P.T.M.
Healthcare Business Solutions

2022 External Quality Review

Compliance

Healthy Blue

Measurement Period: Calendar Year 2021
Validation Period: Feb-May 2022
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MoHealth Net

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1.0 OVERVIEW

The Department of Social Services, Missouri HealthNet Division (MHD) is officially designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (CHIP)(Title XXI) programs. Missouri has an approved combination CHIP under Title XXI of the Social Security Act. Missouri's CHIP uses funds provided under Title XXI to expand eligibility under Missouri's State Medicaid Plan and obtain coverage that meets the requirements for a separate child health program. The 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 improve accessibility and quality of the healthcare services to all the eligible populations while reducing the cost of providing that care. Participation in Managed Care is mandatory for the eligible groups within the regions in operation. Coverage under CHIP is provided statewide through the Managed Care delivery system.

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; CHIP children; and foster care children. An amendment to the Missouri constitution passed in August 2020 required the MHD to modify its Medicaid and CHIP programs to include low-income adults ages nineteen to sixty-four. The new population is called as “Adult Expansion Group-AEG.” The MHD began enrolling AEG in the Managed Care effective Oct 1, 2021, under section 1932(a). The total number of Managed Care (Medicaid, CHIP, and AEG) enrollees in June 2022 was 1,006,657, representing an increase of 24.47% compared to the end of SFY 2021.

The MHD contracts with Managed Care Organizations (MCOs), also referred to as "Health Plans," to provide health care services to its Managed Care enrollees. Healthy Blue is one of the three MCOs operating in Missouri. The MHD works closely with Healthy Blue to monitor quality, enrollee satisfaction, and contract compliance. Quality is monitored through various ongoing methods, including MCO's Healthcare Effectiveness Data and Information Set (HEDIS®) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and an annual external quality review (EQR).

On Jan 1, 2018, the MHD contracted with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to conduct the EQR activities for five years. In the fifth year of the contract, Primaris ceased its operations. Primaris transitioned its contract to PRO Team Management Healthcare Business Solutions, LLC (hereinafter stated PTM) following all the legal requirements per the Office of Administration (OA), State of Missouri.

PTM will assume all responsibilities for fulfilling the terms of the EQRO contract.
An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCO, or its contractors, furnish to Medicaid beneficiaries (Figure 1). The review period for EQR 2022 is the calendar year (CY) 2021.

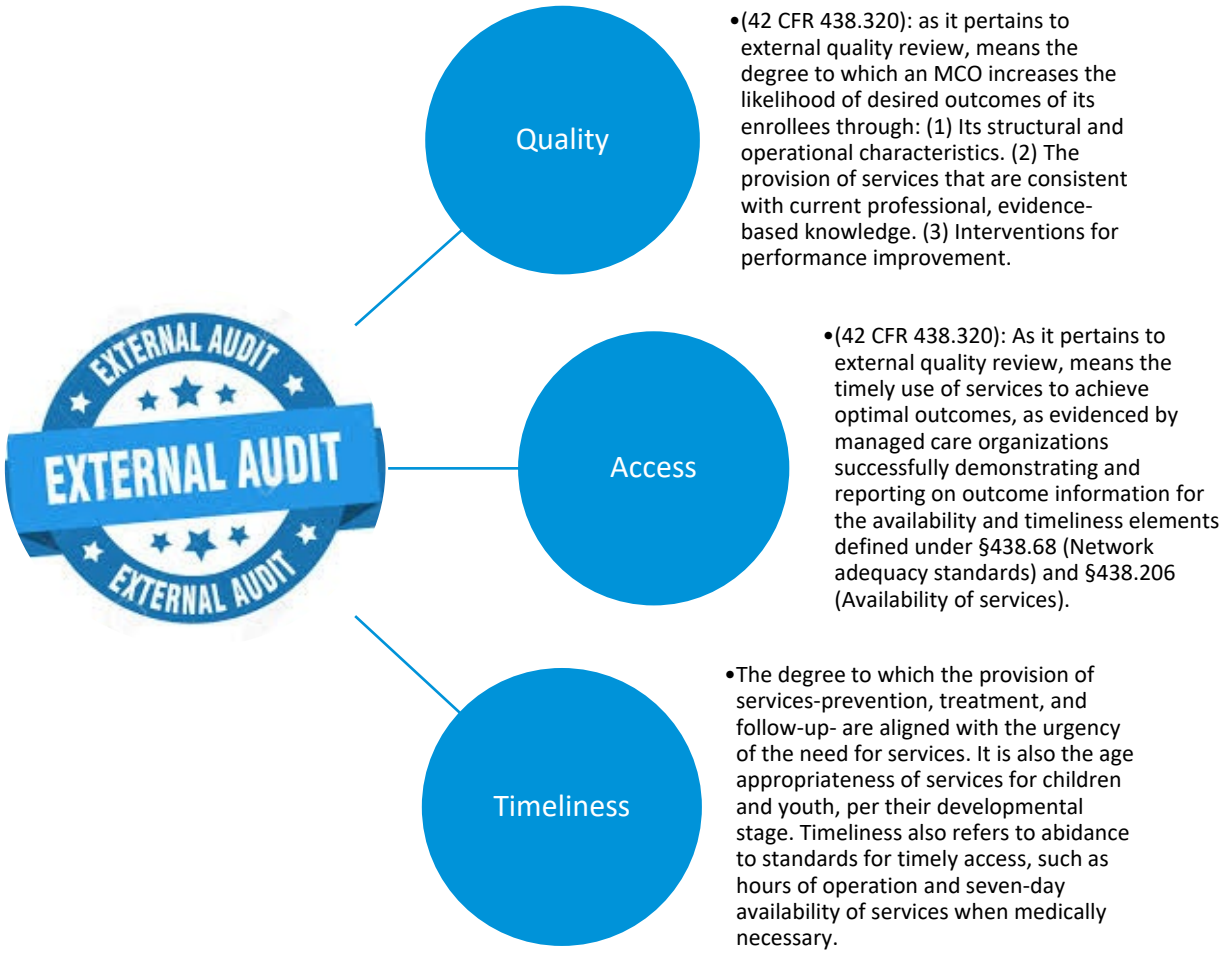

Figure 1. External Quality Review

2.0 OBJECTIVE

Review of Compliance with Medicaid and CHIP Managed Care regulations is a mandatory EQR activity. The Code of Federal Regulations (CFR), 42 CFR 438.358(b)(1)(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. PTM will review these regulations (standards) during the current three-year review cycle, EQR 2021-EQR 2023, as planned in Table 1. EQR 2022 is the second year of the review cycle (highlighted in Table 1).

PTM assessed Healthy Blue's compliance with the 42 CFR 438/42 CFR 457, the MHD Quality Improvement Strategy (QIS) 2021, the MHD Managed Care contract, and the progress made in achieving quality, access, and timeliness to services from the previous year's review.

Table 1. Review Cycle: EQR 2021-EQR 2023

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	457.1233(b)	Subcontractual relationships and delegation
	438.236	457.1233(c)	Practice guidelines
	438.242	457.1233(d)	Health information systems
EQR 2022 (2-year)	438.206	457.1230(a)	Availability of services
	438.207	457.1230(b)	Assurances of adequate capacity and services
	438.208	457.1230(c)	Coordination and continuity of care
	438.210	457.1230(d)	Coverage and authorization of services
	438.214	457.1233(a)	Provider selection
	438.224	457.1110	Confidentiality
	438.228	457.1260	Grievance and appeal system
EQR 2023 (3-year)	438.330	457.1240(b)	Quality assessment and performance improvement program

3.0 TECHNICAL METHODS

The compliance review was conducted in February-May 2022, following the guidelines from the Centers for Medicare and Medicaid Services (CMS), EQR Protocol 3. The process included the following steps (Figure 2):

Collaboration: PTM collaborated with the MHD/Healthy Blue for the following:

- To determine the scope of the review, scoring methodology, and data collection methods.
- To develop the site review (virtual meeting) agenda.
- To provide preparation instructions and expectations.
- To collect and review data/documents before, during, and after the site meeting.
- To submit deficiencies in writing following the preliminary review and site meeting.
- To compile data and information, and analyze the findings.
- To prepare a report related to the findings of the current year.

- To review Healthy Blue's corrective actions in response to the previous year's recommendations.

Figure 2. Compliance Evaluation Process

Evaluation Tools: PTM created evaluation tools based on the CFR, EQR protocol, the MHD Managed Care contract, and the QIS 2021 (Appendices A-G).

Technical Assistance (TA): PTM sent the evaluation tools to Healthy Blue in advance of the preliminary review, setting the expectations for the documents' submissions. The preliminary review findings and requirements were also submitted to Healthy Blue in writing before the site meeting.

Documents' Submissions: Healthy Blue uploaded its documents to PTM's secure web-based file storage platform, enabling a complete and in-depth analysis of its compliance with the regulations. PTM reviewed policies and procedures, spreadsheets, PowerPoint presentations, reports, newsletters, mailers, templates, emails, toolkits, and print screens as follows: (Note: A document is listed only once if it was reviewed for more than one regulation.)

Availability of Services: Access and Availability-After Hours-MO; Network Development, Monitoring and Management-MO; MHD Managed Care Provider Manual; Member Handbook; Second Opinion-MO; Out-of-Network Authorization Process-MO; 2021 Health Plan Consumer Advisory Committee Plan; Anthem Committees Charter-Requirement and Purpose, Responsibilities, Membership; Anthem DEI Hiring and Training Review; Caring for Diverse Population; Culturally and Linguistically Appropriate Services; Development of Marketing and Member Communications; Member Rights and Responsibilities; Access and

Availability Results; Number of Completed Surveys 2021; and CAHPS Results.

Assurances of Adequate Capacity and Services: Network Development, Monitoring and Management; Hospital Listing (Sept 2021); Provider Agreement; Primary Care Provider (PCP) Assignment-MO; Behavioral Health Practitioner (non-physicians)-Education Criteria; NET01-INS DentaQuest-Network Development, Maintenance, and Use; CL02-INS Claims Payment; Healthy Blue Network Access Results 2021; and Network Access Plan Approved-Email.

Coordination and Continuity of Care: Member Rights and Responsibilities-MO; Primary Care Provider (PCP) Assignment-MO; Continuity of Care-Core Process-MO; Provider Agreement; CPP208 Safeguards; CPP522 Treatment, Payment and Healthcare Operations Disclosures; CPP1001 Minimum Necessary Requirements; Introduction of Healthy Blue Care Management Team-Letter; Initial Health Risk Screening Guidelines for Care Management-MO; Face-to-Face Intervention-MO; Access and Availability-After Hours-MO; and Out of Network Authorization Process-MO; Care Manager Role and Function in Complex Care Management-MO; Concurrent Review (Telephonic and On-site) and Onsite Review Protocol Process-MO; Follow-up After Hospital Assessment; Complex Care Management-MO; Care Management Assessment-MO; and Care Management Associate Training-MO.

Coverage and Authorization of Services: Clinical Criteria for UM Decisions-Core Process-MO; EPSDT Services-Core Policy-MO; HCY/EPSDT Corporate Outreach and Monitoring-MO; HCY/EPSDT Internal Reminder System Data Extract Process-MO; Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO; Health Care Management Denial-Core Process-MO; Pre-Certification of Requested Services-Core Process-MO; and Prohibiting the Use of Financial Incentives When Making Medical Necessity Determinations-Core Process-MO.

Provider Selection: Credentialing; Missouri Medicaid Supplemental Credentialing; 12 Ongoing Sanction Monitoring; MO Additional State-Specific Regulatory or Contractual Requirements for Missouri; Advance Directives; Missouri Medicaid Supplemental Credentialing Policy; Anthem Provider Data Operations (APDO) Provider Data Updates-Turnaround Times; Statement of Work (SOW) Medical Transportation Management; Missouri Master Service Agreement MTM-Exhibit D; and Guidelines for Prospective Suppliers.

Confidentiality: CPP101 Purpose and General Rules of the Privacy Policies; CPP201 Business Associate Agreements; CPP1401 Verification and Authentication; CPP520 Specialized/Non-Routine Disclosures (No Authorization Required); CPP209 Workforce Training; CPP208 Safeguards; CPP903 Methods for Sending Electronic/Telephonic PHI

(ePHI); CPP509 Disclosure with Authorization; CPP1401 Verification and Authentication; CPP504 Disclosure of Protected Health Information Outside of Anthem; CPP1301 Sensitive Services; CPP1303 Sensitive Services-Substance Use Disorder; GBD-Member Privacy Rights; CPP1201 Privacy and Security Incident Response and Reporting; CPP204 Non-Retaliation Policy; CPP522 Treatment, Payment and Health Care Operations Disclosures; CPP102 De-Identification; CPP1001 Minimum Necessary Requirements; CPP605 Right to Request an Accounting of Disclosures of PHI; CPP602 Right of Access to Inspect/Copy PHI; Preliminary Disclosure Urgent Secure; Missouri Medicaid Privacy Incidents; CPP207 Records Management (Retention and Disposal) Policy; CPP801 Marketing Activities; Ethics and Compliance Certification; DO The Right Thing: Protecting Information; Member Authorization Form; HIPAA Verification and Disclosure Guide; Medicaid and Medicare Privacy Incident Reporting-MO; De-identification and Limited Data Set Procedures for Medicaid Plans and Lines of Business; and MO Medicaid Breech Notification;

Grievance and Appeal System: Health Care Management Denial Core Process-MO; Member Appeals-MO; Member Inquiries and Grievances-MO; Member Appeals-MO; Notice of Healthy Blue Adverse Benefit Determination; MOGR03 Member Grievance Resolution Letter; DentaQuest (Ancillary Services Agreement); March Vision Service Agreement; and Complaint Issue.

Site Interviews: PTM conducted a site meeting with Healthy Blue on May 3, 2022. Due to the Covid-19 pandemic (public health emergency), the site meeting was conducted virtually (Table 2). The purpose of the interviews during the site meeting was to collect data to supplement and verify the findings of the preliminary document review.

Healthy Blue team included: Director I, Clinical Medical Services; Director, Network Management; Manager, Provider Experience; Manager, Community Outreach; Medical Director, Plan Performance; Director II, Government Business Division, Quality Management; Clinical Program Development Manager; Director, Behavioral Health Service; Manager II, Credentialing; Manager II, Grievance and Appeals; Manager I, Grievance and Appeal; and Manager, Compliance.

Table 2: MCO Information
MCO Name: Healthy Blue
MCO Location: 1831 Chestnut, St. Louis, MO, 63103
Audit Contact: Russell Oppenborn, Director, State Regulatory Affairs

Compliance Ratings

PTM analyzed the information provided by Healthy Blue and assigned a score for each regulation. Then an overall compliance score for all the regulations was calculated. Two points were assigned to each section/criterion in the evaluation tool (denominator) and scored (numerator) Fully Met (two points), Partially Met (one point), or Not Met (zero points) based on the definitions from the CMS, EQR Protocol 3 (Table 3).

Table 3. Compliance Rating Scale

●	**Fully Met**: 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**: 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**: 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.

Note: If Healthy Blue did not have documentation to comply with a criterion during the review period (CY 2021) but updated a document after PTM identified the deficiency during the preliminary review, Healthy Blue did not receive points for the updated documents. However, PTM allowed updating inconsistent/inaccurate information, and those changes were considered for scoring.

The compliance score is categorized in terms of the level of compliance as follows (Table 4):

Table 4: Compliance Level

Compliance Level	Score%
High Compliance	90% and above
Moderate Compliance	75%-89%
Low Compliance	Less than 75%

Corrective Action Process

PTM initiates a corrective action plan (CAP) after submitting the final report to the MHD. The CAP will be recommended for all weaknesses identified, including the Not Met/Partially Met criteria. The CAP must detail the interventions Healthy Blue plans to implement to comply with the regulations, including how Healthy Blue measures the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. Healthy Blue must submit the CAP to the MHD within 10 calendar days of its initiation. When deemed sufficient, the MHD, in consultation with PTM, will approve Healthy Blue's CAP. Within 90 calendar days of CAP approval, Healthy Blue must submit its documentation to close the identified gaps. The results of the corrective actions taken by Healthy Blue during the previous year's review are presented in section 5.2 of this report.

4.0 ANALYSIS OF QUALITY, TIMELINESS, AND ACCESS TO CARE

4.1 Summary of Findings

EQR 2022 assessed seven federal regulations, with Healthy Blue achieving a compliance score of 76.5%. Table 5 summarizes the findings from the first (EQR 2021) and second year (EQR 2022) of the current three-year review cycle (EQR 2021-2023).

Table 5: Compliance Summary for EQR 2021-2022

		Number of Sections						
42 CFR 438/457	Medicaid/CHIP Regulation	Total	Fully Met	Partially Met	Not Met	Score	Score %	Confidence Level
438.206 457.1230(a)	Availability of services	10	5	5	0	15	75	Moderate
438.207 457.1230(b)	Assurances of adequate capacity and services	14	2	11	1	15	53.6	Low
438.208 457.1230(c)	Coordination and continuity of care	19	15	3	1	33	86.8	Moderate
438.210 1230(d)	Coverage and authorization of services	19	16	3	0	34	89.5	Moderate
438.214 457.1233(a)	Provider selection	14	5	1	8	11	39.3	Low
438.224 457.1110	Confidentiality	22	18	2	2	38	86.4	Moderate
438.228 457.1260	Grievance and appeal system	34	22	12	0	56	82.4	Moderate
Overall Result EQR 2022 (2-Year)		**132**				**202**	**76.5**	**Moderate**
438.56 457.1212	Disenrollment: Requirements and limitations	18	14	3	1	31	**86.1**	Moderate
438.100 457.1220	Enrollee rights	18	8	10	0	26	**72.2**	Low

438.114 457.1228	Emergency and post-stabilization services	12	11	1	0	23	**95.8**	High
438.230 457.1233(b)	Subcontractual relationships and delegation	12	10	2	0	22	**91.7**	High
438.236 457.1233(c)	Practice guidelines	06	6	0	0	12	**100**	High
438.242 457.1233(d)	Health information systems	16	7	7	2	21	**65.6**	Low
Overall Result EQR 2021 (1-Year)		**82**				**135**	**82.3**	**Moderate**

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

Healthy Blue's strengths and weaknesses in the healthcare services regarding Quality, Timeliness, and Access to Care are summarized as follows. The detailed findings are presented in Appendices A to G.

4.2 Regulation I- Availability of Services

A detailed evaluation is provided in Appendix A.

4.2.1 Strengths

a. Healthy Blue complies with the geographic standards set forth by the State of Missouri per 20CSR 400-7.095-HMO Access Plans and State of Missouri Distance standards. Upon enrollment, each member is assigned to a PCP no further than 10, 20, or 30 miles from their residence, depending on whether the Department of Commerce and Insurance classifies the county of residence as urban, basic, or rural, respectively. During the interview, the staff was knowledgeable about the geographical access reporting system Healthy Blue utilized to track the provider member ratio and geographic distribution of providers and members.

b. Healthy Blue disseminates to participating providers the appointment standards of the MHD program, and the contractual requirements through the provider manual, provider newsletter, and provider representative office visits. Healthy Blue members shall be informed about appointment standards through the Healthy Blue's member handbook and Customer Service Department. Members are encouraged to contact Healthy Blue Customer Service Department if appointment standards are not reasonably met.

c. Network Management Department, in conjunction with input from several departments and providers, regularly monitors network adequacy parameters on both a scheduled and ad-hoc basis. Healthy Blue's Provider Relations (PR) or its vendor will

survey a portion of the provider network to monitor compliance with appointment standards quarterly. A CAP is initiated for the non-compliant providers.

d. Healthy Blue provides the option of an independent assessment of the medical necessity for a treatment plan and of the medical care options for a treatment plan or elective surgical procedures so that the member can make an informed choice. The second opinion may be both in-network and out-of-network when requested by a member and at no cost to the member.

e. Healthy Blue authorizes treatment by the out-of-network providers and executes single case or blanket letters of agreement to ensure that members have access to all medically necessary care at no greater cost than they would incur if a network provider saw them.

f. During the interview, Healthy Blue informed PTM that they are in the process of earning a distinction from National Committee for Quality Assurance (NCQA) in multicultural healthcare and has a work plan for its implementation.

4.2.2 Weaknesses and Recommendations

Areas of concern and the recommendations to close the identified gaps are listed in Table 6.

Table 6. Availability of Services

Weakness	EQRO Recommendation
a. The provider manual states that PCPs should offer routine/preventive care appointments within 6 weeks.	Update provider manual to reflect the correct appointment timeframe for routine/preventive care within 30 calendar days.
b. None of the policies addressed the requirement of ensuring that the network providers offer hours of operation that are no less than those offered to commercial enrollees or comparable to Medicaid FFS.	The policy should incorporate the requirement and describe the process for ensuring no discrimination related to the work hours of its Medicaid enrollees.
c. The policies partially addressed the contractual requirements regarding Access and Cultural consideration per the MHD contract, section 2.3.1.	Update documentation to include: The MCO shall regularly inform the public about the MCO's progress and successful innovations in implementing culturally and linguistically appropriate services and provide public notice in their communities about the availability of this information.
d. The policy, "Development of Marketing and Member Communications," incorrectly	Update policy. The marketing and education materials are not deemed

states that the marketing and education materials are deemed approved if a response from the state agency is not returned within 30 calendar days following receipt of the materials by the state agency.	approved if there is no response from the MHD within 30 calendar days, per the MHD contract.
e. The providers must provide physical accessibility to Missouri Managed Care members was not addressed in any policies. However, Healthy Blue updated its policy, "Access and Availability-After Hours-MO," to meet the requirements after PTM identified the deficiency.	Communicate the accessibility requirements to Healthy Blue network providers and send the updated policy to the MHD for approval.
f. A policy that allows members direct access to the services of the in-network OB/GYN of their choice to provide covered services (women's routine and preventive healthcare services) was not submitted.	Submit policy and procedure on provision of direct access to the OB/GYN providers for its female enrollees.

4.3 Regulation II- Assurances of Adequate Capacity and Services

A detailed evaluation is provided in Appendix B.

4.3.1 Strengths

a. The responsibilities of Primary Care Providers (PCPs) are documented in policies and communicated to the providers via the provider manual. The PCPs may have formalized relationships with other PCPs to see their members for after-hours care, certain days, certain services, or other reasons to extend their practice.

b. Healthy Blue received an "Approved" status for its Annual Access Plan 2021 from the Department of Commerce and Insurance. The plan describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues. (Note: PTM did not review the Access Plan as the Network Adequacy assessment is out of scope for EQRO and currently carried out by the State.)

4.3.2 Weaknesses and Recommendations

Areas of concern and the recommendations to close the identified gaps are listed in Table 7.

Table 7. Assurances of Adequate Capacity and Services

Weakness	EQRO Recommendation
a. None of the policies specified the types of provider Healthy Blue ensures to include in its network. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after PTM pointed out the deficiency.	Submit the revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval.
b. A policy to show that Healthy Blue maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area was not available during the review period. Also, there was no documentation in any policy to show that Healthy Blue does not require an exclusive relationship or not advertise/hold itself out with any provider. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," to meet all the requirements after PTM identified the deficiencies.	Same comment as above.
c. Provider Manual includes all the specialties eligible to serve as PCPs except for OB/GYN.	Update provider manual.
d. A policy for physicians serving as PCPs in institutions with teaching programs and specialists serving as PCPs for members with chronic and disabling conditions was not submitted. Revisions to the policy, "Primary Care Provider Responsibilities," were made during the review after PTM identified the deficiency.	Submit the revised policy, "Primary Care Provider Responsibilities," for the MHD's approval.
e. Policy/procedure to comply with the requirement that Healthy Blue shall include in its network a mix of mental	Submit the revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval.

health and substance use disorder treatment providers with experience in treating children, adolescents, and adults was not submitted. The provider network, including Community Behavioral Health Organizations (CCBHOs) and Community Mental Health Centers (CMHCs), was not documented. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after PTM identified the deficiencies.	
f. Policy and procedure to contract with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), Family Planning and Sexually Transmitted Disease (STD) Treatment Providers, local public health agencies, tertiary care centers, pediatric hospitals, dental services in school settings in the network were not available during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," to include all the requirements after PTM identified the deficiencies.	Submit the revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval. Healthy Blue should submit an agreement with each local public health agency and Family Planning and STD treatment provider not in the provider network describing, at a minimum, care coordination, medical record management, and billing procedures.
g. No policy and procedure were submitted to comply with the requirement that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP). Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after PTM identified the deficiencies.	Submit the revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval.
h. Policy and procedure to comply with the requirement of network changes that would affect the adequacy of capacity, services, benefits, and geographic service areas have to be notified to the MHD within	Submit documentation to show Healthy Blue's steps to maintain network adequacy when a new population is enrolled.

the timeframe of five business days were not available during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after PTM identified the deficiencies. However, the revised policy did not include Healthy Blue's actions regarding enrolling a new population to maintain the network adequacy.	

