Primaris
Healthcare Business Solutions

2019 External Quality Review
Compliance

home state health

Measurement Period: Calendar Year 2018
Validation Period: Feb-Apr 2019
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MoHealthNet

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1.0 Purpose and Overview

1.1 Background

The Department of Social Services, MO HealthNet Division (MHD) operates a Health Maintenance Organization (HMO) style Managed Care Program called MO HealthNet Managed Care (herein after stated "Managed Care"). MHD contracts with MO HealthNet Managed Care Organizations (MCOs), also referred to as "Health Plans," to provide health care services to Managed Care enrollees.

Managed Care is operated statewide in Missouri in the regions: Central, Eastern, Western, and Southwestern. One of the most important priorities of Managed Care is to provide a quality program that leads the nation and is affordable to members. This program provides Medicaid services to section 1931 children and related poverty level populations; section 1931 adults and related poverty populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children. As of March 2019, the total number of Managed Care enrollees in MHD were 630,254 (1915(b) and CHIP combined). This is a decrease by 11.52 % in comparison to the enrollment data available for the end of SFY 2018.

Home State Health is one of the three MCOs operating in Missouri (MO) that provides services to individuals determined eligible by the state agency for the Managed Care Program on a statewide basis. MHD works closely with the MCO to monitor the services being provided to ensure goals to improve access to needed services and the quality of health care services in the Managed Care and state aid eligible populations are met, while controlling the program's cost.

Home State Health's services are monitored for quality, enrollee satisfaction, and contract compliance. Quality is monitored through various on-going methods including, but not limited to, MCO's Healthcare Effectiveness Data and Information Set (HEDIS) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and an annual external quality review. An External Quality Review Organization (EQRO) evaluates MCO annually, as well. MHD has arranged for an annual, external independent review of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract. The federal and state regulatory requirements and performance standards as they apply to MCOs are evaluated annually for the State in accordance with 42 CFR 438.310 (a) and 42 CFR 438.310 (b).

Primaris Holdings, Inc. (Primaris) is MHD's current EQRO, and started their five-year contract in January 2018. The External Quality Review (EQR) 2019 covers the period of Calendar Year (CY) 2018.

1.2 Description of Compliance with Regulations

The MCOs are audited annually to assess their compliance with the Federal Medicaid Managed Care Regulations; the State Quality Strategy; the MO HealthNet Managed Care contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous review year. The EQR is conducted using the *EQR Protocol 1(Assessment of Compliance with Medicaid Managed Care Regulations, Centers for Medicare and Medicaid Services, Version 2.0, September 2012)* to meet the requirements of Code of Federal Regulations (CFR) 438.358(b) (iii). This section of the CFR requires a review to be conducted within the previous 3-year period, to determine the MCOs' compliance with standards set forth in subpart D of 42 CRF 438 and the quality assessment and performance improvement requirements described in § 438.330. The Centers of Medicare and Medicaid services (CMS) has proposed to include three additional sections (42 CFR 438.56, 438.100, 438.114) for a compliance review. The final decision is yet to be made. Primaris reviewed the following standards from 42 CFR 438 Subpart D (Table 1), during EQR 2019, for Home State Health:

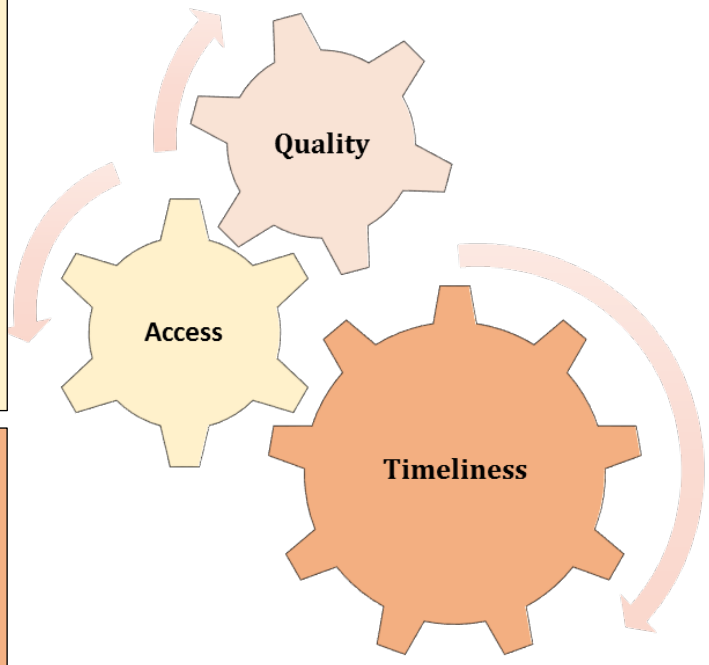
Table 1: 42 CFR 438 Subpart D-MCO, PIHP and PAHP Standards
• §438.206 Availability of services • §438.207 Assurances of adequate capacity and services • §438.208 Coordination and continuity of care • §438.210 Coverage and authorization of services • §438.214 Provider selection • §438.224 Confidentiality • §438.228 Grievance and appeal systems

The overall goal of the compliance with regulations review is to quantify Home State Health's adherence to the federal and state requirements of offering:

- Quality Care
- Highest level of Access to Care
- In a Timely Manner, for all of its Enrollees

Access, (42 CFR 438.320), as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care organizations successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).

Timeliness: Federal Managed Care Regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services.



Quality, (42 CFR 438.320 (2)), as it pertains to external quality review, means the degree to which an MCO increases the likelihood of desired outcomes of its enrollees through:
(1) Its structural and operational characteristics.
(2) The provision of services that are consistent with current professional, evidence-based knowledge.
(3) Interventions for performance improvement.

Figure 1: Federal Requirement for the MCO

2.0 Methodology

The primary objective of Primaris' review is to provide meaningful information to MHD and Home State Health regarding compliance with state and federal guidelines. Primaris collaborated with Home State Health and MHD to:

- Determine the scope of the review, scoring methodology, and data collection methods.
- Finalize the onsite review agenda.
- Collect and review data and documents before, during and after the on-site review.
- Identify key issues through analyzing the data collected.
- Prepare the report related to the findings.
- Review recommendations from the previous CY audits.

Primaris conducted a compliance review in Feb-Apr 2019.The evaluation was performed by requesting and analyzing policies and procedures, documentations, observations and on-site interviews. Primaris provided Technical Assistance (TA) during the review period to help Home State Health towards continuous improvement and excellence.

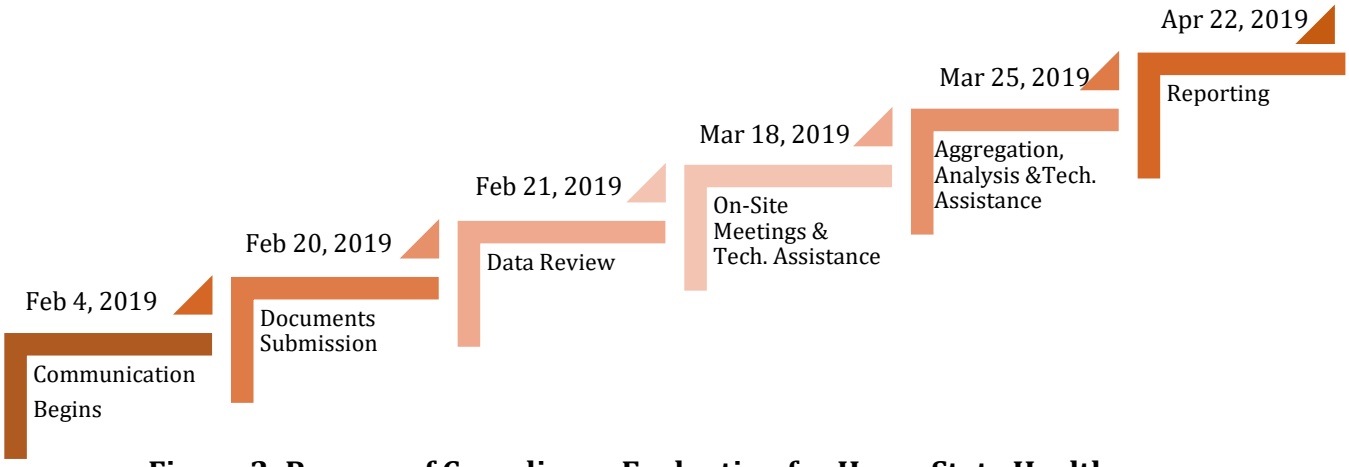


Figure 2: Process of Compliance Evaluation for Home State Health

Evaluation tools were created based on MHD Managed Care Contract and 42CFR 438, subpart D for the seven standards (Appendix A-G).

Home State Health submitted their documents via a secure website service to enable a complete and in-depth analysis of their compliance with standard regulations. These included the policies, procedures, protocols, manuals, logs, power point presentations, reports, and print-screens as follows:

- Availability of services: network adequacy; provider appointment accessibility standards; Home State Health provider manual; network selection and retention; provider manual; program description; single case agreement policy; appointment standards; after-hours availability corrective action plan; cultural competency program; in network referrals policy; member handbook; and ID card.
- Assurances of adequate capacity and services: network adequacy; network selection and retention; network access plan; and tertiary agreement.
- Coordination and continuity of care: distribution of new member materials; member handbook; ID cards; new member welcome call; transition of care; case management program description; obtaining authorization for use or disclosure of protected health information; directory insert; member handbook; benefits handbook; transportation flyer; and an urgent care list.
- Coverage and authorization of services: utilization management (UM) program description; clinical decision criteria and application; timeliness of UM decisions; covered benefits and services; appropriate UM professionals; provider manual; and adverse determination notices.
- Provider selection: practitioner credentialing & re-credentialing; advance directives; sample participating provider agreement professional; provider directory updates; credentialing update dashboard; monthly turnaround time reporting; provider lifecycle overview; and network selection and retention.

- Confidentiality: compliance training; privacy and compliance training; data loss prevention; Centene business ethics and code of conduct; cryptography control standard; cryptography-key management standard; communications security standard-electronic messaging, physical and electronic info transfer, agreement on info transfer, encrypting emails containing confidential data, segregation in network; compliance standard-legal and contractual requirements; obtaining authorization for use or disclose of PHI; privacy and confidentiality training-HIPPA, HITECH; content of notice of privacy policy; treating personal representative as individual; business associate agreement template; confidentiality and release of PHI, maintaining and assessing government contracts and amendments; assurances from business associates to safeguard PHI; records management; record retention schedule; HIPPA policies and record retention; reporting and investigating HIPPA violations; managing alcohol and substance abuse records; disclosing and requesting minimum PHI necessary; disclosing PHI as required by law; and state required deliverables.
- Grievance and appeal systems: grievance appeals member issues (open and closed) logs; screen shots of website for logs; member grievance and appeal system description; member services training-member grievance, provider grievance; single case agreement; grievance system flyer; and member handbook.

Figure 3: Sources of Information from Home State Health

On-Site Review Information

An on-site review was performed at Home State Health office in Missouri, on March 18, 2019. The following personnel from Home State Health were available for an interactive session on 'Compliance with Regulations':

- Sharon Deans, MD Chief Medical Director
- Bob Lampe, Vice President, Compliance

- Megan Barton, Vice President, Medical Management
- Anna Dmuchousky, Vice President of Operations
- Deborah Hahn, Senior director, Contracting & Network Development
- Michael Scheffer, Senior director, Contracting & Network Development
- Lupe Ponce, Accreditation Specialist
- Cynthia Fochtmann, Manager, Utilization Management
- Emily Edwards, Manager, Utilization Management
- Sarah Peipert, Vice President Clinical Operations
- Natasha Shelton, Manager, Denials and Appeals
- Annie Brozio, Senior Director Provider Network
- Anne Campbell, Compliance Analyst
- Kurt Wohlschlaeger, Manager, Customer Service
- Sheryl Jacobs, Project Manager IV, Provider Contracting
- Stacey Schulte, Supervisor Case Management
- Stefanie Throm, Project Manager

Table 2: MCO Information	
MCO Name:	Home State Health
MCO Location:	16090 Swingley Ridge Rd, Suite 300, Chesterfield, MO 63017
On-site Location:	16090 Swingley Ridge Rd, Suite 300, Chesterfield, MO 63017
Audit Contact:	Dr. Sharon D. Deans, MD, MPH, FACOG Chief Medical Director
Contact Email:	Sharon.D.Deans@homestatehealth.com

Compliance Ratings

The information provided by Home State Health was analyzed and an overall compliance score in percentage was given. Each section of an evaluation tool was assigned 2 points (denominator) and was scored as: Met, Partially Met or Not Met. Primaris utilized a compliance rating system as defined in Table 3.

MHD and Home State Health may use the information and findings that resulted from Primaris' review to identify, implement and monitor interventions to improve the aspects of Quality, Timeliness and Access for Healthcare Services to its members.

Table 3: Compliance Rating System

●	**Met** (2 points): All documentation listed under a regulatory provision, or component thereof, is present. MCO staff provide responses to reviewers that are consistent with each other and with the documentation. A State-defined percentage of all data sources–either documents or MCO staff–provide evidence of compliance with regulatory provisions.
●	**Partially Met** (1 point): All documentation listed under a regulatory provision, or component thereof, is present, but MCO staff are unable to consistently articulate evidence of compliance; or MCO staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice; or any combination of "Met," "Partially Met" and "Not Met" determinations for smaller components of a regulatory provision would result in a "Partially Met" designation for the provision as a whole.
●	**Not Met** (0 point): No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with regulatory provisions; or No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with key components (as identified by the State) of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

3.0 Performance Strengths and Areas Requiring Corrective Action

3.1 Summary of Overall Strengths and Corrective Action

- An assessment was done for seven standards and Home State Health scored 100% on each one of them.
- Home State Health is not put on a corrective action plan for any standard this year.
- During the previous year (EQR 2018), Home State Health was not put on a corrective action plan which required a review this year.

Strengths

Home State Health has a member population of about 230,000 with about 21,000 providers in their network. Home State Health workforce comprises of various Quality Committees to ensure delivery of quality, timeliness and access of care to their members:

- CLAS Task Force: The Culturally and Linguistically Appropriate Service (CLAS) Task Force is responsible for the oversight and maintenance of HSH's Cultural Competency Plan.

- Credentialing Committee: This committee is responsible for reviewing presented providers for continued delegation.
- Utilization Management Committee (UMC): UMC is responsible for reporting on authorization requirement changes and updates, UM policy updates and metrics, and network adequacy.)
- Provider Advisory Committee (PAC): The PAC is responsible for providing valuable feedback and input to help ensure Home State Health provides health care coverage that meets the needs of their members.
- HEDIS, EPSDT (Early and Periodic Screening, Diagnostic, and Treatment), CAHPS (Consumer Assessment of Healthcare Providers and Systems): The HEC workgroup is responsible for monitoring and improving HEDIS, EPSDT, and CAHPS scores and processes. This work group reviews rate trending and helps to identify any data concerns.
- Joint Operations Committees (JOC): JOCs are opportunities to meet with HSH's vendors to review contractual obligations and address any disconnects.
- Performance Improvement Team (PIT): The PIT focuses on statewide performance improvement projects which identify, develop, and implement standardized measures and interventions to optimize health outcomes for the members and improve efficiencies related to health care service delivery.

Home State Health's adherence to MHD contract, team work, well written documents, policies and procedures, oversight through various Quality Committees, prompt response to the technical assistance has resulted in a 100% "compliance score."

Figure 4: Strengths of Home State Health

Areas Requiring Corrective Action

Home State Health is not put on a corrective action plan for any standard.

Table 4: Summary of Evaluation Home State Health: Compliance with Regulations

Standard	Standard Name	Number of Sections				Score	Score %
		Total	Met	Partial Met	Not Met		
§438.206	Availability of services	11	11	0	0	**22**	**100**
§438.207	Assurances of adequate capacity and services	10	10	0	0	**20**	**100**
§438.208	Coordination and continuity of care	17	17	0	0	**34**	**100**
§438.210	Coverage and authorization of services	22	22	0	0	**44**	**100**
§438.214	Provider selection	12	12	0	0	**24**	**100**
§438.224	Confidentiality	19	19	0	0	**38**	**100**
§438.228	Grievance and appeal systems	44	44	0	0	**88**	**100**
Total	**7**	**135**				**270**	**100 %**

Compliance Score % (combined for all seven) = $\frac{\text{Total Score X100}}{\text{Total Sections X 2 points}}$ = 100%

3.2 Regulation I- Availability of Services

Home State Health was evaluated for 11 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix A).

3.2.1 Performance Strengths

Home State Health provides a robust service that meets all travel distance requirements, appointment standards, and scope of its network. In regard to cultural competency, they have shown numerous references throughout their infrastructure to ensure compliance and consideration to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, or sexual orientation.

3.2.2 Areas Requiring Corrective Action

There are no areas of concern. No corrective action is required.

3.3 Regulation II- Assurances of Adequate Capacity and Services

Home State Health was evaluated for 10 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix B).

3.3.1 Performance Strengths

Home State Health has thoroughly demonstrated a wide range of preventive, primary care, and specialty services that are adequate for the number of enrollees in their service area. Their network consisted of multiple hospitals, physicians, advanced practice nurses, mental and behavioral health providers, substance use disorder providers, dentists, emergent and non-emergent transportation services, safety net hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended), and all other provider types as required to ensure sufficient capacity to make all services available.

3.3.2 Areas Requiring Corrective Action

There are no areas of concern. No corrective action is required.

3.4 Regulation III- Coordination and Continuity of Care

Home State Health was evaluated for 17 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix C).

3.4.1 Performance Strengths

Home State Health has ensured that they address all aspects of coordination and continuity of care such as transition of care requirements, initial screening, and coordination of all required services. Although they do not cover LTSS, they have shown (by multiple examples) a diverse range of options and services for special needs.

3.4.2 Areas Requiring Corrective Action

There are no areas of concern. No corrective action is required.

3.5 Regulation IV-Coverage and Authorization of Services

Home State Health was evaluated for 22 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix D).

