Primaris
Healthcare Business Solutions

2019 External Quality Review
Compliance

missouricare
A WellCare Company

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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.

Missouri Care 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.

Missouri Care'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 Missouri Care:

Table 1: 42 CFR 438 Subpart D-MCO, PIHP and PAHP Standards

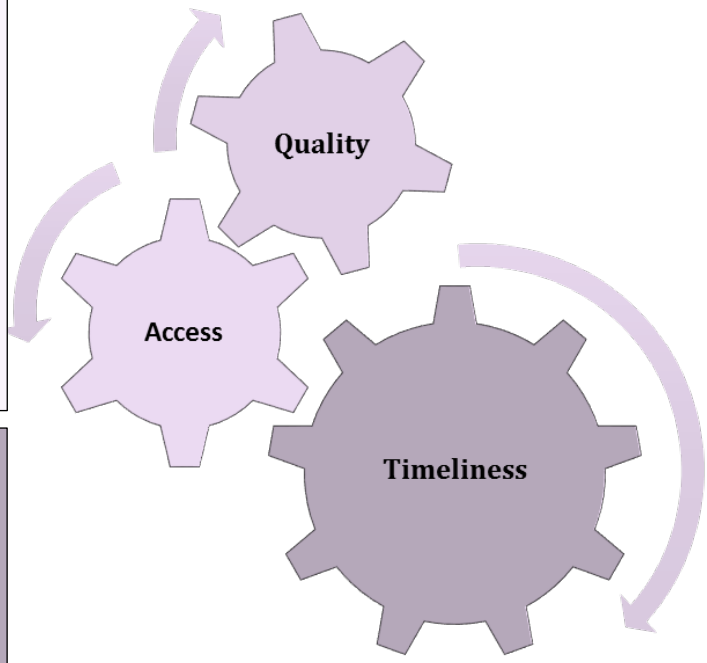
- §438.206 Availability of services
- §438.207 Assurances of adequate capacity and services
- §438.208 Coordination and continuity of care
- §438.210 Coverage and authorization of services
- §438.214 Provider selection
- §438.224 Confidentiality
- §438.228 Grievance and appeal systems

The overall goal of the compliance with regulations review is to quantify Missouri Care'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 Missouri Care regarding compliance with state and federal guidelines. Primaris collaborated with Missouri Care 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 Missouri Care towards continuous improvement and excellence.

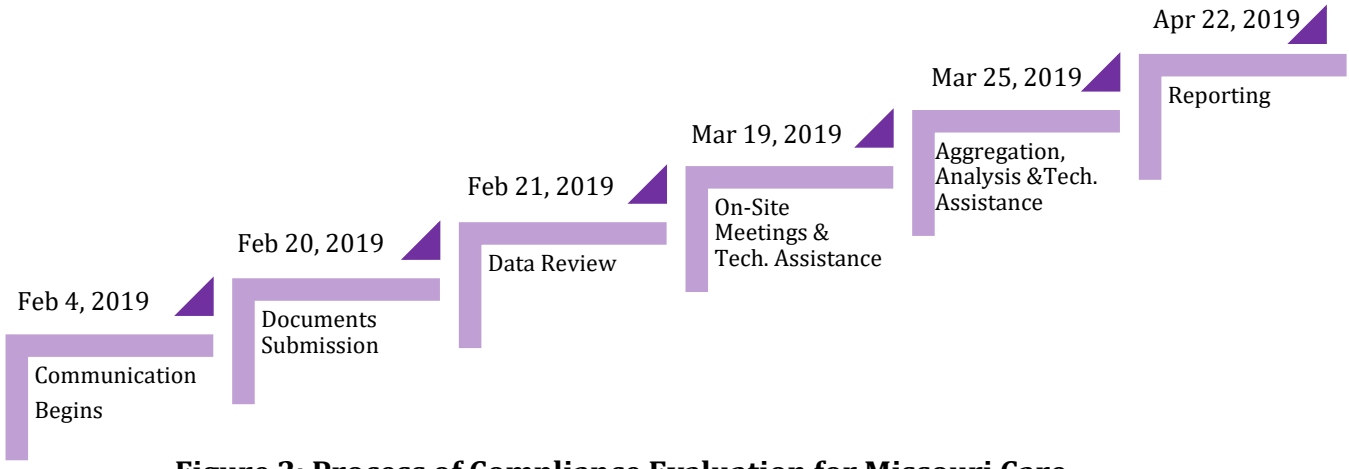


Figure 2: Process of Compliance Evaluation for Missouri Care

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

Missouri Care 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 development, monitoring and management policy; network review; accessibility and availability of health care policy; provider manual; round 1 results from 2018 quarterly appointment audit surveys; quality improvement work plan; network dashboard; single case agreement process; accessibility of services review; member handbook; second opinion policy; cultural needs assessment; executive summary accessibility of services; member communications; and site inspection evaluation survey tool.
- Assurances of adequate capacity and services: claim payments for school based dental services; network access plan; network dashboard; network review; Missouri hospital by county; network quality improvement work plan; network access plan approval; intent to terminate - capital region medical center & capital region medical group; and network development, monitoring and management policy.
- Coordination and continuity of care: transition of care form; care management introduction; insurance identification card; case management welcome letter; Eliza outreach program guide; Eliza program welcome letter with member card; quick start guide; Eliza program overview document; maternity screening; transition of care contact; transition of care from member handbook; transition of care policy; transition of care procedure; transition of care step process; transition of care verbiage from provider manual; primary care provider responsibility to maintain

medical records; privacy in care coordination; addendum regarding health homes; health home contact list; health home primary care provider care gaps; case management annual draft regarding risk stratification and case identification; case management annual evaluation draft 2018 regarding special needs; direct access to specialists provider manual; foster care stratified foster roster; special needs policy; and special needs procedure.

- Coverage and authorization of services: covered services; prior authorization; direct access and standing referrals; concurrent review inpatient; and adverse determinations-proposed actions.
- Provider selection: credentialing and re-credentialing policy; credentialing & re-credentialing procedure; corrective action policy; assessment of organizational providers policy; assessment of organizational providers procedure; Medicare/Medicaid eligibility federal and state sanctions and opt-out policy; reporting adverse actions national practitioner data bank and state agencies policy; ongoing monitoring of providers policy; ongoing monitoring of providers procedure; nondiscrimination policy; Missouri provisional behavioral health providers; quality of care monitoring corrective action; provider load TAT report; and secure provider terminations due to no provider enrollment.
- Confidentiality: HIPPA use and disclosure of protected health information (PHI) standard; HIPPA records and safeguards standard; HIPPA training standard; HIPPA privacy policy; incident response plan standard; HIPPA business associate agreement standard; and HIPPA handbook procedure.
- Grievance and appeal systems: member appeals; member complaints and grievances; adverse determinations-proposed actions; extension of time for appeal resolution; notice of adverse benefit determination; provider complaints and appeals; Excel sheets-logs for member issues (closed and open cases); fax cover sheet-provider authorization approval; illiterate members-cannot read or write; and member flyer.

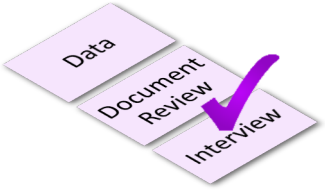


Figure 3: Sources of Information from Missouri Care

On-Site Review Information

An on-site review was performed at Missouri Care office in St. Louis, Missouri, on March 19, 2019. The following personnel from Missouri Care were available for an interactive session on 'Compliance with Regulations':

- Russell Oppenborn, Senior Director, Regulatory Affairs
- Tanesha Simmons, Field Regulatory and Compliance Specialist
- Mark Kapp, Senior Director, Quality Improvement
- Claudia Douds, Vice President, Health Services
- Rhonda Brown, Director, Behavioral Health Services
- Walt Johnson,Manager, Provider Operations
- Karen Brobeck, Director Provider Relations
- Robyn Grier, Senior Manager Field Health Services
- Andrea Gordon, Manager, Network Management
- Megan Reuter, Manager, Appeals and Grievances
- Leslie Chiles, Senior Manager, Clinical Care
- Valda John, Project Manager
- Katrina Davis, Project Manager
- Sharon Noel, Clinical Program Development Manager
- Scott Zinna - Director, Privacy & Info Governance, Compliance Privacy & Info Security

Table 2: MCO Information	
MCO Name:	Missouri Care
MCO Location:	4205 Philips Farm Rd, Suite 100, Columbia, MO 65201
On-site Location:	800 Market Street, 27th Floor, St. Louis, MO 63101
Audit Contact:	Russell Oppenborn Senior Director, State Regulatory Affairs
Contact Email:	Russell.Oppenborn@wellcare.com

Compliance Ratings

The information provided by Missouri Care 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 Missouri Care 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. Missouri Care achieved an overall score of 96.6%.
- Missouri Care is put on a corrective action plan for one standard, "42 CFR 438.224 confidentiality."
- During the previous year (EQR 2018), Missouri Care was not put on a corrective action plan which required a review this year.

Strengths

Missouri Care has a member population of about 242,000 (data: end of March, SFY 2019)

which is 38.44% of the total member population (MO Medicaid Managed Care and CHIP combined). Missouri Care has a Quality Improvement (QI) program that includes the objective and systematic monitoring of the quality, appropriateness, accessibility, and availability of health care and services provided to eligible MO HealthNet members.
Member Engagement: Missouri Care has a multi-touch approach to impact members' quality care, such as educating members on preventive services and mailing reminders. In addition, members are called through their Preventive Services Outreach program to educate them on HEDIS services due and assist them in scheduling appointments via a 3-way call with provider offices. The members are rewarded for taking personal responsibility of their health. Missouri Care's Healthy Rewards Program aims at improving members' quality care, preventive health services, wellness, and engagement milestones.
Provider Engagement: In CY 2018, Missouri Care expanded their Quality Practice Advisors (QPA) to 6 employees. QPA, provider relations representatives and the chief medical officer (CMO) visited high-volume provider offices. During visits, the CMO provided consultations and educated providers on opportunities to improve quality care. The providers were educated on HEDIS coding, distributed HEDIS toolkits, and reviewed medical records to identify care gaps. In addition, Missouri Care hired its first Patient Care Advocate (PCA) with a goal of adding 2 PCA's in CY 2019. PCA's will be embed in provider offices to help encourage members with HEDIS care gaps to come in for care. In CY 2018, Missouri Care also enhanced its provider incentive program and offered them to PCPs and Behavioral Health providers. PCP Incentive Program Providers had an opportunity to earn a Bonus for closing gaps for the selected HEDIS measures.
In order to ensure that Missouri Care's member's cultural and linguistic needs are adequately addressed, they assess the following factors annually:

- Member demographics
- Member translation line usage
- Member usage of in-office interpreter services
- Provider network demographics
- Member grievances relate to age, race, gender, or language
- CAHPS member survey feedback related to communication with Health Care Providers and Customer Service

While there were no reported member grievances associated with segregation or discrimination, the plan tracks and trends issues such as these as a part of their quality assurance program. Providers with repeat grievances against them or quality concerns may be subject to peer review, education, and internal audits.

Missouri Care's adherence to MHD contract, knowledge of the staff during onsite visit, team work, well written documents, policies and procedures, prompt response to the technical assistance have led to a high compliance score.

Figure 4: Strengths of Missouri Care

Table 4: Summary of Evaluation Missouri Care: 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	13	3	3	**29**	**76**
§438.228	Grievance and appeal systems	44	44	0	0	**88**	**100**
Total	**7**	**135**				**261**	**96.6%**

Compliance Score % (combined for all seven) = Total Score X100 = 100%
Total Sections X 2 points

Areas Requiring Corrective Action

Missouri Care is put on a corrective action plan for "42 CFR 438.224 Confidentiality." The details are provided in the section 3.7.

3.2 Regulation I- Availability of Services

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

3.2.1 Performance Strengths

Missouri Care has dedicated many resources and time towards the evaluation of their provider self-reported appointment surveys. They have identified barriers with non-compliant providers and have established mitigating factors. Such factors include the ability for members to access urgent care centers without referral or prior authorization requirements and a nurse advice and crisis line available to members 24/7. Missouri Care provides an eclectic service that meets all travel distance requirements, appointment standards, and scope of its network. In regard to the cultural competency, they have provided multiple polices and examples of their due diligence with the requirements of the standard. In addition, they provide assistance and documentation in multiple languages representing all languages of their members.

