Telligen
Healthcare Intelligence

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External Quality Review: Optum Idaho

Report of Findings

2018 - 2019

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External Quality Review Organization:

Optum Idaho
Annual Review and Summary
2018 - 2019

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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 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 first year that IDHW has requested an EQR of Optum Idaho. This technical report involves Optum Idaho's (Optum) performance as evaluated during desk reviews of Optum's policies and procedures and an onsite review conducted on February 13, 2020 at their Boise, ID location.

During the time of this review (July 1, 2018 through June 30, 2019) Optum reported 261,586 eligible Medicaid lives in Idaho; this is a decrease over the 268,224 lives reported in 2017-2018, and the 291,197 lives reported in 2017-2016. 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 and the Security Administrator. 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

The External Quality Review Team included:

Mary Arnold, Regional Director of Analytics & Reporting
Sara Bartles, External Relations Director
Mohan Basavapatna, Sr. Director Technology
Dennis Baughman, Manager of Medical Clinical Operations
Georganne Benjamin, Executive Director
Galina Gorbatok, Eligibility Systems Analyst, Benefit and Eligibility Operations (BEO)
Alyndia Growette, Claims Auditor Consultant
Karla Hart, Claims Quality Analyst Senior
Emily Heuman, Compliance Analyst
Renee Jackson, Manager Eligibility System Operations
Brenda Jenkins, Clinical Director
Brett Jossis, Compliance and Quality Director
Lyndsay Kadow, Senior Compliance Analyst
Ron Larsen, Chief Medical Officer

Diane Miller, Provider Relations Director
Casey Moyer, Deputy Director
Verushka Nevadomski, Compliance Consultant
Jody Olson, Member & External Communications Manager
Kellie Roberts, Sr. Manager Business System Analysis
Brent Robertson, Principal Information Security Engineering
Arlene Segura, Manager, Data Analytics and Reporting
Delayna Sneed, Associate Director of Client Audit and Regulatory Reporting
Jann Marie Stockwell, Communications Director
Ludmila Timoshek, Senior ESA COSMOS
Adam Zunker, Compliance Director, Optum Exam Management

Telligen, Inc.
Jennifer Bly, RN, Quality Improvement Manager
Brandi Lister, 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 tri-annual review (every three years) of Compliance. 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 a full compliance review year. The IDHW also requires an annual Information Systems Capabilities Assessment (ISCA).

1) Validating Compliance with Managed Care Regulations.[1]

The Team conducted an evaluation of compliance with Quality Standards addressing access to care, structure and operations, and quality management and improvement per 42 CFR §438.

2) Validating Performance Improvement Projects[2]

Optum conducted Performance Improvements Projects (PIPs) during the 12 months preceding the audit, as required in 42 CFR 438.20 (b)(1). Three PIPs were then validated by the Team:

- Appointment Reminder Program
- Substance Abuse American Society of Addiction Medicine (ASAM) Expansion
- Utilization Management (UM) Clinical Review Documentation

3) Validating Performance Measures[3]

One Performance Measures (PM) that was underway the preceding 12 months was validated by the Team as required by 42 CFR 438.20(b)(2). This PM was:

[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, D.C.: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September, 2012. Washington, D.C.: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the PAHP: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, D.C.: Author.

- Critical Appointment Wait Times

and

4) Information Systems Capabilities Assessment (ISCA)[4]

The ISCA is the evaluation of the PAHP's information systems by the Team. This evaluation is intended to assess the strength of those systems and their capability to accurately and reliably produce performance measure data and reports, as well as manage the care of enrollees.

The Team used review procedures for the ISCA that were based on the CMS protocol for this activity. For each ISCA review area, reviewers used the information collected from Optum in the ISCA data collection tool, responses to interview questions, and results of walkthroughs during the on-site visit to rate the PAHP's performance in five review areas.

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 the ISCA.

[4] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Appendix V: Information Systems Capabilities Assessment – Activity Required for Multiple Protocols, Version 2.0, September, 2012. Washington, D.C.: Author.

Compliance
Review of Quality Standards

Technical Methods of Data Collection and Analysis:

As this is Optum's first EQR, it is subject to a full compliance audit. The content of this 2018-19 audit will include a review of the Quality Standards: Enrollee Rights and Protections; Access and Availability; Structure and Operations; and Measurement and Improvement Standards, as defined in 42 CFR 438. 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
- Review of Grievance and Appeals files
- Staff interviews

The Team utilized an administrative review tool which was developed based on the CMS Protocol EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR) (Compliance Protocol). See Attachment 1. 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.

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 1.

Table 1. Compliance Ratings

Measure	2018-2019 Rate
Enrollee Rights and Protections	Proficient
Access and Availability	Proficient
Coordination and Continuity of Care	Proficient
Coverage and Authorization of Services	Proficient
Provider Selection	Proficient
Grievance System	Proficient
Sub-Contractual Relationships and Delegations	Proficient
Enrollment and Disenrollment	n/a
Practice Guidelines	Proficient
Quality Assessment and Performance Improvement Program	Developing
Health Information Systems	Proficient
Overall Rating	Developing

Description of the Data:

The review of Quality Standards was completed using Attachment 1, BBA Quality Standards Review Tool, adapted from 42 CFR 438. The following is a description of the findings by performance category identified in the tool/regulations.

The areas of Access and Availability, Coordination and Continuity of Care, Coverage and Authorization of Services, Enrollee Rights and Protections, Provider Selection, Grievance System, Sub-Contractual Relations and Delegations, and Practice Guidelines were found to meet all required standards.

Quality Assessment and Performance Improvement Program

The category of Quality Assessment and Performance Improvement Program addresses 10 standards. For the 2018 - 2019 review year, Optum was rated as proficient in six standards and developing in four standards.

Health Information Systems

The category of Health Information Systems addresses five standards. For the 2018-2019 review year, Optum was proficient in all five standards.

The two standards that received the rating of developing pertained to Optum's Performance Improvement Projects and Information Systems. Data collection and analysis issues (CFR 438.240(b)(1)) were not present in all PIPs. Two of the three PIPs did not measure quality standards (CFR 438.240(d)(I)(i)); did not contain interventions to be implemented (CFR 438.240(d)(I)(ii)) and thereby did not adequately analyze the effectiveness of interventions (CFR 438.240(d)(1)(iii)). More details regarding the specifics of Optum's performance on these standards can be found in the Performance Improvement Projects and ISCA sections of this report.

Enrollment and Disenrollment

The five standards under Enrollment and Disenrollment are rated as "not applicable". This function has been retained by IDHW.

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 newsletters to members and providers on seasonal topics, as well as an Annual Newsletter to all members. Members are also able to access Optum's website to obtain additional information in real time.

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 and has Performance Measures dedicated to appointment wait times and access.

Quality of Care
The quality of care provided by Optum contracted providers is assured by Optum's compliance with the standards of review set forth in the areas of Quality Assessment. All Optum providers are credentialed and monitored according to required policies and procedures. Additionally, a Member Advisory Committee meets quarterly.

All levels of evaluation during this review show that Optum is committed to their members as the users of its services.

Recommendations for Improvement:

1. The EQRO recommends that Optum make every effort to ensure all performance improvement projects meet the standards of the CMS Protocol 3 "Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQRO)".
2. The EQRO recommends ongoing evaluation of projects that can be fostered into performance improvement projects.
3. The EQRO recommends that Optum continue to place emphasis on the grievances and appeals process, so that they may maintain the gains they have seen in this area.

Performance Improvement Projects

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

- Appointment Reminder Program
- Substance Abuse American Society of Addiction Medicine (ASAM) Expansion
- Utilization Management (UM) Documentation

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 2), 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.

The reviewers incorporated document review, interview, and observation techniques to fully evaluate the components of each Performance Improvement Project. All evaluation was calculated utilizing the CMS Final Protocol, Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review.

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.