3.5.1Performance Strengths

Home State Health has a Utilization Management (UM) Program which defines the structure and processes within the Medical Management Department, including

assignment of responsibility to appropriate individuals, in order to promote fair, impartial and consistent utilization decisions and coordination of care for the health plan members. The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, long term care, and ancillary care services.
The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

3.5.2 Areas Requiring Corrective Action

There are no areas of concern. No corrective action is required.

3.6 Regulation V-Provider Selection

Home State Health was evaluated for 12 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix E).

3.6.1 Performance Strengths

Home State Health has substantial written credentialing and re-credentialing policies and procedures for selecting, monitoring, and maintaining a robust selection of providers. Furthermore, Home State Health makes significant efforts to collect, audit, and ensure data accuracy and provider compliance with their set standards and policies that are in line with the state's requirements. Home State Health also concurrently monitors credentialing and reporting of their providers.

3.6.2 Areas Requiring Corrective Action

There are no areas of concern. No corrective action is required.

3.7 Regulation VI-Confidentiality

Home State Health was evaluated for 19 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix F).

3.7.1Performance Strengths

Home State Health works to protect information assets through a number of technical and physical controls intended to prevent security incidents and reduce their potential impact.

Examples of these controls include: enabling multi-factor authentication to access company systems; providing employee resources and training to promote information security awareness; implementing automated tools for detecting and responding to threats; ensuring appropriate encryption technology is in place for the secure storage and exchange of confidential data; ensuring passwords follow recommended complexity requirements and are updated regularly; verifying professional credentials before granting access to company systems or information; appropriately storing and disposing of both physical and digital documents containing sensitive information; following protocols for securely accessing Company systems; immediately reporting any security incidents or suspicious communications or behaviors to the Chief Security Risk Officer or the Corporate Ethics & Compliance Department.

Home State Health has policies and responsibilities with respect to the use, disclosure and maintenance of hard copy, electronic or oral communication of Protected Health Information (PHI) in order to protect the confidentiality of and to guard against unauthorized access to the same. Disclosures are made to a Business Associate (BA) with whom Home State Health has executed a Business Associate Agreement (BAA), or other written agreement containing Business Associate Provisions. In this agreement, the BA provides satisfactory assurances that the BA will appropriately safeguard the Protected Health Information disclosed.

3.7.2 Areas Requiring Corrective Action

There are no areas of concern. No corrective action is required.

3.8 Regulation VII- Grievance and Appeal System

Home State Health was evaluated for 44 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix G).

3.8.1 Performance Strengths

Home State Health utilizes a "grievance and appeal system" for members that meet all federal and state regulatory requirements, including a grievance process, an appeal process, and access to the State Fair Hearing (SFH) system. Home State Health's grievance and appeals process and related policies and procedures are approved by the Quality Improvement Committee (QIC). They are delegated by, and the direct responsibility of, the Board of Directors.

Home State Health refers all members who are dissatisfied with Home State Health or its subcontractors in any respect to contact the Member Services Department and, when applicable, the expression of dissatisfaction is forwarded to Home State Health's grievance

and appeals coordinator (GAC) to review. The day-to-day responsibility for the coordination of the grievance process resides with the GAC. One of the responsibilities of the GAC is to ensure adherence to the various deadlines in accordance with state and federal laws. The content and substance of a grievance or appeal, including all clinical care aspects involved, are fully investigated and documented according to applicable statutory, regulatory, and contractual provisions and Home State Health's policies and procedures. Resolution and notification of such resolution is made as expeditiously as the member's condition warrants, but no later than the timeframes as outlined in their policy or per state or contractual requirements.

3.8.2 Areas Requiring Corrective Action

There are no areas of concern. No corrective action is required.

4.0 Corrective Action Plan (CAP) Process

Table 5 defines the areas of concern (if any) during the EQR 2019 and the need to take corrective actions by Home State Health:

Table 5: Key Findings and Audit Results for Home State Health

42 CFR 438 Standard	Key Review Findings	# Sections Met	Audit Results
438.206 Availability of services	No concerns identified	11/11	Met
438.207 Assurances of adequate capacity and services	No concerns identified	10/10	Met
438.208 Coordination and continuity of care	No concerns identified	17/17	Met
438.210 Coverage and authorization of services	No concerns identified	22/22	Met
438.214 Provider selection	No concerns identified	12/12	Met
438.224 Confidentiality	No concerns identified	19/19	Met
438.228 Grievance and appeal systems	No concerns identified	44/44	Met

5.0 Conclusions

5.1 Issues

A few weaknesses were noted after reviewing the policies/documents of Home State Health.

Grievance and Appeal System: Some of the policies have an outdated information based on 2015 Managed Care Rule (old CFR). For example:

- MO.UM.01.01 page 5 of 12: A member may request a State Fair Hearing within 90 calendar days from the health plan's notice of action.
- The definition of appeal: A request to change or reverse a previous adverse clinical decision is considered an appeal.
- UM description MHD approved 8-7-18: Members will be provided a reasonable timeframe to file an appeal. This timeframe is no more than 90 days from the date of Home State's notification of adverse determination.
- The term "action" is used in place of "adverse benefit determination" in some places.

5.2 Quality, Timeliness, and Access to Healthcare Services

Home State Health has shown commitment and true diligence in compliance of availability of services in that they continuously measure and analyze for quality and efficiency.

- Home Sate Health collects after-hours accessibility data on PCPs that cover 50% of their members. Home State Health conducts a telephone survey of PCP offices to assess for compliance with appointment accessibility standards which they then submit for analysis. The audit of PCPs for accessibility of routine non-symptomatic, routine symptomatic, and urgent care appointments found that they have met their goal of 90%, or only 1 in 372 PCPs contacted did not meet the appointment standards. Subsequently, a corrective action plan was put in place for the practitioner not able to meet the standards with consequences for not improving upon future surveys.
- Home State Health also monitors high volume specialists to ensure members have access to medical care 24/7. They surveyed 90% of their high-volume OB\GYNS for first, second, third trimester and high-risk pregnancy appointment standards and obtained a 98% compliance in the standard for appointments within 7 calendar days for first and second trimester, and 100% compliance for third trimester and high-risk pregnancies within 3 days of request.

State performance measures and HEDIS measures reporting constitutes the core of the information base that drives Home State Health's clinical quality performance efforts. Home State Health provides a holistic approach to integrated care coordination through the use of multi-disciplinary teams that focus on the whole person rather than just the

diagnosis. Their goal is to ensure Medicaid recipients get the care they need in the most appropriate setting in the following ways:

- Increase primary-care visits and reduce unnecessary emergency room visits.
- Increase EPSDT screenings, prenatal/postpartum care and HEDIS rates.
- Identify and facilitate treatment for secondary conditions.
- Coordinate care to reduce duplication and waste.
- Reduce socioeconomic barriers to care.
- Implement physician-driven strategies that support a Medical Home.

5.3 Improvement by Home State Health

- Home State Health has maintained 100% compliance with federal and state rules and regulations over the last two years (CY 2017 and CY 2018).
- Home State Health was not placed on CAP by the EQRO for the last three consecutive years (CY 2016-CY 2018).
- Follow up on recommendations from last year:

  - During the previous year (EQR 2018), Subpart D Standard 8-42 CFR 438.230 Subcontractual relationships and delegation was evaluated. A recommendation was made for section 2c of the evaluation tool which stated: "the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later (42 CFR 438.230(c) (3) (iii)). Home State Health should work with MHD to align audit rights and related record retention expectations and it is recommended that the 10 years duration be specified in all the delegated subcontractor contracts."
    Home State Health has updated their standard subcontractor required provisions template to include "vendor and sub-contracted Vendor(s) shall maintain all medical records remaining under the care, custody, and control of the vendor and sub-contracted Vendor(s), or the Vendor and sub-contracted vendor(s)'s designee, for a minimum of 10 years from the date of when the last professional service was provided." (Ref. Vendor MOHealthNet 20181109 Pages 5, 9 of 9). Home State Health has stated that this template is currently in use for any new Medicaid related subcontractors and they are working to update this template with the existing subcontractors.

  - In Subcontractual Relationships and Delegation, 2b, Home State Health should work with MHD to consider adding the specific terminology of "computer or electronic systems" to cover all aspects of this requirement in their vendor

agreements. It is currently implied that all records be accessible, but the CFR wording warrants a consideration to include these elements.

Home State Health has updated their standard subcontractor required provisions template to include "computer or other electronic systems" (Ref. Vendor MOHealthNet 20181109 Page 9 of 9). Home State Health has stated that this template is currently in use for any new Medicaid related subcontractors and they are working to update this template with the existing subcontractors.

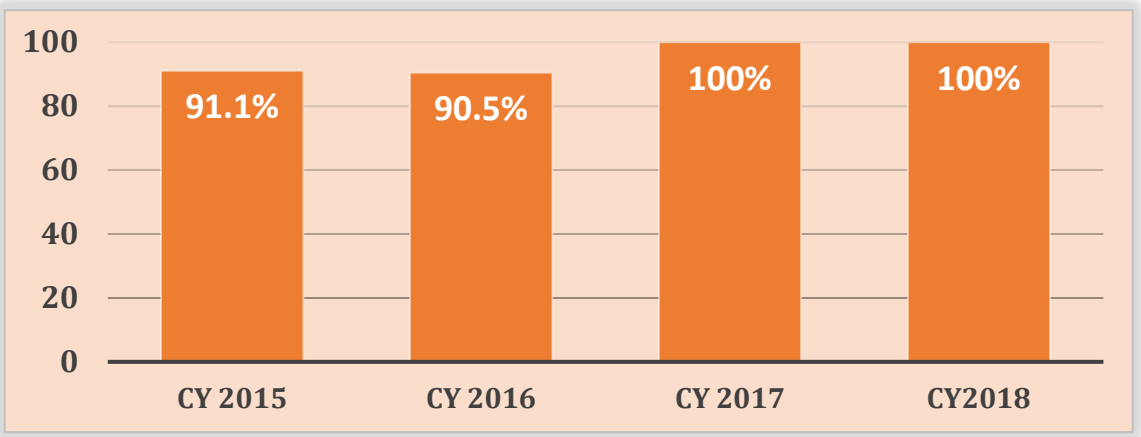


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Figure 5: Compliance Score Trend CY 2015-CY 2018 (%)

6.0 Recommendations

Home State Health

- Primaris recommends that all the policies (wherever applicable) should be updated consistently to reflect the correct information based on "2016 Managed Care Final Rule."
- The revisions to the policies/documents as a result of technical assistance should be submitted to the MHD for approval.
- During onsite visit, Primaris and Home State Health mutually concluded that some areas of improvement include: educating PCPs on the appointment standards and developing tailored actions to ensure all PCP offices are compliant with availability standards. It is further recommended that they do so on a more frequent basis than annually.

MHD

- The definition of "adverse benefit determination" in the MHD contract section 2.15.1 a5 states that "the failure of the MCO to act within the timeframes provided at Section 2.12.16. c. 22 of the contract regarding the standard resolution of grievances and appeals." Though Home State Health follows the definition given in the MHD contract, section 2.12.16 c 22 of the MHD contract does not mention the timeframes for standard resolution of grievances and appeals.
  Primaris recommends that Home State Health should work with MHD to replace section 2.12.16 c 22 by section 2.15.5 e and 2.15.6 m of MHD contract, which states the timeframes for resolution of grievances and appeals per 42 CFR 438.408(b) (1) and (2).
- MHD contract 2.15.5 e states that "The health plan shall resolve each grievance and provide written notice of the resolution of the grievance, as expeditiously as the member's health condition requires but shall not exceed 30 calendar days of the filing date." The CFR states that "standard resolution of grievances may not exceed 90 calendar days from the day the MCO receives the grievance."
  Primaris recommends MHD to specify an action that would be taken by them if Home State Health is not able to resolve a grievance in 30 days but has resolved within 90 days.
  Same would be applicable for "standard authorization" decisions where the time frame specified by the MHD contract is more restrictive than the CFR.
- As a follow up from the previous year (EQR 2018), Subcontractual Relationships and Delegation, 2c, states, "the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later (42 CFR 438.230(c) (3) (iii))."
  Primaris recommends MHD to make an amendment to their MHD Managed Care Contract "section 3.9 Subcontractors," to reflect the duration of "right to audit" for 10 years as opposed to 5 years in the subcontractors section.

Appendix A

Subpart D Standard 1– 42 CFR 438.206 Availability of Services		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. All services covered under the State plan are available and accessible to enrollees of MCO in a timely manner. The MCO provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68.		
(i) Travel distance. The MCOs shall comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095, for all those providers applicable to MHD Managed Care program. For those providers not addressed under 20 CSR 400-7.095, the MCO shall ensure that members have access to those providers within 30 miles, unless the MCO can demonstrate to the state agency that there is no such licensed provider within 30 miles, in which case the MCO shall ensure members have access to those providers within 60 miles *(MHD contract 2.5.2).*	MO.CONT.01 Network Adequacy: Page 4 of 8	Met
Findings: In their policy on Network Adequacy, Home State Health provides sufficient compliance and explanation of travel distance standards. Home State Health shall monitor and comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 as amended and in Attachment 14 of its Managed Care Contract. For those providers not addressed under 20 CSR 400-7.095, Home State Health shall ensure that members have access to those providers within thirty (30) miles, unless the health plan can demonstrate to the state agency that there is no such licensed provider within thirty (30) miles, in which case Home State Health shall ensure members have access to those providers within sixty (60) miles. **Required Actions:** No actions for further evidence/ documentation is required at this time.		

(ii) Appointment standards: a. Waiting times-not exceed one hour from the scheduled appointment time. b. Urgent care appointments for physical or behavioral illness injuries which require care immediately but do not constitute emergencies-within 24 hours. c. Routine care with physical or behavioral symptoms-within 1 week or 5 business days whichever is earlier. d. Routine care without physical or behavioral symptoms-within 30 calendar days. e. Aftercare appointments-within 7 calendar days after hospital discharge. f. For maternity care: • First trimester-within 7 calendar days of first request. • Second trimester-within 7 calendar days of first request. • Third trimester-within 3 calendar days of first request. • High risk pregnancies-within 3 calendar days of identification of high risk to the MCO or maternity care provider, or immediately if an emergency exists *(MHD contract 2.5.3).*	MO.PRVR.04 Provider Appointment Accessibility Standards: Page 1 of 4 MO.PRVR.04 Provider Appointment Accessibility Standards: Pages 2, 3 of 4 Home State Health Provider Manual: Page 21 of 75	Met
Findings: Home State Health follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. They monitor compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization. Home State Health disseminates these appointment and after-hours standard policies to its in-network providers and to its members. Their appointment and after-hours standards are included in Home State Health's provider orientation, reference manual, at least annually in the provider and member newsletters, in the member handbook, and in ongoing provider education materials. The results of the surveys and the calls described above will be tracked by the Provider Relations Department and used to identify providers		

who may need education and/or corrective action plans to bring them into compliance with Home State's appointment and after-hours standards. During our onsite review, Home State Health further explained that they contract with an outside vendor to conduct surveys and collect data on appointment standards for each provider. A corrective action plan is required for providers who don't meet standards and the survey reports are released annually in their newsletter. **Required Actions:** None.		
B. Delivery network. The MCO consistent with the scope of its contracted services, meets the following requirements:		
(i) 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 for all enrollees, including those with limited English proficiency or physical or mental disabilities.	MO.CONT.01 Network Adequacy: Pages 1, 2 of 8 MO.CONT.02 Network Selection and Retention: Page 1 of 6 Home State Provider Manual 2018: Page 30 of 75	Met
Findings: Policies MO.CONT.01 and the MO.CONT.02 (Network Adequacy, Selection and Retention respectively) as well as the Home State Health Provider Manual describes, lists, and supports how Home State Health monitors and maintains their network of providers as well as how they complement their network and accommodate those language barriers. Home State Health will establish, maintain and monitor a network of affiliated providers that is sufficient to provide adequate access to all covered services taking into consideration: the anticipated number of members for Home State Health, the expected utilization of services, the number and types of providers necessary to furnish the covered services, the number of affiliated providers with closed panels, and the geographic location of the affiliated providers and Home State Health members. Home State Health shall establish and maintain credentialed provider networks in geographically accessible locations, in accordance with the travel distance standards consistent with State requirements. Home State Health ensures that its provider selection procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Home State Health Credentialing ensures, through initial Primary Source Verification, it does not contract with providers excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either section 1128 or 1128A of the Social Security Act. Home State Health will offer contracts to all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for inclusion in its provider network. Home State Health ensures in-network providers do not intentionally segregate Home State Health members in any way from other patients receiving care in the provider's office. In addition, Home State Health ensures		

in-network providers provide care without regard to the Home State Health member's race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status or physical or mental disability. Furthermore, as an in-network provider, the Home State Health contract template require providers to abide by these requirements. Home State will ensure the provision of covered services as specified by the State of Missouri. **Required Actions:** None**.**		
(ii) Provides for a second opinion from a network provider or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee. These policies and procedures shall address whether there is a need for referral by the primary care provider or self-referral. Missouri Revised Statutes Section 208.152 states that certain elective surgical procedures require a second medical opinion be provided prior to the surgery. A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion *(MHD contract 2.8).*	Home State Provider Manual 2018: Page 36 of 75 MO.UM.01UM Program Description: Page 12 of 28	Met
Findings: The Home State Health manual and Program description policy (MO.UM.01-UM) both address the requirement of second and third opinions as referenced under B ii. Home State Health provides referral needs: Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Home State network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member. Members have a right to a third surgical opinion when the recommendation of the second surgical opinion fails to confirm the primary recommendation and there is a medical need for a specific treatment, and if the member desires the third opinion. Out-of-network and in- network providers require prior authorization by Home State when performing second and third opinions. **Required Actions:** None**.**		
(iii) If the provider network is unable to provide necessary services, covered under the contract, to a	MO.CONT.01 Network Adequacy: Page 5 of 8	Met

particular enrollee, the MCO must adequately and timely cover these services out of network for the enrollee, for as long as the MCO's provider network is unable to provide them.		
Findings: At least annually, Home State Health evaluates network cultural competency, network adequacy and appointment availability. The assessment is reported to the Quality Improvement Committee (QIC) at the individual practitioner, physician network, and/or medical group levels and/or as an aggregate as appropriate by provider type at least annually, although interim quarterly reports may also be reported to the QIC. **Required Actions:** None.		
(iv) Requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	Single Case Agreement Template: Page 1of 2 Single Case Agreement Policy	Met
Findings: Home State Health ensures that out-of-network providers coordinate with them for payment and the cost to the enrollee is no greater than it would be if the services were furnished within the network. **Required Actions:** None.		
C. Furnishing of services: (i) Timely access. Each MCO must do the following: a. 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 FFS, if the provider serves only Medicaid enrollees. b. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. c. Establish mechanisms to ensure compliance by network providers.	Home State Provider Manual 2018: Pages 16, 19, 22, 23 of 75 Appointment Standards After Hours	Met

d. Monitor network providers regularly to determine compliance. e. Take corrective action if there is a failure to comply by a network provider.		
Findings: Home State Health provided detailed evidence of their compliance with timely access via the provided Home State Health Provider Manual, Appointment standards and their After-Hours Corrective Action Plan: Primary Care Providers (PCP) shall serve as the member's initial and most important contact. Home State will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program ("QIP"). Home State's PCPs, behavioral health providers, and specialty physicians are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to members as needed 24-hours a day, seven days a week. **Required Actions:** None.		
(ii) Access and cultural considerations. Each MCO 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, disabilities, and regardless of gender, sexual orientation or gender identity *(MHD contract 2.3).*	MO.CONT.01 Network Adequacy: Page 5 of 8 MO.CONT.02 Network Selection and Retention: Page 2 of 6 Home State Provider Manual 2018: Page 30 of 75 MO.QI.21 Cultural Competency Program: Pages 15-20 of 23	Met
Findings: Through its contracted provider network, Home State Health shall ensure that all Home State Health covered members receive equitable and effective treatment in a culturally and linguistically appropriate manner. Home State Health facilitates linking of its members with practitioners who can meet members' cultural, ethnic, racial and linguistic needs and preferences. Home State Health ensures in-network providers do not intentionally segregate Home State Health members in any way from other patients receiving care in the provider's office. In addition, Home State Health will ensure in-network providers provide care without regard to the Home State Health member's race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status or physical or mental disability. Furthermore, as an in-network provider, the Home State Health contract template requires provider to abide by these requirements. **Required Actions:** None.		