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

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

3.3.1 Performance Strengths

Missouri Care has demonstrated a wide range of preventive, primary care, and specialty services that are adequate for the number of enrollees in their network.
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

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

3.4.1 Performance Strengths

Missouri Care has a wide range of policies, procedures, and member and provider materials demonstrating outstanding programs and services which ensured that they address all aspects of coordination and continuity of care, e.g., transition of care requirements, communicating with the transferring/receiving MCO, allowing pregnant women to receive services without prior authorization. In addition, special needs cases are identified, and risk stratified for care coordination and case management.

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

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

3.5.1Performance Strengths

Missouri Care provides covered services according to the MO HealthNet Managed Care Contract, Section 2.7. The MCO complies with all state and federal laws pertaining to the provision of such services. Missouri Care's prior authorization function monitors the use of designated services before the services are delivered in order to confirm that they are: provided at an appropriate level of care and place of service; included in the defined benefits, and are appropriate, timely, and cost-effective; coordinated as necessary with Medical Management, Behavioral Health Care Departments or functions, and information is communicated to applicable operations areas (e.g., Finance) or per contractual requirement with external vendors; and accurately documented in order to facilitate accurate and timely reimbursement.

Missouri Care's services are supported by policies and procedures that meet requirements that promote the access of prior authorization services 24 hours a day, 7 days a week via telephonic, electronic and/or web-based systems.

3.5.2 Areas Requiring Corrective Action

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

3.6 Regulation V-Provider Selection

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

3.6.1 Performance Strengths

Missouri Care's credentialing and re-credentialing policies and procedures for selecting, monitoring, and maintaining a robust selection of providers meet the requirement in this standard. Furthermore, Missouri Care 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. Missouri Care also concurrently monitors credentialing and reporting of their providers as required.

3.6.2 Areas Requiring Corrective Action

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

3.7 Regulation VI-Confidentiality

Missouri Care was evaluated for 19 criteria and achieved a compliance score of 76%. They were assigned: "Met" for 13; "Partially Met" for 3; and "Not Met" for 3 of the19 criteria. (Appendix F).

3.7.1Performance Strengths

Missouri Care manages Protected Health Information (PHI) as per Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITEC) which mandates protecting the integrity, confidentiality and availability of PHI regardless of how it is created or maintained including oral, written, and electronic forms. This standard is administered by the compliance department through the activities of the privacy officer and is intended to serve as a foundation for the privacy practices of WellCare (Missouri Care's parent company). Each associate is required to complete a HIPPA training program within 30 days of being hired and annually thereafter. When WellCare's HIPAA Compliance Program is modified, the privacy officer or designee will provide HIPAA training to those associates whose jobs are affected by such modifications.

3.7.2 Areas Requiring Corrective Action

A corrective action plan is raised for the noncompliance criteria (Partially Met/Not Met, as detailed in appendix F).

The policies/documentation submitted by Missouri care did not meet the following criteria:

- Release of PHI to public will be only after prior written consent to the state agency (MHD contract 3.16.1).
- 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 (MHD contract 3.16.2).
- 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) (MHD contract 2.38.2c).
- 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).
- 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).
- 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) (MHD contract 2.38.3p).

3.8 Regulation VII- Grievance and Appeal System

Missouri Care was evaluated for 44 criteria and scored “Met” for all of them resulting in 100% compliance (Appendix G).

3.8.1 Performance Strengths

Missouri Care has a Grievance and Appeal System for members that meets all statutory and regulatory requirements in 42 CFR § 438 Subpart F as controlling law. The Grievance and Appeal System includes a Grievance and Appeal Process and access to the State Fair Hearing (SFH). The member grievances and appeals are acknowledged and addressed within the specified timeframes, in a manner that supports an equitable outcome and processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural grievance by the member. Member inquiries are monitored and addressed so as to validate the possibility of any inquiry actually being a grievance or

appeal and to identify inquiry patterns. Missouri Care have policies that promote member education regarding grievance rights; facilitate the identification and resolution of issues that impact quality of care and services; provide for accurate maintenance of required documentation; and ensure compliance with reporting 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 Missouri Care.

Table 5: Key Findings and Audit Results for Missouri Care

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	Concerns identified, CAP raised	13/19	Not Met
438.228 Grievance and appeal systems	No concerns identified	44/44	Met

Missouri Care must identify, for each criteria that requires a corrective action, the interventions it plans to implement to achieve compliance with the requirement, including how the MCO will measure the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities.
MHD, in consultation with Primaris, will review, and when deemed sufficient, approve Missouri Care's CAP to ensure the CAP sufficiently addresses the interventions needed to bring performance into compliance with the requirements.

5.0 Conclusions

5.1 Issues

A few weaknesses were noted after reviewing the policies/documents of Missouri Care. Grievance and Appeal System: Some of the policies contain outdated information based on 2015 Managed Care Rule (old CFR), for example:

- MO 29 HS UM 002 Notice of action, page 4 of 12: The term "action" is used in place of "adverse benefit determination."
- PA fax provider authorization approval, page 3 of 4: A member may request a State Fair Hearing within 90 calendar days from the health plan's notice of action.

5.2 Quality, Timeliness, and Access to Healthcare Services

Missouri Care has a detailed and well thought-out process to evaluate timely access of services. Missouri Care demonstrated their procedure to Primaris during the onsite visit. Telephone surveys are conducted in a set of 2 rounds quarterly, by their contracted vendor. The various scripts address family practices, internal medicine, general practices, pediatrician practices, obstetrics and gynecology practices, oncology practices, behavioral health providers, and high-volume specialists (including ophthalmology, cardiology, general surgery, dermatology, neurology, orthopedic surgery, and ENT).
The following are evaluated:

- Provider Appointment Compliance Survey Results
- Review of Member Grievances Related to Provider Accessibility & Availability
- Member Services Telephone Accessibility
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) member survey feedback on experience with Getting Needed Care and Getting Care Quickly.

In order to mitigate issues with accessibility, Missouri Care offers a Nurse Advice Line and BH Crisis Line available to members all the time. Members may also access urgent care centers without referral or prior authorization requirements. At the same time, Provider Relations will continue to educate providers on the accessibility requirements.
Missouri Care's QI Program was considered effective for the CY 2018:

- Complaints, Grievances and Appeals department reviewed and resolved all grievances within the contractual timeframes.
- A total of 1,450 new applicants were presented to the WellCare Credentialing Committee. Credentialing applicants were processed within 13 calendar days.
- Customer service average speed of answer for member calls during 2018 was 12 seconds, which exceeded the goal of < 30 seconds. The Average Abandonment Rate

for member calls was 0.57%, which exceeded the goal metric of less than or equal to 5%.

- 50% decrease in the volume of member PCP change requests related to Auto Assigned PCP. One of the factors driving this decrease was a new CY 2018 process to use claims data to identify cases where a member was receiving care from a PCP other than their auto assigned PCP and to update the member's PCP of record in those cases.
- Converted Electronic Medical Records (EMR) transfer process to Electronic Supplemental Data (ESD) process to better capture provider's quality data (ESD/EMR increased to 40% of membership).

5.3 Improvement by Missouri Care

- Missouri Care's compliance with federal and state rules and regulations for EQR 2019 (CY 2018) is 96.6%. This is a drop by 3.4% from previous year (CY 2017).

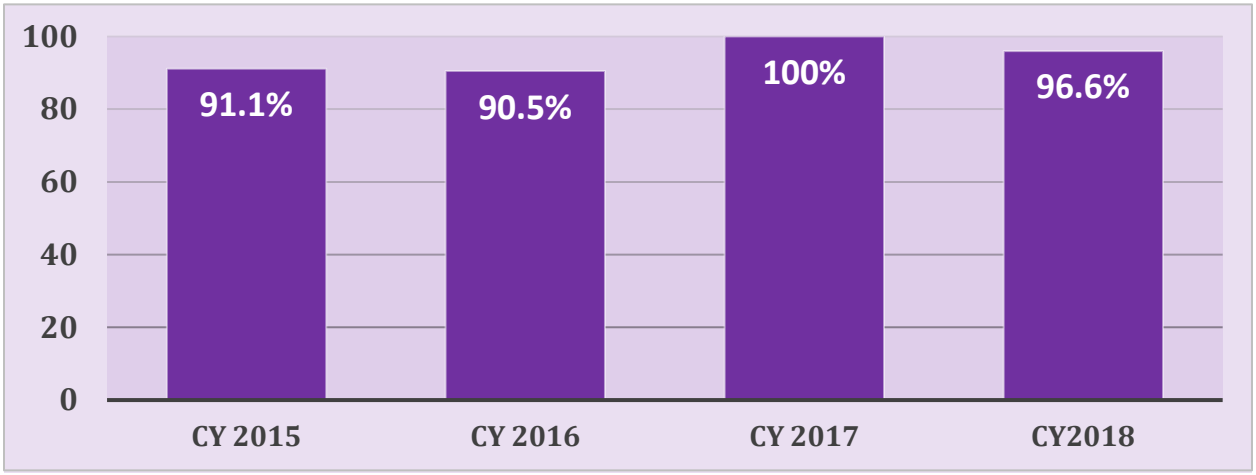


Figure 5: Compliance Score Trend CY 2015-CY 2018 (%)

- 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 438.238(c) (3) (iii), date of applicability, July 01, 2017)."
  Missouri Care was recommended to work with MHD to align audit rights and related record retention expectations to the 10 years duration in all the delegated subcontractor contracts.

The documents submitted by Missouri Care reflected the "right to audit" from 5-10 years duration, at various places in their documents. These documents have not been updated consistently to reflect 10 years in all the subcontractors' agreement, pending amendment in MHD contract.

6.0 Recommendations

Missouri Care

- Primaris recommends that all 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.
- Missouri Care should update all of their subcontractors' agreement with the "right to audit" as per 42 CFR 438.230(c) (3) (iii), consistently. (Date of applicability: July 1, 2017).
- Missouri Care should have state specific (MO) policies, tailored to meet the requirements of MHD contract.
- While Missouri Care has many examples of their compliance readily available upon request, Primaris recommends that for every practice performed, there should be a written procedure or policy which accompanies their statements/narratives.