A summary of compliance with all evaluated Performance Improvement Projects is included in Table 2

Table 2 - Performance Improvement Project Ratings

Step	Appointment Reminder Program	Substance Abuse ASAM Expansion	Utilization Management Clinical Review Documentation
Step 1: Selected Study Topics	Proficient	Developing	Developing
Step 2: Study Questions	Proficient	No Documentation	Developing
Step 3: Study Indicators	Proficient	Developing	Proficient
Step 4: Study Populations	Proficient	Proficient	Proficient
Step 5: Sampling Methods	N/A	N/A	N/A
Step 6: Data Collection Procedures	Developing	No Documentation	Developing
Step 7: Improvement Strategies	Developing	No Documentation	Developing
Step 8: Analysis and Interpretation of Study Results	Developing	No Documentation	Developing
Step 9: Validity of Improvement	Developing	No Documentation	Developing
Step 10: Sustained Improvement	Developing	No Documentation	N/A
Overall Rating	Developing	No Documentation	Developing

Appointment Reminder Program

Description of the Data:
Optum utilized many methods of data collection for this PIP. These data collection methods include:

- Administrative data derived from claims/encounters (inpatient and outpatient)
- Medical Record Abstraction

This PIP focused on the Healthcare Effectiveness Data and Information Set (HEDIS) measure that is used to evaluate patient services after discharge from inpatient care. HEDIS is a tool used by health plans to measure performance on important dimensions of care and services. A HEDIS qualified appointment is an outpatient follow-up appointment (including mental health partial hospitalization) with a licensed mental health practitioner that takes place within 30 days after discharge.

Optum states that the baseline measurement period for this PIP was October – December 2017, however interventions were not implemented until July 2018. Therefore, the first re-measurement period would be July 1, 2018 – June 30, 2019. Re-measurement data for Medicaid enrollees was only reported for April – June 2019 in the PIP documentation received by Telligen.

Optum provided quarterly data to IDHW in their Quality Management and Utilization Management (QMUM) report that was related to this PIP, but they did not report the percentage of enrollees who received a follow-up appointment. For the time period of January through April 2019, in the QMUM report, Optum stated "Out of 945 total discharges received by Optum Idaho from January through April 2019, 203 members participated in ARP (Appointment Reminder Program). Data reflects information received from 6 participating Idaho hospitals. Five hospitals did not submit data."

Optum selected one measurement/indicator for this study.

Study Measurement #1: The study measurement was "the percentage of Idaho Medicaid enrollees discharged from an inpatient psychiatric facility who received a follow-up appointment with a licensed mental health practitioner within 30 days after discharge." The goal for this study measurement was to improve from their baseline of 68.1%.

The Team's evaluation processes incorporated a review of study documentation regarding decision-making processes, identification of interventions, and anticipated change or hypothesis. Results were evaluated for statistical significance and compared to the defined goals for the study year.

Conclusions:
Optum selected this PIP due to the proven effectiveness of follow-up appointments to improve member outcomes. By improving the number of members who have an outpatient follow-up appointment, it has been shown that rehospitalizations decrease and member outcomes improve.

The study question is: "Are members more likely to attend a follow-up appointment after hospitalization if they are reminded to attend through the appointment reminder program?"

Optum has implemented one intervention:

- The intervention was implemented to improve follow-up after hospitalization at a psychiatric inpatient facility. Attempts are made to schedule a follow-up appointment at the time of discharge and calls are made to members following discharge to set up the follow-up appointment if the appointment is not made at discharge. Additionally, reminder calls are made

to members to remind them of the upcoming appointment.

Optum did not report any analysis of the success of the PIP, however, they reported that the follow-up rate decreased from the baseline of 68.1% to 67.0% in the remeasurement period. The PAHP also reported the number of enrollees who participated in the Appointment Reminder Program in the QMUM report (as detailed above). The PAHP was advised to report and analyze data on a minimum of a quarterly basis. The information provided by Optum indicates that the rate of follow-up appointments has not increased as was the intent of the PIP.

Strengths:

1) Optum's rationale for choosing this PIP is clearly documented.
2) Optum's use of HEDIS proven measures to show quality improvement.

Areas for Improvement:

1) Although goals were implied, they were not communicated to the EQRO and an analysis of whether the PAHP reached these goals could not be performed.
2) The EQRO recommends a minimum data analysis cycle of quarterly going forward. This analysis should be done in the context of enrollee outcomes, not in participation in the program or utilization of the program. This would allow Optum to identify any trends and make corrections as needed in a timely manner.

Substance Abuse (ASAM) Expansion

Description of the Data:

Optum utilized administrative data derived from claims data and medical record review of ASAM completion.

Optum submitted documentation to support a PIP that was part of a broader effort to ensure better consistency and delivery of Substance Use Disorder (SUD) services. The use of ASAM allows providers to focus on the member's needs and establish appropriate Level of Care Guidelines for SUD services.

Conclusions:
Optum did not indicate that this PIP would have an impact on health status, functional status, or member satisfaction, or processes of care with a strong association to improved outcomes. In order for a PIP to be considered valid, the CMS Protocol 3 "Validating Performance Improvement Projects", requires that the PIP do one of those things.

Study Question: "How can Optum Idaho better incorporate ASAM into key guidelines, operations, policies, and processes?"

This is not a measurable study question.

Over the time period that Optum implemented this project they did decrease the number of members with an outpatient SUD claim. The PAHP did not have any baseline data to report. However, they did see a decrease from 1,850 SUD claims prior to "going live" with ASAM criteria to 1,826 SUD claims in the month following "going live". Optum believes that this indicates that providers immediately began applying the criteria.

Evaluation of the Study and Recommendations for Improvement:

During the onsite review, the Team discussed with Optum that this PIP was process driven and not performance focused. The PIP is not focused on member outcomes, it is focused on implementation of a new process only. The team advised Optum that for this to be a viable PIP, the PAHP would need to obtain data on the impact this project would have on members.

Strengths:

1) Optum's commitment to improving SUD treatment and outcomes for members.

Areas for Improvement:

1) Optum did not supply data to support that a problem existed prior to implementation of ASAM criteria. Although Optum states that a decrease in claims is evidence of improvement, this was not adequately explained or supported by data that a decrease in outpatient claims was a step in the "right direction". Optum failed to provide any evidence that in fact members were experiencing issues with SUD outpatient claims.

2) There were no indicators that measure changes in health status, functional status, enrollee satisfaction, or processes of care with strong associations with improved outcomes. This project was not a Performance Improvement Project designed to improve outcomes, it does not meet the requirements of a PIP as detailed in CMS Protocol 3.

Utilization Management (UM) Clinical Review Documentation

Description of the Data:

Optum utilized member case review documentation as data collection elements for this PIP.

Optum submitted documentation to support a PIP that was intended to improve inconsistences in member case review documentation and member communications. Optum felt there was a need to streamline the UM clinical review process by improving communication and collaboration between the Care Advocates and Peer Reviewers. Optum did not submit documentation that quantified the level of need for this PIP, however, improvement was evidenced as complaints and comments Adverse Benefit Determination (ABD) and Appeals notifications decreased. Additionally, inter-rater reliability scores increased. However, the link between these improvements and a substantial benefit to members was not substantiated.

Conclusions:
Optum indicated that more collaboration between reviewers would allow for more consideration and consistent application of relevant factors when making case determinations. Members and providers are given more thorough explanations of ABD decisions. Optum will use provider satisfaction scores, member satisfaction scores and inter-rater reliability scores to determine the impact on health status, functional status, or member satisfaction.

Study Question: "How can Optum Idaho streamline Care Advocates and Peer Review templates to improve documentation and internal and external communication? How can Optum Idaho improve UM inter-rater reliability?"

This is not a measurable study question. The study question should be written in a manner that measures improvement for members. The implied link between improved documentation and communication is fairly obvious, however Optum should provide more information regarding the connection between outcomes and communication improvements.

Over the time period that Optum implemented this project they reported an improvement in the quality of ABD and Appeal notifications, resulting in a better understanding of Optum determinations by recipient and a reduction in the amount of questions and complaints. In fact, Optum reported complaints and comments went from "roughly two per quarter to zero" since the project closed. Optum also reported inter-rater reliability scores went from 62% in 2017 to 99% in 2018. However, the PAHP did not report any changes in member outcomes or satisfaction scores.

Evaluation of the Study and Recommendations for Improvement:

During the onsite review, the Team discussed with Optum that this PIP was process driven and not performance focused. The PIP mentions member outcomes, but is focused on implementation of a new process only. The link between decreased complaints and member outcomes should be explained in more detail by the PAHP. Additionally, the link between member outcomes and inter-rater reliability scores should also be explained.

