Primaris
Healthcare Business Solutions

2021 External Quality Review

Compliance

UnitedHealthcare®

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

MoHealthNet

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1.0 OVERVIEW AND OBJECTIVE

1.1 Background

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

The MHD contracts with Managed Care Organizations (MCOs), also referred to as Managed Care Plans/Health Plans, to provide health care services to its Managed Care enrollees. UnitedHealthcare is one of the three MCOs operating in Missouri. The MHD works closely with UnitedHealthcare 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 UnitedHealthcare 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.)

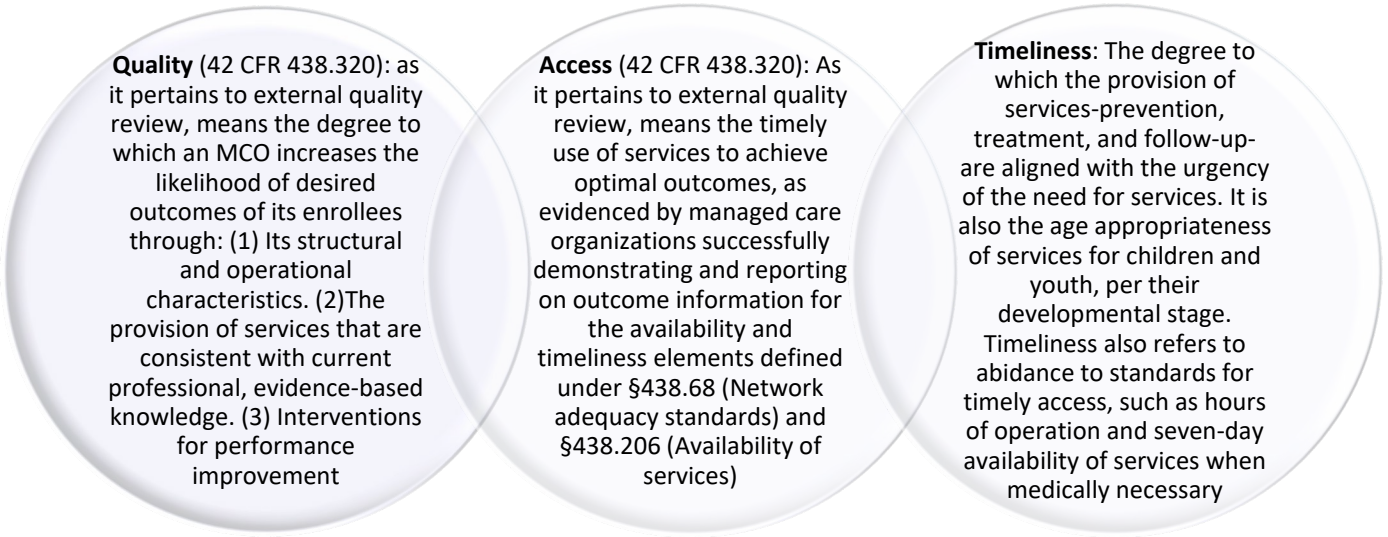

Figure 1. External Quality Review-A Federal Requirement

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 UnitedHealthcare 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 UnitedHealthcare'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

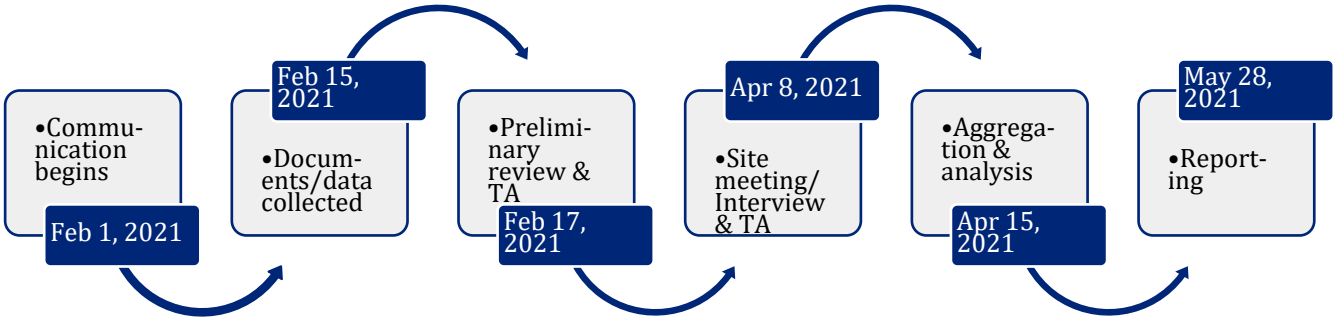

Figure 2. Compliance Evaluation Process

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

to set up the expectations for the documents' submission.

Documents' Submission: UnitedHealthcare 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, and print screens, flow charts as follows:

- Disenrollment-Requirements and Limitations: MO-ENR-01 Disenrollment Effective Dates; and Medicaid Disenrollment Standard Operating Procedure (SOP).
- Enrollee Rights: MR-001 UHC MO Member Rights; Community MO HealthNet Managed Care Member Handbook; Care Provider Manual 2020; MR-001 UHC MO Member Rights; MO-MK001 Marketing Guidelines; MO-PTMN001 Provider Termination Member Notification; Member Notice Template; Provider Directory MO HealthNet Managed Care (Regions: Central, East, West, Southwest); Provider Directory Creation and Distribution; Standard Fields for Directory; Rally-Online Directory; Provider Directory Maintenance Schedule; and Medicaid Refresh Schedule.
- Emergency and Post-stabilization Services: 2020F7012C Reimbursement Policy; and MO-ERPAY-001 Emergency and Post-stabilization Reimbursement.
- Subcontractual Relationships and Delegation: Dental Benefit Providers-Dental Services Agreement and amendment; Rose International, Inc. Master Services Agreement; CareCore National, LLC Addendum 28; March Vision Care Group, Inc-Appendix; Children's Mercy Integrated Care Solutions Inc. Agreement; Medical Transportation Management (MTM) Amendment 9; and MO.SO-003 Subcontractor Oversight.
- Practice Guidelines: Provider Website Distribution of CPGs; Review of Clinical and Preventive Guidelines; Physician Advisory Committee (PAC) Charter; 2020 Quality Improvement Program Description; Review of Clinical and Preventive Guidelines; Utilization Management Program Description: Medical Technology Assessment Committee Meeting Minutes; 2020 Milliman Clinical Guidelines (MCG) IRR Assessments; and MO PCP 2020 Medical Record Review CPG Post-audit.
- Health Information Systems: UnitedHealthcare-Missouri Architecture; HIS System Flows; Health Information Systems; UnitedHealthcare Compliance Program; Control Fraud, Waste, and Abuse; Claims, Billing, and Payments-UHCprovider.com; Enterprise Information Security Brochure; Encounter Data: Acceptance Rate of Submitted Claims; Enterprise Resiliency and Response Program; and MO myUHC.

Site Interviews

Primaris conducted a virtual meeting with UnitedHealthcare on April 8-9, 2021, due to

travel restrictions to the onsite office in Missouri (Table 2) during the Covid-19 Pandemic.

Table 2: MCO Information	
MCO Name:	UnitedHealthcare
MCO Location:	13655 Riverport Dr. Maryland Heights, MO, 63043
Audit Contact:	Katherine M. Whitaker, JD, CHC
Contact Email:	katherine_whitaker@uhc.com

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

Jamie Bruce, Chief Executive Officer
Colleen Giebe, Vice President, Clinical Programs
Chris Hogan, Director, Technology
Katherine Whitaker, Associate Director, Compliance
Lisa Overturf, CPHQ, Associate Director, Clinical Quality
Ken Powell, Associate Director, Provider Services
Melanie Rains-Davie, Associate Director, Case Management
Beth McCrary, Associate Director, General Management
Shannon Zellner, Senior Analyst, Compliance
Kayla Townley, Consultant, Clinical Quality
Shelby Miller, Senior Marketing Business Development Analyst
Ginnah Skula, Senior Research Consultant, Subcontractor Operations

Compliance Ratings

The information provided by UnitedHealthcare 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. UnitedHealthcare must identify for each Not Met/Partially Met criteria the interventions it plans to implement to comply with the regulations, including how UnitedHealthcare measures the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. UnitedHealthcare must submit the CAP to the MHD within 10 days of its initiation. When deemed sufficient, the MHD, in consultation with Primaris, approves UnitedHealthcare's CAP. Within 90 days of approval of the CAP, UnitedHealthcare 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 UnitedHealthcare achieving a compliance score of 85.4% (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	18	0	0	36	**100**
438.100	457.1220	Enrollee rights	18	13	05	0	31	**86.1**
438.114	457.1228	Emergency and post-stabilization services	12	11	01	0	23	**95.8**
438.230	457.1233b	Subcontractual relationships and delegation	12	08	04	0	20	**83.3**
438.236	457.1233c	Practice guidelines	06	06	0	0	12	**100**
438.242	457.1233d	Health information systems	16	05	08	3	18	**56.3**

Total	**82**		**140**	**85.4**

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

3.2 Regulation I- Disenrollment: Requirements and Limitations

UnitedHealthcare was evaluated for 18 criteria under this regulation and received "Fully Met" for all of them, scoring 100% for compliance. Appendix A provides a detailed evaluation of this regulation.

3.2.1 Performance Strengths

UnitedHealthcare has policies and procedures compliant with the Disenrollment: Requirements and Limitations, and the staff is knowledgeable per the CFR and the MHD contract. UnitedHealthcare is aware of 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. UnitedHealthcare shall cite at least one good cause before requesting the MHD to disenroll a member. UnitedHealthcare does not initiate disenrollment because of a medical diagnosis of a member, pre-existing medical conditions, high-cost bills, disruptive behaviors arising from members' special needs, race, color, national origin, gender, gender identity, or sexual disorientation.

At UnitedHealthcare, 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. UnitedHealthcare acknowledges that a member can request for disenrollment for a just cause: if the transfer is a resolution to grievance or appeal; member's Primary Care Physician or specialist does not participate with UnitedHealthcare; due to cultural sensitivity issues; services not covered by UnitedHealthcare due to moral or religious objections; services not covered; correction of an enrollment error made by the broker; bringing all family members under one MCO; and sanctions imposed by the MHD. UnitedHealthcare allows automatic and unlimited changes in the MCO choice as often as circumstances necessitate for the children in care and custody and adoption subsidy. UnitedHealthcare 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, UnitedHealthcare does not assume financial responsibility for members of other MCOs or the MHD Fee-For-Service hospitalized in an acute setting on the

effective date of coverage with UnitedHealthcare until an appropriate acute inpatient hospital discharge.
UnitedHealthcare receives updates from the MHD on newly enrolled or newly disenrolled members with UnitedHealthcare daily and incorporates them in their and the subcontractors' management information system each day. UnitedHealthcare sends weekly, via electronic media, a listing of current members. UnitedHealthcare reconciles this membership list against their internal records within 30 business days of receipt notifies the MHD of any discrepancies.

3.2.1 Corrective Action

There are no areas of concern, so corrective action is not required. However, Primaris noted a weakness in the Disenrollment Standard Operating Procedure (SOP). This document does not list all the reasons when a member can request disenrollment without a cause. Thus, it is inconsistent with UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates.

3.3 Regulation II- Enrollee Rights

UnitedHealthcare was evaluated for 18 criteria under this regulation and received "Fully Met" for 13 and "Partially Met" for five of them, scoring 86.1% for compliance. Appendix B provides a detailed evaluation of this regulation.

3.3.1 Performance Strengths

UnitedHealthcare has a policy in place that guarantees 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; and obtain a copy of medical records free of cost.

UnitedHealthcare provides notice about the termination of a contracted provider to each enrollee who receives 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. UnitedHealthcare 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 UnitedHealthcare. The member handbook is reviewed annually and submitted to the MHD for approval prior to distribution to its members. Provider directories are available on the MCO's website in a machine-readable file. The automated PDF directories are maintained weekly. UnitedHealthcare 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 UnitedHealthcare's

website is made available in a paper form without charge within five business days upon request. UnitedHealthcare 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.

Primaris noted the following weaknesses for the sections that are assigned a score of "Fully Met":

- The policy, MR-001 UHC MO Member Rights, does not describe how UnitedHealthcare ensures Enrollee Rights. However, the team responded during the interview.
- Provider Directory Creation and Distribution policy state that the request for a paper form of provider directory is processed within 48 hours. The requirement is that the directory should be mailed within 48 hours of the enrollee's request.

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: All written materials shall be worded such that the materials are understandable to a member who reads at the sixth-grade reading level (Appendix B: section B1).
  Primaris visited UnitedHealthcare's website on April 23, 2021, and found a newsletter for members (Spring 2021 Health Talk-Take Care). The readability statistics-Flesch-Kincaid Grade Level-was 8.4.
- MCO must give each enrollee notice of any change that the 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 B 3iii).
  During the interview, UnitedHealthcare informed Primaris that letters are mailed to the enrollees whenever there is a change in the provider network. UnitedHealthcare did not provide evidence in support of their statement. For other changes, the member handbook is updated, but the members are not informed.
- 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).
  UnitedHealthcare fully complied with 36 of 48 items, partially complied with nine, and was deficient in three items.
- Provider Directory 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).