4.4 Regulation III- Coordination and Continuity of Care

A detailed evaluation is provided in Appendix C.

4.4.1 Strengths

a. Healthy Blue will contact the members within five business days of Healthy Blue's notification of anticipated enrollment from the State. To the extent provider capacity exists, Healthy Blue will offer freedom of choice to members in making a PCP selection. Members are responsible for contacting their primary care providers as their first point of contact when needing medical care.

b. Healthy Blue has policies and procedures that address the transition of care requirements for newly enrolled members from other MCOs or Fee-For-Service (FFS) programs.

c. Relevant enrollee information is transferred between the subcontractors in a timely manner before transitioning to the new subcontractor if Healthy Blue changes subcontractors.

d. Healthy Blue coordinates with an out-of-network provider and the previous MCO to affect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with physical health or behavioral health provider that is not in Healthy Blue's network. Healthy Blue shall facilitate securing a member's records from the out-of-network providers as needed and pay rates comparable to FFS for these records unless otherwise negotiated.

e. Healthy Blue facilitates continuity of care for medically necessary covered services and is responsible for the costs of continuing such services without prior approval and without regard to whether such services are being provided by in-network or out-of-network providers. The services will continue for the lesser of 60 calendar days or until the member has transferred to an in-network provider without disrupting care.

f. Members in the third trimester of pregnancy will continue to receive services from their prenatal care provider (whether in-network or out-of-network), without prior authorization, through the postpartum period (defined as 60 calendar days from date of birth). All pregnant members will continue to receive services from their behavioral health treatment provider, without prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.

g. Healthy Blue does not require prior authorization during the transition of care for inpatient and residential treatment days.

h. The providers will maintain a medical record of all services rendered by them and other referral providers. The providers will share records subject to applicable confidentiality and HIPAA requirements.

i. In accordance with 45 CFR 164.530(c), Healthy Blue has implemented reasonable administrative, technical, and physical safeguards to protect Protected Health Information (PHI), Personal Information (PI), and Protected Financial Information (PFI), including confidential and proprietary information from unauthorized Use or Disclosure.

j. Healthy Blue coordinates services for the members who are in health homes. Care gaps or areas of duplication through a mutually acceptable method are identified. During the interview, Healthy Blue informed PTM about a pilot program initiated in May 2021, involving monthly rounds with Two Health Homes. The collaboration focuses on high utilizers, collaboration for engagement, and improving coordination. Healthy Blue creates reports to share with the Health Home, including utilization metrics (Emergency Room, In-Patient, and PCP visits) and top utilizers.

k. During the interview, Healthy Blue informed PTM that State Enrollment Broker's Health Risk Assessment (HRA), Internal HRA, and member portal identifies members with special healthcare needs. Members who answer positively to special health care need conditions/diagnoses/needs automatically queue to the Healthy Blue's care management system and trigger care management (CM) outreach and assessment. An interactive assessment is housed on the member portal. Questions include member demographics, personal health history, self-perceived health status, behavioral health strategies, and queries to identify members with special needs. Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the care manager develops an individualized CM plan, including prioritized goals that consider the member and caregivers' goals and preferences and the desired level of involvement.

4.4.2 Weaknesses and Recommendations

Areas of concern and the recommendations to close the identified gaps are listed in Table 8.

Table 8. Coordination and Continuity of Care

Weakness	EQRO Recommendation
a. Documentation on the timeframe (90 days) for conducting an initial screening for need assessment of its members after enrollment to Healthy Blue was not submitted.	Update policy, "Initial Health Risk Screening Guidelines for Care Management-MO."
b. Policies and procedures to address the requirements of the Hospital Care Transition (HCT) program to integrate with, and enhance the discharge planning and care transition activities of the hospital as required by the CMS, were not submitted. However, a policy that addressed some of the discharge planning activities was submitted.	The MHD contract, section 2.11.4(a)(1) requires Healthy Blue to have written policies and procedures for the HCT program and states that this program does not replace the MCO's existing member care management, disease management, or utilization management (UM) programs required under this contract.
c. The policy, "Complex Care Management-MO," does not mention updating a member's care plan.	Update policy about revising member's care plan at least annually and in other circumstances per the MHD contract, section 2.11.1.
d. Direct access and standing referrals to a specialty care center if the member has a life-threatening condition or disease requiring specialized medical care over a prolonged period are not addressed in any policy.	Submit documentation.

4.5 Regulation IV- Coverage and Authorization of Services

A detailed evaluation is provided in Appendix D.

4.5.1 Strengths

a. Healthy Blue shall ensure Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (called Healthy Children and Youth-HCY program in Missouri) are conducted on all eligible members under the age of 21 years to identify health and developmental problems. Healthy Blue has an established process for reminders, follow-ups, and outreach to members, e.g., notifying the parent(s) or guardian(s) of children of the needs and scheduling periodic well-child visits according to the periodicity schedule.

b. Prohibition of prior authorization for emergency medical and behavioral health services, involuntary detentions (96-hour detentions or court-ordered detentions), or commitments for any inpatient days while the court order or commitment is in effect.

c. Compliance with the Wellstone–Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), as applicable to Medicaid MCOs.

d. A referral, assessment, or other requirements prior to the member accessing requested medical or behavioral health, such requirements shall not impede the timely delivery of the medically necessary service.

e. A professional with experience or expertise comparable to the provider requesting the authorization reviews all appeals and denials and makes UM denial decisions.

f. Interim supply of an item is available during the authorization process. Member's treatment regimens are not interrupted or delayed (e.g., physical, occupational, and speech therapy; psychological counseling; home health services; personal care) by the prior authorization process. Payment of custom items (e.g., custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) delivered or placed within six months of approval are made even if the member's enrollment ends.

g. Healthy Blue shall not subsequently retract its authorization, revoke, limit, condition, or otherwise restrict a prior authorization after services have been provided or reduce payment for an item or service (except under some circumstances-misinterpretation or omission of health information, contract termination, coverage termination).

h. Healthy Blue does not deny the physician's request for continuing coverage of an inpatient hospital stay unless an alternative service is recommended by Healthy Blue and scheduled within seven days of discharge that meets the medical needs of the member.

i. Compliance with the timeframes for prior authorization decisions for non-emergency services as determined by emergency room staff (30 minutes), urgent services (24 hours), and standard services within 36 hours of service request. Healthy Blue provides written notification of adverse decisions to the requesting practitioner and member.

j. Healthy Blue does not reward or penalize practitioners, subcontractors, or other individuals (including associates) for issuing denials of coverage of care for financial incentives or nonfinancial incentives such as paid time off.

4.5.2 Weaknesses and Recommendations

Areas of concern and the recommendations to close the identified gaps are listed in Table 9.

Table 9. Coverage and Authorization of Services

Weakness	EQRO Recommendation
a. Healthy Blue did not identify, define, and specify the amount, duration, and scope of services required to offer categorically needy and medically needy members that are sufficient to achieve its purpose.	Submit documentation.
b. Policies did not address the services to be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS.	Submit documentation.
c. The policy "Clinical Criteria for UM Decisions-Core Process-MO" is inconsistent in defining the criteria that constitute "Medical Necessity." Another policy, "Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO," does not fully comply with all the "Medical Necessity" criteria.	Update policies to define "Medical Necessity accurately.
d. Policy on protecting and enabling the enrollee's freedom to choose the method of family planning was not submitted.	Submit policy.

4.6 Regulation V- Provider Selection

A detailed evaluation is provided in Appendix E.

4.6.1 Strengths

a. Healthy Blue verifies the credentialing data, including a license to practice in the state(s) in which the practitioner will be treating members. The credentialing department performs ongoing monitoring (monthly) to help ensure continued compliance with credentialing standards and assess for occurrences that may reflect substandard professional conduct and competence issues. The Council for Affordable Quality Healthcare (CAQH) ProView system is utilized for practitioners.

b. A practitioner is screened for Medicare, Medicaid, or Federal Employees Health Benefits (FEHB) Program sanctions. An applicant must not be currently federally sanctioned, debarred, or excluded from participating in the following programs: Medicare, Medicaid, or FEHBP.

c. Healthy Blue will not discriminate against any applicant based on the risk of the population they serve or against those who specialize in treating costly conditions.

d. Healthy Blue's Supplier Diversity Program is dedicated to diversifying its supplier base to include minority-owned, women-owned, veteran-owned, LGBT (Lesbian, Gay, Bi-Sexual, Transgender)-owned, and disabled-owned businesses wherever possible. Healthy Blue actively works to include diverse suppliers in every bidding opportunity. Healthy Blue has established a 12% Supplier Diversity goal.

4.6.2 Weaknesses and Recommendations

Areas of concern and the recommendations to close the identified gaps are listed in Table 10.

Table 10. Provider Selection

Weakness	EQRO Recommendation
a. Healthy Blue did not submit a policy and evidence of an audit of medical records as a part of the re-credentialing process to determine if the providers meet the Advance Directives requirements.	Submit documentation.
b. No documentation on "Ownership or Controlling Interest Disclosure," "Transaction Disclosure," and "Provider and Subcontractor Disclosure" was submitted. Verifying documentation from Missouri Medicaid Audit & Compliance (MMAC) was not submitted confirming that MMAC has maintained all provider credentialing information.	Develop policy and procedure to meet this section's requirements and submit any waiver they have received from MMAC.
c. No documentation was provided to show provisions in its subcontracts for health care services notifying the provider or benefits management organization to provide the disclosures (as noted in section b above) to Healthy Blue.	Submit documentation.

d. Healthy Blue did not have a policy about notifying the state agency of any denial of enrollment due to the provider credentialing or re-credentialing process results during the review period. However, Healthy Blue updated its policy, "Missouri Medicaid Supplemental Credentialing Policy," to include the requirements after PTM identified the deficiency during the preliminary review. Healthy Blue did not submit enrollment data to show any denials or provider terminations during CY 2021 to meet the requirements of this section.	Submit policy, "Missouri Medicaid Supplemental Credentialing Policy," for the MHD's approval. Submit documentation for enrollment denials during CY 2021.
e. Healthy Blue did not have a policy to meet the requirements of loading the credentialed providers into the claim adjudication and payment system within the time frames provided in the MHD contract, section 2.18.8(c). Healthy Blue updated its policy, "Anthem Provider Data Operations (APDO) Provider Data Updates-Turnaround Times," to include the requirements after PTM identified the deficiency. Healthy Blue did not submit data to show the turnaround time for uploading the provider data into the claim adjudication and payment system.	Submit policy, "Anthem Provider Data Operations (APDO) Provider Data Updates-Turnaround Times," for the MHD's approval. Submit documentation on the turnaround time for uploading the provider data into the claim adjudication and payment system.
f. No documentation on the payment cycle and loading the provider data in the provider directory was submitted.	Submit documentation.
g. Data on compliance with the credentialing timeframe and the number of providers who were not credentialed according to the requirements by provider type was not submitted.	Submit credentialing data for CY 2021
h. The policy, "Credentialing," did not include all the nondiscrimination laws per the MHD contract, section 2.2.7.	Update policy, "Credentialing,"

4.7 Regulation VI- Confidentiality

A detailed evaluation is provided in Appendix F.

4.7.1 Strengths

a. Healthy Blue associates must read and sign Healthy Blue's Privacy Policy Summary document, which is part of the new hire Ethics, Privacy, Information Security, Compliance training program online. Temporary workers who are on-boarded through the Fieldglass system must complete the Healthy Blue Overview for Temporary Workers and Contractor education materials (provided by the supplier agency), including signed certification documents before beginning work functions and annually after that.

b. In accordance with 45 CFR 164.530(c), Healthy Blue has implemented reasonable Administrative, Technical and Physical safeguards to protect PHI, PI, and PFI, including confidential and proprietary information, from unauthorized Use or Disclosure. The PHI can be in any form, including verbal, written, and electronic. Administrative safeguards apply for oral communications, telephone messages, faxes, emails, copying and printing, clean desk policy, removal of PHI, destruction standards, usage of sensitive financial information, and external business controls.

c. Authorized Healthy Blue associates may disclose the minimum amount of PHI necessary to comply with a request from a regulatory body that has authority over Healthy Blue. Healthy Blue associates take appropriate steps to verify the identity and authority of the individual, requesting that their PHI be disclosed prior to processing an authorization.

d. The Disclosure of Substance Use Disorder (SUD) information complies with all applicable Federal and State privacy laws, including 42 CFR Part 2 rules for the Confidentiality of Substance Use Disorder Patient Records, promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

e. An individual authorization is required before Healthy Blue can disclose the Sensitive Services information. Some examples of Sensitive Services may include but are not limited to records relating to HIV/AIDS, mental health, reproductive services, abortion, abuse, genetic information, and substance use disorder.

f. Healthy Blue complies with the HITECH Act, the HIPAA Omnibus Final Rule, applicable federal (45 CFR 164.400 to 164.414), state and applicable international laws and regulations, and applicable contractual obligations. Healthy Blue may disclose PHI to the subcontractor only if: a Business Associate Agreement (BAA) is in place with the subcontractor; and the BAA contains the same restrictions and conditions that apply to

Healthy Blue regarding safeguarding PHI.

g. Healthy Blue workforce members will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person who is testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under the Administrative Simplification Provisions of the HIPAA. Health Blue shall immediately report breaches identified by completing the Probability of Compromise.

h. Healthy Blue associates may disclose the minimum amount of PHI necessary without the individual's authorization to perform Healthy Blue's Treatment, Payment, and Healthcare Operations (TPO). Healthy Blue may disclose PHI without authorization in response to a court or administrative tribunal order, a subpoena, discovery request, or other lawful processes.

i. Healthy Blue follows contractual requirements that restrict de-identification or limit the use of de-identified data. Requests to create a limited data set for external disclosure should be submitted to the Privacy Department for approval. Limited Data Sets can only be disclosed if the Privacy Department determines, in consultation with the Legal Department, that Healthy Blue enters into a Data Use Agreement with the Limited Data Set recipient prior to the disclosure that allows Healthy Blue to terminate the Data Use Agreement if the agreement is violated.

j. Healthy Blue shall provide an accounting of disclosures of PHI regarding an individual; and the access to the PHI in an individual's designated record set to the MHD by no later than five calendar days of the request.

k. Health Blue shall immediately report breaches identified by completing the Probability of Compromise analysis.

l. Consistent with Healthy Blue's Records Management Policy and the HIPAA privacy rule, Healthy Blue must retain specified documentation for at least six years from its creation or when it last was in effect. Healthy Blue may be required to retain records over six years to the extent required under Healthy Blue's Records Retention Schedule.

m. Except as otherwise permitted under HIPAA, Healthy Blue associates may not use or disclose PHI for marketing purposes without an individual's authorization for marketing which must state that the Covered Entity may receive direct or indirect remuneration from the party whose product is being described in the Marketing activity.

4.7.2 Weaknesses and Recommendations

Areas of concern and the recommendations to close the identified gaps are listed in Table 11.

Table 11. Confidentiality

Weakness	EQRO Recommendation
a. None of the policies stated that member reports, documentation, or material prepared, as required by the MHD contract would be released to the public only with the prior written consent of the state agency (MHD contract, section 3.16.1).	Include the requirement from the MHD contract in a policy.
b. Policy to comply with the usage of PHI to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B), (MHD contract 2.38.2(f)) is not submitted.	Submit documentation.
c. Healthy Blue's BAA does not state the timeframe (10 calendar days) within which a BA will submit documentation (internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of PHI) to the Covered Entity (State, Secretary of the Department of Health and Human Services) on request.	Update BAA and disseminate the information to the BAs.
d. Documentation to comply with the timeframe (5 calendar days) requirement of the State for accessing the PHI (Designated Record Set) was not submitted.	Update policy, "Right of Access to Inspect/Copy PHI."
e. Documentation to show that Healthy Blue shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s), or subcontractor(s), was not submitted.	Submit documentation.

4.8 Regulation VII-Grievance and Appeal System

A detailed evaluation is provided in Appendix G.

4.8.1 Strengths

a. Healthy Blue has a grievance and appeal system for members that defines their rights regarding disputed matters with Healthy Blue. Healthy Blue's grievance and appeal system includes a grievance and appeals process and access to the State's Fair Hearing process as outlined in the MHD contract, section 2.15 and 42 CFR 438.402.

b. The member service representatives try to resolve all inquiries during the initial call. Any inquiry that cannot be resolved to the member's satisfaction is documented as a grievance.

c. Healthy Blue's policies comply with the requirements: persons who have the authority to file; procedure to file a grievance, appeal, or a State Fair Hearing; timings of notice of adverse benefit determination; acknowledging each grievance and appeal in writing (within 10 business days after receiving a grievance or appeal); timely filing (within 10 calendar days of notification) for the continuation of benefits when an appeal or State Fair Hearing is pending; extension timeframes of appeals (not more than 14 calendar days); the format of notice of resolution; and process for an expedited resolution of appeals.

d. Healthy Blue gives members reasonable assistance in completing forms and taking other procedural steps related to a grievance or an appeal. The assistance includes but is not limited to auxiliary aids and services upon requests, such as providing interpreter services for members/authorized representatives with limited English proficiency and toll-free numbers that have adequate TTY/TTD (Teletypewriter/Telecommunications Device for the Deaf) and interpreter capability and American Sign Language services for members and authorized representatives with visual or other communicative impairments and challenges.

e. The member or the member's representative may request the member's case file free of charge, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Healthy Blue in connection with the appeal of the adverse benefit determination. Healthy Blue will ensure that members and authorized representatives acting on behalf of the member will not receive punitive action for requesting the appeal and have a full and fair process to appeal, either verbally or in writing, any adverse decision (e.g., benefit, coverage, quality of care, administrative).

d. Healthy Blue is knowledgeable of its role after the final resolution of appeal or State

Fair Hearing. If the decision is against the enrollee, Healthy Blue may recover the cost of services furnished to the enrollee for the period appeal, or State Fair Hearing was pending. Healthy Blue must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the adverse benefit determination.

4.8.2 Weaknesses and Recommendations

Areas of concern and the recommendations to close the identified gaps are listed in Table 12.

Table 12. Grievance and Appeal System

Weakness	EQRO Recommendation
a. Even though the definitions of grievance, appeal, grievance and appeal system, inquiry, adverse benefit determination, and State Fair Hearing are accurately defined in the policies, the provider manual does not include an accurate definition of adverse benefit determination and appeal.	Update the provider manual with accurate definitions of adverse benefit determination, and appeal per 42 CFR 438.400.
b. Healthy Blue did not submit its member flyer for review as requested.	Submit member flyer.
c. The member handbook does not mention the timing for filing a grievance.	Update member handbook.
d. The policy, "Member Appeals-MO," states that the medical director or the practitioner who made the initial decision may review the case and overturn their initial decision.	Update the policy and procedure. An appeal is not reviewed by a medical director or a practitioner who has made an initial decision. This does not comply with the 42 CFR 438.406.
e. The timeframe of post-service appeal resolution within 60 days mentioned in the member handbook is not per the MHD contract/CFR.	Update member handbook. Healthy Blue must resolve an appeal within 30 days of filing by a member.
f. The policy, "Member Appeals-MO," states that if Healthy Blue fails to adhere to the notice and timing requirements under the MHD contract, section 2.12.16 (c.)(22), and in accordance with 42 CFR 438.408, the member is deemed to have exhausted	The MHD contract, section 1.12.16(c)(22), does not mention the timeframe requirement. The policy should be updated to exclude this section from its policy and quote the correct section on the timeframe from the MHD contract.

Healthy Blue's internal level of appeal and may initiate a State Fair Hearing.	
g. The member handbook does not have information to file a State Fair Hearing in case of deemed exhaustion of appeal process.	Update member handbook.
h. The provider manual has incorrect information stating that a member, or the member's representative, can file an appeal within 90 calendar days from the date on Healthy Blue's notice of action.	Update the provider manual to reflect the correct timeframe of 60 days for filing an appeal after Healthy Blue's notice of adverse benefit determination.
i. The Medical Transportation Management (MTM) Statement of Work (SOW) does not include all the information about the grievance and appeal system that must be provided when they entered a contract with Healthy Blue per 42 CFR 438.414.	Update MTM's SOW.
j. DentaQuest Ancillary Services Agreement states that a provider may file a verbal or written complaint or appeal within 90 days or within the specified time frame of adverse benefit determination.	Update Dental Quest Ancillary Services Agreement with an accurate timeframe (30 days) and process for filing an appeal (oral or written).
k. Healthy Blue's website for provider resources does not provide grievance and appeal system information. The Quick Reference Guide posted on the website for providers also does not incorporate information. The grievance and appeal system information must be provided to the providers and subcontractors when they enter a contract with Healthy Blue per 42 CFR 438.414.	Update documentation for compliance with the requirement.
l. Healthy Blue did not submit logs of closed and open cases of grievances and appeals for the review period. Thus, PTM could not determine compliance.	Submit records (logs) for CY 2021.

m. Healthy Blue's provider manual requires member records be retained for at least seven years after the last product, service, or supply has been provided to a member or an authorized agent unless those records are subject to review, audit, or investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	The provider manual is updated to reflect the accurate timeframe of record retention per 42 CFR 438.3(u).

5.0 CONCLUSION

Table 13 presents the key findings from the evaluation of Quality, Timeliness, and Access to Healthcare services provided by Healthy Blue in the current review cycle: EQR 2021-2023.

Table 13. Audit Results-EQR 2021-2022

42 CFR 438/457 Regulation	Key Finding	CAP (Yes/No)
438.206/457.1230(a) Availability of services	Concerns identified	Yes
438.207/457.1230(b) Assurances of adequate capacity and services	Concerns identified	Yes
438.208/457.1230(c) Coordination and continuity of care	Concerns identified	Yes
438.210/457.1230(d) Coverage and authorization of services	Concerns identified	Yes
438.214/457.1233(a) Provider selection	Concerns identified	Yes
438.224/457.1110 Confidentiality	Concerns identified	Yes
438.228/457.1260 Grievance and appeal system	Concerns identified	Yes
438.56/457.1212 Disenrollment: Requirements and limitations	Concerns identified	Yes
438.100/457.1220 Enrollee rights	Concerns identified	Yes
438.114/457.1228 Emergency and post-stabilization services	Concerns identified	Yes
438.230/457.1233(b) Subcontractual relationships and delegation	Concerns identified	Yes

438.236/457.1233(c) Practice guidelines	No concerns identified	No
438.242/457.1233(d) Health information systems	Concerns identified	Yes

5.1 Improvement by Healthy Blue

Healthy Blue's overall score for compliance with Medicaid and CHIP managed care regulations in EQR 2022 is 76.9%, compared to 82.3% achieved in EQR 2021. Healthy Blue is placed on a CAP for all seven regulations in the EQR 2022. During the previous EQR 2021, 5 of 6 regulations were included in the CAP.