(iii) Accessibility considerations. Each MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	MO.QI.21 Cultural Competency Program: Pages 15-20 of 23 Home State Provider Manual 2018: Page 62 of 75	Met
Findings: With respect to the Americans with Disabilities Act, Home State Health is required to take steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the public accommodation can demonstrate that taking such steps would fundamentally alter the nature of the goods, services, facilities, advantages, or accommodations being offered or would result in undue burden. Auxiliary aids may include offering materials in alternative formats (i.e. large print, tape or Braille) and interpreters, or real-time captioning to accommodate the needs of persons with disabilities that affect communication. **Required Actions:** None.		
D. Direct Access and standing referrals		
(i) Standing referral from a specialist if the member has a condition which requires on-going care from a specialist. (ii) Access to a specialty care center if the member has a life-threatening condition or disease either of which requires specialized medical care over a prolonged period of time. (iii) Provides female enrollees with direct access to a women's health specialist within the provider 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 *(MHD contract 2.5.8).*	MO.UM.54 In Network Referrals Policy: Page 2 of 4 Home State Health Member Handbook 2018: Pages 15, 37 of 68 MO.UM.01 UM Program Description: Page 12 of 28 MO CONT 02 Network Selection and Retention: Page 1 of 6	Met
Findings: A PCP may refer members with chronic, disabling, or degenerative conditions or diseases to a specialist for a set number of visits within a specific time period. Home State Health Medical Director must approve standing referrals. Established processes are in place		

by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the policies include guidance on how members with life-threatening conditions or diseases which require specialized medical care over a prolonged period of time can request and obtain access to specialty care centers. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the covered services, including ensuring female members have direct access to an in-network women's health specialist to provide routine and preventive health care services and members needing a course of treatment or regular care have direct access to specialists. **Required Actions:** None.		
E. MCO shall provide a member handbook, and other written materials with information on how to access services, to all members within 10 business days of being notified of their future enrollment with the MCO. Information will be considered to be provided if the MCO: • Mails a printed copy of the information to the member's mailing address. • Provides the information by email after obtaining the member's agreement to receive the information by email. • Posts the information on the Web site of the MCO and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Provides the information by any other method that can reasonably be expected to result in the member receiving that information *(MHD contract 2.12.16).*	MO.MBRS.06 Member Handbook and ID Card: Page 1 of 10	Met

Findings: Home State Health policy MO.MBRS.06 on Member Handbook states the requirement from this section such as the timeliness of receiving the member handbook (within 10 days). Besides print, they provide the information online via the member's account log in and email. A link and downloadable version were also provided: Home State shall send new members a Member Handbook as part of the New Member Packet to all members within 10 business days of being notified of their future enrollment with the health plan. The member will receive 2 identification cards. The state agency will issue an identification card to all MO HealthNet eligibles. There will be no MCO specific information printed on the card. The MCO shall issue a membership card that contains information more specific to the health plan. At a minimum, the MCO issued membership card must contain the member's name, identification number, primary care provider name and telephone number, instructions for emergencies, and other relevant toll-free lines for access such as behavioral health, dental, and nurse advice lines. The membership card must be issued to the member prior to the member's effective date of coverage with the health plan.
Required Actions: None.

Compliance Score – Availability of Services						
Total	Met	=	11	×2	=	22
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	
Denominator	Total Sections	=	11	×2	=	22
Score						**100%**

Appendix B

Subpart D Standard 2-42 CFR 438.207 Assurances of Adequate Capacity and Services		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. Each MCO must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:		
(i) Offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area. The MCO's network shall consist of, at minimum, hospitals, physicians, advanced practice nurses, mental health providers, substance use disorder providers, dentists, emergent and non-emergent transportation services, safety net hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended), and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified herein *(MHD contract 2.4.1a).*	MO.CONT.01Network Adequacy MO.CONT.02Network Selection and Retention: Pages 1, 2, 3 of 6 Home State Health Network Access Plan Final 2018 Cover Letter Home State Health Network Access Plan	Met
Findings: Home State Health's provider network shall consist of hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, safety net hospitals, and all other provider types necessary to ensure sufficient capacity, in accordance with the accessibility service standards consistent with state requirements. **Required Actions:** None.		
(ii) Behavioral Health Providers. To ensure a broad range of treatment options are available, the MCO shall include in its network a mix of mental health and substance use disorder treatment providers with experience	MO.CONT.01Network Adequacy: Pages 1, 2, 3 of 8	Met

in treating children, adolescents, and adults. To be considered adequate, the behavioral health provider network shall, at a minimum, include- a. Qualified Behavioral Healthcare Professionals (QBHP), certified substance use disorder or co-occurring treatment professionals, licensed psychiatrists, licensed psychologists, provisionally licensed psychologists, licensed psychiatric nurse practitioners, licensed professional counselors, provisionally licensed professional counselors, licensed clinical social workers, licensed master social workers, and licensed psychiatric clinical nurse specialists b. The majority of Community Mental Health Centers (CMHC), within each county where the MCO provides coverage and the majority of Certified Community Behavioral Health Clinics (CCBHC) within the DMH. If there is not a CMHC in that county, the health plan must contract with a CMHC within 30 miles of a county where the MCO has coverage. If there is not a CMHC within 30 miles of that county, the health plan must contract with a CMHC in the Department of Mental Health (DMH), *(MHD contract 2.4.8).*	MO.CONT.02Network Selection and Retention: Page 1 of 6 Home State Health Network Access Plan Final 2018 Cover Letter–Home State Health Network Access Plan	
Findings: Through its contracted vendor, Cenpatico, Home State Health's behavioral health network shall include a mix of behavioral health and substance abuse providers with experience in treating children, adolescents and adults. At a minimum, Home State Health's behavioral health provider network shall at a minimum include Qualified Behavioral Health Professionals (QBHP), Substance Abuse Professionals (QSAP), licensed psychiatrists, licensed psychologists, licensed psychiatric nurses, licensed professional counselors, licensed master social workers, and licensed clinical nurse specialists. Home State Health's behavioral health network shall include Community Mental Health Centers (CMHC) within each county included in the Managed Care area where Home State Health covered members		

live. To the maximum extent possible, Home State Health shall include all CMHCs in its behavioral network. If there is not a CMHC within a county where a Home State Health covered member lives, through its contracted vendor, Cenpatico, Home State Health will contract with a CMHC within thirty (30) miles of a county where the Home State Health covered member lives. If there is not a CMHC within thirty (30) miles of that county, Home State Health will contract with a CMHC in the Department of Mental Health (DMH) CMHC catchment area for any country where the Home State Health covered member lives. **Required Actions:** None.		
(iii) Federally Qualified Health Centers and Rural Health Clinics. The MCO shall offer a contract to all FQHCs, Provider-Based Rural Health Clinics (PBRHCs), and Independent Rural Health Clinics (IRHCs) at the rates established herein. If there is not an FQHC in the county, the MCO must have a contract with an FQHC within thirty (30) miles of a county where the health plan has coverage for members *(MHD contract 2.4.9).*	MO.CONT.01Network Adequacy: Pages 1, 2, 3 of 8	Met
Findings: FQHCs and RHCs. Home State Health's provider network shall include Federally Qualified Health Centers (FQHCs), Independent Rural Health Clinics (IRHCs), and Provider-Based Rural Health Clinics (PBRHCs) within each county included in the Managed Care area where Home State Health has covered members. If there is not a FQHC within a county where a Home State Health covered member lives, Home State Health will contract with a FQHC within thirty (30) miles of a county where the Home State Health covered member lives. To the maximum extent possible, Home State Health shall include all FQHCs in its network. **Required Actions:** None.		
(iv) Family Planning and Sexually Transmitted Disease (STD) Treatment Providers. The MCO shall include Title X and STD providers in its provider network to serve members covered under the comprehensive and extended family planning, women's reproductive health, and sexually transmitted diseases benefit packages. The MCO shall establish an agreement with each Family Planning and STD treatment provider not in the provider network describing, at a	MO.CONT.01Network Adequacy: Pages 1, 2, 3 of 8	Met

minimum, care coordination, medical record management, and billing procedures. The health plan shall allow for full freedom of choice for the provision of these services *(MHD contract 2.4.10).*		
Findings: Family Planning and STDs. Home State Health shall include in its provider network, Title X and STD providers to serve its members covered under the comprehensive and extended family planning, women's reproductive health and sexually transmitted diseases benefit packages. Home State Health shall establish an agreement with each Family Planning and STD treatment provider not in the provider network describing at a minimum, care coordination, medical record management, and billing procedures. **Required Actions:** None.		
(v) Local Public Health Agencies. The MCO shall include local public health agencies in its provider network for the local public health agency services described herein and for other services such as care management and services provided under the Local Community Care Coordination Program (LCCCP), *(MHD contract 2.4.11).*	MO.CONT.01Network Adequacy: Page 3 of 8	Met
Findings: Home State Health shall include local public health agencies in its provider network for the public health agency services consistent with state requirements and for other services provided under the Local Community Care Coordination Program (LCCCP). Home State Health may establish an agreement with each local public health agency not in its provider network describing at a minimum, care coordination, medical record management, and billing procedures. **Required Actions:** None.		
(vi) School Based Dental Services. The MCO shall contract with and reimburse any licensed dental provider who provides preventive dental services (i.e., dental exams, prophylaxis, and sealants) in a school setting *(MHD contract 2.4.15).*	Home State Health Network Access Plan Final 2018: Pages 1, 2, 3 of 5	Met
Findings: Home State Health's specialty division for vision and dental services contracts for and makes school-based services available. Care is reimbursed provided it's billed with a		

designed place-of-service utilizing Current Dental Terminology (CDT) valid coding on an ADA form. **Required Actions:** None.		
(vii) Tertiary Care. The MCO shall provide tertiary care services including trauma centers, burn centers, stroke centers, ST-Elevation Myocardial Infarction (STEMI) centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available 24 hours per day in the regions covered by the contract. If the MCO does not have a full range of tertiary care services, the health plan shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers *(MHD contract 2.4.16).*	MO.CONT.01Network Adequacy: Page 4 of 8 Tertiary Agreement	Met
Findings: Home State Health provides tertiary services. Home State Health's provider network shall include tertiary care providers consisting of highly-specialized providers available 24 hours per day in all service areas. Tertiary care providers shall include trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, medical sub-specialists, and specialty pediatric hospitals as defined in 13 CSR 70-15.010(2)(P), or as amended. During the onsite review, Home State Health was asked to provide an example of such transfer agreement(s) and/or and documentation of arrangements with out-of-network providers if stroke centers and ST-Elevation Myocardial Infarction (STEMI) centers are available 24 hours per day in the regions covered by the contract via other arrangements to ensure compliance with this section. Home State Health has provided sufficient documentation after the onsite visit. **Required Actions:** None.		
B. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees	MO.CONT.01Network Adequacy	Met

that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider *(MHD contract 2.4.1 b).*		
Findings: Home State Health will establish, maintain, and monitor a network of affiliated providers that is sufficient to provide adequate access to all covered services taking into consideration: the anticipated number of members for Home State Health, the expected utilization of services, the number and types of providers necessary to furnish the covered services, the number of affiliated providers with closed panels, and the geographic location of the Affiliated Providers and Home State Health members. **Required Actions:** None.		
C. Timing of documentation. Each MCO must submit the documentation as specified by the State, but no less frequently than the following, to comply with section A of this evaluation tool:		
(i) On an annual basis. Access Plan: In accordance with State requirements specified at 20 CSR 400-7.095, the MCO shall file an annual access plan, by March 1 of each year, with the Department of Insurance, Financial Institutions and Professional Registration that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues *(MHD contract 2.5.4).*	Home State Health Network Access Plan Final 2018 Cover Letter Home State Health Network Access Plan	Met
Findings: The Home State Health document titled "Network Access Plan Final 2018" and supplied cover letter to the Home State Health Network Access Plan shows compliance with all requirements described in Section C i. **Required Actions:** None.		
(ii) At any time there has been a significant change (as defined by the State) in the MCO's operations that	MO.CONT.02Network Selection and Retention: Page 3 of 6	Met

would affect the adequacy of capacity and services, including a. A decrease in the total number of primary care providers by more than five percent (5%). b. A loss of providers that will result in the health plan failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095. c. A loss of any hospital regardless of whether the loss will result in the health plan failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095. d. Any other adverse change to the composition of the provider network which impairs or denies the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity*(MHD contract 2.4.12 a)* e. Enrollment of a new population in the MCO.		

Findings: Home State Health shall notify the state agency when there is:

- A decrease in the total number of PCPs by more than five percent (5%).
- A loss of providers that will result in the health plan failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095.
- A loss of any hospital regardless of whether the loss will result in the health plan failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095.
- Any other adverse change to the composition of the provider network which impairs or denies the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity.
- Any significant changes in services, benefits, geographic services area, or payments.
- Enrollment of a new population in the MCO.

Required Actions: None.

Compliance Score – Assurances of Adequate Capacity and Services						
Total	Met	=	10	×2	=	20
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	20
Denominator	Total Sections	=	10	×2	=	20
Score						**100%**

Appendix C

Subpart D Standard 3–42 CFR 438.208 Coordination and Continuity of Care		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO must ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity.	Member Handbook & ID Cards MO.MBRS.04 Distribution of New Member Materials: Pages 1, 2 of 3 MO.MBRS.06 Distribution of New Member Materials: Pages 1, 8 of 10	Met
Findings: Home State Health shall send new members a Member Handbook containing information on how to contact member services and a description of its function and notice that a member may receive services from an out of network provider when Home State Health does not have an in-network provider with appropriate training and experience to meet the particular health care needs of the member and the procedure by which the member can obtain such referral. **Required Actions:** None.		
B. MCO makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.	MO.MBRS.43 New Member Welcome Call: Page 1 of 2	Met
Findings: Home State Health conducts welcome calls upon enrollment of the member and continue in accordance with state or federal contract. The intent of the call is to welcome new members, educate them on the program, assist them in establishing a relationship with their primary care provider (PCP), ensure they have access to services, and perform an initial health risk screen (HRS) to identify potential case management needs. **Required Actions:** None.		
C. Coordinate the services the MCO furnishes to the enrollee/Transition of care. The MCO must have written policies and procedures that address all transition of care requirements:		

(i) Regarding transition of care for newly enrolled members transitioning to the MCO from fee-for-service or another MCO and for members transitioning out of the MCO to another MCO, the MCO at a minimum, shall carry out the following responsibilities- a. Immediately following the state agency's notification to the MCO to proceed with contract services, the health plan shall provide the state agency with a contact person for transition of care information. b. If a member enrolls with the MCO from another MCO, the new MCO, within 5 business days from the date of the state agency's notification to the new MCO of the member's anticipated enrollment date, contact the member to determine the name of the previous MCO in order to request relevant member information from them. c. The MCO will provide for the transfer of relevant member information, including medical records and other pertinent materials, to another MCO within 5 days of receiving the request. d. If the MCO receives new members who were previously members in the fee-for-service program, the MCO must contact the member's provider within 5 business days of the state agency's notification to the MCO of the member's anticipated enrollment date, to request the necessary	MO.CM.17 Transition of Care Policy and Procedure: Pages 1, 2 of 4	Met

medical records and information *(MHD contract 2.5.9).*		
Findings: Home State Health will provide for the transfer of relevant member information, including medical records and other pertinent materials, to another MCO upon notification of establishment of care such that the transition of care shall be smooth. Immediately following the state agency's notification to the health plan to proceed with contract services, the health plan shall provide the state agency with a contact person for transition of care information. All examples listed, a-d have been addressed in their Transition of Care Policy and Procedure MO.CM.17. **Required Actions:** None.		
(ii) Provide care coordination for prescheduled health services, access to preventive and specialized care, care management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans.	MO.CM.17 Transition of Care Policy and Procedure: Page 2 of 4	Met
Findings: Home State Health Plan will provide care coordination for prescheduled health services, access to preventative and specialized care, care management, member services, and education with minimal disruption to members established relationships with providers and existing care treatment plans. **Required Actions:** None.		
(iii) MCO shall facilitate the securing of a member's records from the out-of-network providers as needed and pay rates comparable to fee-for-service for these records, unless otherwise negotiated.	MO.CM.17 Transition of Care Policy and Procedure: Page 2 of 4	Met
Findings: Home State Health works with an out-of-network provider and/or the previous MCO to effect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a medical health, behavioral health, or substance abuse provider that is not in the health plan's network. At a minimum, the MCO shall (1) facilitate in the securing of a member's records from the out-of-network providers as needed, and (2) pay rates comparable to fee-for-service for these records, unless otherwise negotiated. **Required Actions:** None.		