3.4 Regulation III- Emergency and Post-stabilization Services

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

3.4.1 Performance Strengths

UnitedHealthcare has policies and procedures for not denying 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. UnitedHealthcare 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 UnitedHealthcare of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. An enrollee with an emergency medical condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize him/her.

3.4.2 Corrective Action

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

Primaris noted a weakness for a criterion that is assigned a score of "Fully Met." The definition of an emergency medical condition and emergency services are not consistent and accurate in one of their policies and in the member handbook.

In reference to the evaluation tool (Appendix C), Primaris identified the following criterion that was "Partially Met":
MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO (in-network or out-of-network). MCO and providers to reach an agreement on payment for services. (MHD contract, section 2.6.12a, b), (Appendix C: section B1).

- UnitedHealthcare did not submit documentation to show an agreement with providers on payment for services.
- UnitedHealthcare must update the other supporting documents.
    - Provider Manual states, "After the member has received emergency care; the hospital must seek approval within one hour for pre-approval for more care to

make sure the member remains stable." The duration should be updated to 30 minutes instead of one hour.
- UB-04, 2020F7012C Reimbursement Policy does not incorporate the point (B 1iii) regarding the payment agreement.

3.5 Regulation IV- Subcontractual Relationships and Delegation

UnitedHealthcare was evaluated for 12 criteria under this regulation and received "Fully Met" for eight and "Partially Met" for four of them, scoring 83.3% for compliance. Appendix D provides a detailed evaluation of this regulation.

3.5.1 Performance Strengths

UnitedHealthcare has a policy and procedure in place to establish any new or change subcontracting arrangements. Primaris reviewed six subcontracts submitted by UnitedHealthcare. UnitedHealthcare acknowledged that they or their subcontractors should not knowingly employ, hire for employment, or continue to employ an unauthorized alien to perform work within the state of Missouri. All the subcontractors agreed to perform the delegated activities and reporting responsibilities specified in UnitedHealthcare's contract obligations. The contracts or written arrangements provide for revocation of the delegation of activities or obligations or specify other remedies when the MHD or UnitedHealthcare determine that the subcontractors did not perform satisfactorily.

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

3.5.2 Corrective Action

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

Primaris noted weaknesses for criteria that are assigned a score of "Fully Met."

- Rose International, Inc. Master Services Agreement (Exhibit G) is for Medicare Advantage subcontractors that comply with the criterion, "the subcontractor will make available, for purposes of an audit, evaluation, or inspection its premises,

physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees (Appendix D: section C2). This agreement does not specify its applicability Missouri Medicaid.

- The duration of record retention for 10 years is inaccurate and inconsistent in Rose International, Inc. and CareCore National, LLC. (Appendix D: section C3).

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

- MCO shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract. Primaris reviewed six contracts/agreements submitted by UnitedHealthcare for their subcontracted services. All the contracts had a similar language, as applicable, to the services. Even though the language implied that UnitedHealthcare was accountable, the contract did not explicitly state: "MCO shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract" (Appendix D: section A).
  UnitedHealthcare did not submit a policy/procedure or a Master Service Agreement that meets this criterion.
- The MHD contract, section 3.9.6 requires UnitedHealthcare to specify the delegated activities or obligations, and related reporting responsibilities, in the subcontract or written agreement (Appendix D: section B3).
  Except for one of the six subcontracts (Dental Benefit Providers), the subcontracts did not incorporate all the 19 items required by the MHD.
- Any subcontracts must include 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 (Appendix D: section D).
  Four of the six subcontracts have Fully Met this requirement, March Vision Care Group, Inc. is inconsistent with the requirement, and Rose International, Inc. does not indemnify the MHD.
- 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, its officers, employees, agents, and enrolled, Managed Care members….(Appendix D: section E)
  Primaris noted that two of the six contracts, namely, Rose International, Inc. and CareCore National, LLC, do not meet the requirement in its entirety.

3.6 Regulation V- Practice Guidelines

UnitedHealthcare 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

UnitedHealthcare has practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals. These are adopted in consultation with the network providers and reviewed and updated annually or more often as indicated by the newly published evidence. The enrollee needs are considered for developing the practice guidelines. The Member Advisory Committee (MAC), chaired by UnitedHealthcare's Director of Provider Operations and Member Engagement, is a forum for members to provide feedback and insights about services and experiences, including but not limited to cultural and linguistic needs. Furthermore, UnitedHealthcare applies Population Health Management Strategy to explore the enrollee's needs. UnitedHealthcare disseminates the guidelines to all affected providers through the company websites. On an annual basis, practitioners are notified via mail, fax, or email about the availability of these guidelines on the website. These are provided to the enrollees and potential enrollees upon request.

UnitedHealthcare 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; Inter-Rater-Reliability (IRR) assessments; conducting member surveys by external vendor; and development of targeted, relevant action plans for continuous process improvement activities.

3.6.2 Corrective Action

There are no areas of concern, so corrective action is not required.

3.7 Regulation VI- Health Information Systems

UnitedHealthcare was evaluated for 16 criteria under this regulation and received "Fully Met" for five, "Partially Met" for eight, and "Not Met" for three of them, scoring 56.3% for compliance. Appendix F provides a detailed evaluation of this regulation.

3.7.1 Performance Strengths

UnitedHealthcare maintains a health information system that supports collecting, integrating, tracking, analyzing, and reporting data. The encounters are submitted to the MHD within 30 days of payment of the claim. UnitedHealthcare maintains at least a ninety-eight percent (98%) acceptance rate on encounters submissions monthly.

3.7.2 Corrective Action

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

- MCO must provide information on areas: Utilization, grievance and appeals, and disenrollment for other than loss of eligibility (Appendix F: sections B1, B3, B4). Primaris noted that UnitedHealthcare submitted only the flow charts showing their IT architecture. UnitedHealthcare did not provide an explanation/description of their process as to how the health information system provides information on the Utilization management (UM), claims, grievances and appeals, and disenrollment.
- MCO should comply with Section 6504(a) of the Affordable Care Act, which requires claims processing and retrieval systems to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation to meet the requirements of section 1903(r)(1)(F) of the Act (Appendix F: section C1). Primaris noted that UnitedHealthcare has a policy stating its Management Information System (MIS) complies with all the Missouri Medicaid Program requirements, including Section 6405 of the Affordable Care Act. However, no documentation was provided to assess that data elements for electronic transmission of claims are consistent with the Medicaid Statistical Information System MMIS to detect fraud and abuse necessary for program integrity, program oversight, and administration. (Note: UnitedHealthcare did not have electronic transmission of claims during the review period. They did not submit data integrity requirements for processing the paper claims.
- Adherence to Key Transaction Standards: MCO shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18, 455.19, and RSMo 376.383 and 376.384 (Appendix F-section C2ii). Primaris noted that policy and procedure on HIPAA standards related to claims processing, electronic transaction standards are not submitted by UnitedHealthcare. However, they have introduced a flow chart for claims showing HIPAA Strategic National Implementation Process (SNIP) validations. (Primaris noted that UnitedHealthcare did not have Electronic Claims Management during the review period).
- MCO must have a mechanism to ensure that data received from providers are accurate and complete (Appendix F: section C3).
  UnitedHealthcare did not submit how they verify the provider data's timeliness and data collection from providers in standardized formats, including secure information exchanges and technologies utilized for MHD's quality improvement and care coordination efforts.

- MCO must collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (Appendix F: section D). UnitedHealthcare did not submit a description, and the process followed for collection and maintenance of sufficient enrollee encounter data that identifies providers who deliver the services or items.
- MCO shall ensure that critical member and provider Internet and telephone-based functions and information, including but not limited to electronic claims management and self-service customer service functions, are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the state agency and the MCO (Appendix F: section E).
  The provider's Internet and telephone-based functions and information, including but not limited to electronic claims management, were not seen on the website in March-April 2021 when Primaris conducted a desk audit/preliminary review. UnitedHealthcare had launched this functionality later in April 2021 and then submitted the screenshots, which Primaris validated on May 6, 2021.

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

- MCO has in place an electronic claims management (ECM) capability that accepts and processes claims submitted electronically (Appendix F: section C2i).
  Primaris noted during the review period, UnitedHealthcare did not have ECM functionality. UnitedHealthcare informed Primaris about its plan to launch the initiative to replace paper checks with electronic payment on April 23, 2021. During the post-site review (May 6, 2021), Primaris visited UHCprovider.com and found that UHC has launched its ECM functionality and is rolling out its electronic payment solutions.
- 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). UnitedHealthcare has not submitted any documentation in support of this requirement.
- Specifications for submitting encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 (Appendix F: section Dv).
  UnitedHealthcare submitted a policy post-site meeting with a statement that they submit encounters to the state of Missouri in ANSI Standard X12 837 format. No details are mentioned on which Primaris can ascertain UnitedHealthcare’s compliance with this criterion.

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 UnitedHealthcare 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	No concerns identified	Fully Met
438.100 (457.1220) Enrollee rights	Concerns identified	Partially Met
438.114 (457.1228) Emergency and post-stabilization services	Concerns identified	Partially Met
438.230 (457.1233b) Subcontractual relationships and delegation	Concerns identified	Partially Met
§438.236 (457.1233c) Practice guidelines	No concerns identified	Fully Met
§438.242 (457.1233d) Health information systems	Concerns identified	Not Met

4.1 Improvement by UnitedHealthcare

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

UnitedHealthcare 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. UnitedHealthcare's Response to the Previous Year's Recommendations

Recommendations	Action by UnitedHealthcare	Comment by EQRO
1. An analysis and evaluation of disease management program: The active participation rate (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility) was not reported by UnitedHealthcare. (Scored as Partially Met.) UnitedHealthcare had stated that they did not write these rates due to the technology upgradation requirement for such reporting. Primaris recommended that UnitedHealthcare provide these rates in QAPI and should communicate its difficulties to the MHD.	UnitedHealthcare provided the active participant rate for its disease management program in the most current QAPI 2020. The rate range was 95%-99% for asthma, hypertension, obesity, diabetes, depression, and attention deficit hyperactivity disorder disease management.	Fully Met There is no data from the previous year to compare and provide an analysis and evaluation. No further action is required for this year. However, UnitedHealthcare must analyze and evaluate its data in QAPI instead of only presenting the figures in the future.
2. UnitedHealthcare should report data and analysis on the availability of appointments for routine symptomatic patients per the MHD contractual requirements. (Scored as Partially Met.)	UnitedHealthcare reported its data in the current QAPI 2020. Appointment availability for routine symptomatic patients within one week of seeking an appointment was 80%.	Fully Met There is no data from the previous year to compare and provide an analysis and evaluation. No further action is required for this year. However, UnitedHealthcare must analyze and evaluate its data in QAPI instead of only presenting the figures in the future.
3. Grievances and Appeals: UnitedHealthcare reported Member	UnitedHealthcare acted on this issue by reaching out to	The issue remains open

Appeals under categories such as Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. Primaris finds these categories not aligned with the definition of adverse benefit determination & appeals per 42 CFR 438.400. Primaris recommends that UnitedHealthcare seek written clarification on expectations from the MHD. UnitedHealthcare should update data in the 2019 QAPI report and comply with the MHD's instructions for future reporting.	MHD after post-site meeting. No changes are made in the current QAPI 2020. The MHD will provide their decision	until MHD provides a clarification.

5.0 RECOMMENDATIONS

5.1 UnitedHealthcare

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

Disenrollment: Requirements and Limitations

UnitedHealthcare update its Disenrollment SOP by incorporating all the reasons when a member can request for disenrollment without cause.

Enrollee rights

- UnitedHealthcare should update its policy, MR-001 UHC MO Member Rights, to describe how UnitedHealthcare ensures Enrollee Rights. Primaris suggests UnitedHealthcare survey members for the areas not addressed in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to assess the extent to which the Enrollee's Rights are met. The providers should also be educated at regular intervals on the state and federal requirements.
- UnitedHealthcare post the member rights and responsibilities on their website under member resources so that members are aware of these even without reading the member handbook.
- UnitedHealthcare update its policy, MO-MK001 Marketing Guidelines, with the font size requirement to "conspicuously visible size" of the taglines instead of "18 font size." UnitedHealthcare member materials should be readable at the sixth grade

level.

- UnitedHealthcare must explore different ways to notify changes impacting members at least 30 days before the effective day of change and implement them.
- UnitedHealthcare must 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.
- UnitedHealthcare must update its policy, Rally-Online Directory, 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 in the network per the 42 CFR 438.10h and MHD contract, section 2.12.17. UnitedHealthcare should educate its providers about the contractual requirement for submitting their information to UnitedHealthcare.
- UnitedHealthcare should update its policy, Provider Directory Creation and Distribution, to clearly state what they mean by "processing the request within 48 hours." UnitedHealthcare is required to mail the directories to the members within 48 hours of their requests.
- UnitedHealthcare should consider providing a notification for their members on the website about requesting a paper directory.
- The only means of disseminating information to the members regarding Enrollee Rights, per 42 CFR 438.10, is via a member handbook. UnitedHealthcare should consider using its website to disseminate information about access to member-related information in a paper format. Newsletters and flyers, blogs are some suggested ways of communicating information on Enrollee Rights.

