Primaris
Healthcare Business Solutions

2019 External Quality Review
Compliance

UnitedHealthcare®

Measurement Period: Calendar Year 2018
Validation Period: Feb-Apr 2019
Publish Date: July 22, 2019

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.

UnitedHealthcare 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.

UnitedHealthcare'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 UnitedHealthcare:

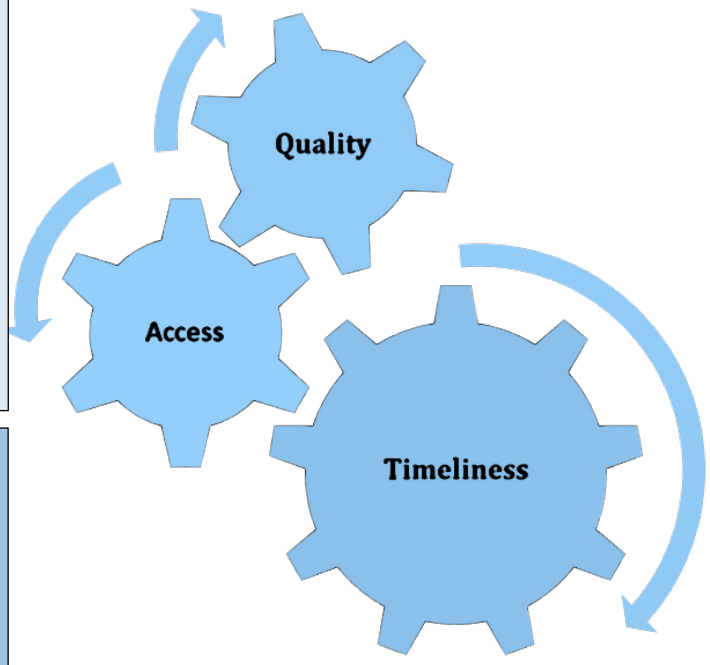
Table 1: 42 CFR 438 Subpart D-MCO, PIHP and PAHP Standards
• §438.206 Availability of services • §438.207 Assurances of adequate capacity and services • §438.208 Coordination and continuity of care • §438.210 Coverage and authorization of services • §438.214 Provider selection • §438.224 Confidentiality • §438.228 Grievance and appeal systems • §438.230 Subcontractual relationships and delegation • §438.236 Practice guidelines • §438.242 Health information systems

The overall goal of the compliance with regulations review is to quantify UnitedHealthcare'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

Figure 1: Federal Requirement for the MCO

2.0 Methodology

The primary objective of Primaris' review is to provide meaningful information to MHD and UnitedHealthcare regarding compliance with state and federal guidelines. Primaris collaborated with UnitedHealthcare 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 UnitedHealthcare towards continuous improvement and excellence.

Figure 2: Process of Compliance Evaluation for UnitedHealthcare

Evaluation tools were created based on MHD Managed Care Contract and 42CFR 438, subpart D for the ten standards (Appendix A-J).
UnitedHealthcare 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: Availability of services: travel distance requirements; appointment standards; UnitedHealthcare credentialing plan; provider manual; provider directory; UnitedHealthcare clinical services medical management operational policy - accessibility and initial response; second opinion policy; UnitedHealthcare clinical services medical management operational policy - out-of-network requests and continuing care; single case agreement process; UnitedHealthcare clinical services medical management operational policy - public communication and marketing; and five-day enrollment PCP Letter.
- Assurances of adequate capacity and services: provider directory; behavioral health provider look up; provider manual; Twin Rivers closure document; termination Mercy East document; and Ripley County hospital closure document; and state notification provider termination.
- Coordination and continuity of care: Member Handbook; case management policy; transition of care policy; UnitedHealthcare clinical services medical management operational policy-out-of-network requests and continuing care; and health home procedure document.

- Coverage and authorization of services: clinical peer review referral; training care management staff; utilization review staff qualifications; non-certifications of requests for services; utilization management (UM) decision making; clinical certification of services-initial clinical review; Excel sheet-Missouri eviCore standard compliance grid; applying UM criteria; peer clinical review; initial review timeframes; consumer safety; appeal peer review qualifications; initial adverse determination notices; performance assessment and incentives; UM of behavioral health benefits; clinical review criteria; and initial clinical review.
- Provider selection: UnitedHealthcare credentialing plan; additional state and federal credentialing requirements; state loading requirements; practitioners sanctions monitoring; state credentialing application; Missouri facilities medical record review instructions; advanced directives; disclosure form; national program disclosure policy; disclosure processing; escalation process for provider; and credentialing to load report.
- Confidentiality: document retention policy; privacy manual; MO privacy and confidentiality; identification and authentication; and business associate agreement.
- Grievance and appeal systems: escalation tracking system (ETS) power point presentation; member handbook; provider manual; appeal review timeframes; appeal process and record documentation; appeal notices; approved definitions; initial adverse determination notices; appeal peer reviewer qualifications; independent review organization; member explanation of benefits; member appeal, state fair hearing, and grievance policy (old and updated version); document retention policy; document oversight and adherence; narratives on inquiry, member explanation of benefits, family planning, payment for custom items; grievance and appeal flyer; single case agreement template; welcome letter to providers; and member issue logs (open and closed cases).
- Subcontractual relationships and delegation: subcontractor oversight; contracts/agreements with-Dental Benefit Providers, Inc., CareCore national, Inc., March vision, Medical Transportation Management, Rose International, Inc.; Children's Mercy Integrated Care Solutions, Inc.; and Missouri state programs regulatory requirements.
- Practice guidelines: development of Clinical Practice Guidelines/Preventive Health Recommendations; hierarchy of clinical evidence; review of clinical and preventive guidelines; Medicaid newsletter; medical technology assessment committee minutes of meeting; clinical practice guidelines; and UM program description; child and adolescent level of care utilization system (CALOCUS); and level of care utilization system (LOCUS) for psychiatric and addiction services.

- Health information systems: 2019 Missouri EQRO health information systems narrative; UnitedHealthcare Missouri architecture system architecture-enrollment, provider, claims, encounters, finance, reporting, and clinical system flows.

Figure 3: Sources of Information from UnitedHealthcare

On-Site Review Information

An on-site review was performed at UnitedHealthcare office in St. Louis, Missouri, on March 20-21, 2019. The following personnel from UnitedHealthcare were available for an interactive session on 'Compliance with Regulations':

- Robbyn Roth, Senior Director, Clinical Quality Missouri Medicaid
- Dr. Ravi Johar, MD, Chief Medical Officer
- Todd Crippin, Vice President, Network
- Chris Hogan, Director, Technology
- Cybele Kanin, Director, Technology
- Shannon Zellner, Senior Compliance Analyst
- Ginnah Skula, Senior Research Consultant
- Lisa Overturf, Associate Director, Clinical Quality
- Beth McCrary, Associate Director, General Management
- Ken Powell, Director Provider Operations and Member Engagement
- Katherine Whitaker, Associate Director, Compliance
- Colleen Giebe, Director, Health Services
- Paula Stewart, Senior Clinical Admin Nurse
- Carey Merzlicker, Chief Financial Officer/Chief Operating Officer
- Jamie Bruce, Missouri Health Plan CEO

Table 2: MCO Information	
MCO Name:	UnitedHealthcare
MCO Location:	13655 Riverport Dr. Maryland Heights, MO. 63043
On-site Location:	13655 Riverport Dr. Maryland Heights, MO. 63043
Audit Contact:	Robbyn S Roth, MSN, BSN,RN-BC, NE-BC, CPHQ Senior Director, Clinical Quality Missouri Medicaid
Contact Email:	robbyn.roth@uhc.com

Compliance Ratings

The information provided by UnitedHealthcare 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 UnitedHealthcare 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 ten standards. UnitedHealthcare achieved an overall score of 99.4 %.
- UnitedHealthcare is not put on a corrective action plan for any standard.
- MHD contracted with UnitedHealthcare (a new MCO in Missouri) on May 1, 2017. Since UnitedHealthcare did not provide Managed Care Services for a full CY 2017, their evaluation by EQRO was out of scope for "EQR 2018." Hence there is no compliance review findings available from last year.

Table 4: Summary of Evaluation UnitedHealthcare: Compliance with Regulations

		Number of Sections					
Standard	**Standard Name**	**Total**	**Met**	**Partial Met**	**Not Met**	**Score**	**Score %**
§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	20	2	0	**42**	**95.5**
§438.214	Provider selection	12	12	0	0	**24**	**100**
§438.224	Confidentiality	19	19	0	0	**38**	**100**
§438.228	Grievance and appeal systems	44	44	0	0	**88**	**100**
§438.230	Sub Contractual Relationships and Delegation	7	7	0	0	**14**	**100**
§438.236	Practice Guidelines	6	6	0	0	**12**	**100**
§438.242	Health Information Systems	7	7	0	0	**14**	**100**
Total	**10**	**155**				**308**	**99.4 %**

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

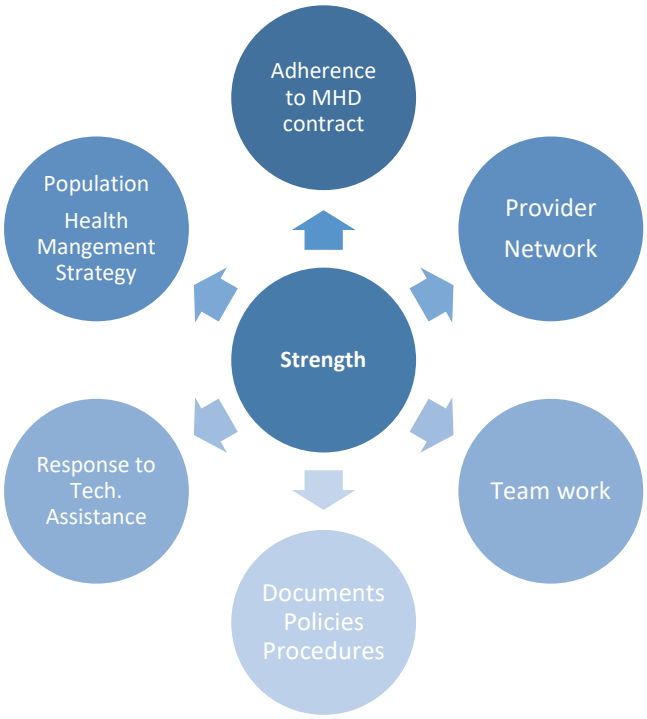


Figure 4: Strengths of UnitedHealthcare

Strengths

UnitedHealthcare has a member population of about 160,000 (data: end of March, SFY 2019) which is 25.39 % of the total member population (MO Medicaid Managed Care and CHIP combined). UnitedHealthcare expanded their provider network through contracting with Cox Health System. Medical Management/UM program is a consumer focused healthcare program that facilitates member access to care and services. The UM program is designed to provide mechanisms for evaluating the quality, continuity, accessibility, timeliness and outcomes of services rendered and the implementation of appropriate action plans. It includes a process and quality improvement program designed to monitor efficiency and effectiveness. Utilization review activities are supported by evidence-based nationally recognized medical policies, clinical guidelines and criteria. These policies, guidelines and criteria influence care decisions to promote delivery of appropriate care in the most appropriate setting at the appropriate time. Delivery of person-centered care; community based care, expansion of case management staffing to accommodate membership growth, population management strategy, robust information systems has enabled UnitedHealthcare to meet all the state performance targets.

The UM Program strategy, initiatives, metrics and outcomes are monitored through the National Medical Care Management Committee (NMCMC). The goal of this quality oversight

committee is to provide a consistent and structured process for monitoring program activities, analyzing data and identifying opportunities to improve the effectiveness and efficiency of processes.
UnitedHealthcare's adherence to MHD contract, knowledge of the staff during onsite visit, team work, documentations, policies and procedures, prompt response to the technical assistance have led to a high compliance score.

Areas Requiring Corrective Action
UnitedHealthcare is not put on a corrective action plan for any standard. However, they are required to work on two criteria which are assigned a score of "Partially Met" for the standard "42 CFR 438.210 Coverage and authorization of services." The details are provided in the section 3.5.

3.2 Regulation I- Availability of Services
UnitedHealthcare was evaluated for 11 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix A).

3.2.1 Performance Strengths
UnitedHealthcare provides a full range of medical providers that consists of hospitals, primary care physicians, specialists, advanced practice nurses, safety net hospitals, FQHCs, Provider-Based Rural Health Clinics (PBRHCs), Independent Rural Health Clinics (IRHCs), local public health agencies, and tertiary care. In 2018 UnitedHealthcare expanded their provider network.

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

3.3.1 Performance Strengths
UnitedHealthcare examines medical, behavioral and social/environmental concerns to help members get the right care from the right care provider in the right place and at the right time. Their programs provide interventions to members with complex medical, behavioral, social, pharmacy and specialty needs, aiming to increase quality of life, improve access to health care and reduce expenses. Care management/coordination team aims to increase

member engagement by offering resources to fill gaps in care and developing personalized health goals using evidence-based clinical guidelines.

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

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

3.4.1 Performance Strengths

UnitedHealthcare provides timely and consistent determinations and notices for all out-of-network coverage requests and ensures consumers have needed information regarding alternatives for continuing care. UnitedHealthcare also provides a well-defined process for the transfer of relevant member information, including medical records and other pertinent materials, to another MCO upon notification of establishment of care. UnitedHealthcare has further established a consistent process for assessment and the development of an evidence based, person centered plan of care for individuals identified and enrolled in case management. This includes outlining a process for monitoring, reassessment and ongoing management of the plan of care and defining a process to measure satisfaction with case management services.

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

UnitedHealthcare was evaluated for 22 criteria. They scored "Met" for 20 and "Partially Met" for 2 of 22 criteria resulting in 95.5 % compliance (Appendix D).

3.5.1Performance Strengths

UnitedHealthcare has formal systems and workflows designed to process pre-service, post-stabilization, continued stay and post-service requests for coverage and authorization of services provided to its enrollees by in-network (INN) and out-of-network (OON) practitioners, facilities and agencies. UnitedHealthcare's utilization management (UM) program establishes and maintains required expedited and standard timeframes and extensions for administrative and clinical reviews conducted on a prospective, concurrent or retrospective basis. Staff members comply with the established timeframe

requirements or the more stringent/restrictive applicable accreditation, state and federal laws, contract, or government program requirements when conducting reviews. UnitedHealthcare ensures that UM decisions accommodate urgency and minimize disruption in the provision of health care, and that Clinical Certification and Notification staff will not engage in unnecessary repetitive contacts with providers or patients to obtain information, and all information relevant to a certification request is maintained with the electronic record.

3.5.2 Areas Requiring Corrective Action

A corrective action plan is not raised. However, UnitedHealthcare has to work towards the following weaknesses (details in appendix D). These are assigned a score of "Partially Met":

- UnitedHealthcare's member handbook provides information about family planning services; however, the member handbook or their policies do not state that "family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20."
- The 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 six (6) months of approval, even if the member's enrollment in the health plan ends (MHD contract 2.5.5h): UnitedHealthcare stated that they have not had any occurrences of this issue since May 01, 2017 (effective date of contract with MHD), and were unaware of a need for this policy. However, UnitedHealthcare has a new setup which pays for these custom items.

3.6 Regulation V-Provider Selection

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

3.6.1 Performance Strengths

UnitedHealthcare's credentialing and re-credentialing plan is well detailed and outlined. UnitedHealthcare also follows stringent sanctions as they actively monitor sanction alerts arising from review of information from government agencies and authorities including but not limited to, the Centers for Medicare and Medicaid Services (CMS), Medicaid agencies, state licensing boards, and the Office of the Inspector General (OIG). If such information is found (through rigorous monitoring), and relates to any of their providers,

UnitedHealthcare has a plan of appropriate action which shall be take in accordance with their provider participation agreements and credentialing policies.

3.6.2 Areas Requiring Corrective Action

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

3.7 Regulation VI-Confidentiality

UnitedHealthcare was evaluated for 19 criteria and scored “Met” for all of them resulting in 100% compliance (Appendix E).

3.7.1Performance Strengths

UnitedHealthcare, their business associates (BA), subcontractors, other business organizations (as applicable), adhere to HIPAA Privacy Policy (Manual) which operates in conjunction with the UnitedHealthcare’s Personal Information Privacy and Data Protection Policy. These policies describe UnitedHealthcare's approach to the protection of information about individuals under applicable laws. UnitedHealthcare manages Protected Health Information ("PHI") responsibly and legally that serves their business objectives and helps build trust with stakeholders such as customers, partners, and regulators.
UnitedHealthcare requires that a security risk assessment be performed at the onset of a new business arrangement or material change of services, prior to granting an external party organization, or external party information technology systems, connectivity or access to UnitedHealth Group's information technology systems or information assets. The security exhibit external access agreement along with the business associate agreement (BAA) supplements any customer contracted service level agreements (SLA).
Enterprise Information Security is responsible for determining the scope of assessment that must be performed. The security assessment may include, but is not limited to, completion of the Information Security Assessment Survey and a review of the external party's network topology.