5.2 Response to Previous Year's Recommendations

Table 14 shows the degree to which Healthy Blue responded to PTM's recommendations from the previous year's EQR. PTM reviewed the documents to assess the non-compliant criteria per the CAP and the weaknesses identified in EQR 2021 (Table 15). Each item was assigned two points (denominator), and the response was evaluated and categorized (numerator) as follows:

- High (Two points): MCO fully addressed the recommendation, complied with the requirement, and the item is closed. (Overall score > 90%)
- Medium (One point): MCO partially addressed the recommendation, the same recommendation applies, or a new recommendation is provided, and the item remains open. (Overall score 75-89%).
- Low: (Zero points) Minimal action/no action was taken, the same recommendation applies, and the item remains open. (Overall score <75%).

Table 14. Score for Degree of Response						
Total	High	=	14	×2	=	28
	Medium	=	9	×1	=	9
	Low	=	11	×0	=	0
Numerator	Score Obtained					37
Denominator	Total Sections	=	34	×2	=	68
Overall Score= Low						**54.4%**

Table 15. Healthy Blue's Response to the Previous Year's Recommendations

Recommendations	Action by Healthy Blue	Degree of Response
EQR 2021		
1. Disenrollment: Requirements and Limitations		
a. Healthy Blue must incorporate in their policy, "MO29-OP-CS-003 Member Disenrollment," to request disenrollment upon automatic re-enrollment if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.	Disenrollment-MO: page 3 Healthy Blue updated the above policy to meet the requirement. Also, merged the information presented in MO29-OP-CS-003 policy into one single policy (stated above).	**High**
b. Healthy Blue incorporate in their policy on Member Disenrollment and implement the member's right to request disenrollment if Healthy Blue does not cover services the member seeks because of moral or religious objections.	Disenrollment-MO: page 3 The policy is updated.	**High**
c. Healthy Blue must have a written procedure for complying with the MHD's disenrollment orders.	Disenrollment-MO: page 6 The Enrollment and Billing Department will process the HIPAA 834 file, and the enrollment transaction is generated for the MHD in accordance with all contractual requirements.	**Low** Healthy Blue must describe the procedure for disenrollment orders. The same recommendation applies.
d. Healthy Blue should have a documented procedure for receiving enrollment and disenrollment updates and incorporating them daily in Healthy Blue and the subcontractor management system. Healthy Blue should also list the procedure for weekly membership reconciliation with the MHD's 834 files.	Disenrollment-MO: page 6 Same comment as above (section c)	**Low** Healthy Blue must describe the procedure for disenrollment orders. The same recommendation applies.
2. Enrollee Rights		

a. Healthy Blue must have a policy/guideline regarding member resources per 42 CFR 438.10 and revise Welcome Quick Guide to a sixth grade reading level.	MAMCOM Member Materials-Appropriateness: pages-13, 14 Welcome Quick Guide Flyer (revised-reading level sixth grade)	**Medium** Healthy Blue must update the policy to meet the font size requirements for Taglines in its member materials per the 42 CFR 438.10. Taglines are no longer required to be of font size 18.
b. Healthy Blue must address the requirement to notify its members 15 calendar days after receipt or issuance of the termination notice to any provider.	Provider Termination Enterprise Playbook (updated-snapshot)	**High**
c. Healthy Blue must have a policy about providing a member handbook and other written materials with information on how to access services to all members within 10 business days of being notified by the MHD of their future enrollment with Healthy Blue.	New Member Materials Distribution: page 4	**High**
d. Healthy Blue update its policy, Development of Marketing and Member Communications, and align it with the MHD contract, section 2.13.2. Per the MHD contract, the marketing materials are not deemed approved if there is no response from the State within 30 calendar days.	MAMCOM Member Materials-Appropriateness: page 14 Development of Marketing and Member Communications: page 4	**Medium** HB has submitted another policy that meets the requirement of the MHD contract. However, Healthy Blue has not revised its policy as recommended.
e. Healthy Blue must maintain a log with the changes they made each year to its member handbook along with the date of approval by the MHD.	Healthy Blue informed PTM that they maintain records of all changes related to the member handbook. All changes are then submitted to the State for approval and recorded accordingly.	**Low** Healthy Blue has not submitted a log with changes in the previous years.
f. Healthy Blue must notify its enrollees of any change the MHD defines as	Healthy Blue informed PTM that the member	**Low**

significant in the enrollee handbook at least 30 calendar days before the intended effective date of the change.	Handbook is updated annually per the MHD. They do not recall receiving any significant changes which would require notification to the enrollee.	Healthy Blue did not submit a policy or documentation to meet the requirement. (Note: PTM suggested Healthy Blue submit evidence as to how they informed the potential enrollees about that Medicaid Expansion that was implemented in CY 2020.)
g. Healthy Blue is recommended to update its member handbook to meet all the 48 criteria listed in the MHD contract, section 2.12.16, even though the MHD provides a template.	Member Handbook: pages-36, 49	**Medium** The same recommendation applies.
Findings: Out of 48 criteria required in the member handbook per the MHD contract 2.12.16, six were "Partially Met," and two were "Not Met" during EQR 2021. PTM re-reviewed the revised member handbook 2021 available at Healthy Blue's website and found that four of nine "Partially Met" criteria were addressed. Thus, five criteria remain "Partially Met," and two remain "Not Met." (Alphabets used below refer to the criteria from EQR 2021 Compliance Report). The "Partially Met" criteria are as follows: h. Information on how and where members can access benefits provided by the State is not present. t. All the conditions under which an enrollee can disenroll with or without cause are not listed, e.g., upon automatic re-enrollment, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity, the enrollee can request for disenrollment. v. Time allocated to file a grievance is not addressed. A member must complete a written request for an appeal even if the member filed orally is incorrect (page 58) per 42 CFR 438 effective Dec 14, 2020. a.9 A statement that Healthy Blue shall protect its members in the event of insolvency and it shall not hold its members liable under certain conditions as in the MHD contract is not written.		

a.18. Healthy Blue did not include a statement of "any limitation regarding the implementation of advance directives as a matter of conscience" as required per the MHD contract. Healthy Blue informed EQRO that the MHD provides the language for Advance Directives as a template. The "Not Met" criteria are as follows: 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.		
h. Healthy Blue should consider revising the documentation in Providers Resource on their website on "encouraging members to receive family planning services within the network." Per 42 CFR 441.20, for beneficiaries eligible under the plan for family planning services, the plan must provide that each beneficiary is free from coercion or mental pressure and free to choose the family planning method. The MHD contract, section 2.12.16, states that members may obtain family planning services and supplies from out-of-network providers.	Provider Quick Reference Card: page 4	**Low** Provider Quick Reference Guide posted on the website is not revised.
i. Healthy Blue consistently reports all the provider directory requirements for its providers, including hospitals in the network per the 42 CFR 438.10h and the MHD contract, section 2.12.17. Healthy Blue should educate its providers about the contractual requirement for submitting their information to Healthy Blue. Healthy Blue should update its policy, Provider Listing Updates, with the missing	Provider Listing Updates-MO: pages-1 to 3 Physicians and Medical Professional Search (Apr 26, 2022)	**Medium** Healthy Blue has updated its policy. PTM searched the website for a provider directory. The search resulted in a pdf document that did not provide board-certified status, panel status, cultural and

information about the requirements and submit it to the MHD for approval.		linguistic capabilities, or accommodations for all the providers. However, all the information is available online, and the provider directory posted in a comma-delimited format. PTM recommends that Healthy Blue should have the ability to provide all the required information in a format that can be easily understood, downloaded, and read on an electronic device by Medicaid members.
j. Healthy Blue upload their provider directory on their website in a machine-readable format (computer/mobile readable). Members should have access to them once downloaded on their computer or mobile, even without internet accessibility/availability.		**Medium** A PDF document can be generated after searching the provider on the website. The directory uploaded on the website is in a comma-delimited format that a person with limited IT knowledge will not understand. PTM recommends that Healthy Blue uploads the provider directory in Word or PDF format.
k. Healthy Blue quotes the references from federal regulations in its policy, Member Rights and Responsibilities-	Member Rights and Responsibilities-MO policy is not updated to	**Low**

MO, that expresses Healthy Blue's commitment to comply with all the regulations on observing and protecting enrollee rights (indiscrimination).	show the federal regulations covered in its Indiscrimination statement.	
3. Emergency and Post-stabilization Services		
a. Healthy Blue must submit documentation to show that Healthy Blue and providers have an agreement on payment for the emergency and post-stabilization services.	Healthy Blue did not submit supporting documentation (Single Case Agreement).	**Low**
4. Subcontractual Relationships and Delegation		
a. Healthy Blue must update its contract with March Vision Care Group, Inc. and MTM Inc. with the requirements set in the MHD contract, section 3.9.6 (delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement).	March Vision Care Group, Inc. Amendment (Mar 01, 2017): pages-4, 5, 6, 11 March Vision Care Group, Inc. Fifth Amendment: page 6 MTM Inc. Amendment SOW 1 (Jan 1, 2022): pages-10, 11	**High** Healthy Blue submitted documents that meet requirements related to the deficient items from the previous year's EQR.
b. Healthy Blue must update its agreement with the March Vision Care Group, Inc. to indemnify the state in case of a dispute between Healthy Blue and the subcontracted providers.	March Vision Care Group, Inc. Amendment (Mar 01, 2017): page 10	**High** Same comment as above.
5. Practice Guidelines		
a. Healthy Blue staff's knowledge during the interview and policies, e.g., QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring, must be consistent with each other regarding the frequency of updating practice guidelines. Inconsistent information about the frequency of the updating the CPGs-annually or biennially, was provided.	Healthy Blue did report any action to resolve the issue.	**Low**

b. Primaris (PTM) recommends Healthy Blue inform its members about the existence and availability of practice guidelines via member handbooks, newsletters, or mailers and how to request these documents.	Healthy Blue did report any action towards the recommendation.	**Low**
6. Health Information Systems		
a. Healthy Blue must explain/describe its process as to how Healthy Blue's health information system provides information on the Grievances and Appeals.	Grievance and Appeals MIS Overview: pages-1, 2 Healthy Blue submitted flow charts.	**Medium** Healthy blue did not describe how the information system provides information on Grievances and Appeals.
b. Healthy Blue must submit documentation to show that its claims processing system is capable of detecting fraud, waste, and abuse in compliance with section 6504(a) of the Affordable Care Act and 1903(r)(1)(F) of the Act.	Encounters Completeness, Timeliness and Accuracy Policy: page 6 Acknowledgment of Receipt and Received Date for Electronic Data Interchange (EDI) Submissions: page 2 Reconciliation Ticket Process: pages-3 to 21 Providers_In Queue: pages 1 to 4	**Medium** The policy addresses the accuracy of claims. Healthy Blue 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.
c. Healthy Blue has phone-based capabilities to obtain claims processing status information and provide documentation supporting this requirement.	Operational Data Exchange Interfaces (flow chart)	**Medium** The flow chart shows IVR eligibility, claims, and authorization status inquiry. PTM recommends that Healthy Blue describes its process.

d. Healthy Blue must address the federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. The requirements stated in RSMo 376.383 and 376.384 also need to be addressed, and supporting documents be submitted.	Electronic X12 837 CLM06 (Snapshot submitted Electronic Transaction Standard: page 1	**High**
e. Healthy Blue must have policies and procedures to verify the consistency and timeliness of reported data, including data from network providers Healthy Blue compensates based on capitation payments.	Encounters Completeness, Timeliness and Accuracy Policy: pages-5, 6 Timeliness July 2021 (Snapshot)	**High**
f. Healthy Blue annotate its policy that all data collected will be submitted to CMS and other state agencies if requested.	Encounters Completeness, Timeliness and Accuracy Policy: page 1	**High** Healthy Blue's policy states that they collect and maintain 100% of all encounter data for each covered service and supplemental benefit services provided to Members, including encounter data from any sub-capitated sources for the MHD. The MHD uses the data for federal reporting.
g. Healthy Blue has a policy and supporting documentation on the frequency and acceptance rate of enrollee encounter data to the MHD.	Encounters Completeness, Timeliness and Accuracy Policy: page 6 Acceptance Rate July 2021 (Snapshot) Encounters Reported July 2021 (Excel)	**High**

h. Healthy Blue has a policy/procedure and submission of all enrollee data, including allowed and paid amounts.	Encounters Completeness, Timeliness and Accuracy Policy: page 6 Acceptance Rate July 2021 (Snapshot) Completeness Monthly Summary Jan-Jul 2021 (Snapshot)	**Medium** The policy meets the requirements of this section except for the submission of allowed claims. The data (snapshots) submitted show only the paid amounts. PTM noted that other MCOs reported their inability to submit the allowed amount due to a constraint in the MHD's encounter system process.
i. Healthy Blue develop a policy on the timeframe for submission of encounters to the MHD. Additionally, documentary evidence must be submitted to show that they have complied with this requirement.	Encounters Completeness, Timeliness and Accuracy Policy: page 5 Completeness Monthly Summary (Jan-Jul 2021)	**High**
j. Healthy Blue addresses the requirements, both in their policies and practice, related to the availability of information systems during normal operations and in the event of a major failure or disaster. Healthy Blue is expected to submit documentation to comply with the requirement that critical member and provider Internet and telephone-based functions and information, including critical provider internet and telephone-based functions, and electronic claims management are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week. Healthy Blue must address the contractual requirement in the event of a declared major failure or disaster: Healthy Blue's core eligibility/enrollment and claims	No documentation was submitted.	**Low**

processing systems shall be back online within 72 hours of the failure's or disaster's occurrence.		
k. Application Programming Interface (API) as specified in 42 CFR 431.60 and 431.70. API was required to be implemented by Jan 1, 2021. (Appendix F: section C5). However, per CMS's letter dated Aug 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 Jul 1, 2021. PTM will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.	Interoperability API Endpoint Support Healthy Blue confirmed the implementation of API and submitted a supporting document.	**High**
EQR 2020		
1. Multilingual Services: An analysis and evaluation of the multilingual services provided, including: A count of members needing communication accommodations due to hearing impairments or a physical disability. Missouri Care (currently dba Healthy Blue) did not report this in QAPI.	Count of Members MO_TTY-TDD (Excel) QAPI Annual Evaluation MY 2021: pages-37, 38	**High** Healthy Blue has created reporting of Multilingual services and a count of members needing communication accommodations due to hearing impairment or a physical disability. Healthy Blue stated that they would report these results in future QAPI reports.
2. Grievances and Appeals: Healthy Blue has reported Member Appeals under categories such as Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. EQRO finds these categories not aligned with the definition of adverse benefit determination & appeals per 42 CFR 438.400. EQRO recommends that	QAPI Annual Evaluation MY 2021: pages-66 to 68 Healthy Blue stated that due to NCQA requirements, these categories would need to remain in the report, and they cannot modify	**Low** Healthy Blue has presented categories based on NCQA but not per the CFR. The same recommendation applies.

Healthy Blue seek written clarification on expectations from the MHD. Healthy Blue should update data in the 2019 QAPI report and comply with the MHD's instructions for future reporting.	previous reports. In future reports, Healthy Blue will add sub-categories under the definitions of Adverse Benefit Determination as aligned per 42 CFR 4.38.400 and report accordingly.	
EQR 2019		
1. Policy update required: Release of PHI to the public will be only after prior written consent from the state agency (MHD contract 3.16.1). (Scored as Partially Met).	Healthy Blue has submitted information on how they ensure a policy is disseminated to all its staff. Ethics and Compliance Certification has instructions for all its employees before releasing any member-related records/data.	**High** Healthy Blue has rules for releasing PHI to public officials and other requesters. However, the release of PHI only after written consent from the state agency is not explicitly mentioned. PTM recommends that Healthy Blue must incorporate this requirement in its policy.

6.0 RECOMMENDATIONS

6.1 Healthy Blue

PTM recommends that Healthy Blue submits its CAP to include all the weaknesses listed for regulations in sections 4.2 to 4.8. Healthy Blue must also address "Low" and "Medium" response items from section 5.2 on the previous year's recommendations (Table 15). Healthy Blue must proactively develop its policies and procedures for all the regulations covered in the compliance review.

6.2 MHD

The following recommendations would improve the EQR process and findings.
1. The MHD contract with Healthy Blue should include a requirement to have policies and procedures for all the regulations covered under compliance review for the Medicaid and CHIP Managed Care Regulations.

2. The MHD collaborate with PTM and Healthy Blue on ways to increase the significance of the EQR.

3. Include PTM in quality-related meetings with Healthy Blue and EQR as a standing agenda item.

4. The MHD should recommend to Healthy Blue to focus on adopting documented and measurable ways to "ensure" that its providers and staff follow the regulations instead of relying on member complaint system for issues. The MHD should provide guidance for Healthy Blue on conducting member surveys, provider surveys in addition to Consumer Assessment of Healthcare Providers and Systems (CAHPS).

5. Identify ways PTM can assist Healthy Blue in meeting quality requirements, e.g., TA with quality improvement measures and models.

Specific recommendations based on the issues identified during the EQR are as follows:
1. The definition of "adverse benefit determination" in the MHD contract section 2.15.1(a)(5) states that "the failure of the MCO to act within the timeframes provided at section 2.12.16(c)(22) of the contract regarding the standard resolution of grievances and appeals." The MCOs are quoting the same statement in their policies. However, PTM noted that the MHD contract, section 2.12.16(c)(22), does not mention the timeframe. PTM recommends that the MHD replaces section 2.12.16(c)(22) with sections 2.15.5(e) and 2.15.6(l) of the MHD contract, which states the timeframes for resolution of grievances and appeals per 42 CFR 438.408(b) (1) and (2).

2. The MHD contract 2.15.5(e) states that "The health plan shall resolve each grievance and provide written notice of the resolution of the grievance, as expeditiously as the member's health condition requires but shall not exceed thirty (30) calendar days of the filing date." The CFR states that the standard resolution of grievances may not exceed 90 calendar days from the day the MCO receives the grievance. PTM recommends that the MHD specifies an action they would take if the MCOs cannot resolve a grievance in 30 calendar days but has resolved it within 90 calendar days.

3. The following sections from the 42 CFR 438.238 Grievance and appeal system (Medicaid managed care) differ from the 42 CFR 457.1260 Grievance system (CHIP managed care). However, PTM noted that the MHD contract does not differentiate between the grievance and appeal system for the Medicaid and CHIP members.

a. Definition of adverse benefit determination (42 CFR 438.400): For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise their right, under §438.52(b)(2)(ii), to obtain services outside the network (N/A for CHIP).

b. CHIP enrollees have the right to request a State External Review in accordance with 42 CFR 457.1130 and 457.1260(b)(2)).

c. Continuation of benefits while an appeal is pending (42 CFR 438.420)-N/A CHIP.

d. CHIP does not require a State to pay for disputed services furnished while an appeal is pending (42 CFR 438.424).

PTM recommends that the MHD consider aligning the grievance and appeal system per the CHIP regulations.

4. The MHD must upgrade its Missouri Medicaid Information System to allow Healthy Blue to submit encounter data including allowed and paid amounts to its providers as required per 42 CFR 438.242(c).

5. MHD contract section 2.13.2 (j) states that the MCO shall not submit provider-facing materials to the state agency for review and approval. These materials are coordinated between the MCO and the providers. PTM recommends that the MHD reviews certain provider facing documents that impact members' care, e.g., provider manual. During EQR 2022, several inaccuracies were noted while reviewing information presented in the provider manual corresponding to a regulation.

Appendix A

Standard 7–42 CFR: 438.206, 457.1230(a)-Availability of Services		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. All services covered under the State plan are available and accessible to enrollees of MCO in a timely manner. The MCO provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68. Travel distance: The MCOs shall comply with travel distance standards as set forth by the Department of Commerce and Insurance, in 20 CSR 400-7.095, for all those providers applicable to the MHD Managed Care program. For those providers not addressed under 20 CSR 400-7.095, the MCO shall ensure that members have access to those providers within 30 miles, unless the MCO can demonstrate to the state agency that there is no such licensed provider within 30 miles, in which case the MCO shall ensure members have access to those providers within 60 miles (MHD contract 2.5.2).	Access and Availability-After Hours-MO: pages-1, 2 Network Development, Monitoring and Management-MO: page 1	Fully Met
Findings: Healthy Blue has adopted geographic standards set forth by the State of Missouri per 20CSR 400-7.095-HMO Access Plans and State of Missouri Distance standards. Upon enrollment, each member is assigned to a PCP no further than ten 10, 20, or 30 miles from his/her place of residence, depending on whether the county of residence is classified by the Department of Commerce and Insurance as urban, basic, or rural, respectively. For providers not addressed under 20 CSR 400-7.095 Missouri Healthy Blue will ensure members have access to those providers within 60 miles. For High Volume Specialists and High Impact Specialist, for providers not addressed under 20 CSR 400-7.095 Missouri Healthy Blue will ensure members have access to those providers within 60 miles. **Required Actions:** None.		
B. Appointment standards (MHD contract 2.5.3):	Access and Availability-After Hours-MO: pages-2, 3 MHD Managed Care Provider Manual: pages-15, 17, 74	Partially Met

i. The MCO shall have policies and procedures in accordance with these appointment standards: a. Waiting times defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments do not exceed one hour from the scheduled appointment time. b. Urgent care appointments for physical or behavioral illness injuries which require care immediately but do not constitute emergencies- available within 24 hours. c. Routine care with physical or behavioral symptoms-available within 1 week or 5 business days whichever is earlier. d. Routine care without physical or behavioral symptoms-within 30 calendar days. e. Aftercare appointments-within 7 calendar days after hospital discharge. f. For maternity care: First trimester-within 7 calendar days of first request. Second trimester-within 7 calendar days of first request. Third trimester-within 3 calendar days of first request. High risk pregnancies-within 3 calendar days of identification of high risk to the MCO or maternity care provider, or immediately if an emergency exists.		
Findings: Healthy Blue's policy "Access and Availability-After Hours-MO" meets the requirements of this section.		

Healthy Blue's provider manual states that PCPs should offer appointments for routine/preventive care within 6 weeks. PTM noted that the six weeks' timeframe does not comply with the MHD contract timeframe requirements of 30 calendar days. **Required Actions:** PTM recommends that Healthy Blue updates its provider manual to reflect the correct appointment timeframe for routine/preventive care.		
ii. The policies and procedures should address the following: a. The methods for educating both the providers and the members about appointment standards. b. The MCO shall disseminate the appointment standard policies and procedures to its in-network providers and to its members. c. The MCO shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.	Access and Availability-After Hours-MO: pages 5, 6 MHD Managed Care Provider Manual: pages-15, 17, 74 Member Handbook: page 18 <u>Onsite Submission</u> Access and Availability Results (Presentation) Number of Completed Surveys 2021 (snapshot)	Fully Met
Findings: a, b. Healthy Blue will disseminate the appointment standards to participating providers, the MHD program and the contractual requirements along with other provider information to manage the network, and promote compliance with Healthy Blue, the MHD program, and other regulatory entities. Healthy Blue will communicate current and updated requirements to providers through the provider manual, provider newsletter, and provider representative office visits. Healthy Blue members are informed regarding appointment standards through the Healthy Blue's member handbook and Customer Service Department. Members are encouraged to contact Healthy Blue Customer Service Department if appointment standards are not reasonably met. c. Provider Relations (PR) or its vendor will survey a portion of the provider network to monitor compliance on a quarterly basis. • The provider's office is contacted to make appointments to determine if the office can offer access to medical assistance with the established standards. The appointment availability study will determine if the provider can offer timely appointments according to the requirements for urgent or routine medical care and obstetrical appointments. • Results of the study will be computed and submitted to the proper internal departments, as well as the necessary external regulatory agencies.		

