Primaris
Healthcare Business Solutions

2021 External Quality Review

Compliance

Healthy Blue

Measurement Period: Calendar Year 2020
Validation Period: February-May 2021
Publish Date: June 21, 2021

MoHealthNet

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1.0 OVERVIEW AND OBJECTIVE

1.1 Background

The Department of Social Services, Missouri HealthNet Division (MHD), operates a Health Maintenance Organization (HMO) style Managed Care program called Missouri (MO) HealthNet Managed Care (hereinafter stated "Managed Care"). Managed Care is extended statewide in four regions: Central, Eastern, Western, and Southwestern to ensure all Missourians receive quality care. Participation in Managed Care is mandatory for the eligible groups within the regions in operation. The Managed Care program enables the MHD to provide Medicaid services to section 1931 children and related poverty level populations; section 1931 adults and related poverty level populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children. Currently, coverage under CHIP is provided statewide through the Managed Care delivery system. The total number of Managed Care (Medicaid and CHIP combined) enrollees in Apr 2021 was 793,871, representing an increase of 20.74% compared to the end of SFY 2020.

The MHD contracts with Managed Care Organizations (MCOs), also referred to as Managed Care Plans/Health Plans, to provide health care services to its Managed Care enrollees. Healthy Blue[1] is one of the three MCOs operating in Missouri. The MHD works closely with Healthy Blue to monitor quality, enrollee satisfaction, and contract compliance. Quality is monitored through various ongoing methods, including 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 (EQR).

The MHD contracts with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to perform an EQR. An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a Managed Care Plan, or its contractors, furnish to Medicaid beneficiaries (Figure 1). The review period for EQR 2021 is the calendar year (CY) 2020.

1.2 Compliance with Regulations

"Review of Compliance with Medicaid and CHIP Managed Care regulations" is a mandatory EQR activity. Primaris audited Healthy Blue to assess its compliance with the Code of Federal Regulations (42 CFR 438 and 42 CFR 457); the MHD Quality Improvement Strategy

[1] Previous MCO, Missouri Care was acquired by Anthem, Inc. effective Jan 23, 2020, and is doing business as Healthy Blue in Missouri. Any information/documents pertaining to Missouri Care is referred to as of Healthy Blue in this report.

(QIS); the MHD Managed Care contract; and the progress made in achieving quality, access, and timeliness to services from the previous year's review. The guidelines utilized for the review/audit were from the Centers for Medicare and Medicaid Services (CMS), EQR Protocol 3, version Oct 2019.

42 CFR 438.358(b)(iii) requires a review conducted within a previous three-year period to determine the MCO's compliance with standards set forth 42 CFR 438, subpart D; 438.56; 438.100; § 438.114; and 438.330. Primaris will cover these regulations during the current three-year review cycle per Table 1. EQR 2021 is the first year of the review cycle and will include 42 CFR: 438.56; 438.100; 438.114; 438.230; 438.236; and 438.242 with a cross-reference to CHIP regulations.

(Note: This report does not include a summary of findings from the previous reviews as this is the first year within the current three-year review cycle.)

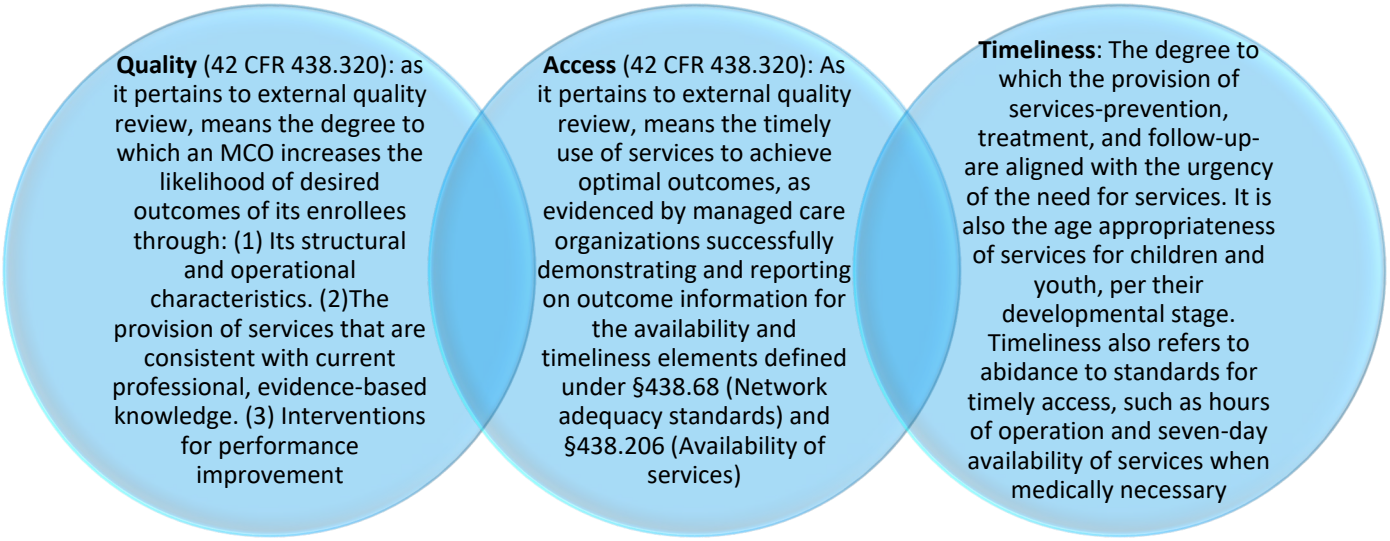

Figure 1. External Quality Review-A Federal Requirement

2.0 METHODOLOGY

The compliance review was conducted in February-May 2021 and included the following steps (Figure 2):

Collaboration: Primaris collaborated with the MHD and Healthy Blue to:

- Determine the scope of the review, scoring methodology, and data collection methods.
- Finalize the site review (virtual meeting) agenda.
- Collect and review data/documents before, during, and after the site meeting.

- Analyze the data.
- Prepare a report related to the findings of the current year.
- Review Healthy Blue's response to previous EQR recommendations.

Table 1. Regulations for Current Review Cycle

Year	42 CFR 438 (Medicaid)	42 CFR 457 (CHIP)	Standard Name
EQR 2021 (1-year)	438.56	457.1212	Disenrollment: Requirements and limitations
	438.100	457.1220	Enrollee rights
	438.114	457.1228	Emergency and post-stabilization services
	438.230	457.1233b	Subcontractual relationships and delegation
	438.236	457.1233c	Practice guidelines
	438.242	457.1233d	Health information systems
EQR 2022 (2-year)	438.206	457.1230a	Availability of services
	438.207	457.1230b	Assurances of adequate capacity and services
	438.208	457.1230c	Coordination and continuity of care
	438.210	457.1230d	Coverage and authorization of services
	438.214	457.1233a	Provider selection
	438.224	457.1110	Confidentiality
	438.228	457.1260	Grievance and appeal systems
EQR 2023 (3-year)	438.330	457.1240b	Quality assessment and performance improvement program

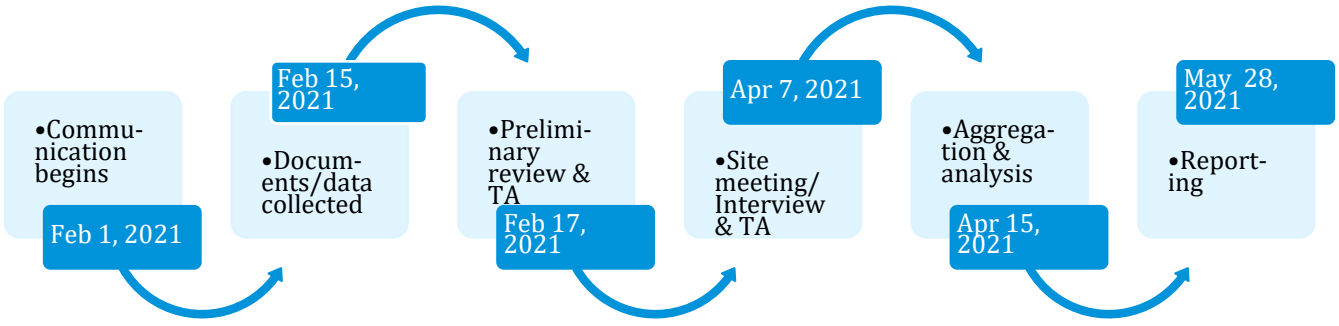

Figure 2. Compliance Evaluation Process

Evaluation Tools: Primaris created evaluation tools based on the CFR, EQR protocol, the

MHD Managed Care contract, and the QIS (Appendices A-F).

Technical Assistance (TA): Primaris provided TA to Healthy Blue pre-and post-site meeting. Before the preliminary review, the evaluation tools were sent to Healthy Blue to set up the expectations for the documents' submission.

Documents' Submission: Healthy Blue submitted its documents via Amazon Web Services-simple storage services (AWS S3) to enable a complete and in-depth analysis of its compliance with regulations. These documents included policies, procedures, spreadsheets, PowerPoint presentations, reports, newsletters, mailers, and print screens, flow charts as follows:

- Disenrollment-Requirements and Limitations: MO29-OP-CS-003 Member Disenrollment; and Disenrollment MO.
- Enrollee Rights: Member Rights and Responsibilities-MO; BMO-MEM-0114-20 Welcome Quick Guide-Flier; Provider Termination Enterprise Playbook; Development of Marketing and Member Communications; Healthy Blue Member Handbook; Provider Directory (southwest region); and Provider Listing Updates.
- Emergency and Post-stabilization Services: Emergency Services-Core Process; and Coverage for Post-stabilization Care Services.
- Subcontractual Relationships and Delegation: Delegate/Vendor Oversight and Management Program; Medical Transportation Management (MTM) Inc. Statement of Work (SOW) and Agreement; March Vision Care Group, Inc., Service Agreement and Amendment; and Ancillary Services Agreement and Amendment (Dental).
- Practice Guidelines: Healthy Blue Clinical Practice Guidelines (CPGs); QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring; UMAC Minutes CPG; Medicaid Provider Manual; MO Inpatient Inter-Rater Reliability (IRR) Report and MO Outpatient IRR Report; and IRR Assessments.
- Health Information Systems: Government Business Division (GBD) Management Information System (MIS); CareCompass-Information Flow; Regulatory Compliance Reporting System-Context Diagram; Utilization Management (UM) Import Subsystem Guide; UM Processing User Guide and Supplement; UM Reference User Guide and Supplement; Claims Process-Flow; Claims Process-Schematic Description; Claims Processing User Guide; NextGen Grievance and Appeals (G & A)-Context Diagram; Enrollment Flow; Electronic Transaction Standard; Provider User Guide; Provider Date Exchanges-Flow; Anthem: Credentialing; Encounters Flow; Encounters Life Cycle; MO HealthNet EDI Companion Guide; HIPAA Transaction Standard Companion Guide; and Enterprise Business Continuity Program Guidance.

Site Interviews

Compliance: Healthy Blue

Primaris conducted a virtual meeting with Healthy Blue on April 7, 2021, due to travel restrictions to the onsite office in Missouri (Table 2) during the Covid-19 Pandemic.

Table 2: MCO Information	
MCO Name:	Healthy Blue
MCO Location:	1831 Chestnut St. Louis, MO, 63103
Audit Contact:	Russell Oppenborn
Contact Email:	Russell.Oppenborn@healthybluemo.com

The purpose of interviews was to collect data to supplement and verify the learnings through the preliminary document review. The following personnel from Healthy Blue were available for an interactive session:

Russell Oppenborn, Director, State Regulatory Affairs
Gretchen Atkins, Director, Membership
James Blackburn, Director, Network Management
Sharon Deans, MD, Medical Director, Plan Performance
Leslie Chiles, Director I, Medical Clinical
Mark Kapp, Director II, Quality Management
Jason Adams, Executive Advisor, Account Management
Ed Williams, Manager, Community Outreach
Leigh Ann Cole, Manager, Clinical Quality
Vanessa Baker, Business Analyst

Compliance Ratings

The information provided by Healthy Blue was analyzed and assigned an overall compliance score. Two points were assigned for each section of an evaluation tool (denominator) and scored as Fully Met (2 points), Partially Met (1 point), or Not Met (0 points). Primaris utilized the compliance rating system (Table 3) from EQR Protocol 3.

Table 3. Compliance Scoring System

●	**Fully 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–provides 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 points): 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.

Corrective Action Process

Primaris initiates a corrective action plan (CAP) after submitting the final report to the MHD. Healthy Blue must identify for each Not Met/Partially Met criteria the interventions it plans to implement to comply with the regulations, including how Healthy Blue measures the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. Healthy Blue must submit the CAP to the MHD within 10 days of its initiation. When deemed sufficient, the MHD, in consultation with Primaris, approves Healthy Blue's CAP. Within 90 days of approval of the CAP, Healthy Blue must submit its documentation to close the identified gaps.

3.0 ANALYSIS OF QUALITY, TIMELINESS, AND ACCESS TO HEALTHCARE SERVICES

3.1 Summary of Findings

EQR 2021 involved assessing six federal regulations, with Healthy Blue achieving a compliance score of 82.3% (Table 4).

Table 4. Compliance Summary-EQR 2021 (1-Year)

Medicaid	CHIP		Number of Sections					
42 CFR 438	42 CFR 457	Regulation	Total	Fully Met	Partially Met	Not Met	Score	Score %
438.56	457.1212	Disenrollment: Requirements and limitations	18	14	3	1	31	**86.1**
438.100	457.1220	Enrollee rights	18	8	10	0	26	**72.2**
438.114	457.1228	Emergency and post-stabilization services	12	11	1	0	23	**95.8**
438.230	457.1233b	Subcontractual relationships and delegation	12	10	2	0	22	**91.7**
438.236	457.1233c	Practice guidelines	6	6	0	0	12	**100**
438.242	457.1233d	Health information systems	16	7	7	2	21	**65.6**
Total			**82**				**135**	**82.3**

Compliance: Healthy Blue

Compliance Score % = Total Score X100 = 100%
Total Sections X 2 (points)

3.2 Regulation I- Disenrollment: Requirements and Limitations

Healthy Blue was evaluated for 18 criteria under this regulation and received "Fully Met" for 14, "Partially Met" for three, and "Not Met" for one of them, scoring 86.1% for compliance. Appendix A provides a detailed evaluation of this regulation.

3.2.1 Performance Strengths

Healthy Blue staff is knowledgeable about the Disenrollment requirements and limitations per the CFR and the MHD contract. Healthy Blue has policies for initiating a disenrollment for the reasons: member not following the prescribed treatment; missing appointments without notification; fraudulently misusing the MHD Managed Care program; indulging in misconduct; or requesting a home birth service. Healthy Blue shall cite at least one good cause before requesting MHD to disenroll a member. Healthy Blue does not initiate disenrollment because of a medical diagnosis of a member, pre-existing medical conditions, high-cost bills, disruptive behaviors arising from members' special needs, race, color, national origin, gender, gender identity, or sexual disorientation.

At Healthy Blue, a member can request disenrollment without a cause during open enrollment; within 90 days of initial enrollment; and when the MHD imposes intermediate sanctions. Healthy Blue acknowledged that a member could request for disenrollment for a just cause: if the transfer is a resolution to grievance or appeal; member's Primary Care Physician or specialist does not participate with Health Blue; due to cultural sensitivity issues; services not covered; correction of an enrollment error made by the broker; bringing all family members under one MCO; and sanctions imposed by the MHD. Healthy Blue allows automatic and unlimited changes in the MCO choice as often as circumstances necessitate for the children in care and custody and adoption subsidy. Healthy Blue does not require its members to go through an appeal process before asking for disenrollment, but they have an option to do so.

Except for newborns, Healthy Blue does not assume financial responsibility for members of other MCOs and Fee-For-Service program hospitalized in an acute setting on the effective date of coverage with Healthy Blue until an appropriate acute inpatient hospital discharge.

3.2.1 Corrective Action

There are areas of concern, so corrective action is required.
In reference to the evaluation tool (Appendix A), Primaris identified the following criteria that were "Partially Met":

- Disenrollment can be requested by a member without cause (Appendix A: section E). Healthy Blue did not incorporate in their policy MO29-OP-CS-003 Member Disenrollment, one reason for disenrollment without cause, namely, upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.
- Disenrollment is requested by a member for a just cause, at any time, if the MCO does not cover services the member seeks because of moral or religious objections (Appendix A: section F6). Healthy Blue did not submit documentation on this requirement.
- MCO shall have written policies and procedures for complying with MHD's disenrollment orders (Appendix A: section H). Though Healthy Blue stated that its Enrollment and Billing Department will process all 834 disenrollment within 24 hours of receipt from MHD in accordance with the contract, the procedure for complying with MHD's disenrollment orders was not submitted for review.

In reference to the evaluation tool (Appendix A), Primaris identified the following criterion that was "Not Met":
MCO shall implement written policies and procedures to receive updates on enrollment and disenrollment and incorporate them in MCO and MCO's subcontractors' management information system each day. MCO shall reconcile this membership list against the MCO's internal records within 30 business days of receipt and shall notify the state agency of any discrepancies (Appendix A: section I). Healthy Blue did not submit a procedure for receiving, incorporating, and reconciling membership as stated in its policy.

