Primaris
Healthcare Business Solutions

2021 External Quality Review

Compliance

home state health

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

MoHealth Net

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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. Home State Health is one of the three MCOs operating in Missouri. The MHD works closely with Home State Health 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 Home State Health to assess its compliance with the Code of Federal Regulations (42 CFR 438 and 42 CFR 457); the MHD Quality Improvement Strategy (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.)

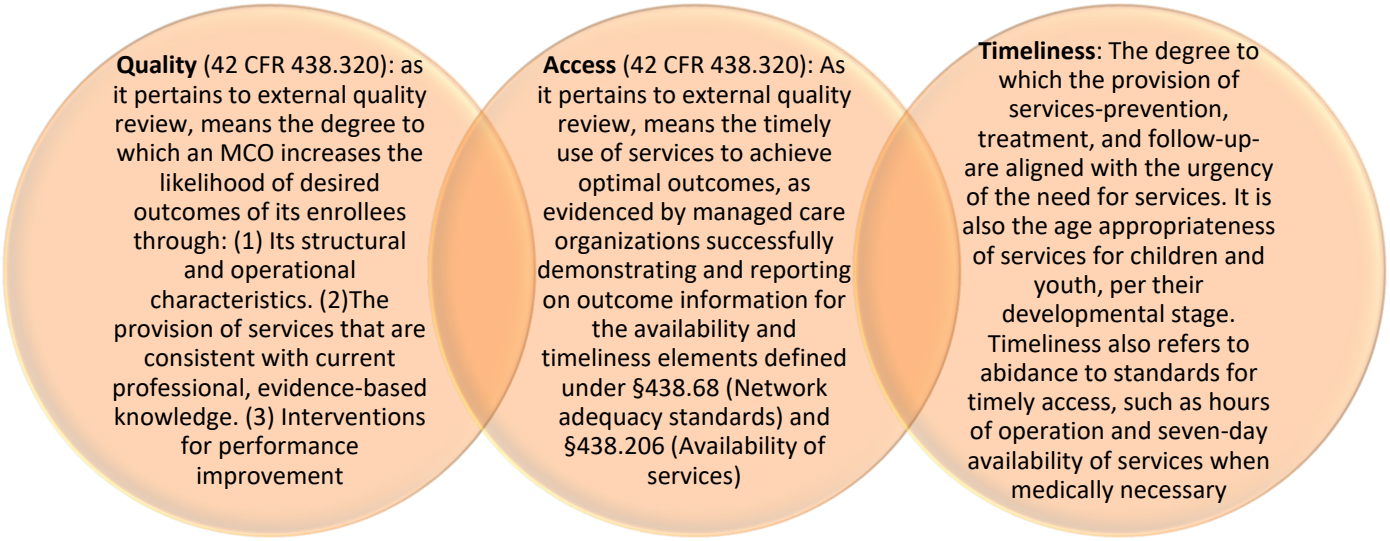

Figure 1. External Quality Review-A Federal Requirement

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 Home State Health 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 Home State Health'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

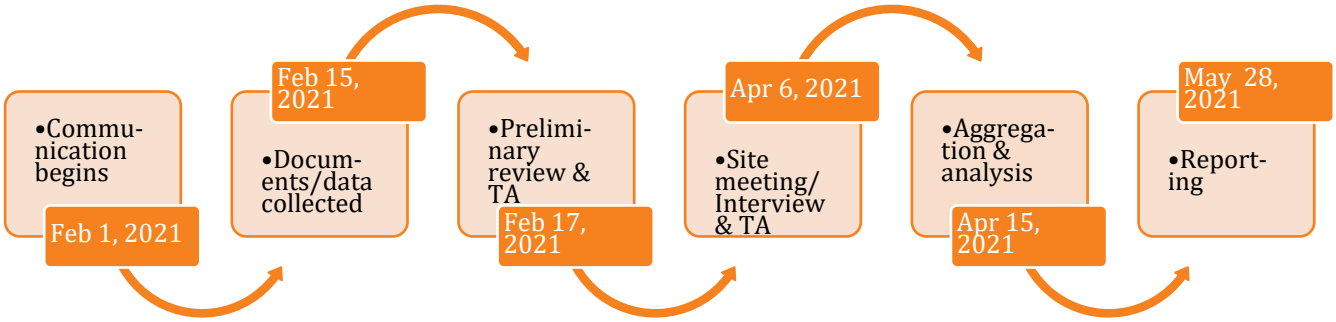

Figure 2. Compliance Evaluation Process

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 Home State Health pre-and post-site meeting. Before the preliminary review, the evaluation tools were sent to Home State

Health to set up the expectations for the documents' submission.

Documents' Submission: Home State Health 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 as follows:

- Disenrollment-Requirements and limitations: MO.ELIG.02 Disenrollment; and MO.ELIG.01 Eligibility Guidelines.
- Enrollee rights: MO.MBRS.25 Member Rights and Responsibilities; MO.COMP.PRVC.23 Individual Rights to Protect Health Information-Accounting; CC.COMP.PRVC.04 Assurances from Business Associates to Safeguard Protected Health Information; CC.COMP.PRVC.09 Disclosing and Requesting only the Minimum Amount of Protected Health Information Necessary; CC.COMP.PRVC.14 Managing Unauthorized Uses/Disclosures and Privacy Breaches; and Breach Notification Process; Get the Most from Your Coverage; Member Handbook; MO.MBRS.06 Member Handbook and ID Cards; Interpreter Requests; Language Interpreter Requests; MO.QI.02 QI Program Operations; Work Process-Marketing Member-Facing Material Submission to MHD; Work Process-Member Materials in Alternate Formats; Member Handbook Font Size Proof; Cancer Screening, Caring For Yourself In Times Of Change, NCQA Mailer; MO.PRVR.23 Provider Termination Policy; 2020 Member Newsletters; Handbook Timeline July; Provider Directory (MO-Central, Eastern, Southwest, West); MO.PRVR.19 Provider Directory Updates; Whole You; MO.COMP.01 MO HealthNet Managed Care Contract Administrative Requirements; and MO.HUMR.32 Anti-Harassment and Non-Discrimination.
- Emergency and post-stabilization services: MO.UM.12 Emergency Services; and Participating Provider Agreement.
- Subcontractual relationships and delegation: MO.COMP.21 Oversight of Delegated Vendor; Approval Request-TurningPoint; TurningPoint-Master Service Agreement and Addendum 8; MO.COMP.21 Oversight of Delegated Vendor; and MO.COMP.02 Audit Requirements for External Agencies.
- Practice guidelines: CP.CPC.01 Clinical Policy Committee; CP.CPC.03 Preventive Health and CPGs; MO.QI.01. Quality Program Description; MO.UM.01 Utilization Management Program; Provider Reference Manual: Asthma Care Management Playbook; Behavior Health CM Program Overview; NCQA Mailer 2021; Cancer Screening/Whole You; CC.UM.02.05 Interrater Reliability-Associates, Medical Directors, and Therapists; and InterQual Inter-Rater Reliability (IRR) Scorecard.
- Health information systems: MO.UM.01.03 Monitoring Utilization; MO.CLMS.01 Claims Administration and Systems; Six Steps of Adjudication-Claims; Appeals

Workflow; Prime Overview; Home Birth Disenrollment Process; CC.COMP.16 Fraud, Waste, and Abuse; Billing Manual; Provider Billing and Claims Filing Instructions; MO.COMP.09 State Required Deliverables; HIPAA X 12 Transaction Standards-Companion Guide; MO.ENC.01 Encounters Business Operations; Encounter Submission Policy and Procedures for Home State Health; HIPAA X 12 Transaction Standards-Companion Guide; 837 Companion Guide; Member Services/Provider Services Calls Hotline; and Business Continuity Plan.

Site Interviews

Primaris conducted a virtual meeting with Home State Health on April 6, 2021, due to travel restrictions to the onsite office in Missouri (Table 2) during the Covid-19 Pandemic.

Table 2: MCO Information	
MCO Name:	Home State Health
MCO Location:	11720 Borman Drive, St. Louis, MO, 63146
Audit Contact:	Patrick Mullins, Director Compliance
Contact Email:	PMULLINS@homestatehealth.com

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

Megan Barton, Senior Vice President, Population & Clinical Operations–Region 3
Bob Lampe, Vice President, Compliance
Anna Dmuchovsky, Vice President, Operations
Corina Bohrer, Senior Director, Utilization Management
Kelley Peters, Senior Director, Case Management
Mona Desmond, Senior Director, Community Relations
Annie Brozio, Senior Director, Provider Network
Patrick Mullins, Director, Compliance
Lucian Nevatt, Director, Quality
Geoff Seebeck, Director, Reporting and Business Analytics
Kim Bales, Director, Operations
Lupe Ponce, Senior Quality Management Specialist
Amy Roeske, Senior Manager, Credentialing & Provider Data Management
Jennifer Broughton, Business Analyst II

Compliance Ratings

The information provided by Home State Health 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. Home State Health must identify for each Not Met/Partially Met criteria the interventions it plans to implement to comply with the regulations, including how Home State Health measures the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. Home State Health must submit the CAP to the MHD within 10 days of its initiation. When deemed sufficient, the MHD, in consultation with Primaris, approves Home State Health's CAP. Within 90 days of approval of the CAP, Home State Health 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 Home State Health achieving a compliance score of 91.5% (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	16	2	0	34	**94.4**
438.100	457.1220	Enrollee rights	18	11	6	1	28	**77.8**
438.114	457.1228	Emergency and post-stabilization services	12	12	0	0	24	**100**
438.230	457.1233b	Subcontractual relationships and delegation	12	10	2	0	22	**91.7**
438.236	457.1233c	Practice guidelines	06	06	0	0	12	**100**
438.242	457.1233d	Health information systems	16	14	2	0	30	**93.8**
Total			**82**				**150**	**91.5**

Compliance Score % = $\frac{\text{Total Score X100}}{\text{Total Sections X 2 (points)}}$

3.2 Regulation I- Disenrollment: Requirements and Limitations

Home State Health was evaluated for 18 criteria under this regulation and received "Fully Met" for 16 and "Partially Met" for two of them, scoring 94.4% for compliance. Appendix A provides a detailed evaluation of this regulation.

3.2.1 Performance Strengths

Home State Health staff is knowledgeable about the Disenrollment requirements and limitations per the CFR and the MHD contract. Home State Health has policies and procedures 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. Home State Health shall cite at least one good cause before requesting the MHD to disenroll a member. Home State Health 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. Until the member is disenrolled by the Department of Social Services (DSS), Home State Health continues to provide all core benefits and services to the member.

At Home State Health, a member can request disenrollment without a cause during open enrollment; within 90 days of initial enrollment; when misses the annual disenrollment opportunity in case of temporary loss of Medicaid eligibility followed by auto-enrollment;

and when the MHD imposes intermediate sanctions. Home State Health acknowledged that a member could request for disenrollment for a just cause: if the transfer is a resolution to grievance or appeal; if the member's Primary Care Physician or specialist does not participate with Home State Health; due to cultural sensitivity issues; due to services not covered; for correction of an enrollment error made by the broker; bringing all family members under one MCO; and due to sanctions imposed by the MHD. Home State Health allows automatic and unlimited changes in the MCO choice as often as circumstances necessitate for the children in state care and custody and adoption subsidy. Home State Health 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, Home State Health does not assume financial responsibility for members of other MCOs hospitalized in an acute setting on the effective date of coverage with Home State Health until an appropriate acute inpatient hospital discharge.

A member is considered a Home State Health member until the receipt of the 834-enrollment files from Wipro (MHD's Fiscal agent), indicating disenrollment. Home State Health does not disenroll any member. The disenrollment shall be no later than the first day of the second month following the month in which the enrollee or Home State Health files the request. The disenrollment request is deemed approved if the state fails to make the disenrollment determination within the specified timeframes. On each business day, Home State Health process the daily HIPAA 834 enrollment files obtained from Wipro for any edits and disenrollment and loads them into its claims adjudication system. Home State Health processes daily 834 files and ensures that all discrepancies are resolved within five business days from the receipt of the 834 enrollment files.