Emergency and Post-stabilization Services

- UnitedHealthcare must consistently update definitions of an emergency medical condition, emergency services, and post-stabilization services in all of its documents. UnitedHealthcare should update the policy, 2020F7012C Reimbursement, on the definition of an emergency medical condition. Also, update the definition of "emergency services" in the member handbook.
- UnitedHealthcare must update the Provider Manual that states, "After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable." The duration for approval must be updated to 30 minutes instead of one hour.
- UnitedHealthcare must provide documentation on the payment agreement with its providers on emergency and post-stabilization services (Appendix C: section B 1iii).

Suggestions

- During the interview, UnitedHealthcare informed Primaris that their Medicaid and

CHIP enrollees utilize 50% 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 UnitedHealthcare 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: 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. UnitedHealthcare responded that the health coach contacts the members after an emergency room visit but does not capture the wait time. Primaris recommends that UnitedHealthcare contact the members receiving emergency services and capture the wait time information. This data can be analyzed, compared with the national average wait time, and utlized to improve emergency services.

Subcontractual Relationships and Delegation

- UnitedHealthcare explicitly and consistently write in all the subcontracts that UnitedHealthcare shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract. UnitedHealthcare must have a policy or guidelines or Master Service Agreement that meets this criterion.
- UnitedHealthcare update all their contracts other than the Dental Benefit Providers' contract, with the requirements set under the MHD contract, section 3.9.6.

[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/
[3] https://www.bluechoicesc.com/great-expectations/ERCG

- UnitedHealthcare should update its contract with Rose International, Inc. and include Missouri Medicaid on the "right to audit."
- UnitedHealthcare should update the duration of record retention for 10 years consistently at all places in all the subcontracts.
- UnitedHealthcare update the Rose International, Inc. Master Services Agreement and March Vision Care Group, Inc., contract to consistently to ensure 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.
- UnitedHealthcare should update its subcontract with Rose International, Inc. to indemnify the state in case of any dispute between UnitedHealthcare and its providers. CareCore National, LLC contract should be updated to mention that the state will not be involved in any dispute between UnitedHealthcare and the subcontractor.

Practice Guidelines

Primaris recommends that UnitedHealthcare inform its members via any medium, e.g., member handbook, mailers, newsletters, about the availability and access of evidence-based practice guidelines.

Health Information Systems

- UnitedHealthcare must have documentation regarding the data elements for electronic transmission of claims consistent with the Medicaid Statistical Information System to detect fraud and abuse necessary for program integrity, program oversight, and administration.
- UnitedHealthcare must have policies in place for ECM and provide phone-based capabilities to obtain claims processing status information.
- UnitedHealthcare must have policies and procedures to address HIPAA standards related to claims processing, electronic transaction standards.
- UnitedHealthcare must have policies and detailed process/procedures describing their HIS System flow charts' functional/operational aspects. Also, they must address how they verify the timeliness of the reported provider data and collecting data from providers in standardized formats, including secure information exchanges and technologies utilized for MHD quality improvement and care coordination efforts.
- UnitedHealthcare 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.
- UnitedHealthcare must have a detailed description of its process and data elements

captured to identify the providers delivering services or items to enrollees.

- UnitedHealthcare should have a policy and submit evidence to show that their encounter data submitted to the MHD includes the allowed and paid amounts per 42 CFR 438.818.
- UnitedHealthcare must submit sufficient documentation to show that encounter data submitted to the MHD comply with standardized Accredited Standards Committee (ASC) X12N 837 and has implemented version 5010 transaction set.

5.2 MHD

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

- Incorporate in the MHD contract with UnitedHealthcare 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 UnitedHealthcare on ways to increase the significance of the EQR.
- Include Primaris in quality-related meetings with UnitedHealthcare and include EQR as a standing agenda item.
- Emphasize that UnitedHealthcare focus on adopting documented and measurable ways to "ensure" that its providers and staff follow the regulations per the MHD contract and the 42 CFR 438 instead of tracking the member complaint system for issues, and training/educating the staff/providers, e.g., conducting member surveys, provider surveys in addition to CAHPS.
- Identify additional ways the EQRO can assist UnitedHealthcare in meeting quality requirements, e.g., TA with quality improvement measures and models.
- **Enrollee rights**
  - Revise the MHD contract, section 2.14.6b, which states "written materials must include taglines in the prevalent non-English languages in the state, as well as large print (font size no smaller than 18 points)…" Per the Managed Care Final Rule 2020, effective December 14, 2020, the requirement of the font size 18 is replaced by "conspicuously visible size" for the taglines.
  - Primaris has not evaluated one of the criteria listed under section 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. UnitedHealthcare was required to address "the specific regulations that support or the change in federal or state law that requires the action." UnitedHealthcare did not address

this requirement due to a lack of clarity. Primaris recommends the MHD provides a clarification/expectation on this requirement.

- **Emergency and post-stabilization services**
  The MHD should revise its MHD contract, section 2.6.12i, "MCO's financial responsibility for post-stabilization care services which the MCO has not pre-approved ends when (Appendix C: section B 6):
  - An MCO physician with privileges at the treating hospital assumes responsibility for the member's care.
  - An MCO physician assumes responsibility for the member's care through transfer.
  - An MCO representative and the treating physician reach an agreement concerning the member's care.
  - The member is discharged (MHD contract, section 2.6.12i).

  In reference to the 42 CFR 422.113(c)(3), Primaris recommends the MHD update the statement in the MHD contract for the first two bullet points above to read as follows:
  - **Member's** MCO physician with privileges at the treating hospital assumes responsibility for the member's care.
  - **Member's** MCO physician assumes responsibility for the member's care through transfer.

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Appendix A

Standard 1-42 CFR 438.56 Disenrollment: Requirements and Limitations		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO may request disenrollment of an enrollee for the following reasons (MHD contract 2.12.18d1):		
1. Member persistently refuses to follow prescribed treatments or comply with MCO requirements that are consistent with federal and state laws and regulations, as amended. 2. Member consistently misses appointments without prior notification to the provider. 3. Member fraudulently misuses the MHD managed care program or demonstrates abusive or threatening conduct. Giving or loaning a member's membership card to another person, for the purpose of using services, constitutes a fraudulent action that may justify MCO's request to disenroll the member. 4. Member requests a home birth service.	MO-ENR-01 Disenrollment Effective Dates: Page 2	Fully Met
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with all the criteria listed under this section (A) of the evaluation tool. During the interview, UnitedHealthcare confirmed that they do not initiate disenrollment for any other reason than those listed above. **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-ENR-01 Disenrollment Effective Dates: Page 3	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: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with all the criteria listed under this section (B) of the evaluation tool. **Required Actions:** None.		
C. MCO must assure MHD that it does not request disenrollment for reasons other than those permitted under the MHD contract 2.12.18.		
1. Prior to requesting a disenrollment or transfer of a member, MCO shall document at least three interventions over a period of 90 calendar days which occurred through treatment, member education, coordination of services, and care management to resolve any difficulty leading to the request unless the member has demonstrated abusive or threatening behavior in which case only one attempt is required (MHD contract 2.12.18d3).	MO-ENR-01 Disenrollment Effective Dates: Page 3	Fully Met
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with all the criteria listed under 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-ENR-01 Disenrollment Effective Dates: Page 3	Fully Met
Findings: UnitedHealthcare shall cite at least one good cause before requesting that the state agency disenroll that member. **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-ENR-01 Disenrollment Effective Dates: Page 3	Fully Met
Findings: UnitedHealthcare intends to proceed with disenrollment during the 90-calendar day period, UnitedHealthcare shall give a notice citing the appropriate reason to both the member and the state agency at least 30 calendar days before the end of the 90-calendar day period. UnitedHealthcare shall document all notifications regarding requests for disenrollment. **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-ENR-01 Disenrollment Effective Dates: Page 3	Fully Met
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with all the criteria listed under this section (C4) of the evaluation tool. During the interview, UnitedHealthcare stated that it does not require a member to go through an appeal process at UnitedHealthcare before asking for disenrollment but member has the option to do so. Appeals for disenrollment are processed per the timeline in the contract. Members can challenge UnitedHealthcare's decision.		

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-ENR-01 Disenrollment Effective Dates: Page 3	Fully Met
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with all the criteria listed under 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).	MO-ENR-01 Disenrollment Effective Dates: Page 4	Fully Met
Findings: UnitedHealthcare acknowledged if it recommends disenrollment or transfer for reasons other than those stated above, the MHD shall consider UnitedHealthcare to have breached the provisions and requirements of the contract and may be subject to sanctions as described in the MHD 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	Medicaid Disenrollment Standard Operating Procedure (SOP): Page 6 MO-ENR-01 Disenrollment Effective Dates: Pages-1, 2, 5	Fully Met

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 requirement under sections 1903(m) or 1932 of the Act.).		
Findings: The Medicaid disenrollment SOP for Missouri does not state all conditions listed in this section (E) when a member can request for disenrollment without a cause. However, the policy complies with all the requirements of this section. **Required Actions:** UnitedHealthcare is recommended to update their SOP for disenrollment.		
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.	MO-ENR-01 Disenrollment Effective Dates: Pages-1, 2	Fully Met

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. 7. Reasons including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs. 8. Transfer to another MCO is necessary to correct an error made by the enrollment broker or MHD during the previous assignment process. 9. May also request a transfer for all family members to be enrolled with the same MCO. 10. When the MHD imposes sanctions on MCO for non-performance of contract requirements.		
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with all the criteria listed in this section (F) of the evaluation tool. **Required Actions:** None.		
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	MO-ENR-01 Disenrollment Effective Dates: Page 2	Fully Met

foster care placement (MHD contract 2.12.18c).		
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with all the criteria listed in this section (F) of the evaluation tool. **Required Actions:** None.		
H. Disenrollment Effective Dates:		
Member disenrollment outside of the open enrollment process shall become effective on the date specified by MHD and shall be no later than the first day of the second month following the month in which the enrollee or the MCO files the request. The disenrollment request is deemed approved if the MHD fails to make the disenrollment determination within the specified timeframes. MCO shall have written policies and procedures for complying with MHD's disenrollment orders (MHD contract 2.12.18e).	<u>Post-site meeting revision</u> MO-ENR-01 Disenrollment Effective Dates: Pages-4, 5	Fully Met
Findings: UnitedHealthcare stated they will comply with MHD's disenrollment orders upon notification or via electronic changes in the 834 enrollment file. Every business day, MHD makes available, via electronic media, updates on members newly enrolled or disenrolled in UnitedHealthcare. UnitedHealthcare receives these updates and incorporates them in their as well as the subcontractors' management information system each day. The MHD sends weekly, via electronic media, a listing of current members. UHC reconciles this membership list against their internal records within 30 business days of receipt and notifies the MHD of any discrepancies. **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-ENR-01 Disenrollment Effective Dates: Page 5	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: Every business day, the MHD provides updates on members enrollment and disenrollment data via electronic media. UnitedHealthcare receives these updates and incorporates them in theirs, as well as the subcontractors' management information system daily. UnitedHealthcare sends weekly, via electronic media, a list of current members to MHD. UnitedHealthcare reconciles this membership list against their internal records within 30 business days of receipt and notifies the MHD of any discrepancies. **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-ENR-01 Disenrollment Effective Dates: Page 4	Fully Met
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with the requirement stated in this section (J1) of the evaluation tool. **Required Actions:** None.		
2. Members, including newborn members, who are in another MCO at the time of acute inpatient	MO-ENR-01 Disenrollment Effective Dates: Page 4	Fully Met

hospitalization on the effective date of coverage, shall remain with that MCO until an appropriate acute inpatient hospital discharge.		
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with the requirement stated in this section (J2) of the evaluation tool. **Required Actions:** None.		
3. Members, including newborn members, who are hospitalized in an acute setting, shall not be disenrolled from MCO until an appropriate acute inpatient hospital discharge unless the member is no longer MHD Fee-For-Service or MHD Managed Care eligible or opts out.	MO-ENR-01 Disenrollment Effective Dates: Page 4	Fully Met
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with the requirement stated in this section (J3) of the evaluation tool. **Required Actions:** None.		
4. For the purpose of a member moving from one MCO to another MCO, in addition to acute inpatient hospitalizations, admissions to facilities that provide a lower level of care in lieu of an acute inpatient admission may be considered as an acute inpatient hospitalization for purposes of this section. MHD reserves the right to determine if such an admission qualifies as an acute inpatient hospitalization. Only acute inpatient hospitalization shall apply when a new member moves from the MHD Fee-For-Service Program to MHD Managed Care. MCO shall provide timely notification to MHD of a member's acute inpatient hospitalization on the effective date of coverage to affect a retroactive/prospective adjustment in the coverage dates for MHD Managed Care.	MO-ENR-01 Disenrollment Effective Dates: Page 4	Fully Met

Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, complies with the requirement stated in 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 the open enrollment, the first 90 calendar days of initial enrollment, or for just cause. 2. To implement the decision of a hearing officer in a grievance proceeding by the member against the MCO, or by the MCO against the member. 3. Loss of eligibility for either MHD Fee-For-Service or Managed Care. 4. Member exercises choice to voluntarily disenroll, or opt-out, as specified herein under MHD Managed Care Program eligibility groups (MHD contract, section 2.12.18a).	MO-ENR-01 Disenrollment Effective Dates: Page 1	Fully Met
Findings: UnitedHealthcare's policy, MO-ENR-01 Disenrollment Effective Dates, acknowledges MHD's criteria for disenrollment of members. **Required Actions:** None.		