Strengths:

1) Optum's commitment to improving the processes and documentation of communication.
2) Optum's commitment to improve inter-rater reliability.
3) Optum recognizes that the PIP should focus on member and provider satisfaction.

Areas for Improvement:

1) Optum's goal of improving the processes and documentation of communication is not supported by data to show that communication requires improvement. Optum didn't cite reasons that improvements in communications would impact a broad spectrum of key aspects of enrollee care and services. Optum failed to provide any evidence that in fact members were experiencing issues with communications, however they did provide evidence that complaints decreased.

2) There were no indicators that measure changes in health status, functional status, enrollee satisfaction, or processes of care with strong associations with improved outcomes.

Overall Evaluation and Recommendations for Improvement

Access to Care

Optum was clearly focused on the access to services delivered to the population in the Appointment Reminder Program PIP. The Critical Appointment Wait Times PIP is a project that should ensure members receive access to appointments.

Quality of Care

Although Optum attempts to utilize the PIP process to improve the quality of their communication and UM inter-rater reliability, the PIP is not member focused and does not have measurable member outcomes or interventions. Similarly, the ASAM PIP is focused on providers implementing the tool, but not on member outcomes. Without these things, the projects as presented cannot be considered PIPs.

Recommendations:

1) Continue to 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.
3) Focus PIPs on member outcomes, PIPs should have the end goal of improving the health of members.
4) Consider expanding PIPs beyond the obvious. Look at "what if's".
5) Consider digging a bit deeper, analysis of some reasons for members' non-compliance may further a PIP's usefulness.

Optum is an organization with a commitment to excellence for their members; this is a significant strength. It is the opinion of this Team that the Appointment Reminder PIP and UM Clinical Documentation PIPs warrant ratings of Developing and the SUD ASAM PIP warrants a rating of No Documentation.

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[5], 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 four activities:

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. Submitted ISCA tools are thoroughly reviewed. Follow-up is conducted as needed.

Activity 3: Onsite visits and walkthroughs with the PAHP are conducted. Data center security walkthroughs are conducted. In-depth interviews with knowledgeable PAHP staff are conducted. Additional documents are requested if needed, based upon interviews and walkthroughs completed at the PAHP.

Activity 4: Analysis of the findings from the PAHP's information systems onsite review. In this phase, the material and findings from the first three phases are reviewed. The PAHP-specific ISCA evaluation report is then finalized.

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

[5] Ibid.

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. Workstations will go inactive after not being logged into for 30 days and can't go active on the network until they have verified that it is appropriately patched. External Applications timeout after 30 mins of inactivity.
2. 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.
3. Optum encrypts data at rest without regard to its content or type at the storage media level on both disk and tape.
4. 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.
5. Windows patches are applied per company policy and are sure to patch each system in a timely manner. They allow the applications team to patch their system on their own as long as they comply with company policy
6. Third party patches are treated the same as windows patches and are equally important, so they are sure to patch these within the same specified timeframe of the corporate policy.

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, 2019 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 utilized via their off-site storage location being in a different geographic location which would minimize the potential for a same event impacting primary and offsite locations.
5. In both the Mainframe and iSeries environments, Optum maintains Production and high availability paired storage devices at their primary data center and another set of Rapid Recovery storage devices at their DR data center to ensure that three current copies of critical data are maintained on-line at all times. Optum maintains sole custody of all data by continuously replicating between data centers over their secured channels.

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, 2019 findings validation, onsite interviews, and facility review.

Strengths:

1. Critical computing areas are monitored
2. They utilize Learn Source for their training platform and at a minimum require annual security and privacy training. Additional training maybe assigned throughout the year based on their phishing campaign results.
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. Optum has a visitor sign in sheet for non-public areas. Visitors are identified via a government issued ID. Sign in sheet captures visitor's name, signature, company name, time of entry, time of exit and name of Optum employee that will be their escort.
6. Optum verifies integrity of the backups during their Sarbanes Oxley testing

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, 2019 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. Medicaid enrollment information is updated with daily changes that are sent to Optum on 834 eligibility files from Molina/DXC. Files are received and loaded Monday through Friday, except for the next day after Idaho State Holiday
6. 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.

Performance Measures

As a part of the EQR evaluation, Optum reported the results of two Performance Measures (PMs) for this evaluation period. These PMs were:

Critical Appointment Wait Times

and

Geographic Availability of Providers

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 3), 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.

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 Reported by the MCO: 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
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 because PAHP did not have any Medicaid enrollees that qualified for the denominator.

A summary of compliance for the evaluated PM is included in Table 4.

Table 4: Performance Measure Compliance Rating Summary Table

Step	Critical Appointment Wait Times
Documentation	Fully Compliant
Denominator: Data Source	Fully Compliant
Denominator: Calculation	Fully Compliant
Numerator: Data Source	Fully Compliant
Numerator: Calculation	Fully Compliant
Numerator: Integration	Fully Compliant
Numerator: Validation	Fully Compliant
Sampling: Unbiased	n/a
Sampling: Methodologies	n/a
Reporting	Fully Compliant
Overall Compliance Rating*	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.)

Critical Appointment Wait Times

Description of Data:

Optum utilized data obtained by making calls to network providers. The study provided a measure of timeliness of critical appointments. The study denominator included all calls made to Network Providers during the timeframe. The time-period reported during this review was July 2018 – June 2019. During this time period 681 calls were made.

The measure evaluated was:

1. Total number of network providers that adhered to the specific access standard for critical appointments being offered within 6 hours of requests.

Conclusions:

The number of calls that meet the critical appointment wait times are reported to IDHW through monthly reports. These reports were not provided to Telligen for validation.

Evaluation of the Study and Recommendations for Improvement:

This Performance Measure is a measure of the access and availability of network providers for a critical appointment. The standard is that a critical appointment is offered within 6 hours of request.

Based on documentation supplied by Optum and on the Team's ISCA review, the process used to collect, integrate and report this measure meets all standards. However, Telligen was not provided with the source data to recalculate this measure. Telligen believes that the measure was calculated correctly as the same methodology is reported by Optum to be used each year. During the on-site review, the Team and Optum discussed the possibility of new Performance Measures to be reviewed in the coming year. This performance measure has become part of Optum's day to day operation and has 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.

Areas for Improvement:

1. The narrative supplied to the Team for review did not contain a description of the data source or calculation of the Denominator.

Recommendations:

1. Reference the CMS Protocol, Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR) 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. Work with IDHW to propose new Performance Measures for the coming year.

4. To prevent miscommunication, Optum should provide a narrative explanation of the Performance Measure that can be read prior to the on-site review. This information should include all documentation of the denominator and numerator calculations or at least a direct link to that documentation. Having this information in one document will prevent the EQRO from missing critical information.

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 Appointment Wait Times was an effort to impact the timing of care received by its enrollees. This was to be accomplished by ensuring members received critical appointments quickly.

Access to Care

Optum placed a great deal of emphasis on their enrollees' access to care. Optum should begin to shape outreach projects and additional enrollee interventions that will further improve the rates for the PMs and may lead to the development of PIPs.

Quality of Care

Optum was fully committed to their members' quality of care. In addition, to the Critical Appointment Wait Times PM that was validated in this report, the PAHP submits the following Performance Measures to IDHW:

Claims
Complaints
Critical Incidents
Customer Service (Provider Calls) Standards
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 study presented for review during this measurement year be considered: Fully Compliant. It is also the opinion of the Team that this study has become a part Optum's day-to-day operation and no longer requires 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.

ATTACHMENTS

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Attachment 1

BBA Compliance Audit Tool

2018 -19 Compliance Review

Attachment 1

Idaho EQR Tool – Optum Idaho (February 2020 onsite for timeframe July 1, 2018 – June 30, 2019)

* – 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.

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights.