(iv) Facilitate continuity of care for medically necessary covered services. In the event a member entering the MCO is receiving medically necessary covered services, the day before enrollment to the MCO, the MCO be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by in-network or out-of-network providers. a. The health plan shall provide continuation of such services for the lesser of - 60 calendar days, or until the member has transferred, without disruption of care, to an in-network provider. b. For members eligible for care management, the new MCO shall provide continuation of services authorized by the prior health plan for up to 60 calendar days after the member's enrollment in the new MCO and shall not reduce services until an assessment supporting services reduction is conducted by the new MCO.	MO.CM.17 Transition of Care: Pages 2,3 of 4	Met
Findings: Home State Health will facilitate continuity of care for medically necessary covered services. In the event a member entering the MCO is receiving medically necessary covered services, in addition to or other than prenatal services the day before enrollment into the MCO, the MCO shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by in-network or out-of-network providers. This includes providing continuation of such services for the lesser of (1) 60 calendar days, or (2) until the member has transferred, without disruption of care, to an in-network provider. Also included in the policy was that for members eligible for case management, the new health plan shall provide continuation of services authorized by the prior health plan for up to a minimum of 60 calendar days after the member's enrollment in the new		

health plan and shall not reduce services until an assessment supporting services reduction is conducted by the new MCO. **Required Actions:** None.		
(v) Allow non-pregnant members receiving a physician authorized course of treatment to continue to receive such treatment, without any form of prior authorization and without regard to whether such services are being provided by in-network or out-of-network providers, for- the lesser of 60 calendar days or until the member has been seen by the assigned primary care provider who has authorized a course of treatment.	MO.CM.17 Transition of Care Policy and Procedure: Page 1 of 4	Met
Findings: Home State Health allows non-pregnant members receiving a physician authorized course of treatment to continue to receive such treatment, without any form of prior approval and without regard to whether such services are being provided by in-network or out-of-network providers for the lesser of 60 days or until the member has been seen by the assigned primary care provider who has authorized a course of treatment. **Required Actions:** None.		
(vi) Allow members in their third trimester of pregnancy to continue to receive services from their prenatal care provider (whether in-network or out-of-network), without any form of prior authorization, through the postpartum period (defined as 60 calendar days from date of birth).	MO.CM.17 Transition of Care Policy and Procedure: Pages 2, 3 of 4	Met
Findings: Home State Health states that they shall allow members in their third trimester of pregnancy to continue to receive services from their prenatal care provider (whether in-network or out-of-network) through the postpartum period (defined as 60 days from date of birth). **Required Actions:** None.		
(vii) Allow pregnant members to continue to receive services from their behavioral health treatment	MO.CM.17 Transition of Care Policy and Procedure: Pages 3, 4 of 4	Met

provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.		
Findings: Home State Health states that they shall allow pregnant members to continue to receive services from their behavioral health and/or substance abuse treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility. **Required Actions:** None.		
(viii) Ensure that inpatient and residential treatment days are not prior authorized during transition of care.	MO.CM.17 Transition of Care Policy and Procedure: Page 4 of 4	Met
Findings: Home State Health states that they shall allow pregnant members to continue to receive services from their behavioral health and/or substance abuse treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility. **Required Actions:** None.		
D. Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards, to prevent duplication of those activities.	Home State Health Provider Manual: Page 16 of 75	Met
Findings: Primary Care Providers (PCP) shall serve as the member's initial and most important contact. PCP's responsibilities include maintaining current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services. **Required Actions:** None.		
E. 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.	CC.COMP.PRVC.13 Individual Right Screen-Shot from Cornerstone Training	Met
Findings: The Home State Health states that the Health Plan Privacy Official or his/her designee in concurrence with the Vice President of Medical Affairs will obtain a signed		

authorization from all members before using or disclosing their protected health information for purposes other than treatment, payment or health care operations. **Required Actions:** None.		
F. MCO must coordinate services for its members who are in health homes. They must identify any care gaps or areas of duplication through a mutually acceptable method. MCO is responsible for being the primary source of care management for conditions other than or beyond those included in the state Health Home program *(MHD contract 2.11.1 d).*	Case Management Program Description MO.CM.01: Page 28 of 35	Met
Findings: The Home State Health policy number MO.CM.01: Case Management Program Description adequately meets the requirements of Section F stating that Home State Health must coordinate services for its members who are in health homes. The health plan must identify any care gaps or areas of duplication through a mutually acceptable method. The health plan is responsible for being the primary source of care management for conditions other than or beyond those included in the state Health home program. The conditions are listed in the Case Management Program Description. **Required Actions:** None.		
G. Additional services for enrollees with special health care needs or who need LTSS*:		
(i) Identification. Implement mechanisms to identify persons who need LTSS or persons with special health care needs as specified in State's quality strategy.	MO.CM.01 Case Management Program: Pages 1, 5, 12-14, 17,18, 21-28, 30-37 of 37 *N/A per MHD contract	Met
Findings: Home State Health does not cover LTSS but after clarification during our onsite review, they have provided supporting documents for special needs. One of case managements' primary functions as listed in the Home State Health Case Management Program Description is the early identification of members who have special needs. **Required Actions:** None.		
(ii) Assessment. The MCO must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State to MCO, of any ongoing special conditions of the enrollee	MO.CM.01 Case Management Program: Pages 1, 5, 12-14, 17-18, 21-28, and 30-37 of 37 Home State Health MO Directory Insert 2018 11-20 hi-res	Met

that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO as appropriate.	Home State Health MO v4 member handbook 2018 12-17 hi-res Home State Health_5.5x8.5_Benefits_Handbook -2017 (006) Transportation Flyer Urgent Care List	
Findings: At least annually, Home State Health will assess the entire member population and any relevant subpopulations (e.g. ABD/SSI, Medicare Dual-eligible Special Needs Plan, Foster Care) to determine if the Care Management Program meets the needs of all members eligible for care management. Data utilized for assessment of the entire member population includes information that may be provided by the state agency and includes information such as age (especially children/adolescents and elderly), sex, ethnicity, race, primary language, and benefit category. Other data used includes diagnostic and utilization data (e.g. overall claims received, inpatient admissions and ED visits, and pharmacy data). The population assessment will specifically address the needs of children and adolescents, individuals with disabilities, and members with serious and persistent mental illness (SPMI). **Required Actions:** None.		
(iii) Treatment/service plans. MCOs must produce a treatment or service plan meeting the following criteria in for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan for the enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: a. Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee; b. Developed by a person trained in person-centered planning using a person-centered process and plan	Home State Health Provider Manual: All Pages Home State Health MO Directory Insert 2018 11-20 hi-res Home State Health MO v4 member handbook 2018 12-17 hi-res Home State Health_5.5x8.5_Benefits_Handbook -2017 (006) Transportation Flyer Urgent Care List	Met

as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans; c. Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO. d. In accordance with any applicable State quality assurance and utilization review standards; and e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per §441.301(c) (3).		
Findings: Home State Health's Care Management program and the tools utilized to manage care were developed based on evidence-based clinical practice guidelines and preventive health guidelines adopted by Home State Health. They utilize a high level of case management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs; or those that are frail, elderly, disabled, or at the end of life. A key objective of Home State Health's Case Management Program is early identification of members who have the greatest need for care coordination and case management services. This includes, but is not limited to those classified as children or adults with special health care needs. At least annually, Home State Health will assess the entire member population and any relevant subpopulations (e.g. ABD/SSI, Medicare Dual-eligible Special Needs Plan, Foster Care) to determine if the Care Management Program meets the needs of all members eligible for care management. At least annually (12 months), Home State Health will assess the entire member population and any relevant subpopulation. **Required Actions:** None.		
(iv) Direct access to specialists For enrollees with special health care needs each MCO 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	Home State Health Provider Manual Home State Health MO Directory Insert 2018 11-20 hi-res Home State Health MO v4 member handbook 2018 12-17 hi-res	Met

identified needs *(MHD contract 2.5.8 a).*	Home State Health_5.5X8.5 Benefits Handbook-2017(006) Transportation Flyer Urgent Care List	
Findings: PCP's are responsible for managing the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs. **Required Actions:** None.		

Compliance Score – Coordination and Continuity of Care						
Total	Met	=	17	×2	=	34
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	
Denominator	Total Sections	=	17	×2	=	34
Total						**100%**

Appendix D

Subpart D Standard 4-42 CFR 438.210 Coverage and Authorization of Services		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. Coverage. Each MCO must do the following: (i) Services identified in MHD contract 2.7 be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid (as set forth in 440.230 of chapter 4 and for enrollees under 21, as set forth in subpart B of part 441 of chapter 4).	MO.UM.01.01 Covered Benefits and Services: Page 1 of 12 MO.UM.01.01 Covered Benefits and Services: Page 1 of 13 (updated) MO.UM.01 Program Description: Page 13 of 28 MO.UM.02 Clinical Decision Criteria and Application: Page 2 of 6	Met
Findings: Home State Health, at a minimum, provides benefits and services that are covered services and benefits as defined by the MO HealthNet contract and MO HealthNet policies and procedures manual, as applicable. Home State Health shall be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. During onsite review, Primaris informed Home State Health that their policies did not indicate "the amount, duration, and scope will be no less than services delivered for Fee-for-Service (FFS)." Home State Health confirmed that they provide benefits and services to Managed Care enrollees which are no less than FFS members. Primaris advised them to update their policy and resubmit it. Home State Health updated their policy as follows: "for inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, Home State Health shall use the same criteria as MHD Fee-For-Service program. Services identified in MHD contract 2.7 will be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid." **Required Actions:** Primaris recommends Home State Health to submit their updated policy to MHD for approval.		
(ii) MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.	MO.UM.02 Clinical Decision Criteria and Application: Page3 of 6	Met

Findings: Home State Health may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. **Required Actions:** None.		
(iii) MCO is permitted to place appropriate limits on a service on the basis of criteria applied under the State plan, such as "medical necessity." The MCO will specify what constitutes "medically necessary services" in a manner that a service: • Prevents, diagnoses, or treats a physical or behavioral health condition or injury. • Is necessary for the member to achieve age appropriate growth and development. • Minimizes the progression of disability. • Is necessary for the member to attain, maintain, or regain functional capacity (MHD contract 2.7.8). • *Provides opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.	MO.UM.01 Program Description: Page 8 of 23 MO.UM.01.01 Covered Benefits and Services: Page 11 of 12 *N/A per MHD contract	Met
Findings: Home State Health considers a service as 'medically necessary' when it fulfils all the above listed criteria. **Required Actions:** None.		
(iv) MCO is permitted to place appropriate limits on a service for the purpose of utilization control, provided that— a. The services furnished can reasonably achieve their purpose, as required in A (i) of this evaluation tool.	MO.UM.01.01 Covered Benefits and Services: Pages 6, 7 of 12 MO.UM.01 Program Description: Page 8 of 23	Met

• *The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and • Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.		
Findings: As per Home State Health, a service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered. Medical necessity determinations are made by appropriate professionals and include decisions about covered medical benefits defined by Home State Health, including inpatient and outpatient services, as listed in the summary of benefits and care or services that could be considered either covered or non-covered, depending on the circumstances. Home State Health may make exceptions to covered service benefit limits as deemed appropriate to provide for medically necessary care as allowed under 13 CSR 70-2.100. Home State Health covers family planning services, as defined by the MO HealthNet Managed Care Policy Statements, provided by any qualified provider whether or not the provider is in-network. Referral/ authorization is not required if a member chooses to receive family planning services and supplies from outside the network. Family planning services are also exempt from any out-of-pocket costs for the member. Home State Health shall allow for full freedom of choice for the provision of these services. **Required Actions:** None.		
B. Authorization of services. (i) MCO is prohibited from requiring prior authorization for emergency medical/ behavioral health services as defined herein *(MHD contract 2.5.5a).*	MO.UM.01 Program Description: Pages 11, 18 of 23 MO.UM.05 Timeliness of UM Decisions and Notifications: Page 1 of 8	Met
Findings: Emergency medical/behavioral health or substance abuse services are available 24 hours/day 7days/week to treat an emergency medical condition. Prior authorization (PA) is not required for emergency services and coverage for such will be based on the severity of the symptoms at the time of presentation. Emergency services are covered		

inpatient and outpatient services furnished by a qualified practitioner that are needed to evaluate or stabilize an emergency medical condition. Home State Health will cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. During onsite review, Home State Health stated that the emergency services are auto-approved. **Required Actions:** None.		
(ii) Involuntary detentions (96 hour detentions or court ordered detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect *(MHD contract 2.5.5e 6).*	Provider Reference Manual: Page 35 of 75 MO.UM.07 Adverse Determination (Denial) Notices: Page 2 of 8	Met
Findings: Home State Health does not prior-authorize involuntary detentions and meets the above requirement from the MHD contract. During onsite review, Home State Health explained that an automatic authorization is created in their system for billing purpose only and there is no requirement of PA for involuntary/court ordered detentions. **Required Actions:** None.		
(iii) MCO policies, procedures and practices shall comply with The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), 45 CFR Parts 146 and 147, and the CMS Final rule on MHPAEA for Medicaid *(MHD contract 2.5.5 b).*	MO.UM.01 Program Description: Pages 19 of 23	Met
Findings: Home State Health complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) as it applies to its Medicaid Managed Care Organizations as described in section 1903(m) of the Social Security Act (the Act); Medicaid Alternative Benefit Plans (ABPs) as described in the Act; and Children's Health Insurance Programs (CHIP) under title XXI of the Act. The Company will ensure that any benefit limitations for mental health or substance use disorder (MH/SUD) benefits are comparable to those for medical/surgical benefits and will not impose less favorable benefit limitations on MH/SUD benefits compared to medical/surgical benefits, including with respect to annual and lifetime dollar limits, financial requirements, or treatment limitations. **Required Actions:** None.		
(iv) If the MCO requires a referral, assessment, or other requirement prior to the member accessing requested medical or behavioral health, such requirements shall not	MO.UM.05 Timeliness of UM Decisions and Notifications: Page 2 of 8	Met

be an impediment to the timely delivery of the medically necessary service. The MCO shall assist the member to make any necessary arrangements to fulfill such requirements (e.g. scheduling appointments, providing comprehensive lists of available providers, etc.). If such arrangements cannot be made timely, the requested services shall be approved *(MHD contract 2.5.5d)*		
Findings: Home State Health shall ensure that the member's treatment regimens are not interrupted or delayed (e.g. physical, occupational, and speech therapy, psychological counseling; home health services; personal care, etc.) by the prior authorization process. Home State Health shall assist the member to make any necessary arrangements to fulfill such requirements (e.g. scheduling appointments, providing comprehensive lists of available providers, etc.). If such arrangements cannot be made timely, the requested services shall be approved. During onsite review, Home State Health explained that if Home State Health decides that a member requires services from out of network provider, they have a "single provider agreement" to meet the member's needs of services. **Required Actions:** None.		
(v) For the processing of requests for initial and continuing authorizations of services, each MCO must have in place, and follow, written policies and procedures and practices that meet the following minimum requirements:	MO.UM.04 Appropriate UM professionals: Pages 1, 2 of 5 MO. UM.05 Timeliness of UM Decisions and Notifications: Page 2 of 8 MO.UM.02 Clinical Decision Criteria and Application: Pages 1, 2 of 6 MO.UM.01 Program Description: Pages 12, 15 of 23 MO.UM.07 Adverse Determination (Denial) Notices: Page 3 of 8	Met

• All appeals and denials must be reviewed by a professional who has appropriate clinical expertise in treating the member's condition or disease. • There is a set of written criteria for review based on sound medical evidence that is updated regularly and consistently applied and for consultations with the requesting provider when appropriate. • Reasons for decisions are clearly documented and assigned a prior authorization number which refers to and documents approvals and denials. • Documentation shall be maintained on any alternative service(s) approved in lieu of the original request. • There is a well-publicized review process for both providers and members (MHD contract 2.5.5e).		

Findings: Home State Health stated that qualified licensed health professionals, who are appropriately trained in the principles, procedures, and standards of utilization and medical necessity review, will conduct authorization and/or concurrent reviews utilizing generally accepted evidenced-based clinical criteria. All appeals and denials must be reviewed by a professional who has appropriate clinical expertise in treating the enrollee's condition or disease. The Medical Director is required to supervise all medical necessity decisions, conducts Level II medical necessity reviews and is the only UM staff member authorized to make a clinical denial based on medical necessity and sign denial letters. At any level, Authorization Nurses are prohibited from making adverse medical necessity determinations.

