievance and appeals tracking reports	Proficient
General requirements Medicaid: 42 C.F.R. § 438.402: General requirements	• Information on: • Whether enrollees are required or permitted to file a grievance with either IDHW or Optum, or both. • Whether providers, or authorized representatives, can act on behalf of the enrollee to request an appeal, file a grievance, or request a state fair hearing or review request. • Whether state offers external medical review.	• Grievance and appeals policies and procedures • Grievance and appeals data • Analytic reports of service utilization • Information systems capability assessment reports • Policies and procedures for auditing data or descriptions of other mechanisms used to check the accuracy and completeness of both internally generated and externally generated data • Completed audits of data or other evidence of data monitoring for accuracy and completeness both for Plan data and contractor (delegate) data • Provider policies and procedures manuals • Provider contracts	Proficient

Grievance System			
Federal Regulation Source(s)	**State Policy/Regulation Information Needed to Determine Plan Compliance**	**Applicable Plan Documents**	**Reviewer Determination**
Timely and Adequate Notice of Adverse Benefit Determination Medicaid: 42 C.F.R. § 438.404: Timely and adequate notice of adverse benefit determination	• Information on the timeframes within which it requires Plans to make standard (initial) coverage and authorization decisions and provide written notice to requesting enrollees. These timeframes will be the required period within which Plans must provide Medicaid/CHIP enrollees written notice of any intent to deny or limit a service (for which previous authorization has not been given by Optum) and the enrollee's right to file a Plan appeal.	• Data on claims denials • Grievance and appeals policies and procedures • Plan adverse benefit determinations • Timing data on adverse benefit determination mailings	Proficient
Handling of Grievances and Appeals Medicaid: 42 C.F.R. § 438.406: Handling of grievances and appeals	• Information on any state requirements concerning handling of grievances and appeals that differ from those required under 438.406. • *Note: See the 'Disenrollment' section in Worksheet 3.2 above for grievances during disenrollment.	• Grievance and appeals policies and procedures • Grievance and appeals data	Proficient

Grievance System			
Federal Regulation Source(s)	**State Policy/Regulation Information Needed to Determine Plan Compliance**	**Applicable Plan Documents**	**Reviewer Determination**
Resolution and notification: Grievances and appeals **Medicaid**: 42 C.F.R. §438.408: Resolution and notification, Grievances and appeals	• Information on: • IDHW-established standard time frames during which IDHW requires Plans to (1) dispose of a grievance and notify the affected parties of the result, and (2) resolve appeals and notify affected parties of the decision. • The methods prescribed by IDHW that Optum must follow to notify an enrollee of the disposition of a grievance. • Information on whether providers, or authorized representatives, can act on behalf of the enrollee to request an appeal, file a grievance, or request a state fair hearing request.	• Grievance and appeals policies and procedures • Grievance and appeal tracking reports • Plan appeal resolution notices	Proficient
Expedited resolution of appeals **Medicaid:** 42 C.F.R. § 438.410: Expedited resolution of appeals		• Grievance and appeals policies and procedures • Grievance and appeal tracking reports	Proficient

Grievance System			
Federal Regulation Source(s)	**State Policy/Regulation Information Needed to Determine Plan Compliance**	**Applicable Plan Documents**	**Reviewer Determination**
Information about the grievance system to providers and subcontractors Medicaid: 42 C.F.R. § 438.414: Information about the grievance and appeal system to providers and subcontractors	• Information on: • Whether IDHW develops or approves Optum's description of its grievance system that Optum is required to provide to all Medicaid/CHIP enrollees (per 438.10(g)(2)(xi). [Note that under regulations at 42 C.F.R. § 438.10(g)(1) IDHW must either develop a description for use by Optum or approve a description developed by Optum.] • If IDHWs approves, rather than develops, the description of Optum's grievance system, information on whether or not IDHW has already approved Optum's description.	• Contracts or written agreements with organizational subcontractors • Completed evaluations of entities conducted before delegation is granted • Provider contracts • Provider procedure manuals	Proficient
Recordkeeping Requirements Medicaid: 42 C.F.R. § 438.416: Recordkeeping Requirements	• Information on any audits or other reviews of Plan records of grievances and appeals conducted by the state.	• Grievance and appeals policies and procedures • Grievance and appeal tracking reports • Sample records of grievances and appeals	Proficient
Continuation of benefits while Optum appeal and IDHW Fair Hearing are pending 42 C.F.R. § 438.420: Continuation of benefits while the MCO, PIHP, or PAHP appeal and IDHW fair hearing are pending	• Information on any state requirements concerning continuation of benefits pending appeal and state fair hearing that differ from those required under 42 C.F.R. § 420. • Information on any audits or other reviews of Plan records of appeals conducted by IDHW, to determine Plan compliance with federal continuation of benefits requirements. • Whether state permits managed care plans to recover the cost of services. See (d) reference to "state's usual policy."	• Grievance and appeals policies and procedures	Proficient

Grievance System			
Federal Regulation Source(s)	**State Policy/Regulation Information Needed to Determine Plan Compliance**	**Applicable Plan Documents**	**Reviewer Determination**
Effectuation of reversed appeal resolutions Medicaid: 42 C.F.R. § 438.424: Effectuation of reversed appeal resolutions.	• Information on which entity- IDHW or Optum- is required to pay for services when IDHW fair hearing officer reversed a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending.	• Grievance and appeals policies and procedures	Proficient