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 Missouri Care 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 Missouri Care 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 Missouri Care 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 subcontractor's 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).*	MO29-HS-PR-004: Pages 3, 4 of 9 MO29-HS-PR-002: Page 2 of 7 Network Review	Met
Findings: Missouri Care has adopted the statutory travel distance standards pursuant to 20 CSR 400-7.095. Upon enrollment, each member is assigned to a Primary Care Provider (PCP) no further than 10, 20, or 30 miles from his/her place of residence, depending on whether the county of residence is classified by the Department of Insurance, Financial Institutions, and Professional Registration (DIFP) as urban, basic, or rural, respectively. For providers not addressed under 20 CSR 400-7.095 Missouri Care shall ensure members have access to those providers within 60 miles. For those providers addressed under 20 CSR 400-7.095 but not applicable to the MO HealthNet Managed Care Program (e.g. chiropractors), the MCO shall not be held accountable for the travel distance standards for those providers. Missouri Care members are not restricted in PCP choice according to travel distance. A member has the option to choose a provider that is located further than the DIFP standard from his/her place of residence. Members have the option of utilizing the		

services of any provider within the Missouri Care Provider Network regardless of distance. A member may utilize the services of any emergency facility or hospital in a life-threatening emergent situation, regardless of distance. On a monthly basis, Network Integrity produces, and Missouri Care reviews a Geo-Access report of its contracted network. The report is analyzed with respect to the statutory travel distance standards and the MCO contract requirements for access to specific health care specialties and services. The results of these analyses are shared with the Director of Provider Relations and the Vice President of Network Management so that any apparent deficiencies can be investigated and addressed as appropriate in a timely manner. **Required Actions:** None.		
(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).*	MO29-HS-PR-002: Page 2 of 7 Provider Manual: Pages 21, 22 of 108 Round 1 Results	Met

Findings: Missouri Care has established policies and procedures to verify that emergency medical/behavioral health services are available 24 hours per day, 7 days per week to treat an emergency medical condition and to verify and monitor the adequacy of provider's appointment processes. Waiting times for appointments are not to exceed 1 hour from scheduled appointment time. Providers must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the member's needs. Missouri Care monitors providers against these standards to ensure members can obtain needed health services for specified appointment types within acceptable in-office wait times. Providers not in compliance with these standards will be required to implement corrective actions set forth by Missouri Care. A grid with visit type, appointment type, and access standard is included with their policy and provider manual. Missouri Care submitted the results of their surveys detailing the performance of their providers' adherence to this standard. **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.	Network Dashboard Provider Manual: Pages 30, 37, 84, 85, 91,92 of 108 MO29-HS-PR-004: Page 3 of 9	Met
Findings: Missouri Care will monitor geographic access through the production of Geo-Access reports and maps; annually identify and prioritize opportunities; implement interventions on a least one opportunity and measure the effectives of the interventions, if applicable; to improve access to Non-behavioral and Behavioral Health Services. **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	MO29-HS-PR-002: Page 6 of 7 MO29-UM-PR-0019: Pages 1-3 of 3 Provider Manual: Pages 56, 57 of 108	Met

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).*		
Findings: A second medical opinion may be requested in any situation where there is a question related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions. A second opinion may be requested by any member of the healthcare team, including a Member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility. The second opinion must be provided by a qualified healthcare professional within the network, or Missouri Care shall arrange for the Member to obtain one outside the network if there is not a participating Provider with the expertise required for the condition. The second opinion shall be provided at no cost to the Member. Certain elective surgical procedures, pursuant to Missouri Law require a second medical opinion be provided prior to 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. **Required Actions:** None.		
(iii) If the provider network is unable to provide necessary services, covered under the contract, to a 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.	SCA Process: Slide 6 of 9 MO29-PR-002: Page 6 of 7	Met
Findings: Missouri Care has provided a process flowsheet and policy detailing steps taken in the event an in-network option is not available. Missouri Care will work with the out of network provider to obtain a single case agreement. **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	MO29-PR-002: Page 6 of 7 SCA Process: Slide 6 of 9	Met

would be if the services were furnished within the network.		
Findings: Missouri Care ensures compliance with out-of-network payment coordination as detailed above. Missouri Care Member(s) may be referred to an out-of-network provider when Missouri Care does not have a health care provider with appropriate training or experience in the network to meet the particular health care needs of the member and/or in instances where access to an in-network provider cannot be assured without unreasonable delay. **Required Actions:** None.		
C. Furnishing of services: (i) Timely access. Each MCO must do the following: 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. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. Establish mechanisms to ensure compliance by network providers. Monitor network providers regularly to determine compliance. Take corrective action if there is a failure to comply by a network provider.	MO29-HS-PR-002: All pages 7 of 7	Met
Findings: Providers are required to establish timely access based on the requirements in this section. Compliance and monitoring are done by surveys. Performance on these surveys are later reviewed and any providers who fail, have to provide evidence of corrective action and compliance post intervention. Missouri Care will provide coverage to members on a 24 hour per day, 7 day per week basis. The members and providers can contact Missouri Care to receive individual instruction or authorization for treatment of an emergent or urgent medical, behavioral health or substance abuse problem and instruction regarding receiving care when the member is out of the Missouri Care geographic service area. Missouri Care will provide for direct contact with qualified clinical staff through a toll-free number or provider services telephone number and a telecommunication device for the deaf telephone number. Missouri Care will provide an accommodation, if needed, to verify all members' equal access to twenty-four hour per day health care coverage.		

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).*	MO29-HS-PR-002: Page 4 of 7 MO29-UM-PR-0019: All 3 pages Provider Manual; Pages 30-32, 42, 46, 84, 87, and 90-94 of 108	Met
Findings: Annually, Missouri Care assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. During this assessment, Missouri Care: Identifies language needs and cultural background of members, such as prevalent languages and cultural groups, using U.S. Census data, enrollment data and member feedback and complaint data; Identifies languages of practitioners in provider network and assesses whether they meet members' language needs and cultural preferences; and Takes action to adjust the practitioner network if the current practitioner network does not meet members' language needs and cultural preferences. **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.	Provider Manual: Page 80 of 108	Met
Findings: Site Inspection Evaluations (SIEs) are conducted in accordance with federal, state and accreditation requirements. Focusing on quality, safety and accessibility, performance standards and thresholds have been established for: Office-site criteria: physical accessibility; physical appearance; and adequacy of waiting room and examination room space Medical/treatment record keeping criteria Evidence that the health plan has determined that the following documents are posted in the Provider's waiting room/reception area: office hours; and member rights and responsibilities. **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).*	Member Handbook: Pages 24, 27 of 96	Met
Findings: According to Missouri Care's Member Handbook, Missouri Care does not require a referral as long as an enrollee's PCP makes arrangements and prior authorization is given (when appropriate). The Member Handbook also states that members can choose an OBGYN as a PCP if they wish. **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.	Member Handbook: Pages 60-64 of 96 Member Communications: All Pages 8 of 8	Met

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).*		
Findings: All newly enrolled members will receive a Member Handbook within 10 business days of receiving the notice of enrollment from Missouri Care. Missouri Care will mail all newly enrolled Members a Member Handbook via U.S. Postal Service. Missouri Care shall develop appropriate methods for communicating with visual and hearing impaired members and accommodating the physically disabled. Missouri Care shall offer members standard materials, such as the member handbook and enrollment materials in alternative formats (i.e., large print, Braille, cassette, and diskette) immediately upon request from members with sensory impairments. Missouri care also provides all information on their website and have methods of obtaining information and contacting via email. **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					22
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).*	MO29-HS-PR-004: Page 2 of 9	Met
Findings: Missouri Care's MO29-HS-PR-004 policy lists all types of 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 in the MHD contract 2.4.1a. **Required Actions:** None.		
(ii) Behavioral Health Providers. To ensure a broad range of treatment options are available, the MCO shall	2019 Exhibit C - Missouri Care: Sheet "CMHC" Network Dashboard	Met

include in its network a mix of mental health and substance use disorder treatment providers with experience 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).*	Network Review	
Findings: Missouri Care provides a broad range of treatment options. Mental health and substance use disorder treatment providers have an experience in treating children, adolescents, and adults. The submitted documents list Qualified Behavioral Healthcare Professionals (QBHP), certified substance use disorder and 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. Missouri Care has also ensured, by providing examples, that if there is not a CMHC in a given county, they contract with a CMHC within 30 miles of a county where Missouri Care has coverage. Missouri Care contracts to meet the intent of the access standards set forth in the plan contract and to ensure the timely and convenient availability of necessary services for their members. **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 30 miles of a county where the health plan has coverage for members *(MHD contract 2.4.9).*	Exhibit C-Missouri Care. Sheets "IRHC" and "PBRHC"	Met
Findings: Missouri Care's documents show compliance with the requirements. They have listed all Federally Qualified Health Centers and Rural Health Clinics. They are contracted with Provider-Based Rural Health Clinics (PBRHCs), and Independent Rural Health Clinics (IRHCs). **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 minimum, care coordination, medical record management, and billing procedures. The health plan shall allow for full freedom of choice for the	Exhibit C - Missouri Care. Sheet "Fam Plan & STD"	Met

provision of these services *(MHD contract 2.4.10).*		
Findings: Missouri Care's example listed above shows compliance with the requirements within their Exhibit C - Missouri Care documents under the sheet titled "Fam Plan & STD". **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).*	Exhibit C-Missouri Care. Sheet "Local Public Health Agencies"	Met
Findings: Missouri Care's example listed above shows compliance with the requirements within their Exhibit C - Missouri Care documents under the sheet titled "Local Public Health Agencies". **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).*	2018 claim payments for school based dental services	Met
Findings: Missouri Care has provided Primaris with their 2018 claim payments for school based dental services which provide evidence of their contract with reimbursement to licensed dental providers who provide preventive dental services. **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	MO Hospitals by County	Met

process for providing such services including transfer protocols and arrangements with out-of-network providers *(MHD contract 2.4.16).*		
Findings: Missouri Care's MO Hospital List provided, meets the requirements listed above in A. vii. They have listed all tertiary care they are contracted with which includes 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. **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 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).*	Network Dashboard Network Review QI Work Plan–Network	Met
Findings: Missouri Care provided a list of all their 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. **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	Network Access Plan Approval	Met

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).*		
Findings: Missouri Care has provided an example of their annual access plan that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues. **Required Actions:** None.		
(ii) At any time there has been a significant change (as defined by the State) in the MCO's operations that 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)*	Intent to Terminate-Capital Region Medical Center & Capital Region Medical Group	Met

e. Enrollment of a new population in the MCO.		
Findings: Missouri Care has kept the state aware of any action requiring notification. They have also provided an example for change type (c). **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.	CM introduction Card CM Welcome letter Eliza outreach program guide Quickstart guide	Met
Findings: Missouri Care has demonstrated full and exemplary compliance with sources of information and contact info via care coordination services and brief brochures, letters and guides which enrollees receive upon enrollment. In addition, their outreach program also assesses specific members' care needs and promotes benefits and resources available to members. **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.	Eliza Outreach Program Guide Maternity screening	Met
Findings: Missouri Care screens all pregnant members for care management needs and offers care management to all pregnant members. The health plan also offers care management within 15 business days of notification of pregnancy. The initial care management and admission encounter shall include an assessment (face-to-face or phone) of the member's 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	Transition of Care contact (example) Transition of Care form Member Handbook: Pages 62, 63 of 96 Transition of Care policy Transition of Care Procedure Transition of Care Step Process Provider Manual: Pages 57, 58 of 106	Met

medical records and information *(MHD contract 2.5.9).*		
Findings: Missouri Care provides continuation of medically necessary covered services for the lesser of 60 calendar days or until their members have transferred, without disruption of care, to an in-network provider. Missouri Care will continue to be responsible for the costs of continuation of such medically necessary covered services, without any form of prior approval and without regard to whether such services are being provided within or outside Missouri Care's network until such time as Missouri Care can reasonably transfer their member to a service and/or network provider without impeding service delivery that might be harmful to the member's health. **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.	Transition of Care Procedure: Page 3 of 11	Met
Findings: Missouri Care will 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. **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.	Transition of Care Procedure: Page 3 of 11	Met
Findings: Missouri Care is responsible for maintaining transfer-out procedures. If the MCO becomes aware that a member will transfer out of the MO HealthNet managed care program and into the MO HealthNet Fee-For-Service system, the MCO shall contact the state agency within 5 business days of becoming aware of the member's disenrollment to share relevant member information and to respond to questions regarding the member's care needs and services. Missouri Care will work with out-of-network providers and/or the previous health plan to affect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a provider that is not in Missouri Care's network. Missouri Care will facilitate the securing of a member's records from the out-of-network provider(s) when needed and 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.	Transition of Care Procedure: Page 3 of 11	Met
Findings: Missouri Care will facilitate continuity of care for medically necessary covered services. In the event a member entering Missouri Care is receiving medically necessary covered services, the day before enrollment into the health plan, Missouri Care will 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. Missouri Care will provide 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. Missouri Care will provide continuation of services authorized by the prior health plan for up to 60 calendar days after the member's enrollment in Missouri Care. **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.	Transition of Care Procedure: Page 5 of 11	Met
Findings: Non-pregnant members receiving a physician authorized course of treatment may elect 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 transferred without disruption of care to an in-network provider or 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).	Transition of Care Procedure: Page 3 of 11	Met
Findings: Members in their third trimester of pregnancy will be allowed to continue receiving services from their prenatal care providers, whether in-network or out-of-network, without any form of prior authorization, through the postpartum period. This period is defined as 60 calendar days from the baby's date of birth. **Required Actions:** None.		
(vii) Allow pregnant members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.	Transition of Care Procedure: Page 3 of 11	Met