Evidence-based, nationally recognized clinical support tools are used to make decisions about medical necessity and prior authorization, e.g., Most recently available written/electronic version of McKesson's *InterQual Products,* Milliman Care Guidelines. For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, the Home State Health shall use LOCUS/CALOCUS. Centene's (Home State Health's parent company) clinical policy committee will determine clinical policy related to new and emerging technologies and new uses for existing technologies and these clinical

policies will be available to Medical Director(s) (see associated policy). Clinical policies are reviewed and updated at least annually by the committee. The date/time of receipt is documented for all requests. All requests for prior authorization/certification are assigned a prior authorization/certification number which refers to and documents associated approvals and denials. Upon any adverse determination for medical or behavioral health services made by the Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination will also be provided when applicable. All notifications will be provided within the timeframes as noted in the "timeliness of UM decisions and notifications" policy. The written notification will be easily understandable and will include the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. The Medical Director may approve an alternative to the service being requested. If the requesting provider and/or member do not agree to the alternative, the originally requested service may be denied. However, if the requesting provider and/or member agree(s) with the alternative and the care is authorized, the requesting provider has essentially withdrawn his or her initial request and this would not be considered a denial. **Required Actions:** None.		
(vi) The MCO will- • Consult with the requesting provider for medical services when appropriate. • *Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.	MO.UM.01 Program Description: Page 15 of 23	Met
Findings: Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. The Medical Director or appropriate practitioner reviewer (behavioral health practitioner, dentist, pharmacist, etc.) serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template. **Required Actions:** None.		
(vii) 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	MO.UM.04 Appropriate UM professionals: Page1 of 5 MO.UM.01 Program Description: Page 9 of 23	Met

made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.		
Findings: A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under Home State Health's medical benefits. Appropriate practitioners may include, but are not limited to physicians; behavioral health practitioners including psychiatrists, doctoral level clinical psychologists or certified addiction medicine specialists; chiropractors; and dentists. Two levels of utilization management (UM) medical necessity review are available for all authorization requests. A level I review is conducted on covered medical benefits by a Utilization Review Nurse who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. At no time shall a Level I review result in a reduction, denial, or termination of service. Adverse determinations can only be made by a Medical Director or qualified designee during a Level II review. **Required Actions:** None.		
(viii) MCO shall ensure that members are not without necessary medical supplies, oxygen, nutrition, etc., and shall have written procedures for making an interim supply of an item available *(MHD contract 2.5.5f).*	MO.UM.01 Program Description: Page 11 of 23 MO. UM.05 Timeliness of UM Decisions and Notifications: Page 2 of 8	Met
Findings: Home State Health shall ensure that members are not without necessary medical supplies, oxygen, nutrition, etc. and will follow established procedures to ensure that an interim supply of an item is made available while the authorization process is occurring. During onsite review, Home State Health explained that there is a 24 hours-Nurse triage line-phone call services, after hour services, in house one person to meet the interim needs of members. **Required Actions:** None.		
(ix) MCO shall ensure that the member's treatment regimens are not interrupted or delayed (e.g. physical, occupational, and speech therapy; psychological counseling; home health services; personal care, etc.) by the prior authorization process *(MHD contract 2.5.5g).*	MO. UM.05 Timeliness of UM Decisions and Notifications: Page 2 of 8	Met

Findings: Home State Health shall ensure that the member's treatment regimens are not interrupted or delayed (e.g. physical, occupational, and speech therapy, psychological counseling; home health services; personal care, etc.) by the prior authorization process. **Required Actions:** None.		
(x) MCO is responsible for payment of custom items (e.g. custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) that are delivered or placed within 6 months of approval, even if the member's enrollment with the MCO ends *(MHD contract 2.5.5h).*	MO. UM.05 Timeliness of UM Decisions and Notifications: Page 5 of 8	Met
Findings: Home State Health is responsible for payment of custom items (e.g. custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment or augmentative communications devices) that are delivered or placed within 6 months of approval, even if the member's enrollment with the MCO ends. **Required Actions:** None.		
(xi) If the MCO prior authorizes health care services, the MCO shall not subsequently retract its authorization after the services have been provided, or reduce payment for an item or service unless: • The authorization is based on material misrepresentation or omission about the treated person's health condition or the cause of the health condition. • MCO's contract terminates before the health care services are provided. • The covered person's coverage under the MCO terminates before the health care services are provided *(MHD contract 2.5.5i).*	MO. UM.05 Timeliness of UM Decisions and Notifications: Page 5 of 8	Met
Findings: Section E-Retraction of Approved Services, of the policy "timeliness of UM decisions and notifications" complies with the all listed contractual requirements for this section. **Required Actions:** None.		

(xii) MCO shall not deny physician requested continuing coverage of an inpatient hospital stay unless an alternative service is recommended by the MCO and such alternative care is available and has been scheduled within 7 days of discharge and is appropriate to meet the medical needs of the member *(MHD contract 2.5.5j).*	MO.UM.07 Adverse Determination (Denial)Notices: Page 3 of 8 MO.UM.01 Program Description: Page 15 of 23	Met
Findings: Home State Health will not deny physician requested continuing coverage of an inpatient hospital stay unless an alternative service is recommended by Home State Health and such alternative care is available and has been scheduled within 7 days of discharge and is appropriate to meet the medical needs of the member. The Medical Director may approve an alternative to the service being requested. **Required Actions:** None.		
C. Timeframe for authorization decisions. The review process is completed and communicated to the provider in a timely manner, as indicated below, or the denials shall be deemed approved. Each MCO must provide decisions and notices as follows *(MHD contract 2.5.5e 6):*		
(i) Approval or denial of non-emergency services, when determined as such by emergency room staff, shall be provided by the MCO within 30 minutes of request.	MO. UM.05 Timeliness of UM Decisions and Notifications: Page 1 of 8 MO.UM.07 Adverse Determination (Denial) Notices: Page 1 of 8	Met
Findings: There is no requirement of prior authorization for services provided in emergency room. All services provided by the emergency room staff are paid by Home State Health. **Required Actions:** None.		
(ii) Approval or denial shall be provided within 24 hours of request for services determined to be urgent by the treating provider.	MO. UM.05 Timeliness of UM Decisions and Notifications: Pages 1, 3 of 8 MO.UM.07 Adverse Determination (Denial) Notices: Page 1 of 8	Met

Findings: Determinations for urgent pre-service prior authorization requests are made within 24 hours of receipt of the request. **Required Actions:** None.		
(iii) Standard authorization decisions. a. Approval or denial shall be provided within 36 hours, which shall include 1 working day, of obtaining all necessary information for routine services. ("Necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.) b. MCO shall notify the requesting provider within 36 hours, which shall include one 1working day following the receipt of the request of service, regarding any additional information necessary to make a determination. c. MCO shall not exceed fourteen 14 calendar days following the receipt of the request of service to provide approval or denial with the possible extension of up to 14 additional calendar days if the enrollee or the provider requests extension or if the MCO justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest.	MO. UM.05 Timeliness of UM Decisions and Notifications: Pages 1, 2, 3 of 8 MO.UM.07 Adverse Determination (Denial) Notices: Page 2 of 8 MO.UM.01 Program Description: Page 15 of 23	Met
Findings: Determinations for non-urgent, routine prior authorization requests are made within 36 hours inclusive of one working day of receipt of necessary clinical information. If a determination cannot be made due to lack of necessary information, the UM designee will notify the requesting provider within 36 hours inclusive of one working day following the receipt of the request of service regarding any additional information necessary to make a determination. If additional information is received, a decision is made within two		

working days of receipt of the information. At no time shall the entire process exceed 14 calendar days from the original receipt of request. **Required Actions:** None.		
(iv) Expedited authorization decisions For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function: a. MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. b. The MCO may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.	MO. UM.05 Timeliness of UM Decisions and Notifications: Page 3 of 8	Met
Findings: Home State Health considers all expedited prior authorizations as "urgent pre-service decisions" which are made within 24 hours of receipt of request. The nurse reviewer provides written notification of all determinations by close of business on the day the determination is made. The nurse reviewer will also attempt to provide verbal notification to the requesting provider for any denial determination by close of business on the day the determination is made. If the determination results in a denial, reduction or termination of coverage, notification will include the right to a peer-to-peer discussion and/or appeal. A written or electronic notice of the decision, including the right to appeal and appeal process, is issued to the member and treating practitioner, and/or facility by close of business on the day the determination is made. During onsite review, Home State Health explained that when there is a need for additional information, Home State Health contacts the provider the same day. If the information is not present, then the expedited authorization is converted to standard authorization. **Required Actions:** None.		

D. Notice of adverse benefit determination. Each MCO must notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The enrollee's notice must meet the requirements of §438.404.	MO.UM.01 Program Description: Pages 15, 16 of 23 MO.QI.11 Member Grievance and Appeal System Description: Page 2 of 17 MO.UM.07 Adverse Benefit Determination: Page 4 of 8	Met
Findings: Upon any adverse determination for medical or behavioral health services made by the Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination will also be provided when applicable. All notifications will be provided within the timeframes as noted in the timeliness of UM decisions and notifications policy. The written notification will be easily understandable and will include the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. The notice is consistent with the requirements of 42 CFR 438.10, 438.404. **Required Actions:** None.		
E. Compensation for utilization management activities. Each contract between a State and MCO must provide that, consistent with §438.3(i), and 422.208 of 42 CFR chapter iv, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee *(MHD contract 2.18.8b).*	MO.UM.04 Appropriate UM Professionals: Page 4 of 5	Met
Findings: All individuals involved in UM decision making annually sign an 'Affirmative Statement about Incentives' acknowledging that UM decisions are based on appropriateness of care and existence of coverage. The organization does not reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. During onsite review, Home State Health indicated the UM decisions are not based on any form of compensation. **Required Actions:** None.		

Compliance Score-Coverage and Authorization of Services						
Total	Met	=	22	×2	=	44
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	44
Denominator	Total Sections	=	22	×2	=	44
Score %						**100%**

Appendix E

Subpart D Standard 5 – 42 CFR 438.214 Provider Selection		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO shall have written credentialing and re-credentialing policies and procedures: (i) For determining and assuring that all in-network providers are licensed by the State in which they practice and are qualified to perform their services. (ii) All network providers must be enrolled with MO HealthNet as a Medicaid provider as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b). (iii) For monitoring the in-network providers, reporting the results of the monitoring process, and disciplining in-network providers found to be out-of-compliance with the health plan's medical management standards. (iv) MCO shall use the Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180, as amended. (v) Following the effective date of the contract, the health plan shall provide the state agency with the Social Security Number of the providers *(MHD contract 2.18.8 c).*	CC.CRED.01 Practitioner Credentialing & Re-credentialing: Page 13, 21, 60, 61 of 95	Met
Findings: Home State Health' Practitioner Credentialing & Re-credentialing policy and procedures ensure the minimum verification elements needed for Provisional Credentialing: licensing, enrollment with MO HealthNet, monitoring and reporting, use of Universal Credentialing Data Source Form (UCDS), and providing the Social Security Number of the providers.		

During the onsite review, Primaris asked for the application form for the providers and confirmed that their policies matched practices. The Social Security Number field is included on the Credentialing application that is completed by network providers. **Required Actions:** None.		
B. MCO shall credential and re-credential all in-network providers listed within the contract. Provisionally licensed psychologists and provisionally licensed professional counselors are included in this requirement. The credentialing process shall not take longer than sixty (60) business days pursuant to RSMo 376.1578 *(MHD contract 2.18.8c 1).*	CC.CRED.01 Practitioner Credentialing & Recredentialing: Pages 1-5, 60 of 95	Met
Findings: The Home State Health may determine the need to occasionally make practitioners available to members prior to the completion of the entire initial credentialing process. The option for provisional credentialing is only available to practitioners who are applying for the first time to the MCO practitioner network. A practitioner may only be provisionally credentialed once and for a time-period no longer than 60 calendar days **Required Actions:** None.		
C. As part of re-credentialing, the MCO shall audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives *(MHD contract 2.18.8c 2).*	MO.CM.10 Advance Directives	Met
Findings: Home State Health will provide and/or ensure that network practitioners provide written information to all adult members receiving medical care with respect to their rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives and information regarding the implementation of such a directive by the MCO. Neither the MCO nor its providers will condition the authorization or provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. Home State Health will facilitate communications between a member or member's authorized representative and the member's provider if/when the need is identified to ensure that they are involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment. **Required Actions:** None.		

D. As part of credentialing and re-credentialing, the MCO shall collect from providers directly contracted with the MCO, full and complete information, as described herein, regarding ownership and control, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, CHIP, or any other Federal health care program, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1051. The MCO shall provide this information to the state agency in the format and frequency specified by the state agency in "Ownership or Controlling Interest Disclosure", "Transaction Disclosure", and "Provider and Subcontractor Disclosure" located and periodically updated on the MO HealthNet website at Health Plan Reporting Schedule and Templates *(MHD contract 2.18.8c 3).*	CC.CRED.01 Practitioner Credentialing & Recredentialing: Pages 9, 36, 38 of 95	Met
Findings: Home State Health is compliant with the above requirements as stated in their policy. Upon notification from the Corporate Compliance department of a verified exclusion status of an individual or entity with an ownership or controlling interest in the provider or a managing employee of the provider, Home State Health will initiate the appropriate actions specified in contract, up to and including termination of the contracting process or participation status. **Required Actions:** None.		
E. MCO shall collect the information from the provider and retain evidence of having done so to produce to the state agency upon request; or if the MCO has verifying documentation that the Missouri Medicaid Audit & Compliance (MMAC) has collected the required disclosures from the provider, then the health plan may utilize the collected disclosures from MMAC: • At the stage of provider credentialing and re-credentialing;	CC.CRED.01 Practitioner Credentialing & Re-credentialing: Pages 60, 61 of 95	Met

• Upon execution of the provider agreement; • Within 35 days of any change in ownership of the provider; and • At any time upon the request of the state agency for any or all of the information described in this section *(MHD contract 2.18.8c 3).*		
Findings: The procedures for Home State Health's Unique Requirements for Credentialing are listed in Attachment E of their Practitioner Credentialing & Recredentialing Policy and Procedure. Home State Health will notify the state agency of any denial of provider credentialing or re-credentialing in a timely manner and will report provider terminations as part of its quarterly fraud and abuse report following the State provided forms. Home State Health will initially submit Credentialing Policies & procedures to MO HealthNet for approval in compliance with section 2.18.8c, 2.18.8c5, 3.9, 3.9.6 of the contract and thereafter as changes are made. **Required Actions:** None.		
F. Per the subcontracting requirements specified herein, the MCO shall include provisions in its subcontracts for health care services notifying the provider or benefit management organization to provide the disclosures to the MCO. The MCO must retain evidence that it received the proper disclosures or documentation of the disclosures and produce the same for the State upon request and in accordance with prescribed timeframes *(MHD contract 2.18.8c 4).*	PPA Sample Participating Provider Agreement Professional: Page 6 of 25	Met
Findings: Home State Health's PPA Sample Participating Provider Agreement has a clause stating that the provider agrees to furnish to Health Plan complete and accurate information necessary to permit the MCO to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit MCO to comply with such requirements. **Required Actions:** None.		
G. MCO shall promptly notify the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing	CC.CRED.01 Practitioner Credentialing & Recredentialing: Pages 43 and 61 of 95	Met

process. This requirement is in addition to the requirement herein for the MCO to report provider terminations as part of its quarterly fraud, waste, and abuse report *(MHD contract 2.18.8c 5*).	CC.CRED.07 Practitioner Disciplinary Action and Reporting: Page 22 of 41	
Findings: Home State Health had also shown examples of their notifications to the state agency of denials of enrollment and provider terminations. The Credentialing committee notifies the MCO about the denials as soon as possible, after proceedings conclude. They shall also notify the state agency upon any denials or limitations for program integrity reasons. Home State Health Plan will notify the state agency of any denial of provider credentialing or re-credentialing in a timely manner and will report provider terminations as part of its quarterly fraud and abuse report following the State provided forms. **Required Actions:** None.		
H. As part of credentialing and re-credentialing, the MCO shall screen all health care service subcontractors to determine whether the subcontractor or any of its employees or subcontractors has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care program (as defined in Section 1128B (f) of the Act); has failed to renew license or certification registration; has revoked professional license or certification; or has been terminated by the state agency. The screening shall consist of, at a minimum, consulting the following databases on at least a monthly basis: the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS) and the National Plan and Provider Enumeration System (NPPES), located in the Missouri Professional Registration Boards website, and any such other State or Federal required databases. MCO shall deny/terminate credentialing or re-credentialing to any subcontractor that falls within this section *(MHD contract 2.18.8c 6).*	CC.CRED.01 Practitioner Credentialing & Recredentialing: Pages 19 (section E i), 21 (section A v) and 33 (section vii) of 95.	Met

Findings: The Home State Health Practitioner Credentialing & Recredentialing policy listed above meets all requirement listed in Section H. Their policy states that one of the minimum administrative requirements that must be met includes containing information that the practitioner has been excluded from participation in the federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. In addition, one of the minimum verification elements needed for Provisional Credentialing is Medicare/Medicaid-specific exclusions and that OIG LEIE will be queried through the Office of Inspector General's website. Finally, attestation elements are required to include history of loss or limitation of license and/or felony convictions. **Required Actions:** None.		
I. Claims and Payment System		
(i) Unless otherwise written in the subcontract, MCO shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to the MCO by the provider: a. Newly credentialed provider attached to a new contract within 10 business days after completing credentialing. b. Newly credentialed hospital or facility attached to a new contract within 15 business days after completing credentialing. c. Newly credentialed provider attached to an existing contract 5 business days after completing credentialing. d. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within 5 business days after completing re-credentialing. e. Change in existing contract terms within ten 10 business days of the effective date after the change. f. Changes in provider service location or demographic data or	CC.CRED.01 Practitioner Credentialing & Recredentialing: Pages 45, 60 of 95 CC.PDM.03 Practitioner Affiliation Start Date: Page 1 of 1	Met

other information related to member's access to services must be updated no later than 30 calendar days after the health plan receives updated provider information *(MHD contract 2.18.8c 7).*		
Findings: The Home State Health states that once credentialing is complete, Provider Data Management Department (PDM) performs a quality check and makes the provider "par" (i.e. participating) in the Provider Data Management system. Once made par, the record is fed to both the online directory, the call center system, the claims system, and the eligibility system for member cards and enrollment. **Required Actions:** None.		
(ii) Payment should be made on the next payment cycle following the requirement outlined in I (i) above. In no case shall a provider be loaded into the provider directory which cannot receive payment on the health plan's current payment cycle.	MO.PRVR.19 Provider Directory Updates: Pages 1, 2, 3 of 3 Reconciliation with Portico to Amisys: Page 1 of 1	Met
Findings: Home State Health has stated that once a provider is loaded as participating (PAR) within the claim adjudication and payment system, the provider's claims will process according to the provider's contract within the appropriate pay class configuration. **Required Actions:** None.		
J. Upon request by the state agency, the MCO shall provide a report demonstrating the following: • Compliance with the credentialing requirements herein including but not limited to the average number of days taken to complete credentialing by provider type, and the number of providers who were not credentialed according to the requirements by provider type; and • Compliance with the required timeframes for loading credentialed providers *(MHD contract 8.18.8c 8).*	Credentialing Update Dashboard Monthly Turn Around Time Reporting Provider Lifecycle Overview	Met

Findings: Home State Health has stated that they will be able to provide the state agency with a credentialing report upon request that meets the requirements outlined in J. During the onsite review, Primaris requested Home Sate Health to provide documentation in support of their statement. Home State Health submitted multiple documents (listed above) which do in fact support their compliance with section J. **Required Actions:** None.		
K. Nondiscrimination. MCO network 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.	MO.CONT.02 Network Selection and Retention: Page 2 of 6	Met
Findings: The Home State Health MO.CONT.02 Network Selection and Retention policy listed above meets the requirement listed in Section K by stating that Home State Health will ensure in-network providers do not intentionally segregate Home State Health members in any way from other patients receiving care in the provider's office. In addition, Home State Health will ensure in-network providers provide care without regard to the Home State Health member's race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status or physical or mental disability. Furthermore, as an in-network provider, the Home State Health contract template requires provider to abide by these requirements. **Required Actions:** None.		