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 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). Home State Health did not submit documentation on this requirement.
- Hospitalization at the time of enrollment or disenrollment (Appendix A: section J): Home State Health did not address that Fee-For-Service members will continue to remain in Fee-For-Service until an appropriate acute inpatient hospital discharge.

3.3 Regulation II- Enrollee Rights

Home State Health was evaluated for 18 criteria under this regulation and received "Fully Met" for 11, "Partially Met" for six, and "Not Met" for one of them, scoring 77.8% for compliance. Appendix B provides a detailed evaluation of this regulation.

3.3.1 Performance Strengths

Home State Health 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.

Home State Health provides notice about the termination of a contracted provider to each enrollee who receives the primary care by the terminated provider. The notice is provided 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later. Home State Health provides its members a member handbook and other written materials with information on how to access services within 10 business days of being notified by the MHD of their future enrollment with Home State Health. Home State Health maintains its web-based data (tool) for the provider directory current. Online data is continually available for Data Quality Checks. Home State Health shall have printed hard copies of the provider directory mailed within 48 hours of a member's request. The enrollees are informed via the member handbook that the information provided on Home State Health's website is mailed in a paper form without charge within five business days upon request. Home State Health notifies its members about the non-discrimination policy in the member handbook.

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: section B1). Home State Health does not have a documentation that meets all the requirements such as:
  - MCO will have written materials 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.
  - Auxiliary aids and services must be made available upon request of the potential enrollee or enrollee at no cost.
  - Language assistance will be provided to enrollees who do not speak English as their primary language and have a limited ability to read, write, speak, or

understand English.
    - MCO shall make available general services and materials, such as MCO's member handbook, in the 15 languages identified by the MHD that is spoken by individuals 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.
- On an annual basis, MCO shall review the member handbook, revise as necessary, and document that such review occurred (Appendix B: section B3ii). Even though Home State Health revises its member handbook annually, Home State Health's policy, MO.MBRS.06 Member Handbook and ID Cards miss three sections that must be included in the member handbook based on the MHD contract, section 2.12.16. These are as follows:
    - 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.
    - Information on how to access auxiliary aids and services, including additional information in alternative formats or languages.
    - Information on how and where members can access any benefits provided by the state, including how transportation is provided.
- The information about tort, product liability, or medical malpractice lawsuits is not stated in the policy or member handbook.
- 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). Home State Health fully complied with 40 of 48 items, partially complied with seven items, and deficient in one item.
- The provider directory (for all regions) submitted by Home State Health does not include all the information for all the 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).
  The policy, MO.PRVR.19 Provider Directory Updates, submitted post-site meeting does not include the information on website URL; accommodations for people with physical disabilities including offices, exam rooms, and equipment; American Sign Language or skilled medical interpreter availability at provider's office.
- 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 Home State Health's website in March 2021 and a provider directory was not found. Instead, Home State Health 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.

In reference to the evaluation tool (Appendix B), Primaris identified the following criterion that was "Not Met":
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). Home State Health did not submit a policy/procedure/documentary evidence of notifying their enrollees of any significant change in the member handbook. Home State Health submitted an email written to the state about the changes and requested approval.

3.4 Regulation III- Emergency and Post-stabilization Services

Home State Health was evaluated for 12 criteria under this regulation and received "Fully Met" for all of them, scoring 100% for compliance. Appendix C provides a detailed evaluation of this regulation.

3.4.1 Performance Strengths

Home State Health 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 Home State Health (in-network or out-of-network); have an agreement with the providers on payment for services; 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 Home State Health 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 are no areas of concern, so corrective action is not required. However, Primaris noted a weakness in the document, Participating Provider Agreement for Medicaid, that states medical records retention period of 7 years from the last date of the professional service provided. The duration for the record retention does not comply with the requirement stated in 42 CFR 438.230. The records should be retained for 10 years from

the last day of the contract period or from the date of completion of any audit, whichever is later.

3.5 Regulation IV- Subcontractual Relationships and Delegation

Home State Health 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

Home State Health submitted one subcontract, The TurningPoint Healthcare Solutions, for review. Primaris determined that Home State Health has acknowledged that their subcontractor will not knowingly employ, hire for employment, or continue to employ an unauthorized alien to perform work within the state of Missouri. The subcontractor agreed to perform the delegated activities and reporting responsibilities specified in the contractual obligations. The contract provides for revocation of the delegation of activities or obligations or specifies other remedies when the MHD or Home State Health determines that the subcontractors did not perform satisfactorily.

The MHD contract, section 3.9.6, requires Home State Health to specify the delegated activities or obligations, and related reporting responsibilities, in the subcontract or written agreement. The subcontract incorporates all the 19 items mandated by the MHD.

The subcontractor 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 Home State Health'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.

The subcontract includes appropriate provisions and contractual obligations to ensure that the MHD 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. All disputes between Home State Health and any subcontractor shall be solely between such subcontractor and Home State Health.

3.5.2 Corrective Action

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

Primaris noted weakness for a criterion that is assigned a score of "Fully Met."
The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Home State Health's policy, MO.COMP.21 Oversight of Delegated Vendor states that each health care provider maintains comprehensive medical records for a minimum of seven (7) years.

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

- The TurningPoint Healthcare Solutions subcontract does not incorporate the responsibility/accountability of Home State Health for all legal and financial responsibilities related to the execution of a subcontract. However, Home State Health has a policy that assumes Home State Health's responsibility for the actions of its subcontractors (Appendix D: section A).
- Home State Health did not submit a policy or procedure for establishing any new subcontracting arrangements or changing subcontractors, including seeking approval from the MHD before the subcontract was effective for the MHD Managed Care members (Appendix D: section B1). Primaris noted that the Addendum 8 of the Master Service Agreement between Home State Health (as applicable to the MHD Managed Care Contract) was effective August 21, 2019, and the MHD approved it later on August 30, 2019.

3.6 Regulation V- Practice Guidelines

Home State Health 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

Home State Health has practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals. Home State Health's corporate Clinical Policy Committee is responsible for researching evidence-based guidelines. These are adopted in consultation with the network providers and reviewed and updated annually and upon significant change to evidence-based guidelines. Practice Guidelines are based on the population's health needs and opportunities for improvement as identified through the Quality Assessment and Performance Improvement (QAPI) Program. New or updated guidelines are disseminated to providers via Home State Health's website as soon as possible. A listing of adopted clinical practice and preventive health guidelines is

maintained in the provider manual, with the links to the full guidelines or with a notation that the links and full guidelines are available on the website or a hard copy upon request. These are also provided to the enrollees and potential enrollees upon request.

Home State Health 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 process audits and Inter-Rater Reliability. At least annually, the chief medical director and vice president of medical management (VPMM) assess the consistency with which medical directors and other UM staff making clinical decisions apply UM criteria in decision-making.

3.6.2 Corrective Action

There are no areas of concern, so corrective action is not required. However, a weakness was noted when Primaris visited Home State Health's website on April 13, 2021. The immunization schedule uploaded on the website is an old version from May 2017.

3.7 Regulation VI- Health Information Systems

Home State Health was evaluated for 16 criteria under this regulation and received "Fully Met" for 14 and "Partially Met" for two of them, scoring 93.8% for compliance. Appendix F provides a detailed evaluation of this regulation.

3.7.1 Performance Strengths

Home State Health maintains a health information system (HIS) to collect, integrate, track, analyze, and report data. The HIS provides information on but is not limited to, Utilization, Claims, Grievance and Appeals, and Disenrollment other than loss of eligibility. Home State Health reports an expanded set of data elements for electronic transmission of claims data consistent with the Medicaid Statistical Information System to detect fraud and abuse necessary for program integrity, program oversight, and administration. Thus, Home State Health is compliant with section 6504a of the Affordable Care Act and section 1903(r)(1)(F) of the Act. Home State Health has in place an electronic claims management (ECM) capability that accepts and processes claims submitted electronically, except claims that require written documentation to justify the payment. Home State Health has a mechanism to ensure that data received from providers are accurate and complete. The encounters are submitted to the MHD within 30 days of payment of the claim. Home State Health maintains a ninety-eight percent (98%) acceptance rate on encounters submissions monthly. Sufficient enrollee encounter data is collected and maintained to identify the provider who delivers any item(s) or service(s) to enrollees. The provider identifiers required in the transactions are National Provider Identifiers (NPI), the billing provider primary identifier, the rendering provider, atypical provider. The Companion Guide

provides Centene (Home State Health's parent company) trading partners with guidelines for submitting 5010 version of 837 Professional and Institutional Claims.

Home State Health's toll-free member hotline is staffed with Member/Provider Services Representatives (MSRs/PSRs) during regular business hours (8:00 am to 5:00 pm Monday through Friday excluding state holidays). After-hour member/provider hotline calls are answered by an automated attendant that furnishes the member/provider with information on office hours and confirms member enrollment. The callers will have the option to talk with Nursewise, Home State Health's 24-hour nurse information and triage line, for prior authorizations and confirmation of covered services. In the event of a major disaster, Home State Health's claims processing system shall be back online within 36 hours of the failure's or disaster's occurrence. Medicaid customer services, including enrollment and claims information, will be back in less than four hours.

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":

- Adherence to Key Transaction Standards: MCO shall adhere 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). Primaris noted that Home State Health did not address signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19.
  Additionally, Primaris noted that RSMo 376.383 states, "if the health carrier has not paid the claimant on or before the forty-fifth processing day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month and a penalty in an amount equal to one percent of the claim per day." However, Home State Health's Provider Billing and Claims Filling Instructions state that Home State Health will process 99% of clean claims within 90 business days of receipt.
- 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). Home State Health has not submitted information that complies with the "allowed amount" requirement for the services by the providers.

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 Home State Health 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	Partially Met
438.100 (457.1220) Enrollee rights	Concerns identified	Not Met
438.114 (457.1228) Emergency and post-stabilization services	No Concerns identified	Fully 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	Partially Met

4.1 Improvement by Home State Health

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

Home State Health 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. Home State Health's Response to the Previous Year's Recommendations

Recommendations	Action by Home State Health	Comment by EQRO
1. Home State Health did not report on several measures provided by the Department of Health and Senior Services (DHSS): Adequacy of Prenatal Care, Early (1st Trimester) Prenatal Care, Low Birth Weight (LBW Less than 2500G), LBW (<2500G) Delivered in Level II/III Hospital, VLBW (<1500G) Delivered in Level III Hospital, Smoking During Pregnancy, Spacing Less Than 18 Months, Birth Mothers Less than 18 Years, Repeat Births to Teen Mothers (<20 Years), Prenatal WIC Participants. (Scored as Partially Met.)	QAPI 2020: Pages-85 to 95 QAPI 2020 includes analysis, evaluation of the DHSS measures for CY 2020 and Home State Health's actions for further improvement	Fully Met
2. Home State Heath reported rates for 16 HEDIS® measures for CY 2019 along with trends in the previous two years. However, Home State Health did not evaluate or analyze their performance measures. (Scored as Partially Met.)	QAPI 2020: Pages-77 to 82 QAPI 2020 includes analysis, evaluation of the HEDIS® measures for CY 2020 and Home State Health's actions for further improvement.	Fully Met
3. Home State Health should present analysis, evaluation, trends, and recommendations for the future year regarding information related to cultural competence and requests to change practitioners. (Scored as Partially Met.)	QAPI 2020: Pages-18, 19, 20, 104 QAPI included data for CY 2020, analysis, future actions planned by Home State Health for cultural competence, and requests to change Primary Care Practitioners (PCPs).	Partially Met QAPI 2020 did not include the trends related to cultural competence and change requests for PCPs.
4. Home State Health is required to provide analysis and evaluation of A summary of services provided to members with visual or hearing impairments or members who are physically disabled (e.g., Braille, large print, cassette, sign interpreters); an inventory of member materials available in alternative formats. (Scored as Partially Met.)	QAPI 2020: Pages- 22-27 Members identified as having visual impairment were 0.03%, and mobility impairment was 0.13%. In CY 2020, no requests were received for the Alternative Format request. A catalog of documents available in Spanish and Alternative	Partially Met QAPI Evaluation requires data from the review and previous years to show the trend, followed by evaluation, analysis, and future action for improvement.