Findings: Pregnant members will additionally be allowed to continue to receive services from their behavioral health treatment providers, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or the loss of eligibility. **Required Actions:** None.		
(viii) Ensure that inpatient and residential treatment days are not prior authorized during transition of care.	Transition of Care policy: Page 4 of 11	Met
Findings: Under the Missouri Care Transition of Care policy provided, transition of care for inpatient and residential treatment days, does not require concurrent review. For new enrollees and terminating members, prospective inpatient and residential treatment days shall not be prior authorized during transition of care. **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.	Transition of Care policy Missouri Care Provider Manual: Page 21 of 106	Met
Findings: Providers must adhere to the standards of timeliness for appointments and in-office waiting times for various types of services that take into consideration the immediacy of the member needs. Missouri Care shall monitor Providers against these standards to ensure members can obtain needed health services for specified appointment types within acceptable in-office wait times. Providers not in compliance with these standards will be required to implement corrective actions set forth by Missouri Care. **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.	Privacy in Care Coordination	Met
Findings: The Missouri Care Privacy in Care Coordination policy provides ensurance, when applicable, of the enrollees privacy protection in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E. **Required Actions:** None.		
F. MCO must coordinate services for its members who are in health homes. They must identify any care	Coordination with Health Homes Addendum	Met

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).*	Health homes contact list PCP care gap reports	
Findings: The provided addendum along with the contact list and PCP care gap reports show Missouri Care's responsibility for being the primary source of care management for conditions other than or beyond those included in the state Health Home program as described in the MHD contract 2.11.1 d. CM of a member will notify the respective health home contact via email to verify that coordination needs are met and to check on member's utilization. Health Homes notify the MCO via email of members that have discharged from their services, members that are in need of CM services that are out of their scope of practice, and members that are in transition of care. **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.	Foster care stratified foster roster Example of Case Management annual draft on risk stratification and case identification *N/A per MHD Contract	Met
Findings: Under Missouri Care, foster care members are identified for care coordination/case management as a special needs population by use of data mining, referrals, grand rounds, and inpatient census. Missouri Care employs a variety of strategies to identify members with special health care needs including: special needs members outreached through welcome calls, health risk assessments, transition of care activities, or coordination of care. Missouri Care also attempts to reach all newly enrolled members to conduct a health risk assessment, which may identify children with special health care needs. Following completion of the assessment and the identification of any gaps in the members' care, the health plan offered care management services. **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	Example of Case management annual evaluation draft	Met

special conditions of the enrollee 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.	Case management annual draft re risk stratification and case identification	
Findings: Missouri Care's draft annual CM evaluation and identification stratification provides adequate assessment using implementation mechanisms to comprehensively assess each Medicaid enrollee identified by the State to Missouri Care as described above in Section G Subpart ii. **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 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	Example of Case management annual evaluation draft Special needs policy Special needs procedure	Met

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: Missouri Care requires that contracted providers assess members and develop a plan of care or treatment plan for the Company's members determined to need a course of treatment or routine care. The provider coordinates the treatment plan with the member, family and/or specialist caring for the member. Missouri Care requires that the plan of care or treatment plan adheres to community standards for documentation and any applicable agency quality assurance and utilization review standards. WellCare has in place policies governing the mechanisms utilized to identify, screen and assess individuals with special health care needs. WellCare produces a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring. **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 identified needs *(MHD contract 2.5.8 a).*	Member Handbook. Page 27 of 96 Individuals with Special Health Care Needs Policy: Page 2 of 14	Met
Findings: For members with special health care needs determined through assessment by appropriate health care professionals to need a course of treatment or routine care monitoring, the member will be allowed direct access through standing referrals or approved visits, as appropriate for the member's condition and needs. The specialist will continue to keep the primary care physician (PCP) informed of the member's progress and needs through progress notes and/or consultation reports. **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					34
Denominator	Total Sections	=	17	×2	=	34
Score						**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).	MO29-HS-UM-016 Covered Services: Page 1 of 13 MO29-HS-UM-016 Covered Services: Page 1 of 13 (updated)	Met
Findings: Missouri Care shall ensure the provision of services is sufficient in amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished and shall ensure the provision of the covered services as defined and specified in this Contract. During onsite review, Primaris brought to the notice of Missouri Care that their policy did not state that "the amount, duration, and scope will be no less than the services furnished to FFS beneficiaries." Missouri Care confirmed that they comply with the requirement. They updated their policy and resubmitted to Primaris. **Required Actions:** Missouri Care should 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.	MO29-HS-UM-016 Covered Services: Page 1 of 13	Met
Findings: The MCO shall not arbitrarily deny or reduce the amount, duration, and scope of a required service solely because of the diagnosis, type of illness, or condition. **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:	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 4 of 16 MO29-HS-UM-016 Covered Services: Page 1 of 13	Met

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.	*N/A per MHD contract	
Findings: Services may be limited by medical necessity. A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health condition or injury; (2) is necessary for the member to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity. 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. **Required Actions:** None.		
(iv) MCO is permitted to place appropriate limits on a service for the purpose of utilization control, provided that— The services furnished can reasonably achieve their purpose, as required in A (i) of this evaluation tool. *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	MO29-HS-UM-016 Covered Services: Pages 1, 7 of 13 *N/A per MHD contract	Met

and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.		
Findings: Missouri Care may place appropriate limits on a service on the basis of such criteria as medical necessity or for utilization control, consistent with the terms of this Contract, provided the services furnished can be reasonably expected to achieve their purpose. Missouri Care shall be financially liable for payment to providers, whether in-network or out-of-network, in accordance with Federal freedom of choice provisions. **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).*	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 5 of 16	Met
Findings: Missouri Care states that emergency medical, behavioral health, and substance abuse services will be delivered without obtaining prior authorization. However, notification requirements may apply. If a member is placed in an observation setting or is admitted after emergency department treatment, the facility must notify Missouri Care of the admission according to plan requirements. The notification will be documented by the Prior Authorization Department or concurrent review nurse. Missouri Care shall cover and pay for emergency services whether or not the provider is in-network or out-of-network. **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).*	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 5 of 16	Met
Findings: Missouri Care complies with the above requirement from MHD contract. During onsite review, Missouri Care official stated that all court ordered detentions are authorized up to 21 days and can extend for further duration based on court order. **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	MO29-HS-UM-010 Concurrent Review Inpatient: Page 6 of 13	Met

and 147, and the CMS Final rule on MHPAEA for Medicaid *(MHD contract 2.5.5 b).*	MO29-HS-UM-016 Covered Services: Page 2 of 13	
Findings: Missouri Care's services shall comply with the Paul Wellston and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR 146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits, with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan. **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 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)*	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 10 of 16	Met
Findings: When Missouri Care requires a referral, assessment, or other requirement prior to the member accessing requested medical, behavioral health, or substance services, such requirements shall not be an impediment to the timely delivery of the medically necessary service. Missouri Care shall assist the member to make any necessary arrangement to fulfill such requirements (e.g., scheduling appointments, providing comprehensive lists of available providers, etc.). If such arrangements or the review process and the communication to the provider cannot be made timely, the requested services shall be approved. **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:	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Pages 1, 2, 7, 10, 11 of 16	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: The prior authorization function in Missouri Care is supported by policies and procedures that meet requirements that all appeals, and denials are reviewed by a professional who has appropriate clinical experience in treating the enrollee's condition or disease.

To support prior authorization decisions, Missouri Care uses nationally-recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system. The criteria are consistently applied, even for consultations with requesting providers/practitioners when appropriate. For prior authorization of elective inpatient and outpatient medical services, Missouri Care uses the following medical review criteria. These are to be consulted in the order listed:

Criteria required by applicable state or federal regulatory agency or client contract.

WellCare (Missouri Care's parent company) Clinical Coverage Guidelines (CCGs) as the primary decision support for most diagnoses and conditions.

Applicable InterQual criteria as the primary decision support for most diagnoses and conditions.

The following list is applied for behavioral health service requests and is consulted in the order listed based on the primary presenting condition and level of care being requested:

Level of Care Utilization System (LOCUS)/Child & Adolescent Level of Care Utilization System (CALOCUS) Guidelines are used exclusively for psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews. Other criteria as required by contract (e.g., American Psychiatric Association [APA] Practice Guidelines). WellCare Clinical Coverage Guidelines (CCGs). If criteria is not clear enough to make a determination or the requested service is not addressed by the WellCare CCGs, the Medical Director may submit a request for a position determination to the Senior Director of Clinical Policy and Innovation or designee, using the Clinical Policy Request form. The Senior Director of Clinical Policy and Innovation or designee creates the guideline in draft format based on the finding(s) of the research. The Medical Policy Committee reviews, offers feedback and approves the Guideline. Reasons for decisions are clearly documented and assigned a prior authorization number, which refer to and documents approvals and denials. Documentation is maintained, including any alternative services approved in lieu of the original request. There is a well-publicized review process for both providers and members. During onsite review, Missouri Care stated that they are not using InterQual. Milliman Care Guidelines have replaced it effective March 04, 2019. **Required Actions:** It is recommended that Missouri Care updates their policies to reflect the current information.		
(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.	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Pages 11 of 16 *N/A per MHD contract	Met
Findings: When the review criteria are present but unclear in relation to the situation, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area in accordance with Missouri Care Policy "Use of Board Certified Specialty Reviewer" before making a determination of medical necessity. Practitioners and providers may request a peer-to-peer consultation to discuss denied authorizations with the medical director reviewer by calling Missouri Care. Peer to peer reviews are conducted in accordance with Missouri Care's peer-to-peer review policy. During onsite review, Missouri Care explained that the peer-to-peer review is conducted within three business days of request. **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	MO29-HS-UM-014 Adverse Determinations-Proposed Actions: Page 2 of 6	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: Any decision to deny a service authorization request or to authorize a service in an amount, duration, and scope that is less than requested will be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. **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).*	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 14 of 16	Met
Findings: Missouri Care will ensure that members are not without necessary medical supplies, oxygen, nutrition, etc., requests for interim or necessary medical supplies are treated as urgent requests and processed the same day if necessary. During onsite review, Missouri Care explained that services are prior authorized even during afterhours and weekends, to ensure there are no gaps in care. The case managers anticipate the members' requirements, the nurses work over the weekends, and they reach out providers. The member services can be called for assistance. The phone lines roll over to an on call registered nurse. **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).*	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 14 of 16	Met
Findings: Missouri Care will ensure that the member's treatment regimens are not interrupted or delayed (e.g. physical, occupational, and speech therapy; psychological counseling; home health services; and personal care) by the prior authorization process. During onsite review, Missouri Care explained that their staff reviews previous authorizations to make sure there are no gaps in the services. They call the providers for clarification. The registered nurse covers for expedited requests. Case managers review all prior authorizations to make sure that the patients are not without treatment. **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 in the health plan ends *(MHD contract 2.5.5h).*	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 14 of 16	Met
Findings: Missouri Care 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 in Missouri Care 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. The health plan's contract terminates before the health care services are provided. The covered person's coverage under the health plan terminates before the health care services are provided *(MHD contract 2.5.5i).*	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 14 of 16	Met
Findings: Missouri Care meets all the above listed criteria from their MHD contract. During onsite review, Missouri Care stated that they do not retract services that are authorized by state or other MCO. **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 health plan 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).*	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 2 to 16	Met
Findings: Missouri Care shall not deny a physician's requested continuation of coverage of an inpatient hospital stay unless an alternative service is recommended by Missouri Care, 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. **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.	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 12 of 16	Met
Findings: Missouri Care is compliant with the above time frame. During onsite review, Missouri Care explained that no authorization is required for emergency services. However, retrospectively the members are educated by the care coordinators to go to PCPs or urgent care centers for non-emergent conditions. No prior authorizations are required for behavioral health conditions as well. The sequence of events: patient visits emergency room followed by a triage, the inpatient psychiatric facility is called in case of an emergent issue. The facility will admit the patient, and within 24 hours, the inpatient facility notifies the MCO for an authorization. **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.	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 12 of 16	Met

Findings: Approval or denial of services determined to be urgent by the treating provider shall be provided within 24 hours of the request for services. **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.	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Pages 11, 12 of 16 MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 12 of 16 (updated)	Met
Findings: Approval or denial shall be provided within 36 hours, to include 1 working day of obtaining all necessary information for routine services. Missouri Care shall notify the requesting provider within two business days following the receipt of the request of service regarding any additional information necessary to make a determination. In no case shall Missouri Care exceed 14 calendar days following the receipt of the request of service to provide approval or denial.		