Compliance Score – Provider Selection						
Total	Met	=	12	× 2	=	24
	Partial Met	=	0	× 1	=	0
	Not Met	=	0	× 0	=	0
Numerator	Score Obtained				=	24
Denominator	Total Sections	=	12	× 2	=	24
Score						**100%**

Appendix F

Subpart D Standard 6–42 CFR 438.224 Confidentiality		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO shall agree and understand that all discussions with the MCO and all information gained by the MCO as a result of the MCO's performance under the contract, including member information, medical records, data, and data elements established, collected, maintained, or used in the administration of the contract, shall be confidential and that no reports, documentation, or material prepared as required by the contract shall be released to the public without the prior written consent of the state agency *(MHD contract 3.16.1)*.	CC.COMP.28 Data Loss Prevention: Page 1 of 4 CC.COMP.00 Centene Business Ethics and Code of Conduct: Pages 22, 24 of 64 General Compliance Training 06.06.18: LG V004 CC.COMP.04 Confidentiality and Release of PHI: Page 5 of 27 MO.COMP.09 State Required Deliverables: Page 2 of 6	Met
Findings: It is the policy of Centene Corporation to protect and safeguard protected health information (PHI), personally identifiable information (PII), confidential company information, internal work product, and other sensitive data (collectively, "Confidential Data") by preventing or mitigating its disclosure to unauthorized external individuals, entities, and locations. Employees of the Corporation are prohibited from transmitting, or attempting to transmit, Confidential Data to any unauthorized location, including but not limited to, unauthorized external third party locations and non-business related or personal accounts. Whenever accessing or disclosing confidential personal or health information, employees must ensure that a legitimate business reason exists for the access or disclosure, that they share only the minimum amount of information necessary to achieve that business purpose, and that protected data is transmitted over a secure network. Disclosures will be made to a business associate with whom the corporation has executed a business associate agreement (or other written agreement containing business associate provisions) in which the Business Associate provides satisfactory assurances that the Business Associate will appropriately safeguard the protected health information disclosed. Home State Health agrees and understands that all discussions between Home State Health and MHD and all information gained by Home State Health as a result of the Home State Health's performance under the contract, including member information, medical records, data, and data elements established, collected, maintained, or used in the administration of the contract, shall be confidential and that no reports, documentation, or material prepared		

as required by the contract shall be released to the public without the prior written consent of MHD. During onsite review, Primaris brought to the attention of Home State Health that there is a need to add one statement to their policy "any release of information to public will be made only after written consent of state agency." Home State Health promptly responded to the recommendation by updating their policy (MO.COMP.09 State Required Deliverables) to incorporate that statement. **Required Actions:** Primaris recommends that Home State Health should send the updated policy to MHD for their approval.		
B. If required by the state agency, MCO and any required MCO personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request. Failure of MCO and any required personnel to sign such documents shall be considered a breach of contract and subject to the cancellation provisions of this document *(MHD contract 3.16.2).*	MO.COMP.09 State Required Deliverables: Page 1 of 6	Met
Findings: During onsite review, Primaris informed Home State Health to update their policy to reflect the section 3.16.2 from MHD contract. The Home State Health officials stated that they are in compliance with the above requirement in practice and would update their policy within the stipulated time. Primaris reviewed their updated policy and scored them-"met." **Required Actions:** Home State Health should obtain approval for the revised policy from MHD.		
C. MCO shall provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract. *(MHD contract 3.16.3, 2.23.3b).* Such safeguards shall include, but not be limited to: • Workforce training on the appropriate uses and disclosures of Protected Health Information pursuant to the terms of the contract. • Policies and procedures implemented by the MCO to prevent inappropriate uses and disclosures of Protected Health Information by	2018 Privacy and Confidentiality Training Centene Business Ethics and Code of Conduct: Pages 22, 24, 28 of 64 CC.COMP.04 Confidentiality and Release of PHI: Pages 9, 10 of 28 CC.SECR.13.2.C Communications Security Standard: Electronic Messaging: Page 1 of 3 CC.SECR.13.2.A Communications Security	Met

its workforce and subcontractors, if applicable. • Encryption of any portable device used to access or maintain Protected Health Information or use of equivalent safeguard. • Encryption of any transmission of electronic communication containing Protected Health Information or use of equivalent safeguard.	Standard - Physical and Electronic Info Transfer: Pages 1, 2 of 3 CC.SECR.18.1. A : Information Security Compliance Standard Legal and Contractual Requirements: Pages 1, 2 of 3	
Findings: Confidentiality and Security. Corporation employees are initially educated on standards of conduct in new employee orientation. The security end user policy, business ethics and conduct policy, and unacceptable activities address confidentiality and security topics and are covered in the employee handbook. Human Resources retain employee acknowledgement and commitment to follow Corporation policies. Annually thereafter, employees complete business ethics and conduct and security end user surveys. Access to Protected Health Information while on a computer or electronic device is strictly limited to Centene-issued and/or approved devices, systems, and applications, including internal Centene network email. The use of unauthorized computers or electronic devices to access, store, or transport PHI without prior approval is strictly prohibited. If Protected Health Information is being accessed or viewed via computer, a password-protected screen saver must be used when the work area is vacant or when a computer workstation is not in use. When Protected Health Information is maintained in electronic format, access to databases containing Protected Health Information shall be secured through IS programming and limited to those employees of the corporation having a need to access such Protected Health Information as part of their job functions. All electronic messages containing restricted or confidential data must be encrypted when sent through a public or private network. All electronic messaging systems must utilize encryption to ensure secure transmission of data to internal and external recipients. All electronic messaging system and services must be configured to use Transport Layer Security (TLS) or other means approved by management to encrypt messages. During onsite review, Home State Health stated that all portable device requires IT approval and are encrypted. **Required Actions:** None.		
D. MCO shall not disclose the contents of member information or records to anyone other than the state agency, the member or the member's legal guardian, or other parties with the	MO.COMP.28 Providing Member Medical Records to State Agency: Pages1, 3 of 3	Met

member's written consent *(MHD contract 3.16.4).*	CC.COMP.PRVC.28 Treating a Personal Representative of the Individual as the Individual: Pages 1, 2 of 3 CC.COMP.04 Confidentiality and Release of PHI: Page 7of 27	
Findings: Home State Health will make such medical records available to duly authorized representatives of the state agency and the United States Department of Health and Human Services to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed. The Health Plan Privacy Official or his/her designee in concurrence with the Vice President of Medical Affairs will obtain a signed authorization from all members before using or disclosing their protected health information for purposes other than treatment, payment, or health care operations. Permitted Uses and Disclosures. Corporation employees shall comply with written or verbal requests for written or verbal disclosure of Protected Health Information relating to a Member, whether from: • A law enforcement officer; • A government agency; • A legislative office; • An employer of one or more Members; • A State Agency; or any other third party who is not the Member or the Member's Personal Representative, only if such disclosure would constitute a Permitted Use or Disclosure under this Policy (CC.COMP.PRVC.38, CC.COMP.PRVC.36, CC.COMP.PRVC.49). Uses, Disclosures and Requests Involving the Entire Medical Record. With respect to all uses, disclosures, or requests for Protected Health Information, the Corporation may not use, disclose or request an entire medical record except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure, or request. If the use, disclosure, or request is for treatment purposes, the entire medical record is always justified as the reasonably necessary amount needed. **Required Actions:** None.		
E. MCO shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance and 42 CFR Part 2, as amended, regarding confidentiality of substance use	2018 Privacy and Confidentiality Training: Privacy and substance use disorders MO.COMP.PRVC.56 Managing Alcohol and	Met

disorder member records *(MHD contract 3.16.5).*	Substance Abuse Records: Page 1 of 4	
Findings: Home State Health will manage and disclose records in accordance with state laws and federal statutes and regulations governing the use and disclosure of alcohol and substance abuse treatment records. Records containing the identity, diagnosis, and/or treatment of drug and/or alcohol abuse information, which are received from or maintained by a Part 2 covered entity, are confidential and may be disclosed only under the circumstances expressly authorized by the individual. The authorization for the use or disclosure of sensitive health information form must be received by the MCO signed by the member or their authorized representative. Without prior written consent from the individual for whom the record exists, the content of any record may not be disclosed or re-disclosed for any purpose, including: care coordination; case management; or other treatment, payment, or health care operations related to activities such as discharge planning. **Required Actions:** None.		
F. MCO shall have written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records for adult and adolescent STDs and adolescent family planning services *(MHD contract 3.16.6).*	CC.COMP.PRVC.14 Authorization for the Use or Disclosure of Sensitive Health Information: Page 1, 3 of 7 CC.COMP.04 Confidentiality and Release of PHI: Page 1 of 27	Met
Findings: The above stated policies define the requirements for using or disclosing sensitive health information. Sensitive health information includes but is not limited to psychotherapy notes, mental health information, substance abuse information, and HIV/AIDS status. The Corporation will document and retain the signed authorization for a period of at least 10 years from the date of its creation or the date when it last was in effect, whichever is later. **Required Actions:** None.		
G. Each MCO uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.		
(i) MCO must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the	CC.COMP.00 Centene Business Ethics and Code of Conduct: page 24 of 64	Met

Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) (collectively HIPAA) and all regulations promulgated pursuant to authority granted therein. The MCO constitutes a "Business Associate" of the state agency *(MHD contract 2.38.1).*	Privacy and Confidentiality Training External Medicaid – HSH BAA Template 20181105: Page 1	
Findings: A number of regulations govern the access and exchange of personal and health information, such as the Health Insurance Portability and Accountability Act in the United States and the General Data Protection Regulation of the European Union. Centene is committed to complying with these and all other relevant data privacy laws and regulations to ensure we appropriately safeguard confidential information. Covered Entity and Business Associate agree as follows: The Health Insurance Portability and Accountability Act of 1996 (*HIPAA*), the Health Information Technology for Economic and Clinical Health Act (*HITECH*), and the implementing regulations thereunder, including but not limited to the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164 (the *Privacy Rule*) and the Security Standards for the Protection of Electronic Health Information at 45 C.F.R. Parts 160 and 164 (the *Security Rule*), and the requirements of the final modifications to the HIPAA Privacy Rule, Security, Rule, et al., issued on January 25, 2013 and effective March 26, 2013, as may be amended from time to time, shall collectively be referred to as the "*HIPAA Authorities*." **Required Actions:** None.		
(ii) The MCO agrees that the term Protected Health Information shall also be deemed to include Electronic Protected Health Information *(MHD contract 2.38.1).*	CC.COMP.PRVC.02 HIPAA Glossary: Page 17 of 22 External Medicaid – HSH BAA Template 20181105 Page 2 of 23	Met
Findings: Protected health information means individually identifiable health information that is transmitted by electronic media, maintained in any medium described in the definition of electronic media, or transmitted or maintained in any other form or medium. **Required Actions:** None.		
(iii) MCO may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1) and shall notify the state agency by no later than 10 calendar days after the MCO becomes aware of the disclosure of the Protected Health Information *(MHD contract 2.38.2c).*	External Medicaid – HSH BAA Template 20181105 page 6 of 23 CC.COMP.PRVC.36 Disclosing Protected Health Information for Health Oversight Release: Page 1 of 3	Met

	MO.COMP.PRVC.54 Reporting and Investigating HIPAA Violations: Page 2 of 4	
Findings: Business associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(l) and shall notify the state agency by no later than 10 calendar days after the business associate becomes aware of the disclosure of the PHI. Home State Heath may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings; except as otherwise stated in the policy and procedure (CC.COMP.PRVC.36). Home State Health's policy MO.COMP.PRVC.54: By no later than 5 calendar days after the compliance officer becomes aware of any unauthorized use or disclosure, security incident, or breach, the compliance officer shall provide the state agency's privacy or security officer with: (1) a description of the unauthorized use or disclosure, security incident, or breach; (2) the information compromised by the unauthorized use or disclosure, security incident, or breach; (3) any remedial action taken to mitigate any harmful effect of such unauthorized use or disclosure, security incident, or breach; and (4) a proposed written plan for approval that describes plans for preventing any such future incidents. **Required Actions:** None.		
(iv) If required to properly perform the contract and subject to the terms of the MHD contract, the MCO may use or disclose Protected Health Information, if necessary, for the proper management and administration of MCO's business *(MHD contract 2.38.2d).*	CC.COMP.04 Confidentiality and Release of PHI: Page 1, 2 External Medicaid – HSH BAA Template 20181105 Page 6 of 23	Met
Findings: It is the policy of the corporation to comply with provisions set forth in all governing contracts under which they operate, for all lines of business, and meet or exceed all requirements and timeframes outlined in those contracts. Compliance with all applicable laws is required by Home State Health with respect to all uses and disclosures of protected health information, confidential provider information, and confidential company information. In accordance with the terms of the Home State Health's contracts with state agencies and with all applicable laws, confidential provider information must be kept confidential and may only be released according to the peer review policy & procedure by Home State Health's employees having access to such information. **Required Actions:** None.		
(v) If the disclosure is required by law, the MCO may disclose Protected Health	CC.COMP.PRVC.34 Disclosing Protected Health	Met

Information to carry out the legal responsibilities of the MCO *(MHD contract 2.38.2e).*	Information as Required by Law	
Findings: Home State Health has the above policy which provides guidance and ensure compliance with all relevant laws and regulations when using or disclosing protected health information as required by law. If federal, state, and/or local law requires a use or disclosure of protected health information, the corporation may use or disclose protected health information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. Home State Health will refer to specific policies and procedures to determine whether or not the MCO must obtain authorization or give the member the opportunity to agree or object to use or disclose protected health information. In the event that two or more laws or regulations governing the same use or disclosure conflict, the corporation will comply with the more restrictive laws or regulations. **Required Actions:** None.		
(vi) If applicable, the MCO may use Protected Health Information to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B) *(MHD contract 2.38.2f).*	MO.COMP.28 Providing Member Medical Records to State Agency: Page 2 of 3 External Medicaid – HSH BAA Template 20181105: Page 6 of 23	Met
Findings: If applicable, Home State Health may use protected health information (PHI) to provide Data Aggregation services to the state agency as permitted by 45 C.F.R. 164.504(e)(2)(i)(B). During onsite review, Home State Health explained that usually MHD asks for a background information related to a complaint/inquiry by a member. Home State Health tracks all requests of PHI from MHD. Home State Health aggregates data and sends it to the MHD in the requested format. **Required Actions:** None.		
(vii) The MCO may not use Protected Health Information to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the state agency to do so *(MHD contract 2.38.2f).*	MO.COMP.28 Providing Member Medical Records to State Agency: Page 2 of 3 External Medicaid–HSH BAA Template 20181105: Page 6 of 23	Met
Findings: Home State Health my not use PHI to de-identify or re-identify the information in accordance with 45 C.F.R. 164.514(a)-(c) without specific written permission from the state agency to do so. **Required Actions:** None.		