	Formats is provided. There is no data for trends and analysis.	
5. Information Management: Analysis and evaluation of Information System in relation to membership and providers is not provided in QAPI. (Scored as Partially Met.)	QAPI 2020: Pages-17,143, 144 Description of Information System is provided. Data on membership is provided for CY 2020. There is no data to show the trend and analyses for members and providers.	Partially Met QAPI Evaluation requires data from the review and previous years to show the trend, followed by evaluation and analysis.
6. Integrated Care Management (CM) Services for Physical and Behavioral Health. Home State Health should evaluate and analyze data regarding integrated physical and behavioral health CM. (Scored Partially Met.)	QAPI 2020: Pages-136, 137, 138 Information about the pregnancy with substance use disorder (SUD) program, data on enrollment and outreach in CY 2019 and CY 2020 is presented. The decrease in 11.3% points in enrollment is attributed to the Covid-19 Pandemic.	Partially Met Home State Health should evaluate and analyze data regarding integrated physical and behavioral health CM of pregnancy/SUD program and other members who are not pregnant and are in CM program for behavioral and physical health issues.
7. Home State Health has not provided analysis and evaluation of Average Length of Stay (ALOS); Readmissions/1000 members; Emergency Department Utilization (EDU)/1000 members; Outpatient Visits (OPV)/1000 members; Inter-Rater Reliability; Timeliness of Prior Authorization/Certification Decision Making. (Scored as Partially Met.)	QAPI 2020: Pages-157, 158, 159, 162, 163 ALOS, EDU/OPV measures have a data comparison and some analysis; other measures are reported for CY 2020 without data comparison and analysis.	Partially Met QAPI Evaluation must include data trends, evaluation, and analysis to determine the cause and actions that Home State Health will take towards improvement.
8. Home State Health should submit an evaluation and analysis of provider profiling regarding utilization of services and outcomes for CY 2019. (Scored as Partially Met.)	QAPI 2020: Pages-164 Data on utilization of services and spend rates, comparison with data from the previous year, analysis, and their plan to continue to evaluate and	Fully Met

	access utilization to identify engagement and network accessibility is provided.	

5.0 RECOMMENDATIONS

5.1 Home State Health

Primaris recommends the following based on the deficiencies and weaknesses noted in compliance with the regulations. Home State Health 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.
Home State Health should develop policies and procedures for all the regulations covered for the compliance review proactively.

Disenrollment: Requirements and Limitations

- Primaris recommends that Home State Health update its policy, MO.ELIG.02 Disenrollment, and implement the member's right to request disenrollment if Home State Health does not cover services the member seeks because of moral or religious objections.
- Home State Health should specify in their policy, MO.ELIG.01 Eligibility Guidelines that Fee-For-Service members will continue to remain in Fee-For-Service until an appropriate acute inpatient hospital discharge.

Enrollee Rights

- During the interview, Home State Health stated that they do not monitor whether their providers explain various treatment options to the members. Primaris suggests Home State Health educate their providers on explaining the provision in the CFR about providing treatment options to their members. Additionally, Home State Health can conduct member surveys internally to seek information from the members regarding various treatment options offered by the treating doctor.
- Home State Health must have a policy based on 42 CFR 438.10 for disseminating member information. There is no requirement for taglines to be in font size 18, per CFR effective December 14, 2020. Home State Health should update their policy to reflect this change after discussing with the MHD for amending their contract.
- Home State Health update their policy, MO.MBRS.06 Member Handbook and ID Cards based on the MHD contract section 2.12.16.
- Home State Health should have a policy/procedure of notifying their enrollees of any significant change in the member handbook at least 30 days before the intended effective date of the change. Supporting evidence (mail letters, newsletters) should be submitted.

- Home State Health is recommended to update its member handbook to meet all the 48 items listed in the MHD contract, section 2.12.16, even though the MHD provides a template.
- Home State Health is recommended to update their policy, MO.PRVR.19 Provider Directory Updates, to include all the requirements about their network providers listed under this section of the evaluation tool. The provider directory (PDF version) submitted to Primaris should be updated to consistently reflect all the criteria for every provider and hospital in the network per the 42 CFR 438.10h and MHD contract, section 2.12.17. Home State Health should educate its providers about the contractual requirement for submitting their information to Home State Health.
- Home State Health is recommended to 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.

Emergency and Post-stabilization Services

- Home State Health is recommended to update their Participating Provider Agreement for Medicaid with medical records retention to 10 years from the last date of the contract period or from the date of completion of any audit, whichever is later (ref. 42 CFR 438.230).

Suggestions

- During the interview, Home State Health informed Primaris that their Medicaid and CHIP enrollees utilize 61% 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,[1] is a useful resource for decreasing ER utilization. Additionally, Primaris suggests other resources and methods referenced below that Home State Health 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.[2]
  - 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:

[1] https://aspe.hhs.gov/system/files/pdf/265086/ED-report-to-Congress.pdf
[2] https://carenethealthcare.com/how_to_improve_health_plan_er_diversion_strategy/

Lifestyle/wellness coaching (e.g., tobacco cessation, weight management); chronic condition coaching; acute medical case management; and behavioral health coaching.[3]

- 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. Home State Health responded they do not measure the average wait time. They have not received any complaints from the members. Primaris recommends that Home State Health contacts the members receiving emergency services and captures the wait time information. This data can be analyzed and compared with the national average wait time for providing inputs to the providers to improve emergency services[4].

Subcontractual Relationships and Delegation

- Home State Health include a language regarding "legal and financial aspects" of their responsibility/accountability in their policy explicitly. Also, Home State Health must incorporate it in the subcontract with TurningPoint Healthcare Solutions and all other subcontracted vendors.
- Home State Health have a policy/procedure regarding establishing new subcontracting arrangements or changing subcontractors. The MHD's approval is required before any subcontract is effective.
- Home State Health update their policy, MO.COMP.21 Oversight of Delegated Vendor, to require its providers to maintain the records for a minimum of 10 years duration from the final date of the contract period or from the date of completion of any audit, whichever is later.

Practice Guidelines

- Home State Health update the immunization schedule posted on their website with the most current version.
- Home State Health follow what it has stated in its policy regarding informing its members about the practice guidelines. The information about practice guidelines and the members' right to request these may be disseminated via member handbook, newsletters, mailers, website, or other ways available at Home State Health. Currently, the care managers at Home State Health inform the members enrolled in the care management program about the availability of these guidelines.

[3] https://www.bluechoicesc.com/great-expectations/ERCG
[4] https://www.cdc.gov/nchs/about/factsheets/factsheet_nhcs.htm

Health Information Systems

- Home State Health must address signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. Also, Primaris suggests Home State Health align its claims processing deadlines per RSMo 376.383.
- Submit information on the "allowed amount" in the encounter data submitted to the MHD and Primaris for evaluation.
- Home State Health 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.

5.2 MHD

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

- Incorporate in the MHD contract with Home State Health 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 Home State Health on ways to increase the significance of the EQR.
- Include Primaris in quality-related meetings with Home State Health and include EQR as a standing agenda item.
- Emphasize that Home State Health focuses 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 only relying on 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 Home State Health in meeting the 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 B3v of the evaluation tool (Appendix B). This section is related to the member handbook in

the context of information on the Grievance and Appeals. Home State Health was required to address "the specific regulations that support or the change in Federal or State law that requires the action." Home State Health did not handle 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.	MO.ELIG.02 Disenrollment: Page 2	Fully Met
Findings: Home State Health's policy, MO.ELIG.02 Disenrollment, complies with all the elements listed above in section A of this evaluation tool. **Required Actions:** None.		
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.	MO.ELIG.02 Disenrollment: Page 2	Fully Met

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.		
Findings: Home State Health's policy, MO.ELIG.02 Disenrollment, complies with all the conditions listed in this section (B) of the evaluation tool. The policy states: "Until the member is disenrolled by the Department of Social Services (DSS), Home State Health shall continue to be responsible for the provision of all core benefits and services to the member. **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).	MO.ELIG.02 Disenrollment: Page 2	Fully Met
Findings: Home State Health's policy, MO.ELIG.02 Disenrollment, complies with the requirement stated in this section (C1) 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).	MO.ELIG.02 Disenrollment: Page 2	Fully Met
Findings: Home State Health shall cite at least one good cause before requesting that the state agency disenroll that member, per their policy: MO.ELIG.02 Disenrollment. **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).	MO.ELIG.02 Disenrollment: Page 2	Fully Met
Findings: Home State Health's policy, MO.ELIG.02 Disenrollment, complies with the requirement stated in this section (C3) 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).	MO.ELIG.02 Disenrollment: Page 2	Fully Met
Findings: Home State Health's policy, MO.ELIG.02 Disenrollment, complies with the requirement stated in this section (C4) 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).	MO.ELIG.02 Disenrollment: Page 3	Fully Met

Findings: Home State Health's policy, MO.ELIG.02 Disenrollment, complies with the requirement stated in this section (C5) 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).	Post-site meeting revision MO.ELIG.02 Disenrollment:	Fully Met
Findings: Home State Health acknowledges if they recommend disenrollment or transfer for reasons other than those stated in the MHD contract, the MHD shall consider the Home State Health to have breached the provisions and requirements of the contract and may be subject to sanctions as described in their MHD Managed Care contract. **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	MO.ELIG.02 Disenrollment: Pages-1, 2	Fully Met

requirement under sections 1903(m) or 1932 of the Act.).		
Findings: A member is allowed to request disenrollment when the state imposes sanctions on Home State Health for non-performance of the contract requirements. Home State Health is compliant with all the reasons listed under this section of the evaluation tool, for their members' requests for disenrollment. **Required Actions:** None.		
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.	MO.ELIG.02 Disenrollment: Pages-1, 2	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 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: Home State Health's policy complies with all but one requirement (point 6) for the member disenrollment listed under this section of the evaluation tool. **Required Actions:** Primaris recommends Home State Health document and implement the member's right to request for disenrollment if Home State Health 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).	MO.ELIG.02 Disenrollment: Page 2	Fully Met
Findings: Home State Health's policy, MO.ELIG.02 Disenrollment, states: "Children in COA 4 will be allowed automatic and unlimited changes in health plan choice as often as circumstances necessitate." **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).	MO.ELIG.02 Disenrollment: Page 3 MO.ELIG.01 Eligibility Guidelines: Pages-3, 4	Fully Met
Findings: Home State Health's policy, MO.ELIG.02 Disenrollment, states a member is considered to be a Home State Health member until the receipt of the 834-enrollment files from Wipro, indicating disenrollment. Home State Health will not disenroll any member. Home State Health's policy, MO.ELIG.02 Disenrollment, states that the disenrollment shall be no later than the first day of the second month following the month in which the enrollee or the health plan files the request. The disenrollment request is deemed approved if the state fails to make the disenrollment determination within the specified timeframes. Home State Health has a written policy and procedure for complying with state agency disenrollment orders. Home State Health utilizes the process with the MHD and Wipro for the management in the electronic transmission and receipt of the 834 enrollment files. On each business day, Home State Health process the daily HIPAA 834 enrollment files obtained from Wipro for any edits and disenrollment and loads into their claims adjudication system. Home State Health processes daily 834 files and ensures all discrepancies are resolved within five business days from the receipt of the 834 enrollment files. **Required Actions:** None.		
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	MO.ELIG.01 Eligibility Guidelines: Pages-1, 2 MO.ELIG.02 Disenrollment: Page 3	Fully Met