• A list of providers who have failed to meet the standards will be generated for review. Providers on this list will be sent a letter informing them of the results of the study and will request a corrective action plan. This list will then be presented to the QM committee for discussion of actions. • The PR department will follow-up on the committee recommended actions. Healthy Blue submitted snapshots of number of completed surveys and appointment results of PCPs, OBGYN providers, pediatricians, oncologists, and other high volume specialists. **Required Actions:** None.		
C. Delivery network. The MCO consistent with the scope of its contracted services, meets the following requirements:		
i. Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.	Network Development, Monitoring and Management-MO: pages-1 to 4	Fully Met
Findings: Healthy Blue's Network Management Department, in conjunction with input from several departments and providers, regularly monitors network adequacy parameters on both a scheduled and on an adhoc basis. On a monthly basis, Healthy Blue's Network Integrity produces a geographic access report of its contracted network. The report is analyzed with respect to the statutory travel distance standards and plan contract requirements for access to specific health care specialties and services. The results of these analyses are shared with the Director of Provider Relations and the Director of Network Management so that any apparent deficiencies can be investigated and addressed as appropriate in a timely manner. On a quarterly basis, a formal review is performed with responses saved as the Exception History Log (EHL). The EHL is a snapshot of deficiencies with a narrative on why the deficiency exists. Annually, Healthy Blue assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. Healthy Blue reviews the number of providers-to-members as part of the network review process. Healthy Blue has adopted the Missouri HMO Numeric Availability Standards from the Provider Availability State Tables. **Required Actions:** None.		
ii. The MCO shall have and implement policies and procedures for rendering second opinions both in-network and out-of-network when requested by a	Second Opinion-MO: pages-1, 2	Fully Met

member, at no cost to the enrollee. These policies and procedures shall address whether there is a need for referral by the primary care provider or self-referral. Missouri Revised Statutes Section 208.152 states that certain elective surgical procedures require a second medical opinion be provided prior to the surgery. A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion (MHD contract 2.8).		
Findings: Healthy Blue provides members and/or physicians the option of an independent assessment of the medical necessity for a treatment plan and of the medical care options to a treatment plan or elective surgical procedures so that the member can make an informed choice. The second opinion may be both in-network and out-of-network when requested by a member and at no cost to the member. The PCP arranges an appointment with a participating network provider or a non-participating (non-par) provider if there is no provider in the network with the expertise required for the condition. (Non-par is approved by the Healthy Blue's Health Care Management Department.) A third surgical opinion, provided by a third provider, will be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion. **Required Actions:** None.		
iii. If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out-of-network for the enrollee, for as long as the MCO's provider network is unable to provide them. The out-of-network providers will coordinate with the MCO for payment and the MCO ensures the cost to the enrollee is no greater than it would be if	Access and Availability-After Hours-MO: page 7 Network Development, Monitoring and Management-MO: page 5 Out-of-Network Authorization Process-MO: pages-1 to 5	 Fully Met

the services were furnished within the network.		
Findings: To meet the needs of members during the contracting process, Healthy Blue authorizes treatment by out-of-network providers and executes single case or blanket letters of agreement to ensure that members have access to all medically necessary care at no greater cost than they would incur if they were seen by a network provider. **Required Actions:** None.		
D. Timely access: Each MCO must do the following: a. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees. b. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. c. Establish mechanisms to ensure compliance by network providers. d. Monitor network providers regularly to determine compliance. e. Take corrective action if there is a failure to comply by a network provider.	Access and Availability-After Hours-MO: pages-1, 3, 6, 7 MHD Managed Care Provider Manual: page 15 Network Development, Monitoring and Management-MO: pages-3, 4 <u>Onsite Submission</u> CAHPS Results	Partially Met
Findings: a. The provider manual states that behavioral health providers shall offer hours of operation that are no less than the hours of operation offered to commercial members. PTM noted that the same requirement on hours of operation is not posted for PCPs. PTM noted that Healthy Blue did not address this criterion in its policy. However, during the interview, Healthy Blue stated that the workhours are reviewed with the providers at the time of contracting. b. Healthy Blue has established policies and procedures to verify that emergency medical/behavioral health services are available 24 hours, seven days per week to treat an emergency medical condition.		

Healthy Blue will provide coverage to members on a 24 hours per day, seven days per week basis. The members and providers can contact Healthy Blue to receive individual instruction or authorization for treatment of an emergent or urgent medical, behavioral health or substance abuse problem and instruction regarding receiving care when the member is out of Healthy Blue geographic service area. Healthy Blue will provide for direct contact with qualified clinical staff through a toll-free number or provider services telephone number and a telecommunication device for the deaf telephone number. c, d, e. An annual analysis of the availability and accessibility data along with member grievances and appeals; CAHPS survey results; and out of network services data is completed to identify any issues related to access to care. The survey reports include data at the practitioner-level, allowing practitioner level analysis across all primary care, high volume & high impact specialists. A quantitative and qualitative analysis is performed with identification of barriers and opportunities for improvement which are prioritized, and interventions implemented, as appropriate, and presented to the Quality Management committee. Effectiveness of interventions is measured on an annual basis. Healthy Blue conducts quarterly telephonic surveys of a random sample of PCP's and specialists. At a minimum, the survey asks about availability of timely appointments, provider panel status (open and closed), number of members they can take as patients, 85% threshold reached, and service coverage after normal business hours. Providers who are not in compliance with the service accessibility standards set forth by the State are notified of the deficiency and asked to take corrective action. If an issue is noted upon follow-up, the noncompliant providers are placed on a formal corrective action plan that may include reassignment of members to compliant providers. **Required Actions:** PTM recommends Healthy Blue addresses criteria "a" in its policy and has a procedure to ensure no discrimination related to the work hours available to its Medicaid enrollees. For e.g., in the member survey, incorporating questions about the appointment availability timings, delay between a member's request for appointment and when the member was given an appointment may give an insight to any unusual pattern. Also, Healthy Blue must update its provider manual based on the deficiency identified.		
E. Access and cultural considerations: Each MCO participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. The MCO shall exhibit congruent behaviors, attitudes, and policies that come together in a system that enables	2021 Health Plan Consumer Advisory Committee Plan (Template): pages-1 to 6 Anthem Committees Charter-Requirement and Purpose, Responsibilities, Membership: pages-1, 3, 4 Anthem DEI Hiring and Training Review: pages 1 to 5	Partially Met

effective work in cross-cultural situations. The MCO shall adhere to the following standards (MHD contract 2.3.1): i. The MCO shall ensure that members receive from all providers and staff effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. ii. The MCO shall implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff and leadership that are representative of the demographic characteristics of regions covered by the contract. iii. The MCO shall ensure that staff, at all levels and across all disciplines, receives ongoing education and training in culturally and linguistically appropriate service delivery. iv. The MCO shall provide to members, in their preferred language, both verbal offers and written notices, when required, informing them of their right to receive language assistance services. v. The MCO shall make available easily-understood member-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in regions covered by the contract. vi. The MCO shall develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to	Appendix A (A writeup for EQRO) Caring for Diverse Population (Toolkit for Physicians and Healthcare Professionals) Culturally and Linguistically Appropriate Services: pages-3 to 6, 9, 10 Development of Marketing and Member Communications: page 4 Member Rights and Responsibilities: page 2	

provide culturally and linguistically appropriate services. vii. The MCO shall ensure that data on the individual member's race, ethnicity, and spoken and written language are collected in health records, integrated into the MCO's management information systems, and periodically updated. viii. The MCO shall maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of regions covered by the contract. ix. The MCO shall develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and member involvement in designing and implementing culturally and linguistically appropriate services in health care. x. The MCO shall ensure that the grievance and appeal resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural grievance and appeals by the member. xi. The MCO shall regularly make information available to the public about the MCO's progress and successful innovations in implementing culturally and linguistically appropriate services and provide public notice in their communities about the availability of this information.		

Findings: "Health Plan Consumer Advisory Committee Plan" template submitted by Healthy Blue incorporates all the criterion listed in this section except for ii and xi. Other documentation combined, complies with all the criteria except for xi.

PTM noted that submission of a blank template does not meet the compliance criteria for this section.

i. Healthy Blue tracks: member/provider satisfaction surveys response to cultural-competence related questions, specifically those pertaining to appointment availability, communication with physicians and need for a translator; members' grievance analyses of issues that may relate to cultural competency; and call monitoring and reporting information to identify areas for improvement of staff awareness and practice of cultural competence knowledge and skills.

ii. Healthy Blue recruits and employs qualified leadership, management, and staff to administer and support Healthy Blue's services and programs. Healthy Blue's recruits bilingual associates who reflect the demographics of the membership and may require bilingual capabilities in certain job positions. Associates who identify themselves as bilingual are objectively assessed to determine targeted language proficiency.

iii. Healthy Blue's governance, leadership, and all workforce complete cultural competency training annually or as needed to help support the diverse needs of the membership. Completion of training is documented and available for review upon request. Network providers receive ongoing training and information by the Healthy Blue staff through newsletters, provider bulletins, and updates on the Healthy Blue's provider website, in addition to direct training when possible.

iv, v. In the member handbook and member newsletters, members are informed of their right to free interpreter services 24 hours a day, seven days a week, including sign language interpreters; TTY services; materials in non-English languages and alternative formats (including Braille, large print, and audio CD) at no cost; and language assistance with the grievance and appeals process. A language assistance tagline is also included with all member materials. Signage regarding language assistance availability and member language identification is available to providers on the Healthy Blue's provider portal.

vi. Work Plan objective of Healthy Blue's Consumer Advisory Committee is to define and implement a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

vii, viii. Healthy Blue collects member language information from Medicaid eligibility files, which are loaded to membership databases. Healthy Blue's staff reviews language indicator data received from the MHD to trend and analyze number of members speaking a language other than English to determine necessity for developing member/enrollee materials in other languages.

ix. Healthy Blue utilizes community resources as needed to plan and implement services that respond to the diversity of the Healthy Blue's membership. Healthy Blue identifies culturally appropriate agencies and contacts county-specific organizations for resources. Members and providers are referred to community organizations and agencies when appropriate. Healthy Blue associates document requests for cultural services. x. Culturally and Linguistically Appropriate Services (CLAS) related grievances are identified using the following categories: disability (ability), ethnicity/culture, insurance (status), language, race, and other (age, gender, sexual orientation, gender identity, sexual harassment, weight, etc.). For Administrative Issues (Quality of Service) related to cultural and linguistic grievances, Grievance and Appeal associates consult with appropriate departments to investigate these issues. Interpreter services (telephonic and face-to-face interpreters, including sign language) and toll-free TTY/TDD numbers are available to members free of charge. Interpreter services (telephonic and face-to-face interpreters, including sign language) and toll-free TTY/TDD numbers are available to associates to facilitate investigation and resolution of grievances and appeals through all levels of the process, including assisting with completion of forms and other procedural steps. xi. Healthy Blue did not address this requirement. PTM noted that the policy, "Development of Marketing and Member Communications," incorrectly states that the marketing and education materials are deemed approved if a response from the state agency is not returned within 30 calendar days following receipt of the materials by the state agency. During the interview, Healthy Blue informed PTM that they have created a workplan to earn distinction from NCQA in multicultural healthcare. **Required Actions:** PTM recommends that Healthy Blue addresses criterion xi and update its policy, "Development of Marketing and Member Communications," based on the identified deficiency.		
F. Accessibility considerations: Each MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	Access and Availability-After Hours-MO: page 7 Culturally and Linguistically Appropriate Services: page 23 <u>Onsite Submission</u> Access and Availability-After Hours-MO (revised): page 6	Partially Met
Findings: Healthy Blue will provide an accommodation, if needed, to verify all members' equal access to twenty-four hour per day health care coverage.		

Healthy Blue's policy, "Culturally and Linguistically Appropriate Services" states that Healthy Blue must ensure newly constructed and altered facilities are physically accessible to individuals with disabilities. PTM noted that the requirement regarding physical accessibility was listed for another state and not specific to Missouri Medicaid. Healthy Blue updated its policy, "Access and Availability-After Hours-MO" to meet the requirements of this section after the deficiency was pointed out by PTM. Since the requirement was not incorporated during the review period, the score assigned is "Partially Met." **Required Actions:** PTM recommends that Healthy Blue communicates the accessibility requirements to its network providers and the updated policy is sent to the MHD for approval.		
G. Direct Access to Female Enrollees: In accordance with state law, the MCO shall allow members direct access to the services of the in-network OB/GYN of their choice for the provision of covered services (women's routine and preventive healthcare services). This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.	Member Handbook: page 28	Partially Met
Findings: Healthy Blue's member handbook states that women may go to any in-network OB/GYN providers without a PCP referral. PTM noted that Healthy Blue did not submit a policy/documentation as to how they communicate this information to its staff. **Required Actions:** Healthy Blue develop documentation for the provision of direct access to the OB/GYN providers for its female enrollees for staff.		

Compliance Score – Availability of Services						
Total	Met	=	5	×2	=	10
	Partial Met	=	5	×1	=	5
	Not Met	=	0	×0	=	0
Numerator	Score Obtained					15
Denominator	Total Sections	=	10	×2	=	20
Score						**75%**

Appendix B

Standard 8-42 CFR: 438.207, 457.1230(b)-Assurances of Adequate Capacity and Services		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. The MCO must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirement: i. MCO offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees for the service area. The MCO's network shall consist of, at minimum, hospitals, physicians, advanced practice nurses, mental health providers, substance use disorder providers, dentists, emergent and non-emergent transportation services, safety net hospitals (including acute care safety net hospitals as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended), and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified herein (MHD contract 2.4.1(a)).	Network Development, Monitoring and Management-MO: pages-1, 2 Hospital Listing (Sept 2021-Excel) <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 1	Partially Met
Findings: Healthy Blue will measure the availability of each type of high-volume specialty care providers (SCP) according to the numeric standards of 0.3:1,000 and the geographic access standards. Healthy Blue regularly reviews the adequacy of the high impact specialists (e.g., Oncologists). The geographic distribution of high impact specialists (HIS) will be measured according to the same numerical standards as high volume specialists (HVS) including acceptable distance/time from the members' home to the provider office. To ensure availability of Behavioral Health practitioners, Healthy Blue utilizes the State of Missouri groupings (Adult Psychiatry, Child/Adolescent Psychiatry, and Psychologists/Other Therapists) and geographic access standards.		

PTM noted incomplete documentation regarding the provider types during the preliminary review. Healthy Blue revised its documentation to meet all the requirements of this section after the deficiency was identified by PTM. As Healthy Blue did not have complete documentation during the review period, PTM scored this section "Partially Met." **Required Actions:** None. However, PTM recommends that Healthy Blue submits its revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval.		
ii. The MCO maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider (MHD contract 2.4.1(b)).	Provider Agreement: page 13 Hospital Listing (Sept 2021-Excel) <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 9	Partially Met
Findings: Healthy Blue's provider agreement has a clause on Non-Exclusive Participation, which states that none of the provisions of the agreement between Healthy Blue and a provider will prevent the provider or Healthy Blue from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Hospital listing (Excel Sept 2021) shows the providers who have contracts with the other MCOs operating in Missouri along with Healthy Blue. PTM noted that Healthy Blue did not have a policy to meet all the requirements of this section during the review period. Healthy Blue revised its policy after the deficiency was identified by PTM. Thus, PTM scored this section as "Partially Met." **Required Actions:** None.		
B. Primary Care Providers (PCPs): The MCO shall have written policies and procedures for all its primary care provider (PCP) activities. The	PCP Assignment-MO: page 1 MHD Managed Care Provider Manual: pages-12 to 14	Fully Met

primary care provider shall serve as the member's initial and most important contact. i. The PCPs responsibilities must include at a minimum (MHD contract 2.4.2(a)): a. Maintaining continuity of each member's health care. b. Making referrals for specialty care and other medically necessary services to both in-network and out-of-network providers. c. Participating in the MCO's care management team, as applicable and medically necessary and working with MCO care managers in developing plans of care for members receiving care management services. d. Conducting a behavioral health screen to determine whether the member needs behavioral health services. e. Maintaining a comprehensive, current medical record for the member, including documentation of all services provided to the member by the primary care provider, as well as any specialty or referral services, diagnostic reports, physical and behavioral health screens.		
Findings: Healthy Blue's policy "PCP Assignment-MO" incorporates all the responsibilities of PCP from this section. PCP serves as a central part of the member's health care home and is the member's initial and most important contact. PCPs may have formalized relationships with other PCPs to see their members for after-hours care, during certain days, for certain services or other reasons to extend their practice. Healthy Blue's provider manual details all the responsibilities of a PCP.		

Required Actions: None.		
ii. PCP (Eligible Specialties): a. The MCO shall limit its PCPs to licensed physicians specializing in family and general practice, pediatrics, obstetrics and gynecology (OB/GYN), and internal medicine; and registered nurses who are advanced practice nurses with specialties in family practice, pediatric practice, behavioral health, and OB/GYN practice (MHD contract 2.4.3). b. If the MCO provider network includes institutions with teaching programs, primary care provider teams (comprised of residents and a supervising faculty physician) may serve as a primary care provider. PCP teams may include advanced practice nurses or physician assistants recognized by the Board of Healing Arts who, at the member's discretion, may serve as the point of first contact for the member (MHD contract 2.4.4). c. The MCO shall organize its PCP teams so as to ensure continuity of care to members and identify a "lead physician" within the team for each member. The "lead physician" must be an attending physician and not a resident. d. The MCO shall allow specialists to serve as primary care providers for members with disabling conditions or chronic conditions which require ongoing care from a specialist so long as the specialist agrees, in writing, to accept the member as a primary care patient and to assume the responsibilities listed herein (MHD contract 2.4.6).	PCP Assignment-MO: page 4 MHD Managed Care Provider Manual: page 15 <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): pages-1, 2	Partially Met

Findings: a. Provider manual includes all the specialties except for OB/GYN who can serve as a PCP. d. Members with disabling conditions or chronic illnesses may request that their PCP be a specialist, such as a psychiatrist, oncologist, obstetrician, gynecologist, or other such specialist. Healthy Blue has procedures for ensuring access to needed services for those members or the request will be granted. The specialist must accept the member as a primary care patient and accept the responsibility of a PCP. Prior approval by Healthy Blue is required for the authorization of a specialist as a PCP. Healthy Blue shall consider such requests on a case-by-case basis. A Healthy Blue ID card will be issued with the name, location, and telephone number of their PCP. Healthy Blue did not have documentation to the meet criteria a, b, and c of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. **Required Actions:** PTM recommends that Healthy Blue updates its provider manual to include OB/GYN providers who can serve as a PCP.		
C. Behavioral Health Providers: To ensure a broad range of treatment options are available, the MCO shall include in its network a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults. To be considered adequate, the behavioral health provider network shall, at a minimum, include (MHD contract 2.4.8)- i. Qualified Behavioral Healthcare Professionals (QBHP), certified substance use disorder or co-occurring treatment professionals, licensed psychiatrists, licensed psychologists, provisionally licensed psychologists, licensed psychiatric nurse practitioners, licensed professional counselors, provisionally licensed professional counselors, licensed clinical social workers, licensed master social workers, licensed martial and family therapists (LMFT), provisional licensed martial	Behavioral Health Practitioner (non-physicians)-Education Criteria: pages 4 to 8 <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 7	Partially Met

and family therapists (PLMFT), and licensed psychiatric clinical nurse specialists. ii. The majority of Community Mental Health Centers (CMHC), within each county where the MCO provides coverage and the majority of Certified Community Behavioral Health Organizations (CCBHO). If there is not a CMHC in that county, the MCO must contract with a CMHC within 30 miles of a county where the MCO has coverage. If there is not a CMHC within 30 miles of that county, the MCO must contract with a CMHC in the Department of Mental Health (DMH).		
Findings: Healthy Blue did not have a policy and procedure that included all the providers listed under criterion i and did not meet the requirements of criterion ii. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. **Required Actions:** None.		
D. Federally Qualified Health Centers and Rural Health Clinics. The MCO shall offer a contract to all FQHCs, Provider-Based Rural Health Clinics (PBRHCs), and Independent Rural Health Clinics (IRHCs) at the rates established in the MHD contract. If there is not an FQHC in the county, the MCO must have a contract with an FQHC within 30 miles of a county where the MCO has coverage for members (MHD contract 2.4.9).	Hospital Listing (Sept 2021-Excel) <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 7	Partially Met
Findings: Healthy Blue did not have policy and procedure to meet the requirements of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. The hospital listing submitted by Healthy Blue showed the contracted FQHCs, PBRHCs and IRHCs in its provider network.		

Required Actions: None.		
E. Family Planning and Sexually Transmitted Disease (STD) Treatment Providers. The MCO shall include Title X and STD providers in its provider network to serve members covered under the comprehensive and extended family planning, women's reproductive health, and sexually transmitted diseases benefit packages. The MCO shall establish an agreement with each Family Planning and STD treatment provider not in the provider network describing, at a minimum, care coordination, medical record management, and billing procedures. The MCO shall allow for full freedom of choice for the provision of these services (MHD contract 2.4.10).	Hospital Listing (Sept 2021-Excel) <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 8	Partially Met
Findings: Healthy Blue did not have documentation to meet the requirements of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. The hospital listing submitted by Healthy Blue showed the contracted Family Planning and Sexually Transmitted Disease (STD) Treatment Providers. **Required Actions:** None.		
F. Local Public Health Agencies. The MCO shall include local public health agencies in its provider network for the local public health agency services described in the MHD contract and for other services such as care management and services provided under the Local Community Care Coordination Program (LCCCP). The MCO should establish an agreement with each local public health agency not in the provider network describing, at a minimum, care coordination, medical record	Hospital Listing (Sept 2021-Excel) <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 8	Partially Met

management, and billing procedures (MHD contract 2.4.11).		
Findings: Healthy Blue did not have documentation to meet the requirements of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. The hospital listing submitted by Healthy Blue showed the contracted Local Public Health Agencies. **Required Actions:** PTM recommends that Healthy Blue submits its revised policy for the MHD's approval.		
G. School Based Dental Services. The MCO shall contract with and reimburse any licensed dental provider who provides preventive dental services (i.e., dental exams, prophylaxis, and sealants) in a school setting (MHD contract 2.4.15).	NET01-INS DentaQuest- Network Development, Maintenance, and Use <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 8 CL02-INS Claims Payment	Partially Met
Findings: PTM noted that the policy "DentaQuest- Network Development, Maintenance, and Use" is not specific to Missouri Medicaid, but for other States. Also, the policy was effective Jan 6, 2022 and not during the review period (CY 2021). Healthy Blue did not have policy and procedure to meet the requirements of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. Onsite submission included additional documentation on Claims Payment that can be considered to partially meet the requirements of this section. **Required Actions:** None.		
H. Tertiary Care. The MCO shall provide tertiary care services including trauma centers, burn centers, stroke centers, ST-Elevation Myocardial Infarction (STEMI) centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available 24 hours per day in the regions covered by the contract. If the MCO does not	Hospital Listing (Sept 2021) <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 8 Healthy Blue Network Access Results 2021	Partially Met

have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers (MHD contract 2.4.16).		
Findings: Healthy Blue did not have policy and procedure to meet the requirements of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were pointed out by PTM. Healthy Blue submitted a Hospital List from Sept 2021 which showed the contracted secondary hospitals, neonatal or perinatology hospitals. Healthy Blue Network Access Results 2021 show overall 99% compliance. **Required Actions:** None.		
I. Specialty Pediatric Hospitals. The MCO shall include specialty pediatric hospitals as defined in 13 CSR 70-15.010(2)(Q), as amended, in its provider network.	Hospital Listing (Sept 2021-Excel): rows-120, 121 <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 9	Partially Met
Findings: Healthy Blue did not have policy and procedure to meet the requirements of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. The hospital listing submitted by Healthy Blue showed the contracted with Pediatric Hospitals. **Required Actions:** None.		
J. American Indian/Alaskan Natives: The MCO shall ensure that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP) as defined in 42 CFR 438.14 (MHD contract 2.4.18). i. The MCO must demonstrate that there are sufficient IHCPs participating in the provider network of the MCO to ensure timely access to services available under the contract	<u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 4	Not Met

from such providers for Indian enrollees who are eligible to receive services. ii. Permit any Indian who is enrolled in a MCO entity that is not an IMCE and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services. iii. Permit Indian enrollees to obtain services covered under the contract between the State and the MCO from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.		
Findings: Healthy Blue did not have policy and procedure to meet the requirements of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. **Required Actions:** None.		
K. Timing of documentation. Each MCO must submit the documentation as specified by the MHD, but no less frequently than the following:		
i. On an annual basis. Access Plan: In accordance with State requirements specified at 20 CSR 400-7.095, the MCO shall file an annual access plan, by March 1 of each year, with the Department of Commerce and Insurance, that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues (MHD contract 2.5.4). (Note: Evaluation of the access plan is out of scope of EQR 2022. However,	Network Development, Monitoring and Management-MO: page 4 <u>Onsite Submission</u> Network Access Plan Approved (E-mail)	Fully Met

the MCO must submit a document of assurance of compliance from the State that the MCO meets the requirements for availability of services, as set forth in § 438.68 and § 438.206.)		
Findings: The director of provider relations in conjunction with the director of network management and the director of State Regulatory Affairs compiles the Annual Network Access Plan for submission to the Missouri Department of Commerce and Insurance. Pursuant to 20 CSR 400-7.095, the Network Access Plan consists of a listing of network providers classified by specialty and type of services offered and a membership demographic file to allow for an assessment of Healthy Blue compliance with statutory travel distance standards. Healthy Blue adopts these standards and the current distance standard with a ratio of 1 provider per miles radius. Prior to submission to the Department of Commerce and Insurance, the executive director and chief medical officer must review and approve the plan. Healthy Blue submitted an email showing State's approval of its provider network Access Plan that included Excel sheets showing the percentage compliance data of its provider network. **Required Actions:** None.		
ii. Network Changes. At any time, there has been a significant change (as defined by the MHD) in the MCO's operations that would affect the adequacy of capacity, services, benefits, geographic service areas in addition to the following. The MCO shall notify the state agency within five business days of first awareness/notification of changes to the composition of the MCO provider network or the health care service subcontractors' provider network that materially affect the MCO's ability to make available all covered services in a timely manner. a. A decrease in the total number of primary care providers by more than five percent (5%).	Network Development, Monitoring and Management-MO: page 4 <u>Onsite Submission</u> Network Development, Monitoring and Management-MO (revised): page 4	Partially Met

b. A loss of providers that will result in the MCO failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095. c. A loss of any hospital regardless of whether the loss will result in the MCO failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095. d. Any other adverse change to the composition of the provider network which impairs or denies the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity (MHD contract 2.4.12 (a)). e. Enrollment of a new population in the MCO.		
Findings: d. Healthy Blue requires its providers report on the number of members they will accept as patients (in the case of PCPs) or limitations to the number of referrals they will accept (in the case of non-PCPs). This information is to be reported upon initial contracting and anytime thereafter when panel status changes. In addition, Healthy Blue requires that all providers report to the Provider Relations Department when they have reached 85% of their panel capacity**.** Healthy Blue submitted a policy that partially complied with the criterion d. However, Healthy Blue did not have documentation to meet all the requirements of this section during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after the deficiencies were identified by PTM. **Required Actions:** PTM recommends that Healthy Blue incorporates criterion e and submit supporting document for compliance. Medicaid expansion included a new population in CY 2021.		