3.7.2 Areas Requiring Corrective Action

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

3.8 Regulation VII- Grievance and Appeal System

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

3.8.1 Performance Strengths

UnitedHealthcare processes appeals and grievances submitted by members and by authorized representatives, including providers submitting on behalf of members in accordance with applicable state and federal regulatory requirements, and the member's plan coverage documents. UnitedHealthcare maintains a full and fair review process for resolving member appeals of an adverse determination made by UnitedHealthcare and responding to member requests to review expressions of dissatisfaction unrelated to an adverse determination in accordance with 42 CFR 438.400.

In conducting the review, the Resolving Analyst (RA) and/or decision-maker(s) conduct(s) a full investigation of the substance of the appeal or grievance to include review of the member's governing plan documents, Member Handbook, and as applicable, the state MO HealthNet contract, for an appeal the previous adverse benefit determination and follows the processing requirements.

3.8.2 Areas Requiring Corrective Action

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

3.9 Regulation VIII Subcontractual relationships and delegation

UnitedHealthcare was evaluated for 7 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix H).

3.9.1 Performance Strengths

UnitedHealthcare has an agreement with their subcontractors/vendors who are required to follow Missouri state program regulatory requirements. These requirements are related, but not limited to: the covered services; Medicaid eligibility; accessibility standards; hours of operations, appointments; hold state harmless; indemnification; provider selection; restrictions on referrals; subcontracts; record retentions; record access; government audit and investigations; privacy, confidentiality; compliance with law; physician incentive plans; lobbying; excluded individual and entities; cultural competency; marketing; fraud, waste, and abuse prevention; data, reports; insurance requirements; licensure; quality; utilization management; transition of covered persons; continuity of care; termination; prohibited services; Federally Qualified Health Centers; birth notifications; claims; consumer protections; national provider identifier; off-shoring; complaints and appeals; clinical laboratory improvement act (CLIA) certification or waiver; and attestations.

3.9.2 Areas Requiring Corrective Action

There are no areas of concern. No corrective action is required; however, there is a recommendation related to "right to audit for 10 years duration." (Ref. 6.0 Recommendations section of this report.)

3.10 Regulation IX Practice guidelines

UnitedHealthcare was evaluated for 6 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix I).

3.10.1 Performance Strengths

UnitedHealthcare develops and adopts Clinical Practice Guidelines (CPG) and Preventive Health Recommendations (PHR) in collaboration with the UnitedHealth Coverage Determination Committee appropriate for the MCO population. They have established a process for the development, review, adoption, and distribution of CPG and PHR. Evidence-based national guidelines from recognized sources are utilized during development of CPG/PHR and address the provision of acute, chronic, behavioral, and preventive health care. When evidence-based guidelines are not available, consensus guidelines are used (appropriate specialist review required). CPGs are reviewed and/or revised annually whereas PHR are revised annually or more frequently if revisions are required. PHR may be distributed to the members in the following ways: periodic member mailings, internet posting, and targeted mailings. Members will be provided with a copy of PHR upon request.

3.10.2 Areas Requiring Corrective Action

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

3.11 Regulation X- Health Information Systems

UnitedHealthcare was evaluated for 7 criteria and scored "Met" for all of them resulting in 100% compliance (Appendix J).

3.11.1 Performance Strengths

UnitedHealthcare utilizes a well-structured integrated management information system that supports the Missouri Medicaid program. Their state-of-the art, scalable platform integrates physical health, behavioral health, and social services. All inbound data from providers is validated through multiple edits and uses standard formats to the extent feasible and appropriate. Data will be rejected back to the provider if it does not meet minimum requirements for completeness, logic and consistency.

3.11.2 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 UnitedHealthcare.

Table 5: Key Findings and Audit Results for UnitedHealthcare

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	Concerns identified, CAP raised	20/22	Partially Met
438.214 Provider selection	No concerns identified	12/12	Met
438.224 Confidentiality	No concerns identified	19/19	Met
438.228 Grievance and appeal systems	No concerns identified	44/44	Met
§438.230 Sub Contractual Relationships and Delegation	No concerns identified	7/7	Met
§438.236 Practice Guidelines	No concerns identified	6/6	Met
§438.242 Health Information Systems	No concerns identified	7/7	Met

UnitedHealthcare 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 UnitedHealthcare'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 UnitedHealthcare. Coverage and Authorization of services: Some of the policies have inconsistent information about the timeframes that do not abide by the MHD contract in some instances, for example:

MO UM of behavioral health benefits policy, page 13 of 18: Turnaround Time for Standard Cases

- The Care Advocate sends a Request for Information letter by mail to the enrollee/enrollee's authorized representative, provider within 5 calendar days of the request.
- The recipient has 45 calendar days from receipt to submit the requested information.

5.2 Quality, Timeliness, and Access to Healthcare Services

UnitedHealthcare has demonstrated a vast amount of resources available to its members which not only fulfill the compliance requirements but also simplify and effectively coordinate their services to their members. The following are some of accomplishments of UnitedHealthcare during CY 2018. These reflect their aim to provide access to quality health services in a timely manner to its member population:

- Launched Member incentive program (Well-Child visits in third, fourth, fifth and sixth years of life, Adolescent Well-Care Visits, Annual Dental Visit & Comprehensive Diabetes Care).
- Achieved and exceeded the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) withhold goal of MHD in all four regions. The MCO must meet the required 65% participant ratio for the Categories of Aid and age groups (infants less than one year old and children ages one (1) through less than six (6)) specified for the contract period. MHD withholds one percent (1.0%) of monthly capitation payments made to the MCO for this performance category. This is returned to the MCO in full, if the participant ratio is met in aggregate for the specified Categories of Aid and age groups.
- Developed and conducted a Provider Dental Barrier Analysis.
- Developed Population Health Management Strategy.
- Met and/or exceeded all goals for State P4P (Pay for Performance) program.
- Received Interim NCQA accreditation; (final accreditation onsite scheduled May 2019).

- Provider incentive program reached 52% of providers (State goal was 10%).
- Membership in Foster Care program doubled and expanded care management staffing to accommodate for membership growth.
- Expanded care management and changed to multi-disciplinary team approach.
- Met all state performance targets.

5.3 Improvement by UnitedHealthcare

There is no data available for comparison from last year as UnitedHealthcare was not evaluated in EQR 2018.

6.0 Recommendations

UnitedHealthcare

- Primaris recommends that all the policies (wherever applicable) should be updated consistently to reflect the correct information based on "2016 Managed Care Final Rule" and MHD contract.
- While UnitedHealthcare has many examples of their compliance readily available upon request, we do recommend that for every practice performed to achieve 100% compliance, there is a written procedure or policy which accompanies their statements/narratives.
- The revisions to the policies/documents as a result of technical assistance should be submitted to the MHD for approval.
- UnitedHealthcare should update all of their subcontractors' agreement with the "right to audit for 10 years…." as per 42 CFR 438.230(c) (3) (iii), consistently. (Date of applicability: July 1, 2017).
- UnitedHealthcare may adopt the language used in CFR and MHD contract; however, they are advised to incorporate the guidelines/rules as their own organization's policy versus copying the exact language from the CFR and MHD contract which is for all MCOs, PIHPs, and PAHPs. Furthermore, using specific and relevant language pertaining to a particular MCO would help ensure full understanding of all requirements provided by the state.

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 UnitedHealthcare 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 UnitedHealthcare 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 thirty (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 UnitedHealthcare 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.
- 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.
- MHD and all MCOs in MO should collaborate for some of the CPGs related to high risk conditions/diseases prevalent in their member population. This would bring consistencies in medical management. As the member population switches between the MCOs on a frequent basis for varying reasons, their treatment plan would (potentially) not be affected.

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).*	CS Travel Distance Requirements-State of Missouri: Pages 28, 29 of 77	Met
Findings: Documentation provided (CS Travel Distance Requirements-State of Missouri. Pages 28-29) lists the following UHS requirements: • Primary Care Providers: 10 miles urban, within 20 miles for basic and 30 miles for rural. • Physical Therapy: within 30 miles. • Pre-natal OBG: within 15 miles urban, within 30 miles for basic and 60 miles for rural. • Specialty: within 25 miles urban, within 50 miles for basic and 100 miles for rural (exceptions exist) • Ancillary Provider: within 30 miles		

The internal requirement policy further states that for those providers not addressed under 20 CSR 400-7.095, the health plan shall ensure that members have access to those providers within thirty (30) miles. **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).*	Appointment Standards MO Healthnet: Pages 1,2,3 of 5	Met
Findings: UnitedHealthcare's Appointment Standards require that waiting times for appointments should not exceed one (1) hour from the scheduled appointment time. Waiting time includes time spent in the lobby and the examination room prior to being seen by a provider. Emergency Care–a provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care as defined by State requirement §354.400 RSMo (Revised Statutes of Missouri). Regarding provider appointment scheduling standards;		

<table>
<tr><td colspan="3">

- Routine care, without symptoms – within thirty (30) calendar days from the time the enrollee contacts the provider.
- Routine care, with symptoms – within one (1) week or (5) business days, whichever is earlier from the time the enrollee contacts the provider.
- Urgent care for physical or behavioral illness/injuries which require care immediately, but which do not constitute emergencies as defined by §354.400 RSMo – within twenty-four (24) hours from the time the enrollee contacts the provider.
- Emergency care – a provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care as defined by §354.400 RSMo.
- Obstetrical care – within seven (7) calendar days of request for enrollees in the first or second trimester of pregnancy; within three (3) days for enrollees in the third trimester.
- Obstetrical Care High Risk within three (3) calendar days of identification of high risk.
- Mental health care – shall be available twenty-four (24) hours per day, seven (7) days per week.
- After care must be within seven (7) calendar days after hospital discharge.

Required Actions: None.
</td></tr>
<tr><td>B. Delivery network. The MCO consistent with the scope of its contracted services, meets the following requirements:</td><td></td><td></td></tr>
<tr><td>(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.</td><td>2017-2019 UnitedHealthcare Credentialing Plan

MO Provider Manual

MO HealthNet Provider Directory

UCSMM 06 11 Accessibility and Initial Response</td><td>Met</td></tr>
<tr><td colspan="3">**Findings:** UnitedHealthcare supplied a comprehensive directory of all appropriate providers for all enrollees. UnitedHealthcare also provides simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. They also provide materials for visually impaired members. For all other languages and needs they provide oral interpreter services 24 hours a day, seven days a week to their members free of charge.
Required Actions: None.</td></tr>
<tr><td>(ii) Provides for a second opinion from a network provider or arranges for the enrollee to obtain one outside</td><td>UHCP MO Second Opinion Policy: Pages 1, 2, 3, of 3</td><td>Met</td></tr>
</table>

the network, at no cost to the enrollee. These policies and procedures shall address whether there is a need for referral by the primary care provider or self-referral. Missouri Revised Statutes Section 208.152 states that certain elective surgical procedures require a second medical opinion be provided prior to the surgery. A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion *(MHD contract 2.8).*	UCSMM 06 21 Out of Network Request and Continuing Care: Page 5 of 6 MO Care Provider manual: Pages 35, 36 of 91 MO+ Healthnet Handbook WEB: Page 23 of 90	
Findings: UnitedHealthcare's adherence to second and third opinions as well as referral mechanisms is primarily addressed in UHCP MO Second Opinion Policy and policy # UCSMM 06 21 Out of Network Request and Continuing Care. These requirements are further addressed in their Provider Manual and Handbook. UnitedHealthcare has formal systems and workflows designed to provide for a second opinion from qualified behavioral health providers. If a UnitedHealthcare member asks for a second opinion about a treatment or procedure, UnitedHealthcare will cover that cost. Scheduling the appointment for the second opinion should follow the access standards established by the Missouri Department of Social Services. The care provider giving the second opinion must not be affiliated with the attending care provider. A third surgical opinion, provided by a third care provider, is allowed if the second opinion does not confirm a medical need for the surgery 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.	MO C&S Single Case Agreement Process UCSMM 06 21 Out of Network Requests and Continuing Care. Pages 1, 2 of 6	Met
Findings: UnitedHealthcare's policy # UCSMM 06 21 - Out of Network Requests and Continuing Care contains information and documentation following the above description		

on pages 1-2. Single Case Agreements will be created and negotiated with out of network providers for services needed to be provided to a member that are not available with a participating provider. Upon receipt of a provider or consumer coverage request to begin or continue treatment with an out-of-network provider, the utilization management program will provide administrative and/or clinical reviews in accordance with the consumer's benefit plan and in compliance with state, federal, government program and accreditation requirements. If the consumer's benefit plan coverage of services is exhausted while the consumer still needs care, the organization will offer, as required, to educate the consumer about alternatives for continuing care and how to obtain care. **Required Actions:** None.		
(iv) Requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.	UCSMM 06 21 Out of Network Requests and Continuing Care: Pages 1, 2 of 6 MO C&S Single Case Agreement Process	Met
Findings: Out of network requests for services are to be rendered by an out-of-network provider and covered at the in-network level of benefits when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise. **Required Actions:** None.		
C. Furnishing of services: (i) Timely access. Each MCO must do the following: a. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees. b. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. c. Establish mechanisms to ensure compliance by network providers. d. Monitor network providers regularly to determine compliance.	Appointment Standards MO Healthnet UCSMM 06 11 Accessibility and Initial Response: Page 3 of 3	Met

e. Take corrective action if there is a failure to comply by a network provider.		

Findings: UnitedHealthcare lists acceptable hours as follows:

- The office telephone is answered after normal business hours by an answering service that meets language requirements of the major population groups and which can contact the PCP or another designated medical practitioner;
- The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable to meet the standard; and
- The office telephone is transferred after office hours to another location that meets language requirements where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner.

And unacceptable as follows:

- Office telephone is only answered during office hours;
- Office telephone is answered after hours by a recording that tells members to leave a message or send a page;
- Office telephone is answered after hours by a recording that directs members to go to an Emergency Room for any services needed; and
- Returning after-hour calls outside of the thirty (30) minute timeline.

Secret shopper calls will be made to complete the accessibility survey by measuring accessibility performance based on the individual UnitedHealthcare Community Plan PCPs (which include PCPs for both Adult and Pediatric members) from each service delivery area, as identified by total panel size. Each identified provider is reviewed at least once during the calendar year. The results of the measurements are compared to standards annually and are reported to the QIC.

The Network Management/Provider Relations Department (and/or authorized vendor) calls the identified provider in the study sample after normal business hours to conduct the After-Hours Accessibility survey. The results of the providers' compliance to accessibility are recorded and analyzed. These collective results are presented to the Quality Management Department annually for review, proposed interventions, and approval. The Quality Improvement and Network Management/Provider Relations Departments may also elect to establish interventions and address corrective actions prior to committee reporting and results are reported to the QIC. Providers who fail to meet the UnitedHealthcare Community Plan's accessibility and/or availability standards will be informed, by writing of less than 100% compliance and advises them in writing that the UnitedHealthcare Community Plan standards are not being met, and that the standards must be achieved within thirty (30) calendar days.

Required Actions: None.