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 of receipt and shall notify the state agency of any discrepancies.		
Findings: Home State Health's policy, MO.ELIG.01 Eligibility Guidelines, describes the procedure Home State Health will utilize with the DSS, MHD, and Wipro, for the management in the electronic transmission and receipt of the 834 enrollment files. On each business day, Home State Health will process the daily 834 enrollment files obtain from Wipro for any adds, changes, and disenrollment as provided on the file and load in Home State Health's claims adjudication system. Home State Health will process the daily 834 files and ensure that all discrepancies are resolved within five business days from the receipt of the 834 Enrollment file. Home State Health's policy, MO.ELIG.02 Disenrollment, states: "Home State Health will reconcile membership on the weekly 834 enrollment file against Home State Health's internal records and notify the state agency of any discrepancies within 30 business days of receipt of the weekly 834 files and notify the state agency of any discrepancies utilizing an agreed-upon procedure." **Required Actions:** None.		
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.	MO.ELIG.01 Eligibility Guidelines: Page 4	Partially Met

Findings: Newborns of Home State Health members will be enrolled in Home State Health unless the mother selects another MCO. Newborns will receive all covered services required to be provided to each member as of midnight on the newborn's date of birth passed on the 834-enrollment file and shall remain until the member is disenrolled from Home State Health. Members hospitalized at the time of enrollment will remain with the current MCO until after the member's discharge date and shall remain until the member is disenrolled. DSS will manage the member's hospitalization and will send an end date via the 834 after the member is discharged. **Required Actions:** Home State Health should specify in their policy Fee-For-Service members will continue to remain in Fee-For-Service until an appropriate acute inpatient hospital discharge.		
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.	MO.ELIG.01 Eligibility Guidelines: Page 4	Fully Met
Findings: When a participant is an inpatient at the time of enrollment with an MCO or at the time of transfer to a different MCO, enrollment with the MCO will be extended until the day of hospital discharge and the effective enrollment date with the new MCO will be delayed until the day following discharge from the hospital. **Required Actions:** Home State Health should specify at all places in their policy whether they are referencing to Home State Health or another MCO.		
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.	MO.ELIG.01 Eligibility Guidelines: Page 4	Fully Met
Findings: When a participant is an inpatient at the time of enrollment with an MCO or at the time of transfer to a different MCO, enrollment with the first MCO will be extended until the day of hospital discharge. The effective enrollment date with the new MCO will be delayed until the day following discharge from the hospital. When a participant is an inpatient at the time of disenrollment from an MCO and the disenrollment is due to the loss of MHD Fee-For-Service eligibility, MHD Managed Care eligibility, or SSI opt-out, enrollment is not extended until the day of hospital discharge. **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.	MO.ELIG.01 Eligibility Guidelines: Page 5	Fully Met
Findings: Home State Health's policy, MO.ELIG.01 Eligibility Guidelines, is compliant with the requirement of this section (J4) 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. 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 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	MO.ELIG.02 Disenrollment: Page 1	Fully Met

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: Home State Health's policy, MO.ELIG.02 Disenrollment, acknowledges MHD's criteria for disenrollment of members. During the interview, Home State Health informed Primaris that MHD does not require members to go through their process of Grievance and Appeals before requesting disenrollment. **Required Actions:** None.		

Compliance Score– Disenrollment: Requirements and Limitations						
Total	Met	=	16	×2	=	32
	Partial Met	=	2	×1	=	2
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	34
Denominator	Total Sections	=	18	×2	=	36
Score%						94.44%

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 the 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.	MO.MBRS.25 Member Rights and Responsibilities: Pages-1, 2, 3 MO.COMP.PRVC.23 Individual Rights to Protect Health Information-Accounting: Pages-1 to 6 CC.COMP.PRVC.04 Assurances from Business Associates to Safeguard Protected Health Information: Pages-1 to 4 CC.COMP.PRVC.09 Disclosing and Requesting only the Minimum Amount of Protected Health Information Necessary: Page 1 CC.COMP.PRVC.14 Managing Unauthorized Uses/Disclosures and Privacy Breaches; and	Fully Met

	Breach Notification Process: Pages-1 to 7 Get the Most from Your Coverage-Mailer Member Handbook: Page 50	
Findings: Home State Health's policy, MO.MBRS.25 Member Rights and Responsibilities, advise their members of their rights and responsibilities and how they will be protected per the CMS regulations, state regulations, and National Committee for Quality Assurance (NCQA) guidelines. Home State Health representatives treat all members with dignity and respect, acknowledging their rights. Home State Health has policies that define the method by which Home State Health shall assure the privacy and security of protected health information (PHI) when disclosing PHI to its business associates. Home State Health will document satisfactory assurances of compliance on the part of the business associates with the policies and procedures by either executing a business associate agreement with each of its business associates or amending the services contracts between Home State Health and each of its business associates to include business associate provisions, which establish the permitted and required uses and disclosures of PHI. The business associate agreement or business associate provisions will authorize Home State Health to terminate the services contract between Home State Health and the business associate if Home State Health determines that the business associate has violated a material term of the business associate agreement or the business associate provisions. Home State Health will follow proper procedures to ensure only the minimum amount of a member's PHI necessary to accomplish the specific purpose of a use or disclosure is used or disclosed. Home State Health will request only the minimum amount of a member's PHI necessary to accomplish the specific purpose of the request. Home State Health will allow a member to obtain an accounting of instances when their PHI has been disclosed except for the purpose per 45 CFR Part 164. During the interview, Home State Health stated they inform the providers about enrollee rights via provider manual, provider contract, orientation sessions, annual training for nondiscriminatory and culturally behavior towards enrollees. Home State Health tracks member complaints and care managers monitor the medical records for issues. The special investigation unit (SIU) monitors the medical records of providers when there is a suspicion or a concern via data analytics. **Required Actions:** None.		
2. Receive information on available treatment options. Each member is guaranteed the right to receive information on available treatment	MO.MBRS.25 Member Rights and Responsibilities: Page 3 Member Handbook: Page 50	Fully Met

options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.		
Findings: Home State Health's policy, MO.MBRS.25 Member Rights and Responsibilities, states Home State Health members will receive information about their health care and treatment options. This information is also provided in the member handbook. During the interview, Home State Health reported they do not monitor the treatment options presented to members. However, the providers are given the guidelines and the Utilization Management staff conducts the concurrent reviews when a member is hospitalized. Upon receiving a request for prior authorizations, Home State Health works with the providers to review alternative treatment options. **Required Actions:** None. However, Primaris suggests Home State Health educate their providers regarding the CFR about providing treatment options to their members. Additionally, Home State Health can conduct member surveys internally to seek information from the members regarding various treatment options provided to the member by the doctor.		
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.	MO.MBRS.25 Member Rights and Responsibilities: Page 3 Member Handbook: Page 50	Fully Met
Findings: Home State Health's policy, MO.MBRS.25 Member Rights and Responsibilities, states Home State Health members have a right to participate in decision-making about their health care. This information is also provided in the member handbook. During the interview, Home State Health reported the care management program managers call the members to discuss options, member needs, expectations, encourage members to tell their story. If needed, the care managers would communicate to the providers about member's requirements. **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.	MO.MBRS.25 Member Rights and Responsibilities: Page 3 Member Handbook: Page 51	Fully Met
Findings: Home State Health's policy, MO.MBRS.25 Member Rights and Responsibilities, states, " the members will be free of restraint or seclusion from a provider who wants to make a member do something the member should not do; punish a member; get back at		

the member, or make things easier for him or her (provider)." This is also explained in the member handbook. **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).	MO.MBRS.25 Member Rights and Responsibilities: Page 3 Get the Most from Your Coverage-Mailer Member Handbook: Page 51	Fully Met
Findings: Home State Health's policy, MO.MBRS.25 Member Rights and Responsibilities, states their members have the right to receive one copy of their medical records once a year at no cost to them. This is also explained in the member handbook and the mailers sent to the Home State Health members. **Required Actions:** None.		
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.	MO.MBRS.25 Member Rights and Responsibilities: Page 3 Member Handbook: Page 51	Fully Met
Findings: Home State Health's policy and member handbook states Home State Health members will be free to exercise all the above-stated rights (as listed under section A:1 to 6 of this evaluation tool) without any retaliation. This information is also provided in the member handbook. **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.	MO.MBRS.06 Member Handbook and ID Cards: Page 8 Interpreter Requests: Pages-1 to 5 Language Interpreter Requests: MO-Voiance	Partially Met

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 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	MO.QI.02 QI Program Operations: Page 3 <u>Post-site meeting submissions</u> Work Process-Marketing Member-Facing Material Submission to MHD: Pages-5,6 Work Process-Member Materials in Alternate Formats: Page 1 Member Handbook Font Size Proof Mailers-Cancer Screening, Caring For Yourself In Times Of Change, NCQA Mailer	

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: Various documents/mailers submitted by Home State Health post-site meeting comply with a few subsections listed under B1 of this evaluation tool to some extent namely, (i), (iii), (vii), (viii). Home State Health does not have a policy that meets the requirement of all criteria listed under the B1 section. **Required Actions:** Home State Health must have a policy based on 42 CFR 438.10 for disseminating member information. There is no requirement for taglines to be in font size 18, per CFR effective Dec 14, 2020. Home State Health should update their policy to reflect this change after a discussion with the MHD for amending their contract.		
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.	MO.PRVR.23 Provider Termination Policy: Page 1	Fully Met
Findings: Notice to the member regarding provider termination shall be mailed 30 calendar days prior to the effective date of the termination. If a provider fails to provide Home State Health with notice prior to the effective date of termination, Home State Health will provide notice to affected members within 15 calendar days of receipt of notification.		

Required Actions: None.		
3. Enrollee/Member handbook. i. MCO shall provide a member handbook and other written materials with information on how to access services, to all members within 10 business days of being notified of their future enrollment with the MCO. Information will be considered to be provided if the MCO: • Mails a printed copy of the information to the 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.	MO.MBRS.06 Member Handbook and ID Cards: Page 1 2020 Member Newsletters Get the Most from Your Coverage-Mailer	Fully Met
Findings: Home State Health shall mail a member handbook to new member's mailing address as part of the "New Member Packet" to all members within 10 business days of being notified of their future enrollment with Home State Health. Members may also request to have information emailed to them by contacting Members Services. Home State Health informs its members about the member handbook, and services via newsletters, and mailers. Home State Health reported they can email documents that do not contain PII or PHI to members upon member request. **Required Actions:** None.		