Tool	CFR		Score*
A-1	**438.100**	**§438.100(a)** *General rule.* The State must ensure that- **(1)** each Plan has written policies regarding the enrollee rights specified in this section; and **(2)** each Plan complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees. **(b)** *Specific rights* – **(1)** *Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in this section. **(2)** An enrollee of a Plan has the following rights: The right to—**(i)** receive information in accordance with §438.10: **§438.10** *Information requirements.* ***(b)*** *Basic rules.* **(1)** Each Plan must	
*A-2	438.10(b)(1)	Provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood. *("easily understood" not specifically defined by State)*	P
A-4	438.10(b)(3)	Each Plan must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of Optum.	P
A-6	438.10(c)(2)	Make available written information in each prevalent non-English language. *(prevalent not defined by State)*	P
*A-8	438.10(c)(4)	Make oral interpretation services available and require each Plan to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent. *(prevalent not defined by State)*	P
*A-9	438.10(c)(5)(i-ii)	Notify enrollees and potential enrollees, and require each Plan to notify its enrollees—(i) That oral interpretation is available for any language and written information is available in prevalent languages; and (ii) How to access those services. *(prevalent not defined by State)*	P
A-10	438.10(d)(1)(i)	Format. (1) Written material must – (i) Use easily understood language and format *("easily understood" not specifically defined by State)*	P
A-11	438.10(d)(1)(ii)	Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	P
*A-12	438.10(d)(2)	All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.	P
		438.10(e) *Information for potential enrollees.* (1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:	
		438.10(f) *General information for all enrollees of Plans.* Information must be furnished to Plan enrollees as follows:	
*A-26	438.10(f)(3)	The State, its contracted representative, or Optum must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after Optum receives, from the State or its contracted representative, notice of the recipient's enrollment.	P
*A-27	438.10(f)(4)	The State, its contracted representative, or Optum must give each enrollee written notice of any change (that the State defines as ''significant'') in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change. *("significant" not defined by State)*	P
A-28	438.10(f)(5)	Optum must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)			
Tool	**CFR**		**Score***
		438.10(f)(6) The State, its contracted representative, or Optum must provide the following information to all enrollees:	
A-29	438.10(f)(6)(i)	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For Plans this includes, at a minimum, information on primary care physicians, specialists, and hospitals. *(related to 438.10(e)(2)(ii)(D) for State above)*	P
A-30	438.10(f)(6)(ii)	Any restrictions on the enrollee's freedom of choice among network providers.	P
A-31	438.10(f)(6)(iii)	Enrollee rights and protections, as specified in § 438.100. (following pages)	P
A-32	438.10(f)(6)(iv)	Information on grievance and fair hearing procedures, and for Plan enrollees, the information specified in § 438.10(g)(1), *and for PAHP enrollees, the information specified in § 438.10(h)(1).*	P
A-33	438.10(f)(6)(v)	The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	P
A-34	438.10(f)(6)(vi)	Procedures for obtaining benefits, including authorization requirements.	P
A-35	438.10(f)(6)(vii)	The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of- network providers.	P
A-36	438.10(f)(6)(viii)	The extent to which, and how, after-hours and emergency coverage are provided, including: (A) What constitutes emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in § 438.114(a). *(attached for reference)*	P
A-37	438.10(f)(6)(viii) (B)	The fact that prior authorization is not required for emergency services.	P
A-38	438.10(f)(6)(viii) (C)	The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	P
A-39	438.10(f)(6)(viii) (D)	The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.	P
A-40	438.10(f)(6)(viii) (E)	The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.	P
A-41	438.10(f)(6)(ix)	The post-stabilization care services rules set forth at § 422.113(c) of this chapter.	P
A-42	438.10(f)(6)(x)	Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.	P
A-43	438.10(f)(6)(xi)	Cost sharing, if any.	P
A-44	438.10(f)(6)(xii)	How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided. For a counseling or referral service that Optum does not cover because of moral or religious objections, Optum need not furnish information on how and where to obtain the service. The State must provide information on how and where to obtain the service.	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)			
Tool	**CFR**		**Score***
		438.10(g) *Specific information requirements for enrollees of Plans.* In addition to the requirements in § 438.10(f), the State, its contracted representative, or Optum must provide the following information to their enrollees: 438.10(g)(1)(i)(A) Grievance, appeal, and fair hearing procedures and timeframes, as provided in §§ 438.400 through 438.424, in a State-developed or State-approved description, that must include the following:	
A-45	438.10(g)(1)(i)(A)	For State fair hearing— (A) The right to hearing;	P
A-46	438.10(g)(1)(i)(B)	The method for obtaining a hearing;	P
A-47	438.10(g)(1)(i)(C)	The rules that govern representation at the hearing.	P
A-48	438.10(g)(1)(ii)	The right to file grievances and appeals.	P
A-49	438.10(g)(1)(iii)	The requirements and timeframes for filing a grievance or appeal.	P
A-50	438.10(g)(1)(iv)	The availability of assistance in the filing process.	P
A-51	438.10(g)(1)(v)	The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.	P
		438.10(g)(1)(vi) The fact that, when requested by the enrollee—	
A-52	438.10(g)(1)(vi)(A)	Benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and	P
A-53	438.10(g)(1)(vi)(B)	The enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.	P
A-54	438.10(g)(1)(vii)	Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.	P
A-55	438.10(g)(2)	Advance directives, as set forth in § 438.6(i)(2). *(adults only)*	P
		438.10(g)(3) Additional information that is available upon request, including the following:	
A-56	438.10(g)(3)(i)	Information on the structure and operation of Optum.	P
A-57	438.10(g)(3)(ii)	Physician incentive plans as set forth in § 438.6(h) of this chapter.	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)			
Tool	**CFR**		**Score***
		438.10(h) *Specific information for PAHPs.* The State, its contracted representative, or the PAHP must provide the following information to their enrollees: 438.10(h)(1) The right to a State fair hearing, including the following:	
A-58	438.10(h)(1)(i)	The right to a hearing.	P
A-59	438.10(h)(1)(ii)	The method for obtaining a hearing.	P
A-60	438.10(h)(1)(iii)	The rules that govern representation.	P
A-61	438.10(h)(2)	Advance directives, as set forth in § 438.6(i)(2), to the extent that the PAHP includes any of the providers listed in § 489.102(a) of this chapter. *438.6(i)(2): All PAHP contracts must provide for compliance with the requirements of § 422.128 of this chapter for maintaining written policies and procedures for advance directives if the PAHP includes, in its network, any of those providers listed in § 489.102(a) of this chapter.*	P
A-62	438.10(h)(3)	Upon request, physician incentive plans as set forth in § 438.6(h).	P
		438.10(i) *Special rules: States with mandatory enrollment under State plan authority*—(1) *Basic rule.* If the State plan provides for mandatory enrollment under § 438.50, the State or its contracted representative must provide information on Plans (as specified in paragraph (i)(3) of this section), either directly or through Optum. (2) *When and how the information must be furnished.* The information must be furnished as follows:	
*A-64	438.10(i)(2)(ii)	For enrollees, annually and upon request.	n/a
		438.10(i)(3) *Required information.* Some of the information is the same as the information required for potential enrollees under paragraph (e) of this section and for enrollees under paragraph (f) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (i)(2) of this section, and includes the following for each contracting Plan in the potential enrollees and enrollee's service area:	
*A-66	438.10(i)(3)(iv)	To the extent available, quality and performance indicators, including enrollee satisfaction.	n/a
A-67	438.100(b)(2)(ii)	Be treated with respect and with due consideration for his or her dignity and privacy.	P
A-68	438.100(b)(2)(iii)	Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. [The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in § 438.10(f)(6)(xii).] Include requirements of **§438.102** (next page)	P