Compliance Score–Disenrollment: Requirements and Limitations						
Total	Met	=	18	×2	=	36
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	36
Denominator	Total Sections	=	18	×2	=	36
Score%						100

Appendix B

Standard 2-42 CFR 438.100 Enrollee Rights		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. MCO should have written policies regarding enrollee rights. The MCO shall include, in its policies and procedures, a description of how it will ensure that the rights of members/enrollees are safeguarded and how the MCO will (1) comply with any applicable federal and state laws that pertain to member rights, and (2) ensure that its staff and in-network providers take those rights into account when furnishing services to members. These include the right to (MHD contract 2.14.8):		
1. Dignity and privacy. Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.	MR-001 UHC MO Member Rights: Page 1 Community MO HealthNet Managed Care-Member Handbook: Page 78 Care Provider Manual 2020: Page 56	Fully Met
Findings: UnitedHealthcare's policy, MR-001 UHC MO Member Rights, complies with the requirement of this section (A1). UnitedHealthcare's member handbook incorporates this information. UnitedHealthcare informs its providers on the member rights and responsibilities via their provider manual. However, Primaris did not find the information on the website following the link provided in the manual (UHCprovider.com/mocommunityplan). This information is present at another place on the website and may not be easily accessed by a member. **Required Actions:** Primaris recommends UnitedHealthcare to post the member rights and responsibilities on their website under member resources, in addition to the information provided in the member handbook.		
2. Receive information on available treatment options. Each member is guaranteed the right to receive information on available treatment	MR-001 UHC MO Member Rights: Page 1	Fully Met

options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.		
Findings: UnitedHealthcare's policy, MR-001 UHC MO Member Rights, complies with the requirement of this section (A2). UnitedHealthcare's member handbook incorporates this information. **Required Actions:** None.		
3. Participate in decisions. Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.	MR-001 UHC MO Member Rights: Page 1	Fully Met
Findings: UnitedHealthcare's policy, MR-001 UHC MO Member Rights, complies with the requirement of this section (A3). UnitedHealthcare's member handbook incorporates this information. During the interview, UnitedHealthcare reported that members participate in decision-making regarding their health through the care management program. This serves as a platform for collaboration between the member, caregiver, care manager, and provider. The care manager assesses the member and creates a list of questions to ask the provider. A conference call is set up with the member and provider. **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.	MR-001 UHC MO Member Rights: Page 1	Fully Met
Findings: UnitedHealthcare's policy, MR-001 UHC MO Member Rights, complies with the requirement of this section (A4). UnitedHealthcare's member handbook incorporates this information. **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	MR-001 UHC MO Member Rights: Page 1	Fully Met

164.526 (if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies).		
Findings: UnitedHealthcare's policy, MR-001 UHC MO Member Rights, complies with the requirement of this section (A5). UnitedHealthcare's member handbook incorporates this information. **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.	MR-001 UHC MO Member Rights: Page 1	Fully Met
Findings: UnitedHealthcare's policy, MR-001 UHC MO Member Rights, complies with the requirement of this section (A6). UnitedHealthcare's member handbook incorporates this information. **Required Actions:** None.		
B. Enrollees should receive information in accordance with 42 CFR 438.10.		
1. Language and Format (MHD contract 2.14.6). All written materials for enrollees should be consistent with the following: i. Easily understood language and format. Font size no smaller than 12 points/conspicuously visible font size. ii. Written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service area. iii. Written materials that are critical to obtaining services must also be	MO-MK001 Marketing Guidelines: Pages-5, 6	Partially Met

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 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: UnitedHealthcare's policy, MO-MK001 Marketing Guidelines, meets all the requirements listed in this section (B1) of this evaluation tool. However, Primaris visited UnitedHealthcare's website on April 23, 2021, and found a newsletter for members (Spring 2021 Health Talk-Take Care) with the readability statistics-Flesch-Kincaid Grade Level of 8.4. **Required Actions:** Primaris recommends UnitedHealthcare update its policy with the font size requirement to "conspicuously visible size" of the taglines as opposed to"18 font size." The same will be communicated to the MHD to amend the MHD contract. UnitedHealthcare member materials should be readable at the sixth grade level.		
2. MCO must make a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from or was seen on a regular basis by, the terminated provider. Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.	MO-MK001 Marketing Guidelines: Page 6 MO-PTMN001 Provider Termination Member Notification: Page 1 <u>Post-site meeting submission:</u> Member Notice Template	Fully Met
Findings: At UnitedHealthcare, if a primary care provider ceases participation in UnitedHealthcare's provider network, UnitedHealthcare will send written notices to the members who have chosen or are assigned to that provider as their primary care provider. UnitedHealthcare shall mail information about how to select a new primary care provider, at least thirty (30) calendar days prior to the effective date of the termination, or 15 calendar days after receipt of issuance of the termination notice. **Required Actions:** None.		
3. Enrollee/Member handbook. i. MCO shall provide a member handbook and other written materials with information on how to access	MO-MK001 Marketing Guidelines: Pages-6, 7	Fully Met

services, to all members within 10 business days of being notified of their future enrollment with the MCO. Information will be considered to be provided if the MCO: • Mails a printed copy of the information to the enrollee's mailing address; • Provides the information by email after obtaining the enrollee's agreement to receive the information by email; • Posts the information on the website of the MCO and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or • Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.		
Findings: UnitedHealthcare's policy, MO-MK001 Marketing Guidelines, meets all the requirements listed in this section (B3i) of this evaluation tool. **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-MK001 Marketing Guidelines: Page 7	Fully Met
Findings: UnitedHealthcare's policy, MO-MK001 Marketing Guidelines, meets all the requirements listed in this section (B3ii) of this evaluation tool. UnitedHealthcare		

submitted its member handbook with annual revisions to the MHD on Jun 23, 2020, and received approval from the MHD. **Required Actions:** None.		
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).	MO-MK001 Marketing Guidelines: Page 7	Partially Met
Findings: UnitedHealthcare states that they shall give each enrollee notice of any change that the state defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. During the interview, UnitedHealthcare reported whenever there is a change in the provider network, letters are mailed to the enrollees. It is unclear if the letters are mailed to all the enrollees or to the affected enrollees. For other changes, the member handbook is updated but the members are not informed. No evidence was submitted to assess compliance with this section of the evaluation tool. **Required Actions:** UnitedHealthcare must explore and implement different ways to notify changes impacting members at least 30 days before the effective day of change.		
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.	Community MO HealthNet Managed Care-Member Handbook: Pages-3, 5, 7-12, 15, 20-23, 27-30, 32-69, 72, 75-82, 84	Partially Met

d. A listing of the member's rights and responsibilities as described in MHD contract 2.14.8 (section A of this tool). e. Appointment procedures and the appointment standards described in the MHD contract. f. Notice that the adult member must present the MHD identification card (or other documentation provided by the state agency demonstrating MHD eligibility), as well as the MCO membership card, in order to access non-emergency services, and a warning that any transfer of the identification card or membership card to a person other than the adult member for the purpose of using services constitutes a fraudulent act by the adult member. g. A description of all available MCO services, an explanation of any service limitations or exclusions from coverage, and a notice stating that MCO shall be liable only for those services authorized by MCO. h. Information on how and where members can access any benefits provided by the state, including how transportation is provided. i. A description of all available services outside the comprehensive benefit package. Such information shall include information on where and how members may access benefits not available under the comprehensive benefit package. j. The definition of medical necessity used in determining whether benefits will be covered.		

(Note: A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health condition or injury; (2) is necessary for the member to achieve age-appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity.) k. A description of all prior authorization or other requirements for treatments and services. l. A description of utilization review policies and procedures used by MCO. m. An explanation of a member's financial responsibility for payment when services are provided by an out-of-network provider or by any provider without required authorization or when a procedure, treatment, or service is not covered by the MO HealthNet Managed Care Program. n. Notice that a member may receive services from an out-of-network provider when MCO does not have an in-network provider with appropriate training and experience to meet the health care needs of the member and the procedure by which the member can obtain such referral. o. Notice that a member with a condition that 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 another 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: UnitedHealthcare's member handbook "Met" 36 of 48 criteria mandated in the MHD contract. There are nine criteria scored as "Partially Met" and three criteria are scored as "Not Met." Primaris has assigned a combined score of "Partially Met" for the Member handbook compliance (section B3iv of this evaluation tool).
The following nine criteria are "Partially Met":

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

i. A description of all available services outside the comprehensive benefit package including information on where and how members may access benefits not available under the comprehensive benefit package-is not stated.
Primaris requested clarification from UnitedHealthcare and UnitedHealthcare responded just one service, Healthy First Steps, is outside of the comprehensive benefit package.

t. All the conditions under which an enrollee can disenroll with or without cause are not listed.

v. Time allowed to file a grievance is not indicated. UnitedHealthcare requires a member to complete a written request for an appeal even if the member filed orally: however, 42 CFR 438.402 allows an enrollee to request an appeal either orally or in writing effective Dec 14, 2020.

a6. Information on how to access behavioral health when in crisis, is not indicated. UnitedHealthcare responded the member should use the same toll-free number provided for emergency medical services. Primaris recommends UnitedHealthcare clearly state in their member handbook that the same toll-free number is applied for both emergency medical services and emergency behavioral health services.

a.15 Information on how to access auxiliary aids and services, including additional information in alternative formats or languages is not provided for the members. This requirement is stated under the "state fair hearing."

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

a.20. Information on how a member can request to obtain a free copy of his/her medical record annually is not provided.

a.22. Information on how members can obtain information from the state agency about the access of the services that MCO does not cover because of moral or religious objections is not mentioned.

There are three criteria scored as "Not Met" in the member handbook: k. A description of all prior authorization or other requirements for treatments and services is missing. q. How a member with life a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, may request access to a specialty care center and the procedure by which such access may be obtained. y. Information about the disease management program is not provided. UnitedHealthcare informed Primaris that they do not have a separate program, it is included in the care management. Primaris recommends UnitedHealthcare include a reference to disease management in the description of care management program per the requirement of the MHD contract. Primaris has not evaluated one of the criteria listed under section B3iv (v) of this evaluation tool: "The specific regulations that support or the change in federal or state law that requires the action." Primaris has requested a clarification on this requirement from MHD. Also, UnitedHealthcare has not addressed it in their member handbook as they are unaware of this requirement. **Required Actions:** UnitedHealthcare is recommended to update its member handbook to meet all the 48 criteria 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	Provider Directory MO HealthNet Managed Care (Regions: Central, East, West, Southwest) Provider Directory Creation and Distribution (old): Page 1 Attachment: Excel sheet-Standard Fields for Directory <u>Post-site meeting submission</u> Provider Directory Creation and Distribution (latest): Page 1 Rally-Online Directory: Pages-2, 3	Partially Met

offices, exam room(s), and equipment.		

Findings: UnitedHealthcare's policy, Rally-Online Directory states that the Rally Connect directory (online tool) is utilized by members when locating a doctor. Rally allows the ability to search for a provider by:

- Zip Code
- Facility / Provider
- Specialty Type
- Plan Name (Plan/Product)

Ability to further refine the search in Rally include:

- Distance (Location)
- Preferred Provider Status (If applicable to the Healthplan)
- Patient Reviews
- Specialties/Desired PCP
- Accepts Medicaid
- Language
- Gender
- Hospital Affiliation
- Areas of Expertise (if applicable)
- Cultural Competency (if Yes)
- Home and Community-Based Services (if applicable)

Primaris noted that the information on panel status and URL Website is missing in UnitedHealthcare's policy, Rally-Online Directory.

Primaris evaluated the PDF version of the provider directory submitted by UnitedHealthcare. The information on cultural and linguistic capabilities including American Sign Language or a skilled medical interpreter at the provider's office is not provided for all the providers. Information on accommodations for people with physical disabilities, including offices, exam room(s), and equipment is also not provided. UnitedHealthcare responded on the issue by stating the information is displayed for those providers who submit this information as part of their provider record set up.
Required Actions: UnitedHealthcare is recommended to update their policy, Rally-Online Directory, 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. The providers should be informed about the contractual requirement of these criteria for submitting their information at UnitedHealthcare.