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.	MO.MBRS.06 Member Handbook and ID Cards: Page 8 Post-site meeting submission Member Handbook Documented Revisions	Partially Met
Findings: Home State Health submits the member handbook to the state agency for approval prior to distribution to members. Home State Health modifies the member handbook language if ordered by the state agency to comply with the requirements. On an annual basis, Home State Health shall review the member handbook, revise as necessary, and document that such review occurred. Home State Health reported the member handbook was reviewed on 6.16.20 with no changes identified. Home State Health submitted a log of annual revisions made to their member handbook and documented the change along with the MHD's approval dates. Primaris noted a few revisions were made in CY 2020. Home State Health's policy, MO.MBRS.06 Member Handbook and ID Cards, misses three sections that must be included in the member handbook based on MHD contract, section, 2.12.16. These are as follows: • 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. • Information on how to access auxiliary aids and services, including additional information in alternative formats or languages. • Information on how and where members can access any benefits provided by the state, including how transportation is provided. Additionally, a statement regarding any member who 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 the MCO, should be amended to include information about tort, product liability, or medical malpractice lawsuits. **Required Actions:** Primaris recommends Home State Health to update their policy, MO.MBRS.06 Member Handbook and ID Cards based on the MHD contract section 2.12.16.		
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).	Post-site meeting submission Handbook Timeline July	Not Met

Findings: Home State Health did not submit a policy/procedure/documentary evidence of notifying their enrollees of any significant change in the member handbook. During the interview Home State Health reported sending yearly postcard reminders to the members directing them to the website, newsletters, or mailing a letter. Home State Health submitted an email written to the MHD about the changes and requesting approval. In June 2020 the following changes were made to the handbook: Removal of provider locations and addition of the following verbiage: "You can utilize the Find A Provider tool on your member portal and/or the Home State Health website 24/7 to search for a current list of in-network Urgent Care facilities, ERs, and hospitals in your area. If you have additional questions or need assistance accessing this information, you can call a HSH customer service representative at (855) 694-HOME (4663) anytime M-F from 9 a.m.-5 p.m. CST." Also, at the bottom of the page, Home State Health removed the full TTY/TDD number. Another change was made in Sept 2020 regarding an addition of a requirement from Eligibility, Enrollment, and Disenrollment from MHD contract, section 2.12.16c35. **Required Actions:** Home State Health should have a policy/procedure of notifying their enrollees of any significant change in the member handbook. Supporting evidence (mail letters, newsletters) should be submitted.		
iv. The content of the member handbook must include all the requirements stated in the MHD contract 2.12.16. a. Table of contents. 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 members' rights and responsibilities as described in MHD contract 2.14.8 (section A of this tool).	Member Handbook: Pages-3, 4, 7 to 20, 22 to 37, 39, 40, 42, 43, 46 to 53, 61, 62	Partially Met

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: o A member may request a state fair hearing within one hundred twenty (120) calendar days from MCO's notice of appeal resolution; and o 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: Home State Health's member handbook "Met" 40 of 48 criteria mandated in the MHD contract. There are seven criteria scored as "Partially Met" and one criterion is 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 are the "Partially Met" criteria:
i. The information on where and how members may access benefits not available under the comprehensive benefit package, is not presented in the member handbook for all the services.

J. The definition of medical necessity used in determining whether benefits will be covered should be updated according to the MHD contract.

t. The information on the member's right to disenroll with or without cause is not complete.

v. The timeframe for filing a grievance is not written. The 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. A written request for appeal is not required.

a10. The member handbook statement directing members to contact the MCO who have 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 also include tort, product liability, or medical practice lawsuit language.

a.18. The language for Advance Directives is provided by MHD as a template. Home State did not include a statement of "any limitation regarding the implementation of advance directives as a matter of conscience" as required in the MHD contract. During the interview, Home State Health informed that there is no limitation imposed by them.

a19. A description of the additional information that is available upon request, including the availability of information on Home State Health structure is missing.

a.22. MCO must inform members how they can obtain information from the state agency about how to access the services which are not covered by MCO because of moral or religious objections is not mentioned in the member handbook.

There is one criterion (q) which is scored as "Not Met" included in the member handbook: 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. Home State Health is also unaware of this requirement and has not addressed it in their member handbook.

Required Actions: Home State Health is recommended to update their member handbook to meet all the 48 items listed in the MHD contract, section 2.12.16.		
4. Provider Directory. i. MCO must make available in paper upon request and electronic format the 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.	Provider Directory: MO-Central, Eastern, Southwest, West <u>Post-site meeting submission</u> MO.PRVR.19 Provider Directory Updates: Page 1 Online Directory Screen Shots	Partially Met
Findings: The policy, MO.PRVR.19 Provider Directory Updates, submitted post-site meeting does not include the information on website URL; accommodations for people with physical disabilities including offices, exam rooms, and equipment; American sign language or skilled medical interpreter availability at provider's office. Primaris noted the provider directory (for all regions) submitted by Home State Health shows an inconsistent presentation of information on board certification status for physicians; panel status; and cultural and linguistic capabilities (including American Sign Language or skilled medical interpreter at provider's office). **Required Actions:** Home State Health is recommended to update their policy to include all the requirements about their network providers listed under this section of the evaluation tool. The provider directory (PDF version) submitted to Primaris should be updated as well to consistently reflect all the criteria for every provider in the network. Following are suggestions for improving the provider directory in a user-friendly format: • At the beginning of the provider directory, there should be instructions to the members as to how they can access information presented in the directory.		

• All the criteria listed in this section should be presented in bold/icons on the Instructions page. • All providers should have information about all these criteria. Information on the panel was found only for some providers who were accepting new patients and for some providers who were not accepting patients. • Every page has a footnote: * contact provider for office hours and appointments. There is no reference to (*) in the providers' listings. Either there should be a reference or (*) should be removed.		
ii. The provider directory must include the information stated above (section 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.	Provider Directory: MO-Central, Eastern, Southwest, West	Partially Met
Findings: Information on panel, linguistic capabilities, availability of sign language services are not available for hospitals. **Required Actions:** The provider directory (PDF version) submitted to Primaris should be updated to consistently reflect all the criteria listed under section B4 (i) for every provider in the network.		
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).	<u>Post-site meeting submission</u> MO.PRVR.19 Provider Directory Updates: Pages-1, 2	Fully Met
Findings: Home State Health stated that their web-based data is sourced directly from the Portico Provider Data Management system. Updates to the Portico system are automatically made to the web-based Provider Directory to keep all data current. Print, hard copy directories are sourced from the Portico Provider Data Management System as		

well. Provider data for print directories are updated daily. Print Directories are printed upon member or provider request. Portico Print Directory files (provider and practitioner) are scheduled to run weekly and are housed on the shared drive. The Home State Health Provider Partnership Management Representatives periodically conduct random checks to ensure accuracy as verified during provider engagement meetings and interactions. The online directory is continually available for Data Quality checks. **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).	Member Handbook: Page 28 <u>Post-site meeting submission</u> MO.PRVR.19 Provider Directory Updates: Page 2	Partially Met
Findings: Home State Health distributes paper directories within 48 hours of a written or telephonic request from a member or Provider. The member handbook has the following information: "You can find the most current version of Home State Health's provider directory on our website at HomeStateHealth.com. At any time, you can also request a printed copy of the directory. You will receive the copy within forty-eight (48) hours after the request. Both the online and printed version gives you providers to choose from, including health care providers and hospitals. Home State Health can also help you pick a PCP. Just call Member Services toll-free at 1-855-694-HOME (4663)." Primaris visited Home State Health's website in March 2021, and did not find a provider directory. Instead, Home State Health has a web-based search tool that allows members to search for a provider/practitioner or a health center, clinic, hospital, and ancillary services-vision or dental. **Required Actions:** Primaris recommends Home State Health upload their provider directory on their website, in a machine-readable format (computer/mobile readable). This will allow the members to have access 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 without charge upon request and provides it upon request within 5 business days (42CFR 438.10c6v).	Member Handbook: Page 11 Post-site meeting submissions Newsletters/Mailers-Whole You (Quarter 2, 3, 4)	Fully Met
Findings: Home State Health's member handbook provides information about access to up-to-date information about Home State Health on their website at www.HomeStateHealth.com. The members are advised to visit the website to get information about the services Home State Health provides, provider network, frequently asked questions (FAQ), contact phone numbers, and e-mail addresses. Home State Health will send the members, a printed copy of the information on the website at no cost to them within five business days of a member's request." In March 2021, Primaris confirmed Home State Health has member resources posted on the website. **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 Handbook: Pages-64, 65 Post-site meeting submissions MO.COMP.01 MO HealthNet Managed Care Contract Administrative Requirements: Pages-3, 4 MO.HUMR.32 Anti-Harassment and Non-Discrimination: Page 1 MO.MBRS.25 Member Rights and Responsibilities: Page 2	Fully Met
Findings: Home State Health member handbook has a non-discriminatory notice: "Home State Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.		

Home State Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex." The member handbook also states that if a member believes Home State Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, the member may file a grievance with Home State Health or US Department of Health and Human Services.

Home State Health's policy, MO.COMP.01 MO HealthNet Managed Care Contract Administrative Requirements, complies with non-discrimination in hiring and provision of services as per applicable federal and state regulations mentioned in this section of the evaluation tool.

Home State Health's policy, MO.HUMR.32 Anti-Harassment and Non-Discrimination, states, "All employees are responsible to help assure that harassment and discrimination are avoided by, honoring our member's beliefs, being sensitive to cultural diversity and, fostering attitudes and interpersonal communication styles which respect the members' cultural backgrounds, through education and training of employees and providers."
Home State Health's policy, MO.MBRS.25 Member Rights and Responsibilities, states, "Home State Representatives do not discriminate against any potential member because of race, creed, age, color, sex, religion, culture, national origin, ancestry, marital status, sexual orientation, physical or mental disability, health status, or requirements for health care services."

Required Actions: None.

Compliance Score–Enrollee Rights						
Total	Met	=	11	×2	=	22
	Partial Met	=	6	×1	=	6
	Not Met	=	1	×0	=	0
Numerator	Score Obtained				=	28
Denominator	Total Sections	=	18	×2	=	36
Score%						77.77%

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).	MO.UM.12 Emergency Services: Page 4	Fully Met
Findings: Home State Health's policy, MO.UM.12 Emergency Services, states: "An emergency medical condition means a medical, behavioral health, or substance use-related 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 physical or behavioral health of the individual (or, with respect to 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 abuse emergency; injury to self or		

bodily harm to others; or 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." **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.	MO.UM.12 Emergency Services: Page 4	Fully Met
Findings: Home State Health's policy, MO.UM.12 Emergency Services states: "Emergency medical, behavioral health, and substance abuse services covered inpatient and outpatient services that are furnished by a provider qualified to furnish these services; and needed to evaluate or stabilize an emergency medical condition." **Required Actions:** None.		
3. Post-stabilization care services means covered services, related to an emergency medical condition that are 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.	MO.UM.12 Emergency Services: Page 4	Fully Met
Findings: Home State Health's policy, MO.UM.12 Emergency Services defines post-stabilization care as "the covered services related to an emergency condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition." **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).	MO.UM.12 Emergency Services: Page 2 Post-site meeting submission	Fully Met

i. MCO shall pay out-of-network providers for emergency services at the 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).	Participating Provider Agreement: Pages-6, 13, 19	
Findings: Home State Health's policy, MO.UM.12 Emergency Services, complies with all the criteria listed in section B1 of this evaluation tool. Home State Health submitted a sample of Participating Provider Agreement which requires each Hospital (contracted provider or a provider) shall provide emergency care per the regulatory requirements. The contracted provider shall notify Home State Health's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. Primaris noted the Provider Payment Agreement, section 3.9 of Attachment A, states that a provider shall maintain all medical records remaining under the care, custody, and control of the provider, or the provider's designee, for a minimum of seven years from the date of when the last professional service was provided. **Required Actions:** Primaris recommends Home State Health to update their Participating Provider Agreement for Medicaid with medical records retention to 10 years from the last date of the contract period or from the date of completion of any audit, whichever is later (ref. 42 CFR 438.230).		
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 an emergency medical condition. ii. A representative of the MCO instructs the enrollee to seek emergency services.	MO.UM.12 Emergency Services: Page 2	Fully Met