(ii) Access and cultural considerations. Each MCO	MO Care provider manual: Page 6, 28 of 91	Met

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).*	UCSMM 0313 Public Communication and Marketing: Pages 3, 4 of 4	
Findings: UnitedHealthcare Community Plan has developed a Cultural Competency Program. Linguistic and cultural barriers can negatively affect access to health care participation. Providers must help UnitedHealthcare Community Plan meet this obligation for their members. Programs are based upon the findings from their Health Education, Cultural and Linguistic Group Needs Assessment (GNA) and will identify the health education, cultural and linguistic needs. The health plan shall provide to members, in their preferred language, both verbal offers and written notices, when required, informing them of their right to receive language assistance services. The health plan shall make available easily-understood member-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in regions covered by the contract. **Required Actions:** None.		
(iii) Accessibility considerations. Each MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	MO Care Provider Manual: Page 18 of 91	Met
Findings: On Page 18 of UnitedHealthcare's MO Care Provider Manual specifies accessibility standards that require maintaining a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards. UnitedHealthcare also requires compliance with the Missouri DSS Access and Availability standards for scheduling emergency, urgent care and routine visits. **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.	MO-Care-Provider-Manual-Final Chapter 4 page 35 of 91	Met

(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).*	Medical Provider Look Up MO HealthNet Provider Directory East, West, Southwest, & Central)	
Findings: UnitedHealthcare's provider manual and directories for all regions list a full range of medical providers (including Women's Health Services) consisting of hospitals, primary care physicians, specialists, advanced practice nurses, safety net hospitals, FQHCs, Provider-Based Rural Health Clinics (PBRHCs), Independent Rural Health Clinics (IRHCs), local public health agencies, and tertiary care. Members may also choose a Rural Health Clinic (RHC), a Federally Qualified Health Center (FQHC) or a Primary Care Clinic (PCC) as their PCP. **Required Actions:** None.		
E. MCO shall provide a member handbook, and other written materials with information on how to access services, to all members within 10 business days of being notified of their future enrollment with the MCO. Information will be considered to be provided if the MCO: • Mails a printed copy of the information to the member's mailing address. • Provides the information by email after obtaining the member's agreement to receive the information by email. • Posts the information on the Web site of the MCO and advises the member in paper or electronic form that the information is available on the Internet and	MO+ Healthnet Handbook WEB WEB MO Healthnet Handbook Search CS MO2706 Five-day Enrollment PCP Letter	Met

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: Important letters and information will be mailed to the address that members have provided. New members shall receive a member ID card in the mail. Members can get up-to-date information about their MO HealthNet Managed Care health plan on UnitedHealthcare's website at myuhc.com/CommunityPlan. They can also visit their website to get information about the services they provide, their provider network, frequently asked questions, contact phone numbers and email addresses. UnitedHealthcare shall also send a printed copy of the information on their website at no cost within 5 business days of a request. **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	=		×	=	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).*	Medical Provider Look Up MO HealthNet Provider Directory East MO HealthNet Provider Directory Southwest MO HealthNet Provider Directory Central MO HealthNet Provider Directory West	Met
Findings: UnitedHealthcare provided provider directories for all covered regions. Using the search instructions and documents provided, a full range of preventive services, primary care, specialty services, and LTSS consisting of hospitals, physicians, advanced practice nurses, safety net hospitals, FQHCs, Provider-Based Rural Health Clinics (PBRHCs), Independent Rural Health Clinics (IRHCs), local public health agencies, and tertiary care services were found in their directory. The evidence provided has shown compliance with this section, as defined in 13 CSR 70-15.010 of the Code of State Regulations and described in MHD contract 2.4.1a was found. **Required Actions:** None.		
(ii) Behavioral Health Providers.	Behavioral Health Provider Look Up	Met

To ensure a broad range of treatment options are available, the MCO shall include in its network a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults. To be considered adequate, the behavioral health provider network shall, at a minimum, include- a. Qualified Behavioral Healthcare Professionals (QBHP), certified substance use disorder or co-occurring treatment professionals, licensed psychiatrists, licensed psychologists, provisionally licensed psychologists, licensed psychiatric nurse practitioners, licensed professional counselors, provisionally licensed professional counselors, licensed clinical social workers, licensed master social workers, and licensed psychiatric clinical nurse specialists b. The majority of Community Mental Health Centers (CMHC), within each county where the MCO provides coverage and the majority of Certified Community Behavioral Health Clinics (CCBHC) within the DMH. If there is not a CMHC in that county, the health plan must contract with a CMHC within 30 miles of a county where the MCO has coverage. If there is not a CMHC within 30 miles of that county, the health plan must contract with a CMHC in the Department of Mental Health (DMH), *(MHD contract 2.4.8).*	MO HealthNet Provider Directory East MO HealthNet Provider Directory Southwest MO HealthNet Provider Directory Central MO HealthNet Provider Directory West	
Findings: A full range of behavioral health providers, including community mental health centers as described in MHD contract 2.4.8 are included in the directories of UnitedHealthcare. UnitedHealthcare behavioral health and substance use disorder		

treatment professionals can be found in the Behavioral Health Providers section of the directories. **Required Actions:** None.		
(iii) Federally Qualified Health Centers and Rural Health Clinics. The MCO shall offer a contract to all FQHCs, Provider-Based Rural Health Clinics (PBRHCs), and Independent Rural Health Clinics (IRHCs) at the rates established herein. If there is not an FQHC in the county, the MCO must have a contract with an FQHC within thirty (30) miles of a county where the health plan has coverage for members *(MHD contract 2.4.9).*	Medical Provider Look Up MO HealthNet Provider Directory East MO HealthNet Provider Directory Southwest MO HealthNet Provider Directory Central MO HealthNet Provider Directory West	Met
Findings: A full range of medical providers that consists of hospitals, physicians, advanced practice nurses, safety net hospitals, FQHCs, Provider-Based Rural Health Clinics (PBRHCs), Independent Rural Health Clinics (IRHCs), local public health agencies, as described in MHD contract 2.4.9 are included in the UnitedHealthcare directories. **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 provision of these services *(MHD contract 2.4.10).*	Medical Provider Look Up MO HealthNet Provider Directory East MO HealthNet Provider Directory Southwest MO HealthNet Provider Directory Central MO HealthNet Provider Directory West Provider Manual Chapter 4. Page 27 of 91	Met

Findings: UnitedHealthcare Community Plan members may access preventive health, medical, counseling and educational services without a referral. They may also seek family planning services at the care provider of their choice. The following services are included: • Annual gynecological examination • Annual pap smear • Contraceptive supplies, devices and medications for specific treatment • Contraceptive counseling • Laboratory services **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).*	Medical Provider Look Up MO HealthNet Provider Directory East MO HealthNet Provider Directory Southwest MO HealthNet Provider Directory Central MO HealthNet Provider Directory West	Met
Findings: Local public health agencies as described in MHD contract 2.4.11 are included in all the directories submitted by UnitedHealthcare. **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).*	Dental Provider Look Up MO HealthNet Provider Directory East MO HealthNet Provider Directory Southwest MO HealthNet Provider Directory Central MO HealthNet Provider Directory West	Met
Findings: Using the search instructions and documents provided, School Based Dental Services as described in MHD contract 2.4.15 were found. **Required Actions:** None.		
(vii) Tertiary Care.	Medical Provider Look Up	Met

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 twenty-four (24) hours per day in the regions covered by the contract. If the MCO does not have a full range of tertiary care services, the health plan shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers *(MHD contract 2.4.16).*	MO HealthNet Provider Directory East MO HealthNet Provider Directory Southwest MO HealthNet Provider Directory Central MO HealthNet Provider Directory West	
Findings: Using the search instructions and documents provided, a full range of Tertiary Care services as described in MHD contract 2.4.16 were found. **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).*	Medical Provider Look Up Dental Provider Look Up Behavioral Health Provider Look Up MO HealthNet Provider Directory East MO HealthNet Provider Directory Southwest MO HealthNet Provider Directory Central MO HealthNet Provider Directory West	Met
Findings: UnitedHealthcare has a robust network of providers as described in MHD contract 2.4.1b. The provided directories cover a network of providers with a sufficient mix and geographic distribution, meeting the needs of their anticipated number of enrollees in each of their service areas. **Required Actions:** None.		

C. Timing of documentation. Each MCO must submit the documentation as specified by the State, but no less frequently than the following, to comply with section A of this evaluation tool:		
(i) On an annual basis. Access Plan: In accordance with State requirements specified at 20 CSR 400-7.095, the MCO shall file an annual access plan, by March 1 of each year, with the Department of Insurance, Financial Institutions and Professional Registration that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues *(MHD contract 2.5.4).*	2017 UHLC 131007298 at a glance + conditional approval 2018 UHLC 131405663 closed 11-21-18 filing at a glance	Met
Findings: UnitedHealthcare Community Plan of Missouri has filed, on an annual basis, an access plan to the Department of Insurance for adequacy of its provider network. **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	Twin Rivers closure document Termination Mercy East document Ripley County Hospital closure document (New) State Notification of Provider Termination: Page 1 of 2	Met

accessibility standards defined herein and in 20 CSR 400-7.095. d. Any other adverse change to the composition of the provider network which impairs or denies the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity*(MHD contract 2.4.12 a)* e. Enrollment of a new population in the MCO.		
Findings: UnitedHealthcare has not had any significant changes for a, b, d, e listed in this section of evaluation tool. They have encountered a situation stated in "c": "A loss of any hospital regardless of whether the loss will result in the health plan failing to meet the service accessibility standards." UnitedHealthcare notified MHD about the same. During onsite review, UnitedHealthcare was asked about policies available on submitting documentation to the state regarding any changes. They provided all the documentation regarding their notification to MHD, but they did not have a policy to meet these requirements listed in MHD contract 2.4.12 a. UnitedHealthcare created a policy, at the recommendation of Primaris, and submitted within the stipulated timeframe. **Required Actions:** UnitedHealthcare should get their policy approved by MHD.		

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	=		✕	=	20
Total						**100%**

Appendix C

Subpart D Standard 3–42 CFR 438.208 Coordination and Continuity of Care		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO must ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity.	Member Handbook: Pages 17, 18, 31, 39, 73, 83, 85 of 90	Met
Findings: The UnitedHealthcare Member Handbook is the only source cited for proof of ensuring ongoing source of appropriate care and contacts but does so sufficiently. When members call member services, they are connected with a trained advocate who will help members receive the care they needed and enrolled for. In addition, the advocate will answer questions, resolve issues, help set up doctor appointments, and directly connect members with available and appropriate services. **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.	HRA HRCM policy: Pages 1, 2, 7, 10 of 11	Met
Findings: The Care Manager (CM) will complete the initial comprehensive assessment as expeditiously as the member's condition requires within the timeframes established by regulatory requirements, but no later than 30 calendar days from identification of the member as appropriate for high risk case management and is completed within 60 days of identification. The assessment will be completed telephonically or face to face based on member condition and regulatory guidance. **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	CM002 Transition of Care: Pages 1, 2 of 4	Met

medical records and information *(MHD contract 2.5.9).*		
Findings: Upon receipt of a notification from the state of a member's enrollment date from another MCO, a transition coordinator will outreach to the member within 5 business days to request the name of the other MCO. If UnitedHealthcare is contacted by a member's new MCO, requesting relevant member information, the transition coordinator will provide the relevant member information to the requesting health plan within five (5) business days of receiving the request. If UnitedHealthcare becomes aware that a member will transfer to another MCO, the transition coordinator will reach out to the designated contact in that MCO within five (5) business days to provide relevant member information. Upon receipt of new members' anticipated enrollment date from the state FFS program, the transition coordinator will contact the member's provider within five (5) business days of the notification. **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.	CM002 Transition of Care: Pages 1, 3 of 4	Met
Findings: UnitedHealthcare shall provide for the transfer of relevant member information using HIPAA compliant processes, including medical records and other pertinent materials, to another MCO to facilitate a smooth transfer of care and 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.	UCSMM 06 21 Out-of-Network Requests and Continuing Care: Pages 5, 6 of 6	Met

Findings: Regarding transition of care for newly enrolled members transitioning to UnitedHeathcare from fee-for-service or another MCO and for members transitioning out of UnitedHeathcare to another MCO, UnitedHealthcare shall follow the transition of care policy and, at a minimum provide for the transfer of relevant member information, including medical records and other pertinent materials, to another health plan upon notification of establishment of care such that the transition of care shall be smooth. If UnitedHealthcare receives new members who were previously members in the fee-for-service program, UnitedHealthcare must contact the member's provider within five (5) business days of the state agency's notification to UnitedHealthcare of the member's anticipated enrollment date, to request the necessary medical records and information. **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.	UCSMM 06 21 Out-of-Network Requests and Continuing Care	Met

Findings: UnitedHealthcare shall 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. For members eligible for care management, the new MCO shall provide continuation of services authorized by the prior MCO for up to 60 calendar days after the member's enrollment with the new MCO and shall not reduce services until an assessment supporting services reduction is conducted by the new health plan. **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.	UCSMM 06 21 Out-of-Network Requests and Continuing Care: Pages 4, 5 of 6	Met
Findings: UnitedHealthcare policy UCSMM 06 21 Out-of-Network Requests and Continuing Care states that they shall 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. **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 sixty (60) calendar days from date of birth).	UCSMM 06 21 Out-of-Network Requests and Continuing Care: Pages 2, 3, 4, 5 of 6	Met
Findings: UnitedHealthcare shall allow members in their third trimester of pregnancy to continue to receive services from their prenatal care provider (whether in-network or out-of-network), without any form of prior authorization through the postpartum period (defined as 60 calendar days from 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.	UCSMM 06 21 Out-of-Network Requests and Continuing Care: Pages 2, 3, 4, 5 of 6	Met
Findings: UnitedHealthcare shall 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. **Required Actions:** None.		
(viii) Ensure that inpatient and residential treatment days are not prior authorized during transition of care.	UCSMM 06 21 Out-of-Network Requests and Continuing Care: Page 5 of 6	Met
Findings: UnitedHealthcare shall ensure that inpatient and residential treatment days are not 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.	UCSMM 06 21 Out-of-Network Requests and Continuing Care: Page 1 of 6.	Met
Findings: Upon receipt of a provider or consumer coverage request to begin or continue treatment with an out-of-network provider, the utilization management program will provide administrative and/or clinical reviews in accordance with the consumer's benefit plan and in compliance with state, federal, government program and accreditation requirements. If the consumer's benefit plan coverage of services is exhausted while the consumer still needs care, the organization will offer, as required, to educate the consumer about alternatives for continuing care and how to obtain 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.	CM002 Transition of Care: Page 1 of 4. Provider Manual: Pages 51, 52, 53, 54, 55, 56, 57 of 88.	Met

Findings: UnitedHealthcare, under its transition of care policy shall provide for the transfer of relevant member information using HIPAA compliant processes, including medical records and other pertinent materials, to another MCO to facilitate a smooth transfer of care and 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.		
F. MCO must coordinate services for its members who are in health homes. They must identify any care gaps or areas of duplication through a mutually acceptable method. MCO is responsible for being the primary source of care management for conditions other than or beyond those included in the state Health Home program *(MHD contract 2.11.1 d).*	Mo Health Home Procedure Document Health Home ADT job aid	Met
Findings: Health Homes shall communicate with UnitedHealthcare plan care gaps requiring assistance for closure. Health Home transformation consultant (as an added measure) will monitor open care gap reports for each health home and provide requested resources to ensure closure. **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.	Case Management Policy: Page 1 of 11 *N/A per MHD Contract	Met
Findings: LTSS is not a population that is managed by the Managed Care Organizations in the state of Missouri. LTSS is managed exclusively by the state FFS program. Prior to initiating contact with the member, the case/care manager will review the referral source and risk stratification data to identify complex or special needs, current and/or future risks, as well as the utilization history of member. If the member is transitioning from another MCO or FFS Medicaid, and has been previously engaged in case management, the CM will also request and review information provided by the previous health plan, as available, to support the transition of case management services. This will include notifying the physical health or behavioral health primary care provider of the change with the MCO and case management contact. **Required Actions:** None.		