Compliance: Healthy Blue

Compliance Score – Assurances of Adequate Capacity and Services						
Total	Met	=	2	×2	=	4
	Partial Met	=	11	×1	=	11
	Not Met	=	1	×0	=	0
Numerator	Score Obtained					15
Denominator	Total Sections	=	14	×2	=	28
Score						**53.57%**

Appendix C

Standard 9–42 CFR: 438.208, 457.1230(c)-Coordination and Continuity of care		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
The MCO must implement procedures to deliver care to and coordinate services for all enrollees. These procedures must meet State requirements and must do the following:		
A. The MCO must ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity.	Member Rights and Responsibilities-MO: pages-1 to 4 Primary Care Provider (PCP) Assignment-MO: page 1 Member Handbook: pages-iii, 1	Fully Met
Findings: New members and new providers are informed about the member rights and responsibilities at enrollment or when they join the network. Existing members and existing providers are provided the member rights and responsibilities at least annually. Members are informed of their rights and responsibilities through the Enrollee Handbook, member newsletters and the member website. Healthy Blue provides a member handbook and other written materials with information on how to access services to all members within 10 business days of being notified of their future enrollment with Healthy Blue. The PCP serves as a central part of the member's health care home and is the member's initial and most important contact. Members are responsible for contacting their primary care providers as their first point of contact when needing medical care. Members with questions concerning benefits, grievances, appeals, medical provider qualifications, changing PCPs are to contact Healthy Blue's Customer Services Department. Healthy Blue will contact the members within five business days of Healthy Blue's notification of anticipated enrollment from the State. To the extent provider capacity exists, Healthy Blue will offer freedom of choice to members in making a PCP selection. **Required Actions:** None.		
B. The MCO makes a best effort to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including	Initial Health Risk Screening Guidelines for Care Management-MO: page 2	Partially Met

subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.		
Findings: Healthy Blue's policy, "Initial Health Risk Screening Guidelines for Care Management-MO," states that the individual procedure and process involved in initiating a health risk screening tool will be dependent on the business needs and contractual requirements of the plan or region. This procedure will be used as a guide for care management plan/region leadership to assist in the overall development and implementation of a health risk screening tool for a required population. An outreach to the members is made by mailing Welcome Letters, using an Interactive Voice Response (IVR) vendor-ELISA, and/or during New Member Welcome Calls. PTM noted that Healthy Blue has not submitted a documentation on the timeframe for conducting an initial screening. However, Healthy Blue informed PTM that the Welcome Calls are made with 90 days of enrollment of a member to Healthy Blue and the calls include initial screening. **Required Actions:** PTM recommends that Healthy Blue updates its policy to mention the timeframe as required in this section.		
C. Coordination of services/Transition of care: The MCO must have written policies and procedures that address all transition of care requirements (MHD contract 2.5.9):		
i. Regarding transition of care for newly enrolled members transitioning to the MCO from Fee-For-Service or another MCO and for members transitioning out of the MCO to another MCO, the MCO at a minimum, shall carry out the following responsibilities- a. Immediately following the state agency's notification to the MCO to proceed with contract services, the MCO shall provide the state agency with a contact person for transition of care information.	Continuity of Care-Core Process-MO: pages-4, 5	Fully Met

b. If a member enrolls with the MCO from another MCO, the new MCO, within five business days from the date of the state agency's notification to the new MCO of the member's anticipated enrollment date, contact the member to determine the name of the previous MCO in order to request relevant member information from them. c. The MCO will provide for the transfer of relevant member information, including medical records and other pertinent materials, to another MCO within five business days of receiving the request. d. If the MCO receives new members who were previously members in the fee-for-service program, the MCO must contact the member's provider within five business days of the state agency's notification to the MCO of the member's anticipated enrollment date, to request the necessary medical records and information.		
Findings: Healthy Blue's policy, "Continuity of Care-Core Process-MO," meets all requirements of this section. **Required Actions:** None.		
ii. Provide care coordination for prescheduled health services, access to preventive and specialized care, care management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans.	Continuity of Care-Core Process-MO: page 5	Fully Met

If the MCO changes subcontractors, the MCO shall ensure that relevant member information is transferred between the subcontractors within a timely manner prior to transitioning to the new subcontractor.		
Findings: Healthy Blue's policy, "Continuity of Care-Core Process-MO," meets the requirements of this section. **Required Actions:** None.		
iii. Work with an out-of-network provider and/or the previous MCO to affect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a physical health or behavioral health provider that is not in the MCO's network. The MCO shall facilitate the securing of a member's records from the out-of-network providers as needed and pay rates comparable to fee-for-service for these records, unless otherwise negotiated.	Continuity of Care-Core Process-MO: page 5	Fully Met
Findings: Healthy Blue's policy, "Continuity of Care-Core Process-MO," meets the requirements of this section. **Required Actions:** None.		
iv. Facilitate continuity of care for medically necessary covered services. In the event a member entering the MCO is receiving medically necessary covered services, the day before enrollment to the MCO, the MCO be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without	Continuity of Care-Core Process-MO: pages-5, 6	Fully Met

regard to whether such services are being provided by in-network or out-of-network providers. a. The MCO shall provide continuation of such services for the lesser of 60 calendar days, or until the member has transferred, without disruption of care, to an in-network provider. b. For members eligible for care management, the new MCO shall provide continuation of services authorized by the prior MCO for up to 60 calendar days after the member's enrollment in the new MCO and shall not reduce services until an assessment supporting services reduction is conducted by the new MCO. c. Ensure that any member entering the MCO is held harmless by the provider for the costs of medically necessary covered services except for applicable MHD cost sharing.		
Findings: Healthy Blue's policy, "Continuity of Care-Core Process-MO," meets all requirements of this section. **Required Actions:** None.		
v. Allow non-pregnant members receiving a physician authorized course of treatment to continue to receive such treatment, without any form of prior authorization and without regard to whether such services are being provided by in-network or out-of-network providers, for- the lesser of 60 calendar days or until the member has been seen by the assigned	Continuity of Care-Core Process-MO: page 6	Fully Met

primary care provider who has authorized a course of treatment.		
Findings: Healthy Blue's policy "Continuity of Care-Core Process-MO" meets the requirement of this section. **Required Actions:** None.		
vi. Allow members in their third trimester of pregnancy to continue to receive services from their prenatal care provider (whether in-network or out-of-network), without any form of prior authorization, through the postpartum period (defined as 60 calendar days from date of birth).	Continuity of Care-Core Process-MO: page 7	Fully Met
Findings: Healthy Blue allows members in their second or third trimester of pregnancy to continue to receive services from their prenatal care provider (in-network or out-of-network), without any form of prior authorization, through the postpartum period (defined as 60 calendar days from date of birth). **Required Actions:** None.		
vii. Allow pregnant members to continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth of the child, the cessation of pregnancy, or loss of eligibility.	Continuity of Care-Core Process-MO: page 7	Fully Met
Findings: Healthy Blue's policy, "Continuity of Care-Core Process-MO," meets the requirement of this section. **Required Actions:** None.		
D. Ensure that inpatient and residential treatment days are not prior authorized during transition of care.	Continuity of Care-Core Process-MO: page 6	Fully Met
Findings: Healthy Blue's policy, "Continuity of Care-Core Process-MO," meets the requirement of this section. **Required Actions:** None.		

E. Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards, to prevent duplication of those activities.	Provider Agreement: page 7 MHD Managed Care Provider Manual: page 12	Fully Met
Findings: Providers will maintain a medical record of all services rendered by them and other referral providers. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Agreement(s). Following a request, provider shall transfer a member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a member at no cost to Healthy Blue, the member, or other treating health care providers. Providers will share records subject to applicable confidentiality and HIPAA requirements. Upon notification of the member's transfer to another MCO, Healthy Blue will request copies of the member's medical record, unless the member has arranged for the transfer. The provider must transfer a copy of the member's complete medical record and allow the receiving MCO access (immediately upon request) to all medical information necessary for the care of that member. **Required Actions:** None.		
F. Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.	CPP208 Safeguards: pages-1, 3 CPP522 Treatment, Payment and Healthcare Operations Disclosures: page 1 CPP1001 Minimum Necessary Requirements: pages-1, 2 Provider Agreement: pages-6, 7	Fully Met
Findings: In accordance with 45 CFR 164.530(c), Healthy Blue has implemented reasonable administrative, technical, and physical safeguards in order to protect Protected Health Information (PHI), Personal Information (PI), Protected Financial Information, including confidential and proprietary information from unauthorized Use or Disclosure. When using external vendors to perform services on behalf of Healthy Blue, Healthy Blue ensures a Business Associate Agreement is obtained for all vendors who will have access to or possession of PHI. Associates must ensure only the minimum amount of PHI or other confidential information is being exchanged or used to accomplish the task or service and that a review of the information is being conducted prior to releasing or moving forward.		

Required Actions: None.		
G. The MCO must coordinate services for its members who are in health homes. They must identify any care gaps or areas of duplication through a mutually acceptable method. The MCO is responsible for being the primary source of care management for conditions other than or beyond those included in the State Health Home program (MHD contract 2.11.1(d)(6).	Introduction of Healthy Blue Care Management Team-Letter (Template) <u>Onsite Submission</u> Care Manager Role and Function in Complex Care Management-MO: page 3	Fully Met
Findings: Healthy Blue's policy "Care Manager Role and Function in Complex Care Management-MO" states that the care manager may assist with coordination of care with existing community-based programs and services to meet the identified needs of the member. Care coordination may include referrals to external agencies and organizations for medical, psychological, financial, or social needs, using available resource information. Healthy Blue informed PTM that the State sends list of members receiving services at State Health Homes. Healthy Blue provides a notification, "blast," to Health Home entities to try to improve coordination with the Health Homes. Healthy Blue submitted a letter template that it uses for Health Homes to communicate and coordinate services. Healthy Blue informed PTM about a pilot program initiated in May 2021, involving monthly rounds with Two Health Homes. The collaboration focuses on high utilizers, collaboration for engagement and improving coordination. Healthy Blue creates reports to share with the Health Home that includes utilization metrics (Emergency Room, In-Patient, and PCP visits) and top utilizers. **Required Actions:** None.		
H. The MCO must coordinate the services it furnishes to the enrollee between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. The services provided under the Hospital Care Transition (HCT) program must integrate with, and enhance the discharge planning and care transition activities of the hospital as required by the CMS.		

i. HCT Management: The MCO shall have written policies and procedures that address all HCT requirements herein (MHD contract 2.11.4). a. HCT coordinators will collaborate with facility staff responsible for discharge planning to understand the discharge risk assessment, patient and caregiver and goals of care, and provider recommendations. The HCT coordinators will assist the member in the transition of members' care by providing education about in-network care providers, programs they may be eligible for, and community-based resources. In doing so, HCT coordinators will abide by facility policies and procedures, and other applicable federal and state laws governing access to patients and secure patient data. b. The MCO shall develop a plan with the hospital to facilitate transition of care for members, employing the use of HCT coordinators to engage members at the bedside and provide transition of care assistance, as determined by the MCO's care management team. c. HCT coordinators shall be onsite at the facility, when MCO members are identified with an admission requiring HCT management services, in order to work directly with the hospital staff to assist members in their care transition.	<u>Onsite Submission</u> Concurrent Review (Telephonic and On-site) and Onsite Review Protocol Process-MO: pages-2, 7 Face-to-Face Intervention-MO: page 3 Follow-up After Hospital Assessment (Writeup for EQRO)	Not Met

Findings: PTM noted that Healthy Blue did not submit written policies and procedures about HCT program and activities. However, they submitted documentation about Concurrent Review which includes discharge planning activities. Healthy Blue's policy, "Face-to-Face intervention," states that their care management includes a high-touch, face-to-face engagement for high-risk members, including those who have complex care needs, are difficult to engage through telephonic care management, are residing in or transitioning from an institution, access care primarily through emergency services, or are frequently admitted to inpatient settings. c. During the onsite meeting, Healthy Blue stated that the HCT Amendment to the MHD contract was introduced during the Covid-19 pandemic (CY 2020). Currently, hospitals do not allow Healthy Blue associates onsite. Once the hospitals allow Healthy Blue teams onsite, they will start onsite collaboration. Healthy Blue's staff coordinate with its inpatient members virtually using Zoom (meeting platform) capabilities. PTM acknowledged a writeup submitted by Healthy Blue regarding the deficiencies identified by the PTM during the preliminary review. PTM noted the information referenced follow-up after hospitalization of behavioral health members. The document stated that Healthy Blue's behavioral health UM team will be in communication with discharge planners within the In-Patient facility throughout the admission to collaborate on discharge planning, and behavioral health resources. **Required Actions:** PTM recommends that Healthy Blue complies with the MHD contract, section 2.11.4(a)(1) that requires the MCO to have written policies and procedures for HCT program. This program does not replace the MCO's existing member care management, disease management, or UM programs required under this contract.		
ii. Services provided by HCT coordinators include, but are not limited to: a. Obtaining discharge disposition/location, including post-discharge contact information. b. Collaborating to ensure referral and access to high-quality, in-network secondary level of care (e.g., acute inpatient rehabilitation, long-term acute care hospitals, skilled nursing facilities, behavioral health services.) c. Coordinating home care services (e.g., home health, home infusion,	<u>Onsite Submission</u> Concurrent Review (Telephonic and On-site) and Onsite Review Protocol Process-MO: pages-2, 7	Partially Met

durable medical equipment, pharmacy). d. Coordinating community services (e.g., transportation, other resources and services to address social determinants, etc.). e. Providing member benefit education (prescriptions, member concerns, chart/medical history). f. Scheduling or validating follow-up appointments with providers as recommended by the hospital attending physician and that the MCO is in alignment with the member and caregiver goals. g. Ensuring the member has an assigned primary care physician. h. Maintaining continuum of care by helping to ensure connections and communications with post-discharge programs. i. Helping members and caregivers understand discharge plans, current medication lists, transfer plans, and instructions.		
Findings: PTM noted that the Healthy Blue does not have written policies and procedures that address all HCT requirements herein. However, Healthy Blue has submitted a policy on Concurrent Review that includes discharge planning activities addressing criteria a, b, c, d, e, f, h, i. Criterion g is not addressed. **Required Actions:** PTM recommends that Healthy Blue develop written documentation and conduct all the activities of the MCT program as listed in this section.		
I. Additional services for enrollees with special health care needs or who need LTSS*:		
i. Identification. Implement mechanisms to identify persons who need LTSS or persons with	Initial Health Risk Screening Guidelines for Care Management-MO: page 1	Fully Met

special health care needs as specified in State's quality strategy. State may use State staff, the State's enrollment broker, or the State's MCOs. *LTSS is N/A per the MHD Contract	Face-to-Face Intervention-MO: page 2 Onsite Submission Complex Care Management-MO: page 1	
Findings: Initial Health Risk Screening Tool-Healthy Blue uses a manual or automated brief questionnaire seeking to obtain preliminary health information from the member/member's authorized representative/personal representative who will assist the care management team in the overall CM identification and referral process. The information collected will generally reflect the member's physical, behavioral, social, functional and psychological status and potential needs. Questions in the tool will adhere to plan/region and overall Government Business Division (GBD) CM requirements. Healthy Blue's proprietary predictive modeling is the primary identification method for Complex Care Management (CCM) eligible members. Members may also be identified and/or referred to CCM by, but not limited to, HRA, plan-specific Health Risk Screener (HRS), UM, social workers, provider(s), non-clinical support associate, care managers from other internal programs, such as Post Discharge Management (PDM), Discharge planning, Disease Management, health plan state regulatory/contractual requirements, and member self-referral. Healthy Blue informed PTM that State Enrollment Broker's HRA, Internal HRA, and member portal, identifies members with special healthcare needs. Members who answer positively to special health care need condition/diagnoses/needs automatically queue to the Healthy Blue's care management system and trigger a CM outreach and assessment. **Required Actions:** None.		
ii. Assessment. The MCO must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State to MCO, of any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO as appropriate.	Face-to-Face Intervention-MO: pages 2, 3 Initial Health Risk Screening Guidelines for Care Management-MO: page 1 Onsite Submission Care Management Assessment-MO: pages-1 to 6	Fully Met
Findings: An interactive assessment is housed on the member portal. Questions include member demographics, personal health history, self-perceived health status, behavioral		

health strategies and queries to identify members with special needs. After the member completes the assessment a summary of an individual's risk or wellness profile is prepared. **Required Actions:** None.		
iii. Treatment/service plans. MCOs must produce a treatment or service plan meeting the following criteria for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan for the enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be: a. Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee. b. Developed by a person trained in person-centered planning using a person-centered process and plan as defined in §441.301(c)(1) and (2) of this chapter for LTSS treatment or service plans. c. Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO. d. In accordance with any applicable State quality assurance and utilization review standards. e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the	<u>Onsite Submission</u> Complex Care Management-MO: pages-1 to 3 Care Management Associate Training-MO: page 1	Fully Met

request of the enrollee per §441.301(c)(3).		
Findings: All criteria listed in this section are met as follows: a, b. Licensed clinical/professional care managers collaborate, advocate and educate members in receiving the appropriate care at the appropriate time in the appropriate setting. The Learning and Development Training Team provides an orientation and training program specifically for care management (CM) associates. c, d. Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the care manager develops an individualized CM plan, including prioritized goals that consider the member's and caregivers' goals and preferences, and desired level of involvement in the CM plan. The CM plan includes prioritized goals, interventions designed to assist the member in achieving these goals, and identification of barriers and challenges to meeting goals or complying with the CM and/or provider plan of care. As a part of the care planning process, utilization of community resources is included in the process, as well as coordination with other disciplines that are involved in the care of the member. e. The CCM process involves a continuous process of delivering and monitoring interventions designed to meet the goals of the CM plan along with ongoing assessment of progress toward achieving those goals. The CM plan is an evolving document that may need to be evaluated and re-negotiated based on the member's level of progress. The care manager review will consist of assessment of the member's progress, changes, and results of interventions and reinforcement of education. The care manager will determine when the member's case can be closed utilizing established guidelines for case closure reasons. **Required Actions:** PTM recommends that Healthy Blue updates its policy "Complex Care Management-MO" about revising member's care plan at least annually.		
J. Direct Access and standing referrals: The MCO shall have direct access and standing referral policies and procedures that address how a member, including but not limited to those with special health care needs, may request and obtain the following (MHD contract 2.5.8): i. A referral to an out-of-network provider when the MCO does not have a health care provider in the network with appropriate training or experience to meet the	Access and Availability-After Hours-MO: page 7 Out of Network Authorization Process-MO: pages-3 to 5 Primary Care Provider (PCP) Assignment-MO: page 4 Member Handbook: page 36	Partially Met

particular health care needs of the member. ii. A standing referral from a specialist if the member has a condition which requires on-going care from a specialist. iii. Access to a specialty care center if the member has a life-threatening condition or disease either of which requires specialized medical care over a prolonged period of time.		

Findings: i. Healthy Blue's policy "Access and Availability-After Hours-MO" states that Missouri Healthy Blue Member(s) may be referred to an out-of-network provider when Missouri Healthy Blue does not have a health care provider with appropriate training or experience in the network to meet the specific health care needs of the member and/or in instances where access to an in-network provider cannot be assured without unreasonable delay. Missouri Healthy Blue will negotiate mutually acceptable payment rates and payment time frames with out-of-network providers. Charges will be limited to amounts no greater than what the member would be charged if he or she had obtained the services through an in-network provider.

Healthy Blue's policy, "Out-of-Network Authorization Process-MO," states that Health Care Management arranges for necessary health services for its members from non-contracted providers in cases when the needed services are not available within the network, but are available through a non-contracted provider, or in the event of Continuity of Care (COC).

The member handbook states that members must contact member services in case the needed services are not available within network.

ii. Members with disabling conditions or chronic illnesses may request that their PCP be a specialist, such as a psychiatrist, oncologist, obstetrician, gynecologist, or other such specialist. Healthy Blue will have procedures for ensuring access to needed services for those members or the request will be granted. The specialist must accept the member as a Primary care patient and accept the responsibility of a PCP. A Healthy Blue ID card will be issued with the name, location and telephone number of their PCP.

iii. PTM noted that Healthy Blue did not address this criterion.

Required Actions: PTM recommends that Healthy Blue submits documentation to address process in criterion iii.