According to the requirement listed in C (iii) b above, the MCOs have to notify the provider within 36 hours of request if they need additional information which should include one business day, whereas Missouri Care states that they would notify a provider in two business days following the receipt of request. During onsite review, Primaris informed Missouri Care that they should update their policy to reflect "one" business day instead of "two" business days. Missouri Care updated their policy and resubmitted. Primaris scored them as "met." **Required Actions:** Missouri Care should send their updated policy to MHD for approval.		
(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.	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Pages 11, 13 of 16	Met
Findings: Approval or denial of services determined to be urgent by the treating provider shall be provided within 24 hours of the request for services. Missouri Care does not extend timeframes for urgent prior authorization decisions (Medical, Behavioral Health, and Substance Abuse). During onsite review, Missouri Care stated that all expedited authorization decisions are taken in 24 hours and they do not extend it to 14 days. If they need more information from the provider, they make 3-20 attempts to reach out the provider. If they still fail to get the information, they escalate to the Medical Director. **Required Actions:** None.		
D. Notice of adverse benefit determination. Each MCO must	MO29-HS-UM-002 Prior Authorization, Direct	Met

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.	Access and Standing Referrals: Pages 12, 13 of 16 MO29-HS-UM-014 Adverse Determinations - Proposed Actions: Pages 4, 5 of 6	
Findings: Missouri Care sends a notice of action to members when an action taken by Missouri Care that denies a service authorization request, limits a service in amount, duration and scope that is less than requested or denies payment, in whole or part, for a service. The notice meets all the requirements of 42 CFR 438.404. **Required Actions:** It is recommended that Missouri Care updates their policies with the term "adverse benefit determination" in place of "action."		
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).*	MO29-HS-UM-014 Adverse Determinations - Proposed Actions: Page 4 of 6	Met
Findings: Compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives to the individual or entity to deny, limit, or discontinue medically necessary services to any member. **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).*	C6-CR-001 Credentialing and Re-Credentialing Policy C6-CR-001-PR-001 Credentialing and Re-Credentialing Procedure C6-CR-009 Assessment of Organizational Credentialing Policy C6-CR-009-PR-001 Assessment of Organizational Credentialing Procedure Example Email - “Secure” Provider Terminations Due to NO Provider Enrollment with MMAC C6-CR-024 Medicare and Medicaid Eligibility Federal and State Sanctions and Opt-Out C6-CR-046 Ongoing Monitoring of Providers C6-CR-046-PR001 Ongoing Monitoring of Providers Procedure C6-CR-007 Corrective Action MO29-HS-QI-002 Quality of Care Monitoring Corrective Action	Met

	C6-CR-001-PR-001 Credentialing and Re-Credentialing Procedure	
Findings: The Missouri Care Credentialing procedures and policies listed above meet all requirements of Section A. During the credentialing process, the providers Social Security Number is requested and part of the process. Through its multiple policies and procedures, Missouri Care is in compliance with all applicable federal and state statutes, regulations, administrative rules, as well as applicable state Medicaid contract requirements that govern the credentialing and re-credentialing of its providers of care. **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 60 business days pursuant to RSMo 376.1578 *(MHD contract 2.18.8c 1).*	C6-CR-001 Credentialing and Re-Credentialing Policy C6-CR-001-PR-001 Credentialing and Re-Credentialing Procedure C6-CR-009 Assessment of Organizational Credentialing Policy C6-CR-009-PR-001 Assessment of Organizational Credentialing Procedure MO Provisional BH Credentialed Provider Report	Met
Findings: The Missouri Care Credentialing procedures and policies listed above meet all requirements of Section B. The minimum documents are returned to the MCO within 10 days of receiving the completed application The Credentialing department presents the file to the Credentialing Committee for granting of temporary/provisional privileges. The entire process is completed within 14 days of receipt of the completed application. The temporary/provisional privileges are granted for no more than 60 days. Therefore, the time frame for processing initial credentialing applications will be performed within 60 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	C6-CR-001 Credentialing and Re-Credentialing	Met

hospices to determine whether the provider is following the policies and procedures related to advance directives *(MHD contract 2.18.8c 2).*	C6-CR-001-PR001 Credentialing and Re-Credentialing Procedure	
Findings: A credentialing quality auditor performs credentialing audits of a random sample of files per month to verify for accuracy and consistency. Audit results are maintained in the Credentialing Department. In addition, WellCare establishes ongoing monitoring of provider sanctions, complaints and quality issues between re-credentialing cycles, and takes appropriate action. **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).*	C6-CR-001 Credentialing and Re-Credentialing C6-CR-001-PR-001 Credentialing and Re-Credentialing Procedure C6-CR-009 Assessment of Organizational Credentialing Policy C6-CR-009-PR-001 Assessment of Organizational Credentialing Procedure	Met
Findings: Information and documentation on organizational providers is collected, verified, reviewed and evaluated in order to achieve a decision to approve or deny network participation. Before contracting an organizational provider, the MCO performs an assessment of the organizational provider. An initial assessment includes a multitude of criterion along with criminal history background screening. Disclosure related to ownership and management, business transactions, and conviction of crimes. **Required Actions:** None.		
E. MCO shall collect the information from the provider and retain evidence	C6-CR-001 Credentialing and Re-Credentialing	Met

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; 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).*	C6-CR-001-PR-001 Credentialing and Re-Credentialing Procedure C6-CR-009 Assessment of Organizational Credentialing Policy C6-CR-009-PR-001 Assessment of Organizational Credentialing Procedure	
Findings: According to Missouri Care's credentialing and re-credentialing policy, they must provide written disclosures of certain information upon contract execution, upon any renewal or extension of the contract and within 35 calendar days of any change in ownership. **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).*	C6-CR-001 Credentialing and Re-Credentialing C6-CR-001-PR001 Credentialing and Re-Credentialing Procedure	Met
Findings: The process for verification of Provider credentials and insurance includes retaining evidence that it received the proper disclosures or documentation of the disclosures. **Required Actions:** None.		
G. MCO shall promptly notify the state agency of any denial of enrollment due	C6-CR-025 Reporting Adverse Actions National	Met

to the results of the provider credentialing or re-credentialing 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*).	Practitioner Date Bank and State Agencies	
Findings: Missouri Care policies require they promptly notify the state agency of any denial of provider credentialing or re-credentialing in addition to the requirement to report provider terminations as part of its quarterly fraud and abuse report. **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).*	C6-CR-001 Credentialing and Re-Credentialing C6-CR-001-PR-001 Credentialing and Re-Credentialing Procedure C6-CR-009 Assessment of Organizational Credentialing Policy C6-CR-009-PR-001 Assessment of Organizational Credentialing Procedure C6-CR-046 On-Going Monitoring of Providers C6-CR-046-PR-001 On-Going Monitoring of Providers Procedure	Met
Findings: As part of credentialing and re-credentialing, the Missouri Care screens all health care service subcontractors to determine whether the subcontractor or any of its		

employees or subcontractors have 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 consists of, at a minimum, consulting the following databases on at least a monthly basis: The List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) maintained by the Office of Inspector General (OIG) located online at https://exclusions.oig.hhs.gov/. The screening also consists of consulting the following additional databases, consistent with State and Federal requirements: The National Plan and Provider Enumeration System (NPPES), located online at https://nppes.cms.hhs.gov/NPPES/Welcome.do, the Missouri Professional Registration Boards website, and any such other State or Federal required databases. In addition, Missouri Care terminates the provider contract of any subcontractor for which a check reveals that the subcontractor falls within this section. **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: Newly credentialed provider attached to a new contract within 10 business days after completing credentialing. Newly credentialed hospital or facility attached to a new contract within 15 business days after completing credentialing. Newly credentialed provider attached to an existing contract 5 business days after completing credentialing. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within 5 business days after completing re-credentialing. Change in existing contract terms within ten 10 business days of the effective date after the change.	C6-CR-001 Credentialing and Re-Credentialing C6-CR-001-PR001 Credentialing and Re-Credentialing Procedure	Met

Changes in provider service location or demographic data or 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: Missouri Care does not load providers into Xcelys that cannot be paid. From the time and day, they are loaded into Xcelys, they are available for claim adjudication. **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.	C6-CR-001 Credentialing and Re-Credentialing C6-CR-001-PR001 Credentialing and Re-Credentialing Procedure	Met
Findings: The Missouri Care Credentialing procedures and policies listed above meet all requirements of Section I. ii. Of note, Missouri Care has stated that they do not load providers into their Xcelys payer solution system who cannot be paid. Therefore, from the day they are loaded into Xcelys they are payable providers. **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).*	Provider Load TAT Report	Met
Findings: Provided document: Provider Load TAT Report shows compliance with the requirement in this section as the document provides 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. The times are in compliance with the required timeframes for loading credentialed providers. **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.	C6-CR-049 Non Discrimination.	Met
Findings: The Missouri Care C6-CR-049 Non-Discrimination Policy meets all requirements of Section K. Missouri Care does not make credentialing and re-credentialing decisions based solely on an applicant's race, ethnicity, national identity, religion, gender, age, sexual orientation or the type of procedure or patient (e.g., Medicaid) in which the practitioner specializes. Missouri Care does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatments. To assure there is no discrimination in the making of credentialing decisions, Missouri Care maintains a heterogeneous credentialing committee membership and those responsible for making credentialing decisions affirm they will not discriminate when making credentialing decisions. **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	×	=	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)*.	C13-HIP-01-002-ST HIPAA Records and Safeguards Standard: Pages 1, 2 of 3 C13-HIP-01-004-PR-001 HIPAA Handbook Procedure: Page 12 of 37	Partially Met
Findings: Access to all Protected Health Information (PHI) regardless of the how it is created or maintained including oral, written, and electronic forms will be managed in such a manner as to protect the integrity, confidentiality, and availability of PHI. This standard applies to both living and deceased members and is administered by the compliance department through the activities of the privacy officer and is intended to serve as a foundation for the privacy practices of WellCare. On Public Interest and Benefit Activities-PHI may be disclosed without authorization from a member, for the national priority purposes. Contact the Privacy Office for additional guidance before disclosure. Non-Routine disclosures (anything outside of Treatment, Payment, Healthcare operations (TPO)) require approval by the Chief Compliance Officer or designees. Missouri Care's policy does not mention that the release of information to public will be after written consent of state agency. **Required Actions:** Primaris recommends that Missouri Care updates their policies to meet the requirement of this section (A).		
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		Not Met

subject to the cancellation provisions of this document *(MHD contract 3.16.2).*		
Findings: The documents submitted by Missouri Care do not show that they meet the requirements listed in MHD contract 3.16.2. **Required Actions:** Missouri Care should update their documents/policies to show that they abide with the contractual requirements of section 3.16.2 of MHD contract.		
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 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.	C13-HIP-01-004-ST HIPAA Training Standard: Page 2 of 3 C13-HIP-01-002-ST HIPAA Records and Safeguards Standard: Page 2 of 3 C13-HIP-01-004-PR-001 HIPAA handbook Procedure: Page 24 of 37	Met
Findings: Missouri Care requires each associate to complete the HIPAA Training Program. This training is delivered within 30 days of being hired and annually thereafter. An introduction to safeguarding PHI training brings awareness to the basics safeguarding that Missouri Care incorporates to protect member's PHI. This training is delivered within the first few days of an associate's start of employment date. When WellCare's HIPAA compliance program is modified, the privacy officer or designee will provide HIPAA training to those associates whose jobs are affected by such modifications.		