(ii) Assessment. The MCO must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State to MCO, of any ongoing special conditions of the enrollee 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 Policy: Page 1 of 11	Met
Findings: If the member agrees to participate, the care manager completes the initial comprehensive assessment. The assessment is completed based on information provided by the member and/or their caregiver (with the member's consent), the member's PCP, other medical and behavioral health providers including external case managers involved in the members care. **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	Case Management Policy: Page 1 of 11 *N/A per MHD contract	Met

(2) of this chapter for LTSS treatment or service plans; c. Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO. d. In accordance with any applicable State quality assurance and utilization review standards; and e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per §441.301(c) (3).		
Findings: In addition to the requirements applicable to all care providers, the responsibilities of the PCPs include consulting with other appropriate health care professionals to assess and develop individualized treatment plans for enrollees with special health care needs. For high risk members, the assessment includes identification of special needs, i.e. need for extended nursing hours, ventilator dependence, development delay, and specialized medical condition. **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).*	Specialist Look-up Central Specialist Directory Western Specialist Directory Eastern Specialist Directory SW Specialist Directory	Met
Findings: The UnitedHealthcare's directories consist of hospitals, physicians, advanced practice nurses, safety net hospitals, FQHCs, Provider-Based Rural Health Clinics (PBRHCs), Independent Rural Health Clinics (IRHCs), local public health agencies, and tertiary care. **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).	UCSMM.06.10 Clinical Review Criteria: Page 5 of 5 (Updated)UCSMM.06.10 Clinical Review Criteria: Page 3 of 5	Met
Findings: UnitedHealthcare shall be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. During onsite, UnitedHealthcare was informed that they have missed the point in their policy that "services will be the same in amount, duration, and scope as furnished to FFS beneficiaries." UnitedHealthcare confirmed that their operational process ensures the services are furnished no less than the amount, duration, and scope as FFS as it is a federal requirement. They updated their policy and resubmitted to Primaris based on the recommendation. **Required Actions:** UnitedHealthcare should send the 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.	UCSMM.06.10 Clinical Review Criteria: Page 4 of 5 Utilization Management of Behavioral Health Benefits: Page 2 of 18	Met
Findings: UnitedHealthcare does not arbitrarily deny or reduce the amount, duration or scope of a required service but may place appropriate limits on a service based on criteria applied under the benefit plan, and on the enrollee's needs through fair and culturally competent decision-making to provide equitable access to the best available care for the enrollee to ensure proper, efficient and effective administration of the benefit. **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	UCSMM.06.10 Clinical Review Criteria: Page 5 of 5	Met

necessity." The MCO will specify what constitutes "medically necessary services" in a manner that a service: • Prevents, diagnoses, or treats a physical or behavioral health condition or injury. • Is necessary for the member to achieve age appropriate growth and development. • Minimizes the progression of disability. • Is necessary for the member to attain, maintain, or regain functional capacity (MHD contract 2.7.8). • Provides opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.		
Findings: Services may be limited by medical necessity at UnitedHealthcare. 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	UCSMM.06.10 Clinical Review Criteria: Page 4 of 5 *N/A as per MHD contract	Partially Met

require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and • Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.	Member Handbook: Pages 56, 61 of 90	
Findings: UnitedHealthcare may manage specific services as long as they provide services that are medically necessary. UnitedHealthcare shall have a process for allowing exceptions that are in accordance with 13 CSR 70-2.100. UnitedHealthcare's member handbook provides information about family planning services: "All MO HealthNet Managed Care health plan members can get family planning services no matter what age. These services will be kept private. You may go to a UnitedHealthcare or a MO HealthNet Fee-for-Service approved provider to get family planning services. You do not need to ask UnitedHealthcare first. UnitedHealthcare will pay for your family planning services. MO HealthNet Managed Care covers family planning services, including contraceptive care and pregnancy tests. You do not need to get our approval before using these services. There is no limit to how often you can use them." During onsite Primaris informed UnitedHealthcare that their policies did not state that family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. The MCO must provide that "each beneficiary is free from coercion or mental pressure and free to choose the method of family planning to be used." **Required Actions:** UnitedHealthcare has agreed that they would update their Member Handbook that will reflect compliance with 42 CFR 441.20.		
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).*	Utilization Management of Behavioral Health Benefits: Pages 3, 13 of 18	Met
Findings: UnitedHealthcare does not withhold benefit coverage for emergency services in situations where an enrollee, believing there was a true emergency, obtained emergency room services without notifying the MCO or obtaining pre-approval.		

During onsite, UnitedHealthcare affirmed that no prior-authorization is required for emergency services. **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).*	UCSMM.06.10 Clinical Review Criteria: Page 3 of 5	Met
Findings: UnitedHealthcare is compliant with the above contractual requirement. **Required Actions:** None.		
(iii) MCO policies, procedures and practices shall comply with The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), 45 CFR Parts 146 and 147, and the CMS Final rule on MHPAEA for Medicaid *(MHD contract 2.5.5 b).*	Utilization Management of Behavioral Health Benefits: Page 1 of 18	Met
Findings: This policy is based on statutory requirements, prohibitions, and procedures set forth in 42 CFR §438 and on the specific requirements in the contract between the State of Missouri and UnitedHealthcare of Missouri and complies with the standards and regulations set forth by NCQA, URAC, and HIPAA; regulatory requirements of the State of Missouri, and applicable Federal requirements including the Mental Health Parity and Addiction Equity Act (MHPAEA). **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	UCSMM.06.10 Clinical Review Criteria: Page 3 of 5	Met

timely, the requested services shall be approved *(MHD contract 2.5.5d)*		
Findings: UnitedHealthcare follows the above contractual requirement. During onsite, UnitedHealthcare explained that the services are not interrupted. The members can have escalated approvals: 36 hours (including 1 business day)/24 hours. If PA cannot be obtained, it is auto-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: • 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).	UCSMM.06.15 Peer Clinical Review: Pages 1, 2, 4 of 4 UCSMM.06.10 Clinical Review Criteria: Pages 1, 2, of 5 UCSMM.06.14 Initial Clinical Review: Page 2	Met
Findings: Staff members who conduct peer clinical review will be qualified health professionals, with a current license to practice in accordance with their license, or current license in the same category as the treating/ordering provider or an administrative license		

to review UM cases. The peer clinical reviewer will be available to provide peer-to-peer discussion. Only peer clinical reviewers will render adverse determinations for clinical review outcomes.
There are fair and unbiased policies and procedures for reconsideration requests when the attending physician, the hospital, or the member disagrees with the health plan's determination regarding inpatient hospital admission or continued stays.
UnitedHealthcare Clinical Services Medical Management (UCSMM) utilizes external and internal clinical review criteria that are evaluated annually by the quality oversight committee and approved by the medical director or equivalent designee.
External clinical review criteria are based on applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines such as MCG Care Guidelines or InterQual.
Internal clinical review criteria are developed by UnitedHealthcare (UHC) through review of current, new and emerging medical technologies:

- UnitedHealthcare Executive Medical Policy Committee prepares and publishes internal review criteria such as Medical Policy, Coverage Determination Guidelines and Utilization Review Guidelines for staff access as outlined by the Utilization Management Program Description (UMPD).

Required data is entered into the system with principal reason provided for adverse determinations and identification of the peer clinical reviewer. The peer clinical reviewer who rendered an adverse determination will document an electronic identifier in the medical management system. 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.
During onsite, UnitedHealthcare explained an approval can be by a nurse but all denials can only occur from a licensed clinician. It is clearly documented, given a Prior Authorization number and there is an opportunity for peer- to-peer review.
Required Actions: None.

(vi) The MCO will- • Consult with the requesting provider for medical services when appropriate. • *Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.	UCSMM.06.10 Clinical Review Criteria: Page 3 of 5 UCSMM.06.15 Peer Clinical Review: Pages 1, 2 of 4 *N/A per MHD contract	Met

Findings: The peer clinical reviewer will be available to provide peer-to-peer discussion. Only peer clinical reviewers will render adverse determinations for clinical review outcomes. In the case of clinical adverse determination, the peer clinical reviewer or their alternate will be available within one business day to discuss determinations with requesting providers. Providers will have access to clinical review criteria upon request and will be advised in writing how to obtain criteria. All adverse determination letters

state that the clinical review criteria upon which the non-certification determination was made are available upon request by the consumer or provider in accordance with operational policy UCSMM.06.18 Initial Adverse Determination Notice. This information is provided in writing when requested. 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 made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.	UCSMM 06 15 Peer Clinical Review: Page 1 of 5 eviCore- CM 0212 Utilization Review Staff Qualifications: Page 2 of 5	Met
Findings: Determinations to deny or limit services are made by practitioners or clinical peer reviewers under the direction and supervision of the individual eviCore Program Chief Medical Officer (CMO). eviCore clinical peer reviewers hold current unrestricted licenses to practice medicine or a health profession from a U.S. state or territory. They are qualified to render a clinical opinion about the clinical service under review and are located in a U.S. state or territory when conducting the review. A Clinical Peer Reviewer can issue an adverse medical necessity determination if they hold a current and valid license in the same category as the ordering provider or they are a Doctor of Medicine or osteopathic medicine. **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).*	UCSMM.06.10 Clinical Review Criteria: Page 3 of 5	Met
Findings: UnitedHealthcare complies with the above contractual requirement. During onsite, UnitedHealthcare stated that notification staff are available over the weekends to ensure interim supply of items. **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).*	UCSMM.06.10 Clinical Review Criteria: Page 3 of 5	Met

Findings: UnitedHealthcare complies with the above contractual requirement. During onsite, UnitedHealthcare explained that their staff makes sure even before expiration of services whether there is a need to continue a service. **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 six (6) months of approval, even if the member's enrollment in the health plan ends *(MHD contract 2.5.5h).*		Partially Met
Findings: During onsite, UnitedHealthcare stated that "they have not had any occurrences of this issue since May 01, 2017 (effective date of contract with MHD) and were unaware of a need for this policy. We will be creating a payment policy that will address this issue in the future should it arise. Until that policy is in place, we would expect that the initial claim would deny due to the member being ineligible. The provider would then re-submit the claim for reconsideration at which time it would be processed and paid per the state contract." UnitedHealthcare has a new setup which pays for these custom items. **Required Actions:** UnitedHealthcare has admitted that they need to have a written policy to address this situation.		
(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.	Clinical Certification of Services – Initial Clinical Review: Pages 5, 8 of 37 UCSMM.06.14 Initial Clinical Review: Page 4 of 4	Met

The covered person's coverage under the health plan terminates before the health care services are provided *(MHD contract 2.5.5i).*		
Findings: eviCore will not reduce or terminate previously approved services for a member in the course of treatment, unless the member, their authorized representative, physician or attending health care professional are given time to request another review before any reduction or termination becomes effective. Certified requests cannot be reversed unless new information relevant to the certification that was not available at the time of the original certification indicates the service is not medically indicated. eviCore does not reduce or terminate a previously approved course of care. Once services have been authorized, the authorization will be honored except under the unusual circumstances noted below: eviCore may correct an administrative error that may have been communicated to the member and physician or attending health care professional. In these instances, the member, physician or attending health care professional would be notified of the error verbally and then follow with a corrected letter. For concurrent review, notification would be issued early enough to allow the member the opportunity to review the decision before the termination/reduction occurs. In this event, services that may have been provided between the time of issuing the original approval (certification) and the time the patient received notification of the corrected decision and will be allowed up to the patient's benefit maximums that occurred. eviCore does not reverse an approval (certification) decision regardless of any new clinical information presented. UnitedHealthcare policy does list the conditions stated in the MHD contract (also mentioned in B (ix) above) for reversal of their decision once prior authorization decision is given. **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).*	UCSMM 06 14 Initial Clinical Review: Page 4	Met
Findings: UnitedHealthcare complies with the above stated contractual requirement. During onsite, UnitedHealthcare explained that there are daily discussions with the UM staff and alternatives are discussed with the providers. **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.	UCSMM.06.16 Initial Review Timeframes: Page 6 of 8 eviCore UHC CP Missouri eviCore Standard Compliance Grid	Met
Findings: UnitedHeathcare complies with the time frame for emergency services. During onsite, UnitedHealthcare stated that no PA is needed for ER services. They are auto-paid. **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.	UCSMM.06.16 Initial Review Timeframes: Page 6 of 8 eviCore UHC CP Missouri eviCore Standard Compliance Grid	Met
Findings: UnitedHeathcare complies with the time frame for urgent services. During onsite, UnitedHealthcare explained that urgent services are auto-approved, if no decision is given within 24 hours. **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.)	UCSMM.06.16 Initial Review Timeframes: Page 6 of 8 eviCore UHC CP Missouri eviCore Standard Compliance Grid	Met

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.		
Findings: UnitedHeathcare complies with the time frame for preauthorization of standard services. **Required Actions:** None.		
(iv) Expedited authorization decisions For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function: a. MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service. b. The MCO may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO justifies (to	Clinical Certification of Services–Initial Clinical Review: Page 6 of 37 UCSMM.06.16 Initial Review Timeframes: Page 6 of 8	Met

the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.		
Findings: Urgent pre-service decisions are issued within 24 hours of the receipt of the necessary information. If additional information is needed, notice of the information required will be provided within 24 hours of receipt of the request and the information may be submitted within 48 hours. A decision will be issued no later than 72 hours from receipt of the request. During onsite, UnitedHealthcare explained that a decision is given within 24 hours for expedited authorization. In case of denial, peer to peer review takes place. **Required Actions:** None.		
D. Notice of adverse benefit determination. Each MCO must notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The enrollee's notice must meet the requirements of §438.404.	UCSMM 06.18 Initial Adverse Determination Notice: Pages 1, 4, 5 of 5 eviCore-CM0029-Non-Certification of Requests for Services: Pages 1, 2, 9 of 17	Met
Findings: A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. UnitedHealthcare shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information. During onsite, UnitedHealthcare stated that notice is sent via phone followed by a letter. Peer-to-peer information is provided for an appeal. **Required Actions:** None.		
E. Compensation for utilization management activities. Each contract between a State and MCO must provide that, consistent with §438.3(i), and 422.208 of 42 CFR chapter iv, compensation to individuals or entities that conduct utilization management activities is	UCSMM.02.12 Performance Assessment and Incentives: Page 1 of 2 eviCore Utilization Management Decision Making - Pages 1, 2 of 3	Met

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).*		
Findings: The utilization management program will not hire, promote or terminate staff members based on a perceived or actual possibility for making an adverse determination of benefit coverage. Staff members will not receive financial incentives based on consumer utilization of healthcare services. Staff members will be considered for performance rewards in accordance with corporate performance rewards programs. eviCore will ensure all licensed employees who make medical necessity-based coverage decisions, and those who supervise them, will base their determinations only on appropriateness of care. eviCore does not specifically reward practitioners, or other individuals conducting utilization review, for issuing non-certifications of coverage or service. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization. Compensation is not based on the number of telephone calls or other contact with health care providers. During onsite, UnitedHealthcare stated that the RNs and Medical Directors are not incentivized to deny or approve cases. There is an "attestation" regarding this requirement. **Required Actions:** None.		

Compliance score-Coverage and Authorization of Services						
Total	Met	=	20	×2	=	40
	Partial Met	=	2	×1	=	2
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	42
Denominator	Total Sections	=	22	×2	=	44
Score						**95.5%**

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).*	2017-2019 UnitedHealthcare Credentialing Plan: Pages 9, 10, 11, 12 of 28 Additional State and Federal Credentialing Requirements: Pages 32, 33 of 70 MO State Loading Requirements: Row 55 Practitioners Sanctions Monitoring State Application	Met
Findings: Credentialing is required for all licensed independent practitioners to whom UnitedHealthcare directs covered persons to receive care under a benefit plan as part of UnitedHealthcare's network of participating providers, including providers participating through a leased network agreement. All network providers are also required to be enrolled with MO HealthNet.		

Whenever the credentialing entity's quality of care department staff receives information suggesting that suspension, restriction, or termination of a provider's participation may be warranted based on a potential quality of care concern, it should compile all pertinent information and refer the matter to the medical director for review. If the medical director, determines that a failure to take action may present an urgent risk to the health of any covered person, the medical director in conjunction with the regional peer review committee chairperson, and the regional chief medical officer may summarily restrict or suspend the provider's participation status in the network. **Required Actions:** None.		
B. MCO shall credential and re-credential all in-network providers listed within the contract. Provisionally licensed psychologists and provisionally licensed professional counselors are included in this requirement. The credentialing process shall not take longer than sixty (60) business days pursuant to RSMo 376.1578 *(MHD contract 2.18.8c 1).*	2017-2019 UnitedHealthcare Credentialing Plan: Pages 9, 10, 11, 12 of 28	Met
Findings: Applicants have the right to be notified of the credentialing decision within 60 calendar days of the national credentialing committee's decision and re-credentialing denials within 60 days of decision date, notwithstanding this provision, credentialing time frames and notification will not exceed timelines required by the credentialing authority. **Required Actions:** None.		
C. As part of re-credentialing, the MCO shall audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives *(MHD contract 2.18.8c 2).*	Missouri Facilities MRR 2018 Instructions Advanced Directives	Met
Findings: The Missouri Facilities 2018 Medical Record Review (MRR) is specifically conducted for the UnitedHealthcare. It is conducted to ensure confidentiality practices are in place, basic documentation standards are met, and the elements related to Advance Directives are reviewed for Missouri contracted facilities. UnitedHealthcare has provided Primaris with their internal instructions for auditing records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives. It is the policy of UnitedHealthcare to monitor provider compliance with UnitedHealthcare's advanced directives. Whether credentialing is delegated or performed by the national		

credentialing center the plan will remain ultimately accountable for ensuring that advance directive requirements are being met. **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).*	Disclosure Processing SOP: Pages 4, 5, 6 of 19 MO Disclosure Form National program disclosure policy	Met
Findings: UnitedHealthcare provider disclosure of ownership form collection process describes; how the UnitedHealthcare provider contracts; data management through the UnitedHealthcare compliance team. This team collects disclosure of ownership and control interest statement (disclosure) forms from the contracted health care providers credentialed under the UnitedHealthcare's authority. The scope of their policy includes the collection, evaluation, exclusion review, storage, tracking, and reporting activities related to the providers in this process. It also includes the following networks: medical, facility and national ancillary, home and community based services, and Optum (UnitedHealthcare's health services platform) health providers. Individual providers and entities that are enrolled to participate in the Medicaid and/or the Children's Health Insurance Program (CHIP) managed care program by UnitedHealthcare (which also includes further sub-delegation by UnitedHealthcare) fall under the UnitedHealthcare's requirement to ensure compliance with 42 CFR 455.106, when such compliance has been delegated to UnitedHealthcare **Required Actions:** None.		
E. MCO shall collect the information from the provider and retain evidence	Disclosure Processing SOP	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 thirty-five (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).*	MO Disclosure Form National program disclosure policy	
Findings: Disclosure from any provider or disclosing entity is due at any of the following times: upon the provider or disclosing entity submitting the provider application; upon the provider or disclosing entity executing the provider agreement.; upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414; within 35 days after any change in ownership of the disclosing entity. **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).*	Disclosure Processing SOP MO Disclosure Form National program disclosure policy: Pages 2, 3 of 4	Met
Findings: UnitedHealthcare forms a compliance team which documents the national disclosure database; attaches a copy of the complete disclosure form; updates records as appropriate; and submits updates on a daily basis to the state. **Required Actions:** None.		