Following are a few suggestions for improving the provider directory in a user-friendly format:

• Table of contents should be provided in the provider directory so that members can locate different providers: PCPs; specialists; hospitals; BH providers; ancillary providers; and FQHCs. Currently, there is no differentiation except in the header section. • 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. Currently, some of the icons explained at the beginning of the provider directory (e.g., directory for the central region, page 10) references using in some icons not found in the entire directory.		
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 HealthNet Managed Care (Regions: Central, East, West, Southwest)	Partially Met
Findings: Cultural and linguistic capabilities including American Sign Language or a skilled medical interpreter at the provider's office are not listed for all providers and 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).	Provider Directory Creation and Distribution: Page 2 Attachment: Provider Directory Maintenance Schedule Standard Operating Procedure (SOP): Pages-1 <u>Post-site meeting submission</u> Medicaid Refresh Schedule (log-MO)	Fully Met

Findings: According to UnitedHealthcare's policy, Provider Directory Creation and Distribution, the provider directories are updated weekly on Thursdays and posted to the website on Fridays. Automated directories and manual paper directories are created from the extracts in the Consolidated file. The automated PDF directories are created on the following Tuesday by a vendor, O'Neil, and maintained weekly. **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).	Community MO HealthNet Managed Care-Member Handbook: Pages-21, 78 Provider Directory Creation and Distribution: Page 2	Fully Met
Findings: The member handbook provides information that a member will be provided a provider directory in the mail within 48 hours of his/her request. Primaris verified the provider directory is available on UnitedHealthcare's website in March 2021. UnitedHealthcare explained its process of manually generating a provider directory. When a member or prospective member requests a new or replacement directory: • Orders are generated using Macess or O'Neil's (vendors) online portal. • The requestor will enter the number of directories needed, name, address, city, state, and zip code. • The request is submitted to the vendor to be processed within 48 hours (two business days). **Required Actions:** UnitedHealthcare should update its policy to reflect clearly what they mean by "processing the request within 48 hours." UnitedHealthcare is required to mail the directories to the members within 48 hours of their requests. UnitedHealthcare should consider providing a notification for their members on the website about how to request a paper directory.		
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.	MR-001 UHC MO Member Rights: Page 2 Community MO HealthNet Managed Care-Member Handbook: Pages-18, 21, 25	Fully Met

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).		
Findings: UnitedHealthcare will publish the rights and responsibilities in the member and provider handbooks and distribute them to all new members and new practitioners. These documents will be available to members in additional languages upon request. UnitedHealthcare will annually publish and distribute these rights and responsibilities (via newsletters or manuals) or annually notify members, practitioners, and providers of their availability on the applicable UnitedHealthcare member and provider websites. If a member/provider calls the member/provider services, the agent will direct the member/provider and assist with their questions. The agent will also reference the member rights and responsibilities stated in the member handbook or provider manual. The member handbook states a printed copy of the information on the UnitedHealthcare website will be available at no cost within five business days of the member's request. **Required Actions:** The only means of dissemination of information to the members regarding Enrollee Rights, per 42 CFR 438.10, is via a member handbook. Newsletters and manuals are not used to provide this information. UnitedHealthcare should consider using its website as a means to disseminate information about how to access member-related information in a paper format.		
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.	MR-001 UHC MO Member Rights: Page 2 Community MO HealthNet Managed Care-Member Handbook: Page 4	Fully Met
Findings: Unitedhealthcare has a policy that complies with the requirements listed in this section (C).		

Notification about non-discrimination amongst members because of race, color, national origin, sex, age, or disability is also provided in the member handbook. The members can file a grievance on phone, in person, or writing, if they have a complaint about discrimination, with UnitedHealthcare. The members can also file civil rights complaints with the U.S. Department of Health and Human Services. The contact information and procedure are provided in the member handbook.

Required Actions: None.

Compliance Score–Enrollee Rights						
Total	Met	=	13	×2	=	26
	Partial Met	=	5	×1	=	5
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	31
Denominator	Total Sections	=	18	×2	=	36
Score%						86.11

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).	2020F7012C Reimbursement Policy: Page 1 Community-MO HealthNet Managed Care (Member Handbook): Page 35 <u>Post-site meeting submissions</u> Revised-Community-MO HealthNet Managed Care (Member Handbook): Page 34 MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 1	Fully Met
Findings: The documents submitted by UnitedHealthcare post-site meeting have been updated/created to meet all aspects of the definition for "emergency medical condition." **Required Actions:** Primaris recommends UnitedHealthcare update its policy, 2020F7012C Reimbursement, submitted for desk review to meet the correct definition as provided in this section of the evaluation tool.		
2. Emergency services means covered inpatient and outpatient services that are as follows:	Community-MO HealthNet Managed Care (Member Handbook): Page 35	Fully Met

• 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.	Post-site meeting submission MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 2	
Findings: UnitedHealthcare's policy meets the definition of "emergency services." However, the member handbook does not include the first bullet point mentioned in this section of the evaluation tool. Since Primaris is not evaluating the member handbook under this regulation, it is scored as "Fully Met." The requirements of the member handbook will be evaluated under "Enrollees Rights" and scored accordingly. **Required Actions:** UnitedHealthcare is recommended to update the definition of "emergency services" in the member handbook.		
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.	Community-MO HealthNet Managed Care (Member Handbook): Page 45 Post-site meeting submission MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 2	Fully Met
Findings: UnitedHealthcare has defined the post-stabilization care services correctly in their submitted documents. **Required Actions:** None.		
B. Coverage and Payment of emergency services and Post-stabilization care services:		
1. MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO (in-network or out-of-network). i. MCO shall pay out-of-network providers for emergency services at the current MHD program rates in effect at the time of service.	UB-04, 2020F7012C Reimbursement Policy: Page 2 Community-MO HealthNet Managed Care (Member Handbook): Pages-45, 46 2020 Care Provider Manual: Page 29 Post-site meeting submission	Partially Met

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).	MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 2	
Findings: The document submitted post-site meeting meets the requirement of this section of the evaluation tool. However, UnitedHealthcare has not submitted documentation to show an agreement with providers on payment for services. The other documents listed above need to be updated with the correct information. E.g., • Provider Manual states, "After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable." The duration should be updated to 30 minutes instead of one hour. • UB-04, 2020F7012C Reimbursement Policy does not incorporate the point (iii) regarding payment agreement as mentioned in this section. **Required Actions:** Primaris recommends UnitedHealthcare update its policies/manual with the above-mentioned information. They must submit documentation on agreement with providers on payment for services.		
2. MCO may not deny payment for treatment obtained under either of the following circumstances: i. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of the emergency medical condition. ii. A representative of the MCO instructs the enrollee to seek emergency services.	Post-site meeting submission MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Pages-2, 3	Fully Met
Findings: UnitedHealthcare is compliant with the requirements of this section 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	Post-site meeting submission MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 3	Fully Met

that determination is binding on the MCO as responsible for coverage and payment.		
Findings: UnitedHealthcare is compliant with the requirements of this section of the evaluation tool. **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).	Community-MO HealthNet Managed Care (Member Handbook): Page 45 Post-site meeting submission MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 3	Fully Met
Findings: The member handbook states UnitedHealthcare will pay for post-stabilization care received in or out of network and is pre-approved by a UnitedHealthcare provider or representative. The policy listed above also meets the requirement of this section. **Required Actions:** None.		
5. MCO shall be financially responsible for post-stabilization care services, obtained within or outside the MCO, that are not pre-approved by an MCO provider or other MCO representative but are administered to maintain, 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	Community-MO HealthNet Managed Care (Member Handbook): Page 45 Post-site meeting submission MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 3	Fully Met

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: The policy submitted by the UnitedHealthcare Post-site meeting complies with the requirement listed above under this section 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 agreement concerning the member's care. • The member is discharged (MHD contract, section 2.6.12i).	Community-MO HealthNet Managed Care (Member Handbook): Page 45 <u>Post-site meeting submission</u> MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 3, 4	Fully Met
Findings: UnitedHealthcare's policy submitted Post-site meeting complies with the MHD contract's verbatim. **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).	<u>Post-site meeting submission</u> MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 4	Fully Met

Findings: UnitedHealthcare's policy submitted post-site meeting complies with the requirement of this section. **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.	2020 Care Provider Manual: Page 29 <u>Post-site meeting submission</u> MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 4	Fully Met
Findings: The provider manual states: "Depending on the need, the member may be treated in the ER, in an inpatient hospital room, or another setting. This is called Post Stabilization Services. Members do not pay for these services. This applies whether the member receives emergency services in or outside their service area." The policy submitted post-site meeting complies with the requirement of this section. **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 enrollee's screening and treatment within 10 calendar days of presentation for emergency services.	<u>Post-site meeting submission</u> MO-ERPAY-001 Emergency and Post-stabilization Reimbursement: Page 4	Fully Met
Findings: The policy submitted Post-site meeting complies with the requirement of this section. **Required Actions:** None.		

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

Appendix D

Standard 4–42 CFR 430.230 Subcontractual Relationships and Delegation		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
A. Notwithstanding any relationship(s) that the MCO may have with any subcontractor, the MCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the state. MCO shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract (MHD contract, section 3.9.2).	Dental Benefit Providers-Dental Services Agreement: Page 3 Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 13 Rose International, Inc. Master Services Agreement, Exhibit H: Page 47 CareCore National, LLC Addendum 28 (Missouri State Programs Appendix): Page 7 March Vision Care Group, Inc. (Missouri State Programs Regulatory Requirements Appendix): Page 13 Children's Mercy Integrated Care Solutions (CMICS), Inc. Agreement: Page 35 Medical Transportation Management (MTM) Amendment 9 (Addendum 4): Pages-3, 4	Partially Met
Findings: Primaris reviewed six contracts/agreements submitted by UnitedHealthcare for their subcontracted services. All the contracts had a similar language, as applicable, to the services. Even though the language implied that UnitedHealthcare was accountable, the contract did not explicitly state: "MCO shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract." The Dental Benefit Providers contract states: "UnitedHealthcare understands and agrees that the subcontractor is not responsible for any delay in the performance of the dental services agreement or any non-performance if the delay or non-performance is caused or materially contributed to by UnitedHealthcare's failure to furnish any material information described in		

the dental services agreement. Nothing in the subcontract relieves UnitedHealthcare of its responsibility under the state contract." March Vision Care Group, Inc. Agreement (page 26) states: "Vendor is administratively and financially responsible for full-service benefit plans for any claims for covered services provided prior to expiration or termination date…." This is non-compliant with the criterion under evaluation, even though it is correctly written on another page in the contract. CMICS Agreement states: "Without limiting the foregoing or UnitedHealthcare's delegation of any Managed Care Program Services to CMICS, UnitedHealthcare shall remain accountable to MHD for complying with its obligations under the contract between UnitedHealthcare and MHD." However, on page 27, the contract states, "vendor is administratively and financially responsible…." **Required Actions:** Primaris recommends UnitedHealthcare comply with the requirement that UnitedHealthcare shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract. This requirement should be explicitly and consistently written in all subcontracts. UnitedHealthcare must have a policy or guidelines or Master Service Agreement that meets this criterion.		
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).	<u>Post-site meeting submission</u> MO.SO-003 Subcontractor Oversight	Fully Met
Findings: UnitedHealthcare has acknowledged in its policy that it will obtain approval from the state of Missouri prior to establishing a new contract or making any change to its existing contract. During the interview, UnitedHealthcare reported their process of subcontracting. They utilize their relationships for subcontracting with their other commercial markets. The subcontractors go through a process of pre-audits to test if they meet all the state and federal requirements. **Required Actions:** None.		
2. Pursuant to subsection 1 of section 285.530, RSMo, no contractor or subcontractor shall knowingly employ, hire for employment, or continue to employ an unauthorized alien to	Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 12	Fully Met

perform work within the state of Missouri (MHD Contract, section 3.9.5).	Rose International, Inc. Master Services Agreement: Pages-1, 2 CareCore National, LLC Addendum 28 (Missouri State Programs Appendix): Page 7 March Vision Care Group, Inc. (Missouri State Programs Regulatory Requirements Appendix): Page 12 CMICS, Inc. Agreement: Page 4 MTM Amendment 8 (Missouri State Programs Regulatory Requirements Appendix): Page-11	
Findings: Dental Services Agreement states: "At the time of execution of the agreement and semi-annually thereafter, the subcontractor shall require providers to provide a written attestation that they shall not knowingly utilize the services of an unauthorized alien to perform work under the subcontract and agreement, and shall not knowingly utilize the services of any subcontractor or other provider who will utilize the services of an unauthorized alien." Rose International, Inc., Master Services Agreement states: "Vendor (subcontractor) represents and warrants that all vendor personnel will hold appropriate and valid visas or other work authorizations for the jurisdiction in which such individuals will be working, each of which will be valid for a period at least equal to the anticipated duration of each such individual's assignment to the Customer's (UnitedHealthcare's) account…." CareCore National, LLC Addendum 28 (Missouri State Programs Appendix) complies with this section of the evaluation tool. All six contracts comply with the criterion under evaluation. **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.	Dental Benefit Providers-Dental Services Agreement: Pages-4, 15, 19, 25, 27, Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit A: Pages-4, 5	Partially 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.	Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Pages-4, 5, 6, 7, 11, 12 Rose International, Inc. Master Services Agreement: Pages-1, 3, 43 Rose International, Inc. Statement of Work (SOW): Pages-1, 11, 14, 23 CareCore National, LLC. Addendum 28 (Exhibit A): Pages-3, 5, 6, 10, CareCore National, LLC. Third Amendment to Addendum 28: Pages-8, 9, 10, 11 March Vision Care Group, Inc. Agreement: Pages-4, 5, 14, 19, 20, 21, 23, 24, 26 March Vision Care Group, Inc. (Missouri State Programs Regulatory Requirements Appendix): Page 4, 5, 6, 10, 11, 12 CMICS, Inc. Agreement: Pages-5, 6, 11, 15, 22, 36, 45, 64 CMICS, Inc. (Missouri State Programs Regulatory Requirements-Provider)-Pages-5, 7, 8, 11, 12, 13, 14 MTM Agreement: Page 10, 11, 38 MTM Amendment 8 (Missouri State Programs Regulatory	