3.3 Regulation II- Enrollee Rights

Healthy Blue was evaluated for 18 criteria under this regulation and received "Fully Met" for 8, "Partially Met" for 10, scoring 72.2% for compliance. Appendix B provides a detailed evaluation of this regulation.

3.3.1 Performance Strengths

Healthy Blue has a policy of providing each member the following rights: to be treated with dignity; privacy; receive information on all available treatment options; participate in decisions of their healthcare including refusal of treatment; be free from restraint or seclusion; obtain a copy of medical records free of cost.

Healthy Blue updates its provider and hospital data with changes within 30 days of receipt from the providers. Validation of directory listings occurs on an annual basis through provider and hospital audits. A provider-finding tool containing the entire network is made available on the Healthy Blue website. The website tool is updated through the normal

daily interact file available on the web portal. Healthy Blue departments have access to daily updated electronic copies on the Healthy Blue website. Healthy Blue informs its members via the member handbook that a paper form of provider directory will be mailed to their members within 48 hours of the request. During the interview, Healthy Blue informed Primaris that the members would be communicated via Member Portal messaging and a Blog regarding the member's right to obtain a provider directory on an annual basis, starting July 1, 2021. Healthy Blue has informed its enrollees via the member handbook that the information provided on Healthy Blue's website is made available in a paper form without charge within five business days upon request.

3.3.2 Corrective Action

There are areas of concern, so corrective action is required.

In reference to the evaluation tool (Appendix B), Primaris identified the following criteria that were "Partially Met":

- Enrollees should receive information in accordance with 42 CFR 438.10 (Appendix B: B1). Healthy Blue did not submit its policy on member materials as per 42 CFR 430.10. The Welcome Quick Guide-flier meets all but the following two requirements, as applicable:
  - MCO shall make available general services and materials, such as MCO's member handbook, in the 15 languages identified by the MHD that individuals speak with limited English proficiency for the state of Missouri. The MCO shall include statements in those languages that tell members that translated documents are available and how to obtain them on all materials.
  - All written materials shall be worded such that the materials are understandable to a member who reads at the sixth (6th) grade reading level. Primaris assessed the readability statistics-Flesch Kincaid Grade level-of Welcome Quick Guide to be 10.4, which is not per the MHD contract, section 2.14.6.
- Notice to the enrollee must be provided 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice (Appendix B: section B2). Healthy Blue did not address the requirement to notify 15 calendar days after receipt or issuance of the termination notice.
- 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 (Appendix B: section B3i). Healthy Blue has not submitted a policy/guidelines which meets the requirements of this section. However, Healthy Blue submitted a flier to Primaris, which provides information to its members about accessing the member handbook on their website.
- On an annual basis, MCO shall review the member handbook, revise as necessary, and document that such review occurred (Appendix B: section B3ii). Healthy Blue

has not submitted its revision history or any documentation that confirms this requirement.

- MCO must give each enrollee notice of any change that MHD defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change (42 CFR 438.10g4) (Appendix B: section B3iii). No documentation was submitted for Primaris to ascertain that the members were notified about the change. One such example of a change provided by Healthy Blue was on immunization information.
- The member handbook is deficient in its contents per the instructions provided in the MHD contract, section 2.12.16 (48 items), (Appendix B: section B 3iv). Healthy Blue fully complied with 40 of 48 items, partially complied with six, and was deficient in two items.
- The provider directory (southwest region) submitted by Healthy Blue does not include all the information required for providers and hospitals: name of providers, group affiliations, board certification status, address, telephone number, website URL, specialty, panel status, cultural and linguistic abilities, including American Sign Language or skilled medical interpreter, accommodations for people with disabilities (Appendix B: section B 4i, ii). Healthy Blue submitted a policy, Provider Listing Updates (Draft version), that does not address the requirement on website URL, American Sign Language or skilled medical interpreter availability, and accommodations for people with disabilities. Primaris noted the information on panel status, and accommodation is inconsistently reported for the providers in the directory.
- Provider directories must be made available on the MCO's website in a machine-readable file and format specified by the Secretary (42 CFR 438.10h4) (Appendix B: section B 4iv). Primaris visited Healthy Blue's website in March 2021 and a provider directory was not found. Instead, Healthy Blue has a web-based search tool that allows members to search for a provider/practitioner or a health center, clinic, hospital, ancillary services-vision, or dental.
- MCO must comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights, including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 regarding education programs and activities; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act. (Appendix B: section C). Even though Healthy Blue has notified its members about the non-discrimination policy in the member handbook, the references are not quoted in the policy, Member Rights and

Responsibilities-MO. Thus, Primaris cannot ascertain with confidence that Healthy Blue is fully compliant with the requirement.

3.4 Regulation III- Emergency and Post-stabilization Services

Healthy Blue was evaluated for 12 criteria under this regulation and received "Fully Met" for 11, "Partially Met" for one of them, scoring 95.8% for compliance. Appendix C provides a detailed evaluation of this regulation.

3.4.1 Performance Strengths

Healthy Blue has policies and procedures in place and the staff is knowledgeable about the requirements for Emergency and Post-stabilization Services: covers and pays for the emergency services regardless of whether the provider that furnishes the services has a contract with Healthy Blue (in-network or out-of-network); does not deny payment for treatment obtained for an emergency medical condition and post-stabilization care services within or outside of the network even though not pre-approved under certain circumstances, administered to maintain, improve, or resolve the member's stabilized condition; does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or Healthy Blue of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services; and does not hold an enrollee with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize him/her.

3.4.2 Corrective Action

There is an area of concern, so corrective action is required.

In reference to the evaluation tool (Appendix C), Primaris identified the following criterion that was "Partially Met":
MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO (in-network or out-of-network). MCO and providers to reach an agreement on payment for services. (MHD contract, section 2.6.12a, b) (Appendix C: section B1). In the post-site meeting, Healthy Blue submitted "Single Case Agreement: Process –Missouri Medicaid," which is neither approved by their organization nor by MHD. This document does not meet the requirement of this section.

3.5 Regulation IV- Subcontractual Relationships and Delegation

Healthy Blue was evaluated for 12 criteria under this regulation and received "Fully Met" for 10 and "Partially Met" for two of them, scoring 91.66% for compliance. Appendix D

provides a detailed evaluation of this regulation.

3.5.1 Performance Strengths

Healthy Blue submitted three subcontracts: Ancillary Services Agreement (Dental); MTM Inc.; and March Vision Care Group, Inc. for review. Primaris determined that Healthy Blue has acknowledged that their subcontractors will not knowingly employ, hire for employment, or continue to employ an unauthorized alien to perform work within the state of Missouri. The subcontractors agreed to perform the delegated activities and reporting responsibilities specified in the contractual obligations. The contracts provide revocation of the delegation of activities or obligations or specify other remedies when the MHD or Healthy Blue determines that the subcontractors did not perform satisfactorily.

The subcontractors agreed to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, agreeing that the state, CMS, the Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect at any time, any books, records, contracts, computer or other electronic systems, physical facilities, and premises of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under Healthy Blue's contract with the state. The right to audit exists 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

3.5.2 Corrective Action

There are areas of concern, so corrective action is required.

In reference to the evaluation tool (Appendix D), Primaris identified the following criteria that were "Partially Met":

- The MHD contract, section 3.9.6 requires Healthy Blue to specify the delegated activities or obligations, and related reporting responsibilities, in the subcontract or written agreement (Appendix D: section B3).
  Two of the three subcontracts, March Vision Care Group, Inc. and MTM Inc., did not incorporate all the 19 items required by the MHD.
- "All disputes between the MCO and any subcontractors shall be solely between subcontractors and the MCO. The MCO shall indemnify, defend, save, and hold harmless the state of Missouri, the Department of Social Services and its officers, employees, and agents, and enrolled, managed care members from any and all actions, claims, demands, damages, liabilities, or suits of any nature…." (Appendix D: section E). The March Vision Care Group, Inc. Service Agreement does not mention

state indemnification in a dispute between Healthy Blue and the subcontracted providers. Though, there is a clause for indemnifying each other.

3.6 Regulation V- Practice Guidelines

Healthy Blue was evaluated for six criteria under this regulation and received "Fully Met" for all of them, scoring 100% for compliance. Appendix E provides a detailed evaluation of this regulation.

3.6.1 Performance Strengths

Healthy Blue has practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals. The practice guidelines are adopted in consultation with the network providers and reviewed and updated annually and upon significant change to evidence-based guidelines throughout the year. Practice Guidelines are based on enrollee's health needs obtained from care management and disease management services, Medical Advisory Committee, National guidelines, current literature. Prospective guidelines are evaluated in several areas, such as a condition's prevalence within communities (e.g., Opioid Crisis) and complexity of a disease course (e.g., Diabetes or Schizophrenia). Information about the availability of the guidelines is included in the provider manual, provider newsletters, and bulletins, and through committees. These are placed on the provider website and include links to the guidelines themselves. These are also provided to the enrollees and potential enrollees upon request.

Healthy Blue ensures that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines through Inter Rater Reliability (IRR). Mechanisms, such as the use of hypothetical Utilization Management (UM) test cases or a sample of UM determination files using a National Committee for Quality Assurance (NCQA)-approved auditing method, are utilized to evaluate the consistency of application of criteria.

3.6.2 Corrective Action

There are no areas of concern, so corrective action is not required. However, inconsistent information regarding updating practice guidelines was noted between the policy, QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring, and during the interview. Per the policy, the CPGs are updated at least biennially (every two years) or when changes are made to national guidelines. During the interview, Healthy Blue stated that the guidelines are updated annually or earlier in case of significant changes.

3.7 Regulation VI- Health Information Systems

Healthy Blue was evaluated for 16 criteria under this regulation and received "Fully Met" for seven and "Partially Met" for seven, and "Not Met" for two of them, scoring 65.62% for compliance. Appendix F provides a detailed evaluation of this regulation.

3.7.1 Performance Strengths

Healthy Blue maintains a health information system (HIS) sufficient to support collecting, integrating, tracking, analyzing, and reporting data. The HIS provides information on but is not limited to, Utilization, Claims, and Disenrollment other than loss of eligibility. Sufficient enrollee encounter data is collected and maintained to identify the provider who delivers any item(s) or service(s) to enrollees. Healthy Blue's MIS is 5010 compliant and currently accepts data in the HIPAA standard X12 format. Additionally, Healthy Blue supports Health Level 7 (HL7) and several state-specific formats through a file transfer process.

3.7.2 Corrective Action

There are areas of concern, so corrective action is required.

In reference to the evaluation tool (Appendix F), Primaris identified the following criteria that were "Partially Met":

- Healthy Blue did not provide an explanation/description of their process as to how Healthy Blue's HIS provides information on the Grievances and Appeals. However, Healthy Blue has submitted a flow chart of HIS that includes Grievances and Appeals (Appendix F: section B3).
- MCO should comply with Section 6504(a) of the Affordable Care Act, which requires claims processing and retrieval systems to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation to meet the requirements of section 1903(r)(1)(F) of the Act (Appendix F: section C1). Even though Healthy Blue has documented evidence that their information system with claims management tool offers a high degree of automation and data capture, there is no documentation to ascertain its compliance with section 6504(a) of the Affordable Care Act and 1903(r)(1)(F) of the Act. These sections have a requirement to report an expanded set of data elements under the Medicaid Management Information System to detect fraud and abuse. The automated data system should meet the requirement for program integrity, program oversight, and administration.
- As part of this electronic claims management (ECM) function, the MCO shall provide online and phone-based capabilities to obtain claims processing status information (Appendix F: section C2i). Primaris reviewed the claims processing flow diagram, which shows that providers can submit their claims electronically, in paper format, or online. However, the phone-based capabilities to obtain claims processing status information is not presented.

- Adherence to Key Transaction Standards: MCO shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18, 455.19, and RSMo 376.383 and 376.384 (Appendix F: section C2ii). Healthy Blue has not addressed the federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. The requirements stated in RSMo 376.383 and 376.384 are also not addressed in the documents received by Primaris.
- MCO must have a mechanism to ensure that data received from providers are accurate and complete (Appendix F: section C3). Healthy Blue did not submit policies and procedures to ascertain that data received from providers are consistent and timely reported.
- MCO shall maintain at least a ninety-eight percent (98%) acceptance rate on encounters submissions on a monthly basis (MHD contact 2.26.5 c) (Appendix F: section Dii). Healthy Blue did not submit their policy/supporting documentation on the frequency and acceptance rate of enrollee encounter data to the state.
- MCO shall ensure that critical member and provider Internet and telephone-based functions and information, including but not limited to electronic claims management and self-service customer service functions, are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the state agency and the MCO. MCO's core eligibility/enrollment and claims processing systems shall be back online within 72 hours of the declared major failure or disaster's occurrence. (Appendix F: section E).
  Healthy Blue's Enterprise Business Continuity Program Guidance does not address this requirement of core eligibility/enrollment, and claims processing systems shall be restored within 72 hours of declared major failure or a disaster. Primaris noted that Healthy Blue had not submitted any evidence suggestive of compliance with the requirement that the critical member and provider Internet and telephone-based functions and information, including but not limited to critical provider Internet and telephone-based functions, electronic claims management are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week.

In reference to the evaluation tool (Appendix F), Primaris identified the following criteria that were "Not Met":

- Submission of all enrollee encounter data, including the allowed amount and the paid amount that the state is required to report to CMS under § 438.818 (Appendix

F: section Diii). Healthy Blue has not submitted documentation in support of this requirement.

- Encounters must be submitted within 30 days of the day the MCO pays the claim and must be received no later than two (2) years from the last date of service (MHD contract, 2.26.5h) (Appendix F: section Div).

In the evaluation tool (Appendix F), Primaris marked one criterion as Not Applicable (N/A): Application Programming Interface (API) as specified in 42 CFR 431.60 and 431.70. API was required to be implemented by January 1, 2021. (Appendix F: section C5). However, per CMS's letter dated August 14, 2020, due to the COVID-19 public health emergency, CMS is exercising enforcement discretion and does not expect to enforce this requirement prior to July 1, 2021.

4.0 CONCLUSION

Table 5 incorporates collective evaluation for Quality, Timeliness, and Access to Healthcare services provided by Healthy Blue during the first-year review cycle (EQR 2021).

Table 5. Audit Results-EQR 2021 (1-Year)

42 CFR Regulation	Key Findings	Audit Results
438.56 (457.1212) Disenrollment: Requirements and limitations	Concerns identified	Not Met
438.100 (457.1220) Enrollee rights	Concerns identified	Partially Met
438.114 (457.1228) Emergency and post-stabilization services	Concerns identified	Partially Met
438.230 (457.1233b) Subcontractual relationships and delegation	Concerns identified	Partially Met
§438.236 (457.1233c) Practice guidelines	No concerns identified	Fully Met
§438.242 (457.1233d) Health information systems	Concerns identified	Not Met

4.1 Improvement by Healthy Blue

EQR 2021 is the first year in the current review cycle. Furthermore, three regulations were newly incorporated for a compliance review, namely, 438.56, 438.100, and 438.114 per Managed Care, Final Rule 2020, effective December 14, 2020. So, the scores are not comparable with the previous years.

4.2 Response to Previous Year's Recommendations

Healthy Blue submitted the following documentation supporting its response to all the non-compliant criteria and recommendations by EQRO during the previous year's review (Table 6).

Table 6. Healthy Blue's Response to the Previous Year's Recommendations

Recommendations	Action by Healthy Blue	Comment by EQRO
EQR 2020		
1. Multilingual Services: An analysis and evaluation of the multilingual services provided, to include: A count of members needing communication accommodations due to hearing impairments or a physical disability. This was not reported by Missouri Care (currently dba Healthy Blue) in QAPI. (Scored as Partially Met.) Missouri Care had stated that they do not capture data on this metric, and it was not available in the state enrollment file. Primaris recommended that Missouri Care communicate with MHD if they have issues capturing data for a count of members needing communication accommodations due to hearing impairment or a physical disability. Per information provided by the MHD to Primaris, this data is provided to the MCO when they complete their Health Risk Assessment (HRA).	Healthy Blue responded by stating that the MHD does not ask for this information on the HRA provided by the MHD to the MCO. Healthy Blue sends out its own HRA requesting this additional information. However, due to the low volume of actual returned completed HRAs, Healthy Blue suggests that MHD modifies their HRA to include this information related to the "hearing impairments or a physical disability" at the time of enrollment. This would ensure that the required information is captured.	Partially Met Healthy Blue did not contact MHD to discuss the issue and make their suggestions. Thus, this criterion remains Partially Met. Primaris finds a disconnect between the information provided by the MHD and Healthy Blue. Healthy Blue must contact MHD to find a solution to capture the number of members needing communication accommodations due to hearing impairments or a physical disability.
2. Grievances and Appeals: Healthy Blue has reported Member Appeals under categories such as Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. Primaris finds these categories not aligned with the definition of adverse benefit determination & appeals per 42 CFR 438.400. Primaris recommends that Healthy Blue seek written clarification	Healthy Blue did not submit a response.	The issue remains open. Healthy Blue must contact MHD for clarification and resolution.

on expectations from the MHD. Healthy Blue should update data in the 2019 QAPI report and comply with the MHD's instructions for future reporting.		
EQR 2019		
1. Policy update required: Release of PHI to the public will be only after prior written consent to the state agency (MHD contract 3.16.1). (Scored as Partially Met).	Healthy Blue submitted the following policies: • CPP509 Disclosure with Authorization: Page 1 • CPP1401 Verification and Authentication: Page 5	Partially Met Healthy Blue has rules for releasing PHI to public officials and any other requesters. However, the release of PHI only after written consent from the state agency is not mentioned. Healthy Blue must incorporate this requirement in its policies.
2. Policy update required: MCO may use Protected Health Information to report violations of law to appropriate federal and state authorities, consistent with 45 CFR 164.502(j)(1) (MHD contract 2.38.2c). (Scored as Partially Met).	Healthy Blue submitted the following policy: CPP204 Non-Retaliation: Page	Fully Met
3. Policy update required: 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). (Scored as Partially Met.)	Healthy Blue submitted the following policy: CPP102 De-Identification: Page 7	Fully Met The policy submitted meets the requirement, but it applies to Iowa Medicaid Plans. Healthy Blue must update it to apply for Missouri Medicaid as well.
EQR 2018		
Missouri Care (currently dba Healthy Blue) should update all of their subcontractors' agreements with the "right to audit for 10 years…." as per 42 CFR 438.230(c) (3) (iii), consistently. (Date of applicability: July 1, 2017).	Healthy Blue submitted three subcontracts with updated information.	No further action is required.