Compliance: Healthy Blue

Compliance Score – Coordination and Continuity of care						
Total	Met	=	15	×2	=	30
	Partial Met	=	3	×1	=	3
	Not Met	=	1	×0	=	0
Numerator	Score Obtained					33
Denominator	Total Sections	=	19	×2	=	38
Score						**86.84 %**

Appendix D

Standard 10-42 CFR: 438.210 , 457.1230(d) Coverage and Authorization of Services		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. Coverage: Each MCO must do the following: i. Identify, define, and specify the amount, duration, and scope of each service that the MCO is required to offer for the categorically needy; and each covered group of medically needy (MHD contract 2.7). ii. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.	Clinical Criteria for UM Decisions-Core Process-MO: pages-3, 4	Partially Met
Findings: i. Healthy Blue has not submitted documentation that meets the requirements. ii. Healthy Blue will be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. **Required Actions:** PTM recommends that Healthy Blue submits documentation supporting criterion i.		
iii. Services identified be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid as set forth in 440.230 of chapter IV and for enrollees under 21, as set forth in subpart B of part 441 of chapter IV (Early and Periodic Screening, Diagnosis, and Treatment-EPSDT-of individuals under age 21). (Note: These sections do not apply to CHIP per the CMS EQR protocol). The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible beneficiary solely	Clinical Criteria for UM Decisions-Core Process-MO: pages-2, 6	Partially Met

because of the diagnosis, type of illness, or condition.		
Findings: For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, Healthy Blue will use the same criteria as the MHD Fee-For-Service (FFS) Program. PTM noted that Healthy Blue has not submitted documentation whether all services identified in the Managed Care Program will be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS. The services are not denied based solely on diagnosis, type of illness or condition. If the clinical criteria elements do not appear to be met, or are not appropriate for the individual member, the Health Care Management (HCM)/ Clinical associate refers the case to the Healthy Blue's Medical Director (or appropriate practitioner): • For a medical necessity or clinical determination. • If there are no clinical criteria for the requested service. • If no clinical information is received after attempts to obtain necessary clinical. During the site meeting, Healthy Blue informed PTM that the CHIP members are also provided EPSDT services. **Required Actions:** PTM recommends that Healthy Blue submits documentation based on the deficiency identified by PTM in this section.		
iv. EPSDT Services (known as Healthy Children and Youth-HCY-Program in Missouri) (MHD contract 2.7.5): a. The MCO will have written policies and procedures, and shall conduct outreach and education of children eligible for the HCY/EPSDT program, provide the full HCY/EPSDT services to all eligible children and young adults under the age of 21 years, and conduct and document well child visits (screenings) using the state agency's HCY/EPSDT screening form as amended or through an electronic medical record. The services will include: • A comprehensive health and developmental history including	EPSDT Services-Core Policy-MO: pages-3 to 5 HCY/EPSDT Corporate Outreach and Monitoring-MO: pages-1, 4 HCY/EPSDT Internal Reminder System Data Extract Process-MO: page 1	Fully Met

assessment of both physical and behavioral health developments. • A comprehensive unclothed physical exam. • Health education (including anticipatory guidance). • Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated). • Appropriate immunizations according to age. • Annual verbal lead risk assessment beginning at age six months and through age seventy-two (72) months. • Mandatory blood Lead level testing at 12-24 months of age for all children 6-72 months of age residing in high risk area for lead poisoning. • Hearing screening. • Vision screening. • Dental screening beginning at 6-12 months of age and repeated every 6 months. b. All medically necessary diagnosis and treatment services necessary to ameliorate (prevent from worsening) must be provided as long as they are permitted under the Medicaid statute, whether or not they are covered under the State's Medicaid plan, and without any regard to any restrictions the State may impose on services for adults.		
Findings: a. Healthy Blue requires HCY/EPSDT well child visits be conducted on all eligible members under the age of 21 years to identify health and developmental problems. The state agency recognizes that the decision to not have a child screened is the right of the parent or guardian of the child. Healthy Blue shall follow the state agency's FFS policies for recognition of completion of all components of a full medical HCY/EPSDT well child visit service. A full HCY/EPSDT well child visit includes all the components listed in this section. Segments of the full medical screen (partial screens) may be provided by different providers.		

Healthy Blue has an established process for reminders, follow-ups, and outreach to members. This process includes, but not be limited to, notifying the parent(s) or guardian(s) of children of the needs and scheduling of periodic well child visits according to the periodicity schedule. Healthy Blue contacts new members within 30 calendar days of Healthy Blue enrollment to aid in accessing HCY/EPSDT well child visit services. Healthy Blue provides assistance to members in accessing subsequent HCY/EPSDT well child visits in accordance with the periodicity schedule. At the time of notification, Healthy Blue shall offer transportation and scheduling assistance if necessary. An email is sent annually to Medicaid members approximately 45–90 days prior to their birthday. The email reminds the member to go for their annual visit and contains health tips, as well as the complete schedule of recommended services due in the upcoming year based on the member's age. Healthy Blue follows-up with families who have failed to access well child visits after one hundred and twenty (120) calendar days of when the well child visit was due. Healthy Blue shall provide to each PCP, monthly, a list of the eligible children who are not in compliance with the periodicity schedule. b. Healthy Blue's policy "EPSDT Services-Core Policy-MO" is compliant with the requirements of this criterion. **Required Actions:** None.		
v. The MCO is permitted to place appropriate limits on a service: a. On the basis of criteria applied under the State plan, such as "medical necessity." These are no more restrictive than that used in the State Medicaid program. The MCO will specify what constitutes "medically necessary services." Services that- • Prevents, diagnoses, or treats a physical or behavioral health condition or injury. • Is necessary for the member to achieve age appropriate growth and development. • Minimizes the progression of disability. • Is necessary for the member to attain, maintain, or regain functional capacity. (MHD contract 2.7.8) (Note: This section does not apply to CHIP).	Clinical Criteria for UM Decisions-Core Process-MO: pages-4, 7 Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO: page 3	Partially Met

Findings: PTM noted that Healthy Blue's policy "Clinical Criteria for UM Decisions-Core Process-MO" is inconsistent in defining the criteria that constitutes "Medical Necessity." Another policy "Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO" does not fully comply with all the "Medical Necessity" criteria. Healthy Blue states that their services will be furnished in the most appropriate setting and may be limited by medical necessity. Healthy Blue may place appropriate limits on a service based on criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. **Required Actions:** PTM recommends that Healthy Blue updates its policies consistently in defining Medical Necessity criteria.		
b. For the purpose of utilization control, provided that— • The services furnished can reasonably achieve their purpose, as required in section A of this evaluation tool. • The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports. • Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.	Member Handbook: page 41 Pre-Certification of Requested Services-Core Process-MO: page 8	Partially Met
Findings: Healthy Blue's member handbook states that a member may go to a Healthy Blue's provider or the MHD's FFS approved provider to get family planning services without asking Healthy Blue. PTM noted that Heathy Blue did not submit its policy on protecting and enabling the enrollee's freedom to choose the method of family planning. Healthy Blue's policy, "Pre-Certification of Requested Services-Core Process-MO" states that Healthy Blue will ensure that the member's treatment regimens are not interrupted or delayed (e.g., physical, occupational, and speech therapy; psychological counseling; home health services; personal care, etc.) by the prior authorization process.		

Required Actions: PTM recommends that Healthy Blue submits documentation based on the deficiency identified in this section.		
B. Authorization of services: i. MCO is prohibited from requiring prior authorization for emergency medical/ behavioral health services (MHD contract 2.5.5(a)). ii. Involuntary detentions (96 hour detentions or court ordered detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect (MHD contract 2.5.5(e).	Health Care Management Denial-Core Process-MO: page 16 Pre-Certification of Requested Services-Core Process-MO: page 1	Fully Met
Findings: i. Healthy Blue's policy "Pre-Certification of Requested Services-Core Process-MO" complies with the requirement. ii. Healthy Blue's both policies meet the requirement of the criterion listed in this criterion. **Required Actions:** None.		
iii. MCO policies, procedures and practices shall comply with The Wellstone – Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), 45 CFR Parts 146 and 147, and the CMS Final rule on MHPAEA for Medicaid (MHD contract 2.5.5 (b)).	Clinical Criteria for UM Decisions-Core Process-MO: page 8 Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO: page 4 Pre-Certification of Requested Services-Core Process-MO: page 7	Fully Met
Findings: Healthy Blue's certification review policy, procedures, and practices comply with The Wellstone Domenici Mental Health Parity and Addiction Equality Act of 2008 and 42 CFR part 438, subpart K. **Required Actions:** None.		
iv. If the MCO requires a referral, assessment, or other requirement prior to the member accessing requested medical or behavioral	Pre-Certification of Requested Services-Core Process-MO: page 7	Fully Met

health, such requirements shall not be an impediment to the timely delivery of the medically necessary service. The MCO shall assist the member to make any necessary arrangements to fulfill such requirements (e.g., scheduling appointments, providing comprehensive lists of available providers). If such arrangements cannot be made timely, the requested services shall be approved (MHD contract 2.5.5(d)).		
Findings: Healthy Blue's policy "Pre-Certification of Requested Services-Core Process-MO" is compliant with the requirement of this section. **Required Actions:** None.		
v. For the processing of requests for initial and continuing authorizations of services, each MCO must have in place, and follow, written policies and procedures and practices that meet the following minimum requirements: a. All appeals and denials must be reviewed by a professional who has appropriate clinical expertise in treating the member's condition or disease. b. There is a set of written criteria for review based on sound medical evidence that is updated regularly and consistently applied and for consultations with the requesting provider when appropriate. c. Reasons for decisions are clearly documented and assigned a prior authorization number which refers to and documents approvals and denials.	Clinical Criteria for UM Decisions-Core Process-MO: pages-1, 9 Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO: pages-1, 4, 5 Health Care Management Denial-Core Process-MO: page 6 Pre-Certification of Requested Services-Core Process-MO: page 3	Fully Met

d. Documentation shall be maintained on any alternative service(s) approved in lieu of the original request. e. There is a well-publicized review process for both providers and members (MHD contract 2.5.5e).		

Findings: a. A professional with experience or expertise comparable to the provider requesting the authorization reviews all appeals and denials and makes UM denial decisions. Depending on the type of case, the reviewer may be a Medical Director, or a physician, pharmacist, chiropractor, clinical psychologist, dentist, or other licensed practitioner type as appropriate. Licensed health care professionals may include appropriately qualified practitioners in accordance with state laws.

b. Medical necessity determinations and the appropriateness of physical and behavioral health services follow a clinical criteria hierarchy that could include benefit coverage, medical necessity, and precertification requirements. The list below provides the usual sequence of criteria application:

- State Manuals/State Contracts/State Policy.
- Federal Medicaid Mandates.
- Medical Policies.
- Ingenio Clinical Criteria.
- AIM Clinical Guidelines.
- Clinical UM Guidelines.
- Milliman Clinical Guidelines.®
- The Level of Care Utilization System (LOCUS)/Child and Adolescent Level of Care Utilization System (CALOCUS) for psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, as well as outpatient reviews the organizations.

c. The reasons for decisions and the criterion utilized are clearly documented in the claims payment system per documentation standards; criterion utilized is available upon request and assigned a certification number (reference/authorization number) which refers to and documents approvals and denials.

d. Healthy Blue's policy, "Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO," states that documentation is maintained on any alternative service approved in lieu of the original request.

e. The non-clinician (Customer Care Representative -CCR/Care Specialist) in the Prior Authorization Department or UM Representative in HCM) performs the following actions:

- Checks for Medicaid sanctions.

• Validates Medicaid ID number on every request if indicated for out-of-network practitioners. • Verifies member eligibility, other health insurance (OHI), and benefits coverage. • Creates the authorization shell with appropriate documentation. • The case may be routed to the licensed utilization review nurse or other licensed professional for behavioral health, if indicated. If the clinical information meets the medical necessity criteria used by Healthy Blue, the licensed nurse coordinator or other licensed professional for behavioral health updates the UM system, per documentation standards, and releases the reference number to the requesting (attending/treating) practitioner. If the information provided does not meet pre-certification criteria, the licensed nurse coordinator or other licensed professional for behavioral health updates the UM system, per documentation standards, and forwards the pended case for Medical Director's review and determination. After review by the Medical Director, if the service is denied, the designated HCM associate at the Healthy Blue generates a notice of adverse benefit determination to inform the member and requesting (attending/treating) practitioner. **Required Actions:** None.		
vi. The MCO will consult with the requesting provider for medical services when appropriate. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.	Health Care Management Denial-Core Process-MO: page 5	Fully Met
Findings: Any medical necessity decision, (Medical or Behavioral Health), to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a licensed physician (or appropriate practitioner) as appropriate to the scope of their expertise and training, and as consistent with state and federal regulations and state contracts. **Required Actions:** None.		
vii. MCO shall ensure that members are not without necessary medical supplies, oxygen, nutrition, etc., and shall have written procedures for making an interim supply of an item available (MHD contract 2.5.5f).	Pre-Certification of Requested Services-Core Process-MO: page 8	Fully Met

Findings: Healthy Blue's policy, "Pre-Certification of Requested Services-Core Process-MO," is compliant with the requirement of this section. **Required Actions:** None.		
viii. The MCO shall ensure that the member's treatment regimens are not interrupted or delayed (e.g., physical, occupational, and speech therapy; psychological counseling; home health services; personal care, etc.) by the prior authorization process (MHD contract 2.5.5g).	Pre-Certification of Requested Services-Core Process-MO: page 8	Fully Met
Findings: Healthy Blue's policy, "Pre-Certification of Requested Services-Core Process-MO," is compliant with the requirement of this section. **Required Actions:** None.		
ix. The MCO is responsible for payment of custom items (e.g., custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) that are delivered or placed within six months of approval, even if the member's enrollment in the MCO ends (MHD contract 2.5.5h).	Pre-Certification of Requested Services-Core Process-MO: page 8	Fully Met
Findings: Healthy Blue's policy, "Pre-Certification of Requested Services-Core Process-MO," is compliant with the requirement of this section. **Required Actions:** None.		
x. If the MCO prior authorizes health care services, the MCO shall not subsequently retract its authorization after the services have been provided, or reduce payment for an item or service unless: a. The authorization is based on material misrepresentation or omission about the treated person's health condition or the cause of the health condition.	Pre-Certification of Requested Services-Core Process-MO: page 8	Fully Met

b. The MCO's contract terminates before the health care services are provided. c. The covered person's coverage under the MCO terminates before the health care services are provided (MHD contract 2.5.5i).		
Findings: Healthy Blue's policy, "Pre-Certification of Requested Services-Core Process-MO," complies with the criteria listed in this section. **Required Actions:** None.		
xi. The MCO shall not deny physician requested continuing coverage of an inpatient hospital stay unless an alternative service is recommended by the MCO and such alternative care is available and has been scheduled within seven days of discharge and is appropriate to meet the medical needs of the member (MHD contract 2.5.5j).	Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO: page 8	Fully Met
Findings: Healthy Blue's policy, "Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO," complies with the requirements of this section. **Required Actions:** None.		
C. Timeframe for authorization: The review process is completed and communicated to the provider in a timely manner, as indicated below, or the denials shall be deemed approved. Each MCO must provide decisions and notices as follows (MHD contract 2.5.5e 6):		
i. Approval or denial of non-emergency services, when determined as such by emergency room staff, shall be provided by the MCO within 30 minutes of request.	Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO: page 4	Fully Met

ii. Approval or denial shall be provided within 24 hours of request for services determined to be urgent by the treating provider.	Health Care Management Denial-Core Process-MO: page 16 Pre-Certification of Requested Services-Core Process-MO: page 6	
Findings: Healthy Blue's policies are compliant with the timeframes required for approving or denying a service request. **Required Actions:** None.		
iii. Authorization decisions (Note: There are no separate criteria for standard/expedited authorization decisions time frames in the MHD contract.) a. Approval or denial shall be provided within 36 hours, which shall include one working day of obtaining all necessary information for routine services. ("Necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.) b. The MCO shall notify the requesting provider within 36 hours, which shall include one working day following the receipt of the request of service, regarding any additional information necessary to make a determination. c. The MCO shall not exceed 14 calendar days following the receipt of the request of service to provide approval or denial with the possible extension of up to 14 additional calendar days if the enrollee or the provider requests extension or if the MCO justifies a need (to the state agency, upon request) for additional information and shows how the	Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO: page 4 Pre-Certification of Requested Services-Core Process-MO: page 7	Fully Met

extension is in the enrollee's best interest.		
Findings: Healthy Blue follows the timeframes for authorizing nonurgent concurrent requests as stated below: • Approval or denial for initial determinations will be provided by the Healthy Blue within 36 hours, which shall include one working day of obtaining all necessary information. • Approval or denial for concurrent review determinations will be provided by the Healthy Blue within one working day of obtaining all necessary information. • Approval or denial for retrospective review determinations will be provided by the Healthy Blue within 30 working days of receiving all necessary information. • Healthy Blue shall notify the requesting provider within 36 hours, which will include one working day, following the receipt of the request of service regarding any additional information necessary to make a determination. Healthy Blue's policy "Pre-Certification of Requested Services-Core Process-MO" states that in case of a pre-service non-urgent service request, due to lack of necessary clinical information, Healthy Blue may extend the timeframe once by up to 14 calendar days, under the following conditions: • The member requests an extension, or • Healthy Blue needs additional information, provided it documents that it made at least one attempt to obtain the necessary information. • Healthy Blue justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest. **Required Actions:** None.		
D. Notice of adverse benefit determination: The MCO must notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (The enrollee's notice must meet the requirements of §438.404-evaluated in Appendix G of this evaluation tool.)	Health Care Management Denial-Core Process-MO: pages-3, 10	Fully Met
Findings: Healthy Blue provides written notification of adverse decisions to the requesting practitioner and member. The notice of Adverse Benefit Determination meets the requirements of 42 CFR 438.404 and all requirements on member communication		

materials for accessibility and readability. The notice will be given within the timeframes described in 42 CFR 438.404(c). PTM evaluated and scored the contents of the notice of adverse benefit determination letter utilized by Healthy Blue under Grievance and Appeal Review (Appendix G) and has not scored this requirement here in this section. **Required Actions:** None.		
E. Compensation for utilization management activities (consistent with §438.3(i), and 422.208 of 42 CFR chapter IV): Compensation to the MCO individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee (MHD contract 2.18.8(b)).	Prohibiting the use of Financial Incentives When Making Medical Necessity Determinations-Core Process-MO: page 1	Fully Met
Findings: Healthy Blue will ensure that medical decisions are based solely upon medical necessity consistent with the accepted clinical protocols and/or criteria approved by the organization's Medical Operations Committee (MOC) or medical practice consistent with the medical community. Decisions resulting in a limitation or denial of services are not penalized or rendered in exchange for financial incentives or other nonfinancial incentives. UM decision-making is based only on appropriateness of care and service and existence of coverage. Healthy Blue does not reward or penalize practitioners, subcontractors, or other individuals (including associates) for issuing denials of coverage of care for financial incentives or nonfinancial incentives such as paid time off. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support denials of benefits. Financial or nonfinancial incentives for UM decision-makers do not encourage decisions that result in under or overutilization or create barriers to care and services. **Required Actions:** None.		

Compliance: Healthy Blue

Compliance score-Coverage and Authorization of Services						
Total	Met	=	15	×2	=	30
	Partial Met	=	4	×1	=	4
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	34
Denominator	Total Sections	=	19	×2	=	38
Score						**89.47%**

Appendix E

Standard 11– 42 CFR: 438.214, 457.1233(a)-Provider Selection		
Requirements and references	**Evidence/documentation as submitted by the MCO**	**Score**
A. The MCO shall have written credentialing and re-credentialing policies and procedures (MHD contract 2.18.8 c): i. For determining and assuring that all in-network providers are licensed by the State in which they practice and are qualified to perform their services. All network providers must be enrolled with the MHD as a Medicaid provider as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b). ii. For monitoring the in-network providers, reporting the results of the monitoring process, and disciplining in-network providers found to be out-of-compliance with the MCO's medical management standards. iii. The MCO shall use the Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180, as amended. iv. Following the effective date of the contract, the MCO shall provide the state agency with the Social Security Number of the providers.	Credentialing: pages-5, 7 Missouri Medicaid Supplemental Credentialing: page 1 12 Ongoing Sanction Monitoring: pages-1, 2, 4	Fully Met
Findings: i. During the credentialing process, Healthy Blue will review, among other things, verification of the credentialing data including license to practice in the state(s) in which the practitioner will be treating members. The MHD publishes a report reflecting all the providers in the state who have an active State Medicaid ID number. Healthy Blue implements an automated monthly ingestion process for the State Medicaid Provider ID number report. Healthy Blue validates that all of the providers in the Healthy Blue Missouri network are on the State Medicaid Provider report. If a provider is not on the report or no longer has an active Medicaid State ID		

Number, Healthy Blue will terminate the record and load a not eligible pricing record, which will result in a claim denial. In the event the provider's State Medicaid Provider ID is retrospectively reactivated the providers record will be reactivated based on the publication rate. The claims during the time in which the provider failed to maintain an active State Medicaid Provider ID will not be paid.

ii. To support certain credentialing standards between the re-credentialing cycles, Healthy Blue has established an ongoing monitoring program. The credentialing department performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General (OIG).
- Federal Medicare/Medicaid Reports.
- Office of Personnel Management (OPM).
- State Licensing Boards/Agencies.
- Member/Customer Services Departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available).
- Other internal Healthy Blue departments.
- Any other information received from sources deemed reliable by Healthy Blue.

External sources will be queried every six months if they do not publish information on a set schedule. For these sources, the review will take place when the oversight entity has come to its final determination including but not limited to, probations, sanctions, warnings, public notices of poor performance, or reprimands. Internal sources may be queried periodically (at least every six months) or internal departments may provide reports on a periodic basis (at least every six months) to detect any trends, problems and issues regarding individual practitioners or Health Delivery Organizations (HDOs).

When a participating Practitioner or HDO has been identified by these sources, Level II review requirements and immediate termination requirements will be used to assess the appropriate response. These responses include but not limited to, a review by the chair/vice-chair of the geographic Credentials Committee (CC), review by Healthy Blue's Medical Director, referral to the CC, or termination. Healthy Blue's credentialing departments will report the practitioners to the appropriate authorities as required by law.

iii. Each practitioner or HDO must complete a standard application form deemed acceptable by Healthy Blue when applying for initial participation in one or more of Healthy Blue's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized.

iv. Healthy Blue will collect and report the Provider Social Security Number at the time of

credentialing. **Required Actions:** None.		
B. MCO shall credential and re-credential all in-network providers listed within the contract. Provisionally licensed psychologists and provisionally licensed professional counselors are included in this requirement. The credentialing process shall not take longer than 60 business days pursuant to RSMo 376.1578 (MHD contract 2.18.8(c)).	Credentialing: pages-1, 10, 13, 14 MO Additional State Specific Regulatory or Contractual Requirements for Missouri: pages-2, 3, 4	Fully Met

Findings: List of practitioners for credentialing and re-credentialing will include clinical psychologists, and practitioners with PhD training in clinical psychology. To meet criteria this doctoral program must either be accredited by the American Psychological Association (APA) or be regionally accredited by the Council for Higher Education Accreditation (CHEA). Education/training is considered as eligible if a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a diplomat of the American Board of Professional Psychology. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist because of further training, will be allowed to continue in the Network and will not be subject to the above education criteria

Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type (Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field) will be considered.

Healthy Blue acknowledged the requirement that provisionally licensed professional counselors and provisionally licensed psychologists are required by the MHD contract to be credentialed as of 03.02.2021 in Missouri.

Healthy Blue assesses a healthcare practitioner's completed credentialing application and decides to approve or deny the practitioner's credentialing application and notifies the practitioner of such decision with 60 days of the date of receipt of the completed application. The 60 days deadline established in this section will not apply if the application or subsequent verification of information indicates that the practitioner has the following:

- A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse.
- Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction.

• Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance. • A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit. **Required Actions:** None.		
C. As part of re-credentialing, the MCO shall audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives (MHD contract 2.18.8(c)).	Advance Directives: page 5	Not Met
Findings: At the time of enrollment, Healthy Blue will provide written information to all adult members regarding the member's rights under the Missouri law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, the right to formulate Advance Directives, and the right to file complaints concerning non-compliance with Advance Directive requirements with the appropriate state survey and certification agency. Healthy Blue will provide education to its personnel and members on issues concerning advance directives. During the site meeting Healthy Blue informed PTM that in June 2022, the Credentialing Department will send an attestation to all PCPs, Hospitals, Home Health and Hospices for completion to indicate if they are in compliance with the state Advance Directive requirement. PTM noted that even though Healthy Blue has a policy on advance directives, it does not meet the criteria of this section. Healthy Blue did not conduct an audit of medical records as a part of re-credentialing process to determine if the providers meet the requirements of Advance Directives. **Required Actions:** PTM recommends that Healthy Blue submits its audit policy on advance directive and results as an evidence in support of this section.		
D. As part of credentialing and re-credentialing, the MCO shall collect from providers directly contracted with the MCO, full and complete information, as described herein, regarding ownership and control, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, CHIP, or any other		Not Met

Federal health care program, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1051. The MCO shall provide this information to the state agency in the format and frequency specified by the state agency in "Ownership or Controlling Interest Disclosure", "Transaction Disclosure," and "Provider and Subcontractor Disclosure" located and periodically updated on the MHD website at MCO Reporting Schedule and Templates (MHD contract 2.18.8c).		
Findings: PTM noted that Healthy Blue did not submitted any documentation to support its compliance with the requirements of this section. Healthy Blue informed PTM that they have received confirmation from MMAC in 2021 that MMAC maintains all provider credentialing information. As a result, Healthy Blue no longer needs to obtain this information at time of credentialing or re-credentialing. PTM noted that Healthy Blue has not submitted any verifying documentation from MMAC or evidence of communication from MMAC indicating a waiver to collect the information required in this section. **Required Actions:** PTM recommends that Healthy Blue develops a policy and procedure to meet the requirements of this section and also submit any waiver they have received from MMAC.		
E. MCO shall collect the information from the provider and retain evidence of having done so to produce to the state agency upon request; or if the MCO has verifying documentation that the Missouri Medicaid Audit & Compliance (MMAC) has collected the required disclosures from the provider, then the MCO may utilize the collected disclosures from MMAC: a. At the stage of provider credentialing and re-credentialing. b. Upon execution of the provider agreement.		 Not Met

c. Within 35 days of any change in ownership of the provider. d. At any time upon the request of the state agency for any or all of the information described in this section (MHD contract 2.18.8(c)).		
Findings: Healthy Blue informed PTM that MMAC obtains the provider disclosures for all active Medicaid providers and Healthy Blue may utilize the collected disclosures. PTM noted that Healthy Blue did not submit any documentation to support its compliance with the requirements of this section. No evidence of any communication was submitted from MMAC. **Required Actions:** PTM recommends that Healthy Blue develops a policy and procedure to meet the requirements of this section and also submit any waiver they have received from MMAC.		
F. The MCO shall include provisions in its subcontracts for health care services notifying the provider or benefit management organization to provide the disclosures to the MCO. The MCO must retain evidence that it received the proper disclosures or documentation of the disclosures and produce the same for the State upon request and in accordance with prescribed timeframes (MHD contract 2.18.8(c)).		Not Met
Findings: Healthy Blue has not submitted documentation to support the requirements of this section. **Required Actions:** Healthy Blue must have provisions in its subcontracts for health care services to comply with requirements of this section.		
G. MCO shall promptly notify the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing process. This requirement is in addition to the requirement for the MCO to report provider terminations as part of its quarterly fraud, waste, and abuse report (MHD contract 2.18.8(c)).	Onsite Submission Missouri Medicaid Supplemental Credentialing Policy: page 2	Not Met

Findings: PTM noted that Healthy Blue did not have a policy that met the requirements of this section during the review period. However, Healthy Blue updated its policy after the deficiency was identified by PTM during the preliminary review. Healthy Blue did not submit enrollment data to show any denials or provider terminations during CY 2021 to meet the requirements of this section. **Required Actions:** PTM recommends that Healthy Blue submits data and its notification to the MHD of any denial of enrollment for CY 2021, as a result of provider credentialing or re-credentialing process. Furthermore, the revised policy should be approved by the MHD.		
H. As part of credentialing and re-credentialing, the MCO shall screen all health care service subcontractors to determine whether the subcontractor or any of its employees or subcontractors has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care program (as defined in Section 1128B (f) of the Act); has failed to renew license or certification registration; has revoked professional license or certification; or has been terminated by the state agency. The screening shall consist of, at a minimum, consulting the following databases on at least a monthly basis: The List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS) and the National Plan and Provider Enumeration System (NPPES), located in the Missouri Professional Registration Boards website, and any such other state or federal required databases. MCO shall deny/terminate credentialing or re-credentialing to any subcontractor that falls within this section (MHD contract 2.18.8(c)).	Credentialing: pages-5, 12 Ongoing Sanction Monitoring: page 2	Fully Met
Findings: A practitioner is screened for Medicare, Medicaid, or Federal Employees Health Benefits (FEHB) Program sanctions**.** An applicant must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.		

External sources (e.g., OIG, Federal Medicare/Medicaid Reports, OPM, State Licensing Boards/Agencies) will be queried every six months if they do not publish information on a set schedule Office of the Inspector General (OIG). PTM noted that Healthy Blue's policies maintain querying external sources at least six months. Healthy Blue clarified that they are required monitor sanctions every 30 days according to the NCQA accredited requirements. They ensure all external sources are queried at least every six months. **Required Actions:** None.		
I. Claims and Payment System		
i. Unless otherwise written in the subcontract, MCO shall load credentialed providers into the claim adjudication and payment system within the following time frames in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to the MCO by the provider: a. Newly credentialed provider attached to a new contract within 10 business days after completing credentialing. b. Newly credentialed hospital or facility attached to a new contract within 15 business days after completing credentialing. c. Newly credentialed provider attached to an existing contract within five business days after completing credentialing. d. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within 5 business days after completing re-credentialing.	<u>Onsite Submission</u> Anthem Provider Data Operations (APDO) Provider Data Updates-Turnaround Times (revised): pages-8, 9	Not Met

e. Change in existing contract terms within ten 10 business days of the effective date after the change. f. Changes in provider service location or demographic data or other information related to member's access to services must be updated no later than 30 calendar days after the MCO receives updated provider information (MHD contract 2.18.8(c)).		
Findings: PTM noted that Healthy Blue did not have a policy meeting the requirements of this section during the review period. Healthy Blue updated its policy after PTM identified the deficiency. Furthermore, Healthy Blue did not submit data to show the turnaround time for uploading the provider data into the claim adjudication and payment system. **Required Actions:** PTM recommends that Healthy Blue submits data showing turnaround time and also submit its revised policy for the MHD's approval.		
ii. Payment should be made on the next payment cycle following the requirement outlined in I (i) above. In no case shall a provider be loaded into the provider directory which cannot receive payment on the MCO's current payment cycle (MHD contract 2.18.8(c)).		Not Met
Findings: Healthy Blue did not submit documentation or data to meet the requirements of this section. **Required Actions:** PTM recommends that Healthy Blue submits evidence to comply with the requirements of this section.		
J. Upon request by the state agency, the MCO shall provide a report demonstrating the following: i. Compliance with the credentialing requirements including but not limited to the average number of days taken to complete credentialing by provider type, and the number of providers who were not credentialed according to the requirements by provider type; and		Not Met

ii. Compliance with the required timeframes for loading credentialed providers (MHD contract 2.18.8(c)).		
Findings: Healthy Blue did not submit documentation and data to meet the requirements of this section. **Required Actions:** PTM recommends that Healthy Blue submits evidence to comply with the requirements of this section.		
K. Nondiscrimination in hiring and provision of services (MHD contract 2.2.7): i. The MCO network provider selection policies and procedures, consistent with §438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The MCO shall not discriminate in regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the MCO declines to include individual or groups of providers in its network, the MCO shall give the affected providers written notice of the reason for its decision.	Credentialing: pages-4, 7	Fully Met
Findings: Healthy Blue will not discriminate against any applicant for participation in its programs or provider Network(s) based on race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis. Additionally, Healthy Blue will not discriminate against any applicant based on the risk of population they serve or against those who specialize in the treatment of costly conditions. Information reviewed during credentialing/re-credentialing activity may indicated that the professional conduct and competence standards are no longer being met, and Healthy Blue may terminate practitioners or HDOs. Healthy Blue also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Healthy Blue's Networks for professional conduct and competence reasons,		

or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, Healthy Blue will permit practitioners and HDOs who have been refused initial participation, the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). **Required Actions:** None.		
ii. The MCO shall comply with all federal and state statutes, regulations and executive orders relating to nondiscrimination and equal employment opportunity, including but not limited to (MHD contract 2.2.7): a. Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color, or national origin (this includes individuals with limited English proficiency) in programs and activities receiving federal financial assistance and Title VII of the Act which prohibits discrimination on the basis of race, color, national origin, sex, or religion in all employment activities. b. Equal Pay Act of 1963 (P.L. 88-38, as amended, 29 U.S.C. Section 206 (d)). c. Title IX of the Education Amendments of 1972, as amended (20 U.S.C 1681-1683 and 1685-1686) which prohibits discrimination on the basis of sex. d. Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794) and the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.) which prohibit discrimination on the basis of disabilities. e. The Age Discrimination Act of 1975, as amended (42 U.S.C. 6101-6107) which prohibits discrimination on the basis of age.	Credentialing: page 4 <u>Onsite Submission</u> Statement of Work (SOW) Medical Transportation Management (MTM): pages-16, 17	Partially Met

f. Equal Employment Opportunity – E.O. 11246, "Equal Employment Opportunity", as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity." g. Missouri State Regulation, 19 CSR 10-2.010, Civil Rights Requirements. h. Missouri Governor's E.O. #94-03 (excluding article II due to its repeal). i. Missouri Governor's E.O. #05-30.		
Findings: The policy, "Credentialing" states that Healthy Blue will not discriminate against any applicant for participation in its programs or provider Network(s) based on race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis. PTM noted that the policy, "Credentialing" does not include all the required criteria. The SOW-MTM incorporates most of the requirements, namely, a, c, d, e, f. **Required Actions:** PTM recommends that Healthy Blue develops a policy to include all the criteria listed in this section and apply the same to its subcontractors.		
iii. The MCO shall have specific policy statements on minority inclusion and non-discrimination and procedures to communicate the policy statements and procedures to subcontractors.	<u>Onsite Submission</u> Missouri Master Service Agreement MTM (Exhibit D): page 60 Guidelines for Prospective Suppliers	Fully Met
Findings: Through Healthy Blue's Supplier Diversity Program, Healthy Blue is dedicated to diversifying its supplier base to include minority-owned, women-owned, veteran-owned, LGBT (Lesbian, Gay, Bi-Sexual, Transgender)-owned and disabled-owned businesses wherever possible. Healthy Blue actively works to include diverse suppliers in every bidding opportunity. Healthy Blue has established a 12% Supplier Diversity goal. All direct Healthy Blue (Anthem's) suppliers, including diverse-owned direct suppliers, must meet the 12% contract goals using sub-contractors. PTM noted that Healthy Blue has "Guidelines for Prospective Suppliers" on its website. These guidelines are linked in the subcontract for MTM. **Required Actions:** None.		

Compliance: Healthy Blue

Compliance Score - Provider Selection						
Total	Met	=	5	×2	=	10
	Partial Met	=	1	×1	=	1
	Not Met	=	8	×0	=	0
Numerator	Score Obtained					11
Denominator	Total Sections	=	14	×2	=	28
Score						**39.28 %**

Appendix F

Standard 12–42 CFR: 438.224, 457.1110-Confidentiality		
Requirements and references	**Evidence/documentation as submitted by the MCO**	
A. The MCO shall agree and understand that all discussions with the MCO and all information gained by the MCO as a result of the MCO's performance under the contract, including member information, medical records, data, and data elements established, collected, maintained, or used in the administration of the contract, shall be confidential and that no reports, documentation, or material prepared as required by the contract shall be released to the public without the prior written consent of the state agency (MHD contract 3.16.1).	CPP101 Purpose and General Rules of the Privacy Policies: page 1 CPP201 Business Associate Agreements: page 5 CPP1401 Verification and Authentication: page 5 CPP520 Specialized/Non-Routine Disclosures (No Authorization Required): page 12 <u>Onsite Submission</u> Ethics and Compliance Certification: page 2	Fully Met
Findings: Healthy Blue's privacy policies set forth the guidelines the Healthy Blue associates must follow when collecting, using, or disclosing member information and sets forth a number of rights Individuals have, pursuant to federal and state law. PHI includes identity data, provider data, claims payment information, member financial data, clinical claims data, medical record data, premium information, operational claim data and product data, including summary health and limited data sets. If requested to share PHI with a Covered Entity's other Business Associate, Healthy Blue must receive direction from the Covered Entity to share its PHI with its other Business Associates, and the Covered Entity must have a BAA in place with any such Business Associates. PTM noted that the policy, "Verification and Authentication," states that Healthy Blue has special rules for verifying the public official's (e.g., police officer, Department of Insurance, legislator) or someone acting on their behalf identity before releasing PHI. However, the policy does not mention seeking written consent from the State before releasing PHI. Similarly, PTM noted that the policy, "Specialized/Non-Routine Disclosures (No Authorization Required)," mentions disclosing PHI without authorization for public health activities (a Public Health Authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, e.g., Occupational Safety and Health Administration, the Centers for Disease Control and		

Prevention). However, the policy does not mention about obtaining written consent from the State before releasing PHI. During the site meeting, Healthy Blue submitted its Ethics and Compliance Certification requirements that states federal and state laws govern when and how Healthy Blue can engage with legislators and regulators for official or campaign related matters. Public policy, advocacy, political activity, and government business development on behalf of Anthem must be approved and coordinated by Anthem's (Healthy Blue's parent company) Public Affairs Department and must comply with applicable federal and state laws. Healthy Blue also informed PTM that Healthy Blue does not release member information to the public. PTM noted that even though Healthy Blue does not have a direct statement of seeking written approval from the State before releasing any member related records/data, the Ethics and Compliance Certification has instructions for all its employees meets the requirement of this section. Hence, PTM scored this section "Fully Met." **Required Actions:** PTM recommends that Healthy Blue updates its documents to include the requirement of obtaining written consent from the State before releasing any information to the public.		
B. If required by the state agency, MCO and any required MCO personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request. Failure of MCO and any required personnel to sign such documents shall be considered a breach of contract and subject to the cancellation provisions of this document (MHD contract 3.16.2).	CPP209 Workforce Training: pages-1, 2, 6 <u>Onsite Submission</u> Ethics and Compliance Certification: pages-1 to 3	 Fully Met
Findings: Healthy Blue's non-associates, who are board members and committee members must sign a confidentiality statement annually and prior to participating in any business activity involving member PHI. The business owner of the board or committee will retain these documents. Healthy Blue associates must read and sign Healthy Blue's Privacy Policy Summary document, which is part of the new hire Ethics, Privacy, Information Security, Compliance training program on-line. Temporary workers who are on-boarded through the Fieldglass system are required to complete the Healthy Blue Overview for Temporary Workers and Contractor education materials (provided by the supplier agency) including signed certification documents prior to beginning work functions and annually thereafter. As Healthy Blue requires every employee to acknowledge the "Ethics and Compliance Certification," PTM has assigned this section "Fully Met."		

Required Actions: None.		
C. The MCO shall provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract (MHD contract 3.16.3, 2.38.3(b)). Such safeguards shall include, but not be limited to: a. Workforce training on the appropriate uses and disclosures of Protected Health Information pursuant to the terms of the contract. b. Policies and procedures implemented by the MCO to prevent inappropriate uses and disclosures of PHI by its workforce and subcontractors, if applicable. c. Encryption of any portable device used to access or maintain PHI or use of equivalent safeguard. d. Encryption of any transmission of electronic communication containing PHI or use of equivalent safeguard. e. Any other safeguards necessary to prevent the inappropriate use or disclosure of PHI.	CPP208 Safeguards: page 1 to 5 CPP209 Workforce Training: pages-1, 2, 4, 5 CPP903 Methods for Sending Electronic Telephonic PHI (ePHI): pages- 1, 2, 4 <u>Onsite Submission</u> DO The Right Thing: Protecting Information (Web-based Training Scripts for Incumbent and New Hire)	Fully Met
Findings: a. Healthy Blue associates who have access to PHI will receive detailed training on these policies and on the applicable Business Area Privacy Desktop Procedures necessary and appropriate for them to carry out their business functions. Healthy Blue associates hired on and after April 1, 2003, will receive the appropriate training as a part of their orientation, which must be, completed, no later than 30 days from date of hire. Business Associates are not required to complete privacy training offered by Healthy Blue. The Business Associate must provide privacy training to their employees as required under the terms of the Business Associate Agreement (BAA) and service agreement. b. Healthy Blue's security policies will apply to all members of the workforce who have been granted access to Healthy Blue's assets in accordance with Healthy Blue's policies.		

c. Compact Discs or other portable devices sent outside of Healthy Blue require special handling, including encryption. Only approved wireless phones or headsets distributed by telecommunications are to be used while discussing or disclosing PHI. Disclosure of PHI via cellular telephone is permitted only if the Healthy Blue associate first verifies their cellular telephone is in digital mode. If the cellular telephone is in analog mode, Anthem Associates should not discuss or disclose PHI. d. If Disclosure of PHI/PI/PFI outside of Healthy Blue, is otherwise permitted, associates must take additional safeguard precautions when sending PHI/PI/PFI externally via Healthy Blue's email system. Associates must never place PHI/PI/PFI in the subject line of an external email and must follow Healthy Blue's email encryption policy. Healthy Blue has technical safeguards for internal and external email transmission. It is essential the appropriate medium be used in a secure manner. PHI may be disclosed via text, personal electronic devices, external email, intranet, extranet, and voice response unit. Additional safeguards must be in place with mediums utilized such as telephone, facsimile (Fax), internal email, and instant messaging and web conferencing, as well as, when transporting/traveling with PHI. Text messages containing PHI, PII, or other company confidential information may not be sent using a personal device. Personal devices may only be used when part of an approved "Bring Your Own Device program." e. In accordance with 45 CFR 164.530(c), Healthy Blue has implemented reasonable Administrative, Technical and Physical safeguards to protect PHI, PI, PFI, including confidential and proprietary information from unauthorized Use or Disclosure. There are administrative safeguards apply for oral communications, telephone messages, faxes, mails, copying and printing, clean desk policy, removal of PHI, destruction standards, usage of sensitive financial information, and external business controls. **Required Actions:** None.		
D. The MCO shall not disclose the contents of member information or records to anyone other than the state agency, the member or the member's legal guardian, or other parties with the member's written consent (MHD contract 3.16.4).	CPP509 Disclosure with Authorization: page 1 CPP1401 Verification and Authentication: pages-2 to 4 CPP504 Disclosure of Protected Health Information Outside of Anthem: page 2 <u>Onsite Submission</u> Member Authorization Form	Fully Met
Findings: Healthy Blue associates may disclose PHI pursuant to the terms of an authorization. Healthy Blue's authorization forms should be used by all Healthy Blue		

associates, when appropriate. If a requestor submits a non-Healthy Blue authorization form, Healthy Blue associates should use the authorization checklist to determine if the form is valid. Healthy Blue associates must take appropriate steps to verify the identity and authority of the individual requesting that their PHI be disclosed prior to processing an authorization per Healthy Blue's "Verification and Authentication Policy". This will ensure the Authorization is acceptable. If the requestor is an authorized representative and a HIPAA Member Authorization form has been completed, obtain a copy of the valid Authorization form before disclosing any PHI to the Authorized Representative, and before granting the authorized representative any Individual Rights. Authorized Healthy Blue associates may disclose the minimum amount of PHI necessary to comply with a request from a regulatory body that has authority over Healthy Blue. Examples of regulatory bodies with authority over Healthy Blue are the Department of Insurance, Office for Civil Rights or Centers for Medicare & Medicaid Services. **Required Actions:** None.		
E. MCO shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance and 42 CFR Part 2, as amended, regarding confidentiality of substance use disorder member records (MHD contract 3.16.5).	CPP504 Disclosure of PHI Outside of Anthem: page 1 CPP1301 Sensitive Services: page 1 CPP1303 Sensitive Services-Substance Use Disorder: pages-1, 2 <u>Onsite Submission</u> HIPAA Verification and Disclosure Guide (Screenshot)	Fully Met
Findings: Federal and state laws provide extra requirements for the Use and Disclosure of PHI, pertaining to substance use disorder diagnosis and treatment (sometimes referred to as drug and alcohol abuse). The Disclosure of Substance Use Disorder (SUD) information must comply with all applicable federal and state privacy laws, including 42 CFR. Part 2 rules for the Confidentiality of Substance Use Disorder Patient Records, promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA). While SAMHSA allows Disclosure of SUD information without specific Authorization for certain payment and healthcare operations activities that align with the permissions granted in the HIPAA Privacy Rule, SUD information pertaining to treatment must have specific authorization from the patient before being disclosed to third parties. The authorization must include a specific recipient. General authorization or consent is not acceptable. For SUD information, this means that activities relating to a patient's diagnosis, treatment, or referral for treatment must have the patient's specific authorization to disclose to third parties. **Required Actions:** None.		

F. MCO shall have written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records for adult and adolescent STDs and adolescent family planning services (MHD contract 3.16.6).	CPP1301 Sensitive Services: page 1 GBD-Member Privacy Rights: page 10	Fully Met
Findings: Federal and state laws provide extra protection to certain classes of PHI. For these types of Sensitive Services, an individual authorization is typically required before Healthy Blue can disclose the Sensitive Services information. Some examples of Sensitive Services may include, but are not limited to, records relating to HIV/AIDS, mental health, reproductive services, abortion, abuse, genetic information, and substance use disorder. If a parent is requesting sensitive information (such as an abortion procedure, mental health, substance abuse, HIV or AIDS or any other condition derived from AIDS), Healthy Blue requires its associates to contact the Privacy Professional for information on the parent's rights to obtain this information. **Required Actions:** None.		
G. The MCO uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.		
i. The MCO must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) (PL-111-5) (collectively HIPAA) and all regulations promulgated pursuant to authority granted therein. The MCO constitutes a "Business Associate" of the state agency (MHD contract 2.38.1).	CPP208 Safeguards: page 1 CPP101 Purpose and General Rules of the Privacy Policies: page 1 CPP1201 Privacy and Security Incident Response and Reporting: pages-1, 2 CPP201 Business Associate Agreements (BAA): page 2	Fully Met
Findings: Healthy Blue considers the protection of information to be a high priority and requires Healthy Blue associates to always act in a manner consistent with these policies. The failure of an associate to follow these policies may result in disciplinary action up to and including termination.		