(viii) The MCO agrees to make uses and disclosures and requests for Protected Health Information consistent with the state agency's minimum necessary policies and procedures. *(MHD contract 2.38.2g).*	External Medicaid – HSH BAA Template 20181105: Page 6 of 23 CC.COMP.PRVC.31 Disclosing and Requesting Only the Minimum Amount of Protected Health Information Necessary: Page 1 of 3 2018 Privacy and Confidentiality Training	Met
Findings: Except as otherwise limited in the Business Associate Agreement, business associate may use or disclose PHI to perform those functions, activities, or services that business associate performs for, or on behalf of, covered entity as specified in the services agreement, provided that such use or disclosure would not violate the privacy rule, or the policies and procedures of covered entity relating to the "Minimum Necessary Standard," if done by covered entity. Any such use or disclosure shall be limited to those reasons and those individuals as necessary to meet the business associate's obligations under the services agreement. **Required Actions:** None.		
(ix) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), the MCO shall require that any agent or subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the MCO agrees to the same restrictions, conditions, and requirements that apply to the MCO with respect to such information *(MHD contract 2.38.3d).*	External Medicaid–HSH BAA Template 20181105: Page 4 of 23 CC.COMP.PRVC.11 Assurances from Business Associates to Safeguard PHI: Page 3 of 10	Met
Findings: Prior to the date on which any subcontractor (including any affiliate that is a subcontractor) creates, receives, maintains, or transmits PHI on behalf of business associate in connection with business associate's obligations under the Services Agreement, Business Associate agrees to enter into a written agreement with any Subcontractor ("*Subcontractor Agreement*") to whom business associate provides PHI that requires them: (i) to comply with the same HIPAA Authorities that apply to Business Associate under the Agreement; and (ii) to comply with the same restrictions and conditions that apply to business associate through this Agreement with respect to such PHI. **Required Actions:** None.		
(x) In order to meet the requirements under 45 CFR 164.524, regarding an	MO.COMP.PRVC.17 Individual Rights Regarding	Met

individual's right of access, the contractor shall, within 5 calendar days following a state agency request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, provide the state agency access to the Protected Health Information in an individual's designated record set. If requested by the state agency, the contractor shall provide access to the Protected Health Information in a designated record set directly to the individual for whom such information relates *(MHD contract 2.38.3g).*	Protected Health Information: Granting Access to Inspect and Obtain a Copy: Page 3 of 6 External Medicaid–HSH BAA Template 20181105: Page 4 of 23	
Findings: In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, the health plan shall, within 5 calendar days following a state agency request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, provide the state agency access to the Protected Health Information in an individual's designated record set. However, if requested by the state agency, the health plan shall provide access to the PHI in a designated record set directly to the individual for whom such information relates. **Required Actions:** None.		
(xi) MCO shall report to the state agency's Privacy Officer any unauthorized use or disclosure of Protected Health Information not permitted or required as stated herein immediately upon becoming aware of such use or disclosure and shall take immediate action to stop the unauthorized use or disclosure. By no later than 5 calendar days after the MCO becomes aware of any such use or disclosure, the MCO shall provide the state agency's Privacy Officer with a written description of any remedial action taken to mitigate any harmful effect of such disclosure and a proposed written plan of action for approval that describes plans for preventing any such future	External Medicaid–HSH BAA Template 20181105: Page 3 of 23 MO.COMP.PRVC.54 Reporting and Investigating HIPAA Violations: Page 2 of 4	Met

unauthorized uses or disclosures *(MHD contract 2.38.3J)*		
Findings: Business associate agrees to mitigate, to the extent practicable, any harmful effect that is known to business associate of a use or disclosure of PHI by business associate in violation of the requirements of this Agreement or the HIPAA Authorities and shall take prompt steps to prevent the recurrence of any incident, including any action required by applicable federal and state laws and regulations. All such efforts will be subject to MCO's prior written approval. In the event of an incident, business associate shall promptly, but no less than 5 calendar days, develop and provide to covered entity a written correction action plan which describes the measures to be taken to halt and/or contain such Incident. The written correction action plan also shall describe the measures to prevent any such future incident. As soon as reasonably possible thereafter, in no case more than 5 calendar days following discovery of the incident, business associate shall provide covered entity with a written report which shall include but not be limited to: (i) the name, address, and telephone number of each individual whose information was involved if such information is maintained by business associate; (ii) the electronic address of any individual who has specified a preference of contact by electronic mail; (iii) a brief description of what happened, including the date(s) of the incident and the date(s) of the discovery of the incident; (iv) a description of the types of PHI involved in the incident (such as full name, Social Security Number, date of birth, home address, account number, or disability code) and whether the incident involved unsecured PHI; (v) the recommended steps individuals should take to protect themselves from potential harm resulting from the incident; (vi) a description of any remedial action taken to mitigate any harmful effect of such incident; and (vii) a proposed written plan of action for approval that describes plans for preventing any such future Incidents. During onsite review, it was clarified by Home State Health that no later than 5 days, they provide corrective actions to the State in case of "incident." **Required Actions:** It is recommended that Home State Health updates the duration of reporting corrective action to the state agency's privacy officer to "no greater than 5 days" instead of "no less than 5 days" in their Business Associate Agreement template.		
(xii) In order to meet the requirements under HIPAA and the regulations promulgated thereunder, the MCO shall keep and retain adequate, accurate, and complete records of the documentation required under these provisions for a minimum of 6 years as specified in 45 CFR Part 164 *(MHD contract 2.38.3m).*	CC.COMP.PRVC.01 HIPAA Policies and Record Retention: Page 1 of 4 External Medicaid–HSH BAA Template 20181105: Page 5 of 23	Met
Findings: The Corporate Privacy Officer will maintain documentation, in written or electronic form, of policies, procedures, communications, and other administrative documents for one additional year than required by 45 C.F.R. §164.530 (i) and (j), for a		

period of at least ten (10) years from the date of creation or the date when last in effect, whichever is later (See CC.LEGL.01 - Records Management). Business associate shall document such disclosures of PHI and information related to such disclosures. Such documentation shall be maintained with regard to all disclosures of PHI, except for those disclosures that are expressly exempted from the documentation requirement under the HIPAA Authorities (see, e.g., 45 C.F.R. §§ 164.502; 164.508; 164. 510; 164.512, etc.). Documentation required to be collected by the business associate under this section shall be retained for a minimum of six (6) years, unless otherwise provided under the HIPAA Authorities. **Required Actions:** None.		
(xiii)The MCO shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s) or subcontractor(s). The MCO shall reimburse the state agency for any and all actual and direct costs and/or losses, including those incurred under the civil penalties implemented by legal requirements, including but not limited to HIPAA as amended by the Health Information Technology for Economic and Clinical Health Act, and including reasonable attorney's fees, which may be imposed upon the state agency under legal requirements, including but not limited to HIPAA's Administrative Simplification Rules, arising from or in connection with the MCO's negligent or wrongful actions or inactions or violations of this Agreement *(MHD contract 2.38.3p).*	External Medicaid–HSH BAA Template 20181105: Page 6 of 23	Met
Findings: Indemnification. Each party (the "*Indemnitor*") shall indemnify and hold harmless the other party (the "*Indemnitee*") against, and reimburse such Indemnitee for, any expense, loss, damages, fees, costs, claims or liabilities of any kind arising out of or related to any actions asserted or threatened by a third party arising out of or related to the Indemnitor's acts and omissions associated with its obligations under this agreement or its use or disclosure of PHI or, when the Indemnitor is the business associate, the use of PHI by a subcontractor or affiliate of business associate. Such indemnification shall include, but not be limited to, the payment of all reasonable attorney fees associated with any such Action.		

The agreement does not mention about state agency specifically, but during onsite review, the Home State Health explained that this clause is applicable for the state agency (MHD). "Signatures" of Home State Health on their MHD contract, implies that Home State Health will abide by all clauses in the MHD contract.
Required Actions: None.

Compliance Score-Confidentiality						
Total	Met	=	19	×2	=	38
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	38
Denominator	Total Sections	=	19	×2	=	38
Score %						**100%**

Appendix G

Subpart D Standard 7–42 CFR 438.228 Grievance and Appeal Systems (MHD contract 2.15)		
Requirements and References	**Evidence/Documentation as submitted by the MCO**	**Score**
1. 42 CFR 438.400 Definitions. A. Adverse benefit determination means: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (ii) The reduction, suspension, or termination of a previously authorized service. (iii) The denial, in whole or in part, of payment for a service (Note: CMS has proposed revisions- that it applies to clean claims only.) (iv) The failure to provide services in a timely manner, as defined by the State (MHD contract: 2.15.1 a 4/2.5.3, 20CSR400-7.095). (v) The failure of an MCO to act within the timeframes provided in §438.408(b) (1) and (2) regarding the standard resolution of grievances and appeals. (vi) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b) (2) (ii), to obtain services outside the network. (vii) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.	MO.QI.11 Member Grievance and Appeal System Description: Page 15 of 17	Met
Finding: Home State Health meets the definition of Adverse benefit determination; however, 1A (v) above is stated as follows in their policy-"The failure of the MCO to act within the timeframes provided at Section 2.12.16. c. 22 of the contract regarding the standard resolution of grievances and appeals." Though Home State Health is in compliance with the definition given in the MHD contract, section 2.12.16 c 22 of the MHD contract does not mention the timeframes for standard resolution of grievances and appeals.		

Required Actions: Primaris recommends that Home State Health should work with MHD to replace section 2.12.16 c 22 by section 2.15.5 e and 2.15.6 m of MHD contract, which states the timeframes for resolution of grievances and appeals per 42 CFR 438.408(b) (1) and (2).		
B. Appeal means a review by an MCO of an adverse benefit determination.	MO.QI.11 Member Grievance and Appeal System Description: Page 15 of 17	Met
Findings: Home State Health meets the CFR requirement for this definition. **Required Actions:** None		
C. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may 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 regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.	MO.QI.11 Member Grievance and Appeal System Description: Page 15 of 17	Met
Findings: Home State Health complies with this definition. **Required Actions:** None.		
D. Grievance and appeal system means the processes the MCO implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.	MO.QI.11 Member Grievance and Appeal System Description: Page 16 of 17	Met
Findings: Home State Health complies with this definition. **Required Actions:** None.		
E. Inquiry- A request from a member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function but does not express dissatisfaction *(MHD contract 2.15.1f).*	MO.QI.11 Member Grievance and Appeal System Description: Page 16 of 17	Met
Findings: Home State Health complies with this definition. **Required Actions:** None.		

F. State Fair Hearing- The process set forth at *Section 2.12.16 c. 22 of the MHD contract* and in Subpart E of 42 CFR part 431.	MO.QI.11 Member Grievance and Appeal System Description: Page 16 of 17	Met
Findings: Home State Health complies with this definition. **Required Actions:** None.		
2. 42 CFR 438.402 General requirements. A. The grievance and appeal system. (i) Each MCO must have a grievance and appeal system in place for enrollees. (ii) The MCO shall distribute to members upon enrollment a flyer explaining the grievance and appeal system. (iii) The MCO shall probe inquiries so as to validate the possibility of any inquiry actually being a grievance or appeal. The health plan shall identify any inquiry pattern *(MHD contract 2.15.2).*	MO.QI.11 Member Grievance and Appeal System Description: Pages 2, 4, 5, 7 of 17 Centene Member and Provider Solutions: Work Process-Issues Grievance and Appeals Flyer HSH18415-71118	Met
Findings: Home State Health identifies which department will manage the member grievance system and then maintains procedures for the receipt and prompt internal resolution of all grievances, appeals, and State Fair Hearing processes that comply with all applicable state and federal laws. Home State Health refers all members who are dissatisfied with Home State Health or its subcontractors in any respect to contact the Member Services Department and, when applicable, the expression of dissatisfaction is forwarded to Home State Health's Grievance and Appeals Coordinator (GAC) to review. The content and substance of a grievance or appeal, including all clinical care aspects involved, are fully investigated and documented according to applicable statutory, regulatory, and contractual provisions and Home State Health's policies and procedures. Resolution and notification of such resolution is made as expeditiously as the member's condition warrants but no later than the timeframes as outlined per state or contractual requirements. Members are notified upon enrollment of the procedure for requesting, processing and resolving member grievances, appeals and State Fair Hearing. The notification is provided by a separate flyer and explains specific instructions about how to contact Home State Health's Member Services Department and identifies the GAC as the designated staff who process grievances, appeals and State Fair Hearing. The grievance system flyer shall be readily available in the member's primary language.		

All inquiries received by the Member Services Department are probed to validate the possibility of any inquiry actually being a grievance or appeal. The GAC may also be notified of a grievance and complete the appropriate form. During onsite review, Home State Health explained the process of probing inquiries. When the frontline staff at the call center is unable to resolve a query, it is captured in their system as grievance in OMNI and is sent to their Quality team. OMNI is the system which describes work process for Grievance or Appeals (Issues). Quality team audits calls at the call center- for Customer Service Requests (10 per month). **Required Actions:** None.		
B. Level of appeals. Each MCO may have only one level of appeal for enrollees.	MO.QI.11 Member Grievance and Appeal System Description: page 3 of 17-(4)	Met
Findings: Home State Health has one level of appeal. Home State Health provides information about the member's right to request an appeal of Home State Health's adverse benefit determination including information on exhausting its one level of appeal as described at 42 CFR 438.402(c). **Required Actions:** None.		
C. Authority to file. An enrollee may file a grievance and request an appeal with the MCO. If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State Fair Hearing, on behalf of an enrollee, with an exception that providers cannot request continuation of benefits as specified in 42 C.F.R. §438.420(b)(5).	MO.QI.11 Member Grievance and Appeal System Description Page 2 of 17-A2 Page 5 of 17-B1b Page 7 of 17-C1b	Met
Findings: Home State Health's policy states that a member, an authorized representative acting on the member's behalf, or a provider acting on behalf of the member and with the member's written consent, may file a grievance or an appeal, and may request a State Fair Hearing. During onsite review, Primaris remarked that the CFR requirement: "exception that providers cannot request continuation of benefits," was missing in the policy. Home State Heath updated their policy and submitted to the MHD for approval. **Required Actions:** None.		
D. Deemed exhaustion of appeals processes. In the case of an MCO that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's appeals process. The enrollee may initiate a State Fair Hearing.	MO.QI.11 Member Grievance and Appeal System Description: Page 13 of 17-3	Met

Findings: The policy states that if Home State Health fails to adhere to the notice and timing requirements under Section 2.12.16 c. 22 of the contract the member is deemed to have exhausted Home State Health's internal level of appeal and may initiate a State Fair Hearing. Though the Home State health has followed their MHD contract, this section quoted here does not mention the timing requirements. **Required Actions:** It is recommended that Home State Health works with MHD to update the section in the contract which has actual information about the timeframes for appeals.		
E. Timing for filing. An enrollee may file a grievance with the MCO at any time whereas an enrollee has 60 calendar days from the date of the adverse benefit determination notice, to file a request for an appeal to the MCO.	MO.QI.11 Member Grievance and Appeal System Description: Page 5 of 17-B1d Page 7 of 17-C1c	Met
Findings: Home State Health follows the timing for filing grievance and appeal as per the federal and state guidelines listed above. **Required Actions:** None.		
F. Procedure. (i) Grievance- The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with MCO. (ii) Appeal- The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. (Note: CMS has proposed to remove this requirement of written appeal.)	MO.QI.11 Member Grievance and Appeal System Description Page 5 of 17-B1b Page7,8 of 17-C1c	Met
Findings: Home State Health states that the member, member's authorized representative with the member's written consent, or provider acting on behalf of the member with the member's written consent, may file a grievance or appeal verbally or in writing. Verbal grievances and appeals are generally received by the Member Services Department through Home State Health's toll-free customer service line. Written grievances and appeals are received by mail, fax or email. **Required Actions:** None		
3. 42 CFR 438.404 Timely and adequate notice of adverse benefit determination. A. The notice must explain the following: (i) The adverse benefit determination the MCO has made or intends to make.	MO.QI.11 Member Grievance and Appeal System Description: Page 2, 3 of 17	Met

(ii) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (iii) The enrollee's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal described at §438.402(b) and the right to request a State Fair Hearing consistent with §438.402(c). (iv) The procedures for exercising the rights. (v) The circumstances under which an appeal process can be expedited and how to request it. (vi) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.		
Findings: Page 2, 3 of 17-A4a, of Home State Health's policy MO.QI.11 Member Grievance and Appeal System Description incorporates all the requirements from the CFR as stated above and Primaris confirmed the same while interviewing their officials during onsite review. **Required Actions:** None.		
B. Timing of notice. (MHD contract 2.15.4 c 1) (i) For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the date of adverse benefit determination. No later than the date of adverse benefit determination in case of • Beneficiary's death. • Withdrawal from services.	MO.UM.07 Adverse Determination (Denial) Notices: Page 5, 6 of 8	Met

• Unknown whereabouts-the post office returns MCO's mail directed to the member indicating no forwarding address. In cases of probable fraud-notice will be 5 days before the date of adverse benefit determination.		
Findings: The page numbers listed above from the policy provides an evidence that Home State Health meets the state contractual requirements listed above. **Required Actions:** None.		
(ii) For denial of payment, at the time of any action affecting the claim.	MO.UM.07 Adverse Determination (Denial) Notices: Page 6 of 8	Met
Findings: Home State Health may mail a notice no later than the date of action under the following circumstances: For denial of payment decisions that result in member liability at the time of any action affecting the claim. **Required Actions:** Primaris recommends replacing "date of action" with "date of adverse benefit determination," at all the places where applicable. The term "action" has been replaced by "adverse benefit determination" in the 2016 Managed Care Final Rules.		
(iii) For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d) (1). (Not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days.)	MO.UM.07 Adverse Determination (Denial) Notices: Pages 2, 6 of 8 MO.QI.11 Member Grievance and Appeal System Description: Page 12 of 17	Met
Findings: Home State Health follows the timeframe as specified above for denial and limiting standard service authorization requests in the state contract with an extension of 14 days (MHD contract 2.15.5F). **Required Actions:** None.		
(iv) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.	MO.UM.07 Adverse Determination (Denial) Notices Page 6 of 8-6	Met
Findings: Home State Health is in compliance with the above requirement from CFR. **Required Actions:** None.		
(v) For expedited service authorization decisions, within the timeframes specified in §438.210(d) (2) (No later than 72 hours after	MO.UM.07 Adverse Determination (Denial) Notices	Met

receipt of the request for service. May extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to the state agency upon request) a need for additional information and how the extension is in the enrollee's interest.	Pages 1, 2 of 8	
Findings: Home State Health adheres to the following timeframes for expedited service authorization decisions- Approval or denial of non-emergency services, when determined as such by emergency room staff, shall be provided by the health plan within 30 minutes of request. Approval or denial shall be provided within 24 hours of request for services determined to be urgent by the treating provider. Approval or denial shall be provided within 36 hours, inclusive of one (1) working day, of receipt of obtaining all necessary clinical information for routine services. Home State Health shall notify the requesting provider within 36 hours, inclusive of 1 working day, following the receipt of the request of service regarding any additional clinical information necessary to make a determination. In no case shall the MCO exceed 14 calendar days following the receipt of the request of service to provide approval or denial. **Required Actions:** None.		
(vi) If the MCO meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must— a. 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 b. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	MO.UM.07 Adverse Determination (Denial) Notices Page 2 of 8 MO.UM.05 Timeliness of UM decisions and Notifications: Pages 2, 3 of 8	Met
Findings: Determinations for non-urgent, routine prior authorization requests are made within 36 hours inclusive of one working day of receipt of necessary clinical information. In no case shall Home State Health exceed 14 calendar days following receipt of the request of service to provide approval or denial. **Required Actions:** None.		
4. 42 CFR 438.406 Handling of grievances and appeals.	MO.QI.11 Member Grievance and Appeal System Description	Met