A. Subpart C Regulations: Enrollee Rights and Protections - §438.100 Enrollee rights. (continued)

Tool	CFR		Score*
		438.102 Provider-enrollee communications. *(a) General rules.* (1) A Plan may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: (i) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. (ii) Any information the enrollee needs in order to decide among all relevant treatment options. (iii) The risks, benefits, and consequences of treatment or non-treatment. (iv) The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. (2) Subject to the information requirements of paragraph (b) of this section, a Plan that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement in paragraph (a)(1) of this section is not required to do so if Optum objects to the service on moral or religious grounds. *(b) Information requirements: Plan responsibility.* (1) A Plan that elects the option provided in paragraph (a)(2) of this section must furnish information about the services it does not cover as follows: (i) To the State— (A) With its application for a Medicaid contract; and (B) Whenever it adopts the policy during the term of the contract. (ii) Consistent with the provisions of § 438.10— (A) To potential enrollees, before and during enrollment; and (B) To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle Optum to the option provided in paragraph (a)(2) of this section, the overriding rule in § 438.10(f)(4) requires the State, its contracted representative, or Plan to furnish the information at least 30 days before the effective date of the policy.) (2) As specified in § 438.10, paragraphs (e) and (f), the information that Plans must furnish to enrollees and potential enrollees does not include how and where to obtain the service excluded under paragraph (a)(2) of this section. (c) *Information requirements: State responsibility.* For each service excluded by a Plan under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in § 438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii). (d) *Sanction.* A Plan that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.	
A-69	438.100(b)(2)(iv)	Participate in decisions regarding his or her health care, including the right to refuse treatment.	P
A-70	438.100(b)(2)(v)	Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.	P
A-71	438.100(b)(2)(vi)	If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.	P
A-72	438.100(b)(3)	An enrollee of a Plan (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§438.206 through 438.210.	P
Findings:			

Attachment 1

B. Subpart C Regulations: Access Standards - §438.206 Availability of services.			
Tool	**CFR**		**Score***
	§438.206(a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of Plans. (b) *Delivery network.* The State must ensure, through its contracts, that each Plan consistent with the scope of Optum's contracted services, meets the following requirements:		
*B-1	438.206(1)	Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each Plan must consider the following:	P
B-2	438.206(1)(i)	The anticipated Medicaid enrollment.	P
B-3	438.206(1)(ii)	The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular Plan.	P
B-4	438.206(1)(iii)	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.	P
B-5	438.206(1)(iv)	The numbers of network providers who are not accepting new Medicaid patients.	P
B-6	438.206(1)(v)	The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.	P
B-7	438.206(2)	Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	P
B-8	438.206(3)	Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	P
B-9	438.206(4)	If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, Optum must adequately and timely cover these services out of network for the enrollee, for as long as Optum is unable to provide them.	P
B-10	438.206(5)	Requires out-of-network providers to coordinate with Optum with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.	P
B-11	438.206(6)	Demonstrates that its providers are credentialed as required by § 438.214.	P
		438.206(c)(1) *Timely access.* Each Plan must do the following:	
B-13	438.206(c)(1)(i)	Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.	P
B-14	438.206(c)(1)(ii)	Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.	P
B-15	438.206(c)(1)(iii)	Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.	P
B-16	438.206(c)(1)(iv)	Establish mechanisms to ensure compliance by providers.	P
B-17	438.206(c)(1)(v)	Monitor providers regularly to determine compliance.	P
B-18	438.206(c)(1)(vi)	Take corrective action if there is a failure to comply.	P
B-19	438.206(c)(2)	*Cultural considerations.* Each Plan participates in the State'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.	P
Findings:			

C. Subpart C Regulations: Access Standards- §438.208 Coordination and continuity of care.			
Tool	**CFR**		**Score***
	§438.208(a) *Basic requirement*—(1) *General rule.* Except as specified in paragraphs (a)(2) and (a)(3) of this section, the State must ensure through its contracts, that each Plan complies with the requirements of this section. 438.208(a)(2) *PIHP and PAHP exception.* For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to— *PIHP and PAHP exception.* For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to—		
C-1	438.208(a)(2)(i)	Meet the primary care requirement of paragraph (b)(1) of this section; and	P
C-2	438.208(a)(2)(ii)	Implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in paragraph (c) of this section.	P
C-3	438.208(a)(3)(i)	*Exception for Plans that serve dually eligible enrollees.* (i) For each Plan that serves enrollees who are also enrolled in and receive Medicare benefits from a Medicare+Choice plan, the State determines to what extent Optum must meet the primary care coordination, identification, assessment, and treatment planning provisions of paragraphs (b) and (c) of this section with respect to dually eligible individuals	P
C-4	438.208(a)(3)(ii)	The State bases its determination on the services it requires Optum to furnish to dually eligible enrollees.	P
		438.208(b) *Primary care and coordination of health care services for all Plan enrollees.* Each Plan must implement procedures to deliver primary care to and coordinate health care service for all Plan enrollees. These procedures must meet State requirements and must do the following:	
C-5	438.208(b)(1)	Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.	P
C-6	438.208(b)(2)	Coordinate the services Optum furnishes to the enrollee with the services the enrollee receives from any other Plan.	P
C-7	438.208(b)(3)	Share with other Plans serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.	P
C-8	438.208(b)(4)	Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	P
		438.208(c)(1) *Additional services for enrollees with special health care needs*—(1) *Identification.* The State must implement mechanisms to identify persons with special health care needs to Plans, as those persons are defined by the State. These identification mechanisms—	
C-11	438.208(c)(3)(i)	*Treatment plans.* If the State requires Plans to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be— (i) Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; *(not required by State)*	P
C-12	438.208(c)(3)(ii)	Approved by Optum in a timely manner, if this approval is required by Optum; and	P
C-13	438.208(c)(3)(iii)	In accord with any applicable State quality assurance and utilization review standards.	P
C-14	438.208(c)(4)	*Direct access to specialists.* For enrollees with special health care needs determined through an assessment by appropriate health care professionals [consistent with §438.208(c)(2)] to need a course of treatment or regular care monitoring, each Plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.	P
Findings:			

Attachment 1

D. Subpart C Regulations: Access Standards- §438.210 Coverage and authorization of services.			
Tool	**CFR**		**Score***
D-1	**438.210(b)**	*Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—(including 438.114 emergency and post-stabilization services) (1) That Optum and its subcontractors have in place, and follow, written policies and procedures.	
		438.210(b)(2) That Optum—	
D-2	438.210(b)(2)(i)	Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and	P
D-3	438.210(b)(2)(ii)	Consult with the requesting provider when appropriate.	P
D-4	438.210(b)(3)	That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	P
*D-5	438.210(c)	*Notice of adverse action.* Each contract must provide for Optum to notify the requesting provider, and give the enrollee written notice of any decision by Optum to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For Plans, the notice must meet the requirements of § 438.404, except that the notice to the provider need not be in writing.	P
		438.210(d) *Timeframe for decisions.* Each Plan contract must provide for the following decisions and notices:	
*D-6	438.210(d)(1)	*Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed **14** calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—	P
D-7	438.210(d)(1)(i)	The enrollee, or the provider, requests extension; or	P
D-8	438.210(d)(1)(ii)	Optum justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.	P
D-9	438.210(d)(2)(i)	(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or Optum determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, Optum must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.	P
D-10	438.210(d)(2)(ii)	(ii) Optum may extend the 3 working day time period by up to 14 calendar days if the enrollee requests an extension, or if Optum justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.	P

Findings:
D-6: NCQA requirement is 15 days – EQRO must ensure 14-day timeframe is followed.

Attachment 1

E. Subpart C Regulations: Structure and Operation Standards- §438.214 Provider selection.			
Tool	**CFR**		**Score***
E-2	438.214(b)(2)	Each Plan must follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with Optum.	P
E-3	438.214(c)	*Nondiscrimination.* Plan provider selection policies and procedures, consistent with § 438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	P
E-4	438.214(d)	*Excluded providers.* Plans may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.	P
E-5	438.214(e)	*State requirements.* Each Plan must comply with any additional requirements established by the State. *(n/a)*	n/a
Findings:			