G. MCO shall promptly notify the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing 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*).	Disclosure Processing SOP MO Disclosure Form National program disclosure policy: Page 2 of 4	Met
Findings: UnitedHealthcare reviews the state-based Medicaid exclusion lists. These are considered as a component of the required monthly exclusion reviews of disclosure of ownership forms. UnitedHealthcare notifies the state of any denial of enrollment, in accordance with the process defined in the provider disclosures/national disclosure program policy. **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	2017-2019 UnitedHealthcare Credentialing Plan: Page 10 of 28 Practitioner Sanctions Monitoring: Page 3 of 6	Met

subcontractor that falls within this section *(MHD contract 2.18.8c 6).*		
Findings: The UnitedHealthcare Disclosure 2017-2019, UnitedHealthcare Credentialing Plan, and Practitioner Sanctions Monitoring procedure details their screening procedures in conjunction with the requirements of Section G above and Federal health care program (as defined in Section 1128B (f) of the Act) as well as the MHD contract 2.18.8c 6. UnitedHealthcare clinical services will monitor sanction alerts arising from Optum's review of information from government agencies and authorities including but not limited to the Centers for Medicare and Medicaid Services (CMS), Medicaid agencies, state licensing boards, and the Office of the Inspector General (OIG) that relate to Licensed Independent Practitioners (LIP) and will take appropriate action in accordance with our provider participation agreements, the UnitedHealthcare credentialing plan (if applicable) and regulatory and accreditation requirements. **Required Actions:** None.		
I. Claims and Payment System		
(i) Unless otherwise written in the subcontract, MCO shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to the MCO by the provider: a. Newly credentialed provider attached to a new contract within 10 business days after completing credentialing. b. Newly credentialed hospital or facility attached to a new contract within 15 business days after completing credentialing. c. Newly credentialed provider attached to an existing contract 5 business days after completing credentialing. d. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within 5 business days after completing re-credentialing.	Escalation Process for Provider Adds SOP Additional State and Federal Credentialing Requirements: Page 33 of 70	Met

e. Change in existing contract terms within ten 10 business days of the effective date after the change. f. Changes in provider service location or demographic data or other information related to member's access to services must be updated no later than thirty (30) calendar days after the health plan receives updated provider information *(MHD contract 2.18.8c 7).*		
Findings: UnitedHealthcare 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 health plan 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 within five 5 business days after completing credentialing; • Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within five 5 business days after completing re-credentialing; • Change in existing contract terms within 10 business days of the effective date after the change. **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.	2017-2019 UnitedHealthcare Credentialing Plan: Pages 11, 12 of 28	Met
Findings: The UnitedHealthcare Credentialing Plan states that any credentialing applicant is not considered a participating provider on the decision date and is not entitled to treat covered persons or receive payment from credentialing entity until the participation agreement is signed by both parties with a specified effective date, and the applicant's agreement and demographic information are entered into all pertinent information systems. **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).*	Credentialed to Load Report	Met
Findings: The UnitedHealthcare credentialing process shall not take longer than 60 business days and any newly credentialed provider attached to a new contract shall be loaded within 10 business days after completing credentialing. Whereas newly credentialed providers attached to an existing contract shall be loaded within 5 business days after completing credentialing. UnitedHealthcare demonstrated their compliance with the loading of the credentialed providers' listing, within timeframe stated in MHD contract. **Required Actions:** None.		
K. Nondiscrimination. MCO network provider selection policies and procedures, consistent with §438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	MO Care Provider Manual: Page 13, 36 of 91	Met
Findings: Under the UnitedHealthcare Provider Manual and policy, providers may not refuse an enrollment/assignment or disenroll a member or discriminate against them solely based on age, sex, race, physical or mental handicap, national origin, religion, type of illness or condition. You may only direct the member to another care provider type if that illness or condition may be better treated by someone else. **Required Actions:** None.		

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

Appendix F

Subpart D Standard 6–42 CFR 438.224 Confidentiality		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO shall agree and understand that all discussions with the MCO and all information gained by the MCO as a result of the MCO's performance under the contract, including member information, medical records, data, and data elements established, collected, maintained, or used in the administration of the contract, shall be confidential and that no reports, documentation, or material prepared as required by the contract shall be released to the public without the prior written consent of the state agency *(MHD contract 3.16.1)*.	Privacy Policy Manual: Page viii, 8, 35 of 53 (New) PP-01 MO Privacy and Confidentiality: Page 1 of 3	Met
Findings: Federal, state, and international laws and regulations require the protection of individually identifiable health information (IIHI) and other personal information. These requirements include the establishment of policies and procedures to ensure that proper information management, administrative practices, and other appropriate safeguards are incorporated into the business practices of UnitedHealthcare's businesses. Contracts between UnitedHealthcare and its customers often include similar requirements as well. Each United Covered Entity, either on its own behalf or through shared corporate services, shall document or implement appropriate administrative, technical, and physical safeguards to protect the privacy of all PHI. A United Covered Entity may use or disclose restricted protected health information for any public purpose disclosures under 45 CFR § 164.512 of the Privacy Rule. During onsite, Primaris informed UnitedHealthcare that the Privacy Policy Manual/documents submitted for review do not specify: "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." Primaris recommended that UnitedHealthcare should have policies specific to the requirements of the MHD contract. Based on Primaris' recommendation, UnitedHealthcare created a policy (MO Privacy and Confidentiality), to meet specific requirements of MHD. Primaris reviewed the policy and assigned the score of "Met." **Required Actions:** Primaris recommends that the new policy should be sent to MHD for approval.		

B. If required by the state agency, MCO and any required MCO personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request. Failure of MCO and any required personnel to sign such documents shall be considered a breach of contract and subject to the cancellation provisions of this document *(MHD contract 3.16.2).*	MO Privacy and Confidentiality: Page 1 of 3	Met
Findings: During onsite, Primaris informed UnitedHealthcare that their policies/documents submitted for review did not meet the requirements of this section. Primaris recommended that UnitedHealthcare should have policies specific to the requirements of the MHD contract. Based on the recommendation, UnitedHealthcare created a policy (MO Privacy and Confidentiality), to meet specific requirements of MHD. Primaris reviewed the policy and assigned the score of "Met." **Required Actions:** Primaris recommends that the new policy should be sent to MHD for approval.		
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.	Privacy Policy Manual: Pages 2, 8 of 53	Met

• Encryption of any transmission of electronic communication containing Protected Health Information or use of equivalent safeguard.		

Findings: Each United Covered Entity, either on its own behalf or through shared corporate services, shall document or implement appropriate administrative, technical, and physical safeguards to protect the privacy of all PHI. Such safeguards must be designed to protect against reasonably anticipated: unauthorized uses or disclosures of PHI in violation of the privacy Rule or this Privacy Policy Manual; incidental uses or disclosures; and threats or hazards to the security or integrity of PHI.
The Chief Privacy Officer or a United employee designated by the Chief Privacy Officer will develop and implement a Corporate privacy training program. This program consists of an annual enterprise-wide corporate level HIPAA training and a new hire HlPAA training. The purpose of this program is to train United employees in their obligations to protect and safeguard protected health information. The United Covered Entities and United Business Associates may also provide a variety of business-specific HIPAA trainings.

UnitedHealthcare informed Primaris that due to security reasons some of the policies cannot be shared. However, they have documented the following information which meets the requirements of this section of evaluation tool:
UnitedHealth Group's security controls are designed to satisfy best business practices and regulatory and business requirements to ensure protection of information and business process efficiencies. These security controls include: firewall management; intrusion detection; vulnerability assessments; policy and standard definitions and refinements; encryption; and security administration management tools.

Workstations/Removable Media and Portable Storage Devices/Mobile Devices: All UnitedHealth Group owned, and managed desktops/laptops have industry standard hard drive full disk encryption software installed as part of the device configuration. The software is consistent with National Institute of Standards & Technology (NIST) encryption standard for end user devices. UnitedHealthcare's standard workstation build has the writable functions for USB ports disabled. In addition, a typical user's laptop/desktop does not contain a writable CD/DVD component. The use of removable media and portable storage devices will only be considered for individuals with a specific business or technical need to perform a part of their job function that cannot be accomplished without the use of removable media. Removable storage devices (i.e. USB drives, CD or DVD writers, flash drives, external hard drives, MP3 players, etc.) may not be used unless the device has been approved by Desktop Engineering and Enterprise Information Security. Approval for using the device is obtained from the employee or contractor's manager and the Enterprise Information Security Organization via SECURE. Removable storage devices are not to be used to store data locally.

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).*	Privacy Policy Manual: Page 9, 18, 42 of 53	Met
Findings: A United Covered Entity shall use, disclose or request the minimum necessary amount of protected health information, except for the following: disclosures to a health care provider for treatment; uses or disclosures made to the individual who is the subject of the protected health information; uses or disclosures made pursuant to the individual's valid authorization; disclosures to the Secretary of HHS; uses or disclosures that are required by law. If an exception does not apply, an authorization must be obtained by a United Covered Entity prior to exchanging PHI. The authorization obtained must specifically state that the disclosure will result in remuneration and otherwise comply with the Privacy Rule's requirements related to authorizations. An individual may request that a UnitedHealthcare covered entity provide a copy of his/her protected health information maintained by or for a UnitedHealthcare covered entity to a designated third party. Any request by an individual to send or provide access to a third party must, at the minimum, be in writing, signed by the individual and clearly identify the third party who should be provided with the information or access. **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).*	UHC Identification and Authentication Policy: Pages 2, 3 of 4 Member Handbook: Page 81 of 90	Met
Findings: Before PHI can be provided to any person, such person shall, in all cases (including, but not limited to, telephone, in person, online and IVR communications), be identified and authenticated. If a sensitive service or condition must be discussed, authenticating the identity of an Individual prior to such discussion should be conducted in a manner that best supports the confidentiality of the Individual's PHI. Sensitive services or conditions include drug or alcohol treatment services, HIV/AIDS services, mental health services, reproductive health services, treatment for sexually transmitted diseases, etc. The member handbook of UnitedHealthcare states the restrictions to release of PHI as follows: Federal and state laws may further limit our use of the PHI related to HIV/AIDS,		

mental health, genetic tests, alcohol and drug abuse, sexually transmitted diseases and reproductive health, Child or adult abuse or neglect or sexual assault. **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).*	UHC Identification and Authentication Policy: Pages 2, 3 of 4 Member Handbook: Page 81 of 90	Met
Findings: Same findings as stated above in section E of this evaluation tool. Additional restrictions may exist regarding a minor's emancipation rights when the subject of the PHI is a considered a sensitive service (i.e. Mental Health, Substance Abuse, HIV/AIDS, Sexually Transmitted Disease, Domestic/Physical/Emotional Abuse, Reproductive Services and Genetic Testing). **Required Actions:**		
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).*	Privacy Manual: Page ii of 53	Met
Findings: UnitedHealthcare's privacy manual has a section which defines terms {e.g., Business Associate (BA)} that are used in United's policies implementing its compliance with the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, Subparts A & E, as amended from time to time (the "Privacy Rule") and the privacy provisions contained in the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of		

2009, and its implementing regulations, as amended from time to time (collectively "HITECH"). UnitedHealthcare covered entities, business associates and subcontractors, as well as other business organizations as applicable, will adhere to their HIPAA privacy policy manual. This policy operates in conjunction with UnitedHealthcare's Personal Information Privacy and Data Protection Policy, which broadly describes UnitedHealthcare's approach to protection of information about individuals under applicable laws and other privacy policies of United and its business organizations. During onsite, UnitedHealthcare stated that there is no standalone business Associate (BA) document with the MHD; however, when they sign the contract with MHD, they become BA of MHD. **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).*	Privacy Policy Manual: Page vi of 53	Met
Findings: Protected Health Information ("PHI") means Individually Identifiable Health Information (llHI) transmitted by electronic media, maintained in any form or electronic media, or transmitted or maintained in any other form or medium. **Required Actions:** None.		
(iii) MCO may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1) and shall notify the state agency by no later than 10 calendar days after the MCO becomes aware of the disclosure of the Protected Health Information *(MHD contract 2.38.2c).*	Privacy Policy Manual: Page 8 of 53 Exhibit D: HIPAA and GLBA Business Associate Agreement: Page 2 of 5 MO Privacy and Confidentiality: Page 1 of 3	Met
Findings: No disciplinary actions will be applied against a whistleblower employee (based on the fact that he or she was a whistleblower), or an employee who is a victim of a criminal act and discloses PHI to law enforcement (subject to certain limitations). Post onsite visit, UnitedHealthcare submitted a BAA which states that: "without unreasonable delay, and in any event on or before forty-eight (48) hours after its discovery by vendor, notify customer of any incident that involves an unauthorized acquisition, access, use or disclosure of PHI, even if vendor believes the incident will not rise to the level of a Breach." Based on the recommendation of Primaris, the new policy submitted by UnitedHealthcare states the time limit of informing the state agency as "no later than 10 calendar days….." **Required Actions:** None.		
(iv) If required to properly perform the contract and subject to the terms of the	Privacy Policy Manual: Page 10, 11 of 53	Met

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).*		
Findings: A UnitedHealthcare shall disclose PHI as required by the Privacy Rule, including: to an individual, when the individual requests access to PHI about him or her; to an individual, when the individual requests an accounting of disclosures of such PHI; to HHS when HHS requests access to our facilities, books, records, accounts and other information, including PHI, that are relevant to HHS determining our compliance with the Privacy Rule. **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).*	Privacy Policy Manual: Page 26 of 53	Met
Findings: A UnitedHealthcare may use or disclose protected health information without the consent or authorization of the individual, where required by Jaw, provided the use or disclosure complies with and is limited to the relevant requirements of that law. Additional requirements apply for uses and disclosures required by law, if the purpose of the disclosures relates to victims of abuse, neglect or domestic violence; disclosures for judicial or administrative proceedings or disclosures for law enforcement. **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).*	Privacy Policy Manual: Page 26 of 53	Met
Findings: A UnitedHealthcare business associate may aggregate PHI of more than one covered entity to conduct analyses for the provision of data aggregation services to each covered entity (or business associate on its behalf), provided that the analyses are related to the health care operations of each such covered entity and data aggregation services are authorized by the relevant business associate agreement. During onsite, UnitedHealthcare explained that their staff ensures that the requirement is specifically for MHD. Subsequently, the claims are run through a SQL query. There are national reporting teams that work for UnitedHealthcare (shared resource) for data aggregation. **Required Actions:** None.		