A. General requirements. The MCO must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	Page 2 of 17-A3 Page 8 of 17-4	
Findings: Home State Health gives members reasonable assistance in completing forms and taking other procedural steps of the member grievance and appeal system including, but not limited to, auxiliary aides and services, such as providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD, American Sign Language, and interpreter capability. During onsite review, Home State Health stated that their call center representatives help the members fill out the forms. The members may provide the required information verbally. **Required Actions:** None.		
B. Special requirements. The MCO's process for handling enrollee grievances and appeals of adverse benefit determinations must:		
(i) a. Acknowledge receipt of each grievance and appeal. The MCO shall acknowledge receipt of each grievance and appeal in writing within 10 business days after receiving a grievance. *(MHD contract 2.15.5c, 2.15.6k).* b. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution. (CMS has proposed to eliminate the requirement of confirmation in "writing.")	MO.QI.11 Member Grievance and Appeal System Description: Page 6 of 17-2a Page 8 of 17-d Page 9 of 17-2b Page 7, 8 of 17-Cc (1)	Met
Findings: Acknowledgement of member grievances is sent in writing by the GAC within 10 business days of receipt of the grievance. Home State Health acknowledges all oral and written Standard Appeals in writing within 10 business days of the receipt of a request for an appeal. Expedited Appeals acknowledgement occurs at the same time the resolution is determined. The member may call in to the Member Services Department through HSH's toll-free customer service line. All inquiries received by the Member Services Department are		

probed to validate the possibility of any inquiry actually being a grievance or appeal. The GAC is notified of the appeal and obtains the information from the member relations documentation system and/or documents the information in the clinical documentation system. As stated earlier, all the grievance and appeals are entered in a system-OMNI-so that all inquiries are tracked. **Required Actions:** None.		
(ii) Ensure that the individuals who make decisions on grievances and appeals are individuals— a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	MO.QI.11 Member Grievance and Appeal System Description: Page 1 of 17 Page 6 of 17-4c Page 8 of 17-f	Met
Findings: Home State Health involves individuals who fulfill all the above conditions while making decisions on grievances and appeals. **Required Actions:** None.		
(iii) Provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in 42 CFR 438.408 (b) and (c) in case of expedited resolution.	MO.QI.11 Member Grievance and Appeal System Description Page 3 of 17-7	Met

Findings: Home State Health provides the member a reasonable opportunity, verbally and in writing, to present evidence, testimony, and make legal and factual arguments. Home State Health informs the member of the limited time available in advance of the resolution timeframe for grievances and appeals and in the case of expedited resolution. **Required Actions:** None.		
(iv) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals specified in 42 CFR 438.408.	MO.QI.11 Member Grievance and Appeal System Description Page 4 of 17-8 Page 8 of 17-e	Met
Findings: Home State Health provides the member and his or her representative, free of charge and in advance of the resolution timeframe for grievance and/or appeals: the member's case file, medical records involved, other documents and records, and any new or additional evidence used in the case. **Required Actions:** None.		
(v) Include, as parties to the appeal— a. The enrollee and his or her representative; or b. The legal representative of a deceased enrollee's estate.	MO.QI.11 Member Grievance and Appeal System Description Page 7 of 17-Cb	Met
Findings: The member, member's authorized representative with the member's written consent, provider acting on behalf of the member with the member's written consent, or the legal representative of a deceased member's estate may file an appeal in Home State Health. **Required Actions:** None.		
5. 42 CFR 438.408 Resolution and notification: Grievances and appeals. A. Specific Time Frames. The MCO must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not	MO.QI.11 Member Grievance and Appeal System Description: Page 7 of 17-6b Page 9 of 17-2d (1) Page 11 of 17-f (1)	Met

exceed the timeframes as specified in this section: (i) Standard resolution of grievances. May not exceed 90 calendar days from the day the MCO receives the grievance. The MCO shall resolve each grievance and provide written notice of the resolution of the grievance, as expeditiously as the member's health condition requires but shall not exceed thirty 30 calendar days of the filing date *(MHD contract 2.15.5 e).* (ii) Standard resolution of appeals. No longer than 30 calendar days from the day the MCO receives the appeal. This timeframe may be extended as stated below. (iii) Expedited resolution of appeals. No longer than 72 hours after the MCO receives the appeal. This timeframe may be extended as stated below.		
Findings: Home State Health notifies the member of the grievance resolution as soon as possible after the resolution determination not to exceed the total resolution timeframe of 30 calendar days for a standard grievance. The resolution of the standard appeal is completed within 30 calendar days and the resolution of the expedited appeal is completed within 72 hours of receipt of the expedited appeal request. **Required Actions:** None.		
B. Extension of timeframes. (i) The MCO may extend the timeframes by up to 14 calendar days if: a. The enrollee requests the extension; or b. The MCO 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.	MO.QI.11 Member Grievance and Appeal System Description Page 12 of 17-D1	Met
Findings: Home State Health may extend the timeframe for disposition of a grievance or resolution of an appeal for up to 14 calendar days if the above criteria a. and b. are met. **Required Actions:** None.		

(ii) Requirements following extension. If the MCO extends the timeframes not at the request of the enrollee, it must complete all of the following: a. Make reasonable efforts to give the enrollee prompt oral notice of the delay. b. Within 2 calendar days 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. c. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	MO.QI.11 Member Grievance and Appeal System Description Page 12 of 17-Db(1)	Met
Findings: Home State Health complies with the requirements listed in (ii) a, b, c above if the time frames are extended not at the request of enrollee. **Required Actions:** None.		
C. Format of notice. (i) The MCO will use an established method by the State to notify an enrollee of the resolution of a grievance. (ii) For all appeals, the MCO must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10. For an appeal for expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	MO.QI.11 Member Grievance and Appeal System Description Page7 of 17-6b Page 9 of 17-2d (2) Page 11 of 17-f (2)	Met
Findings: Home State Health notifies the member of the grievance resolution. It is in an easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. It includes any information required by the state that relates to Home State Health's notice of grievance resolution determination. An appeal resolution letter for a standard appeal is sent out as soon as possible after the resolution determination, within the timeframe. For expedited appeal, once a resolution is made, the member is called to discuss the resolution decision. A notice of appeal resolution letter (which also documents the acknowledgement) is sent out after calling the member to confirm the conversation of the resolution decision.		

The member-specific Notice of Appeal Resolution Letter is attached in the member's clinical documentation system utilized at Home State Health. **Required Actions:** None.		
D. Content of notice of appeal resolution. The written notice of the resolution must include the following: (i) The results of the resolution process and the date it was completed. (ii) For appeals not resolved wholly in favor of the enrollees— a. The right to request a State Fair Hearing, and how to do so. b. The right to request and receive benefits while the hearing is pending, and how to make the request. c. That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's adverse benefit determination.	MO.QI.11 Member Grievance and Appeal System Description Page 9 of 17-2d (3) Page 11 of 17-f (4),(5)	Met
Findings: An appeal resolution letter for a standard appeal/expedited appeal is sent out as soon as possible after the resolution determination is made within the given time frames. The written notice of resolution includes the results of the resolution process, the date it was completed and further appeal rights, if applicable. For the appeals not resolved wholly in the favor of enrollees, all requirements listed under D (ii) a, b, c are followed by Home State Health. **Required Actions:** None.		
E. Requirements for State Fair Hearings. (i) An enrollee may request a State Fair Hearing: a. After receiving a notice that the MCO is upholding the adverse benefit determination. b. If deemed to have exhausted the MCO's appeals processes. c. No later than 120 calendar days from the date of the MCO's notice of resolution. The parties would include the MCO as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.	MO.QI.11 Member Grievance and Appeal System Description Page 13 of 17-3a Page 13 of 17-2b	Met

Findings: A member may request a State Fair Hearing, no later than 120 calendar days, from the date an adverse benefit determination is upheld through Home State Health's internal level of appeal and not resolved wholly in favor of the member. If Home State Health fails to adhere to the notice and timing requirements under Section 2.12.16 c. 22 of the contract the member is deemed to have exhausted Home State Health's internal level of appeal and may initiate a State Fair Hearing. The parties to State Fair Hearing include Home State Health, as well as the member, his/her representative, or the legal representative of a deceased member's estate. **Required Actions:** Though Home State Health has followed the federal and state requirements, it is recommended to replace the section 2.12.16c.22 with the correct ones as this section does not include the timing requirements for resolution of appeals.		
(ii) External medical review. The state may offer and arrange for an external medical review if the following conditions are met. a. The review must be at the enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing. b. The review must be independent of both the State and MCO. c. The review must be offered without any cost to the enrollee. d. The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.		Not Applicable for MCO
Findings: N/A **Required Actions:**		
6. 42 CFR 438.410 Expedited resolution of appeals. A. General rule. The MCO must establish and maintain an expedited review process for appeals, when the MCO 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, physical or mental health, or ability to attain, maintain, or regain maximum function.	MO.QI.11 Member Grievance and Appeal System Description Page 10 of 17-3a	Met

Findings: Home State Health shall establish and maintain an expedited review process for appeals when Home State Health determines (for a request from the member) or the provider indicates (in making the request on the member's behalf) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. **Required Actions:** None.		
B. Punitive action. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	MO.QI.11 Member Grievance and Appeal System Description Page 5 of 17-13 Page 10 of 17-3a	Met
Findings: Home State Health assures that no punitive action is taken against a provider or member who files a grievance or appeal, requests an expedited appeal on behalf of a member, or supports a member's grievance, appeal, or request for an expedited appeal. **Required Actions:** None.		
C. Action following denial of a request for expedited resolution: (i) Transfer the appeal to the timeframe for standard resolution. (ii) Follow the requirements for extension as stated in 5B (ii) of this evaluation tool or 42 CFR 438.408 (c) (2).	MO.QI.11 Member Grievance and Appeal System Description Page 10 of 17-3e Page 12 of 17-Db(1)	Met
Findings: If Home State Health denies a request for an expedited appeal, the appeal is automatically transferred to the standard timeframe. A reasonable attempt is made to provide oral notification of the expedited request denial and followed up with written notice within 2 calendar days. The enrollee is informed of the right to file a grievance if he or she disagrees with that decision. Home State Health resolves the appeal or grievance as expeditiously as the member's health condition requires and no later than the date the extension expires **Required Actions:** None.		

7. 42 CFR 438.414 Information about the grievance and appeal system to providers and subcontractors must be provided to them at the time they enter into a contract with the MCO. This should be as per 42 CFR 438.10 (g) (2) (xi) which references the Subpart F of 42 CFR 438. The information to out-of-network providers shall be distributed by the MCO within 10 calendar days of prior approval of a service or the date of receipt of a claim whichever is earlier *(MHD contract 2.15.2 f).*	MO.QI.11 Member Grievance and Appeal System Description Page 4 of 17-9a Single Case Agreement Template: http://www.homestatehealth.com/providers/	Met
Findings: Home State Health provides a copy of the provider manual to all providers/subcontractors at the time Home State Health enters into agreements with said providers/subcontractors, and to out-of-network providers within 10 calendar days of prior approval of a service or the date of receipt of a claim, whichever is earlier. During onsite review, Home State Health stated that they have a single case agreement with the out of network provider which has the link to the Home State Health website. This website has all the information required for the out-of-network providers. **Required Actions:** None.		
8. 42 CFR 438.416 Recordkeeping requirements. A. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. The MCO shall submit the log sheets for all inquiries, grievances, and appeals to the state agency monthly and upon request. If the MCO does not have a separate log for MHD Managed Care members, the log shall distinguish MO HealthNet Managed Care members from other health plan members *(2.15.3 MHD contract).*	MO.QI.11 Member Grievance and Appeal System Description: Page 4 of 17-10 MO HSH December CGA Member_C MO HSH January CGA Member Clos MO HSH January CGA Member Ope MO HSH November CGA Member_C MO. HSH December CG&A Member	Met
Findings: Home State Health maintains a record/log of all open and closed grievances and appeals and submits to the state agency monthly and upon request. The log will be specific to Home State Members; entries in the log will not be intermingled with entries of members from Home State Health's other lines of business. Effective July 01, 2018 MHD requires the MCO to submit a log of their closed and open grievance and appeal cases on a monthly basis in a prescribed format. The format of log is found in http://dss.mo.gov/business-processes/managed-care/health-plan-reporting-schedules-templates/.		

Primaris has reviewed a sample of the logs. The screenshot above (Excel documents) is provided for reference. **Required Actions:** None.		
B. The record of each grievance or appeal must contain, at a minimum, all of the following information: (i) A general description of the reason for the appeal or grievance. (ii) The date received. (iii)The date of each review or, if applicable, review meeting. (iv) Resolution at each level of the appeal or grievance, if applicable. (v) Date of resolution at each level, if applicable. (vi) Name of the covered person for whom the appeal or grievance was filed.	MO.QI.11 Member Grievance and Appeal System Description Page 4 of 17-10, 12	Met
Findings: Home State Health provides the state agency with a monthly report of the grievances and appeals in accordance with the requirements outlined in the contract to include, but not be limited to: member's name and MO HealthNet (Medicaid) number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with member identifying information are redacted and available for public inspection. **Required Actions:** None.		
C. MCO shall retain member grievance and appeal records for a period of no less than ten (10) years. (MHD contract 2.15.3f).	MO.QI.11 Member Grievance and Appeal System Description: Page 5 of 17	Met
Findings: Home State Health maintains records of all grievances and appeals. A copy of grievance logs and records of disposition of appeals will be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later. **Required Actions:** None.		
9. 42 CFR 438.420 Continuation of benefits while the MCO appeal and the State Fair Hearing are pending. A. Timely files means the enrollee files for continuation of benefits on or before the later of the following:	MO.QI.11 Member Grievance and Appeal System Description: Page 7 of 17-C1b Page 13 of 17-3b Page 14 of 17-F1a	Met

(i) Within 10 calendar days of the MCO sending the notice of adverse benefit determination. (ii) The intended effective date of the MCO's proposed adverse benefit determination.		
Findings: Home State Health will continue the member's benefits if the member files the appeal in a timely manner, meaning on or before the later of the following: • Within 10 calendar days of the date on Home State Health's adverse benefit determination notice; or • The intended effective date of HSH's proposed adverse benefit determination. The request must be submitted within 10 calendar days of the date of Home State Health's notice of appeal resolution notice, if the member wishes to have continuation of benefits during the State Fair Hearing. **Required Actions:** None.		
B. Continuation of benefits. The MCO must continue the enrollee's benefits if all of the following occur: (i) The enrollee files the request for an appeal timely in accordance with §438.402(c) (1) (ii) and (c) (2) (ii). (ii) The appeal involves the termination, suspension, or reduction of previously authorized services. (iii) The services were ordered by an authorized provider. (iv) The period covered by the original authorization has not expired. (v) The enrollee timely files for continuation of benefits.	MO.QI.11 Member Grievance and Appeal System Description: Page 14 of 17	Met
Findings: Home State Health meets all the requirements listed above for continuation of benefits. This is stated on page14 of the policy on member grievance and appeal system and confirmed during onsite review, interview process. **Required Actions:** None.		
C. Duration of continued or reinstated benefits. If the MCO continues or reinstates the enrollee's benefits while the appeal or State Fair Hearing is pending, the benefits must be continued until one of following occurs: (i) The enrollee withdraws the appeal or request for State Fair Hearing.	MO.QI.11 Member Grievance and Appeal System Description: Page 14 of 17-(F2)	Met

(ii) The enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the MCO sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2). (iii) A State Fair Hearing office issues a hearing decision adverse to the enrollee.		
Findings: If Home State Health continues or reinstates the member's benefits while the appeal is pending, Home State Health will continue providing the benefits until one of the following occurs: • The member withdraws the request for an appeal or State Fair Hearing. • Ten (10) calendar days pass after Home State Health mails the notice providing the resolution of the appeal against the member, unless the member, within the ten (10) calendar day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached. • The State Fair Hearing officer renders a decision that is adverse to the member. **Required Actions:** None.		
D. If the final resolution of the appeal or State Fair Hearing is adverse to the enrollee, that is, upholds the MCO's adverse benefit determination, the MCO may recover the cost of services furnished to the enrollee while the appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section (42 CFR438.420).	MO.QI.11 Member Grievance and Appeal System Description: Page 14 of 17-(F3)	Met
Findings: If the final resolution of the State Fair Hearing is adverse to the member, Home State Health may recover the costs of the services furnished to the member while the State Fair Hearing was pending, to the extent that the services were furnished solely because of the requirement to continue benefits during the appeal. **Required Actions:** None.		
10. 42 CFR 438.424 Effectuation of reversed appeal resolutions. A. Services not furnished while the appeal is pending. If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no	MO.QI.11 Member Grievance and Appeal System Description: Page 14 of 17-(F4)	Met

later than 72 hours from the date it receives notice reversing the determination.		
Findings: If services were not furnished while the State Fair Hearing was pending, and the State Fair Hearing resolution reverses Home State Health's decision to deny, limit or delay services, Home State Health must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. **Required Actions:** None.		
B. Services furnished while the appeal is pending. If the MCO 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, the MCO or the State must pay for those services, in accordance with State policy and regulations.	MO.QI.11 Member Grievance and Appeal System Description: Page 15 of 17-(F5)	Met
Findings: If services were furnished while the State Fair Hearing was pending, and the State Fair Hearing resolution reverses Home State Health's decision to deny, limit or delay services, Home State Health will pay for disputed services in accordance with state policy and regulations. **Required Actions:** None.		

Compliance Score- Grievance and Appeal System						
Total	Met	=	44	×2	=	88
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	88
Denominator	Total Sections	=	44	×2	=	88
Score						**100%**