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems.			
Tool	**CFR**		**Score***
	Subpart F: Grievance System. § 438.400(a) *Statutory basis.* This subpart is based on sections 1902(a)(3), 1902(a)(4), and 1932(b)(4) of the Act. (1) Section 1902(a)(3) requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. (2) Section 1902(a)(4) requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of Optum. (3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. (b) *Definitions.* As used in this subpart, the following terms have the indicated meanings: *Action* means— In the case of a Plan— (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of a Plan to act within the timeframes provided in § 438.408(b); or (6) For a resident of a rural area with only one Plan, the denial of a Medicaid enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network. *Appeal* means a request for review of an action, as ''action'' is defined in this section. *Grievance* means an expression of dissatisfaction about any matter other than an action, as ''action'' is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at Optum level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.)	
G-2	**438.402**	**§ 438.402 General requirements.** (a) *The grievance system.* Each Plan must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.	P
G-3	438.402(b)(1)(i)	*Filing requirements*—(1) *Authority to file.* (i) An enrollee may file a grievance and a Plan level appeal, and may request a State fair hearing.	P
G-4	438.402(b)(1)(ii)	A provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. A provider may file a grievance or request a State fair hearing on behalf of an enrollee, if the State permits the provider to act as the enrollee's authorized representative in doing so.	P
*G-5	438.402(b)(2)(i)	*Timing.* The State specifies a reasonable timeframe that may be no less than 20 days and not to exceed 90 days from the date on Optum's notice of action. Within that timeframe— The enrollee or the provider may file an appeal; and	P
G-6	438.402(b)(2)(ii)	In a State that does not require exhaustion of Plan level appeals, the enrollee may request a State fair hearing.	P
*G-7	438.402(b)(3)(i)	*Procedures.* (i) The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with Optum.	P
G-8	438.402(b)(3)(ii)	The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.	P
G-9	**438.404(a)**	**§ 438.404 Notice of action.** (a) *Language and format requirements.* The notice must be in writing and must meet the language and format requirements of § 438.10(c) and (d) to ensure ease of understanding.	P
G-10	438.404(b)(1)	*Content of notice.* The notice must explain the following: (1) The action Optum or its contractor has taken or intends to take.	P
G-11	438.404(b)(2)	The reasons for the action.	P
G-12	438.404(b)(3)	The enrollee's or the provider's right to file a Plan appeal.	P
*G-13	438.404(b)(4)	If the State does not require the enrollee to exhaust Optum level appeal procedures, the enrollee's right to request a State fair hearing. *(required)*	P
G-14	438.404(b)(5)	The procedures for exercising the rights specified in this paragraph.	P
G-15	438.404(b)(6)	The circumstances under which expedited resolution is available and how to request it.	P

Attachment 1

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			
Tool	**CFR**		**Score***
G-16	438.404(b)(7)	The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.	P
G-17	438.404(c)(1)	*Timing of notice.* Optum must mail the notice within the following timeframes: (1) For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in §§431.211, 431.213, and 431.214 of this chapter. *(10 days before action)*	P
G-18	438.404(c)(2)	For denial of payment, at the time of any action affecting the claim.	P
G-19	438.404(c)(3)	For standard service authorization decisions that deny or limit services, within the timeframe specified in § 438.210(d)(1). *(within 14 days)*	P
G-20	438.404(c)(4)(i)	If Optum extends the timeframe in accordance with § 438.210(d)(1), it must— (i) Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and	P
G-21	438.404(c)(4)(ii)	Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	P
G-22	438.404(c)(5)	For service authorization decisions not reached within the timeframes specified in § 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.	P
G-23	438.404(c)(6)	For expedited service authorization decisions, within the timeframes specified in § 438.210(d). *(3 days)*	P
		§ 438.406 Handling of grievances and appeals. (a) *General requirements.* In handling grievances and appeals, Plans must meet the following requirements:	
G-24	438.406(a)(1)	Give enrollees any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	P
G-25	438.406(a)(2)	Acknowledge receipt of each grievance and appeal.	P
G-26	438.406(a)(3)(i)	Ensure that the individuals who make decisions on grievances and appeals are individuals—(i) Who were not involved in any previous level of review or decision-making; and	P
G-27	438.406(a)(3)(ii)	(Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease. (A) An appeal of a denial that is based on lack of medical necessity. (B) A grievance regarding denial of expedited resolution of an appeal. (C) A grievance or appeal that involves clinical issues.	P
G-28	438.406(b)(1)	*Special requirements for appeals.* The process for appeals must: (1) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.	P
G-29	438.406(b)(2)	Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (Optum must inform the enrollee of the limited time available for this in the case of expedited resolution.)	P
G-30	438.406(b)(3)	Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.	P
G-31	438.406(b)(4)(i)	Include, as parties to the appeal— The enrollee and his or her representative; (ii) or the legal representative of a deceased enrollee's estate.	P

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			
Tool	**CFR**		**Score***
		§ 438.408 Resolution and notification: Grievances and appeals. (a) *Basic rule.* Optum must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.	
G-32	438.408(b)(1)	*Specific timeframes*—(1) *Standard disposition of grievances.* For standard disposition of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 days from the day Optum receives the grievance.	P
G-33	438.408(b)(2)	*Standard resolution of appeals.* For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 45 days from the day Optum receives the appeal. This timeframe may be extended under paragraph (c) of this section.	P
G-34	438.408(b)(3)	*Expedited resolution of appeals.* For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after Optum receives the appeal. This timeframe may be extended under paragraph (c) of this section.	P
G-35	438.408(c)(1)(i)	*Extension of timeframes*—(1) Optum may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—(i) The enrollee requests the extension; Or	P
G-36	438.408(c)(1)(ii)	Optum shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.	P
G-37	438.408(c)(2)	*Requirements following extension.* If Optum extends the timeframes, it must—for any extension not requested by the enrollee, give the enrollee written notice of the reason for the delay.	P
G-39	438.408(d)(2)(i)	*Appeals.* (i) For all appeals, Optum must provide written notice of disposition.	P
G-40	438.408(d)(2)(ii)	For notice of an expedited resolution, Optum must also make reasonable efforts to provide oral notice.	P
G-41	438.408(e)(1)	*Content of notice of appeal resolution.* The written notice of the resolution must include the following: (1) The results of the resolution process and the date it was completed.	P
G-42	438.408(e)(2)(i)	For appeals not resolved wholly in favor of the enrollees—(i) The right to request a State fair hearing, and how to do so;	P
G-43	438.408(e)(2)(ii)	The right to request to receive benefits while the hearing is pending, and how to make the request; and	P
G-44	438.408(e)(2)(iii)	That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds Optum's action.	P
G-46	438.408(f)(1)(ii)	If the State does not require exhaustion of Optum level appeal procedures and the enrollee appeals directly to the State for a fair hearing, from the date on Optum's notice of action. *(required)*	P
G-48	438.410	§ 438.410 Expedited resolution of appeals. (a) General rule. Each Plan must establish and maintain an expedited review process for appeals, when Optum determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.	P
G-49	438.410(b)	Punitive action. Optum must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	P
G-50	438.410(c)(1)	Action following denial of a request for expedited resolution. If Optum denies a request for expedited resolution of an appeal, it must—(1) Transfer the appeal to the timeframe for standard resolution in accordance with § 438.408(b)(2);	P
G-51	438.410(c)(2)	Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.	P

G. Subpart C: Structure and Operation Standards- §438.228 Grievance systems. (continued)			
Tool	**CFR**		**Score***
G-52	**438.414**	**§ 438.414 Information about the grievance system to providers and subcontractors.** Optum must provide the information specified at § 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.	P
G-53	**438.416**	**§ 438.416 Recordkeeping and reporting requirements.** The State must require Plans to maintain records of grievances and appeals and must review the information as part of the State quality strategy.	P
G-54	**438.420**	**§ 438.420 Continuation of benefits while Optum appeal and the State fair hearing are pending.** (a) *Terminology.* As used in this section, ''timely'' filing means filing on or before the later of the following: (1) Within ten days of Optum mailing the notice of action. (2) The intended effective date of Optum's proposed action.	P
G-55	438.420(b)	*Continuation of benefits.* Optum must continue the enrollee's benefits if— (1) The enrollee or the provider files the appeal timely; (2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) The services were ordered by an authorized provider; (4) The original period covered by the original authorization has not expired; and (5) The enrollee requests extension of benefits.	P
G-56	438.420(c)	*Duration of continued or reinstated benefits.* If, at the enrollee's request, Optum continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs: (1) The enrollee withdraws the appeal. (2) Ten days pass after Optum mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10- day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. (3) A State fair hearing Office issues a hearing decision adverse to the enrollee. (4) The time period or service limits of a previously authorized service has been met.	P
G-57	438.420(d)	*Enrollee responsibility for services furnished while the appeal is pending.* If the final resolution of the appeal is adverse to the enrollee, that is, upholds Optum's action, Optum may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in § 431.230(b) of this chapter.	P
G-58	**438.424**	**§ 438.424 Effectuation of reversed appeal resolutions.** (a) *Services not furnished while the appeal is pending.* If Optum or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Optum must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.	P
G-59	438.424(b)	*Services furnished while the appeal is pending.* If Optum, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, Optum or the State must pay for those services, in accordance with State policy and regulations.	P
Findings:			