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.	Requirements Appendix): Pages-3, 7, 8, 10, 11, 12 MTM Amendment 9 (Addendum 4): Page-3	

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: Dental Benefit Providers' contract is compliant with all the 19 listed criteria in this section B3 of the evaluation tool. The other contracts submitted by UnitedHealthcare fell short of meeting all these requirements listed under section B3 of the evaluation tool, as follows:
Rose International, Inc. states: Before providing any component of the Services from a location outside of the United States, Vendor must obtain Customer's written approval, which may be withheld by Customer in its sole discretion. Before entering into a subcontract for work to be performed outside of the United States, the vendor must provide to the customer a description of the scope and material terms (other than financial) of the proposed subcontract. This is non-compliant with section B3 xviii. Rose International, Inc. is also non-compliant with section B3: v, xii, xiv, xvi (listed for Medicare Advantage and not for Medicaid), iv, xvii; and Partially Met-xviii. The sections not applicable for this contract are vi, vii, ix, x, xi, xiii, xv, xix.

CareCore National, LLC. Partially Met-xiv (no explanation provided about consumer protection); Not Met-xv.

March Vision Care Group, Inc. Partially Met-xii (does not mention contractor should continue services for the period which capitation payment is provided.), xi (RSMo codes for claims, guidelines are missing).

CMICS, Inc. Partially Met-xi, xiv (xix is out of scope).

MTM: Not Met-xiii.

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

Required Actions: Primaris recommends UnitedHealthcare update all their contracts other than the Dental Benefit Providers' contract with the requirements set under the MHD contract, section 3.9.6.

4. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's entity's contract obligations.	Dental Benefit Providers-Dental Services Agreement: Page 22 Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 13 Rose International, Inc. Master Services Agreement, Exhibit H: Page 47 CareCore National, LLC. Third Amendment to Addendum 28: Page 4 March Vision Care Group, Inc. Agreement: Page 21 CMICS, Inc. Agreement: Pages-8, 43 CMICS, Inc. (Missouri State Programs Regulatory Requirements-Provider)-Page-14 Medical Transportation Management (MTM) Agreement: Pages-9, 12, Medical Transportation Management (MTM) Amendment 8 (Missouri State Programs Regulatory Requirements Appendix): Page 9	Fully Met
Findings: All six contracts are compliant with this criterion. The master template (Exhibit H) submitted by UnitedHealthcare in the agreement with Rose International, Inc. states: "Vendor (subcontractor) and customer (UnitedHealthcare) agree to comply with all applicable federal, state, and local laws, rules, and regulations in connection with the performance of their obligations under the agreement. All tasks under the agreement also must be performed in accordance with the requirements of applicable contracts between any customer affiliate and state and/or federal regulatory agencies. The customer will provide or otherwise communicate such requirements to Vendor. Vendor shall ensure all agents, employees,		

assigns and subcontractors, if any, that are involved in providing services under the agreement also comply with this section." CareCore National, LLC. The third Amendment to Addendum 28 is also compliant. CMICS Inc. contract also states that the contractor will comply with applicable regulatory requirements including, but not limited to, those relating to the provision of delegated activities. **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 determine that the subcontractor has not performed satisfactorily.	Dental Benefit Providers-Dental Services Agreement: Page 10 Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 13 Rose International, Inc. Master Services Agreement: Pages-11, 47 (Exhibit H) CareCore National, LLC Addendum 28 (Missouri State Programs Appendix): Page 7 March Vision Care Group, Inc. Agreement: Pages-6, 10 March Vision Care Group, Inc. (Missouri State Programs Regulatory Requirements Appendix): Pages-13, 42, 43 CMICS, Inc. Agreement: Pages-13, 14, 39, 40, 41 CMIS, Inc. (Missouri State Programs Regulatory Requirements-Provider)-Page-14 Medical Transportation Management (MTM) Amendment 8 (Missouri State Programs Regulatory Requirements Appendix): Page-13	Fully Met

Findings: All six contracts are compliant with this criterion. The seventh amendment of the Dental Benefit Providers' Dental Services Agreement states: "In addition to UnitedHealth's termination rights under the subcontract, UnitedHealthcare shall have the right to revoke any functions or activities UnitedHealthcare delegates to the subcontractor under the agreement or impose other sanctions consistent with the state contract if in UnitedHealthcare's reasonable judgment the subcontractor's performance under the subcontract is inadequate. UnitedHealthcare shall also have the right to suspend, deny, refuse to renew or terminate the subcontractor in accordance with the terms of the state contract and applicable law and regulation." **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 the 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.	Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 7 Dental Benefit Providers-Notice of Regulatory Updates (Nov 20, 2019) Rose International, Inc. Master Services Agreement (Exhibit H): Page 49 CareCore National, LLC. Third Amendment to Addendum 28: Page 5 March Vision Care Group, Inc.-Notice of Regulatory updates (Nov 14, 2019) MTM Amendment 8 (Missouri State Programs Regulatory Requirements Appendix): Page 4 CMICS, Inc. (Missouri State Programs Regulatory	Fully Met

	Requirements-Provider)-Page 5	
Findings: UnitedHealthcare served a notice to Dental Benefit Providers, Inc. on Nov 20, 2019, to replace their previous language in Exhibit E with the above language as stated in section C1 of this evaluation tool. A similar notice was also served to March Vision Care Group, Inc. on Nov 14, 2019, as an update to the language in their contract. The master template (Exhibit H) submitted by UnitedHealthcare in the agreement with Rose International, Inc. states: "Vendor (subcontractor) must permit access by the Secretary of HHS and the Office of Inspector General or their designees, in the case of Federally Facilitated Exchange ("FFE") business, or comparable state regulators, in the case of State Exchange business, in connection with their right to evaluate through an audit, inspection, or other means, to vendor's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the UnitedHealthcare's obligations in accordance with federal standards under 45 CFR §156.340…." CareCore National, LLC (Third Amendment to Addendum 28) complies with this requirement. **Required Actions:** UnitedHealthcare is advised to update their March Vision Care Group, Inc. (Missouri State Programs Regulatory Requirements Appendix-Page 7) at all places.		
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.	Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 7 Dental Benefit Providers-Notice of Regulatory Updates (Nov 20, 2019) Rose International, Inc. Master Services Agreement (Exhibit G): Page 44 CareCore National, LLC. Third Amendment to Addendum 28: Page 5 March Vision Care Group, Inc.-Notice of Regulatory updates (Nov 14, 2019) CMICS, Inc. (Missouri State Programs Regulatory Requirements-Provider)-Page 5	Fully Met

	MTM-Amendment 8 (Missouri State Programs Regulatory Requirements Appendix: Page 5 <u>Post-site meeting submission</u> MO.SO-003 Subcontractor Oversight	
Findings: UnitedHealthcare served a notice to Dental Benefit Providers, Inc. on Nov 20, 2019, to replace their previous language in Exhibit E with the above language as stated in section C2 of this evaluation tool. A similar notice was served to March Vision Care Group, Inc. as an update to the language in their contract. Rose International, Inc. Master Services Agreement (Exhibit G) is for Medicare Advantage subcontractors that comply with this section. This contract does not comply with this criterion for MHD. At the post-site meeting, UnitedHealthcare submitted a policy, MO.SO-003 Subcontractor Oversight, which complies with the requirement of this section of the evaluation tool. **Required Actions:** UnitedHealthcare should update its contract with Rose International, Inc. so that it is applicable for Missouri Medicaid.		
3. The right to audit (as listed in section C1 of this evaluation tool) will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.	Dental Benefit Providers-Dental Services Agreement: Page-41 Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 7 Dental Benefit Providers-Notice of Regulatory Updates (Nov 20, 2019) Rose International, Inc. Master Services Agreement, Exhibit H: Page 50; and Exhibit G: Page 44 CareCore National, LLC. Third Amendment to Addendum 28: Page 5	Fully Met

	March Vision Care Group, Inc.- Notice of Regulatory updates (Nov 14, 2019) March Vision Care Group, Inc. Agreement: Page 5 CMICS, Inc. (Missouri State Programs Regulatory Requirements-Provider)-Page 5 MTM Amendment 8 (Missouri State Programs Regulatory Requirements Appendix: Page 4, 5 <u>Post-site meeting submission</u> MO.SO-003 Subcontractor Oversight	
Findings: UnitedHealthcare served a notice to Dental Benefit Providers, Inc. on Nov 20, 2019, to replace their previous language in Exhibit E with the above language as stated in section C3 of this evaluation tool. A similar notice was also served to March Vision Care Group, Inc. on Nov 14, 2019, as an update to the language in their contract. Rose International, Inc., the master template (Exhibit H) submitted by UnitedHealthcare states: "…all records to be retained for at least 10 years from the final date of the agreement period or such lesser period which may be specified in State law for State Exchanges." However, Rose International, Inc., Master Services Agreement (page 13) does not comply with the section. It states record retention for 6 years. CareCore National, LLC. The third Amendment to Addendum 28 is compliant. However, CareCore National, LLC Addendum 28 (Missouri State Programs Appendix), Page 2 states records retention for 5 years. **Required Actions:** UnitedHealthcare is advised to update the duration of record retention for 10 years consistently across all the subcontracts.		
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.	Dental Benefit Providers- Dental Services Agreement (seventh amendment) Exhibit E: Page 7 CareCore National, LLC. Third Amendment to Addendum 28: Page 5	Fully Met

	March Vision Care Group, Inc. Agreement (MO State Programs Regulatory Requirements): Page 7 CMICS, Inc. (Missouri State Programs Regulatory Requirements-Provider)-Page 5 MTM Amendment 8 (Missouri State Programs Regulatory Requirements Appendix: Page 4	
Findings: Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E and March Vision Care Group, Inc. (Missouri State Programs Regulatory Requirements Appendix) states: "Subcontractor acknowledges and agrees and shall require providers to acknowledge and agree that the state and the U.S. Department of Health and Human Services or their authorized representatives shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the state Contract and any other applicable rules. There shall be no restrictions on the right of the state or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the state contract and the reasonableness of their costs." March Vision Care Group, Inc. Agreement (MO State Programs Regulatory Requirements) also states about no restrictions on the right of state or federal govt. to conduct whatever inspections and audits are necessary. CareCore National, LLC. Third Amendment to Addendum 28 and CMICS, Inc. (Missouri State Programs Regulatory Requirements-Provider) complies with the requirement of this section (C4) of the evaluation tool. MTM Amendment 8 also states that immediate access to state and federal authorities will be provided. **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,	Dental Benefit Providers-Dental Services Agreement: Pages-12 Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 6	Partially Met

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).	Rose International, Inc. Master Services Agreement: Pages-8, 9 CareCore National, LLC. Third Amendment to Addendum 28: Page 4 March Vision Care Group, Inc. Agreement: Page 13 March Vision Care Group, Inc. (Missouri State Programs Regulatory Requirements Appendix): Page 6 CMICS, Inc. (Missouri State Programs Regulatory Requirements-Provider)-Page 3 MTM Amendment 8 (Missouri State Programs Regulatory Requirements Appendix: Page 3	
Findings: Dental Services Agreement (seventh amendment) states: To the extent applicable to subcontractor and providers in the performance of the subcontract and agreements, the subcontractor shall and shall require providers to indemnify, defend and hold the state and covered persons harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract and any provider Agreement. CareCore National, LLC. Third Amendment to Addendum 28, CMICS, Inc., and MTM contracts are also compliant with this evaluation criterion. March Vision Care Group, Inc., the contract is inconsistent with this requirement. However, under Missouri State Programs Regulatory Requirements, this criterion is met. Rose International, Inc. Master Services Agreement, mentions indemnification but does not mention indemnifying the state. Exhibit H of the subcontract, Master Community State Appendix, does not have this clause on indemnification.		