WellCare has a duty to protect the confidentiality and integrity of all forms of PHI. Access to PHI will be limited to associates on a "need to know" basis. PHI is not to be accessed by an associate for any reason other than for servicing members and/or their account, or as part of the day-to-day business operations of WellCare. WellCare will maintain a current listing of all workforce members (individuals, contractors and Business Associates) with access to PHI. Appropriate measures must be taken to ensure the security of PHI transmitted by email. Include the word [secure], with brackets and the word can be lower or uppercase (as long as the word secure is in the brackets), in the subject line of outgoing email that contains PHI and/or member information. This will trigger the e-mail scanning system to encrypt the e-mail. Printers and copiers used for printing PHI are to be in a secure, non-public location. PHI should be removed immediately from printers and copiers. As a general rule, WellCare does not promote the use of text messaging PHI and/or confidential information. Appropriate measures must be taken to ensure the security of PHI transmitted by fax. Associates must verify that the correct fax cover sheet is used and that the fax number is correct before sending. Use only the minimum necessary amount of PHI or member information on the fax. Missouri Care also has physical safeguards. WellCare's corporate data processing facility is managed by a tier 1 data center vendor. Physical security measures include access cards/security codes, biometric devices and a man trap as an anti-tailgating measure in the data center lobby. All equipment is physically secured within locked cages with dedicated intra cage video surveillance. Badging and monitoring of maintenance modifications at facilities where electronic information systems are housed. Sensitive areas and equipment must be identified, and the appropriate physical security controls are placed to protect them. Limitations of physical access to facilities that house PHI and to electronic information systems that would contain or provide access to electronic PHI would have controlled access to the physical property that would include appropriate badging privileges. During onsite review, Missouri Care Stated that portable devices at rest and during activity are encrypted at all times. **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 member's written consent *(MHD contract 3.16.4).*	C13.HIP.01.006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Pages 3, 5 of 14	Met
Findings: A valid authorization must be completed and signed by the member and received by WellCare before WellCare will release any PHI, except when PHI is used for healthcare operations or when permitted or required by federal or state law. When WellCare obtains or receives a valid authorization from the member to whom the PHI relates, the use and disclosure of PHI must be consistent with the authorization. Workforce members will notify		

the privacy officer or his/her designee of any request from HHS or the State regarding a member's PHI. WellCare may disclose PHI without member authorization to HHS or the State, as necessary, in a timeframe agreed upon between HHS or the State and WellCare. **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 disorder member records *(MHD contract 3.16.5).*	C13.HIP.01.006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Pages 6, 8 of 14	Met
Findings: Any WellCare health plan that is a government program providing public benefits may disclose PHI to another agency either to enroll or determine member eligibility. Such WellCare health plan may do so if the sharing of PHI is required or authorized by statute. Any WellCare department administering a state or federal government program providing public benefits may disclose PHI to another covered entity that is a like an agency as long as the programs serve the same or similar populations. Alcohol and Drug Abuse Patient Records (as defined in 42 CFR Part 2) and HIV status are considered a unique subset of PHI, which must be treated differently from other types of PHI. Alcohol and Drug Abuse Patient Records and HIV status will be confidential and may be disclosed only for the purposes expressly authorized by the member who is the subject of such information, except as otherwise provided for in this standard. Workforce members must at all times seek the prior approval of the privacy officer or designee prior to disclosing any such information. **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).*	C13.HIP.01.006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Pages 8, 9 of 14	Met
Findings: If a person has authority by law to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to use and disclosure of PHI, WellCare will treat such person as a personal representative. Once a minor is emancipated, a guardian or a parent cannot be recognized as a personal representative. If a minor does not require the consent of an adult and may consent to treatment, the minor will be treated as an individual and may provide a valid authorization for the use and disclosure of PHI. Examples of where a minor, with authority by law, can act as an individual may include:		

diagnosis and treatment of a sexually transmitted disease; family planning services/pregnancy; some outpatient surgeries; alcohol/drug abuse treatment; and abortion. Without the minor's authorization, WellCare will not release to a parent or guardian diagnosis or treatment information regarding: alcohol or drug abuse; sexually transmitted disease; and abortion. Protection of HIV information is stated in "findings" of section D of this evaluation tool. **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 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).*	C13.HIP.01.006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Page 1 of 14 C13-HIP-01-008-ST Business Associate Agreement Standard: Page 1 of 7	Met
Findings: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act require that access to Protected Health Information (PHI) be managed in such a manner as to protect the integrity, confidentiality, and availability of PHI. The Business Associate Agreement applies to all Business Associates hired by WellCare (Missouri Care's parent company) that perform functions and services that involve access to member PHI. This standard is administered by the Compliance Department through the activities of the Privacy Officer and is intended to serve as a foundation for the privacy practices of the BA. Missouri Care stated that when they sign the contract with MHD they become BA of the State and all clauses apply to them in the same manner as mentioned in the BAA standard. **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).*	C13-HIP-01-002-ST HIPAA Records and Safeguards Standard: Page 2 of 3	Met

Findings: Missouri Care states that all PHI regardless of the how it is created or maintained including oral, written, and electronic forms is treated according to HIPPA standards. Missouri Care stated that WellCare's information security policies include, but are not limited to: Computer security incident management, incident response and incident reporting. Appropriate use and monitoring, appropriate use of information technology resources, electronic communications accountability and privacy in the workplace. A Corporate Risk Management Program that monitors, assesses and reviews information technology and security on an annual basis. Mandatory security awareness training for our associates within 30 days of recruitment and annually thereafter. A Disaster Recovery and Business Continuity Plan based on a business impact assessment. A password policy that incorporates requirements for password implementation (including strong password use, password authentication, and third party security requirements) for access to all systems and external parties. Multifactor authentication for remote access. Data loss prevention technology. Antivirus, antispam and malware policies. Malicious code and advanced persistent threat prevention. **Required Actions:**		
(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).*	C13.HIP.01.006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Page 6 of 14 C13-HIP-01-009-ST Incident Response Plan Standard: Page 12 of 26, Addendum 2 C13-HIP-01-008-ST HIPAA BAA Standard: Page 4 of 7	Partially Met
Findings: WellCare may disclose PHI without a member authorization for the following, upon approval from the Privacy Officer or designee: • For reporting of abuse, neglect or domestic violence to a government authority, as permitted or required by law. • To avert a serious and imminent threat to the health or safety of a person or the public. • To law enforcement officials. • When otherwise allowed by law. • A court order, warrant, subpoena, grand jury subpoena, or summons issued by a judicial officer. • An administrative request, including an administrative subpoena or summons, or similar process authorized under law.		

• For law enforcement authorities to identify or apprehend an individual. Reports and communications are made without unreasonable delay and no later than 60 days after the discovery of the incident, unless otherwise stated by law enforcement in writing or orally. If the statement is made in writing, the notification is delayed for the time specified by the official. Addendum 2 of the Incident Response Plan Standard submitted by Missouri Care states that: Timing of notification is based on the specific State requirements. MHD has specified 10 days, which is not reflected in any of the policies/documents. However, BAA standard document submitted by Missouri Care states that: in the case of a breach, BA must notify the MCO of the breach as soon as the BA becomes aware and in no case more than forty-eight (48) hours after the discovery of the breach. **Required Actions:** Missouri Care's documents should be consistent in their documents/policies and specific to MHD requirements. They have not submitted documentary evidence to meet all the requirements from this evaluation tool (G iii) regarding 45 CFR 164.502(j) (1), which speaks about disclosures by whistleblowers.		
(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).*	C13.HIP.01.006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Page 2 of 14	Met
Findings: Workforce members are permitted to disclose PHI for the following routine disclosures: To the individual whose PHI it is. Treatment - For treatment activities of a health care provider. Payment - To another covered entity for payment activities of the covered entity that receives the information. Health Care Operations – Certain administrative, financial, legal and quality improvement activities of a covered entity that are necessary to run its business and to support the core function of treatment and payment. **Required Actions:** None.		
(v) If the disclosure is required by law, the MCO may disclose Protected Health Information to carry out the legal responsibilities of the MCO *(MHD contract 2.38.2e).*	C13.HIP.01.006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Page 5 of 14	Met
Findings: Requests for disclosures of PHI for judicial or administrative proceedings are to be directed to the WellCare Legal department. PHI may be used or disclosed without member authorization for judicial or administrative proceedings that are accompanied by a court order.		

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).*		Not Met
Findings: Missouri Care has not submitted any document/policy that fulfils the above contractual requirement. **Required Actions:** Missouri Care should have a policy/standard/any form of documentation or program description for compliance/template for subcontractors or business associates to show that MCO and their business associates comply with MHD contract 2.38.2 f.		
(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).*	C13-HIP-01-004-PR-001 HIPAA Handbook Procedure: Page 11 of 37	Partially Met
Findings: Missouri Care submitted the above document. Section 1.4.2 Page 11 of 37 states the following process for de-identification: Do not put PHI, PII, and/or member information in the subject line of e-mails. Take steps to de-identify PHI prior to sending it out. De-identification includes the removal of specific identifiers (see chart below) so that the member is not able to be identified by the remaining information. If you are unable to de-identify the data, determine the minimum necessary amount of information required to achieve the intended task. Missouri Care's document does not state that "without specific written permission from the state agency to do so, they will not de-identify or re-identify PHI." **Required Actions:** Missouri Care should have a policy/standard document which shows that they are compliant with MHD contract 2.38.2f.		
(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).*	C13.HIP.01.006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Page 2 of 14	Met
Findings: WellCare will make reasonable efforts to comply with the Minimum Necessary rule set forth in HIPAA by disclosing or requesting only the minimum amount of PHI that is required to accomplish the intended task. The Minimum Necessary rule does not apply to		

disclosures or requests to health care providers for treatment or payment purposes, use and disclosure to a member who is the subject of the PHI, use and disclosure pursuant to a valid authorization or disclosure to the Department of Health and Human Services (HHS), or as otherwise required by law. **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).*	C13-HIP-01-008-ST Business Associate Agreement Standard: Pages 1, 2 of 7	Met
Findings: Missouri Care has Business Associate Agreement standard document. This standard addresses the requirements for BA regarding the access, use, and disclosure of PHI in accordance with the HIPAA and HITECH. This standard pertains to all BAs hired by WellCare that perform functions and services that involve access to member PHI. HIPAA and HITECH require BAs to be compliant with the privacy and security provisions of HIPAA and HITECH in the same manner as the MCO. BAs shall ensure that agents and subcontractors agree to the same restrictions and conditions that apply to the BA with respect to the privacy and security of PHI. **Required actions:** None.		
(x) In order to meet the requirements under 45 CFR 164.524, regarding an 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).*	C13-HIP-01-004-PR-001 HIPPA Handbook Procedure: Page 21 of 37 C13-HIP-01-008-ST HIPAA Business Associate Agreement Standard: Page 3 of 7 C13-HIP-01-006-ST HIPAA Use and Disclosure of Protected Health Information (PHI) Standard: Page 5 of 14	Met

Findings: Missouri Care's HIPPA Handbook Procedure states that Members have the right to inspect and obtain a copy of their PHI for as long as Missouri Care maintain it, subject to certain limitations. Missouri Care is responsible for accounting for non-routine disclosures of PHI. All requests for accounting of disclosures must be submitted in writing and are processed by the Privacy Officer or his/her designee. If approved, the request is fulfilled within 30 days or 60 days if the records are stored off site. An extension to 90 days is available if Missouri Care notifies the member within the first 60 days of the reason for the delay and the date by which action is taken. BAA of Missouri Care states that the members have the right to request an accounting of disclosures of PHI. The BA shall notify the MCO within 5 days from the date the BA receives the request for an accounting of disclosures. Missouri Care stated that since they are BA of the MHD so same is applicable to them. Workforce members will notify the Privacy Officer or his/her designee of any request from HHS or the State regarding a member's PHI. WellCare may disclose PHI without member authorization to HHS or the State, as necessary, in a timeframe agreed upon between HHS or the State and WellCare. **Required Actions:** The policies and documents submitted by Missouri Care are not consistent in the duration stated for the purpose of gaining access to PHI. Primaris recommends that Missouri Care should be submitting policies and documents with consistent information and should have policies specific to the requirements of State of Missouri.		
(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 unauthorized uses or disclosures *(MHD contract 2.38.3j)*	C13-HIP-01-008-ST HIPAA Business Associate Agreement Standard: Page 4 of 7 C13-HIP-01-009-ST: Incident Response Plan Standard: Page 12 of 26	Met

Findings: Reporting of Violations – In the case of a breach, BA must notify the MCO of the breach as soon as the BA becomes aware, and in no case more than forty-eight (48) hours after the discovery of the breach. The BA must also, without unreasonable delay, identify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired or disclosed as a result of the breach, and provide such information to the MCO in order to meet the data breach notification requirements under HITECH. Missouri Care's Incident Response Plan Standard states that: reports and communications are made without unreasonable delay and no later than 60 days after the discovery of the incident, unless otherwise stated by law enforcement in writing or orally. If the statement is made in writing, the notification is delayed for the time specified by the official. Incident reports include a description of the event, the date of the breach and date of discovery, a description of the types of information involved, recommended steps for individuals or organizations affected by the incident, the steps WellCare has or will take to address the incident or breach, and organizational point of contact information. Missouri Care stated that notify the State within 48 hours of discovery of breach. **Required Actions:** The policies and documents submitted by Missouri Care are not consistent. Primaris recommends that Missouri Care should be submitting policies and documents with consistent information and should have policies specific to the requirements of State of Missouri.		
(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).*	C13-HIP-01-004-PR-001 HIPPA Handbook Procedure: Page 21 of 37 C13-HIP-01-009-ST: Incident Response Plan Standard: Page 16 of 26	Met
Findings: The Privacy Office maintains records of non-routine disclosures of PHI, and of requests for the accounting of non-routine disclosures for 6 years. The Information Security and Privacy office or its designee will maintain documentation of the incident, the affected individuals, the steps taken to notify individuals and mitigate harm, and lessons learned for seven years. **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		Not Met

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).*		
Findings: Missouri Care's BAA or other documents that were submitted to Primaris do not show that they meet the contractual requirement. **Required Actions:** Missouri Care should update their policies/BAA to incorporate the above requirement from MHD contract.		