5.0 RECOMMENDATIONS

5.1 Healthy Blue

Primaris recommends the following based on the deficiencies and weaknesses noted in compliance with the regulations. Healthy Blue will be required to submit its response for all the "Partially Met" and "Not Met" criteria within 90 days of approval of the CAP from the MHD. Additionally, all the comments from EQRO in Table 6 must be addressed.
Healthy Blue should develop policies and procedures for all the regulations covered for the compliance review proactively.

Disenrollment: Requirements and Limitations

- Healthy Blue incorporate in their policy on Member Disenrollment, to request disenrollment upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.
- Healthy Blue incorporate in their policy on Member Disenrollment and implement the member's right to request disenrollment if Healthy Blue does not cover services the member seeks because of moral or religious objections.
- Healthy Blue must have a written procedure for complying with MHD's disenrollment orders.
- Healthy Blue should have a documented procedure for receiving enrollment and disenrollment updates and incorporating them in Healthy Blue and the subcontractor management system daily. Healthy Blue should also list the procedure for weekly reconciliation of membership with the MHD's 834 files.

Enrollee Rights

- Healthy Blue must address the requirement to notify its members 15 calendar days after receipt or issuance of the termination notice to any provider.
- Healthy Blue must have a policy about providing a member handbook and other written materials with information on how to access services to all members within 10 business days of being notified by MHD of their future enrollment with Healthy Blue.
- Healthy Blue update their policy, Development of Marketing and Member Communications, and align it with the MHD contract, section 12.13.2. Per the MHD contract, the marketing materials are not deemed approved if there is no response from the state within 30 days.
- Healthy Blue is required to maintain a log with the changes they made each year to its member handbook along with the date of approval by the MHD.

- Healthy Blue is recommended to update its member handbook to meet all the 48 criteria listed in the MHD contract, section 2.12.16, even though the MHD provides a template.
- Healthy Blue should consider revising the documentation in Providers Resource on their website on "encouraging members to receive family planning services within the network." Per 42 CFR 441.20, for beneficiaries eligible under the plan for family planning services, the plan must provide that each beneficiary is free from coercion or mental pressure and free to choose the method family planning to be used. Healthy Blue memberhandbook states that the members are allowed to a Healthy Blue provider or a MHD Fee-for-Service approved provider to get family planning services without a referal. However, per the website, the providers should encourage members to avail family planning services within network. This is contradictory with what is stated in the memberhandbook and the CFR.
- Healthy Blue must notify its enrollees of any change that MHD defines as significant in the enrollee handbook at least 30 days before the intended effective date of the change.
- Healthy Blue consistently report all the provider directory requirements for its providers, including hospitals in the network per the 42 CFR 438.10h and MHD contract, section 2.12.17. Healthy Blue should educate its providers about the contractual requirement for submitting their information to Healthy Blue. Healthy Blue should update their policy, Provider Listing Updates, with the missing information about the requirements and submit it to the MHD for approval.
- Healthy Blue upload their provider directory on their website in a machine-readable format (computer/mobile readable). Thus, the members will have access to them once downloaded on their computer or mobile, even without internet accessibility/availability.
- Healthy Blue quote the references from federal regulations in its policy, Member Rights and Responsibilities-MO, that expresses Healthy Blue's commitment to comply with all the regulations on observing and protecting enrollee rights.

Emergency and Post-stabilization Services

- Healthy Blue must submit documentation to show that Healthy Blue and providers have an agreement on payment for the emergency and post-stabilization services.

Suggestions

- During the interview, Healthy Blue informed Primaris that their Medicaid and CHIP enrollees utilize 24% of the emergency room (ER) care for non-urgent conditions. A report to Congress by the U.S. Department of Health and Human Services, Office of

the Assistant Secretary for Planning and Evaluation, on March 2, 2021,[2] is a useful resource for decreasing ER utilization. Primaris commends Healthy Blue for their efforts in this area as their performance is better than the other MCOs operating in Missouri. However, Primaris suggests other resources and methods referenced below that Healthy Blue may implement to reduce the load and cost of ER services:

- Proactive member education and engagement.
- Post-ER follow-up.
- Help members in provider selection and appointment scheduling.
- Telehealthcare promotion and coordination.[3]
- Making referrals to community resources to help eliminate barriers such as transportation to doctor's appointments, prescription assistance programs, and financial assistance programs.
- Make referrals to population health programs that may benefit members: Lifestyle/wellness coaching (e.g., tobacco cessation, weight management); chronic condition coaching; acute medical case management; and behavioral health coaching.[4]
- Extended work hours at providers' offices, including weekend appointment availability.
- Accept walk-in members at providers' offices.

- During the interview, Primaris inquired about the average wait time for enrollees who seek emergency services and Healthy Blue reported 183 minutes (around 3 hours). Members who left ER before they were attended to was 2%. Patients who presented with stroke symptoms were attended to within the first 45 minutes in 72% of cases. Primaris suggests Healthy Blue analyze and compare its data with the national average wait time to improve emergency services[5].

Subcontractual Relationships and Delegation

- Healthy Blue update its contract with March Vision Care Group, Inc. and MTM Inc. with the requirements set under the MHD contract, section 3.9.6.
- Healthy Blue update their agreement with the March Vision Care Group, Inc. to indemnify the state in case of a dispute between Healthy Blue and the subcontracted providers.

Practice Guidelines

- Healthy Blue staffs' knowledge and policies must be consistent with each other.

[2] https://aspe.hhs.gov/system/files/pdf/265086/ED-report-to-Congress.pdf
[3] https://carenethealthcare.com/how_to_improve_health_plan_er_diversion_strategy/
[4] https://www.bluechoicesc.com/great-expectations/ERCG
[5] https://www.cdc.gov/nchs/about/factsheets/factsheet_nhcs.htm

- Primaris recommends Healthy Blue inform its members about the existence and availability of practice guidelines via member handbooks, newsletters, or mailers and how to request these documents.

Health Information Systems

- Healthy Blue provide an explanation/description of their process as to how Healthy Blue's health information system provides information on the Grievances and Appeals.
- Healthy Blue submit documentation to show that their claims processing system is capable of detecting fraud, waste, and abuse in compliance with section 6504(a) of the Affordable Care Act and 1903(r)(1)(F) of the Act.
- Healthy Blue have phone-based capabilities to obtain claims processing status information and provide documentation in support of this requirement.
- Healthy Blue must address the federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. The requirements stated in RSMo 376.383 and 376.384 also need to be addressed, and supporting documents be submitted.
- Healthy Blue must have policies and procedures to verify the consistency and timeliness of reported data, including data from network providers Healthy Blue compensates based on capitation payments.
- Healthy Blue annotate its policy that all data collected will be submitted to CMS and other state agencies if requested.
- Healthy Blue must implement an Application Programming Interface (API) as specified in 42 CFR 438.242, in reference to 42 CFR 431.60 and 431.70. Primaris will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.
- Healthy Blue have a policy and supporting documentation on submitting all enrollee data, including allowed and paid amounts.
- Healthy Blue have a policy/procedure and evidence to show compliance with the timeframe for submitting encounters to the MHD.
- Healthy Blue address the requirements, both in their policies and in practice, related to the availability of information systems during normal operations and in the event of a declared major failure or disaster.

5.2 MHD

Throughout the process, Primaris reviewed MHD communication and the contract with Healthy Blue. The following recommendations identify issues needing clarification or program enhancements that would improve the EQR process and findings:

- Incorporate in the MHD contract with Healthy Blue the requirement of having policies and procedures for all the regulations covered under compliance review for the Medicaid and CHIP Managed Care Regulations regarding EQR.
- Brainstorm with Primaris and Healthy Blue on ways to increase the significance of the EQR.
- Include Primaris in quality-related meetings with Healthy Blue and include EQR as a standing agenda item.
- Emphasize that Healthy Blue focus on adopting documented and measurable ways to "ensure" that its providers and staff follow the regulations per the MHD contract and the 42 CFR 438 instead of tracking the member complaint system for issues, and training/educating the staff/providers, e.g., conducting member surveys, provider surveys in addition to CAHPS.
- Identify additional ways the EQRO can assist Healthy Blue in meeting quality requirements, e.g., TA with quality improvement measures and models.
- **Enrollee rights**
  - Revise the MHD contract, section 2.14.6b, which states, "written materials must include taglines in the prevalent non-English languages in the state, as well as large print (font size no smaller than 18 points)…." Per the Managed Care Final Rule 2020, effective December 14, 2020, the requirement of the font size 18 is replaced by "conspicuously visible size" for the taglines.
  - Primaris has not evaluated one of the criteria listed under section B3iv (v) of the evaluation tool (Appendix B). This section is related to the member handbook in the context of information on the Grievance and Appeals. Healthy Blue was required to address "the specific regulations that support or the change in federal or state law that requires the action." Healthy Blue did not address this requirement due to a lack of clarity. Primaris recommends the MHD provides a clarification/expectation on this requirement.
- **Emergency and post-stabilization services**
  The MHD should revise its MHD contract, section 2.6.12i, "MCO's financial responsibility for post-stabilization care services which the MCO has not pre-approved ends when (Appendix C: section B 6):
  - An MCO physician with privileges at the treating hospital assumes responsibility for the member's care.
  - An MCO physician assumes responsibility for the member's care through transfer.
  - An MCO representative and the treating physician reach an agreement concerning the member's care.
  - The member is discharged (MHD contract, section 2.6.12i).

In reference to the 42 CFR 422.113(c)(3), Primaris recommends the MHD update the statement in the MHD contract for the first two bullet points above to read as follows:

- **Member's** MCO physician with privileges at the treating hospital assumes responsibility for the member's care.
- **Member's** MCO physician assumes responsibility for the member's care through transfer.

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Appendix A

Standard 1-42 CFR 438.56 Disenrollment: Requirements and Limitations		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO may request disenrollment of an enrollee for the following reasons (MHD contract 2.12.18d1):		
1. Member persistently refuses to follow prescribed treatments or comply with MCO requirements that are consistent with federal and state laws and regulations, as amended. 2. Member consistently misses appointments without prior notification to the provider. 3. Member fraudulently misuses the MHD managed care program or demonstrates abusive or threatening conduct. Giving or loaning a member's membership card to another person, for the purpose of using services, constitutes a fraudulent action that may justify MCO's request to disenroll the member. 4. Member requests a home birth service.	Missouri Member Handbook: Page 66 MO29-OP-CS-003 Member Disenrollment: Page 3	Fully Met
Findings: Healthy Blue meets all the criteria stated in this section for initiating disenrollment. (Note: The policy, MO29-OP-CS-003 Member Disenrollment, submitted by Healthy Blue is from the previous owner, WellCare, Inc. CY 2020 was the transition period for Healthy Blue as the ownership changed from WellCare, Inc. to Anthem, Inc. effective Jan 23, 2020. (Healthy Blue's parent company). Healthy Blue informed Primaris that they will adopt this policy. **Required Actions:** Primaris recommends Healthy Blue to adopt WellCare, Inc.'s policy and to submit it to the MHD for approval. This is needed to meet compliance with the regulation on Disenrollment (42 CFR 438.56).		
B. MCO shall not initiate disenrollment (MHD contract 2.12.18d2):		

1. Because of a medical diagnosis or the health status of a member. 2. Because of the member's attempt to exercise his or her rights under the grievance system. 3. Because of pre-existing medical conditions or high-cost medical bills or an anticipated need for health care. 4. Due to uncooperative or disruptive behaviors resulting from his or her special needs (except when his or her continued enrollment in the MCO, seriously impairs the MCO's ability to furnish services to either this enrollee or other enrollees). 5. Due to race, color, national origin, disability, age, sex, gender identity, or sexual orientation.	MO29-OP-CS-003 Member Disenrollment: Page 3	Fully Met
Findings: Healthy Blue meets all the requirements stated in this section of the evaluation tool. **Required Actions:** None.		
C. MCO must assure MHD that it does not request disenrollment for reasons other than those permitted under the MHD contract 2.12.18.		
1. Prior to requesting a disenrollment or transfer of a member, MCO shall document at least three interventions over a period of 90 calendar days which occurred through treatment, member education, coordination of services, and care management to resolve any difficulty leading to the request unless the member has demonstrated abusive or threatening behavior in which case only one attempt is required (MHD contract 2.12.18d3).	MO29-OP-CS-003 Member Disenrollment: Page 3	Fully Met

Findings: Healthy Blue meets the requirement stated in this section of the evaluation tool. **Required Actions:** None.		
2. MCO shall cite at least one good cause before requesting MHD to disenroll a member (MHD contract 2.12.18d3).	MO29-OP-CS-003 Member Disenrollment: Page 3	Fully Met
Findings: Healthy Blue meets the requirement stated in this section of the evaluation tool. **Required Actions:** None.		
3. If MCO intends to proceed with disenrollment during the 90-calendar day period, the MCO shall give a notice citing the appropriate reason to both the member and MHD at least 30 calendar days before the end of the 90-calendar day period. MCO shall document all notifications regarding requests for disenrollment. (MHD contract 2.12.18d3).	MO29-OP-CS-003 Member Disenrollment: Page 3	Fully Met
Findings: Healthy Blue meets the requirement stated in this section of the evaluation tool. **Required Actions:** None.		
4. Members shall have the right to challenge MCO initiated disenrollment to both MHD and MCO through the appeal process within 90 calendar days of MCO's request to MHD for disenrollment of the member. When a member files an appeal, the process must be completed prior to MCO and MHD continuing disenrollment procedures (MHD contract 2.12.18d3).	MO29-OP-CS-003 Member Disenrollment: Page 3	Fully Met
Findings: Healthy Blue meets the requirement stated in this section of the evaluation tool. **Required Actions:** None.		
5. Within 15 working days of the final notification (after no appeal or a final hearing decision), members shall be enrolled in another MCO or transferred to another provider (MHD contract 2.12.18d3).	MO29-OP-CS-003 Member Disenrollment: Page 4	Fully Met

Findings: Healthy Blue meets the requirement stated in this section of the evaluation tool. **Required Actions:** None.		
D. If MCO recommends disenrollment or transfer for reasons other than those stated MHD contract 2.12.18, MHD shall consider the MCO to have breached the provisions and requirements of the contract and may be subject to sanctions as described in the contract (MHD contract 2.12.18d4).	MO29-OP-CS-003 Member Disenrollment: Page 4	Fully Met
Findings: Per the policy, MO29-OP-CS-003 Member Disenrollment, Healthy Blue acknowledged that MHD will consider a breach of the provisions and requirements of the MHD contract and may subject Healthy Blue to sanctions if Healthy Blue disenrolled or transferred its members for any other reason outside of MHD contract, section 2.12.18. **Required Actions:** None.		
E. Disenrollment can be requested by a member without cause, at the following times:		
1. Member requests MCO transfer during open enrollment. 2. During the 90 days following the date of the beneficiary's initial enrollment with the MCO or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later. 3. Upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity. 4. When the state imposes the intermediate sanction specified in §438.702(a)(4) (Suspension of all new enrollment, including default enrollment, after the date the Secretary or the state notifies the MCO of a determination of a violation of any	MO29-OP-CS-003 Member Disenrollment: Pages-2, 3	Partially Met

requirement under sections 1903(m) or 1932 of the Act.).		
Findings: Healthy Blue is compliant with all the reasons for members' requirements for disenrollment except for the reason listed in point 3 of this section. **Required Actions:** Primaris recommends Healthy Blue develop a policy/documentation to allow members to request for disenrollment upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.		
F. Disenrollment requested by a member for a just cause, at any time (MHD contract 2.12.18b):		
1. Transfer is the resolution to a grievance or appeal. 2. Primary care provider or specialist with whom the member has an established patient/provider relationship does not participate in MCO but does participate in another MCO. Transfers to another MCO will be permitted when necessary, to ensure continuity of care. 3. Member is pregnant, and her primary care provider or obstetrician does not participate in the MCO but does participate in another MCO. 4. Member is a newborn and the primary care provider or pediatrician selected by the mother does not participate in the MCO but does in another MCO. 5. An act of cultural insensitivity that negatively impacts the member's ability to obtain care and cannot be resolved by MCO. 6. MCO does not cover services the member seeks because of moral or religious objections.	MO29-OP-CS-003 Member Disenrollment: Pages-2, 3	Partially Met