Required Actions: Primaris recommends UnitedHealthcare update the Rose International, Inc. Master Services Agreement to meet the requirement of this section. March Vision Care Group, Inc., the contract should be consistently updated.		
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).	Dental Benefit Providers-Dental Services Agreement (seventh amendment) Exhibit E: Page 6 Rose International, Inc. Master Services Agreement: Pages-8, 9 CareCore National, LLC Addendum 28 (Missouri State Programs Appendix): Page 2 March Vision Care Group, Inc. Agreement: Page 12 March Vision Care Group, Inc. (Missouri State Programs Regulatory Requirements Appendix): Page 6 CMICS, Inc. (Missouri State Programs Regulatory Requirements-Provider)-Page 4 MTM Amendment 8 (Missouri State Programs Regulatory Requirements Appendix: Page 3	Partially Met
Findings: Dental Services Agreement with Dental Benefit Providers, Exhibit E, states: "Except for applicable cost-sharing requirements under the state contract, the subcontractor shall and shall require providers to accept payment from UnitedHealthcare as payment in full and look solely to UnitedHealthcare for payment of covered services provided to covered persons pursuant to the subcontract, provider agreement, and the state contract, and to hold the state, the U.S. Department of Health and Human Services, and the covered persons harmless in the event that UnitedHealthcare cannot or will not pay for such covered services." Rose International, Inc., does not mention indemnification of MHD but complies with other requirements.		

CareCore National, LLC Addendum 28 (Missouri State Programs Appendix) states: "To the extent applicable to the subcontractor in performance of the subcontract, the subcontractor shall indemnify, defend and hold the state and Covered persons harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract." The subcontract does not mention that all disputes between UnitedHealthcare and CareCore National, LLC shall be solely between them and the state will not be involved in any dispute.

Medical Transportation Management (MTM) Agreement (page 36) state is not mentioned. However, Amendment 8 complies with the requirement.

Required Actions: UnitedHealthcare should update its subcontract with Rose International, Inc. to indemnify the state in case of any dispute between UnitedHealthcare and its providers. CareCore National, LLC should be updated to mention that the state will not be involved in any dispute between UnitedHealthcare and the subcontractor.

Compliance Score–Subcontractual Relationships and Delegation						
Total	Met	=	8	×2	=	16
	Partial Met	=	4	×1	=	4
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	20
Denominator	Total Sections	=	12	×2	=	24
Score %						83.33

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.	Provider Website Distribution of CPGs: Pages-4 to 9 Review of Clinical and Preventive Guidelines: 1,2	Fully Met
Findings: A list of clinical practice guidelines (CPGs) with their embedded links to the sources, submitted by UnitedHealthcare on 30 topics shows that the CPGs are based on valid and reliable clinical evidence or a consensus of health care professionals. The recognized source(s) are American College of Cardiology; Global Initiative for Asthma; American Heart Association; Society for Cardiovascular Angiography and Interventions; Heart Rhythm Society; American Academy of Pediatrics; American Psychiatric Association; American Academy of Child & Adolescent Psychiatry; U.S. Department of Veterans Affairs; U.S. Preventive Services Task Force (USPSTF); Global Initiative for Chronic Obstructive Lung Disease; American Diabetes Association; U.S. Department of Health and Human Services; Heart Failure Society of America; World Federation of Hemophilia; HIV Medical Association of the Infectious Diseases Society of America; National Kidney Foundation; The Obesity Society; American Academy of Pediatrics/Bright Futures; American College of Obstetricians and Gynecologists; Surviving Sepsis Campaign; Society of Critical Care Medicine; National Heart, Lung, and Blood Institute; and American Medical Association. UnitedHealthcare may have a need occasioned by regulatory requirements, accreditation needs, clinical quality initiatives, or unique market business needs, of a clinical position statement for which an internally developed or nationally recognized and accepted guideline does not exist. UnitedHealthcare uses evidence-based clinical and preventive guidelines from nationally recognized sources to guide its quality and health management programs. The Medical Technology Assessment Committee (MTAC) reviews these guidelines to ensure transparency and consistency and to identify safe and effective health services for their members. Additionally, these documents are reported to the National Medical Care Management Committee (NMCMC) for oversight. **Required Actions:** None.		
2. Consider the needs of the enrollees.	Physician Advisory Committee (PAC) Charter: Pages-1, 2	Fully Met

	2020 Quality Improvement Program Description (QIPD): Pages 11, 12, 25 Review of Clinical and Preventive Guidelines: Pages-1, 2	
Findings: The purpose of the Provider Advisory Committee (PAC) is to promote the safety and appropriateness of medical care delivered to members. PAC is responsible for evaluating the quality, continuity, integration of care, accessibility, availability of medical care rendered within the network, as well as conducting peer review activities. The Member Advisory Committee (MAC) is chaired by UnitedHealthcare's Director of Provider Operations and Member Engagement. It is a forum for members to provide feedback and insights about services and experiences, including but not limited to cultural and linguistic needs. This information is used to modify the Quality Improvement (QI) program and enhance how care and services are delivered to members. The MAC is structured so that the membership of group is actively involved in setting and accomplishing goals that improve services or enhance resources for stakeholders in the community. The MAC discussion and sharing of opinions span a variety of issues including, but not limited to service delivery; quality of covered services; network issues; service improvement opportunities; case manager support; overall member experience including ease of access and usefulness of member materials; health care disparity initiatives; and cultural needs of members. The commitment to patient safety is demonstrated throughout the QI programs and activities which are available to support the members. These efforts are focused on advancing Evidence-Based Medicine (EBM), reducing the potential for medical errors, and educating members, physicians, and hospitals on the importance of patient safety. During the interview, UnitedHealthcare reported they apply population health management strategy to explore their members' needs. Furthermore, the Medical and Technology Assessment Committee is familiar with the Medicaid population nationwide. **Required Actions:** None.		
3. Are adopted in consultation with network providers.	PAC Charter: Pages-1, 2 2020 QIPD: Pages-6, 10, 15 Utilization Management Program Description (UMPD): Page-5	Fully Met

Findings: The PAC offers provider input into the development of clinical programs, adoption of clinical guidelines, and utilization criteria. The committee reviews and accepts nationally endorsed CPGs, providing input as appropriate. The PAC is chaired by the Chief Medical Officers (CMO) of the lines of business offered in Missouri and membership includes CMO, network primary care and subspecialty physicians, and Adhoc specialty physicians (as needed) in addition to the Quality Director and staff. The MTAC's mission is to review the scientifically based clinical evidence used in the development of UnitedHealthcare medical policies and clinical programs. The MTAC convenes once per calendar month and no less than ten times per year. The MTAC is comprised of medical policy development and implementation staff members, non-voting members, and voting members. Voting members are UnitedHealth Group Medical Directors with diverse medical and surgical specialties and subspecialties from health plans, business segments, acquired entities, and clinical review units. **Required Actions:** None.		
4. Are reviewed and updated periodically as appropriate.	Review of Clinical and Preventive Guidelines: Pages-2, 3 PAC Meeting Minutes (May 5, 2020): Page 2 MTAC Meeting Minutes (Apr 2, 2020): Page 1	Fully Met
Findings: Internally developed or locally developed CPGs are reviewed every 12 months or more often as dictated by the availability of newly published evidence. Nationally recognized clinical or preventive guidelines are reviewed every 12 months or as needed. When state regulations require, UnitedHealthcare reviews the CPGs with local practitioners or at their local Quality Improvement Committee. If a guideline no longer meets review criteria due to the development of a medical policy or review of the nationally recognized guideline, the business unit is notified and the internally developed or locally developed guideline will be archived. Interval guideline reviews are re-dated and re-posted in the appropriate location in the Knowledge Library and posted on the physician portal. Practitioners are notified when these changes occur via mail, fax, or e-mail. **Required Actions:** None.		
B. MCO disseminates the guidelines to all affected providers, and upon request, to enrollees and potential enrollees.	2020 QIPD: Page 26 Review of Clinical and Preventive Guidelines: Page-1	Fully Met

	Community MO HealthNet Managed Care Member Handbook: Pages-65, 75	
Findings: The clinical and preventive guidelines are made available to all UnitedHealthcare Employers and Individual (E & I) (commercial products), Medicare and Retiree, community & state, OptumHealth (a division of UnitedHealth Group) and other affiliated plans, clinical personnel, external network practitioners and members through the company web sites. On an annual basis, practitioners are notified via mail, fax, or e-mail of the availability of these guidelines on the website. The member handbook under the section on UM policy and procedure states that decision-making criteria for quality care are available to members if they ask for it. Members are informed about preventive services and directed to the website of USPSTF. During the interview, UnitedHealthcare stated that the members are referred to the member services, and its website. The information is also provided in the member handbook. Primaris determined the member handbook does not have information about members' access to practice guidelines upon request. However, Primaris confirmed as on May 12, 2021, that the clinical guidelines are posted on the website. **Required Actions:** Primaris suggests UnitedHealthcare inform members via any medium, e.g., member handbook, mailers, newsletters about the availability and access of evidence-based practice guidelines.		
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.	UMPD: Pages-4, 7, 8, 9, 17, 18 <u>Post-site meeting submission</u> 2020 Milliman Clinical Guidelines (MCG) Inter-Rater Reliability (IRR) Assessments: Screenshot MO_PCP 2020 Medical Record Review CPG Post-audit: Screenshot	Fully Met
Findings: The Utilization Management (UM) Program activities are monitored through the UnitedHealthcare National Quality Oversight Committee structure. The UnitedHealthcare UM Committee provides oversight of clinical programs and activities. This committee maintains a comprehensive program, description of activities, and ensure an annual review and evaluation of criteria to ensure clinical programs are achieving desired results. The Clinical Coverage Review (CCR) service includes a review of clinical information and benefit plans to determine benefit coverage for requested services in accordance with members' health benefit programs before delivery of the requested services. The primary goal is to provide consistent application of member		

benefit document language in adjudicating benefit coverage. The CCR staff determines benefit coverage consistent with applicable laws and accreditation requirements, as required. CCR staff also use applicable member benefit plan documents, evidence-based medical policy, standardized coverage determination guidelines (CDGs), and nationally recognized clinical guidelines and criteria. Cases requiring clinical review are forwarded to CCR nurses or physicians for review. Medical Technology Assessments, peer-reviewed medical literature, standardized coverage determination guidelines, evidence-based national guidelines, and evidence-based criteria such as the Care Guidelines are used for clinical reviews.

Process improvement is a structured, disciplined approach to maintain consistent application of (UM) processes. It is designed to provide an objective and systematic assessment of the UM Program by measuring the adherence to policies and procedures, licensing/regulatory standards, and customer services. Process improvement reviews include:

- Process audits conducted by clinical managers in regional service centers or by a centralized audit team.
- Inter-rater reliability assessments.
- Member surveys conducted by an external vendor.
- Participation in activities to meet accreditation and regulatory requirements.
- Development of targeted, relevant action plans for continuous process improvement activities.

The medical directors, who are responsible for benefit coverage determinations and medical necessity determinations, participate in IRR exercises, no less than annually, to ensure that benefit document language and clinical review criteria are being applied consistently. Results for IRR program are monitored and tracked for improvement opportunities.

Required Actions: None.