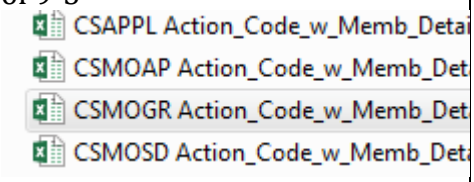
Compliance Score-Confidentiality						
Total	Met	=	13	×2	=	26
	Partial Met	=	3	×1	=	3
	Not Met	=	3	×0	=	0
Numerator	Score Obtained				=	29
Denominator	Total Sections	=	19	×2	=	38
Score						**76%**

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 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,	MO 29-HS-AG-002 Member Appeals page 2 of 17 MO 29-HS-AG-003 Member Complaint Grievance page 2 of 9	Met

deductibles, coinsurance, and other enrollee financial liabilities.		
Findings: Missouri Care follows all the sections stated above for 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 Missouri Care 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 29-HS-AG-002 Member Complaint Grievance page 2 of 17	Met
Findings: Missouri Care is in compliance with this definition from the CFR. **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.	MO29-HS-AG-003 Member Complaint and Grievance page 3 of 9 Updated MO29-HS-AG-003 Member Complaint and Grievance page 3 of 9	Met
Findings: Missouri Care has met all the conditions for the definition of grievance except for one: "Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision." During onsite review, Primaris recommended that Missouri Care should incorporate the missing statement in their definition of "grievance." Missouri Care updated their policy and resubmitted to Primaris following which they were scored "met."		

Required Actions: Missouri Care is advised to get their updated policy approved from MHD.		
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 29-HS-AG-002 Member Appeals page 2 of 17 MO29-HS-AG-003 Member Complaint and Grievance page 3 of 9	Met
Findings: Missouri Care 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).*	MO29-HS-AG-003 Member Complaint and Grievance page 3 of 9	Met
Findings: Missouri Care 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 29-HS-AG-002 Member Appeals page 3 of 17	Met
Findings: Missouri Care has not stated the sections from the CFR or contract while defining "State Fair Hearing." They have defined State Fair Hearing as: "The member and/or the member's representative acting on behalf of the member may request a State Fair Hearing through the MO HealthNet Division." During onsite review, Primaris recommended that Missouri Care should update the definition as stated in the MHD contract. Missouri Care resubmitted their updated policy. **Required Actions:** Missouri Care should send the updated policy to MHD for approval.		
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	MO 29-HS-AG-002 Member Appeals page 4 of 17 MO29-HS-AG-003 Member Complaint and Grievance pages 1, 4 of 9 MO 29-HS-AG-002 Member Appeals page 7 of 17	Met

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).*	MO29-HS-AG-003 Member Complaint and Grievance page 7 of 9-3 	
Findings: Missouri Care's policy of member complaint and grievance describes the responsibility of Missouri Care for acknowledging and resolving member inquiries and complaints National Committee for Quality Assurance (NCQA)/grievances (State Contract). It describes how the MCO complies with rules of state and NCQA requirements related to member's grievance rights. The purpose of the policy on member appeals is to describe Missouri Care legal and contractual obligations regarding a member's right to file an appeal stemming from an Adverse Benefit Determination issued by the MCO, or any of its providers, and to describe the steps a member may take to file a request for expedited resolution, standard appeal and request for a State Fair Hearing. A flyer is distributed upon enrollment, explaining the grievance system and containing specific instructions about how to contact the Missouri Care's member services. It also identifies the person from the MCO who receives and processes grievances. The MCO advises members of their appeal rights in the member handbook, the notice of adverse benefit determination, defined above, and an educational flyer. This flyer can be distributed with the member handbook, but it must be a stand-alone document. The grievance system flyer shall be readily available in the member's primary language. Missouri Care logs and tracks all inquiries and grievances in the MCO operating system. Inquiries are probed to determine if the inquiry is actually a grievance or appeal and are tracked to identify patterns of inquiry. During onsite review, Missouri Care explained that customer services keep track of all inquiries. They submitted their logs (excel sheets screen shot above). **Required Actions:** None.		
B. Level of appeals. Each MCO may have only one level of appeal for enrollees.	MO 29-HS-AG-002 Member Appeals: Page 6 of 17	Met
Findings: Missouri Care has only one level of appeal for members. **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	MO 29-HS-AG-002 Member Appeals: Page 4, 7, 15 of 17 MO29-HS-AG-003 Member Complaint and Grievance: Page 3 of 9	Met

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).		
Findings: Missouri Care member is made aware of their right to have an authorized representative act on his or her behalf to file an appeal, provided he or she has provided written consent to do so. This is explained in detail in the Member Handbook as well as the notice of adverse benefit determination (denial) letter. The parties to an appeal include the member, the legal guardian of the member for minor or an incapacitated adult, member's representative including an attorney or the legal representative of a deceased member's estate, and a provider on behalf of the member with consent, with the exception that providers cannot request continuation of benefits as specified in 42 C.F.R. §438.420(b) (5). **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 29-HS-AG-002 Member Appeals: Page 13 of 17	Met
Findings: Missouri Care acknowledges that if the MCO 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 the MCO's internal level of appeal and may initiate a State Fair Hearing. **Required Actions:** None.		
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 29-HS-AG-002 Member Appeals: Page 8 of 17 MO29-HS-AG-003 Member Complaint and Grievance: Page 3 of 9	Met
Findings: Members may file grievances directly with Missouri Care or the State Agency either orally or in writing at any time. Member, or a member's representative acting on behalf of the member with written consent of the member, must file an appeal no later than 60 calendar days from the date on the Missouri Care notice of adverse benefit determination. The expiration date to file an appeal is included in the Notice of Adverse Benefit Determination. **Required Actions:** None.		
F. Procedure.		Met

(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.)	MO29-HS-AG-003 Member Complaint and Grievance: Page 3 of 9 MO 29-HS-AG-002 Member Appeals: Page 9 of 17	
Findings: Missouri Care confirms that the members or their representative may file an appeal either verbally by contacting Member Advocacy and Customer Service Department at 1-800-322-6027 or by submitting a request in writing. Unless the member is requesting an expedited appeal resolution, a verbal appeal request must be followed by a written and signed appeal. During onsite review, Missouri Care explained that the member may write their complaints even at back of an envelope or fax their appeals-all is acceptable to the MCO. **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. (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	MO29-HS-UM-014 Adverse Determinations - Proposed Actions: Page 5 of 6	Met

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: Missouri Care's notice of action is given in writing to the members and is at a sixth grade reading level. It incorporates all the points listed in 3A (i-vi). **Required Actions:** It is recommended that Missouri Care updates its policy to reflect "adverse benefit determination" in place of "notice of action."		
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 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. Unknown whereabouts-the post office returns MCO's mail directed	MO 29-HS-AG-002 Member Appeals: Page 5, 6 of 17	Met

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: Missouri Care adheres to the timing of notice as per their state requirements listed above in 3B (i). **Required Actions:** None.		
(ii) For denial of payment, at the time of any action affecting the claim.	MO 29-HS-AG-002 Member Appeals: Page 6 of 17	Met
Findings: Missouri Care notifies their members at the time of any adverse benefit determination affecting the claim for denial of payment decisions that result in member liability. **Required Actions:** None.		
(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.)	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals (updated): Page 12 of 16	Met
Findings: Approval or denial shall be provided within 36 hours, to include one (1) working day of obtaining all necessary information for routine services. On Page 12 of the above stated policy, Missouri Care states that they shall notify the requesting provider within two business days following the receipt of the request of service regarding any additional information necessary to make a determination. In no case shall Missouri Care exceed 14 calendar days following the receipt of the request of service to provide approval or denial. On page 13 of the same policy, Missouri Care states that they must notify the member or the requesting practitioner in writing of the need for the extension within 36 hours to include 1 working day following the receipt of the request of service regarding any additional information necessary to make a determination. Section 2.5.5 of MHD contract directs the MCOs to notify the requesting provider within thirty-six hours, which shall include 1 working day, following the receipt of the request of service regarding any additional information necessary to make a determination. During onsite review, Primaris recommended that Missouri Care should be consistent in stating their policy and update “two business days” with “thirty-six hours, which shall include 1		

working day." Missouri Care corrected the error and resubmitted their updated policy to Primaris. **Required Actions:** Missouri Care should get their updated policy approved by MHD.		
(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.	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 13 of 16	Met
Findings: Missouri Care's policy states that they must give notice on the date that timeframes expire if the authorization decision has not been reached. Untimely service authorizations constitute a denial and are considered adverse actions. During onsite review, Missouri Care explained that if they do not meet the timeframes for service authorization decisions, they are auto-approved on the date the timeframe expires. **Required Actions:** None.		
(v) For expedited service authorization decisions, within the timeframes specified in §438.210(d) (2) (No later than 72 hours after 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.	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals Page 11, 13 of 16	Met
Findings: For urgent pre-service approval or denial, the decision/notification timeframe in Missouri Care is 24 hours (1 Calendar day) from the receipt of request. Oral and electronic/written notification is sent to the practitioner/and member**.** Missouri Care does not extend timeframes for urgent prior authorization decisions (Medical, Behavioral Health, and Substance Abuse). **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—	MO29-HS-UM-002 Prior Authorization, Direct Access and Standing Referrals: Page 13 MO 29-HS-AG-002 Member Appeals: Page 11 of 17	Met

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.		
Findings: The above stated policy explains that Missouri Care must notify the member or the requesting practitioner in writing of the need for the extension. The notice must include the specific information needed to make the decision and the time period given to provide the information. Missouri Care may deny the request if the needed information is not received within the time frame. If Missouri Care extends the timeframe, it shall, for any extension not requested by the member, make reasonable efforts to give the member prompt oral notice of the delay. Within 2 calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision and resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. **Required Actions:** None.		
4. 42 CFR 438.406 Handling of grievances and appeals. 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.	MO 29-HS-AG-002 Member Appeals: Page 4 of 17 MO29-HS-AG-003 Member Complaint and Grievance: Page 3 of 9 Medicaid-Members who cannot Read or Write: pages 1, 2 of 2	Met
Findings: Missouri Care will give members any reasonable assistance in completing forms and taking other procedural steps for grievances and appeals. This includes, but is not		

limited to, providing interpreter services and toll-free numbers that have adequate teletypewriting device for the deaf/teletypewriter (TTY/TTD) and interpreter capability. During onsite review, Missouri Care explained that they have a process for assisting members who cannot read or write. A member may call Missouri Care requesting assistance reading a letter they received from Missouri Care or may request assistance filling out a form. Customer service agents and appeals team help the members in filling the information required in the forms. The members may provide the information verbally and the representative from Missouri Care would fill up the form. **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 this requirement of confirmation in "writing.")	MO 29-HS-AG-002 Member Appeals page 9 of 17 MO29-HS-AG-003 Member Complaint and Grievance: Page 7 of 9	Met
Findings: In Missouri Care all verbal member grievances are acknowledged verbally at the time of receipt and an acknowledgment letter is sent within 10 business days. All written member grievances are acknowledged in writing within 10 business days. Missouri Care will acknowledge the receipt of each appeal in writing within 10 business days after receiving an appeal request. The appeals process must require that oral inquiries seeking to appeal are treated as appeals (to establish the earliest possible filing date for the appeal) and will be confirmed in writing, unless the member or the provider requests expedited resolution. **Required Actions:** None.		
(ii) Ensure that the individuals who make decisions on grievances and appeals are individuals—	MO 29-HS-AG-002 Member Appeals: Page 8	Met