(vii) The MCO may not use Protected Health Information to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the state agency to do so *(MHD contract 2.38.2f).*	Privacy Policy Manual: Pages 25, 26 of 53 (New) PP-01 MO Privacy and Confidentiality: Page 1 of 3	Met
Findings: UnitedHealthcare may use and disclose de-identified health information. Employees should refer to the business organizations de-identification procedures to ensure that they are de-identifying protected health information in accordance with the appropriate procedures. UnitedHealthcare may assign a unique code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified. De-identified information that has been re-identified may not be disclosed or used except as permitted under the privacy rule. During onsite, Primaris informed UnitedHealthcare that they should incorporate "taking permission from the state before de-identifying or re-identifying PHI" in their policies. UnitedHealthcare complied with recommendation and submitted a new policy which met the requirement. **Required Actions:** UnitedHealthcare should submit their new policy to MHD for approval.		
(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).*	Privacy Policy Manual: Page 9 of 53	Met
Findings: It is the policy of UnitedHealthcare that a United Covered Entity when using or disclosing protected health information or when requesting protected health information from another covered entity, must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. As a general rule, for those uses, disclosures or requests of PHI to which the minimum necessary requirement applies, a United Covered Entity will not use, disclose or request an entire medical record of an individual unless the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure or request. United Covered Entities may document in their policies and procedures routine types of uses, disclosures, or requests which may require an entire medical record. **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	Privacy Policy Manual: Page viii of 53	Met

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).*		
Findings: The HIPAA Privacy Rule (45 CFR Parts 160 and 164, subparts A & E) permits legally separate Covered Entities under common ownership and control to designate themselves as a single affiliated covered entity (e.g. Optum ACE or UnitedHealth Plan SAGE), which then permits the sharing of PHI among all components of the ACE as if it were a single covered entity (45 CFR 164.105(b)). Detailed operational policies, procedures and protocols that implement the enterprise wide policies in the Privacy Policy Manual may be maintained by each business organization (whether a business group, business segment, distinct business unit or functional department) responsible for providing specific business services and operations. **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).*	Privacy Policy Manual: Pages 40, 41 of 53 Exhibit D: HIPAA and GLBA Business Associate Agreement: Page 3 of 5 (New) PP-01 MO Privacy and Confidentiality: Page 1 of 3	Partially Met
Findings: An individual or an individual's representative may, subject to approval, inspect and obtain a copy of his or her information maintained in a designated record set by or for a UnitedHealthcare covered entity. Except in the circumstances described in the policy related to psychotherapy notes; or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, individuals have the right of access to their protected health Information maintained in the designated record set of a United Covered Entity. UnitedHealthcare will provide clear and concise information to individuals requesting access regarding the processes and requirements to access all or part of the designated record set maintained by them. Requests shall be acted upon by a		

United Covered Entity within 30 days of receipt of the request. If the request cannot be acted upon within this deadline, it may be extended once by no more than 30 days by providing the individual (within the allotted timeframe) with a written statement of the reasons for the delay and the date by which action on the request will be completed. BAA submitted by UnitedHealthcare states: UnitedHealthcare/its BAA will provide access to Customer, within fifteen (15) days after receiving a written request from Customer, to PHI in a Designated Record Set about an Individual, or when and as requested by Customer, provide that access directly to an Individual, all in accordance with the requirements of 45 C.F.R. § 164.524, including as of the Compliance Date, providing or sending a copy to a designated third party and providing or sending a copy in electronic format in accordance with 45 C.F.R. § 164.524. During onsite, UnitedHealthcare informed Primaris that MHD gives them a due date when they request a PHI. Primaris recommended that UnitedHealthcare should have a customized policy/BAA for State of Missouri to meet the specific requirements of MHD contract. UnitedHealthcare complied with the recommendation. **Required Actions:** UnitedHealthcare should submit their new policy to MHD for approval.		
(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)*	Privacy Policy Manual: Page 6 of 53 (New) PP-01 MO Privacy and Confidentiality: Page 1 of 3	Met
Findings: If UnitedHealthcare becomes aware of a pattern of activity or a practice by a business associate that constitutes a material breach or violation of its obligations under the business associate agreement between the parties, the United Covered Entity should mitigate consequences and damages arising from the breach. UnitedHealthcare must take reasonable steps to cure the breach or end the violation, and if such steps are unsuccessful it must terminate the contract, if feasible.		

During onsite, Primaris informed UnitedHealthcare that their documents did not state that "they should submit a written plan for preventing any future unauthorized uses or disclosures to MHD within 5 days." Post onsite, UnitedHealthcare submitted a policy which met the MHD contractual requirement for this section. **Required Actions:** UnitedHealthcare should get their new policy approved by MHD.		
(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).*	Documentation Retention: Pages 1, 2 of 2 Privacy Policy Manual: Page 8 of 53	Met
Findings: Beginning April 14, 2003, all documentation related to PHI must be retained for a minimum of six years from the date of creation or the date when it was last in effect, whichever is later. For CMS regulated entities, such documentation must be retained for a minimum of ten 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 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).*	(New)PP-01 MO Privacy and Confidentiality: Page 2 of 3	Met

Findings: During onsite, Primaris informed UnitedHealthcare that based on their submitted documents, they do not meet this contractual requirement.
UnitedHealthcare created a policy to meet the specific requirements of MHD after recommendation from Primaris.
Required Actions: UnitedHealthcare should submit this policy to MHD for approval.

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

Appendix G

Subpart D Standard 7-42 CFR 438.228 Grievance and Appeal Systems (MHD contract 2.15)		
Requirements and References	Evidence/Documentation as submitted by the MCO	Score
1. 42 CFR 438.400 Definitions. A. Adverse benefit determination means: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (ii) The reduction, suspension, or termination of a previously authorized service. (iii) The denial, in whole or in part, of payment for a service (Note: CMS has proposed that it applies to clean claims only.) (iv) The failure to provide services in a timely manner, as defined by the State (MHD contract: 2.15.1 a 4/2.5.3, 20CSR400-7.095). (v) The failure of an MCO to act within the timeframes provided in §438.408(b) (1) and (2) regarding the standard resolution of grievances and appeals. (vi) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b) (2) (ii), to obtain services outside the network. (vii) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 1, 2 of 22 UCSMM.01.11 Document Oversight and Adherence: Page 4 of 5	 Met
Findings: UnitedHealthcare meets the definition of Adverse benefit determination; however, 1A (v) above is stated as follows in their policy-"The failure of the MCO to act within the		

timeframes provided at Section 2.12.16. c. 22 of the contract regarding the standard resolution of grievances and appeals." Though UnitedHealthcare 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 UnitedHealthcare 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). Required Actions: None.		
B. Appeal means a review by an MCO of an adverse benefit determination.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page 3 of 22	Met
Findings: UnitedHealthcare complies with the definition of 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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page 3 of 22 UCSMM.01.11 Document Oversight and Adherence: Page 5 of 5	Met
Findings: UnitedHealthcare complies with the definition of CFR. **Required Actions:** None.		
D. Grievance and appeal system means the processes the MCO implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.	UCSMM.01.11 Document Oversight and Adherence: Page 5 of 5	Met
Findings: UnitedHealthcare complies with the definition of CFR. **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).*	UCSMM.01.11 Document Oversight and Adherence Pages 1, 5 of 5	Met
Findings: In their list of approved definitions #154-Inquiries is defined as questions about utilization management process or the consumer's benefit plan. Inquiries are not complaints or concerns. **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.	UCSMM.01.11 Document Oversight and Adherence Page 5 of 5 POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page 5 of 22	Met
Findings: UnitedHealthcare complies with the definition of MHD contract. **Required Actions:** None.		
2. 42 CFR 438.402 General requirements. A. The grievance and appeal system. (i) Each MCO must have a grievance and appeal system in place for enrollees. (ii) The MCO shall distribute to members upon enrollment a flyer explaining the grievance and appeal system. (iii) The MCO shall probe inquiries so as to validate the possibility of any inquiry actually being a grievance or appeal. The health plan shall identify any inquiry pattern *(MHD contract 2.15.2).*	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy 07_22 Grievance and Appeal flyer 07 Escalation Tracking System (ETS)	Met
Findings: UnitedHealthcare Community and State Appeals (CSA) organization processes appeals and grievances submitted by members and by authorized representatives, including providers submitting on behalf of members in accordance with applicable state and federal regulatory requirements, and the member's plan coverage documents. The policy and		

procedure sets forth the process used to meet the federal requirements and enumerates state and contractual variances. UnitedHealthcare informs the members about their grievance and appeals system through MO HealthNet member handbook and a flyer. UnitedHealthcare states that they have an Escalation Tracking System (ETS) project with a primary purpose to develop and implement a centralized database to support the operational redesign of the current escalation process with the goal of improving the overall appeal/grievance/ complaint process. Each member outreach that is received by the appeals and grievance department is reviewed by an analyst during entry into the Escalation Tracking System to identify if it should be classified as an appeal, grievance or inquiry based on the how each is defined in the MO National Medicaid Member Appeal and Grievance Policy. Receipts that do not fall into a grievance or appeal category are classified as inquiries. Inquiries are reviewed and responded to by the resolving analysts within 30 calendar days. Inquiry trending is available by utilizing reporting that can be pulled out of the Escalation Tracking System that is used to track all grievances, appeals and inquiries. During onsite, UnitedHealthcare explained that a flyer is a State mandated document which is given to the member in the "welcome packet" at the time of enrollment. Members can submit their complaint/grievance/appeal via phone. The call center staff answers the phone, probes the members to determine if their call is regarding a grievance/appeal/inquiry. The call center documents all the calls. If the call center does not have an answer or there is a need for further review, it is entered in the ETS. UnitedHealthcare uses definitions to decide if it is a grievance/appeal/inquiry. UnitedHealthcare explained their entire ETS via a power point presentation. **Required Actions:** None.		
B. Level of appeals. Each MCO may have only one level of appeal for enrollees.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy Page 3 of 22	Met
Findings: The single level of appeal is further categorized by UnitedHealthcare as: An administrative appeal-an appeal of an adverse benefit determination which is based on the member's MO HealthNet benefit plan, e.g., the service is excluded under the plan. A clinical appeal-an appeal of a utilization review adverse benefit determination, in which the adverse benefit determination is based upon medical necessity or because the service requested is considered experimental, investigational or unproven. A pre-service appeal-a request to change a plan denial of care or a service prior to the member obtaining the care or service. Examples include appeals of pre-authorization requests. A post-service appeal-a request to change a claim denial or reduction of payment for services already received by the member. **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	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy Pages 3, 8 of 22	Met

representative may request an appeal or file a grievance, or request a State Fair Hearing, on behalf of an enrollee, with an exception that providers cannot request continuation of benefits as specified in 42 C.F.R. §438.420(b)(5).	(Updated) POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page 11 of 17	
Findings: The member, and with the written consent of the member, a provider or an authorized representative, may file a grievance and an appeal either orally or in writing. A member, or authorized representative, but not a provider, may be entitled to request continuation of benefits while the appeal and State Fair Hearing are pending. During onsite review, Primaris informed UnitedHealthcare that their policy does not clearly state "with a written consent of the member, a provider or an authorized representative can request a State Fair Hearing." UnitedHealthcare confirmed that they allow a provider or an authorized representative of a member to request a State Fair Hearing. They resubmitted a revised policy to incorporate the missing statement. **Required Actions:** It is recommended that UnitedHealthcare submits their revised policy to MHD for approval.		
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.	UCSMM 07.12 Appeal Process and Record Documentation: Page 4 of 6	Met
Findings: UnitedHealthcare complies with the MHD's contractual requirement in section 2.15.2 k which states that if 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:** Section 2.12.16c. 22 of MHD contract does not mention the timing requirements of standard and expedited appeals. It is recommended that UnitedHealthcare works with MHD to update the section in the contract which has actual information about the timeframes for appeals.		
E. Timing for filing. An enrollee may file a grievance with the MCO at any time whereas an enrollee has 60 calendar days from the date of the adverse benefit determination notice, to file a request for an appeal to the MCO.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 8, 17 of 22 UCSMM 07.11 Appeal Review Timeframes: Page 3	Met

Findings: UnitedHealthcare complies with the CFR related to the timings requirement for filing a grievance and appeal. **Required Actions:** None.		
F. Procedure. (i) Grievance- The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with MCO. (ii) Appeal- The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. (Note: CMS has proposed to remove this requirement of written appeal.)	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 8, 17 of 22	Met
Findings: UnitedHealthcare member, and with the written consent of the member, a provider or an authorized representative, may file an appeal either orally or in writing. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. A grievance may be filed either orally or in writing. If State law permits and with the written consent of the member, a provider or an authorized representative may request a grievance, on behalf of a member. **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 evidentiary standards used in setting coverage limits.	UCSMM.06.18 Initial Adverse Determination Notices: Page 4 of 5	Met

(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: UnitedHealthcare issues the notice of adverse benefit determination to its members which consists of all the above listed requirements from CFR and MHD contract section 2.15.4. **Required Actions:** None.		
B. Timing of notice. (MHD contract 2.15.4 c 1) (i) For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the date of adverse benefit determination. No later than the date of adverse benefit determination in case of Beneficiary's death. Withdrawal from services. Unknown whereabouts-the post office returns MCO's mail directed to the member indicating no forwarding address. In cases of probable fraud-notice will be 5 days before the date of adverse benefit determination.	UCSMM.06.16 Initial Review Timeframes: Page7 of 8	 Met

Findings: UnitedHealthcare follows the timing of notice of adverse benefit determination as stated in their policy and confirmed onsite during interview. **Required Actions:** None.		
(ii) For denial of payment, at the time of any action affecting the claim.	UCSMM.06.16 Initial Review Timeframes: Page7 of 8 Member Explanation of Benefits	Met
Findings: Missouri members can review claim Explanation of Benefits (EOB) electronically via the Member Portal which is located at www.myuhc.com. EOB files are submitted daily, Monday - Friday, as part of the daily batch process. EOBs can also be mailed to a member if the member requests a paper copy. Primaris reviewed the EOB mailed to members and found a statement, "if you do have a financial liability, we will send you an adverse benefit determination letter informing you of the reason for denial and amount you owe." During onsite this point was discussed that there is a need to revise UHC's EOB statement, as Medicaid members do not have a financial liability for their services. **Required Actions:** Primaris recommends UnitedHealthcare to revise their EOB based on MHD guidelines.		
(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.)	UCSMM.06.16 Initial Review Timeframes: Pages 6, 7 of 8	Met
Findings: Approval or denial for initial determinations shall be provided by the UnitedHeathcare within 36 hours, which shall include 1 working day, of obtaining all necessary information. UnitedHealthcare shall notify the requesting provider within 36 hours, which shall include 1 working day, following the receipt of the request of service regarding any additional information necessary to make a determination. UnitedHeathcare shall not exceed 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 UnitedHealthcare justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest. **Required Actions:** None.		
(iv) For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus	UCSMM.06.16 Initial Review Timeframes: Page 8 of 8	Met

an adverse benefit determination), on the date that the timeframes expire.		
Findings: For service authorization decisions not reached within the required timeframes as per the MHD contract section 2.5.5 and 2.5.6 in addition to the CFR, the notice of the adverse benefit determination must be mailed by the date that 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.	UCSMM.06.16 Initial Review Timeframes: Page 6 of 8	Met
Findings: The review process shall be completed and communicated to the provider and member in a timely manner, as indicated below or the denials shall be deemed approved. Approval or denial of non-emergency services, when determined as such by emergency room staff, shall be provided by the health plan within 30 minutes of request. Approval or denial shall be provided within twenty-four24 hours of request for services determined to be urgent by the treating provider. UnitedHealthcare complies with the time frame requirements set in CFR. **Required Actions:** None.		
(vi) If the MCO meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must— a. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and b. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	UCSMM.06.16 Initial Review Timeframes: Page 8 of 8	Met

Findings: UnitedHealthcare acknowledges the above listed criteria for extension of timeframe for standard authorization of services through their policy and follows the same in practice. **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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 8, 17 of 22 UCSMM 07.12 Appeal Process and Record Documentation: Page 5	Met
Findings: The resolving analyst of UnitedHealthcare will provide reasonable assistance to the member in completing forms and taking other procedural steps related to a grievance and 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, American Sign Language services and interpreter capability, and providing written notices in a secondary language per a member's request. During onsite, UnitedHealthcare stated that all the calls are received by a call center. A representative helps the member or reaches out to resolving analyst for the procedural steps related to grievance or appeal. They help the members in filling out the forms. All the information is captured in writing at the call center and is turned into the ETS. **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 ten (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	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 9, 17 of 22 UCSMM 07.12 Appeal Process and Record Documentation page 5 of 6	Met