Findings: Home State Health's policy, MO.UM.12 Emergency Services, complies with 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.	MO.UM.12 Emergency Services: Pages-1, 3	Fully Met
Findings: Home State Health's policy, MO.UM.12 Emergency Services states: "The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Home State Health. Home State Health will cover all emergency services to screen and stabilize a member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical, behavioral health or substance abuse condition existed." **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).	MO.UM.12 Emergency Services: Page 3	Fully Met
Findings: Home State Health's policy, MO.UM.12 Emergency Services, states: "Home State Health shall be financially responsible for post-stabilization care services, obtained within or outside the health plan, which are pre-approved by a Home State Health provider or other Home State Health representative." **Required Actions:** None.		
5. MCO shall be financially responsible for post-stabilization care services,	MO.UM.12 Emergency Services: Page 3	Fully Met

obtained within or outside the MCO, that are not pre-approved by an MCO provider or other MCO representative but are administered to maintain, 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: Home State Health's policy, MO.UM.12 Emergency Services, complies with the requirements of this section (B5) of the evaluation tool. **Required Actions:** None.		
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. • An MCO representative and the treating physician reach an	MO.UM.12 Emergency Services: Page 3	Fully Met

agreement concerning the member's care. • The member is discharged (MHD contract, section 2.6.12i).		
Findings: Home State Health's policy, MO.UM.12 Emergency Services, complies with the requirement of 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).	MO.UM.12 Emergency Services: Page 4	Fully Met
Findings: Home State Health's policy, MO.UM.12 Emergency Services, states: Home State Health shall limit charges to members for post-stabilization care services to an amount no greater than what Home State Health would charge the member if he or she had obtained the services through Home State Health. **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.	MO.UM.12 Emergency Services: Page 3	Fully Met
Findings: Home State Health's policy, MO.UM.12 Emergency Services, complies with the requirement of 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 the enrollee's primary care provider, MCO, or applicable state entity of the	MO.UM.12 Emergency Services: Pages-1, 2, 3	Fully Met

enrollee's screening and treatment within 10 calendar days of presentation for emergency services.		
Findings: Home State Health will not limit what constitutes an emergency medical condition as noted in the definition, on the basis of lists of diagnoses or symptoms. Home State Health shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or the health plan of the member's screening and treatment within 10 calendar days of presentation for emergency services. **Required Actions:** None.		

Compliance Score–Emergency and Post-stabilization Services						
Total	Met	=	12	×2	=	24
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	24
Denominator	Total Sections	=	12	×2	=	24
Score%						100.00

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).	MO.COMP.21 Oversight of Delegated Vendor: Page 1	Partially Met
Findings: Home State Health's policy states: "Home State Health assumes responsibility for actions of their subcontractors for any of the contractual products/services they provide and in no way relieves Home State Health the responsibility for providing the products/services as described and set forth herein." "TurningPoint Healthcare Solutions (TurningPoint)" subcontract does not incorporate this responsibility/accountability of Home State Health. **Required Actions:** Primaris recommends Home State Health explicitly include a language regarding "legal and financial aspects" of their responsibility/accountability in their policy. Also, this criterion must be included in their subcontract with TurningPoint and all other subcontracted vendors.		
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).	Approval Request-TurningPoint (Aug 22, 2019)	Partially Met

Findings: Home State Health submitted documentation (Outlook email) regarding their communication with MHD for approval of new subcontractor "TurningPoint Healthcare Solutions (TurningPoint)" to perform utilization management services related to musculoskeletal procedures effective Dec 1, 2019. On Aug 31, 2020, Home State Health communicated with MHD for approval of scope expansion (Ear, Nose, and Throat related procedures) for the same contractor. Both the requests were approved by MHD. Primaris noted the Addendum 8 of Master Service Agreement between Home State Health (as applicable to MHD Managed Care Contract) was effective Aug 21, 2019, and the MHD approved it later on Aug 30, 2019. Home State Health did not submit a policy or procedure for establishing any new subcontracting arrangements and or changing any subcontractors including seeking approval from MHD prior to the subcontract being effective for MHD Managed Care members. During the interview, Home State Health described their process of subcontracting with vendors. They look for reputed vendors, have a pre-delegation audit, assess for IT, HIPAA violations, certifications, and finally seek approval from MHD. **Required Actions:** Primaris recommends Home State Health have a policy/procedure in place regarding establishing new subcontracting arrangements or changing any subcontractors. MHD's approval is required before any subcontract is effective.		
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).	TurningPoint-Master Service Agreement, Addendum 8: Page 7	Fully Met
Findings: The TurningPoint-Master Service Agreement, Addendum 8 complies with the criterion above. **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.	TurningPoint-Master Service Agreement, Addendum 8: Pages-2, 7, 8, 9, 11, 12 TurningPoint-Master Service Agreement, Amendment 1: Pages-5, 8, 20	Fully Met

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. 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.	MO.COMP.21 Oversight of Delegated Vendor: Page 4	

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 TurningPoint subcontract includes all the listed 19 requirements under this section regarding delegated activities or obligations, and related reporting responsibilities. **Required Actions:** None.		
4. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's entity's contract obligations.	TurningPoint-Master Service Agreement, Addendum 8: Page 4	Fully Met
Findings: TurningPoint-Master Service Agreement, Addendum 8 states: "Vendor agrees and understands that covered services shall be provided by the contract between the MHD and Home State Health ("state contract"), this product attachment, the agreement, Home State Health's Provider Manual, any applicable State Medicaid Program Provider Manuals and Handbooks, and all applicable state and federal laws and regulations." **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.	TurningPoint-Master Service Agreement, Addendum 8: Page 8	Fully Met
Findings: TurningPoint-Master Service Agreement, Addendum 8 states: "Vendor and subcontracted vendor(s) acknowledges and agrees that Home State Health may revoke the agreement or impose other sanctions if the vendor and subcontracted vendor(s)'s performance is inadequate."		

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 subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the state.	TurningPoint-Master Service Agreement, Addendum 8: Page 11	Fully Met
Findings: The TurningPoint-Master Service Agreement, Addendum 8 complies with the criterion in totality. **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.	TurningPoint-Master Service Agreement, Addendum 8: Page 11 MO.COMP.02 Audit Requirements for External Agencies: Page 7	Fully Met
Findings: The TurningPoint-Master Service Agreement, Addendum 8 complies with the criterion above. Home State Health's policy, MO.COMP.02 Audit Requirements for External Agencies, states that during normal business hours (defined as 8:00 a.m. through 5:00 p.m., Central Time, Monday through Friday, except state-designated holidays), Home State Health shall allow duly authorized agents or representatives of the federal or state government access to Home State Health's premises or Home State Health's subcontractor's premises to inspect, audit, monitor, or otherwise evaluate the performance of Home State Health or its subcontractors." **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	TurningPoint-Master Service Agreement, Addendum 8: Page 11	Fully Met

the contract period or from the date of completion of any audit, whichever is later.	MO.COMP.21 Oversight of Delegated Vendor: Page 2	
Findings: The TurningPoint-Master Service Agreement, Addendum 8 complies with the criterion above. Home State Health's policy, MO.COMP.21 Oversight of Delegated Vendor, requires each health care provider to maintain comprehensive medical records for a minimum of seven (7) years. **Required Actions:** Primaris recommends Home State Health update their policy, MO.COMP.21 Oversight of Delegated Vendor, to require its providers to maintain the records for a minimum of 10 years duration from the final date of the contract period or from the date of completion of any audit, whichever is later.		
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.	TurningPoint-Master Service Agreement, Addendum 8: Page 11	Fully Met
Findings: The TurningPoint-Master Service Agreement, Addendum 8 complies with the criterion above. **Required Actions:** None.		
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).	TurningPoint-Master Service Agreement, Addendum 8: Pages-4, 9 MO.COMP.21 Oversight of Delegated Vendor: Page 1	Fully Met
Findings: Home State Health policy on Oversight of Delegated Vendor describes the method used for formal monitoring and tracking the oversight of delegated vendors to ensure delegates meet state contract requirements, NCQA requirements, and Home State performance standards. The following evidence is maintained for each delegated vendor:		

types of delegated service, covered lines of business, tracking of vendor reporting, evidence of monitoring vendor adherence to performance standards, meeting minutes, quality/service improvement plans, corrective action plans, ratings of vendor responsiveness, a method to automatically notify corporate of vendor issues, vendor-Home State Health contracts and amendments, policies, and procedures, program descriptions, audit tools, vendor attestations of contract compliance. TurningPoint-Master Service Agreement, Addendum 8 states: "The vendor and subcontracted vendor(s) shall indemnify, save and hold harmless the state of Missouri from and against any and all claims of damage, loss, and cost (including attorney fees) of any kind in those matters described in the contract between the state of Missouri and the Home State Health." **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 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).	TurningPoint-Master Service Agreement, Addendum 8: Page 9	Fully Met
Findings: TurningPoint-Master Service Agreement, Addendum 8 states: "All disputes between the Home State Health and the vendor and subcontracted vendor(s) shall be solely between the Home State Health and the vendor and subcontracted vendor(s). The Vendor and subcontracted vendors shall indemnify, defend, save, and hold harmless the State of Missouri, the Department of Social Services and its officers, employees, and agents, and enrolled MO HealthNet Managed Care members from any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever…" **Required Actions:** None.		

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.	CP.CPC.01 Clinical Policy Committee (CPC): Page 1 CP.CPC.03 Preventive Health and CPGs: Page 1 MO.QI.01. Quality Program Description: Page 41 MO.UM.01 Utilization Management (UM) Program: Page 10	Fully Met
Findings: Home State Health's corporate CPC is responsible for researching evidence-based guidelines. Whenever possible, guidelines from recognized sources are adopted. Source data is documented in the guidelines to include the scientific basis or the authority upon which it is based. If guidelines from a recognized source cannot be found, Home State Health's corporate CPC is consulted for assistance in guideline sourcing or development. The CPC or assigned designee reviews appropriate information to make medical necessity decisions including published scientific evidence, applicable government regulatory body information, CMS's National Coverage Decisions database/manual, and input from relevant specialists and professionals who have expertise in the technology. Home State Health utilizes evidence-based clinical practice guidelines, preventive health guidelines, and/or other scientific evidence, as applicable, in developing, implementing, and maintaining clinical decision support tools used to support utilization and care management. When appropriate, Home State Health may choose to use a vendor's clinical decision support tools and will ensure through due diligence and regular updates that evidence-based practice is utilized in the development of the clinical decision support tools. Primaris has confirmed the availability of CPGs on 35 diseases and conditions on Home State Health's website and their recognized sources. **Required Actions:** None.		
2. Consider the needs of the enrollees.	CP.CPC.03 Preventive Health and CPGs: Page 1	Fully Met

	CP.CPC.01 Clinical Policy Committee (CPC): Pages-1, 2, 4 MO.QI.01. Quality Program Description: Page 41	
Findings: Home State Health adopts clinical practice guidelines which are relevant to their population. Guidelines are based on the population's health needs and/or opportunities for improvement as identified through the Quality Assessment and Performance Improvement (QAPI) Program. Home State Health also adopts applicable preventive health guidelines for perinatal care, care for children up to 24 months old, care for children 2–19 years old, care for adults 20–64 years old, and care for adults 65 years and older. The clinical policies include medical, behavioral health, and durable medical equipment and devices. These policies include but are not limited to: • New and emerging technologies identified through trade publications. • New uses for existing technologies. • Coverage issues relating to new and existing technologies. • Clinical guidelines for the evaluation and treatment of specific conditions. • Clinical/medical criteria or information used in the pre-or post-service review. • Through UM authorization requests. • Inquiries from providers and vendors. • Review of appeals cases. Coordinating research and development of clinical policies includes prioritizing all inquiries for new policies and maintaining an electronic log of all requests for research and new policies with the requestor and subject of review. The highest priority is given to inquires based on open medical management cases such as pending authorizations or appeals cases. Response to these requests typically occurs within 24 hours. The priority then continues based on requests originating from providers or members, needs identified through financial analysis, followed by inquiries by vendors and technologies identified through trade publications. During the interview, Home State Health reported their corporate team reviews the UM pattern with a focus on high utilization services. Guidelines are developed on those areas, e.g., ER for non-emergent causes, Asthma CM program. **Required Actions:** None.		
3. Are adopted in consultation with network providers.	CP.CPC.03 Preventive Health and CPGs: Page 1 MO.QI.01. Quality Program Description: Page 41	Fully Met