H. Subpart C: Structure and Operation Standards - §438.230 Sub contractual relationships and delegation.			
Tool	**CFR**		**Score**
H-2	438.230(b)(1)	*Specific conditions.* (1) Before any delegation, each Plan evaluates the prospective subcontractor's ability to perform the activities to be delegated.	P
H-3	438.230(b)(2)(i)	There is a written agreement that—(i) Specifies the activities and report responsibilities delegated to the subcontractor; and	P
H-4	438.230(b)(2)(i)	Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	P
H-5	438.230(b)(3)	Optum monitors the subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by the State, consistent with industry standards or State PAHP laws and regulations.	P
H-6	438.230(b)(4)	If any Plan identifies deficiencies or areas for improvement, Optum and the subcontractor take corrective action.	P
Findings:			

I. Subpart C: Measurement and Improvement Standards - §438.236 Practice guidelines			
Tool	**CFR**		**Score**
		438.236(a) *Basic rule: The state must ensure through its contracts that each Plan meets the requirements of this section. Each Plan adopts practice guidelines that meet the following requirements:*	
I-1	438.236(b)(1)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	P
I-2	438.236(b)(2)	Consider the needs of Optum's enrollees.	P
I-3	438.236(b)(3)	Are adopted in consultation with contracting health care professionals.	P
I-4	438.236(b)(4)	Are reviewed and updated periodically, as appropriate.	P
I-5	438.236(c)	Optum disseminates the guidelines to all affected providers, and upon request, to enrollees and potential enrollees.	P
I-8	438.236(d)	Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	P

Findings:
I-4: NCQA prescribes updating the guidelines at least every two years.
I-8: EQRO must determine whether enrollee education is consistent with the guidelines.

J. Subpart C: Measurement and Improvement Standards - §438.240 Quality assessment and performance improvement program.			
Tool	**CFR**		**Score**
		438.240(b) *Basic elements of Plan quality assessment and performance improvement programs.* At a minimum, the State must require that each Plan comply with the following requirements:	
J-3	438.240(b)(1)	Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.	D
J-4	438.240(b)(2)	Submit performance measurement data as described in paragraph (c) of this section.	P
J-5	438.240(b)(3)	Have in effect mechanisms to detect both underutilization and overutilization of services.	P
J-6	438.240(b)(4)	Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	P
*J-7	438.240(c)(1)	*Performance measurement.* Annually each Plan must—(1) Measure and report to the State its performance, using standard measures required by the State including those that incorporate the requirements of § 438.204(c) and § 438.240(a)(2); (2) Submit to the State, data specified by the State, that enables the State to measure Optum's performance; or (3) Perform a combination of the activities described in paragraphs (c)(1) and (c)(2) of this section.	P
J-8	438.240(d)(1)(i)	*Performance improvement projects.* (1) Plans must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas, and that involve the following: (i) Measurement of performance using objective quality indicators.	D
J-9	438.240(d)(1)(ii)	Implementation of system interventions to achieve improvement in quality.	D
J-10	438.240(d)(1)(iii)	Evaluation of the effectiveness of the interventions.	D
J-11	438.240(d)(1)(iv)	Planning and initiation of activities for increasing or sustaining improvement.	D
J-12	438.240(d)(2)	Each Plan must report the status and results of each project to the State as requested, including those that incorporate the requirements of § 438.240(a)(2). Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.	P
J-15	438.240(e)(2)	The State may require that a Plan have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. (n/a with EQR)	n/a

Findings:
J-3 PIPs submitted by Optum require modifications in design, data collection and analysis. J-8, J-9, J-10 & J-11 Optum's PIP submissions did not meet Protocol requirements.

Attachment 1

K. Subpart C: Measurement and Improvement Standards - §438.242 Health information systems.			
Tool	**CFR**		**Score**
K-1	**438.242(a)**	*General rule.* The State must ensure, through its contracts, that each Plan maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this subpart. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. (b) *Basic elements of a health information system.* The State must require, at a minimum, that each Plan comply with the following:	
K-2	438.242(b)(1)	(1) Collect data on enrollee and provider characteristics as specified by the State, and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.	P
K-3	438.242(b)(2)(i)	Ensure that data received from providers is accurate and complete by—(i) Verifying the accuracy and timeliness of reported data;	P
K-4	438.242(b)(2)(ii)	Screening the data for completeness, logic, and consistency; and	P
K-5	438.242(b)(2)(iii)	Collecting service information in standardized formats to the extent feasible and appropriate.	P
K-6	438.242(b)(3)	Make all collected data available to the State and upon request to CMS, as required in this subpart.	P

***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.

Attachment 2

PIP Audit Tools

- Appointment Reminder Program
- Substance Abuse American Society of Addiction Medicine (ASAM) Expansion
- Utilization Management Documentation

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

Demographic Information

Plan Name or ID: Optum Idaho
Name of PIP: Appointment Reminder Program
Dates in Study Period: 07/01/2018 to 06/30/2019

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	P	
1.2. Did Optum's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	P	
1.3. Did Optum's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	P	
Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was/were the study question(s) stated clearly in writing?	P	Are members more likely to attend a follow-up appointment after hospitalization if ty are reminded to attend through the appointment reminder program?
Step 3: REVIEW SELECTED STUDY INDICATOR(S)		
3.1 Did the study use objective, clearly defined, measurable indicators?	P	HEDIS 2019 technical specifications used for the Follow Up After Hospitalization (FUH).
3.2 Did the indicators measure changes in health status, functional status or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	P	

Component/Standard	Score	Comments
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did Optum clearly define all Medicaid enrollees to whom the study question and indicators are relevant?	P	All Medicaid enrollees are included.
4.2 If Optum studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	P	
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (overestimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	n/a	
5.2 Did Optum employ valid sampling techniques that protected against bias? Specify the type of sampling or census used:	n/a	
5.3 Did the sample contain a sufficient number of enrollees?	n/a	
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	P	
6.2 Did the study design clearly specify the sources of data?	P	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	P	
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	P	
6.5 Did the study design prospectively specify a data analysis plan?	D	Data is analyzed annually according to the HEDIS specifications and specifications of the FUH. During the on-site review, the EQRO discussed with Optum the need to analyze data on a minimum of quarterly basis. Although Optum supplies information quarterly in their QMUM report, it is not supplied as a response to this PIP at the study question level.

Component/Standard	Score	Comments
Step 6: REVIEW DATA COLLECTION PROCEDURES (continued)		
6.6 Were qualified staff and personnel used to collect the data?	P	
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	D	Optum did not list specific interventions other than asking hospitals to sign up participants and Optum staff taking over those duties.
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	D	The baseline was presented, and one remeasurement quarter. Although Optum supplies information quarterly in their QMUM report, it is not supplied as a response to this PIP at the study question level.
8.2 Did Optum present numerical PIP results and findings accurately and clearly?	D	The baseline was presented and one remeasurement quarter. Although Optum supplies information quarterly in their QMUM report, it is not supplied as a response to this PIP at the study question level.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	D	There was no improvement seen between the baseline and remeasurement period and the PAHP did not give an explanation for the decrease.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	D	There was no improvement seen between the baseline and remeasurement period and the PAHP did not give an explanation for the decrease.
*Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	n/a	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	n/a	
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of Optum quality improvement intervention?	n/a	

9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	n/a	
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	n/a	
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	
1. Were the initial study findings verified upon repeat measurement?	n/a	

ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.

Optum should not rely entirely on the HEDIS timeline for the evaluation of this PIP. There was no improvement seen between the baseline and remeasurement period and the PAHP did not give an explanation for the decrease.