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.")		
Findings: An acknowledgement letter is sent upon case entry into the tracking system. Written acknowledgment of the receipt of an appeal is completed within 10 business days per contract section 2.15.6.k. UnitedHeathcare states that if required, a written acknowledgement letter is sent upon case entry into the tracking system within 10 business days per contract section 2.15.5 c for grievance. UnitedHealthcare shall provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or provider requests expedited resolution. During onsite, UnitedHealthcare confirmed that they send a written acknowledgement letter within 10 business days of entry into the ETS. There is an error in their policy statement "UnitedHeathcare states that if required, a written acknowledgement letter is sent upon case entry…." **Required Actions:** It is recommended that UnitedHealthcare updates their policy by stating that written acknowledgement will be sent within the 10 business days of receiving a grievance.		
(ii) Ensure that the individuals who make decisions on grievances and appeals are individuals— a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease: An appeal of a denial that is based on lack of medical necessity. A grievance regarding denial of expedited resolution of an appeal. A grievance or appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the enrollee	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 10, 18 of 22	Met

or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.		
Findings: The resolving analyst assigned to the case is an individual not involved in the previous decision and is not a subordinate of the individual who made the previous decision on appeals or grievance. The review analyst responsible for managing the case ensures individuals who make decisions on appeals/grievances are individuals who meet all the above listed requirements. During onsite, UnitedHealthcare confirmed that all cases are reviewed by a resolving analyst. The case may be assigned to a different resolving analyst if needed. Clinical reviewer can review as well. **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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 9 of 22	Met
Findings: A member may present evidence, or submit written comments, documents, records and other information relevant to the appeal. Submission of additional information does not affect the timeframe within which an appeal decision must be rendered. When the appeal is expedited, the review analyst informs the member of the limited time available for this sufficiently in advance of the resolution timeframe. During onsite, UnitedHealthcare stated that the members are given the opportunity to come to the Westport office. They are provided with phone services and transportation services. **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	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page10 of 22	Met

the resolution timeframe for appeals specified in 42 CFR 438.408.		
Findings: A UnitedHealthcare member and his or her representative may request the member's case file at no cost in advance of the decision (as specified at section 2.12.16 c. 22 of the contract), including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated in connection with the appeal of the adverse benefit determination. During onsite, UnitedHealthcare confirmed that members are provided with documents/medical records free of cost. **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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page10 of 22	Met
Findings: This requirement is met by UnitedHealthcare. **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 thirty (30) calendar days of the filing date *(MHD contract 2.15.5 e).*	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 10, 11, 12, 18 of 22 UCSMM 07.11 Appeal Review Timeframes page 3 of 4	Met

(ii) Standard resolution of appeals. No longer than 30 calendar days from the day the MCO receives the appeal. This timeframe may be extended as stated below. (iii) Expedited resolution of appeals. No longer than 72 hours after the MCO receives the appeal. This timeframe may be extended as stated below.		
Findings: The timeframe to resolve an appeal is 30 calendar days from the date of UHC's receipt, or as expeditiously as the member's health condition requires. When filed orally, and later confirmed in writing, the date of the oral appeal filing will be used as the date of receipt. For an expedited appeal, the review analyst of UnitedHealthcare provides the member, and if applicable other affected parties, with oral notification of the decision within 72 hours, followed by written resolution within three calendar days of oral notification. The standard timeframe to resolve a grievance shall not exceed 30 calendar days per contract section 2.15.5 e. from UHC's receipt or as expeditiously as the member's health condition requires. **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.	UCSMM 07.11 Appeal Review Timeframes page 3 of 4 POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 11, 18 of 22	Met
Findings: UnitedHeathcare extends the duration of timeframes by 14 days for grievance and appeals (standard and expedited) in case of above listed conditions. **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	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 11, 19 of 22 UCSMM 07.11 Appeal Review Timeframes page: 3 of 4	Met

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.		
Findings: Following an extension, the review analyst at UnitedHealthcare makes reasonable efforts to give the member prompt oral notice of the delay and within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. The appeal resolution is completed 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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 12, 19 of 22 UCSMM 07.13 Appeal Notices page 3 of 3	Met
Findings: When required, written grievance decisions are issued within applicable regulatory timeframe requirements, and must include the following elements, if applicable: •The letter is addressed to the grieving party, and where applicable, the provider or facility. •The specific reason(s) for the decision, in easily understandable language. •The right of a member to appeal a grievance decision For all appeals UnitedHealthcare issues written notice of the resolution that is linguistically and culturally appropriate which includes the results of the resolution process and the date it was completed. **Required Actions:** None.		
D. Content of notice of appeal resolution.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 12, 13 of 22	Met

The written notice of the resolution must include the following: (i) The results of the resolution process and the date it was completed. (ii) For appeals not resolved wholly in favor of the enrollees— a. The right to request a State Fair Hearing, and how to do so. b. The right to request and receive benefits while the hearing is pending, and how to make the request. c. That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's adverse benefit determination.	UCSMM 07.13 Appeal Notices: Page 3 of 3	
Findings: The written notice of resolution of appeals consists of results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the member, the notice of resolution also contains the following requirements at UnitedHealthcare: • The right to request a State Fair Hearing within 120 calendar days of the date of the plan's notice of appeal resolution, and how to do so. • The right to request to receive benefits during the State Fair Hearing process, how to make the request, and the timeframe in which to do so within 10 calendar days of the plan notice of appeal resolution. • Notice that the member may be held liable for the cost of those benefits if the State Fair Hearing decision upholds the plan's adverse benefit determination. • Specific reasons for the appeal decision, in easily understandable language. • A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal determination was based. • Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal determination was based, upon request. • Notification that the member is entitled to receive reasonable access to and copies of all documents, upon request. • A list of titles and qualifications, including specialties, of individuals participating in the appeal review. **Required Actions:** None.		
E. Requirements for State Fair Hearings. (i) An enrollee may request a State Fair Hearing:	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 15 of 22	Met

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.	UCSMM 07.12 Appeal Process and Record Documentation: Page 4 of 6 UCSMM 07.11 Appeal Review Timeframes: Page 3 of 4	
Findings: UnitedHealthcare policies have incorporated all the above requirements from CFR and follow the same in practice. This was confirmed at the time of onsite review. **Required Actions:** None.		
(ii) External medical review. The state may offer and arrange for an external medical review if the following conditions are met. 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.		Not applicable for MCO
Findings: N/A **Required Actions**:		
6. 42 CFR 438.410 Expedited resolution of appeals. A. General rule. The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 4 of 22	Met

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.		
Findings: UnitedHealthcare has established and maintains an expedited review process for appeals in the above situations. **Required Actions:** None.		
B. Punitive action. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	UCSMM 07.12 Appeal Process and Record Documentation page 6 of 6 POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 13, 19 of 22	Met
Findings: UnitedHealthcare does not take punitive or retaliatory actions against a member, or provider supporting a member, for filing an appeal and grievance. **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).	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page11 of 22 UCSMM 07.11 Appeal Review Timeframes: Page 3 of 4	Met
Findings: If a review analyst of UnitedHealthcare with appropriate clinical expertise denies a request for an expedited appeal, then review analyst would transfer the appeal to the standard resolution process, in which the calendar day period to resolve begins on the original date UnitedHealthcare received the request for appeal; and make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days for the reasons for the decision and the right to file a grievance. The appeal resolution is completed 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	Provider Manual: Page 76	Met

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 ten (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).*	UCSMM.07.12 Appeal Process and Record Documentation: Page 1 of 6 Single Case Letter of Agreement: Page 1 of 4	
Findings: Page 1 of UCSMM.07.12 Appeal Process and Record Documentation states that a consumer, their representative and/or provider who requests appeal policies and procedures will be provided written policies and procedures or a summary which clearly describes both expedited and standard appeal process, their appeal rights, and how to access copies of documents relevant to their appeal free of charge. The provider manual submitted by UnitedHealthcare has information about grievance and appeal system. During onsite review, Primaris informed UnitedHealthcare that, there is no documentation about the timings of distribution of the information to in network or out-of-network provided as per the CFR/MHD contract in any of grievance and appeals policies submitted to Primaris. UnitedHealthcare clarified that the provider manual is given to the providers and contractors when they enter their contract. However, for out-of-network providers UnitedHealthcare submitted a revised "Single Case Letter of Agreement" which guides the providers to visit the website of UnitedHealthcare to access details about grievance and appeals system. This Agreement shall be for the purpose of making available to the covered person identified in the Agreement ("Covered Person"), certain medically necessary covered services (the "Covered Services"). **Required Actions:** UnitedHealthcare should submit the revised document to MHD for approval.		
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	UCSMM 07.12 Appeal Process and Record Documentation: Page 4 of 6	Met

Care members from other health plan members *(2.15.3 MHD contract).*	07_MO_Member_Issue_Log_Closed_07.18 07_MO_Member_Issue_Log_Closed_08.18 07_MO_Member_Issue_Log_Closed_09.18 07_MO_Member_Issue_Log_Closed_10.18 07_MO_Member_Issue_Log_Closed_11.18 07_MO_Member_Issue_Log_Closed_12.18 07_MO_Member_Issue_Log_Open_07.18 07_MO_Member_Issue_Log_Open_08.18 07_MO_Member_Issue_Log_Open_09.18 07_MO_Member_Issue_Log_Open_10.18 07_MO_Member_Issue_Log_Open_11.18 07_MO_Member_Issue_Log_Open_12.18 07_MO_Member_Issues_Log_Q1_2018 07_MO_Member_Issues_Log_Q2_2018	
Findings: UnitedHealthcare submits the log sheets for all inquiries, grievances, and appeals to the state agency monthly and upon request. 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 UnitedHealthcare is provided for reference. UnitedHealthcare is compliant with this requirement. **Required Actions:** None.		
B. The record of each grievance or appeal must contain, at a minimum, all of the following information: 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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page13, 19 of 22 UCSMM 07.12 Appeal Process and Record Documentation: Page 2 of 6 07_ETS Presentation	Met
Findings: UnitedHealthcare shall maintain records of appeals and grievances, whether received verbally or in writing, that include a short, dated summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution. During onsite, UnitedHealthcare presented the screenshots with all the above fields in their ETS. **Required Actions:** None.		

C. MCO shall retain member grievance and appeal records for a period of no less than ten (10) years. (MHD contract 2.15.3f).	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page13, 19 of 22 UCSMM 07.12 Appeal Process and Record Documentation: Page 4 of 6 UHC Privacy Policy P 15 Document Retention: Page 1 of 2	Met
Findings: Record pertaining to an appeal and grievance is maintained in ETS in an accessible manner to CMS and the State for a minimum of ten years. **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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 8, 9 of 22 UCSMM 07.11 Appeal Review Timeframes: Page 6 of 6	Met
Findings: UnitedHealthcare complies with the above said criteria for timely filing in case the enrollee wants continuation of benefits. **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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 8, 9 of 22	Met

The period covered by the original authorization has not expired. The enrollee timely files for continuation of benefits.		
Findings: UnitedHealthcare continues the benefit of its enrollees under all the above listed conditions. **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 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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 9, 15 of 22 UCSMM 07.12 Appeal Process and Record Documentation page 6 of 6	Met
Findings: UnitedHealthcare continues or reinstates the member's benefits while the appeal or State Fair Hearing is pending, until one of above listed condition occurs. In UCSMM 07.12 Appeal Process and Record Documentation page 6 of 6, there is omission of word-until- in section 2.15.6t. This changes the meaning of the entire section. **Required Actions:** It is recommended that UnitedHealthcare revisits their policy and corrects the typing error (omission of word- until).		
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).	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Page16 of 22 UCSMM 07.12 Appeal Process and Record Documentation: Page 6 of 6	Met

Findings: When the State Fair Hearing decision upholds UnitedHealthcare's decision, the State Fair Hearing coordinator may initiate cost recovery for the service or services provided pending the outcome of the hearing decision. **Required Actions:** None.		
10. 42 CFR 438.424 Effectuation of reversed appeal resolutions. A. Services not furnished while the appeal is pending. If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 13, 16 of 22 UCSMM 07.11 Appeal Review Timeframes: Page 4 of 4	Met
Findings: When an appeal resolution is reversed, as expeditiously as the member's health condition requires, but no later than 72 hours from the date UnitedHealthcare staff receives notice, the authorization will be updated to provide the service or services. **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.	POL2015-07 Member Appeal, State Fair Hearing, and Grievance policy: Pages 13, 16 of 22 UCSMM 07.12 Appeal Process and Record Documentation: Page 6 of 6	Met
Findings: When an appeal resolution is reversed in State Fair Hearing in favor of the member and the service or services were provided pending the outcome of the appeal, a State Fair Hearing coordinator will update the system authorization to approve payment. **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		=	
Score %						**100%**

Appendix H

Subpart D Standard 8–42 CFR 438.238 Subcontractual Relationships and Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
1. If any of the MCO's activities or obligations under its contract with the State are delegated to a subcontractor— (i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. (ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's entity's contract obligations. (iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO determine that the subcontractor has not performed satisfactorily. (438.230 (c) (1).	Dental Benefit Providers, Inc. Pages 10, 19 of 20 CareCore national, LLC: Pages 3, 7, 8, 28 of 28 March Vision Care Group, Inc. : Pages 8, 23 of 63 Medical Transportation Management (MTM): Pages 5, 12, 18 of 19 Children's Mercy Integrated Care Solutions, Inc. : Pages 42, 43, 61-64 Rose International, Inc. : Pages 1, 2, 11 of 50	Met
Findings: UnitedHealthcare submitted the above list of contracts with their subcontractors. The delegated activities and obligations are specified in all the contracts and are in compliance with the MCO's contract obligations. The contracts with these subcontractors state that: In addition to UnitedHealthcare's termination rights under the subcontract, UnitedHealthcare shall have the right to revoke any functions or activities UnitedHealthcare delegates to subcontractor under the Agreement or impose other sanctions consistent with the state contract if in UnitedHealthcare's reasonable judgment subcontractor's performance under the subcontract is inadequate. UnitedHealthcare shall also have the right to suspend, deny, refuse to renew or terminate subcontractor in accordance with the terms of the state contract and applicable law and regulation. During onsite, UnitedHealthcare informed that they have oversight committee meetings on a monthly/quarterly basis with their vendors/subcontractors. Their performance is rated on a performance score card. **Required Actions:** None.		

2. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, agreeing that:		
a. The State, CMS, the HHS Inspector General, or their designees, have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State.	March Vision Care Group, Inc. : Pages 6, 33 of 63 Dental Benefit Providers, Inc. Page 13 of 20 Medical Transportation Management (MTM): 11 of 19 CareCore national, LLC: Pages 23 of 28 Children's Mercy Integrated Care Solutions, Inc. (Regulatory Requirements Appendix : Page 4 of 13 Rose International, Inc. : Page 44 of 50	Met
Findings: Government and accrediting agencies which license the operation of UnitedHealthcare or vendor shall have the right to inspect, evaluate and audit applicable records. UnitedHealthcare and vendor are hereby authorized to release all information and records or copies of such within the possession of UnitedHealthcare or vendor that are pertinent to and involve transactions related to this agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UnitedHealthcare or vendor. Subcontractor acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, computer or other· electronic systems (including medical records), patient care documentation and other records and information belonging to Subcontractor and Participating Providers that involve transactions related to the CMS Contract. **Required Actions: consistent requirements to be written in all contracts given to vendors.**		
b. The subcontractor will make available, for purposes of an audit, evaluation, or inspection (42 CFR 430.230(c)(3)(ii)) its premises,	March Vision Care Group, Inc. : Pages 6, 44 of 63 Dental Benefit Providers, Inc. Page 13 of 20	Met

physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees.	Medical Transportation Management (MTM): Page 10 of 19 CareCore national, LLC: Pages 23 of 28 Children's Mercy Integrated Care Solutions, Inc. (Regulatory Requirements Appendix : Page 4 of 13 Rose International, Inc. : Page 44 of 50 (Updated) Subcontractor Oversight: Page 3 of 5	
Findings: Subcontractor acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Subcontractor shall require Providers to provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. During onsite, Primaris recommended that UnitedHealthcare should update all the contracts with the vendors to state that: for the purpose of evaluation/audit their premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Medicaid enrollees will be available. UnitedHealthcare has updated their policy on "Subcontractor Oversight" to meet the requirements from CFR. **Required Actions:** UnitedHealthcare should update all the contracts with the vendors and submit their revised policy to MHD for approval.		
c. 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 430.230(c) (3) (iii).	March Vision Care Group, Inc. : Pages 5, 44 of 63 Dental Benefit Providers, Inc. Page 13 of 20 Medical Transportation Management (MTM): 10 of 19 CareCore national, LLC: Pages 23 of 28 Children's Mercy Integrated Care Solutions, Inc.	Met

	(Regulatory Requirements Appendix : Page 4 of 13 Rose International, Inc. : Page 44 of 50 (Updated) Subcontractor Oversight: Page 3 of 5	

Findings: Primaris reviewed the contracts of some of the subcontractors/vendors of UnitedHealthcare. In March Vision Care Group, page 5 states that all books, accounts and records shall be maintained in compliance with the applicable laws and regulations of the state in which United is domiciled and in accordance with prudent standards of insurance record keeping. Vendor shall maintain at its principal administrative office, and shall require, as applicable, Participating Providers and any subcontractors to maintain, adequate books and records of all transactions related to the services provided pursuant to this Agreement. Vendor shall maintain such books and records for 10 years after the date the records were created unless a different retention period is specified by applicable law or regulation, then such records shall be preserved for such period as required by applicable law or regulation.