	CP.CPC.01 Clinical Policy Committee (CPC): Page 2	
Findings: Board-certified practitioners who will utilize the guidelines have the opportunity to review and give advice on the guidelines through the corporate CPC and the Home State Health's quality committee. Specialist review is documented in the meeting minutes, as applicable. Opinions from external physicians are solicited as appropriate, including behavioral health physicians. The Chief Medical Officer or designee acts as the chairperson for meetings and activities performed by the CPC. Other voting members include corporate medical directors. **Required Actions**:		
4. Are reviewed and updated periodically as appropriate.	CP.CPC.01 Clinical Policy Committee (CPC): Page 1 CP.CPC.02 Clinical Policy Web Posting: Page 1 CP.CPC.03 Preventive Health and CPGs: Page 1	Fully Met
Findings: The corporate clinical policy team and clinical policy committee review and approve all corporate clinical policies on an annual basis and upon significant change to evidence-based guidelines. The Home State Health designee reviews the clinical policy web posting folder on at least a quarterly basis to ensure: • All policies are current. • All policies are still appropriate to be posted on the public website. • Any appropriate new policies are added. • Any retired policies are made non-searchable. **Required Actions:** None.		
B. MCO disseminates the guidelines to all affected providers, and upon request, to enrollees and potential enrollees.	CP.CPC.02 Clinical Policy Web Posting: Pages-1, 2 CP.CPC.03 Preventive Health and CPGs: Pages-2, 3 MO.QI.01. Quality Program Description: Page 41 CP.CPC.01 Clinical Policy Committee (CPC): Page 3 Provider Reference Manual (website): Page 40	Fully Met

	Post-site meeting submissions: Asthma Care Management (CM) Playbook Behavior Health CM Program Overview NCQA Mailer Revised 2021 Mailers-Cancer Screening/Whole You	

Findings: Home State Health distributes guidelines to all practitioners who are likely to use them and upon request to members/enrollees, potential members/enrollees, and providers. The revised guidelines are distributed on a timely basis. Home State Health also distributes guidelines to new practitioners if the original distribution has already occurred. New or updated guidelines are disseminated to providers via Home State Health's website as soon as possible (or per state contract timeframe, if applicable). A listing of adopted clinical practice and preventive health guidelines is maintained in the provider manual, with the links to the full guidelines or with a notation that the links and/or full guidelines are available on the website or hard copy upon request. Communication of these policies to provider networks is arranged by Home State Health's marketing or provider network department.

Members/enrollees may be notified of their right to request guidelines in the member handbook, member newsletter, or other member materials. If a member or potential member requests a copy of guidelines, it is noted in the member services call tracking system, and the member is referred to Home State Health's website, or a hard copy is mailed to the member if requested.

Mechanisms to notify and distribute guidelines may include, but are not limited to:

- New practitioner orientation materials
- Provider and member/enrollee newsletters
- Member/enrollee handbook
- Special mailings

The adoption, updating, and distribution for behavioral health guidelines or specific disease-related CPGs may be delegated to a behavioral health vendor or a disease management vendor under Home State Health's Delegated Quality Improvement Policy and procedure.

Home State Health submitted documents post-site meeting (referenced above) and provided links to their website with the member-related resources (e.g., https://www.homestatehealth.com/members/medicaid/health-management/get-vaccinated.html). One of the mailers on cancer screening has a link to the guidelines

about cancer screening. Primaris found that the immunization schedule uploaded on their website is from May 2017 (as reviewed on 4.13.21) During the interview, Home State Health reported their CM team informs the members about the practice guidelines. Primaris noted that some of the links related to the common health conditions e.g., lung conditions, mental health, cancer are posted on the website under member resources. **Required Actions:** Primaris recommends Home State Health update the immunization schedule posted on their website with the most current version. Home State Health should follow their policies regarding informing their members about the practice guidelines. The information about practice guidelines and the members' right to request for these, may be disseminated via member handbook, newsletters, mailers, website, or other ways available at Home State Health.		
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.	CP.CPC.03 Preventive Health and CPGs: Page 2 MO.QI.01 Quality Program Description: Page 41 MO.UM.01 UM Program: Page 11 <u>Post-site meeting submission:</u> CC.UM.02.05 Interrater Reliability-Associates, Medical Directors, and Therapists: Pages-1 to 4 InterQual Inter-Rater Reliability (IRR) Scorecard	Fully Met
Findings: Based on the state contract and accreditation (e.g., NCQA, URAC) requirements, if applicable, Home State Health measures practitioner compliance with at least two important aspects of each of the four clinical guidelines (two of which must be behavioral health) and two preventive health guidelines at least annually. The analysis can be either population or practice-based. • If population-based, the services/treatments received by members/enrollees are assessed, via claims data or HEDIS rates, to measure compliance with the guidelines. • If practice-based, a sample of practitioners' or practices' records may be evaluated for adherence to specific guidelines. Whenever possible, Home State Health uses applicable HEDIS measures to monitor practitioner compliance with adopted guidelines.		

At least annually, the chief medical director and vice president of medical management (VPMM) assess the consistency with which medical directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the VPMM or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, Home State Health's Medical Management leadership takes corrective action. New UM staff are required to complete inter-rater reliability testing before being released from training oversight.

Successful demonstration of the UM process and proficient application of relevant medical necessity criteria including InterQual, Milliman Clinical Guidelines (MCG), American Society of Addiction Medicine (ASAM), Level of Care Utilization/Child/Adolescents of Care Utilization System, and/or Applied Behavioral Analysis is validated through audits and testing before release from orientation. Managers and Clinical Trainers receive scores for their respective staff. A score of less than 90% for any subset is considered a failure. Inability to pass retesting/audit review as a condition of the CAP will be subject to further action as defined by the Plan VPPHCO or VPMA, up to or including termination. In addition to IRR testing, Home State Health works to ensure this same staff is notified of the annual changes to InterQual Criteria. Results of each medical director and therapist's IRR test results and peer review participation is collected and tracked over time. It may be determined that additional education and/or increased supervision of review decisions is necessary based on the results. Testing may be done more frequently than once per year if the need is identified. The IRR testing focuses on the correct application of clinical criteria as well as the appropriateness of identifying quality issues. Medical Directors and therapists also participate in Peer Review discussions three times per year. The purpose of Peer Review is to measure compatibility amongst Medical Directors and Therapists to ensure fairness and equality in the process of medical necessity review.

During the interview, Home State Health reiterated their corporate CPC updates the policies and are sent to the voting members. The comments are disseminated to all the physicians for their feedback. IRR is an annual exercise for physicians and reviewers.

Required Actions: None.

Compliance Score–Practice Guidelines						
Total	Met	=	6	×2	=	12
	Partial Met	=	0	×1	=	0
	Not Met	=		×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.	MO.QI.01 Quality Program Description: Pages-28, 29, 30	Fully Met
Findings: The information technology (IT) infrastructure integrates data for monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of health care furnished to all members, including those with special health care needs. Home State Health IT systems and informatics tools support advanced assessment and improvement of both quality and value, including a collection of all quality performance data, with the ability to stratify data at the regional level, across provider types, and across member populations. These systems capture, store, and analyze data from the internal, subcontractor, and external sources and for effective use through a suite of data informatics and reporting solutions. The Internal monitoring processes are supported by Centelligence, a family of integrated decision support and health care informatics solutions that facilitates the use of data by collecting, integrating, storing, analyzing, and reporting data from all available sources. **Required Actions:** None.		
B. MCO's health information system provides information on areas:		
1. Utilization.	MO.QI.01 Quality Program Description: Pages-29, 30 MO.UM.01.03 Monitoring Utilization: Pages-1, 2	Fully Met
Findings: Home State Health's health information systems collect, analyze, integrate, and report encounter data and other types of data to support utilization, complaints/grievances and appeals, care management/coordination, and all quality activities. Home State Health utilizes TruCare, a member-centric health management platform for collaborative care management, care coordination, and behavioral health, condition, and utilization management. Integrated with Centelligence for access to supporting clinical data, TruCare allows Population Health and Clinical Outcomes and Quality department staff to capture utilization, care, and population health management data, to proactively identify, stratify, and monitor high-risk enrollees, to consistently determine appropriate levels of care through integration with InterQual® medical necessity criteria and clinical policies, and capture the impact of programs and interventions.		

The Clinical Decision Support application is a multi-dimensional, episode-based predictive modeling and care management analytics tool that allows the quality and care management teams to use clinical, risk, and administrative profile information obtained from medical, behavioral, and pharmacy claims data and lab value data to identify high-risk members. The Enterprise Data Warehouse (EDW- Home State Health's Centelligence proprietary data integration and reporting strategy) updates the Clinical Decision Support system bi-weekly with data, including eligibility, medical, behavioral, and pharmacy claims data, demographic data, and lab test results to calculate and continuously update each member's risk score. **Required Actions:** None.		
2. Claims.	MO.CLMS.01 Claims Administration and Systems: Page 1 Presentation: Six Steps of Adjudication-Claims	Fully Met
Findings: Home State Health's claims and information management systems/infrastructure can perform the following activities and more: • Transmit and receive data (including enrollment data). • Receive electronic claims. • Support provider claims and capitation payment. • Comply with data reporting requirements. • Assign member-specific primary care providers. • Maintain provider network data. • Submit encounter data. • Support web-and mobile-based member and provider self-service functionality. **Required Actions:** None.		
3. Grievances and appeals.	MO.QI.01 Quality Program Description: Pages-28, 30 Post-site meeting submission Appeals Workflow Prime Overview	Fully Met
Findings: The OMNI, Customer Service platform enables Home State Health to identify, engage, and serve members, providers, and federal/state partners in a holistic and coordinated fashion across wellness, clinical, administrative, and financial matters. The OMNI platform captures, tracks, and allows Home State Health staff to manage complaints, grievances, and appeals for all required reporting. Home State Health has submitted a process flow of how member grievances and appeals are captured, processed, and reported in their workflow management system-OMNI Prime. **Required Actions**: None.		

4. Disenrollment for other than loss of Medicaid eligibility.	MO.ELIG.01 Eligibility Guidelines: Page 3 Presentation: Six Steps of Adjudication-Claims Post-site meeting submission Presentation: Home Birth Disenrollment Process	Fully Met
Findings: On each business day, Home State Health processes the daily HIPAA 834 Enrollment Files obtained from Wipro for any additions, changes, and disenrollment as provided on the file and loads into their claims adjudication system. Home State Health processes daily 834 files and ensures that all discrepancies are resolved within five business days from the receipt of the 834 Enrollment file. The only time Home State Health initiates a disenrollment process is when a pregnant member opts for a home birth. Home State Health submits the request of the member to the MHD. The MHD sends a disenrollment form to the member. The member is disenrolled after three days post receipt of the disenrollment form. **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 fraud and abuse necessary for program integrity, program oversight, and administration.)	MO.CLMS.01 Claims Administration and Systems: Page 1 Presentation: Six Steps of Adjudication-Claims Post-site meeting submission CC.COMP.16 Fraud, Waste, and Abuse: Pages-5, 6	Fully Met
Findings: Home State Health adheres to all federally required Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) Operating Rule Sets.		

Home State Health maintains a fully integrated claims processing system; uses all HIPAA compliant code sets and transaction requirements in the development of claims, benefit, and payment configuration; accepts claim electronically (837I and 837P), via mail (CMS-1500 and UB-04 forms), or via the web. Home State Health allows providers to verify eligibility, submit and view authorizations, find a provider in its network, view claims, submit reconsideration requests, track both via its online secure portal, and offers providers the option to choose to receive paper or electronic remittance advice (RA/ERA) also known as the Evidence of Payment (EOP).