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.		
Findings: Missouri Care is compliant with all the requirements listed in this section 4B (ii). During onsite review, Missouri Care explained that all the appeals go to the external vendor- Medical Review Institute of America. **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 29-HS-AG-002 Member Appeals: Page 7 of 17	Met
Findings: Missouri Care gives members, a member's legal guardian for minor or an incapacitated adult, the member representative or provider acting on the member's behalf		

with consent the opportunity to submit written comments, documents, records, evidence and allegations of fact or law and other information relevant to the appeal in person or in writing. Missouri Care states that upon request from the member to present evidence and allegations of fact or law in person and/or in writing, the appeals coordinator will inform the member by phone that Missouri Care will arrange a time to meet or conduct a conference call. The appeals coordinator will request the member's availability. MCO will document the case file of the member's request. The appeals coordinator will notify Missouri Care's Medical Directors of the member's request to discuss the issue with Missouri Care and establish their availability for the meeting or conference call. At the meeting or conference call, the member will present his or her evidence. Then, Missouri Care will advise the member that it will discuss the evidence and make a determination in writing within the required time frame. The information about timeframe of expedited appeals is provided in the member handbook, adverse benefit determination notice, and by customer service department. **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 29-HS-AG-002 Member Appeals: Page 7 of 17	Met
Findings: At any time during the appeal process, the member and his or her representative may examine the member's case file, including medical records and any other documents considered during the appeal process. The member may also request status updates, additional information, or assistance (including requests for duplicate notice of adverse benefit determination letters, copies of all documents used during the review, standards on which the decision was based) free of charge and sufficiently in advance of the resolution timeframe for appeal on his or her appeal by contacting Customer Service Department. **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 29-HS-AG-002 Member Appeals: Page 7 of 17	Met

Findings: In Missouri Care the parties to an appeal include the member, the legal guardian of the member for minor or an incapacitated adult, member's representative including an attorney or the legal representative of a deceased member's estate and a provider on behalf of the member with consent. **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 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 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.	MO29-HS-AG-003 Member Complaint and Grievance: Page 7 of 9 MO 29-HS-AG-002 Member Appeals: Page 9 of 17	Met

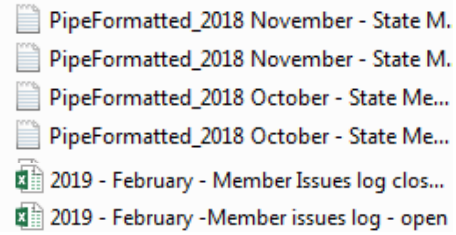
Findings: Missouri Care will resolve and respond to grievances in writing and shall not exceed 30 calendar days of the filing date, taking into consideration the urgency of the situation or whether the resolution timeframe has been extended. Missouri Care shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires but will not exceed 30 calendar days from the date the appeal is received. For expedited resolution of an appeal and notice to affected parties, Missouri Care has no longer than seventy-two (72) hours after the appeal is received. **Required Actions:** None.		
B. Extension of timeframes. (i) The MCO may extend the timeframes by up to 14 calendar days if: The enrollee requests the extension; or 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 29-HS-AG-002 Member Appeals: Page 9 of 17	Met
Findings: Missouri Care follows the above listed criteria from the CFR/MHD contract. **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: Make reasonable efforts to give the enrollee prompt oral notice of the delay. 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. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	MO 29-HS-AG-002 Member Appeals: Page 9 of 17	Met

Findings: If Missouri Care extends the timeframe, it shall, for any extension not requested by the member, make reasonable efforts to give the member prompt oral notice of the delay. Within 2 calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision and resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. **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 29-HS-AG-002 Member Appeals: Page 12 of 17 MO29-HS-AG-003 Member Complaint and Grievance Page 7 of 9	Met
Findings: All members are advised in writing of the outcome of the investigation of the grievance, inclusive of appeal rights when necessary. Missouri Care will provide notices of appeals to members in a culturally and linguistically appropriate manner. Written documents relating to an appeal, including the acknowledgment letter, notice of extension for resolution and appeal resolution letter, will be written in English, will include an offer of language assistance in the most common languages spoken by members, and will be made available in the member's language upon request. In addition, oral interpretation services will be available to members. **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.	MO 29-HS-AG-002 Member Appeals: Page 12, 13 of 17	Met

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.		
Findings: Missouri Care's written notice of the appeal resolution includes all the above listed requirements from the CFR. **Required Actions:** None.		
E. Requirements for State Fair Hearings. (i) An enrollee may request a State Fair Hearing: After receiving a notice that the MCO is upholding the adverse benefit determination. If deemed to have exhausted the MCO's appeals processes. 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 29-HS-AG-002 Member Appeals: Page 13 of 17	Met
Findings: Missouri Care's member may request a State Fair Hearing, no later than 120 calendar days, from the date an adverse benefit determination is upheld through the MCO's internal level of appeal and not resolved wholly in favor of the member. If the MCO 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 the MCO's internal level of appeal and may initiate a State Fair Hearing. The parties to the State Fair Hearing include the MCO, the member, and his or her representative or the representative of a deceased member's estate. **Required Actions:** None.		
(ii) External medical review. The state may offer and arrange for an external medical review if the following conditions are met.		This is not applicable to the MCO

The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State Fair Hearing. The review must be independent of both the State and MCO. The review must be offered without any cost to the enrollee. The review must not extend any of the timeframes specified in §438.408 and must not disrupt the continuation of benefits in §438.420.		
Findings: N/A **Required Actions:** N/A		
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 29-HS-AG-002 Member Appeals: Page 9 of 17	Met
Findings: MCO shall establish and maintain an expedited review process for appeals when it is determined by the MCO (for a request from the member), or if the provider indicates (in making the request on the member's behalf) that taking the time for standard resolution could seriously jeopardize the member's life or 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	MO 29-HS-AG-002 Member Appeals: Page 9 of 17	Met

requests an expedited resolution or supports an enrollee's appeal.		
Findings: Missouri Care shall ensure that punitive action is not taken in retaliation against a member who requests an appeal or a provider who requests an expedited resolution or supports a member's 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 29-HS-AG-002 Member Appeals: Page 9 of 17	Met
Findings: If a member's request for expedited resolution is denied, the appeal will be transferred to the timeframe for standard resolution, specified herein, and Missouri Care shall make reasonable efforts to give the member prompt verbal notice of the denial and follow up within 2 calendar days with a written notice, resolve the appeal 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).*	MO29-HS-AG-003 Member Complaint and Grievance: Page 6 of 9 MO29-HS-AG-001 Provider Complaints and Appeals: Page 4 of 6	Met
Findings: Information regarding the grievance system is distributed to all in-network providers at the time they enter into a contract and to out-of-network providers within ten 10 calendar days of prior approval of a service or the date of receipt of a claim, whichever is earlier, via the member flyer. Missouri Care will notify providers of the complaint and appeal procedures at the time of contracting with Missouri Care. Providers will receive information packets containing the		

complaint and appeal policies and procedures, specific instructions regarding how to contact Missouri Care Provider Relations Department, and also identify the Grievance Coordinator who receives and processes provider complaints and appeals. Participating and nonparticipating providers receive notice of the complaint and appeal procedure as part of the Missouri Care approval or denial notice. **Required Actions:** It is recommended that Missouri Care updates their policy MO29-HS-AG-003 Member Complaint and Grievance: page 6 of 9 to mention "grievance and appeal system" in place of "grievance system." The term "grievance system" was used in Oct 2015 Managed Care rules which did not include "grievance."		
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 29-HS-AG-002 Member Appeals: Page 15, 16 of 17 MO29-HS-AG-003 Member Complaint and Grievance: Page 8 of 9 	Met
Findings: MCO shall submit the log sheets for all inquiries, grievances, and appeals to the state agency monthly and upon request. All documents and records shall be scanned and maintained in the secured grievance and appeals electronic archive system. The records will be accurately maintained in a manner accessible to the state and available to CMS upon request in format and frequency specified by the state agency. The MCO system shall be able to distinguish MO Health Net Managed Care members from other health plan members. 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 of the logs submitted by Missouri Care 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:	MO 29-HS-AG-002 Member Appeals: Page 16 of 17	Met

A general description of the reason for the appeal or grievance. The date received. The date of each review or, if applicable, review meeting. Resolution at each level of the appeal or grievance, if applicable. Date of resolution at each level, if applicable. Name of the covered person for whom the appeal or grievance was filed.	MO29-HS-AG-003 Member Complaint and Grievance: Page 8 of 9	
Findings: Missouri Care maintains records of their grievances and appeals which at a minimum contains all the above listed requirements from the CFR. During onsite review, Missouri Care displayed their Internal Access Appeals Database which had all the listed fields. **Required Actions:** None.		
C. The MCO shall retain member grievance and appeal records for a period of no less than 10 years. (MHD contract 2.15.3f).	MO 29-HS-AG-002 Member Appeals: Page 16 of 17 MO29-HS-AG-003 Member Complaint and Grievance: Page 8 of 9	Met
Findings: Missouri Care shall retain member grievance and appeal records for a period of no less than 10 years. The appeals coordinator will maintain a file on each appeal, whether received verbally or in writing, for no less than 10 years in accordance with contractual requirements for recordkeeping and confidentiality of member's medical records. **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: Within 10 calendar days of the MCO sending the notice of adverse benefit determination. The intended effective date of the MCO's proposed adverse benefit determination.	MO 29-HS-AG-002 Member Appeals: Page 14 of 17	Met

Findings: A member may continue to receive services during the appeals process under the following circumstances: As used in this policy, "timely" filing means filing in writing on or before, whichever is later, of the following: -Within 10 calendar days of the mailing of the notice of Adverse Benefit Determination. -The intended effective date of the proposed Adverse Benefit Determination. **Required Actions:** None.		
B. Continuation of benefits. The MCO must continue the enrollee's benefits if all of the following occur: The enrollee files the request for an appeal timely in accordance with §438.402(c) (1) (ii) and (c) (2) (ii). The appeal involves the termination, suspension, or reduction of previously authorized services. The services were ordered by an authorized provider. The period covered by the original authorization has not expired. The enrollee timely files for continuation of benefits.	MO 29-HS-AG-002 Member Appeals: Page 15 of 17	Met
Findings: Missouri Care's member's benefits shall be continued if the member or the provider files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits. **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. (ii) The enrollee fails to request a State Fair Hearing and continuation	MO 29-HS-AG-002 Member Appeals: Page 15 of 17	Met

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: Missouri Care follows all the above listed requirement for the duration of continued or reinstated benefits. **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 29-HS-AG-002 Member Appeals: Page 15 of 17	Met
Findings: If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section from the CFR. **Required Actions:** It is recommended that Missouri Care replaces the word "action" with "adverse benefit determination" wherever applicable throughout their policies.		
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 later than 72 hours from the date it	MO 29-HS-AG-002 Member Appeals: Page 15 of 17	Met

receives notice reversing the determination.		
Findings: 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 shall 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 29-HS-AG-002 Member Appeals: Page 15 of 17	Met
Findings: Missouri Care states that in the above condition they shall pay for those services which were provided while the appeal was pending and the decision to deny authorization of services was reversed. **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%**