In the same contract on page 44 of 63 the contract states that: as required under State or federal law or the State Contract, Subcontractor shall and shall require Providers to maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Such records shall be maintained for five (5) years as specified by the State Contract, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by United if the Subcontract is continuous.

Page 44 of 50, Rose International, Inc. states record retention period of at least 10 years from final date of the CMS contract period in effect at the time the records were created, or such longer period as required by the law.

All the other contracts submitted by UnitedHealthcare show a record retention period of 5 years.

During onsite, Primaris explained that the CFR states that the “right to audit” is for the duration of 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.” UnitedHealthcare should update their documents/subcontracts to reflect the correct duration.

During onsite, UnitedHealthcare was informed that they should update their subcontractors’ contracts to state that “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.”

UnitedHealthcare updated their policy on “subcontractor oversight” to reflect the correct duration of “right to audit.”

Required Actions: UnitedHealthcare should implement this change in all of their subcontractors' contracts and submit their revised policy to MHD for approval. **Recommendation to MHD:** The MHD contract needs to be amended to align with the duration of "10 years" based on the CFR. Currently the duration of right to audit is stated as 5 years in their contract with the MCOs.		
d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	March Vision Care Group, Inc.: Pages 6, 44 of 63 Dental Benefit Providers, Inc. Page 13 of 20 Medical Transportation Management (MTM): Page 10 of 19 CareCore national, LLC: Pages 23 of 28 Children's Mercy Integrated Care Solutions, Inc. (Regulatory Requirements Appendix : Page 4 of 13 Rose International, Inc. : Page 44 of 50	Met
Findings: Upon reasonable notice, during normal business hours and at a reasonable time and place, UnitedHealthcare or its designee shall have the right to examine any books or records of Vendor that relate to this Agreement during the term of this Agreement and for 3 years thereafter unless otherwise required by law. Subcontractor shall and shall require Providers to provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs. **Required Actions:** None.		
3. Any subcontracts for the products/services described herein must include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to	March Vision Care Group, Inc. : Page 43 of 63 Dental Benefit Providers, Inc. Page 12 of 20	Met

by the health plan and the State of Missouri and to ensure that the State of Missouri is indemnified, saved, and held harmless from and against any and all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract in those matters described in the contract between the State of Missouri and the health plan (MO HealthNet Managed Care Contract section 3.9).	Medical Transportation Management (MTM): Pages 9, 10 of 19 CareCore national, LLC: Pages 23 of 28 Children's Mercy Integrated Care Solutions, Inc. (Regulatory Requirements Appendix : Pages 3, 4 of 13 Rose International, Inc. : Pages 8, 9 of 50	
Findings: Except for applicable cost-sharing requirements under the state contract, subcontractor shall and shall require Providers to accept payment from UnitedHealthcare as payment in full and look solely to UnitedHealthcare for payment of covered services provided to covered persons pursuant to the subcontract, provider agreement and the state contract, and to hold the state, the U.S. Department of Health and Human Services and covered persons harmless in the event that UnitedHealthcare cannot or will not pay for such Covered Services. In accordance with 42 CFR Section 447.15, as may be amended- from time to time, the covered person is not liable to provider for any services for which UnitedHealthcare is liable and as specified under the state's relevant health insurance or managed care statutes, rules or administrative agency guidance. Subcontractor shall require that providers may not require any copayment or cost sharing for covered services provided under their provider agreement unless expressly permitted under the state contract. Providers shall also be prohibited from charging covered persons for missed appointments if such practice is prohibited under the state contract or applicable law. This provision shall survive any termination of the subcontract and provider agreements, including breach of the due to insolvency. **Required Actions:** None.		
4. Health Plan Disputes With Other Providers: All disputes between the health plan and any subcontractors shall be solely between such subcontractors and the health plan. The health plan shall indemnify, defend, save, and hold harmless the State of Missouri, the Department of Social Services and its officers, employees, and agents, and enrolled MO HealthNet Managed	March Vision Care Group, Inc. : Page 43 of 63 Dental Benefit Providers, Inc. Page 12 of 20 Medical Transportation Management (MTM): Pages 9, 10 of 19 CareCore national, LLC: Pages 23 of 28	Met

Care members from any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of the contract because of any breach of the contract by the health plan, its subcontractors, agents, providers, or employees, including but not limited to any negligent or wrongful acts, occurrence or omission of commission, or negligence of the health plan, its subcontractors, agents, providers, or employees (MO HealthNet Managed Care Contract 3.9.1).	Children's Mercy Integrated Care Solutions, Inc. (Regulatory Requirements Appendix : Pages 3, 4 of 13 Rose International, Inc. : Pages 8, 9 of 50	
Findings: To the extent applicable to subcontractor and providers in performance of the subcontract and agreements, subcontractor shall and shall require Providers to indemnify, defend and hold the Department and Covered Persons harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract and any provider agreement. This clause shall survive the termination of the subcontract and any provider agreement for any reason, including breach due to insolvency. **Required Actions:** None.		

Compliance Score- Subcontractual Relationships and Delegation						
Total	Met	=	7	✕2	=	14
	Partial Met	=	0	✕1	=	0
	Not Met	=	0	✕0	=	0
Numerator	Score Obtained				=	14
Denominator	Total Sections	=	7	✕2	=	14
Score						**100%**

Appendix I

Subpart D Standard 9-42 CFR 438.236 Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
Practice Guidelines (MO HealthNet Managed Care Contract 2.18.5)		
1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	CW-HS-HS-901 Development of Clinical Practice Guidelines/ Preventive Health Recommendations: Page 2 of 4 Review of Clinical and Preventive Guidelines policy: Page 2 of 3 Hierarchy of Clinical Evidence policy: Page 1 of 3	Met
Findings: UnitedHealthcare staff with clinical experience develop the Clinical Practice Guidelines (CPGs)/Preventive Health Recommendations (PHR). These CPGs are based on National Professional Societies guidelines and scientific peer reviewed literature. Preventive Health Recommendations are based on National and Governmental Organizational Guidelines for prevention or interventions, as appropriated for specific Age, Gender and/or Risk factor. Any internally developed, locally developed, or nationally recognized guideline submitted must meet the following criteria: The guideline is based upon published clinical evidence, or in the absence of published clinical evidence, is based upon a national consensus of scientific experts. The business unit identifies need for a clinical or preventive guideline. The business unit submits an internally developed, locally developed, or nationally recognized guideline to the MTAC Chairperson. **Required Actions:** None.		
2. Consider the needs of the members	CW-HS-HS-901 Development of Clinical Practice Guidelines/ Preventive Health Recommendations: Page 2 of 4 Review of Clinical and Preventive Guidelines policy: Page 1 of 3	Met
Findings: Guidelines shall be based upon professionally recognized standards of practice and shall address the provision of acute, chronic, behavioral, and preventive health care.		

This need may be occasioned by regulatory requirements, accreditation needs, clinical quality initiatives, or unique market business needs. The business unit identifies need for a clinical or preventive guideline. The business unit submits an internally developed, locally developed, or nationally recognized guideline to the Medical Technology Assessment Committee (MTAC Chairperson). Occasionally, a business unit will have need of a clinical position statement for which a UnitedHealthcare internally developed or nationally recognized and accepted guideline does not exist. During onsite, UnitedHealthcare explained that member needs are identified through various sources: a list from the State e.g., special care members; tracking and trending admissions; health risk assessment that takes place at the admission and is reviewed by the case managers; follow up by care managers; and clinical program. **Required Actions:** None.		
3. Are adopted in consultation with contracting health care professionals;	CW-HS-HS-901 Development of Clinical Practice Guidelines/ Preventive Health Recommendations: Page 2 of 4 Medical Technology Assessment Committee (MTAC) May 3, 2018 Minutes	Met
Findings: The Medical Policy Committee and Coverage Determination Guideline Committee (CDGC) in collaboration with the Medical Management Guideline Committee (MMGC) work to develop and adopt CPG/PHR. Reviewers will be identified from among UnitedHealthcare Clinical staff, regional committee members, and/or external specialists. An opportunity for informational review of guidelines by the staff and medical directors in respective states will be provided. Feedback should be directed to the guideline author for consideration. Reviews and/or feedback will be summarized for presentation to the CDGC and MMGC. **Required Actions**: None.		
4. Are reviewed and updated periodically as appropriate; and	CW-HS-HS-901 Development of Clinical Practice Guidelines/ Preventive Health Recommendations: Page 2 of 4 Review of Clinical and Preventive Guidelines policy: Page 3 of 3	Met
Findings: Clinical or preventive guidelines from all sources are subject to periodic review, revision (if necessary), and approval.		

• Internally developed or locally developed guidelines will be reviewed every 12 months or more often as dictated by the availability of new published evidence. • Nationally recognized clinical or preventive guideline policy review will occur every 12 months or as needed. • When state regulations require that they do so, MCO will review the guidelines with local practitioners or at their local Quality Improvement Committee. • PHR will be revised annually or more frequently if revisions are required. **Required Actions:** None.		
5. Are disseminated to all affected providers, and upon request, to members and potential members.	CW-HS-HS-901 Development of Clinical Practice Guidelines/ Preventive Health Recommendations: Page 3 of 4 Review of Clinical and Preventive Guidelines policy: Page 1 of 3	Met
Findings: Dissemination of CPG/PHR is undertaken at the regional level. • Each market will distribute the CPG/PHR to all new and existing PCPs and appropriate specialists as applicable. • Updates are distributed to physicians when new CPG/PHR is developed and/or when existing CPG/PHR are modified. CPG/PHR may be distributed to providers in the following ways: guidelines may be published in the practitioner newsletter and/or provider manual, posting on the Provider Portal and direct mailings. • PHR may be distributed to the members in the following ways: Periodic member mailings, internet posting, and targeted mailings. Members will be provided with a copy of PHR upon request. **Required Actions:** None.		
6. The health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	UHC 2018 UM Program Description: Pages 26, 27, 28 UHC MO 2018 Clinical Practice Guidelines: Page 4 Preventive Services Link to USPSTF Page 10: Chlamydial Infection, Screening Medicaid-Newsletter-Spring-2018 _Page 5_STDs Can Be Silent	Met

	UHC MO Member Handbook: Pages 15, 25 Preventive Screenings for Children and Adults Utilization Management of Behavioral Health Benefits: Page 1 of 18	

Findings: Inpatient Care Managers (ICMs) utilize evidence based MCG Care Guidelines and Inter-Qual Guidelines where a contract dictates to guide length of stay expectations and appropriate levels of care. Application of clinical review criteria is integral to the process of clinical coverage review and inpatient utilization management. UnitedHealthcare's Behavioral Health Level of Care Guidelines, Coverage Determination Guidelines, Medicare Coverage Summaries, Behavioral Clinical Policies, Psychological/Neuropsychological Guidelines, and Best Practice Guidelines, and other guidelines as required by particular state requirements are tools used by care advocates to assist in determining the appropriate type and level of care for a health plan enrollee. Process improvement is a structured, disciplined approach to maintain consistent application of UM processes. It is designed to provide objective and systematic assessment of the care coordination program by measuring the adherence to policies and procedures, licensing/regulatory standards and customer services. Member education is consistent with the CPGs (e.g., chlamydial screening, United States Preventive Services Task Force guidelines, preventive pediatric healthcare screening).
UnitedHealthcare uses the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS). UnitedHealthcare submitted their policy on UM of Behavioral Health Benefits which describes the mechanisms and processes designed to:

- Promote consistency in the management of behavioral health benefits;
- Ensure that enrollees receive appropriate evidence-based, recovery-oriented, resiliency-focused and comprehensive individualized person-centered behavioral health services in a timely, culturally competent manner.

During onsite, UnitedHealthcare explained that their members receive education via health talk news letters in regular mails. Previous Pediatric healthcare screenings are also mailed out. The healthcare guidelines are available in member handbook as well.
Required Actions: None.

Compliance Score-Practice Guidelines						
Total	Met	=	7	×2	=	14
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	14
Denominator	Total Sections	=	7	×2	=	14
Score						**100%**

Appendix J

Subpart D Standard 10–42 CFR 438.242 Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
1. The MCO maintains a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data. §438.242(a)	REQ_1_2.doc System_Flows.pdf System_Architecture.pdf	Met
Findings: UnitedHealthcare maintains a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data. UnitedHealthcare provided their information technology architectural diagram which shows the process described above. **Required Actions:** None.		
2. The MCOs health information system provides information on areas (42 CFR 242(a))including:		
a. Utilization.	REQ_1_2.doc System_Flows.pdf System_Architecture.pdf	Met
Findings: At UnitedHealthcare, utilization management occurs through their authorization and utilization tools. UnitedHealthcare provided their information technology architectural diagram which shows the process described above. **Required Actions:** None.		
b. Grievances and appeals.	REQ_1_2.doc System_Flows.pdf	Met
Findings: At UnitedHealthcare, grievances and appeals occur through their work flow tool and their tracking system for grievances and appeals. During onsite review, UnitedHealthcare explained their Escalation Tracking System. Each member outreach that is received by the appeals and grievance department is reviewed by an analyst during entry into the Escalation Tracking System to identify if it should be classified as an appeal, grievance or inquiry based on the how each is defined in the MO National Medicaid Member Appeal and Grievance Policy. **Required Actions:** None.		

c. Disenrollment for other than loss of Medicaid eligibility.	REQ_1_2.doc System_Architecture.pdf	Met
Findings: Disenrollment for other than loss of Medicaid eligibility is managed through UnitedHealthcare's member and claims platform. UnitedHealthcare uses the Missouri state benefit enrollment and maintenance guide as the source of truth for all member eligibility and if any questions exist will validate with the state system online. Members leaving UnitedHealthcare to other MCOs are part of a transition of care process by which claims and clinical data is shared with the receiving MCO. UnitedHealthcare provided their information technology architectural diagram and system flows mapping which shows the process described above. **Required Actions:** None.		
3. The MCO collects data on:		
a. Enrollee characteristics.	REQ_3.doc System_Flows.pdf System_Architecture.pdf	Met
Findings: UnitedHealthcare has an integrated management information system supporting the Missouri Medicaid program. This platform integrates physical and behavioral health, and social service support in compliance with all Missouri Medicaid Program requirements. Their management information system enables the day-to-day management of key operations of UnitedHealthcare community plan's system including enrollee characteristics such as the following demographic information: age; gender; contact information; and location/address, county. UnitedHealthcare provided their information technology architectural diagram which shows the process described above. **Required Actions:** None.		
b. Services furnished to enrollees.	REQ_3.doc System_Flows.pdf System_Architecture.pdf	Met
Findings: Benefit Information such as: • Medicaid Eligibility (ME) Codes • Plan – i.e. Member population • Product – i.e. Benefits • Subgroup – i.e. state aid or capitation category Are maintained and managed by UnitedHealthcare's customer sponsored provider network facets. Data from their customer sponsored provider network facets supply the following processes:		

<table>
<tr><td colspan="3">• Care Management and Utilization Management systems
• Vendor eligibility feeds (Dental/Vision)
• Reporting and Analytics
• Encounters processing through their encounters system
UnitedHealthcare provided their information technology architectural diagram and system flows mapping which shows the process described above.
Required Actions: None.</td></tr>
<tr><td>4. The MCOs health information system includes a mechanism to ensure that data received from providers are accurate and complete by:
• Verifying the accuracy and timeliness of reported data.
• Screening the data for completeness, logic, and consistency.
• Collecting service information in standardized formats to the extent feasible and appropriate.
• Making all collected data available to the State and upon request to CMS. (42 CFR 438.242(b)(2), 42 CFR 438.242(b)(3))</td><td>REQ_4.doc

System_Flows.pdf

System_Architecture.pdf</td><td>Met</td></tr>
<tr><td colspan="3">Findings: UnitedHealthcare community plan attests that it meets the requirements listed above. All inbound data from providers is validated through multiple edits and uses standard formats to the extent they are feasible and appropriate. Data will be rejected back to the provider if it does not meet minimum requirements for completeness, logic and consistency. UnitedHealthcare community plan also attests that it will make all collected data available upon request. Requests will be fulfilled through internal reporting or technology processes depending on the nature of the request. UnitedHealthcare provided their information technology architectural diagram and system flows mapping which shows the process described above.
Required Actions: None.</td></tr>
</table>

Compliance Score - Health Information Systems						
Total	Met	=	7	×2	=	14
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	14
Denominator	Total Sections	=	7	×2	=	14
Score						**100%**