Home State Health has different types of software and tactics to help identify potentially fraudulent, wasteful, or abusive patterns.

- Cotiviti Nucleus: This fraud detection software profiles providers prior to the payment. When a provider is billing differently than their peers by at least 2.5 standard deviations, Nucleus will flag the claim/provider for review prior to payment. Cotiviti reviews multiple conditions including, but not limited to, billing spikes, up-coding, and excessive services.
- PostShield: This application systematically identifies billing irregularities based on hundreds of industry standards. PostShield is a tool that contains over 1,500 fraud rules and algorithms. Examples of fraud algorithms include high dollar alerts, provider is rendering services in a foreign country, payment spikes, procedure code spikes, inappropriate edits billed, etc. PostShield is used by Home State Health's special investigations unit (SIU) data analysts and investigators to proactively identify provider's aberrant billing patterns.
- Special Investigation Resource and Intelligence System (SIRIS): This is a fraud-fighting tool sponsored by the National Health Care Anti-Fraud Association (NHCAA). Each Home State Health investigator or analyst enters case information into SIRIS including the nature and evidence of suspected fraud. SIRIS shares critical information, including an overview of health care fraud schemes, patterns, investigations, and trends, with law enforcement agencies.
- Ad-Hoc Data Mining–The SIU uses MicroStrategy (MS), as well as other analytical data-aggregation tools, to conduct ad-hoc data-mining efforts to identify potential Fraud, Waste, and Abuse.

Required Actions: None.

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) capability that accepts and processes claims	MO.CLMS.01 Claims Administration and Systems: Page 1	Fully Met

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)	Presentation: Six Steps of Adjudication-Claims Homestatehealth.com/ Providers/tools-resources/provider-rep.html: • Provider Manual: Pages-48, 49 • Billing Manual	
Findings: Network providers are encouraged to participate in the Home State Health electronic claims/encounter filing program. Home State Health can receive an ANSI X12N 837 professional, institutional, or encounter transaction. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an EOP. Home State Health provides an innovative web-based solution for Electronic Funds Transfers (EFT's) and ERA's. Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. Home State Health has partnered with PaySpan to provide an innovative web-based solution for EFTs and Electronic Remittance Advice. Home State Health's provider portal is available 24 hours a day/7 days a week for several activities, e.g., submission of a claim; view a claim; submission of a claim reconsideration request; and submit, view, and track authorization requests. Per Home State Health's website, a provider can contact a Home State Health's provider service representative to assist with claim submission requirements, EOP/remittance advice support and PaySpan (EFT/ERA) assistance. **Required Actions**: None.		
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	MO.CLMS.01 Claims Administration and Systems: Page 1 <u>Post-site meeting submission</u> Provider Billing and Claims Filing Instructions: Page 15	Partially Met

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).		
Findings: Home State Health adheres to the Health Insurance Portability and Accountability Act (HIPAA) standards related to claims, enrollment, eligibility, authorization, and remittance advice processing. Home State Health adheres to all federally required Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) Operating Rule Sets. Home State uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment. This is done by analyzing Current Procedure Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), modifier, place of service codes. Claims billed in a manner that does not adhere to the standards of the code editing software will be denied. The code editing software contains a comprehensive set of rules addressing coding inaccuracies, such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on e.g., the American Medical Association (AMA), CMS' National Correct Coding Initiative (NCCI), Public-domain specialty society guidance, clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario. Primaris noted that RSMo 376.383 states, "if the health carrier has not paid the claimant on or before the forty-fifth processing day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month and a penalty in an amount equal to one percent of the claim per day." However, Home State Health's Provider Billing and Claims Filling Instructions state that Home State Health will process 99% of clean claims within 90 business days of receipt. **Required Actions**: Primaris recommends Home State Health address signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. Also, Primaris suggests Home State Health align its claims processing deadlines per RSMo 376.383.		
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	Presentation: Six Steps of Adjudication-Claims <u>Post-site meeting submission</u>	Fully Met

data from network providers the MCO is 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.	Provider Billing and Claims Filing Instructions: Pages-3, 4	

Findings: All claims filed with Home State are subject to verification procedures. These include but are not limited to verification of the following:

- All claims will be subject to 5010 validation procedures based on CMS and MHD requirements.
- All required fields are to be completed on the current industry standard paper CMS 1500 Claim Form (HCFA), CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted individually or in a batch on our Secure Provider Portal.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service, provider type/specialty billing, bill type, and the age of the patient.
- All Diagnosis Codes are billed to the greatest specificity.
- The Principal Diagnosis billed reflects an allowed Principal Diagnosis as defined in the current volume of International Classification of Diseases (ICD)-9 Clinical Modification (CM), or ICD-10 CM for the date of service billed.
- The Member identification number is located in Box 1A of the paper CMS 1500 claim form and Loop ID 2010 BA Segment NM109 of the 837p.
- A member is eligible for services under Home State during the time in which services were provided.
- Appropriate authorizations must be obtained for the services performed if required.
- Third-party coverage has been identified and appropriate coordination of Benefits (COB) information has been included with the claim submission.

Original claims (first-time claims) must be submitted to Home State within 180 calendar days from the date services were rendered or reimbursable items were provided. Corrected claims must be submitted 180 days from the date of the original Explanation of Payment (EOP) or remit date. When Home State is the secondary payer, claims must be received within 365 calendar days from the date of the final determination of the primary payer. Claims received outside of these time frames will deny untimely submission. All requests for reconsideration or claim disputes must be received within 180 calendar days from the original date of notification of payment or denial.

During the interview, Home State Health informed Primaris that Providers submit their data on a roster. Home State Health uses that data and match to the information in its system. The minimal required field are the same. Then, Home State Health generates the reconciliation reports. **Required Actions**: None.		
4. Make all collected data available to the state and upon request to CMS.	MO.COMP.09 State Required Deliverables: Page 2	Fully Met
Findings: Home State Health has a policy to submit all encounter data submissions to MHD per MHD contract, section 2.26.5. Home State Health will submit to MHD the required certification form concurrently to submission of the reports. The Chief Executive Officer, Chief Financial Officer, or Compliance Officer will complete the Certification Form. The Certification Form will attest, based on best knowledge, information, and belief: to the accuracy, completeness, and truthfulness of the data; and the accuracy, completeness, and truthfulness of the quarterly reports, encounter data, or financial reports. **Required Actions**: Home State Health must update their policy to state the data collected from the providers will be made available to CMS upon request.		
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	HIPAA X 12 Transaction Standards-Companion Guide: Pages-8, 10 Post-site meeting submission	Fully Met

identify the provider who delivers any item(s) or service(s) to enrollees.	MO.ENC.01 Encounters Business Operations: Page 2	
Findings: Home State Health's companion guide posted on their website (homestatehealth.com) provides information on various provider identifiers required for submission of claims. The provider identifiers required in the transactions are National Provider Identifiers (NPI), the billing provider primary identifier, the rendering provider, atypical provider (atypical providers are not always assigned an NPI number, however, if an atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An atypical provider which provides non-medical services is not required to have an NPI number. Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop. During adjudication, claims are validated against Wipro Infocrossing-specific Encounter edits (pre-scrubs) prior to going through a payable. If a claim hits a pre-scrub edit, it is assigned a denial EX (explanation of adjustment) code and the claim or line is denied. An example of a pre-scrub-missing attending provider on an in-patient institutional claim. If the inbound claim is missing an attending provider, the pre-scrub process would force the claim to be denied and EOP/Remittance Advice would be sent to the provider with appropriate adjustment reason code. **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).	Encounter Submission Policy and Procedures for Home State Health: Pages- 3, 4	Fully Met
Findings: Home State Health's EBO team works with IT encounters to ensure a successful encounter delivery. It is the policy of EBO to comply with all HIPAA and government regulations, as well as the contractual agreements related to encounters. Encounter files are submitted in accordance with MHD submission schedule timeframes. Encounters must be submitted within 30 days of the day Home State Health pays the claim and must be received no later than two years from the last date of service. The finalized encounter submission files are submitted via secure File Transfer Protocol (FTP) to Wipro Infocrossing (MHD's Fiscal Agent). Centene (Home State Health's parent company) and Home State Health strive to achieve a pass rate meeting or exceeding the standard 98% accuracy, which is consistent with MHD's requirements for all encounter data submitted. Home State Health strives to achieve 99% and above on first-time submissions.		

Home State Health subcontracted vendors who receive and adjudicate claims from providers on behalf of MHD programs are contractually obligated to submit encounter data to Home State Health in accordance with MHD requirements. **Required Actions**: None.		
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.	Encounter Submission Policy and Procedures for Home State Health: Page 3	Partially Met
Findings: Home State Health submits encounters to MHD for every service rendered to an enrolled member, including procedure codes, diagnoses, and service location, as well as amounts billed by and remitted to providers. Primaris noted that Home State Health has not submitted information that complies with the requirement of the "allowed amount" for the services by the providers. **Required Actions**: Home State Health is recommended to comply with all the components of this section by submitting information on the "allowed amount" in their encounter data submitted to the MHD and Primaris for evaluation.		
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).	Encounter Submission Policy and Procedures for Home State Health: Page 2	Fully Met
Findings: Home State Health follows the timeframes provided in the MHD contract, section 2.26.5h, for submitting encounters. **Required Actions**: None.		
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).	HIPAA X 12 Transaction Standards-Companion Guide 837 Companion Guide	Fully Met

(Note: NCPDP and ASCX12N 835 are not applicable for MCO under MHD.)		
Findings: The Companion Guide provides Centene trading partners with guidelines for submitting 5010 version of 837 Professional and Institutional Claims. The Centene Companion Guide documents any assumptions, conventions, or data issues that may be specific to Centene business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). This document provides information on Centene- specific code handling and situation handling that is within the parameters of the HIPAA administrative simplification rules. 837 Companion Guide provides Centene trading partners with guidelines for submitting the Electronic Data Interchange ASC X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). **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	Member Services/Provider Services Calls Hotline: Pages-1, 2 Business Continuity Plan: Pages-9, 16, 21	Fully Met

failure's or disaster's occurrence (MHD 2.26.8).		

Findings: Home State Health's toll-free member hotline is staffed with Member/Provider Services Representatives (MSRs/PSRs) during normal business hours (8:00 am to 5:00 pm Monday through Friday excluding state holidays).

All after-hour member/provider hotline calls are answered by an automated attendant that will furnish the member/provider with information on office hours and confirm member enrollment. This automated system will provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. Home State Health shall ensure that the voice mailbox has adequate capacity to receive all messages and will include a message stating that MSRs/PSRs shall return all messages on the next Business Day. Callers will have the option to talk with Nursewise, Home State Health's 24-hour nurse information and triage line, for prior authorizations and confirmation of covered services.

Members/providers who call the hotline after normal business hours and have an emergency or a situation and do not want to leave a message will be directed to Nursewise. Members/Providers will have the option to speak with a registered nurse, a clinician, or a behavioral health crisis worker, who are available 24 hours a day, seven (7) days a week, to issue medical advice and instruct members/providers on how to access urgent and emergent services. Members/providers who call the hotline after normal business hours will also receive the MFCU, fraud, and abuse hotline number.

Members (via MSRs/PSRs) have access to bilingual representatives to handle other languages. For languages not spoken by an MSR/PSR, the Plan provides access to interpreter services through Voiance or Language Services Associates (LSA).

In the event of a major disaster, Home State Health's claims processing system shall be back online within 36 hours of the failure's or disaster's occurrence; Medicaid customer services (must be able to see enrollment and claims information) will be back in less than four hours.

Required Actions: None.

Compliance Score–Health Information Systems						
Total	Met	=	14	×2	=	28
	Partial Met	=	2	×1	=	2
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	30
Denominator	Total Sections	=	16	×2	=	32
Score %						93.75