7. Reasons including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs. 8. Transfer to another MCO is necessary to correct an error made by the enrollment broker or MHD during the previous assignment process. 9. May also request a transfer for all family members to be enrolled with the same MCO. 10. When the MHD imposes sanctions on MCO for non-performance of contract requirements.		
Findings: Healthy Blue's policy complies with all but one requirement (point 6) for the member disenrollment listed under this section. **Required Actions:** Primaris recommends Healthy Blue to incorporate in their policy and implement the member's right to request for disenrollment if Healthy Blue does not cover services the member seeks because of moral or religious objections.		
G. Children in COA 4 (MHD Children in care and custody and adoption subsidy): Children in COA 4 will be allowed automatic and unlimited changes in the MCO choice as often as circumstances necessitate. Foster parents will normally have the decision-making responsibility for which MCO shall serve the foster child residing with them; however, there will be situations where the social service worker or the courts shall select the MCO for a child in state custody or foster care placement (MHD contract 2.12.18c).	MO29-OP-CS-003 Member Disenrollment: Page 3	Fully Met
Findings: Healthy Blue complies with the requirements of this section of the evaluation tool. **Required Actions:** None.		
H. Disenrollment Effective Dates:		

Member disenrollment outside of the open enrollment process shall become effective on the date specified by MHD and shall be no later than the first day of the second month following the month in which the enrollee or the MCO files the request. The disenrollment request is deemed approved if the MHD fails to make the disenrollment determination within the specified timeframes. MCO shall have written policies and procedures for complying with MHD's disenrollment orders (MHD contract 2.12.18e).	Disenrollment MO: Page 1 <u>Post-site meeting submission</u> MO29-OP-CS-003 Member Disenrollment: Page 4	Partially Met
Findings: Healthy Blue acknowledged that member disenrollment outside of the open enrollment process shall become effective on the date specified by the state agency. Enrollment and Billing Department will process all 834 disenrollment within 24 hours of receipt from MHD in accordance with the contract. Healthy Blue stated that they will have written policies and procedures for complying with state agency disenrollment orders. However, they did not submit documentation on the procedure for complying with MHD's disenrollment orders. **Required Actions:** Primaris recommends Healthy Blue develop written procedure for complying with MHD's disenrollment process.		
I. Enrollment and disenrollment updates (MHD contract 2.12.12).		
1. Daily: Every business day, MHD shall make available, via electronic media, updates on members newly enrolled in MCO, or newly disenrolled. MCO shall have and implement written policies and procedures for receiving these updates and incorporating them in MCO and MCO's subcontractors' management information system each day. 2. Weekly Reconciliation: On a weekly basis, MCO shall make available, via electronic media, a listing of current members. MCO shall reconcile this membership list against the MCO's internal records within 30 business days	Disenrollment MO: Page 1	Not Met

of receipt and shall notify the state agency of any discrepancies.		
Findings: Healthy Blue's policy states the Enrollment and Billing department will process the HIPAA 834 file and enrollment transaction generated for MHD in accordance with all contractual requirements. Healthy Blue did not submit a procedure for receiving, incorporating, and reconciling membership. **Required Actions:** Healthy Blue should have a documented procedure for receiving enrollment and disenrollment updates and incorporating them in Healthy Blue and the subcontractor management system daily. Healthy Blue should also list the procedure for weekly reconciliation of membership with the MHD's 834 files.		
J. Hospitalization at the time of enrollment or disenrollment (MHD contract 2.12.18f):		
1. Except for newborns, MCO shall not assume financial responsibility for members who are hospitalized in an acute setting on the effective date of coverage until an appropriate acute inpatient hospital discharge. If the member is in the MHD Fee-For-Service program at the time of acute inpatient hospitalization on the effective date of coverage, the member shall remain in the Fee-For-Service program until an appropriate acute inpatient hospital discharge.	Post-site meeting submission MO29-OP-CS-003 Member Disenrollment: Page 4	Fully Met
Findings: Healthy Blue complies with the requirement stated in this section of the evaluation tool. **Required Actions:** None.		
2. Members, including newborn members, who are in another MCO at the time of acute inpatient hospitalization on the effective date of coverage, shall remain with that MCO until an appropriate acute inpatient hospital discharge.	Post-site meeting submission MO29-OP-CS-003 Member Disenrollment: Page 4	Fully Met
Findings: Healthy Blue complies with the requirement stated in this section of the evaluation tool.		

Required Actions: None.		
3. Members, including newborn members, who are hospitalized in an acute setting, shall not be disenrolled from MCO until an appropriate acute inpatient hospital discharge unless the member is no longer MHD Fee-For-Service or MHD Managed Care eligible or opts out.	Post-site meeting submission MO29-OP-CS-003 Member Disenrollment: Page 4	Fully Met
Findings: Healthy Blue complies with the requirement stated in this section of the evaluation tool. **Required Actions:** None.		
4. For the purpose of a member moving from one MCO to another MCO, in addition to acute inpatient hospitalizations, admissions to facilities that provide a lower level of care in lieu of an acute inpatient admission may be considered as an acute inpatient hospitalization for purposes of this section. MHD reserves the right to determine if such an admission qualifies as an acute inpatient hospitalization. Only acute inpatient hospitalization shall apply when a new member moves from the MHD Fee-For-Service Program to MHD Managed Care. MCO shall provide timely notification to MHD of a member's acute inpatient hospitalization on the effective date of coverage to affect a retroactive/prospective adjustment in the coverage dates for MHD Managed Care.	Post-site meeting submission MO29-OP-CS-003 Member Disenrollment: Page 4	Fully Met
Findings: Healthy Blue complies with the requirement stated in this section of the evaluation tool. **Required Actions:** None.		
K. MHD may require that the enrollee seek redress through the MCO's grievance system before making a determination on the enrollee's request.	Post-site meeting submission MO29-OP-CS-003 Member Disenrollment: Page 2	Fully Met

MHD will monitor and approve or disapprove all transfer requests for just cause, within 60 calendar days subject to a medical record review. MHD may disenroll members from an MCO for any of the following reasons: 1. Selection of another MCO during the open enrollment, the first 90 calendar days of initial enrollment, or for just cause. 2. To implement the decision of a hearing officer in a grievance proceeding by the member against the MCO, or by the MCO against the member. 3. Loss of eligibility for either MHD Fee-For-Service or Managed Care. 4. Member exercises choice to voluntarily disenroll, or opt-out, as specified herein under MHD Managed Care Program eligibility groups (MHD contract, section 2.12.18a).		
Findings: Healthy Blue's policy has met all the requirements and staff is aware of the criteria listed under this section. **Required Actions:** None.		

Compliance Score– Disenrollment: Requirements and Limitations						
Total	Met	=	14	×2	=	28
	Partial Met	=	3	×1	=	3
	Not Met	=	1	×0	=	0
Numerator	Score Obtained				=	31
Denominator	Total Sections	=	18	×2	=	36
Score%						86.11

Appendix B

Standard 2-42 CFR 438.100 Enrollee Rights		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO should have written policies regarding enrollee rights. The MCO shall include, in its policies and procedures, a description of how it will ensure that the rights of members/enrollees are safeguarded and how the MCO will (1) comply with any applicable federal and state laws that pertain to member rights, and (2) ensure that its staff and in-network providers take those rights into account when furnishing services to members. These include the right to (MHD contract 2.14.8):		
1. Dignity and privacy. Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.	Member Rights and Responsibilities-MO: Pages-1, 2	Fully Met
Findings: Healthy Blue is committed to ensuring that members are treated in a manner that acknowledges their rights and responsibilities. Healthy Blue will comply with any applicable federal and state laws that pertain to member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to members. Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and his or her right to privacy. During the interview, Healthy Blue stated that it is difficult to ensure providers' compliance but the language regarding enrollee's rights is included in providers' contracts. Healthy Blue monitors complaints and grievances data. If an issue is found then mitigation steps are taken, up to termination of providers. Data is obtained through the CAHPS survey as well on the cultural competency of providers. **Required Actions:** None.		
2. Receive information on available treatment options. Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	Member Rights and Responsibilities-MO: Page 2	Fully Met

Findings: Healthy Blue's policy, Member Rights and Responsibilities-MO, complies with the requirement of this section (A2) of the evaluation tool. During the interview, Healthy Blue stated its providers' contracts include the requirement of providing various treatment options with the members. Annual audits are conducted by the medical director to determine provider compliance. **Required Actions:** None.		
3. Participate in decisions. Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.	Member Rights and Responsibilities-MO: Page 2	Fully Met
Findings: Each member has the right to a candid discussion of appropriate or medically necessary treatment options for his or her condition(s), regardless of cost or benefit coverage, including the right to refuse treatment. During the interview, Healthy Blue reported they provide flyers to all the new enrollees to encourage them to visit the website, create an online account and access various applications (e.g., wellness) and resources. **Required Actions:** None.		
4. Be free from restraint or seclusion. Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Member Rights and Responsibilities-MO: Page 2	Fully Met
Findings: Healthy Blue's policy, Member Rights and Responsibilities-MO, complies with the requirement of this section (A4) of the evaluation tool. **Required Actions:** None.		
5. Obtain a copy of medical records. Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164.524 and 164.526 (if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies).	Member Rights and Responsibilities-MO: Page 2	Fully Met

Findings: Each member is guaranteed the right to request and receive a copy of his or her medical records and to request that they be amended or corrected, as specified in 45 CFR part 164.9. The regulation cited is incorrect. **Required Actions:** Primaris recommends Healthy Blue to rectify the regulation mentioned in their policy, Member Rights and Responsibilities-MO.		
6. Freely exercise these rights. Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way MCO and its providers or MHD treat the member.	Member Rights and Responsibilities-MO: Page 2	Fully Met
Findings: Healthy Blue's policy, Member Rights and Responsibilities-MO, complies with the requirement of this section (A6) of the evaluation tool. **Required Actions:** None.		
B. Enrollees should receive information in accordance with 42 CFR 438.10.		
1. Language and Format (MHD contract 2.14.6). All written materials for enrollees should be consistent with the following: i. Easily understood language and format. Font size no smaller than 12 points/conspicuously visible font size. ii. Written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service area. iii. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of potential enrollee or enrollee at no cost, include taglines in the prevalent non-English languages in	Healthy Blue Member Handbook <u>Post-site meeting submission</u> BMO-MEM-0114-20 Welcome Quick Guide-Flier	Partially Met

a conspicuously visible font-size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. iv. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost. v. Language assistance to enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English. vi. MHD has identified the top 15 languages spoken by individuals with limited English proficiency for the state of Missouri. MCO shall make available general services and materials, such as MCO's member handbook, in that language. MCO shall include, on all materials, language blocks in those languages that tell members that translated documents are available and how to obtain them. vii. Make interpretation services available free of charge to each enrollee. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the state identifies as prevalent.		

viii. All written materials shall be worded such that the materials are understandable to a member who reads at the sixth (6th) grade reading level		
Findings: Healthy Blue has not submitted its policy on member materials as per 42 CFR 430.10. The member-related supporting documents submitted by Healthy Blue meet some of the requirements of this section. The member handbook meets most of the requirements listed in this section. The readability statistic of the member handbook was not submitted. The Welcome Quick Guide-flier meets all but two requirements, vi and viii (ii is not applicable). Primaris assessed the readability statistics-Flesch Kincaid Grade level-of Welcome Quick Guide to be 10.4, which is not per the CFR. **Required Actions:** Healthy Blue must have a policy/guidelines regarding member resources per 42 CFR 438.10 and revise Welcome Quick Guide to a sixth grade reading level.		
2. MCO must make a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from or was seen on a regular basis by, the terminated provider. Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.	<u>Post-site meeting submission</u> Provider Termination Enterprise Playbook: Page 13	Partially Met
Findings: Healthy Blue sends letters to members advising them of their Primary Care Provider's termination 30 days prior to the effective date of termination, as per state requirements. Health Blue uses established member letter templates, modified as needed for local considerations. **Required Actions:** Primaris recommends Healthy Blue update their documentation to reflect the additional requirement of providing notice to its members as per this section of the evaluation tool: "Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice."		
3. Enrollee/Member handbook. i. MCO shall provide a member handbook and other written materials with information on how to access	<u>Post-site meeting submission</u> BMO-MEM-0114-20 Welcome Quick Guide-Flier	Partially Met

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 enrollee's mailing address; • Provides the information by email after obtaining the enrollee's agreement to receive the information by email; • Posts the information on the website of the MCO and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or • Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.		
Findings: Healthy Blue has not submitted a policy/guidelines which meets the requirements of this section. However, Healthy Blue submitted a flier which provides information to its members about how to access the member handbook on their website. **Required Actions:** Healthy Blue must have a policy about providing a member handbook and other written materials with information on how to access services, to all members within 10 business days of being notified by MHD of their future enrollment with Healthy Blue.		
ii. On an annual basis, MCO shall review the member handbook, revise as necessary, and document that such review occurred. The MCO shall submit the member handbook to MHD for approval prior to distribution to members.	Development of Marketing and Member Communications: Page 4	Partially Met

Findings: Healthy Blue submits documents for state approval, if required, as indicated by the Regulatory/Compliance reviewer(s) during their Collateral Materials Approval Process (CMAP)**.** The state agency shall review and respond as soon as possible, but within 30 calendar days of receipt by the state agency. Marketing and education materials are deemed approved if a response from the state agency is not returned within 30 calendar days following receipt of the materials by the state agency. Healthy Blue shall submit to the state agency revised material within 10 business days following receipt date of the written notice from the state agency of problems or issues with the written materials. Healthy Blue has not submitted its revision history or any evidence that confirms this requirement. **Required Actions:** Primaris recommends that Healthy Blue update their policy, Development of Marketing and Member Communications, and align it with the MHD contract, section 12.13.2. The marketing materials are not deemed approved if there is no response from the state within 30 days. Healthy Blue is required to maintain a log with the changes they made each year and the date of approval by the MHD.		
iii. MCO must give each enrollee notice of any change that MHD defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change (42 CFR 438.10g4).	Healthy Blue Member Handbook: Page 37	Partially Met
Findings: The member handbook states that Healthy Blue will send letters to their members anytime there is a change in members' benefits. Healthy Blue will send the letters such that their members receive them at least 30 days before the change takes effect. The letter will inform the members whether benefits have changed or stopped. During the interview, Healthy Blue stated that they annually update the member handbook on the website. The information is provided in the welcome package. Effective July 1, 2021, the members will be informed via electronic messages through the member portal to its current members. Healthy Blue provided an example of a change in immunization. However, no evidence was submitted to ascertain that the members were notified about the change in immunization information. **Required Actions:** Healthy Blue should incorporate and implement all the requirements provided in CFR and MHD contract related to Enrollee rights in their policies and procedures.		
iv. The content of the member handbook must include all the requirements stated in the MHD contract 2.12.16. a. Table of contents.	Healthy Blue Member Handbook: Pages-iv, v, ix, x, xi, 10-35, 37-40, 43-54, 56, 58-61, 63-68	Partially Met

b. Information about choosing and changing primary care providers, types of providers that serve as primary care providers (including information on circumstances under which a specialist may serve as a primary care provider), and the roles and responsibilities of primary care providers. c. Information about the importance of and how to report status changes such as family size changes, relocations out of county or out of state. d. A listing of the member's rights and responsibilities as described in the MHD contract 2.14.8 (section A of this tool). e. Appointment procedures and the appointment standards described in the MHD contract. f. Notice that the adult member must present the MHD identification card (or other documentation provided by the state agency demonstrating MHD eligibility), as well as the MCO membership card, in order to access non-emergency services, and a warning that any transfer of the identification card or membership card to a person other than the adult member for the purpose of using services constitutes a fraudulent act by the adult member. g. A description of all available MCO services, an explanation of any service limitations or exclusions from coverage, and a notice stating that MCO shall be liable only for those services authorized by MCO.		

h. Information on how and where members can access any benefits provided by the state, including how transportation is provided. i. A description of all available services outside the comprehensive benefit package. Such information shall include information on where and how members may access benefits not available under the comprehensive benefit package. j. The definition of medical necessity used in determining whether benefits will be covered. (Note: 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.) k. A description of all prior authorization or other requirements for treatments and services. l. A description of utilization review policies and procedures used by MCO. m. An explanation of a member's financial responsibility for payment when services are provided by an out-of-network provider or by any provider without required authorization or when a procedure, treatment, or service is not covered by the MO HealthNet Managed Care Program.		

n. Notice that a member may receive services from an out-of-network provider when MCO does not have an in-network provider with appropriate training and experience to meet the health care needs of the member and the procedure by which the member can obtain such referral. o. Notice that a member with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral. p. Notice that a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the member's medical care and the procedure for requesting and obtaining such a specialist. q. Notice that a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, may request access to a specialty care center and the procedure by which such access may be obtained. r. A description of the mechanisms by which members may participate in the development of the policies of MCO. s. Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization.		