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

Appendix F

Standard 6–42 CFR 430.242 Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the MCO**	**Score**
A. MCO maintains a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data.	UnitedHealthcare-Missouri Architecture HIS System Flows Post-site meeting submission Health Information Systems: Page 1	Fully Met
Findings: UnitedHealthcare has an integrated management information system (MIS) supporting the Missouri Medicaid program. This scalable platform integrates physical and behavioral health and social service support in compliance with all Missouri Medicaid Program requirements. The MIS enables the day-to-day management of key operations of UnitedHealthcare sufficient to support the collection, integration, tracking, analysis, and reporting of data. UnitedHealthcare submitted their System Architecture workflow diagrams explaining the collection, integration, tracking, analysis, and reporting of enrollment; providers; claims; encounters; financial data; and clinical information. **Required Actions:** None.		
B. MCO's health information system provides information on areas:		
1. Utilization.	HIS System Flows-Clinical: page 7 Post-site meeting submission Health Information Systems: Page 1	Partially Met
Findings: The flow diagram and the policy submitted by UnitedHealthcare shows that Utilization Management occurs through their authorization and utilization tool-Integrated Clinical User Experience ICUE. However, the process of how UnitedHealthcare's MIS provides information is not described. **Required Actions:** UnitedHealthcare should describe the process of their MIS providing information on Utilization Management.		
2. Claims.	HIS System Flows-Claims: page 3 Post-site meeting submission Health Information Systems: Pages-2, 3	Fully Met

Findings: The flow diagram and the policy submitted by UnitedHealthcare shows that the claims are processed through UnitedHealthcare's CSP Facets Member and Claims platform. The CSP Facets maintains enrollee characteristics: demographic information (age, gender, contact information, location/address, county); and benefits Information (ME code, member population, benefits, subgroup i.e., state aid or capitation category). In addition to being UnitedHealthcare's eligibility system, CSP Facets is the Medical and Behavioral Claims Adjudication Platform. Data is screened for completeness, logic, and consistency. Payments are distributed appropriately based on provider contracts covering both fee-for-service and capitation arrangements. Data from CSP Facets supplies the following processes (version 5010 x12 standards where applicable): • Care Management and Utilization Management systems (ICUE, Community Care) • Vendor eligibility feeds (Dental/Vision) • Reporting and Analytics • Encounters processing through National Encounter Management Information System (EMIS). **Required Actions:** None.		
3. Grievances and appeals.	UnitedHealthcare-Missouri Architecture <u>Post-site meeting submission</u> Health Information Systems: Pages-1, 3	Partially Met
Findings: The flow diagram and the policy submitted by UnitedHealthcare shows that the Grievances and Appeals are tracked through UnitedHealthcare's Member And Customer Electronic Service And Support (MACESS) and Escalation Tracking System (ETS). UnitedHealthcare informed Primaris that Appeals information is loaded and tracked in ETS but is not an automated process. Primaris noted that UnitedHealthcare's policy on Health Information submitted post-site meeting does not incorporate the description/process as to how the information systems provide information on grievance and appeals. **Required Actions**: UnitedHealthcare is recommended to provide an explanation/description of their process as to how the health information system provides information on the Grievances and Appeals.		
4. Disenrollment for other than loss of Medicaid eligibility.	MO-ENR-01 Disenrollment Effective Dates: Page5 <u>Post-site meeting submission</u>	Partially Met

	Health Information Systems: Page 1	
Findings: Every business day, MHD shall make available, via electronic media, updates on members newly enrolled in UHC, or newly disenrolled. UHC receives these updates and incorporates them in there, as well as our subcontractors' management information system each day. UnitedHealthcare stated that the disenrollment for other than loss of Medicaid eligibility is managed through UnitedHealthcare's CSP Facets Member and Claims platform. UnitedHealthcare uses the 834 files (from MHD) for the member eligibility and validates them with the state system online, in case of any discrepancy. Members leaving UHC for other MCOs are part of a transition of care process by which claims and clinical data are shared with the receiving MCO. **Required Actions**: UnitedHealthcare should have a policy/procedure describing how their MIS manages the disenrollment of members.		
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.)	UnitedHealthcare-Missouri Architecture HIS System Flows-Claims: Page 3 <u>Post-site meeting submissions</u> UnitedHealthcare Compliance Program Control Fraud, Waste, and Abuse Health Information Systems: Page 1	Partially Met
Findings: UnitedHealthcare has policies and compliance program stating that UnitedHealthcare follows guidelines in accordance with federal and state regulatory guidelines to prevent, detect, correct, and, as appropriate, report potential fraud, waste, and abuse (FWA). UnitedHealthcare has FWA prevention mechanisms including, but not limited to: • Program Governance/High-Level Oversight.		

• Standards, Policies, and Procedures. • Training and Education. • Effective Lines of Communication. UnitedHealthcare has FWA detection mechanisms for monitoring and auditing program activities including, but not limited to: • Data analytics • Prospective detection • Risk assessments • Retrospective detection • Excluded entity monitoring • Internal compliance audits and monitoring of the FWA program • Monitoring and oversight of FWA delegated entities/first tier, downstream, and related entities One of the policies submitted by UnitedHealthcare (post-site meeting) states its MIS complies with all the Missouri Medicaid Program requirements including Section 6405 of the Affordable Care Act. However, there is no documentation to assess that data elements for electronic transmission of claims are consistent with the MSIS to detect fraud and abuse necessary for program integrity, program oversight, and administration. (Note: UnitedHealthcare did not have electronic transmission of claims during the review period. They did not submit data integrity requirements for processing the paper claims.) **Required Actions**: Primaris recommends UnitedHealthcare submit documentation about how their claims processing system is capable of detecting fraud, waste, and abuse.		
2. Collects data on enrollee and provider characteristics as specified by MHD and on all services furnished to enrollees through an encounter data system or other methods specified by the MHD:		
i. Electronic Claims Management (ECM) Functionality: MCO have in place an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.). As part of this ECM function, the MCO shall also provide online and phone-based	Post-site meeting submission Claims, Billing, and Payments: UHCprovider.com	Not Met

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).		
Findings: UnitedHealthcare did not have ECF functionality in CY 2020. At the post-site meeting, UnitedHealthcare informed Primaris about their plan to launch the initiative to replace paper checks with electronic payment on April 23, 2021. Throughout the remainder of 2021, UnitedHealthcare will phase out sending paper checks for payments. UnitedHealthcare has asked its providers to sign up for ACH/direct deposit, the preferred method of payment. If the providers do not sign up, they may receive payment through a virtual card. During the post-site review (May 6, 2021), Primaris visited UHCprovider.com and found UHC launched its ECM functionality and is rolling out its electronic payment solutions. Since UnitedHealthcare did not have ECM in the review period (CY 2020) Primaris assigns a score of Not Met for this criterion. **Required Actions**: UnitedHealthcare must have policies in place for ECM and shall also provide phone-based capabilities to obtain claims processing status information.		
ii. Adherence to Key Transaction Standards: MCO shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, and RSMo 376.383 and 376.384 (MHD contract 2.26.4).	Enterprise Information Security Brochure: Page 6 HIS System Flows-Claims: Page 3 <u>Post-site meeting submission</u> Health Information Systems: Page 1	Partially Met
Findings: UnitedHealthcare's Enterprise Privacy and Information Security programs promote compliance with their security objectives and various federal and state privacy regulations, including HIPAA, GLBA, and state privacy and security requirements. The programs include two major components:		

• The first is to provide employees with training, communications, and resources to support their day-to-day compliance activities • Second, through reporting, monitoring, and control tools, it seeks to ensure employees are complying with existing processes and promotes ongoing compliance. The CMS mandated 1500 and HCFA paper claim forms along with UnitedHealthcare provider contracts overseeing electronic submissions mandate that providers attest that the information they submit is accurate and true; signatures are captured on contracts and paper claim forms. Any providers found submitting incorrect information are subject to review. A UnitedHealthcare policy and procedure on HIPAA standards related to claims processing, electronic transaction standards were not submitted. However, a flow chart for claims shows that HIPAA SNIP validations are performed. Primaris noted that UnitedHealthcare did not have ECM during the review period. **Required Actions**: UnitedHealthcare is recommended to have policies and procedures to address HIPAA standards related to claims processing, electronic transaction standards.		
3. A mechanism to ensure that data received from providers are accurate and complete by: i. Verifying the accuracy and timeliness of reported data including data from network providers the MCO is 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.	HIS System Flows-Claims: Page 3 <u>Post-site meeting submission</u> Health Information Systems: Page 3	Partially Met
Findings: UnitedHealthcare did not submit a policy/procedure related to the criteria under this section of the evaluation tool. Post-site meeting, UnitedHealthcare submitted a policy on Health Information Systems, which states that CSP Facets screen data for completeness, logic, and consistency.		

The claims flow chart references the use of Optum ENS (EDI Claims clearing house) and ClarEDI (SNIP Validation and claim imaging). UnitedHealthcare informed Primaris that these two systems check for compliance and are validated with HIPAA SNIP validations. UnitedHealthcare also informed one capitated provider – Pediatric Care Network and their claims are received through the same process and are held through the same data validation standards. **Required Actions**: UnitedHealthcare develop policies and detailed process/procedures describing the functional/operational aspects presented in their claims flow charts. Also, address how they verify the timeliness of the reported provider data and collecting data from providers in standardized formats including secure information exchanges and technologies utilized for MHD quality improvement and care coordination efforts.		
4. Make all collected data available to the state and upon request to CMS.	Post-site meeting submission Health Information Systems: Page 1 UnitedHealthcare Compliance Program: Page 7	Fully Met
Findings: UnitedHealthcare stated they shall make any/all agreed-upon data available to the state and CMS. UnitedHealthcare's Compliance program includes reporting any identified potential non-compliance or potentially fraudulent activity to various federal and state regulatory authorities. **Required Actions**: None.		
5. Implement an Application Programming Interface (API) as specified in §431.60 as if such requirements applied directly to the MCO and include: All encounter data, including encounter data from any network providers the MCO, is compensating on the basis of capitation payments and adjudicated claims and encounter data from any subcontractors. (Note: Since this requirement was to be implemented by Jan 1, 2021, this is excluded from this year's EQR.)		Not Applicable (N/A)
Findings: N/A for EQR 2021. Per CMS letter dated August 14, 2020, due to the COVID-19 public health emergency, CMS is exercising enforcement discretion, and does not expect to enforce this requirement prior to July 1, 2021.		

Required Actions: Primaris will evaluate the requirements, both for patient access API and provider access API, in EQR 2022, as a follow-up item.		
D. Enrollee encounter data: MCO must provide for- i. Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.	HIS System Flows-Encounters: Page 4 <u>Post-site meeting submission</u> Health Information Systems: Page 4	Partially Met
Findings: UnitedHealthcare reported encounters are processed through the NEMIS encounters system, which allows for the collection of data on enrollees served and providers administering services. A flow chart is submitted. UnitedHealthcare did not submit a description and the process followed for collection and maintenance of sufficient enrollee encounter data that identifies providers who deliver the services or items. **Required Actions**: UnitedHealthcare must have a detailed description of their process and data elements captured to identify the providers delivering services or items to enrollees.		
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).	<u>Post-site meeting submission</u> Health Information Systems: Page 4 Encounter Data: Acceptance Rate of Submitted Claims	Fully Met
Findings: Encounter reports shall be submitted as needed, but no longer than 30 days from the date of claims payment and within 2 years of the date of service, to the state of Missouri in ANSI Standard X12 837 format. UnitedHealthcare submitted an Excel sheet to show their Quarterly acceptance rate of encounters for Quarter-3 and 4 of 2020 region-wise (98%-99%). **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.		Not Met

Findings: UnitedHealthcare has not submitted documentation in support of this requirement. **Required Actions**: UnitedHealthcare should have a policy and submit evidence to show their encounter data submitted to MHD includes the allowed amount and paid amount per 42 CFR 438.818.		
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).	Post-site meeting submission Health Information Systems: Page 4 Encounter Data: Acceptance Rate of Submitted Claims	Fully Met
Findings: UnitedHealthcare submitted a policy which meets the requirement of this section. The Excel sheet submitted for the acceptance rate of submitted claims suggests that the data is computed every month. **Required Actions**: None.		
v. Specifications for submitting encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837. As part of the 1996 HIPAA Title II Act-Administrative Simplification Standards 2009 Modifications, all HIPAA-covered entities are required to implement the Version 5010 transaction set (MHD contract, section 2.26.5e). (Note: NCPDP and ASCX12N 835 are not applicable for MCO under MHD.)		Not Met
Findings: UnitedHealthcare submitted a policy post-site meeting with a statement that they submit encounters to the state of Missouri in ANSI Standard X12 837 format. There are no details mentioned based on which Primaris can ascertain UnitedHealthcare's compliance with this section of the evaluation tool. **Required Actions:** UnitedHealthcare must submit sufficient documentation to show that encounter data submitted to MHD comply with standardized Accredited Standards Committee (ASC) X12N 837 and has implemented version 5010 transaction set.		
E. Information systems availability: The MCO shall ensure that critical member and provider Internet and/or telephone-based functions	Enterprise Resiliency and Response Program: Pages-10, 13 Post-site meeting submission	Partially Met

and information, including but not limited to electronic claims management and self-service customer service functions are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the state agency and the MCO. The MCO shall ensure that, at a minimum, all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., Central Time. Unavailability caused by events outside of the MCO's span of control is outside of the scope of this requirement. In the event of a declared major failure or disaster, the MCO's core eligibility/enrollment and claims processing systems shall be back online within 72 hours of the failure or disaster's occurrence (MHD 2.26.8).	MO myUHC: screenshots Claims, Billing, and Payments: UHCprovider.com	

Findings: Business functions classified as critical provide for near immediate failure of core services by leveraging geographically dispersed redundant operations and maintain a recovery time objective of 72 hours or less. UnitedHealthcare's critical business functions include, but are not limited to, healthcare delivery, customer and provider call services, claims processing services, clinical and pharmaceutical services, banking operations, and core corporate functions.

UnitedHealthcare submitted screenshots from their website for the member services which are accessible 24x7 to their members after they log in.

The provider Internet and/or telephone-based functions and information, including but not limited to electronic claims management was not seen on the website in March-April 2021 when Primaris conducted a desk audit. UnitedHealthcare had launched this functionality later in April 2021 and then submitted the screenshots, which were validated by Primaris on May 6, 2021. Since the review period for the current EQR is CY 2020, Primaris assigns a score of Partially Met for this section of the evaluation tool.

Required Actions: None.

Compliance Score– Health Information Systems						
Total	Met	=	5	×2	=	10
	Partial Met	=	8	×1	=	8
	Not Met	=	3	×0	=	0
Numerator	Score Obtained				=	18
Denominator	Total Sections	=	16	×2	=	32
Score %						56.25