Check one:

- ☐ High confidence in reported Plan PIP results
- ☐ Confidence in reported Plan PIP results
- ☐ Low confidence in reported Plan PIP results
- ☐ Reported Plan PIP results not credible
- ☐ No results reported.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

Demographic Information

Plan Name or ID: Optum Idaho
Name of PIP: Substance Abuse American Society of Addiction Medicine (ASAM) Expansion
Dates in Study Period: 07/01/2018 through 06/30/2019

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	P	Optum states that "the project was part of broader Optum efforts to ensure better consistency and delivery of SUD services."
1.2 Did Optum's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	D	Although Optum states that ASAM focuses on member needs and establishes Level of Care guidelines, Optum failed to provide any evidence that in fact members were experiencing issues. The only evidence of need provided by Optum was the need to incorporate ASAM into guidelines, operations, policies and procedures.
1.3 Did Optum's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	P	
Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was/were the study question(s) stated clearly in writing?	N	How can Optum Idaho better incorporate ASAM into key guidelines, operation, policies, and procedures?
Step 3: REVIEW SELECTED STUDY INDICATOR(S)		
3.1 Did the study use objective, clearly defined, measurable indicators?	P	
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	N	There were no indicators that measure changes in health status, functional status, enrollee satisfaction, or processes of care with strong associations with improved outcomes. This project was not a Performance Improvement Project designed to improved outcomes, it does not meet the requirements of a PIP as detailed in CMS Protocol 3.

Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did Optum clearly define all Medicaid enrollees to whom the study questions and indicators are relevant?	D	Although all members are included in the project, the project isn't designed to measure the effect of any intervention on members.
4.2 If Optum studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	D	Optum is not studying the member population in this project.
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	n/a	
5.2 Did Optum employ valid sampling techniques that protected against bias? Specify the type of sampling or census used:	n/a	
5.3 Did the sample contain a sufficient number of enrollees?	n/a	
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	N	Optum stated: "data to be collected from ASAM and applied to Optum guidelines"
6.2 Did the study design clearly specify the sources of data?	N	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	N	
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	N	
6.5 Did the study design prospectively specify a data analysis plan?	N	This PIP is not designed to show an impact on members. It is basically just a plan to count providers requested by new members.

Component/Standard	Score	Comments
Step 6: REVIEW DATA COLLECTION PROCEDURES (continued)		
6.6 Were qualified staff and personnel used to collect the data?	P	The staff used to collect provider data is qualified.
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	N	No barrier analysis was performed. No interventions were implemented.
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	N	
8.2 Did Optum present numerical PIP results and findings accurately and clearly?	N	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	N	Statistical analysis was not performed. Factors that influence comparability were not discussed, nor factors that threaten validity.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	N	No follow up activities were discussed.
*Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	n/a	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	n/a	
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of Optum quality improvement intervention?	n/a	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	n/a	

Attachment 2

Component/Standard	Score	Comments
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeatedmeasurements over comparable time periods?	n/a	
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	
1. Were the initial study findings verified upon repeat measurement?	N	
ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.		
This project as presented was not a Performance Improvement Project. It was not designed to measure any member outcome and was not designed based on an issue that was identified by member data. It was a project that was designed to respond to requests for additional providers, however no analysis of gaps in the network or proactive steps were taken to determine who may need to be added. The EQR advises Optum to design a PIP that impacts member outcomes and responds to an identified member issue.		
Check one: ☐ High confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible		NO RESULTS REPORTED.

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET

Demographic Information

Plan Name or ID: Optum Idaho
Name of PIP: Utilization Management (UM) Clinical Review Documentation
Dates in Study Period: 07/01/2018 through 06/30/2019

I. ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Step 1: REVIEW THE SELECTED STUDY TOPIC(S)		
Component/Standard	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	P	Optum states that "due to concerns regarding inconsistencies in member case review documentation and member communications, there was a need to streamline the utilization management (UM) clinical review process by improving communication and collaboration between the Care Advocates (CA) and Peer Reviewers. the project was part of broader Optum efforts to ensure better consistency and delivery of SUD services."
1.2 Did Optum's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services?	P	More collaboration between reviewers allows for more consideration and consistent application of relevant factors when making case determinations. Members and providers are given more thorough explanations of a decision.
1.3 Did Optum's PIPs over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)?	P	
Step 2: REVIEW THE STUDY QUESTION(S)		
2.1 Was/were the study question(s) stated clearly in writing?	D	How can we streamline CA and Peer Review templates to improve documentation and internal and external communication? How can we improve UM inter-rater reliability?
Step 3: REVIEW SELECTED STUDY INDICATOR(S)		
3.1 Did the study use objective, clearly defined, measurable indicators?	P	Through member satisfaction and improved process of care.

3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes?	P	
Step 4: REVIEW THE IDENTIFIED STUDY POPULATION		
4.1 Did Optum clearly define all Medicaid enrollees to whom the study questions and indicators are relevant?	P	
4.2 If Optum studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?	P	All Medicaid enrollees are included.
Step 5: REVIEW SAMPLING METHODS		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?	n/a	
5.2 Did Optum employ valid sampling techniques that protected against bias? Specify the type of sampling or census used:	n/a	
5.3 Did the sample contain a sufficient number of enrollees?	n/a	
Step 6: REVIEW DATA COLLECTION PROCEDURES		
6.1 Did the study design clearly specify the data to be collected?	P	The data to be collected is Inter-rater reliability scores, member and provider satisfaction, and complaints filed with Optum
6.2 Did the study design clearly specify the sources of data?	P	
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	P	
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied?	P	
6.5 Did the study design prospectively specify a data analysis plan?	D	This PIP will continue to monitor member and provider complaints, but no mention of collection of provider and member satisfaction data was made in the data analysis plan.

Component/Standard	Score	Comments
Step 6: REVIEW DATA COLLECTION PROCEDURES (continued)		
6.6 Were qualified staff and personnel used to collect the data?	P	The staff used to collect provider data is qualified.
Step 7: ASSESS IMPROVEMENT STRATEGIES		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	D	Interventions included: revised ABD and Appeal letter templates; revised medical director ABD templates; and training of staff
Step 8: REVIEW DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS		
8.1 Was an analysis of the findings performed according to the data analysis plan?	D	
8.2 Did Optum present numerical PIP results and findings accurately and clearly?	D	
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	D	Statistical analysis was not performed. Factors that influence comparability were not discussed, nor factors that threaten validity.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	D	No follow up activities were discussed.
*Step 9: ASSESS WHETHER IMPROVEMENT IS "REAL" IMPROVEMENT		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated?	P	
9.2 Was there any documented, quantitative improvement in processes or outcomes of care?	P	Complaint data and inter-rater reliability data improved.
9.3 Does the reported improvement in performance have "face" validity; i.e., does the improvement in performance appear to be the result of Optum quality improvement intervention?	D	
9.4 Is there any statistical evidence that any observed performance improvement is true improvement?	D	No statistical significance testing was performed.

Attachment 2

Component/Standard	Score	Comments
Step 10: ASSESS SUSTAINED IMPROVEMENT		
10.1 Was sustained improvement demonstrated through repeatedmeasurements over comparable time periods?	n/a	
ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)	Score	
1. Were the initial study findings verified upon repeat measurement?	n/a	
ACTIVITY 3. EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY.		
During the onsite review, the Team discussed with Optum that this PIP was process driven and not performance focused. The PIP mentions member outcomes, but is focused on implementation of a new process only. The link between decreased complaints and member outcomes should be explained in more detail by the PAHP. Additionally, the link between member outcomes and inter-rater reliability scores should also be explained.		
Check one: ☐ High confidence in reported Plan PIP results ☐ Confidence in reported Plan PIP results ☐ Low confidence in reported Plan PIP results ☐ Reported Plan PIP results not credible		

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Attachment 3

Attachment 3

PM Audit Tool

Critical Appointment Wait Times

Attachment 3

Performance Measure Validation Worksheet

Performance Measure to be Validated: Clinical Appointment Wait Times

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	Only Medicaid Network Providers
	• 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 Network Provider appointments.
	• Were continuously enrolled from _____to____with one break per year of up to 45 days allowed.	n/a	This is a measure of Network Provider appointments.

Attachment 3

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 3

Audit Element	Specifications	Score	Comments
NUMERATOR (continued)			
9. Time Period	• Element performed on or between__&____.	Met	Daily, during provider 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 3

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 3

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 Measure was a measure of the Network Providers compliance with Critical Access Appointment Wait Times by Optum.