t. Procedures for disenrollment, including an explanation of the member's right to disenroll with and without cause. u. Information on how to contact member services and a description of its function. v. Information on the grievance, appeal, and state fair hearing procedures and timeframes. Such information shall include: • The right to file grievances and appeals. • The requirement and timeframes for filing a grievance or appeal. • The availability of assistance in the filing process. • The toll-free numbers that the member can use to file a grievance or an appeal by phone. • The procedures for exercising the rights to appeal and request a state fair hearing. • That the member may represent himself or use legal counsel, a relative, a friend, or other spokesperson. • The specific regulations that support or the change in Federal or state law that requires the action. • The fact that when requested by the member: benefits will continue if the member files an appeal or a request for state fair hearing within the timeframes specified for filing; and the member may be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the member. • The following is information about the member's right to request a state fair hearing:		

○ A member may request a state fair hearing within one hundred twenty (120) calendar days from MCO's notice of appeal resolution; and ○ The state agency must reach its decisions within the specified timeframes: For standard resolution: within 90 calendar days from the state agency's receipt of a state fair hearing request. For expedited: within three business days from the state agency's receipt of a state fair hearing request for a denial of a service that meets the criteria for an expedited appeal process but was not resolved using MCO's expedited appeal timeframes or was resolved wholly or partially adversely to the member using MCO's expedited appeal timeframes. w. How to report suspected fraud, waste, and abuse activities, including the Medicaid Fraud Control Unit (MFCU) fraud, waste, and abuse hotline number. x. Information about the care management program to include that the member may request to be screened for care management at any time. y. Information about the disease management programs. z. Pharmacy dispensing fee requirements (if applicable), including a statement that care, shall not be denied due to lack of payment of pharmacy dispensing fee requirements.		

a.1 Information on how to access the provider network directory on MCO's website and how to request a hard copy of the directory. a.2. A description of after-hours and emergency coverage. This description shall include the extent to which, and how, after-hours and emergency coverage is provided, including the following: (a)What constitutes an emergency medical condition, emergency services, and post-stabilization services; (b) The fact that prior authorization is not required for emergency services; (c) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; (d) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; (e) The fact that the member has a right to use any hospital or other setting for emergency care; and (f) The post-stabilization care services rules specified in MHD contract. a.3. Information on how to obtain emergency transportation and non-emergency medically necessary transportation. a.4. Information on EPSDT services including immunization and blood lead testing guidelines designated by the state agency. a.5. Information on maternity, family planning, and sexually transmitted diseases services. This information should include the extent to which, and how, members may obtain family		

planning services and supplies from out-of-network providers. It should also include an explanation that MCO cannot require a member to obtain a referral before choosing a family planning provider. a.6. Information on behavioral health services, including information on how to obtain such services, the rights the member must request such services, and how to access services when in crisis, including the toll-free number to be used to access such services. a.7. Information on travel distance standards. a.8. Information on how to obtain services when out of the member's geographic region and after-hours coverage. a.9. A statement that MCO shall protect its members in the event of insolvency and that MCO shall not hold its members liable for any of the following: • The debts of MCO in the case of MCO insolvency. • Services provided to a member in the event MCO failed to receive payment from the state agency for such service. • Services provided to a member in the event a health care provider with a contractual referral, or other type arrangement with MCO, fails to receive payment from the state agency or MCO for such services. • Payments to a provider that furnishes covered services under a contractual referral, or other type arrangement with MCO in excess of		

the amount that would be owed by the member if MCO had directly provided the services. a.10. A statement that any member that has a worker's compensation claim, or a pending personal injury, or tort, or product liability, or medical malpractice lawsuit, or has been involved in an auto accident, should immediately contact MCO. a.11. A statement that if a member has another health insurance policy, all prepayment requirements must be met as specified by the other health insurance plan and that the member must notify MCO of any changes to their other health insurance policy. The member can contact MCO with any questions. a.12. Information on the Health Insurance Premium Payment (HIPP) program which pays for health insurance for members when it is determined cost-effective. a.13. Information on contributions the member can make towards his or her own health, appropriate and inappropriate behavior, and any other information deemed essential by MCO or the state agency including the member's rights and responsibilities. a.14. Information on the availability of multilingual interpreters and translated written information, how to access those services, and a statement that there is no cost to the member for these services. a.15 Information on how to access auxiliary aids and services, including		

additional information in alternative formats or languages. a.16. Information on the procedures that will be utilized to notify members affected by termination or change in benefits, services, or service delivery office/site. a.17. A statement that MCO shall provide information on MCO's physician incentive plans to any member upon request. a.18. With respect to advance directives, language describing: • The members' rights under state and federal law to exercise an advance directive. • MCO's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience. • That complaints concerning noncompliance with the advance directive requirements may be filed with the state survey and certification agency. a.19. A description of the additional information that is available upon request, including the availability of information on the structure and operation of MCO. a.20. A statement that the member has the right to obtain one free copy of his or her medical records annually and how to make the request.		

a.21. Information on how to request and obtain an Explanation of Benefits (EOB). a.22. In the case of a counseling or referral service that MCO does not cover because of moral or religious objections, MCO must inform members that the service is not covered by MCO; and MCO must inform members how they can obtain information from the state agency about how to access the services.		

Findings: Healthy Blue's member handbook "Met" 40 of 48 criteria mandated in the MHD contract. There are six criteria scored as "Partially Met" and two criteria are scored as "Not Met." Primaris has assigned a combined score of "Partially Met" for the Member handbook compliance (section B3iv of this evaluation tool).

The following six criteria are "Partially Met":

h. Information on how and where members can access benefits provided by the state is not present.

j. The definition of "medical necessity" is incomplete. One of the components, service is necessary for members to achieve age-appropriate growth and development, is missing.

t. All the conditions under which an enrollee can disenroll with or without cause are not listed e.g., upon automatic re-enrollment, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity, the enrollee can request for disenrollment. This is missing in the member handbook.

v. Time to file a grievance is not mentioned. A member must complete a written request for an appeal even if the member filed orally is incorrect per 42 CFR 438 effective Dec 14, 2020. On page 59, the member handbook provides information that Healthy Blue will decide within 30 calendar days after Healthy Blue receives the request for pre-service appeals, within 60 calendar days after they receive the request for post-service appeals. On page 60, it is written that MHD Managed Care allows 90 days for Healthy Blue to decide on an appeal. Primaris determines the above-stated time frames regarding a resolution of the appeal are incorrect. Pre-service or post-service appeals are not mentioned in 42 CFR 438 or the MHD contract.

On page 2 of the member handbook, information about Appeal is incorrect as it states Healthy Blue will make an appeal decision within 45 days of receipt of request. Primaris

noted inconsistencies in member handbook at various places regarding the timeframes mentioned for responding to Appeals.

a.9 A statement that Healthy Blue shall protect its members in the event of insolvency and that MCO shall not hold its members liable under certain conditions as in the MHD contract is not written.

a.18. Healthy Blue did not include a statement of "any limitation regarding the implementation of advance directives as a matter of conscience" as required per the MHD contract. Healthy Blue informed Primaris that the language for Advance Directives is provided by the MHD as a template.

There are two criteria scored as "Not Met" in the member handbook:

k. A description of all prior authorization or other requirements for treatments and services is missing.

q. How a member with life a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, may request access to a specialty care center and the procedure by which such access may be obtained.

Primaris has not evaluated one of the criteria listed under section B3iv (v) of this evaluation tool: "The specific regulations that support or the change in federal or state law that requires the action." Primaris has requested a clarification on this requirement from MHD. Also, Healthy Blue has not addressed it in their member handbook as they are unaware of this requirement.

Regarding criterion (a.5): the members are allowed to obtain family planning services even from out-of-network providers without a referral. The member handbook complies with this criterion. However, Primaris noted on the Healthy Blue website (in March 2021): Providers Resource-Page 5 of 12, states that providers should encourage the patients to receive family planning services in-network to ensure continuity of services. Per 42 CFR 441.20, for beneficiaries eligible under the plan for family planning services, the plan 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: Healthy Blue is recommended to update their member handbook to meet all the 48 criteria listed in the MHD contract, section 2.12.16. Also, Healthy Blue should consider revising the documentation in providers resource on their website on "encouraging members to receive family planning services within the network."

4. Provider Directory. i. MCO must make available in paper upon request and electronic format the	Provider Directory (southwest region)	Partially Met

following information about network providers. • provider's name as well as any group affiliation; • board certification status for physicians; • street address; • telephone number; • website URL, as appropriate; • specialty; • panel status-accepting new enrollees; • cultural and linguistic capabilities including American Sign Language or a skilled medical interpreter at provider's office; and • accommodations for people with physical disabilities, including offices, exam room(s), and equipment.	<u>Post-site meeting submission</u> Provider Listing Updates (Draft version): Pages-1, 2, 3	
Findings: The introduction portion of the provider directory consists of information about aids and services that Healthy Blue will provide to its members at no cost, to help people with disabilities communicate with Healthy Blue. The services include American sign language interpreters. Healthy Blue can also provide information in other formats, e.g., large print, audio, accessible electronic formats, and Braille. There is an alternate languages index and Extended hours (7 a.m. to 9 p.m.) index. Post-site meeting, Healthy Blue submitted a policy, Provider Listing Updates (Draft version). This policy does not address the requirement on website URL, American Sign Language or skilled medical interpreter availability, and accommodations for people with disabilities. Primaris found the information on panel status, accommodations was inconsistently reported for the providers. It could not be determined if documentation was lacking or the non-availability of those services from providers. **Required Actions:** Primaris recommends Healthy Blue consistently report on all the parameters listed in this section of the evaluation tool. They should mention clearly that the provider does not have a particular service. Healthy Blue should update their policy, Provider Listing Updates, with the missing information and submit it to the MHD for approval.		
ii. The provider directory must include the information stated above (section	Provider Directory (southwest region)	Partially Met

B4 above), for each provider types covered under the contract: • Physicians, including specialists. • Hospitals; • Behavioral health providers. Note: Pharmacy and LTSS not applicable to MCO per MHD contract and hence excluded.	Post-site meeting submission Provider Listing Updates (Draft version): Page 3	
Findings: The provider directory meets the requirement for physicians, including specialists and behavioral health providers. Information about interpreter services for hospitals was not provided. Healthy Blue's policy, Provider Listing Updates, states that Healthy Blue includes the following information in its written and internet-based directory to help members and prospective members choose a hospital: facility names; location; and accreditation. **Required Actions:** Primaris recommends Healthy Blue to provide all the information per section B4(i) for hospitals in their provider directory as well as update their policy.		
iii. An electronic provider directory must be updated no later than 30 calendar days after the MCO receives updated provider information. The information included in a paper provider directory must be updated at least- • Monthly, if the MCO does not have a mobile-enabled, electronic directory; or • Quarterly, if the MCO has a mobile-enabled, electronic provider directory (42 CFR 430.10h3).	Post-site meeting submission Provider Listing Updates (Draft version): Page 3	Fully Met
Findings: Healthy Blue updates its provider and hospital directory with changes and/or additions within 30 days of receipt from providers. Validation of directory listings occurs on an annual basis through provider and hospital audits. A provider directory, containing the entire network, is made available on the Healthy Blue website. The website directory is updated through the normal daily interact file available on the web portal. Healthy Blue departments have access to daily updated electronic copies on the Healthy Blue website. The Customer Service staff have access to an up-to-date list of all in-network providers by the following information: • The provider is currently participating in the network. • The provider is accepting new patients.		

Required Actions: None.		
iv. MCO shall notify all members of their right to request and obtain provider directory at least once a year. The MCO shall have printed hard copies available of the provider directory which shall be mailed within 48 hours of a member request for a hard copy version of the provider directory. Provider directories must be made available on the MCO's website in a machine-readable file and format as specified by the Secretary (42 CFR 438.10h4, MHD contract, section 2.12.17).	Healthy Blue Member Handbook: Page 14, 27 <u>Post-site meeting submission</u> Provider Listing Updates (Draft version): Page 3	Partially Met
Findings: According to Healthy Blue's policy, Provider Listing Updates (draft version), submitted post-site meeting Healthy Blue will provide printed, hard copies of the provider listing and directory which shall be mailed within 48 hours of a member request for a hard copy version of the provider directory. Per Healthy Blue's member handbook, Healthy Blue will send a provider directory to their members within 48 hours of the request. The members can call member services at the phone number provided in the handbook. Primaris visited Healthy Blue's website in March 2021 and did not find a provider directory. Instead, Healthy Blue has a web-based search tool that allows members to search for providers. During the interview, Healthy Blue reported that the members will be communicated electronically via Member Portal messaging and a Blog regarding the member's right to obtain a provider directory on an annual basis, starting July 1, 2021. **Required Actions:** Primaris recommends Healthy Blue to provide their provider directory on their website, in a machine-readable format (computer/mobile readable). This will allow the members to have access to it once it is downloaded on their computer or mobile even without internet accessibility/availability.		
5. All enrollees are informed that information available under section B of this evaluation tool (42 CFR 438.10) is placed in a location on MCO's website that is prominent and readily accessible. The enrollee is informed that the information is available in paper form	Healthy Blue Member Handbook: Pages-14, 27	Fully Met

without charge upon request and provides it upon request within 5 business days (42CFR 438.10c6v).		
Findings: Member Handbook states that Health Blue members can get up-to-date information on Healthy Blue's website, healthybluemo.com, about the services provided by Healthy Blue; provider network; frequently asked questions; contact phone numbers; and e-mail addresses. This information can be sent to the members in a printed copy at no cost within five business days of members' requests. **Required Actions:** None.		
C. MCO must comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its employees and contracted providers observe and protect those rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 regarding education programs and activities; Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.	Member Rights and Responsibilities-MO: Page 2 Member Handbook: Page 4	Partially Met
Findings: At Healthy Blue, no member will be denied the benefits of, or participation in, covered services on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. This notification is also provided in the member handbook. The members can file a grievance on the phone, email, fax, or by mail, if they have a complaint about discrimination, with Healthy Blue. The members can also file civil rights complaints with the Department of Health and Human Services. The contact information and procedure are provided in the member handbook. **Required Actions:** Primaris recommends that Healthy Blue quote the references from federal regulations in its policy which ensures that Healthy Blue is commitment to complying with all the regulations listed in this section (C) to the fullest extent.		

Compliance: Healthy Blue

Compliance Score–Enrollee Rights						
Total	Met	=	8	×2	=	16
	Partial Met	=	10	×1	=	10
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	26
Denominator	Total Sections	=	18	×2	=	36
Score%						72.22

Appendix C

Standard 3-42 CFR 438.114 Emergency and Post-stabilization Services		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. Definitions: 1. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. • Serious harm to self or others due to an alcohol or drug use emergency. • Injury to self or bodily harm to others. • With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn (MHD contract, section 2.7.5j).	Emergency Services-Core Process: Page 1 Coverage for Post-stabilization Care Services: Pages-10, 11	Fully Met
Findings: Healthy Blue's policies: Emergency Services-Core Process and Coverage for Post-stabilization Care Services comply with the definition of "emergency medical condition" as stated in section A 1 of this evaluation tool. "Health" includes physical or behavioral health. **Required Actions:** None.		

2. Emergency services means covered inpatient and outpatient services that are as follows: • Furnished by a provider that is qualified to furnish these services under the Title 42 Public Health of CFR. • Needed to evaluate or stabilize an emergency medical condition.	Emergency Services-Core Process: Page 2 Coverage for Post-stabilization Care Services: Page 10	Fully Met
Findings: Healthy Blue's policy, Emergency Services-Core Process, defines "Emergency Services" as covered inpatient and outpatient services that are as follows: • Furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act. • Needed to evaluate or stabilize an emergency medical condition that is found to exist under the prudent layperson standard. **Required Actions:** None.		
3. Post-stabilization care services mean covered services, related to an emergency medical condition that is provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances as described in 42 CFR 422.113c (read in reference to an MCO) to improve or resolve the enrollee's condition.	Emergency Services-Core Process: Page 19 Coverage for Post-stabilization Care Services: Page 1	Fully Met
Findings: Healthy Blue's policies, namely Emergency Services-Core Process, and Coverage for Post-Stabilization Care Services comply with the definition of "post-stabilization care services" as stated in section A3 of this evaluation tool. **Required Actions:** None.		
B. Coverage and Payment of emergency services and Post-stabilization care services:		
1. MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO (in-network or out-of-network). i. MCO shall pay out-of-network providers for emergency services at the	Emergency Services-Core Process: Pages-2, 17 Coverage for Post-stabilization Care Services: Page 9	Partially Met

current MHD program rates in effect at the time of service. ii. MCO shall not reimburse for emergency services provided outside the United States. iii. MCO and providers to reach an agreement on payment for services. (MHD contract, section 2.6.12a, b).		
Findings: Healthy Blue states that their organization will cover and pay for emergency services and care, regardless of whether the entity furnishing the services is a participating provider. All coverage and payment for services are contingent on member benefits and eligibility at the time services are rendered. MHD requires Healthy Blue and providers to reach an agreement on payment for services. Healthy Blue shall pay out-of-network providers for emergency services at the current MHD managed care program rates in effect at the time of service. Healthy Blue shall not reimburse for emergency services provided outside the United States. Post-site meeting, Healthy Blue has submitted "Single Case Agreement: Process –Missouri Medicaid" which is neither approved by their organization nor by MHD. This document does not meet the requirement of this section. **Required Actions:** Healthy Blue must submit a documentation to show that Healthy Blue and providers have an agreement on payment for the services.		
2. MCO may not deny payment for treatment obtained under either of the following circumstances: i. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of the emergency medical condition. ii. A representative of the MCO instructs the enrollee to seek emergency services.	Emergency Services-Core Process: Page 18	Fully Met
Findings: Healthy Blue's policy, Emergency Services-Core Process, meets the requirement of this section (B2) of the evaluation tool. **Required Actions:** None.		

3. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO as responsible for coverage and payment.	Emergency Services-Core Process: Page 4 Coverage for Post-stabilization Care Services: Page 9	Fully Met
Findings: Healthy Blue may transfer the member, in accordance with state and federal law, to a participating hospital that has the service capability to treat the member's emergency medical condition. The attending emergency physician, or another appropriate healthcare professional, actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer discharge, and that determination is binding on the entities identified in 42 CFR 438.114(b) as responsible for coverage and payment. **Required Actions:** None.		
4. Post-stabilization care services are covered and paid for in accordance with provisions set forth at §422.113(c) of 42 CFR Chapter IV ("Medicare Advantage Organization" and "financially responsible" will be read as a reference to an MCO). The MCO shall be financially responsible for post-stabilization care services, obtained within or outside the MCO, that are pre-approved by an MCO provider or other MCO representative (MHD contract, section 2.6.12g).	Emergency Services-Core Process: Page 18 Coverage for Post-stabilization Care Services: Page 1	Fully Met
Findings: Healthy Blue's policies, namely Emergency Services-Core Process, and Coverage for Post-stabilization Care Services comply with the requirement stated in this section (B4) of the evaluation tool. **Required Actions:** None.		
5. MCO shall be financially responsible for post-stabilization care services, obtained within or outside the MCO, that are not pre-approved by an MCO provider or other MCO representative but are administered to maintain,	Emergency Services-Core Process: Page 18 Coverage for Post-stabilization Care Services: Pages-1, 10	Fully Met

improve, or resolve the member's stabilized condition if: • The MCO does not respond to a request for pre-approval within 30 minutes. • The MCO cannot be contacted. • The MCO representative and the treating physician cannot reach an agreement concerning the member's care and an MCO physician is not available for consultation. In this situation, the MCO shall give the treating physician the opportunity to consult with an MCO physician and the treating physician may continue with care of the member until an MCO physician is reached or one of the criteria listed below is met (MHD contract 2.6.12h). Refer to section B6.		
Findings: Healthy Blue policies: Emergency Services-Core Process; and Coverage for Post-stabilization Care Services (section under Missouri) comply with the requirements stated in this section (B5) of the evaluation tool. However, Primaris noticed a weakness in one of the policies as follows: The policy on Coverage for Post-stabilization Care Services states the response time of Healthy Blue for a pre-approval request as one hour versus the contractual requirement of response time within 30 minutes. **Required Actions:** Primaris recommends Healthy Blue update their response time for pre-approval of a request for post-stabilization services to 30 minutes at all places, as applicable, in their policy on Coverage for Post-stabilization Care Services.		
6. MCO's financial responsibility for post-stabilization care services which the MCO has not pre-approved ends when • An MCO physician with privileges at the treating hospital assumes responsibility for the member's care. • An MCO physician assumes responsibility for the member's care through transfer.	Emergency Services-Core Process: Page 19 Coverage for Post-stabilization Care Services: Page-10	Fully Met

• An MCO representative and the treating physician reach an agreement concerning the member's care. • The member is discharged (MHD contract, section 2.6.12i).		
Findings: Healthy Blue's policy, Emergency Services-Core Process, complies with all the conditions stated in this section (B6) of the evaluation tool. **Required Actions:** None.		
7. MCO shall limit charges to members for post-stabilization care services to an amount no greater than what the MCO would charge the member if he or she had obtained the services through the MCO (MHD contract, section 2.6.12j).	Emergency Services-Core Process: Page 19 Coverage for Post-stabilization Care Services: Pages-2, 10	Fully Met
Findings: Healthy Blue shall limit charges to members for post-stabilization care services to an amount no greater than what Healthy Blue would charge the member if he or she had obtained the services through Healthy Blue. **Required Actions:** None.		
8. An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Emergency Services-Core Process: Page 18 Coverage for Post-stabilization Care Services: Page 9	Fully Met
Findings: Healthy Blue's policies: Emergency Services-Core Process; and Coverage for Post-stabilization Care Services comply with the requirement stated in this section (B8) of the evaluation tool. **Required Actions:** None.		
C. MCO may not: 1. Limit what constitutes an emergency medical condition with reference to the definition, on the basis of lists of diagnoses or symptoms. 2. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying	Emergency Services-Core Process: Pages-2, 3 Coverage for Post-stabilization Care Services: Pages-2, 11	Fully Met

the enrollee's primary care provider, MCO, or applicable state entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services.		

Findings: Policy on Emergency Services-Core Process states: "Healthy Blue will not limit what constitutes an emergency medical condition solely on the basis of lists of diagnoses or symptoms. Healthy Blue will not refuse to cover emergency services and care due to a lack of notification to Healthy Blue."
"If the hospital is unable to notify Healthy Blue, the hospital must document its attempts to notify Healthy Blue, or the circumstances that precluded the hospital's ability to notify Healthy Blue. Healthy Blue will not deny payment for emergency services and care based on a hospital's failure to comply with the notification requirements of this section."

Healthy Blue's policy, Coverage for Post-stabilization Care Services, states "If the post-stabilization care services are administratively denied as a result of non-notification, the denial letter includes language explaining if the ordering/admitting physician believes the member was not stable at the time services rendered/admitted, the ordering/admitting physician or the facility acting on his/her behalf may submit medical records for review, and the decision will be reconsidered."

Required Actions: None.

Compliance Score–Emergency and Post-stabilization Services						
Total	Met	=	11	×2	=	22
	Partial Met	=	1	×1	=	1
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	23
Denominator	Total Sections	=	12	×2	=	24
Score%						95.83

Appendix D

Standard 4–42 CFR 430.230 Subcontractual Relationships and Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
A. Notwithstanding any relationship(s) that the MCO may have with any subcontractor, the MCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the state. MCO shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract (MHD contract, section 3.9.2).	Delegate/Vendor Oversight and Management Program: Page 2 Medical Transportation Management (MTM) Inc. Statement of Work (SOW): Page 48, 54 March Vision Care Group, Inc., Service Agreement: Page 33 Ancillary Services Agreement (Dental): Pages-9, 68	Fully Met

Findings: The policy on Delegate/Vendor Oversight and Management Program states: "While Health Blue may contract for a particular function with a delegate/vendor or an organization, the company retains responsibility/accountability for the delegate's/vendor's activities, including the right to make final selection decisions. The company is accountable for such functions, whether they are performed by a delegate/vendor or by a delegate's/vendor's sub-contractor."

Healthy Blue's contract with Medical Transportation Management (MTM) Inc. states that Healthy Blue retains ultimate accountability and responsibility for claims processing activities performed. Responsibility for oversight of activities performed on behalf of Health Plan by monitoring delegate reports and conducting an annual and mock evaluation of delegate including document review and file audit.

March Service Agreement states, "In the event Delegated Entity receives an unpaid claim or portion of such claims for which Company has financial responsibility, whether or not Delegated Entity can determine that Company has such financial responsibility, Delegated Entity agrees to send claim to Company within five (5) days of receipt."

The Ancillary Service Agreement (Dental) states, "responsibility for handling all appeals other than first level appeals by participating providers as described in this schedule shall be retained by Healthy Blue. Healthy Blue retains responsibility for all elements of the Utilization Management program that are not explicitly delegated in this Addendum. Without limiting the generality of the foregoing sentence, Healthy Blue retains responsibility for responding to inquiries, complaints, grievances and appeals received from Members and/or their appointed representatives, providers acting on behalf of Members, and nonparticipating/non-contracted providers." "Healthy Blue retains sole responsibility

and authority for determining and amending all benefit stmctures and other terms and conditions of the Benefit Plans. **Required Actions:** Primaris suggests Healthy Blue include explicit language regarding "legal and financial aspects" of their responsibility/accountability in all their subcontracts and policy.		
B. If any of the MCO's activities or obligations under its contract with the state are delegated to a subcontractor:		
1. The MCO must obtain the approval of the state of Missouri prior to establishing any new subcontracting arrangements and before changing any subcontractors (MHD contract, section 3.9.4).	Ancillary Services Agreement (Dental): Page 40 <u>Post-site meeting submission</u> Delegate/Vendor Oversight and Management Program (Revised):	Fully Met
Findings: Post-site meeting, Healthy Blue has updated their policy to comply with the requirement of this section. Healthy Blue's subcontract for Dental Services states that the subcontractor will not delegate any delegated activities to any other person except upon Healthy Blues's prior written consent and any such delegation, if made, shall be in writing, shall include the applicable requirements of this subcontract, and shall otherwise be in compliance with government program requirements and accreditation body standards. During the interview, Healthy Blue reported their process of subcontracting with vendors. They utilize a standard process: a request for proposal (RFP) is solicited from industry leaders. Pre-delegated assessments and audits take place to finalize the subcontractor. The policies and procedures are reviewed for federal, state, and NCQA requirements. **Required Actions:** None.		
2. Pursuant to subsection 1 of section 285.530, RSMo, no contractor or subcontractor shall knowingly employ, hire for employment, or continue to employ an unauthorized alien to perform work within the state of Missouri (MHD Contract, section 3.9.5).	First Amendment to Ancillary Services Agreement (Dental-Exhibit H): Page 2 Ancillary Services Agreement (Dental): Page 29 Fifth Amendment to Service Agreement (March Vision Care Group, Inc.-Exhibit D): Page 5	Fully Met

	MTM Inc., Missouri Master Service Agreement: Page 63	
Findings: All the three contracts listed above for Dental, Vision, and MTM services comply with the criterion and state: "Vendor shall not knowingly employ, hire for employment, or continue to employ an unauthorized alien to perform work within the state of Missouri." **Required Actions:** None.		
3. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. At least the following items shall be included (MHD contract 3.9.6): i. A description of services to be provided or other activities performed. ii. The timeframes for paying in-network providers for covered services. iii. Provision(s) for release to the MCO of any information necessary for the MCO to perform any of its obligations under the contract including but not limited to compliance with all reporting requirements (for example, encounter data reporting requirements), timely payment requirements, and quality assessment requirements. iv. The provision available to a health care provider to challenge or appeal the failure of the MCO to cover a service. v. A provision that ensures that subcontractors accept payment from the MCO as payment in full (no balance billing) and not collect payment from members. vi. Provision(s) that prohibit any financial incentive arrangement to induce subcontractors to limit medically necessary services. A description of all financial incentive arrangements shall be included in the subcontract.	First Amendment to Ancillary Services Agreement (Dental-Exhibit H): Pages-2, 3, 4, 5 Ancillary Services Agreement (Dental): Pages-3, 5, 6, 9, 19, 24, 25, 26, 29, 30, 31, 54, 57 Fifth Amendment to Healthy Blue Service Agreement (March Vision Care Group, Inc.-Exhibit D): Pages-4, 5, 6, 7 March Vision Care Group, Inc., Service Agreement: Pages-23, 24 March Vision Care Group, Inc., Service Agreement (Delegated Claims Agreement): Page 8 MTM Inc., Missouri Master Service Agreement: Pages-28, 29, 35, 62, 63, 64, 65, 85 MTM Inc. Statement of Work (SOW): Pages-3, 11, 19, 23, 56	Partially Met

vii. Provisions that the MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient. viii. Provisions that subcontractors shall not conduct or participate in MCO enrollment, disenrollment, transfer, or opt-out activities. The subcontractors shall not influence a member's enrollment. ix. If a subcontract is with a federally qualified health center (FQHC) or rural health clinic (RHC) to provide services to members under a prepayment arrangement, a provision that the state agency shall reimburse the FQHC or RHC one hundred percent (100%) of its reasonable cost for covered services. x. All hospital subcontracts must require that the hospital subcontractor notify the MCO of births where the mother is a member. The subcontracts must specify which entity is responsible for notifying the Family Support Division of the birth. xi. For contracted services, the subcontractor shall follow the claim processing requirements set forth by RSMo 376.383 and 376.384, as amended. xii. Provisions that in the event of the subcontractor's insolvency or other cessation of operations, covered services to members shall continue through the period for which a capitation payment has been made to the MCO or until the member's discharge from an inpatient facility, whichever time is greater.		

xiii. MCO and its subcontractors shall establish reasonable timely filing requirements for claims to be filed by a provider for reimbursement. The subcontractor shall inform its provider network of the timely filing requirements. xiv. MCO shall agree and understand that consumer protection shall be integral to the MHD Managed Care Program. xv. Provision(s) that entitle each member to one free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records. xvi. Provisions requiring the subcontractor to screen its employees to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Act); have failed to renew license or certification registration; have revoked professional license or certification; or have been terminated by the state agency. xvii. Provisions requiring that subcontractors that are providers or benefit management organizations make disclosures to the MCO of full and complete information regarding ownership, financial transactions, and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with federal and state requirements, including Public Chapter 379 of the Acts		

of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1002. xviii. Provisions specifying that no services under the subcontract may be performed outside the United States. xix. The subcontracted providers will: • Submit the National Provider Identifier (NPI) on all encounter claim provider fields corresponding to those fields on a claim form where a provider NPI is required to be reported. • Implement a policy of, before providing a Medicaid service to a MHD adult member, requesting and inspecting the member's MHD identification card (or other documentation provided by the state agency demonstrating MHD eligibility) and MCO membership card; and • Report to the MCO any identified instance when the inspection discloses that the person seeking services is not a MO MHD Managed Care Program member.		

Findings: The Ancillary Services Agreement (Dental) fully complies with all the requirements listed under this section (B3) of the evaluation tool. B3-ix and x do not apply to this subcontract.

MTM Inc., Missouri Master Service Agreement complies with all the requirements of this section except for one weakness noted for xi (the SOW does not specify claims processing per RSMo 376.383 and 376.384). B3-vii, ix, x, xv are not applicable for this contract.

March Vision Care Group, Inc. has scored "Not Met" for these criteria-vii, ix, xii, xvii, xix (1st and 3rd bullet points). B3-x is out of the scope of this contract.

Primaris has assigned a combined score of Partially Met to this section.

Required Actions: Primaris recommends Healthy Blue update all their contracts with the requirements set under the MHD contract, section 3.9.6.

4. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's entity's contract obligations.	Ancillary Services Agreement (Dental): Pages-4, 6, 13 March Vision Care Group, Inc. Service Agreement: Page 8 MTM Inc., Missouri Master Service Agreement: Pages-35, 62	Fully Met
Findings: The ancillary Services Agreement for Dental states: "The contracted provider shall provide to and on behalf of and arrange for the provision to and on behalf of, Healthy Blue, the covered ancillary services and delegated administrative services set forth in the delegation addendum (collectively, the "services"). The contracted provider shall provide or arrange for the provision of the services in a diligent and professional manner, and in accordance with the terms and conditions of this agreement, laws, program requirements, and accreditation body standards. March Vision Care Group, Inc. Service Agreement states: "Notwithstanding any contrary interpretation of this agreement or any contracts between the provider and subcontracted providers, the provider acknowledges and agrees that all provisions of this agreement apply to the provider shall apply with equal force to subcontracted providers, unless clearly applicable only to the provider. Provider agrees that it is the provider's responsibility to require the subcontracted providers to fully comply with their obligations under this agreement, and that provider will take all steps necessary to enforce such requirements and to cause subcontracted providers to comply with and perform the terms and conditions of this Agreement." MTM Inc. states: "Notwithstanding Healthy Blue's approval of a subcontract arrangement, MTM Inc. shall remain primarily liable for the performance of all subcontracted obligations and MTM Inc. shall promptly pay for all Services, materials, equipment, and labor used by MTM Inc." **Required Actions:** None.		
5. 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 determines that the subcontractor has not performed satisfactorily.	Ancillary Services Agreement (Dental): Pages- 9, 11, 25 March Vision Care Group, Inc. Service Agreement: Page 7 MTM Inc., Missouri Master Service Agreement: Pages-17, 18	Fully Met

Findings: Ancillary Services Agreement (Dental) states: "In accordance with the terms of this agreement, government contracts (where applicable), laws, program requirements, and accreditation body standards, Healthy Blue shall monitor contracted provider's performance under this Agreement and may revoke the provision of any of the services by the contracted provider." March Vision Care Group, Inc. Service Agreement states: "Provider acknowledges and agrees that Healthy Blue may only delegate its activities and responsibilities under its contract(s) with the state and any applicable regulatory agency, to offer government program plans in a manner consistent with applicable laws, rules, and regulations, and that if any such activity or responsibility is delegated by Healthy Blue to provider, the activity or responsibility may be revoked if CMS, the state or Healthy Blue determine that the provider has not performed satisfactorily." MTM, Inc., Master Service Agreement states: "Healthy Blue, in its sole discretion, may suspend or terminate the entire agreement or any and all Statement Of Works (SOW) (i) immediately if MTM is in breach of security, confidentiality, general warranties or MTM's representations, warranties, and covenants), or (ii) upon thirty (30) days written notice and opportunity to cure in the event of a material breach by MTM if Vendor has not remedied such breach within thirty (30) days of its receipt of written Notice from Healthy Blue of such breach. Should MTM again materially breach the agreement in substantially the same manner as a prior material breach by MTM within one year of such prior material breach, Healthy Blue may terminate any or all SOWs or this entire Agreement upon no less than 10 business days written notice." During the interview, Healthy Blue reported the operational management oversight is on a monthly/quarterly basis. In the joint operation meeting, the shortfalls during an annual audit, vendor capitation reports, complaints, and quarterly performance data are discussed. A corrective action plan is initiated if the score is below 90% for compliance. **Required Actions:** None.		
C. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, agreeing that:		
1. The state, CMS, the Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of a subcontractor, or of the subcontractor's contractor, that pertain to any aspect of	First Amendment to Ancillary Services Agreement (Dental-Exhibit H): Page 5 Fifth Amendment to Service Agreement (March Vision Care Group, Inc.-Exhibit D): Page 7	Fully Met

services and activities performed, or determination of amounts payable under the MCO's contract with the state.	MTM Inc., Missouri Master Service Agreement: Page 65	
Findings: All the three contracts listed above for Dental, Vision and MTM services agreements state: "Contracted provider will cooperate with the Agency or the designee of any of these entities in any audit, evaluation, or inspection (from the beginning of this agreement until ten (10) years from the end date of this agreement or the last audit, whichever is later) of the contracted provider's or delegate's premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its activities under this Agreement, and to the Healthy Blue and the potential and enrolled Medicaid Members. Such audit, evaluations, or inspections may pertain to any aspect of services and activities performed, or determination of amounts payable under the program Contract." Per Healthy Blue's contracts, "Agency" shall mean a federal, state, or local agency, administration, board, or other governing body responsible for the governance or administration of a Program. With respect to the operation of the MHD Managed Care Program, as used herein, Agency also means the Missouri Department of Social Services and the MHD. **Required Actions:** None.		
2. The subcontractor will make available, for purposes of an audit, evaluation, or inspection (as listed above in section C1 of this evaluation tool) its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees.	First Amendment to Ancillary Services Agreement (Dental-Exhibit H): Page 5 Fifth Amendment to Service Agreement (March Vision Care Group, Inc.-Exhibit D): Page 7 MTM Inc., Missouri Master Service Agreement: Page 64, 65	Fully Met
Findings: All the three contracts listed above for Dental, Vision, and MTM services are compliant with this criterion. (Please see the notes as in section C1 of this evaluation tool.) **Required Actions:** None.		
3. The right to audit (as listed in section C1 of this evaluation tool) 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.	First Amendment to Ancillary Services Agreement (Dental-Exhibit H): Page 5 Fifth Amendment to Service Agreement (March Vision	Fully Met

	Care Group, Inc.-Exhibit D): Page 7 MTM Inc., Missouri Master Service Agreement: Page 64	
Findings: All the three contracts listed above for Dental, Vision, and MTM services are compliant with this criterion. (Please see the notes as in section C1 of this evaluation tool.) However, MTM Inc., Missouri Master Service Agreement, page 7-states records retention for 3 years; page 32 states 4 years, but Exhibit E (specific for MHD) states 10 years. **Required Actions:** Primaris recommends the duration of record retention should be per 42 CFR 438.3u at all places in the contract.		
4. 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.	Ancillary Services Agreement (Dental): Page 24, 28 Fifth Amendment to Service Agreement (March Vision Care Group, Inc.-Exhibit D): Page 6 MTM Inc., Missouri Master Service Agreement: Page 64	Fully Met
Findings: Ancillary Services Agreement (Dental) states the following at various places in the document: "The contracted provider's facilities and records shall be open to inspection by Healthy Blue and appropriate federal and state agencies, including without limitation, the state agency. The medical records, or copies thereof, shall be provided to Healthy Blue by the contracted provider, upon request, for transfer to subsequent subcontractors for review by the state agency. Upon Healthy Blue's or the state agency's request, the provider shall provide the state agency with immediate access for an on-site review of medical records." "During normal business hours (defined as 8:00 a.m. through 5:00 p.m., Central Time, Monday through Friday, except state designated holidays), the contracted provider shall allow duly authorized agents or representatives of the federal or state government access to contracted provider's premises to inspect, audit, monitor, or otherwise evaluate the performance of the contracted provider. The contracted provider shall cooperate fully in any state reviews or investigations and any subsequent legal action, and any corrective actions implemented by Healthy Blue in instances of fraud and abuse detected by the state Agency, or other authorized agencies or entities." Fifth Amendment to Service Agreement (March Vision Care Group, Inc.-Exhibit D) states: "If the Agency determines that, there is a reasonable possibility of fraud or similar risk, that entity may inspect evaluate or audit the vendor at any time." MTM Inc. Missouri Service Agreement (Exhibit E) also complies with this criterion.		

Required Actions: Primaris recommends Healthy Blue update the language in the Ancillary Services Agreement (Dental) to explicitly mention that inspection, evaluation, and audit by state/CMS/HHS Inspector General can be conducted "any time" in case of the possibility of fraud or similar risk.		
D. 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 by the MCO 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 MCO (MHD contract, section 3.9).	First Amendment to Ancillary Services Agreement (Dental-Exhibit H): Page 3 Fifth Amendment to Service Agreement (March Vision Care Group, Inc.-Exhibit D): Page 5 MTM Inc., Missouri Master Service Agreement (Exhibit E): Page 63	Fully Met
Findings: Fifth Amendment to Service Agreement with March Vision Care Group, Inc. states: "Without limiting Healthy Blue's rights under the indemnification provision within the agreement, the vendor will indemnify the state for any and all claims, damages, lawsuits, costs, judgments, expenses, and any other liabilities resulting from bodily injury to any person (including injury resulting in death) or damage to property that may arise out of or are related to vendor's performance under the program contract, providing such bodily injury or property damage is due to the negligence of the Vendor, its employees, agents, or subcontractors. The other two contracts, Dental and MTM services, are also compliant with this criterion. **Required Actions:** None.		
E. MCO disputes with other providers: All disputes between the MCO and any subcontractors shall be solely between such subcontractors and the MCO. The MCO shall indemnify, defend, save, and hold harmless the state of Missouri, the Department of Social Services and its officers, employees, and agents, and enrolled, managed 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	Ancillary Services Agreement (Dental): Page 28 March Vision Care Group, Inc. Service Agreement: Page 12	Partially Met

contract by the MCO, 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 MCO, its subcontractors, agents, providers, or employees (MHD contract, section 3.9.1).		

Findings: The Ancillary Services Agreement (dental) states: "All disputes between Healthy Blue and the contracted provider shall be solely between the contracted provider and Healthy Blue. The contracted provider shall and shall require its providers and subcontractors to, indemnify, defend, save, and hold harmless Healthy Blue, the state of Missouri, the Department of Social Services, and their respective officers, employees, and agents and members from any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of this agreement…"

The March Vision Care Group, Inc. Service Agreement does not mention indemnification of state in case of a dispute between Healthy Blue and the subcontracted providers. This agreement states: The parties hereby agree to indemnify and hold each other harmless, including any affiliates, officers, employees, and agents, against any loss, liability, damage, costs, and expenses (including any attorneys' fees) suffered or incurred by the other in connection with any (including any threatened or proposed) action, suit, proceeding, regulatory proceeding, demand, assessment, judgment arising out of or related to the indemnifying party's and/or the indemnifying party's agent's acts and/or omissions under the terms of this agreement.

Required Actions: Healthy Blue is recommended to update their agreement with the March Vision Care Group, Inc. to indemnify the state in case of a dispute between Healthy Blue and the subcontracted providers.

Compliance Score–Subcontractual Relationships and Delegation						
Total	Met	=	10	×2	=	20
	Partial Met	=	2	×1	=	2
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	22
Denominator	Total Sections	=	12	×2	=	24
Score %						91.66

Appendix E

Standard 5: 42 CFR 438.236 Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
A. MCO adopts practice guidelines that meet the following requirements (MHD contract, 2.18.5):		
1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	Healthy Blue Clinical Practice Guidelines (CPGs): Pages 1-21	Fully Met
Findings: A list of CPGs with their embedded links to the sources, submitted by Healthy Blue for 45 conditions/diseases shows that the CPGs are based on valid and reliable clinical evidence or a consensus of health care professionals. The recognized source(s) are American Psychiatric Association; National Institute of Mental Health; National Heart, Lung, and Blood Institute; Global Initiative for Asthma; Canadian Network for Mood and Anxiety Treatments; American Heart Association; American College of Cardiology Foundation; American Society of Hypertension; American College of Gastroenterology; National Kidney Foundation; American Academy of Family Physicians; Centers for Disease Control and Prevention; International Society of Nephrology; Global Initiative for Chronic Obstructive Lung Disease; United States Preventive Services Task Force; American College of Physicians; National Collaborating Centre for Mental Health (commissioned by the National Institute for Health & Clinical Excellence); American Diabetes Association; The Endocrine Society; National Council on Aging; American Heart Association Task Force on Practice Guidelines; Heart Failure Society of America; American Association of Cardiovascular and Pulmonary Rehabilitation; American Academy of Physician Assistants; Association of Black Cardiologists; American College of Preventive Medicine; American Pharmacists Association; American Society of Preventive Cardiology; National Lipid Association; Preventive Cardiovascular Nurses Association; American Geriatrics Society; The Obesity Society; American Psychiatric Association; Department of Veterans Affairs; Department of Defense-The Management of Posttraumatic Stress Disorder Work Group; American College of Rheumatology; College of Psychiatric & Neurologic Pharmacists; Suicide Prevention Resource Center; Agency for Healthcare Research and Quality; Substance Abuse and Mental Health Services Administration; American Association for the Study of Liver Diseases; Infectious Diseases Society of America; World Health Organization; HIV Medicine Association of the Infectious Diseases Society of America; American Academy of Pediatrics; American Academy of Neurology; Child Neurology Society; North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition; National Institute for Health and Care Excellence; National Institute of Health PubMed; National Alliance for Tobacco Cessation; U.S. Department of Health and Human Services; American College of Cardiology; American Congress of Obstetrics and Gynecology; Health Resources and Services Administration; Society for Maternal Fetal Health; and Dartmouth Medical School. **Required Actions:** None.		

2. Consider the needs of the enrollees.	Healthy Blue CPGs: Pages 1-21 <u>Post-site meeting submission</u> QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring: Page 1	Fully Met
Findings: Healthy Blue reviews, adopts, and revises CPGs relevant to the needs of their members to assist practitioners and enrollees in making decisions about acute and chronic medical care, including behavioral health care services; to ensure that Healthy Blue's perinatal and high-risk population management programs incorporate current, evidence-based CPGs from recognized sources; and to meet NCQA, regulatory and/or contractual requirements, as applicable for a Line of Business, specific accreditation or certification requirements. During the interview, Healthy Blue reported they identify the needs of the enrollees from various sources, e.g., care management and disease management services, Medical Advisory Committee, National guidelines, and current literature. **Required Actions:** None. Note: The policy submitted post-site meeting was revised during EQR 2021 and not during the review period (CY 2020). In the future, Healthy Blue is advised to proactively revise its policies to comply with the federal and state guidelines.		
3. Are adopted in consultation with network providers.	UMAC Minutes CPG (Sept 23, 2020) <u>Post-site meeting submission</u> QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring: Pages-2, 3	Fully Met
Findings: Healthy Blue stated that CPGs are adopted by the UMAC Committee that includes network providers. The CPGs use evidence-based research from recognized sources. If such guidelines are unavailable or inappropriate, board-certified practitioners from appropriate specialties are involved in developing clinical guidelines. Recommendations on new and revised guidelines are finalized and presented to the Quality Improvement Committee for their review and approval for use. After review, adoption, and approval by all governing committees, the Office of Medical Policy and Technology Assessment (OMPTA) guidelines coordinator:		

• Submits a request to have CPGs links or information posted and/or updated to each brand/plan's internet site and the clinical solutions intranet site. • Works with appropriate Accreditation or Communications team to update the provider newsletters, postcards, and/or manuals of the availability of the practice guidelines. • Gathers any feedback on the CPGs and refers back to the CPG/Preventive Health Guidelines (PHG) Workgroup for consideration. **Required Actions**: None.		
4. Are reviewed and updated periodically as appropriate.	UMAC Minutes CPG (Sept 23, 2020) Medicaid Provider Manual (on the website: page 64 of 157) <u>Post-site meeting submission</u> QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring: Page 2	Fully Met
Findings: The CPGs are updated at least biennially (every two years) or when changes are made to national guidelines. During the interview, Healthy Blue informed that the guidelines are updated annually. If there is anything significant, it is updated at any time. The internal group of medical directors provides feedback. **Required Actions:** Healthy Blue staffs' knowledge and their policy must be consistent.		
B. MCO disseminates the guidelines to all affected providers, and upon request, to enrollees and potential enrollees.	Medicaid Provider Manual (on the website: page 64 of 157) <u>Post-site meeting submission</u> QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring: Pages-3, 4	Fully Met
Findings: Information about the availability of the CPGs is included in the provider manual, provider newsletters, and bulletins, and through committees. The guidelines are also posted on Healthy Blue's websites. If Member requests, they are also able to view it on this public site. New or revised guidelines will be disseminated to all Medicaid practitioners/providers within 60 days of adoption and/or revision and adoption by the Healthy Blue's quality committee/Medical Advisory Committee (MAC), or sooner based		

on state-specific guidelines. Members or potential members who call customer service for information on CPGs will be directed to the appropriate location on the Healthy Blue website. A written copy of the guidelines is available upon request. **Required Actions:** Primaris recommends Healthy Blue inform its members about the availability of practice guidelines via member handbooks, newsletters, or mailers and how to request these documents.		
C. MCO shall ensure that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.	MO Inpatient IRR Report MO OP IRR Report <u>Post-site meeting submission</u> Inter-Rater Reliability Assessments: Pages-1, 2 QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring: Page 4	Fully Met
Findings: Performance against relevant guidelines is measured per NCQA standards and state contract requirements, as applicable. Healthy Blue stated that their doctors and nurses make decisions and go through Inter-Rater Reliability (IRR) tests to ensure decisions are consistent with guidelines. Appropriate mechanisms, such as the use of hypothetical Utilization Management (UM) test cases or the use of a sample of UM determination files using a National Committee for Quality Assurance-approved auditing method, are utilized to evaluate the consistency of application of criteria. The Inter-Rater Reliability assessment tools, comprised of validated scenarios/questions, are purchased from InterQual as available. Internal assessment tools may be developed by subject matter experts for other applicable clinical criteria and guidelines using the pertinent criteria. An IRR assessment is conducted annually by Corporate Health Care Management (HCM) UM Operations Department. IRR assessment is required for all associates (non-physician) who apply criteria to determine medical necessity, and who have successfully completed their 90 days probationary period. Physician IRR is administered by the Medical Policy and Tech Assessment department. Behavioral Health Medical Directors participate in BH IRR testing administered by an Enterprise Staff VP Medical Director. Upon completion of IRR testing, the Corporate UM Operations staff analyzes the data and forwards their report, along with any resulting recommendations, to the corporate executive HCM staff for review and GBD Medical Operations Committee for approval. The report is then distributed to Healthy Blue's HCM Leadership and applicable corporate departments.		

Required Actions: None.
Note: The policies submitted post-site meeting were revised during EQR 2021. In the future, Healthy Blue is advised to proactively revise its policies to comply with the federal and state guidelines.

Compliance Score–Practice Guidelines						
Total	Met	=	6	×2	=	12
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	12
Denominator	Total Sections	=	6	×2	=	12
Score %						100

Appendix F

Standard 6–42 CFR 430.242 Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
A. MCO maintains a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data.	GBD Management Information System (MIS): Pages-4, 5, 6 CareCompass-Information Flow Regulatory Compliance Reporting System: Context Diagram	Fully Met
Findings: Healthy Blue detailed its state-of-the-art systems infrastructure and high systems reliability. The systems hardware and software architecture permit the scalability of the technology platform to meet current and future capacity needs. Reliable, secure and easily accessible systems facilitate the delivery of quality care; provides a platform for utilizing data for better health outcomes; delivers the most efficient stewardship of taxpayer dollars in Medicaid service delivery; processes prompt payment to providers and helps in communicating with Healthy Blue members. One of the key components of MIS is the Core Service Platform (CSP). TriZetto's Facets serves as the primary component of Healthy Blue's Core Service Platform. Facets provide a high degree of automation and data capture with interfaces that optimize information exchanges with other key systems, documenting and preserving communications as evidence of member care and contacts. The system is fully configurable, with business rules that guide claims payments, authorization requirements, benefit limits, and reporting requirements. Other key components of Healthy Blue's MIS, including the Health Intech platform and data warehouses, are fully interoperable with the system to provide care coordination, online provider and member support solutions, encounter data submission, reporting, and analytics capabilities. **Required Actions:** None.		
B. MCO's health information system provides information on areas:		
1. Utilization.	GBD MIS: Page 11 Utilization Management (UM) Import Subsystem Guide UM Processing User Guide and Supplement	Fully Met

	UM Reference User Guide and Supplement	
Findings: The Health Intech care management platform utilizes data from several components of MIS to support Healthy Blue members, the service management efforts and serves as a system of record for member care coordination, and management information. Member utilization data, such as claims history, authorizations, immunization records, lab results, and care and disease management data, are readily available in an organized format, delivering a holistic picture of the individual's service utilization, care plan, and gaps in care. These systems provide the tools for care coordinators and providers to manage members' needs and to support the development, management, coordination, and communication of the individualized care plan. The Facets Utilization Management Import (UMI) is a batch-load process that easily facilitates the initial loading and subsequent maintenance of UM reviews (referrals and pre-authorizations) to the Facets database. Its purpose is to load referrals and pre-authorizations to the database for access to a member's history when entering new UM Reviews online in Facets, and process claims by matching to the UM Reviews that were batch loaded. **Required Actions:** None.		
2. Claims.	GBD MIS: Page 9 Claims Process-Flow Claims Process-Schematic Description Claims Processing User Guide	Fully Met
Findings: The claims processing system collects, edits, and adjudicates claims for services delivered to members. Healthy Blue assigns a unique number to each incoming claim and captures and maintains its receipt date. A series of edits (including the National Correct Coding Initiative (NCCI)) and business rules validate data on all incoming claims (paper and electronic formats). After initial editing, the system automatically adjudicates claims and performs a variety of automated checks that verify the presence of required prior authorizations, identify duplicates, confirm that services are covered and do not exceed benefit limitations, coordinate benefits with other insurers, and flag services requiring medical review and determination of medical necessity before payment. Healthy Blue pays claims approved for payment by check or electronic funds transfer based on provider preference. **Required Actions:** None.		

3. Grievances and appeals.	NextGen Grievance and Appeals (G & A)-Context Diagram	Partially Met
Findings: Healthy Blue has a submitted a flow chart depicting the process followed for Grievances and Appeal in their Information Systems but has not provided. However, Healthy Blue did not provide an explanation/description of their process as to how Healthy Blue's health information system provides information on the Grievances and Appeals. **Required Actions**: Healthy Blue develop a policy describing their process as to how Healthy Blue's health information system provides information on the Grievances and Appeals.		
4. Disenrollment for other than loss of Medicaid eligibility.	GBD MIS: Pages-7, 8 Enrollment Flow	Fully Met
Findings: Healthy Blue's Core Systems Platform maintains comprehensive demographic and eligibility information on each of its members. Healthy Blue receives and processes ANSI X12 834 files from the state's enrollment broker and add, terminate, or update member data accordingly. The Core Operations System maintains eligibility history by program/plan and date span to show a complete timeline of a member's participation. Comprehensive, timely, and accurate member data is critical for major operations functions, including claims processing, utilization management, and care management. Healthy Blue performs regularly scheduled transmissions of member data to their pharmacy, vision, and transportation subcontractors. Healthy Blue member enrollment processes maintain the integrity of member information used by the claims and finance subsystems, among others. **Required Actions**: None.		
C. Basic elements of health information systems.		
1. MCO should comply with Section 6504(a) of the Affordable Care Act, which requires claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation to meet the requirements of section 1903(r)(1)(F) of the Act. (Note: MCO is expected to report an expanded set of data elements for electronic transmission of claims data consistent with the Medicaid Statistical Information System (MSIS) to detect	GBD MIS: Page 9 Claims Process-Flow Claims Process-Schematic Description Claims Processing User Guide: Pages-20, 897	Partially Met

fraud and abuse necessary for program integrity, program oversight, and administration.)		
Findings: Facets is a premier claims management tool that offers a high degree of automation and data capture. Facets provide three options for claims management: claims adjudication claims pre-pricing and claims logging. Medical and hospital claims can be processed online or electronically. Facets' electronic commerce capabilities are designed to accept external claims. Electronic data interchange (EDI) is the electronic transmission of information between computers. Facets EDI, combined with Facets electronic adjudication, edits submitted claim data for accuracy. The Facets clinical editing product automatically edits claims and authorizations for unbundled procedures, Current Procedural Terminology (CPT)-4 surgical coding errors or invalid data relationships, potential fraud, patterns of utilization deviating from norms, and inappropriate diagnosis usage. It is fully integrated into the Facets Claims Processing and UM systems. Facets automatically edit medical claims and hospital claims (based on parameters) that are processed with its proprietary clinical claims editing software, with tens of thousands of clinical rules and recommendations. This allows Healthy Blue to identify billing problems and eliminate significant overpayment of claims, and consistently catch fraudulent, erroneous, or inconsistent billing practices, a significant factor in cost containment. Even though Healthy Blue has a documented evidence that their information system with claims management tool offers a high degree of automation and data capture, there is no documentation to ascertain its compliance with section 6504(a) of the Affordable Care Act and 1903(r)(1)(F) of the Act. These sections have a requirement to report an expanded set of data elements under the Medicaid Management Information System to detect fraud and abuse. The automated data system should meet the requirement for program integrity, program oversight, and administration. **Required Actions:** Primaris recommends Healthy Blue develop documentation or evidence to show that their claims processing system is capable of detecting fraud, waste, and abuse.		
2. Collects data on enrollee and provider characteristics as specified by MHD and on all services furnished to enrollees through an encounter data system or other methods specified by the MHD:		
i. Electronic Claims Management (ECM) Functionality: MCO have in place an electronic claims management (ECM)	GBD MIS: Page 9 Claims Process-Flow	Partially Met

capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.). As part of this ECM function, the MCO shall also provide online and phone-based capabilities to obtain claims processing status information and shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments (MHD contract, 2.26.3)	Claims Process-Schematic Description Claims Processing User Guide	
Findings: Healthy Blue's Management Information System is capable of receiving claims in electronic format via ANSI X12 837 files or paper via CMS 1500-UB04. They have an automated clearing house mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments. Healthy Blue pays claims approved for payment by check or electronic funds transfer based on the provider preference. Primaris reviewed the claims processing flow diagram, which shows that providers can submit their claims electronically, in paper format, or online. However, the phone-based capabilities to obtain claims processing status information is not presented. **Required Actions**: Primaris recommends Healthy Blue have phone-based capabilities to obtain claims processing status information and develop supporting policies for this requirement.		
ii. Adherence to Key Transaction Standards: MCO shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, and RSMo 376.383 and 376.384 (MHD contract 2.26.4).	Electronic Transaction Standard: Page 1 GBD MIS: Page 23	Partially Met

Findings: Healthy Blue shall conform to the following HIPAA-compliant standards for information exchange of administrative and financial healthcare transactions unless not supported by MHD.
• Batch transaction types
  ○ ASC X12N 834 Enrollment and Audit Transaction
  ○ ASC X12N 837I Institutional Claim/Encounter Transaction
  ○ ASC X12N 837P Professional Claim/Encounter Transaction
  ○ ASC X12N 837D Dental Claim/Encounter Transaction
  ○ NCPDP D.0 Pharmacy Claim/Encounter Transaction
• Online transaction types
  ○ ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
  ○ ASC X12N 276 Claims Status Inquiry
  ○ ASC X12N 277 Claims Status Response
  ○ ASC X12N 278/279 Utilization Review Inquiry/Response
  ○ NCPDP D.0 Pharmacy Claim/Encounter Transaction
 	
Healthy Blue currently supports data exchanges with a variety of entities, including state partners, enrollment brokers, partner (or alliance) organizations, subcontractors, providers, health information exchanges, and other supporting entities, conforming to HIPAA compliance standards, as well as state and federal standards for data management and information exchange. Healthy Blue maintains the systems, processes, tools, and strict security policies and procedures to secure and protect data, assuring the privacy of its members and providers. Security protocols address their responsibility to meet HIPAA, federal, and state standards, regulations, and requirements relating to the protection of electronically protected health information, including Title XIX of the Social Security Act, Medicaid Information Technology Architecture (MITA) – CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E) v2.0, NIST Special Publication SP800-53 R4 Security and Privacy Controls for Federal Information Systems and Organizations, and IRS 1075 rule.
 	
Healthy Blue has not addressed the federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. The requirements stated in RSMo 376.383 and 376.384 are also not addressed in the documents received by Primaris.
 	
Required Actions: Primaris recommends Healthy Blue develop documentation in support of compliance with the sections of the regulations stated herein.		

3. A mechanism to ensure that data received from providers are accurate and complete by: i. Verifying the accuracy and timeliness of reported data including data from network providers the MCO is	GBD MIS: Pages-10, 13, 15 Provider User Guide Provider Date Exchanges-Flow Anthem: Credentialing	Partially Met

compensating on the basis of capitation payments. ii. Screening the data for completeness, logic, and consistency. iii. Collecting data from providers in standardized formats to the extent feasible and appropriate including secure information exchanges and technologies utilized for state Medicaid quality improvement and care coordination efforts.		
Findings: Healthy Blue's Core Systems Platform maintains comprehensive information on their network providers, including demographic data that feeds the provider directory and the information that supports contracting and credentialing activities. As with the member data, provider data supports many other major operational functions, including claims processing and payment, care management, and quality management. Healthy Blue leverages its comprehensive information technology and data infrastructure to drive consistent, timely, evidence-based decision-making and high-quality member outcomes. Health Blue applies pre-cycle edits to confirm that the data files they submit are accurate and complete. Healthy Blue has not submitted policies and procedures to ascertain data received from providers are consistent and timely reported. **Required Actions**: Healthy Blue develop policies and procedures to verify the consistency, and timeliness of reported data including data from network providers Healthy Blue is compensating on the basis of capitation payments.		
4. Make all collected data available to the state and upon request to CMS.	GBD MIS: Pages-5, 15, 16 Encounters Flow Encounters Life Cycle	Fully Met
Findings: Healthy Blue is capable of receiving, processing, and reporting data to and from the state. Healthy Blue's report and data generation process varies based on the type of submission: • Reports include operational data from the current date and any additional data elements requested. Some reports may have additional narrative input to accompany the data. The business owner reviews the report and adds additional narrative as necessary, to provide an explanation or additional information. • A system job scheduler generates data, such as extracts for detailed provider information files. The process includes status, results, and error logs, monitored		

regularly to confirm correct job execution and consistent results, such as the accuracy of record count and transaction formats for encounters. Formal automated notification alerts the business owner that the data are ready for review. • Healthy Blue's process includes checkpoints to confirm that all plans, reports, and data extracts are accurate and meet requirements before submission to MHD. Healthy Blue logs the date for each submission, and their report tracking system automatically generates the due date for the next monthly, quarterly, or annual report. During the interview, Healthy Blue clarified that the reports will be submitted to CMS and other state agencies upon request. **Required Actions**: Primaris recommends Healthy Blue to revise its policy to include reports submitted to CMS and other state agencies if requested.		
5. Implement an Application Programming Interface (API) as specified in §431.60 as if such requirements applied directly to the MCO and include: All encounter data, including encounter data from any network providers the MCO is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors. (Note: Since this requirement was to be implemented by Jan 1, 2021, this is excluded from this year's EQR.)		Not Applicable (N/A)
Findings: N/A for EQR 2021. Per CMS letter dated August 14, 2020, due to the COVID-19 public health emergency, CMS is exercising enforcement discretion, and does not expect to enforce this requirement prior to July 1, 2021. **Required Actions**: Primaris will evaluate the requirements, both for patient access API and provider access API, in EQR 2022, as a follow-up item.		
D. Enrollee encounter data: MCO must provide for- i. Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.	GBD MIS: Page 10 MO HealthNet EDI Companion Guide: Page 19, 23 Encounters Flow Encounters Life Cycle-Flow	Fully Met

	Provider Data Exchanges-Flow	
Findings: The encounter process combines medical, behavioral health, pharmacy, dental, vision, and transportation encounter claims into a single dataset. MO HealthNet EDI Companion Guide submitted by Healthy Blue explains that at a minimum, the National Provider Identifier (NPI), participant (subscriber) number, and the first date of service are required to find a claim. If a provider is using one NPI for multiple MO HealthNet legacy provider numbers then there should be the provider's 10 digit taxonomy code (code designating the provider type, classification, and specialization). Healthy Blue reported that upon encounter file receipt, Strategic National Implementation Process (SNIP) edits are applied to each file, as well as unique provider-edits that may be required on a state-by-state basis. These edits can be applied upon file receipt, or later in the flow, as requested/directed by the state. **Required Actions**: None.		
ii. Submission of enrollee encounter data to the state at a frequency and level of detail to be specified by CMS and the state, based on program administration, oversight, and program integrity needs. MCO shall maintain at least a ninety-eight percent (98%) acceptance rate on encounters submissions on a monthly basis (MHD contact 2.26.5 c).	GBD MIS: Pages-10, 23	Partially Met
Findings: Healthy Blue's integrated encounter solution will produces and submits HIPAA 5010 ANSI X12 837 transactions in professional and institutional formats. Encounter files are built in accordance with state companion guides and payment rules. Healthy Blue transmits encounter files to the state's fiscal agent. Healthy Blue maintains the systems, processes, tools, and strict security policies and procedures to secure and protect data, assuring the privacy of its members and providers. Security protocols address Healthy Blue's responsibility to meet HIPAA, federal, and state standards, regulations, and requirements relating to the protection of electronically protected health information, including Title XIX of the Social Security Act, Medicaid Information Technology Architecture (MITA) – CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E) v2.0, NIST Special Publication SP800-53 R4 Security and Privacy Controls for Federal Information Systems and Organizations, and IRS 1075 rule. **Required Actions**: Healthy Blue develop a policy on frequency and acceptance rate of enrollee encounter data to the MHD.		

iii. Submission of all enrollee encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818.		Not Met
Findings: Healthy Blue has not submitted any documentation that meets the requirement of this section. **Required Actions**: Healthy Blue develop a policy on submission of all enrollee data including allowed and paid amount. Additionally, documentary evidence must be developed to demonstrate compliance with this requirement.		
iv. Encounters must be submitted within 30 days of the day the MCO pays the claim and must be received no later than two (2) years from the last date of service (MHD contract, 2.26.5h).		Not Met
Findings: Healthy Blue has not submitted any documentation that meets the requirement of this section. **Required Actions**: Healthy Blue develop a policy on the timeframe for submission of encounters to the MHD. Additionally, documentary evidence must be submitted to show that they have complied with this requirement.		
v. Specifications for submitting encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. As part of the 1996 HIPAA Title II Act-Administrative Simplification Standards 2009 Modifications, all HIPAA-covered entities are required to implement the Version 5010 transaction set (MHD contract, section 2.26.5e). (Note: NCPDP and ASCX12N 835 are not applicable for MCO under MHD.)	GBD MIS: Pages-5, 9, 10 HIPAA Transaction Standard Companion Guide (Based on ASC X12 Version 00510)	Fully Met
Findings: Healthy Blue's MIS is 5010 compliant and currently accepts data in the HIPAA standard X12 format. Additionally, Healthy Blue supports Health Level 7 (HL7) and several state-specific formats through a file transfer process. The claims processing system collects, edits, and adjudicates claims for services delivered to Healthy Blue members. Healthy Blue's MIS is capable of receiving claims in electronic format via ANSI X12 837 files or paper via CMS 1500-UB04. Healthy Blue's integrated encounter solution produces and submits HIPAA 5010 ANSI X12 837 transactions in professional and		

institutional formats, as well as National Council Prescription Drug Programs (NCPDP) formats. Encounter files are built in accordance with state companion guides and payment rules. Healthy Blue transmits encounter files to the state's fiscal agent. **Required Actions:** None.		
E. Information systems availability: The MCO shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to electronic claims management and self-service customer service functions are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the state agency and the MCO. The MCO shall ensure that, at a minimum, all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., Central Time. Unavailability caused by events outside of the MCO's span of control is outside of the scope of this requirement. In the event of a declared major failure or disaster, the MCO's core eligibility/enrollment and claims processing systems shall be back online within 72 hours of the failure's or disaster's occurrence (MHD 2.26.8).	GBD MIS: Page-6 Enterprise Business Continuity Program Guidance	Partially Met
Findings: Member and provider portals have public and secure self-service areas, and use industry-standard web services, as well as content management system technologies. These portals present a consolidated longitudinal view of a member's information, in an accessible and organized format. Healthy Blue website reports that member services are available from 8 a.m. to 5 p.m. Central Time, Monday through Friday. The Nurse Help Line is available 24 hours. Primaris noted that Healthy Blue's Enterprise Business Continuity Program Guidance does not address the contractual requirement in the event of a declared major failure or disaster: Healthy Blue's core eligibility/enrollment and claims processing systems shall be back online within 72 hours of the failure's or disaster's occurrence.		

Healthy Blue has not submitted documentation suggestive of compliance with the requirement that the critical member and provider Internet and/or telephone-based functions and information, including but not limited to critical provider Internet and/or telephone-based functions, electronic claims management are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week.

Required Actions: Primaris recommends Healthy Blue address these requirements, both in their policies and in practice, related to the availability of information systems during normal operations and in the event of a declared major failure or disaster.

Compliance Score–Health Information Systems						
Total	Met	=	7	×2	=	14
	Partial Met	=	7	×1	=	7
	Not Met	=	2	×0	=	0
Numerator	Score Obtained				=	21
Denominator	Total Sections	=	16	×2	=	32
Score %						65.62