Healthy Blue has adopted policy "Privacy and Security Incident Response and Reporting" to comply with the HITECH Act, the HIPAA Omnibus Final Rule, applicable federal (45 CFR 164.400 to 164.414)and state laws and regulations, applicable international laws and regulations and applicable contractual obligations, and to provide a framework for: • Identifying and internally reporting Incidents. • Investigating, mitigating, and responding to reported Incidents. • Determining whether notification to Individuals, self -funded employer groups, regulators and/or other parties is required; and if so, carrying out the notification process in accordance with applicable law, contractual obligations, and this policy. • Identifying root cause and implementing corrective action plans or sanctions if appropriate. • Identifying key participants and their roles and responsibilities, including the Privacy and Security Advisory Team (PSAT). • Establishing procedures to help ensure response efforts are conducted in a timely, sequenced, coordinated, consistent and effective manner. Depending on the business relationship, Healthy Blue can be the Covered Entity or the Business Associate in the BAA. When Healthy Blue is acting as a Business Associate, it may contract with a subcontractor to create, receive, maintain, or transmit PHI on Healthy Blue's behalf. Healthy Blue may disclose PHI to the subcontractor only if: 1. A BAA is in place with the subcontractor, and 2. The BAA contains the same restrictions and conditions that apply to Healthy Blue regarding safeguarding PHI. **Required Actions:** None.		
ii. The MCO agrees that the term Protected Health Information shall also be deemed to include Electronic Protected Health Information (MHD contract 2.38.1).	CPP208 Safeguards: page 1 CPP903 Methods for Sending Electronic/Telephonic Protected Health Information (ePHI): page 3 GBD-Member Privacy Rights: page 3	Fully Met
Findings: PHI can be in any form, including verbal, written and electronic. Healthy Blue associates are required to safeguard both paper and electronic forms of PHI, PI, PFI and confidential and proprietary information. When transporting ePHI or travelling with ePHI in their possession, associates must take appropriate precautions to protect the ePHI. **Required Actions:** None.		
iii. The MCO may use Protected Health Information to report violations of law to appropriate federal and state authorities, consistent with 45 CFR	CPP204 Non-Retaliation Policy: page 1	Fully Met

164.502(j)(1) and shall notify the state agency by no later than 10 calendar days after the MCO becomes aware of the disclosure of the Protected Health Information (MHD contract 2.38.2(c)).	CPP504 Disclosure of PHI Outside of Anthem: pages-2, 3 CPP520 Specialized/Non-Routine Disclosures (No Authorization Required) Page 13 <u>Onsite Submission</u> Medicaid and Medicare Privacy Incident Reporting-MO: page 23 MO Medicaid Breech Notification (Screenshot)	
Findings: Healthy Blue has adopted a non-retaliation policy, which prohibits Healthy Blue workforce members from intimidating or retaliating against individuals, whistleblowers, Healthy Blue workforce member, crime victims, vendors or others who have filed complaints or exercised any other rights regarding Healthy Blue's privacy policies and procedures or administration thereof. Healthy Blue workforce members will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person who is testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. PHI will be disclosed if required by the law: • For Disclosures about victims of abuse, neglect, or domestic violence. • To comply with judicial release. • To comply with Law Enforcement. • To respond to, and cooperate with, complaint investigations and compliance reviews of Healthy Blue's policies, procedures or practices related to privacy investigations undertaken by the Secretary of the U.S. Department of Health and Human Services or its designee, the Office for Civil Rights (Privacy Department to work directly with Legal Department in these situations). During onsite review, Healthy Blue submitted a screenshot and a policy, "Medicaid and Medicare Privacy Incident Reporting (MO)" stating that Health Blue will immediately report breaches identified by the completion of the Probability of Compromise. The staff was knowledgeable about it at the time of interview. **Required Actions:** None.		
iv. If required to properly perform the contract and subject to the terms of the MHD contract, the MCO may use or	CPP201 Business Associate Agreements: page 3	 Fully Met

disclose Protected Health Information, if necessary, for the proper management and administration of MCO's business (MHD contract 2.38.2(d)).	CPP522 Treatment, Payment and Health Care Operations Disclosures: page 1	

Findings: Business Associates of Healthy Blue are permitted to use or disclose PHI it creates or receives for or from Healthy Blue only as follows:

- To perform specified functions and activities on Healthy Blue's behalf, as set forth in the Business Associate's Agreement; and
- For the management and administration of Business Associate's operations or to carry out Business Associate's legal responsibilities.

The policy "Treatment, Payment and Health Care Operations Disclosures" states that Healthy Blue associates may disclose the minimum amount of Protected Health Information (PHI) necessary without the individual's authorization to perform Healthy Blue's Treatment, Payment, and Healthcare Operations (TPO).

Required Actions: None.

v. If the disclosure is required by law, the MCO may disclose Protected Health Information to carry out the legal responsibilities of the MCO (MHD contract 2.38.2(e)).	CPP520 Specialized/Non-Routine Disclosures (No Authorization Required): pages-4, 8, 10, 11, 13	Fully Met

Findings: If a disclosure is required by law and involves one of the following, then the Healthy Blue must also abide by the requirements set forth when disclosing PHI.

- For Disclosures about victims of abuse, neglect, or domestic violence.
- To comply with judicial release.
- To comply with Law Enforcement.
- To respond to, and cooperate with, complaint investigations and compliance reviews of Healthy Blue's policies, procedures or practices related to privacy investigations undertaken by the Secretary of the U.S. Department of Health and Human Services or its designee, the Office for Civil Rights (Privacy Department to work directly with Legal Department in these situations).

Healthy Blue associate may, in good faith, disclose PHI without authorization, if he believes the Disclosure of PHI:

- Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Disclosure must be to a person(s) who is able to prevent or lessen the threat, including to the target of the threat.
- Is necessary for Law Enforcement Officials to identify or apprehend a person where it appears from all the circumstances the person has escaped from a Correctional Institution or from lawful custody.

• Is necessary for Law Enforcement Officials to identify or apprehend a person because of a statement by a person admitting participation in a violent crime that Healthy Blue reasonably believes may have caused serious physical harm to the victim. • The PHI constitutes evidence of criminal conduct that occurred on the premises of Healthy Blue. • Is necessary for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. • Is necessary for the purpose of alerting Law Enforcement of the death of the Individual if the Anthem Associate has a suspicion that such death may have resulted from criminal conduct. Healthy Blue may disclose PHI without authorization in response to a court or administrative tribunal order, in response to a subpoena, discovery request, or other lawful process. **Required Actions:** None.		
vi. If applicable, the MCO may use Protected Health Information to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B), (MHD contract 2.38.2(f)).		Not Met
Findings: Healthy Blue did not submit documents to ascertain compliance with the requirement. **Required Actions:** PTM recommends that Healthy Blue submits evidence for compliance with this section.		
vii. The MCO may not use Protected Health Information to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the state agency to do so (MHD contract 2.38.2(g)).	CPP102 De-identification: page 1 <u>Onsite Submission</u> De-identification and Limited Data Set Procedures for Medicaid Plans and Lines of Business: pages-1, 6	Fully Met
Findings: Healthy Blue may use or disclose de-identified information in their daily work, including when fulfilling requests for data from third parties. When it is determined the Use or Disclosure of de-identified information is required to fulfill a business need, Healthy Blue must follow Healthy Blue's de-identification Procedure. Healthy Blue must follow contractual requirements that restrict de-identification or limit the use of de-identified data, e.g., certain clients prohibit Healthy Blue from de-identifying data without prior authorization of the use case, while other clients may limit the use of de-identified data to internal testing.		

State Medicaid Regulators may prohibit de-identifying Medicaid member data without the Regulator's prior authorization of the use case. Furthermore, once data is considered de-identified, State Medicaid Regulators may limit the use of de-identified data. Requests to create a limited data set for external disclosure should be submitted to the Privacy Department for approval. Limited Data Sets can only be disclosed if the Privacy Department determines, in consultation with the Legal Department, that Healthy Blue enters into a Data Use Agreement with the Limited Data Set recipient prior to the disclosure that allows Healthy Blue to terminate the Data Use Agreement if the agreement is violated. **Required Actions:** None.		
viii. The MCO agrees to make uses and disclosures and requests for Protected Health Information consistent with the state agency's minimum necessary policies and procedures. (MHD contract 2.38.2(h)).	CPP1001 Minimum Necessary Requirements: page 1, 2	Fully Met
Findings: Healthy Blue associates may only collect, use, and disclose the minimum amount of PHI, PFI, PI, PII, and other confidential and proprietary information, necessary to perform permitted functions set forth in the privacy policies. Authorized Healthy Blue associates may only collect, use, or disclose an entire medical record (as applicable) when the entire medical record is specifically justified as the amount reasonably necessary to accomplish the purpose of the request, Use or Disclosure. Healthy Blue associates should only download the minimum necessary amount of data to a laptop or hard drive when necessary for business purposes. The minimum necessary rule must be followed except under the following situations: • The Disclosure is to or requested by a Health Care Provider for Treatment • The Use or Disclosure is made to the individual who is the subject of the PHI. • The collection, Use or Disclosure is pursuant to an Authorization. • The Disclosure is made to the Department of Health and Human Services. • The collection, Use or Disclosure is required by law. • The collection, Use or Disclosure is required for the compliance with the privacy regulations. **Required Actions:** None.		

H. Obligations and activities of MCO: i. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), the MCO shall require that any agent or subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of the MCO agrees to the same restrictions, conditions, and requirements that apply to the MCO with respect to such information (MHD contract 2.38.3(d)).	CPP201 Business Associate Agreements: pages-1, 2	Fully Met
Findings: Healthy Blue has a Business Associate Agreement policy requiring any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions and conditions that apply to the business associate with respect to such information. Depending on the business relationship, Healthy Blue can be the Covered Entity or the Business Associate in the BAA. Although a business relationship has already been established, it is still essential for Healthy Blue to secure signed BAA from the vendor before PHI is shared. **Required actions:** None.		
ii. By no later than 10 calendar days after receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the MCO shall make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by, or received by the MCO on behalf of the state agency available to the state agency and/or to the Secretary of the Department of Health and Human Services or designee for purposes of determining compliance with the HIPAA Rules and the contract (MHD contract 2.38.3(e)).	CPP201 Business Associate Agreements: page 1	Partially Met
Findings: Healthy Blue's Business Associate Agreement states that as a Covered Entity under HIPAA, Healthy Blue is required to execute contracts called Business Associate		

Agreements to establish the permitted and required Uses and Disclosures of PHI by the Business Associate. The Business Associate will make its internal practices, books, and records relating to the Use and Disclosure of PHI received from or created or received by the Business Associate on behalf of, the Covered Entity available to the secretary for purposes of determining the Covered Entity's compliance with HIPAA. During the site meeting, Healthy Blue staff was knowledgeable about the timeframe required for submission of documents and PHI to the state and federal agencies. **Required Actions:** PTM recommends that Healthy Blue incorporates the timeframe (10 calendar days) within which a BA will submit documentation to the Covered Entity.		
iii. By no later than five calendar days of receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the contractor shall provide an accounting of disclosures of Protected Health Information regarding an individual to the state agency (MHD contract 2.38.3(f)).	CPP1201 Privacy and Security Incident Response and Reporting: page 12 CPP605 Right to Request an Accounting of Disclosures of PHI: pages-1, 6 <u>Onsite Submission</u> Medicaid and Medicare Privacy Incident Reporting-MO: page 23 MO Medicaid Breech Notification (screenshot)	Fully Met
Findings: Inappropriate Disclosures of member PHI under HIPAA are tracked as an "Accountable Disclosure" in the e-Form. A manual process of accounting for these Disclosures may be implemented for all categories of incidents. Accounting of Disclosure can be requested by an individual, individual's personal representative (e.g., parent, conservator, guardian, executor, valid and applicable Power of Attorney). Individuals have a right to request an accounting of Specialized/Non-Routine Disclosures of PHI by Healthy Blue and its Business Associates made on or after April 14, 2003, if the Disclosure is not for Treatment, Payment, and Health Care Operations (TPO) Disclosures. Healthy Blue must encourage its Business Associates to respond to requests for Disclosure of PHI within ten business days. Healthy Blue will provide the accounting of Disclosures Report not later than 60 calendar days after receipt of the request. During the site meeting, Healthy Blue submitted a policy, "Medicaid and Medicare Privacy Incident Reporting" specific for MO stating that Healthy Blue will provide monthly report for impermissible disclosures. The screenshot specific for the MO HealthNet acknowledges 5 calendar days timeframe requirement of this section. The staff was knowledgeable of this at the time of interview.		

Required Actions: None.		
iv. In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, the contractor shall, within five calendar days following a state agency request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, provide the state agency access to the Protected Health Information in an individual's designated record set (MHD contract 2.38.3(g)).	CPP602 Right of Access to Inspect/Copy PHI: pages-1, 4	Partially Met
Findings: Individuals have a right of access to inspect, and/or obtain a copy of their PHI in a Designated Record Set (DRS). Individuals have this right for as long as the PHI is maintained by Healthy Blue in a DRS in accordance with Healthy Blue's Records Management Policy (and any additional retention obligations of Healthy Blue). This right extends to PHI maintained in DRS by Healthy Blue's Business Associates. If Healthy Blue does not maintain the PHI that is the subject of the request for access, and Healthy Blue knows where the information is maintained, the Healthy Blue associate must inform the Individual where to direct the request for access. Healthy Blue must act on a requestor's request for access no later than 30 calendar days after receipt of the request by: • Informing the requestor of the acceptance and providing the access requested; or • Providing the requestor with a written denial. Healthy Blue may extend the timeframe in by no more than 30 calendar days provided: • Healthy Blue provides the requestor with a written statement of the reasons for the delay and the date by which Healthy Blue will complete its action on the request for access. • This written statement must be provided within the original time limits set forth above. • Healthy Blue may only have one such extension of time for each request for access. PTM noted that Healthy Blue has a process of providing access of PHI to an individual, individual's personal representative (e.g., parent, conservator, guardian, executor, valid and applicable Power of Attorney). However, it does not meet the timeframe requirement of the State for accessing the PHI. The staff was knowledgeable of this requirement at the time of interview. **Required Actions:** PTM recommends that Healthy Blue has a documentation to meet the timeframe requirement of this section.		
v. The MCO shall report to the state agency's Privacy Officer any security	CPP1201 Privacy and Security Incident Response	Fully Met

incident, breech, unauthorized use, or disclosure of Protected Health Information not permitted or required as stated herein immediately upon becoming aware of such incident, breech, use or disclosure and shall take immediate action to stop the incident, unauthorized use, or disclosure. By no later than five calendar days after the MCO becomes aware of any such use or disclosure, the MCO shall provide the state agency's Privacy Officer with a written description of the breech, information compromised by the breach, any remedial action taken to mitigate any harmful effect of such incident or disclosure, and a proposed written plan of action for approval that describes plans for preventing any such future incidents, unauthorized uses or disclosures (MHD contract 2.38.3(i, j, k)).	and Reporting: pages-10 to 12 Email: Preliminary Disclosure Urgent Secure Email: Missouri Medicaid Privacy Incidents <u>Onsite Submission</u> Medicaid and Medicare Privacy Incident Reporting-MO: page 23	
Findings: It is Healthy Blue's obligation to identify, investigate, mitigate, and respond to suspected and actual incidents involving the non-permitted Use or Disclosure of Individual/Member Confidential Information or Provider/Broker Confidential Information ("Incident"). Healthy Blue is also obligated to notify impacted individuals/members, regulators, and other parties of any confirmed Incident and/or Breach as required by applicable federal and state laws or regulations, international laws or regulations, contractual obligations (e.g., Business Associate Agreements), or as otherwise deemed appropriate by Healthy Blue. Healthy Blue is required to notify certain entities as defined by state law, federal law or by contract. Notification requirements vary based on the nature of the Incident, the parties impacted and/or the probability of compromise. Healthy Blue may also choose to notify certain agencies or individuals as a courtesy when not required by law or contract. As required by HIPAA and per the terms of Healthy Blue's Business Associate Agreements with its self-funded employer groups and/or State Medicaid agencies, notice of all non-permitted uses and Disclosures, including any Incident constituting a Breach, must be reported to these entities. The following documents must be completed for each Incident: 1. e-Form (Privacy and Security Disclosure Report). 2. Probability of Compromise (POC) Worksheet – unless the Incident is determined to be a non-event. 3. Incident Mitigation Corrective Action Plan. 4. Sanction (Disciplinary Action) Form (for root cause human error Incidents).		

5. There may be certain covered entities who instruct us to use contract specific worksheets and reporting mechanisms. Healthy Blue has submitted two documents comprising of email communications to the MHD regarding a preliminary disclosure of security incident and zero security incident report. During the site meeting, Healthy Blue submitted a policy, "Medicaid and Medicare Privacy Incident Reporting" specific for MO stating that Health Blue shall immediately report breaches identified by the completion of the Probability of Compromise analysis. The staff was knowledgeable about this at the time of interview. **Required Actions:** None.		
vi. In order to meet the requirements under HIPAA and the regulations promulgated thereunder, the MCO shall keep and retain adequate, accurate, and complete records of the documentation required under these provisions for a minimum of 6 years as specified in 45 CFR Part 164 (MHD contract 2.38.3(m)).	CPP207 Records Management (Retention and Disposal) Policy: page 1	Fully Met
Findings: Consistent with Healthy Blue's Records Management Policy (and any related memos) and the HIPAA privacy rule, Healthy Blue must retain specified documentation for a period of at least six years from the date of its creation, or the date when it last was in effect. Healthy Blue may be required to retain records in excess of six years to the extent required under Healthy Blue's Records Retention Schedule. **Required Actions:** None.		
vii. The MCO shall not directly or indirectly receive remuneration in exchange for any Protected Health Information without a valid authorization (MHD contract 2.38.3(n)).	CPP801 Marketing Activities: page 1	Fully Met
Findings: Except as otherwise permitted under HIPAA, Healthy Blue associates may not use or disclose PHI for Marketing purposes without an individual's authorization for marketing which must state that the Covered Entity may receive direct or indirect remuneration from the party whose product is being described in the Marketing activity. **Required Actions:** None.		
viii. The MCO shall indemnify the state agency from any liability resulting from		Not Met

any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s) or subcontractor(s). The MCO shall reimburse the state agency for any and all actual and direct costs and/or losses, including those incurred under the civil penalties implemented by legal requirements, including but not limited to HIPAA as amended by the Health Information Technology for Economic and Clinical Health Act, and including reasonable attorney's fees, which may be imposed upon the state agency under legal requirements, including but not limited to HIPAA's Administrative Simplification Rules, arising from or in connection with the MCO's negligent or wrongful actions or inactions or violations of this Agreement (MHD contract 2.38.3(p)).		
Findings: Healthy Blue did not submit document to comply with the criterion in this section. **Required Actions:** PTM recommends that Healthy Blue submits documents for compliance with the requirement of this section.		

Compliance Score-Confidentiality						
Total	Met	=	18	×2	=	36
	Partial Met	=	2	×1	=	2
	Not Met	=	2	×0	=	0
Numerator	Score Obtained				=	38
Denominator	Total Sections	=	22	×2	=	44
Score						**86.36%**

Appendix G

Standard 13–42 CFR: 438.228 , 457.1260-Grievance and Appeal System		
Requirements and References	**Evidence/Documentation as submitted by the MCO**	**Score**
The MCO shall develop and implement written policies and procedures that detail the operation of the grievance and appeal system and provides simplified instructions on how to file a grievance or appeal and how to request a State Fair Hearing. The policies and procedures shall identify specific individuals who have authority to administer the grievance and appeal system policies (MHD contract 2.15.2)		
A. Definitions (42 CFR 438.400). i. Adverse benefit determination means: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service (applies for clean claims only.) d. The failure to provide services in a timely manner, as defined by the State (MHD contract: 2.15.1 a 4/2.5.3, 20CSR400-7.095).	Health Care Management Denial Core Process-MO: pages-2, 3 Member Appeals-MO: pages-2, 3 Member Inquiries and Grievances-MO: page 4 MHD Managed Care Provider Manual: page 86	Partially Met

e. The failure of an MCO to act within the timeframes provided in §438.408(b)(1),(2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network. (N/A for CHIP). g. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.		
Findings: Healthy Blue's policies comply with the definition of adverse benefit determination. PTM noted that the provider manual does not address b, c, d, e, and partially addresses criterion a. The terms used are proposed action/notice of action instead of adverse benefit determination. **Required Actions:** PTM recommends that Healthy Blue updates its provider manual to include the correct definition of adverse benefit determination.		
ii. Appeal means a review by an MCO of an adverse benefit determination.	Member Appeals-MO: page 3 Member Inquiries and Grievances-MO: page 4 MHD Managed Care Provider Manual: page 44	Partially Met
Findings: Healthy Blue's policies comply with the definition of an appeal. However, PTM noted that the provider manual does not include the correct definition. **Required Actions:** PTM recommends that Healthy Blue updates its provider manual based on the deficiency pointed out in this section.		
iii. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may	Member Appeals-MO: page 3 Member Inquiries and Grievances-MO: page 4	Fully Met

include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.	MHD Managed Care Provider Manual: page 43	
Findings: Healthy Blue's policies and provider manual comply with the definition of Grievance. **Required Actions:** None.		
iv. Grievance and appeal system means the processes the MCO implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.	Member Appeals-MO: page 3 Member Inquiries and Grievances-MO: page 5	Fully Met
Findings: Healthy Blue's policies comply with the definition of grievance and appeal system. **Required Actions:** None.		
v. Inquiry is a request from a member for information that would clarify MCO policy, benefits, procedures, or any aspect of MCO function but does not express dissatisfaction (MHD contract 2.15.1(f)).	Member Appeals-MO: page 4 Member Inquiries and Grievances-MO: page 5	Fully Met
Findings: Healthy Blue's policies comply with the definition of grievance and appeal system. **Required Actions:** None.		
vi. State Fair Hearing is the process set forth in the MHD contract	Member Appeals-MO: page 4	Fully Met

2.12.16(c)(22) and in 42 CFR part 431, subpart E.	Member Inquiries and Grievances-MO: page 5	
Findings: Healthy Blue's policies comply with the definition of State Fair Hearing. A formal proceeding where an impartial Hearings Officer, assigned through a state's administrative process, listens to all the facts of a case (appeal or grievance). Witnesses are sworn in by the Hearings Officer. All proceedings are tape-recorded and are on the record. The Hearings Officer decides within a State's mandated timeframe. **Required Actions:** None.		
B. General requirements (42 CFR 438.402). i. The grievance and appeal system: a. The MCO must have a grievance and appeal system in place for enrollees. b. The MCO shall distribute to members upon enrollment a flyer explaining how to contact the MCO's member services, and shall identify the person from the MCO who receives and processes grievances and appeals. This flyer can be distributed with the member handbook but it must be a stand-alone document (MHD contract 2.15.2(e)). c. The MCO shall probe inquiries so as to validate the possibility of any inquiry actually being a grievance or appeal. The MCO shall identify any inquiry pattern (MHD contract 2.15.2(i)). d. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (42 CFR 406).	Member Appeals-MO: pages-1, 2, 5 Member Inquiries and Grievances-MO: pages-1, 2	Partially Met
Findings: a. Healthy Blue has a grievance and appeal system for members that defines their rights regarding disputed matters with the Healthy Blue. Healthy Blue's grievance and		

appeal system includes a grievance and appeals process and access to the State's Fair Hearing process as outlined in the MHD contract, section 2.15 and 42 CFR 438.402. b. Healthy Blue will distribute a flyer explaining the grievance and appeal system to its members upon enrollment. This flyer will contain specific instructions about how to contact the Healthy Blue's member services and will identify the person from the Healthy Blue who receives and processes grievances and appeals. Members are also informed there is no cost to submit an appeal. This flyer can be distributed with the member handbook but it is a stand-alone document. The grievance and appeal system flyer will be readily available in the member's primary language. In addition, Healthy Blue will demonstrate that they have procedures in place to notify all members, in their primary language, of grievance dispositions and appeal resolutions. PTM noted that Healthy Blue did not submit member flyer for review even though it was requested. c. The member service representatives receive inquiries over the telephone and log them into the electronic documentation system. The representatives are trained in customer relations, including the provision of language services and cultural competency and appropriate methods for resolving common inquiries and the importance of members' rights and responsibilities. They will attempt to resolve all inquiries at the time of the initial call. If an inquiry cannot be resolved to the member's satisfaction, the inquiry is then documented as a grievance. d. The policy, "Member Appeals-MO," states that the verbal inquiries seeking to appeal an adverse benefit determination are considered as appeals. **Required Actions:** PTM recommends that Healthy Blue submits its member flyer for review.		
ii. Level of appeals: The MCO may have only one level of appeal for enrollees.	Member Appeals-MO: page 4	Fully Met
Findings: Healthy Blue's policy, "Member Appeals-MO," complies with the requirement of having only one level of appeals for the enrollees. **Required Actions:** None.		
iii. Authority to file: An enrollee may file a grievance and request an appeal with the MCO. If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or	Member Appeals-MO: page 4 Member Inquiries and Grievances-MO: page 2	Fully Met

request a State Fair Hearing, on behalf of an enrollee, with an exception that providers cannot request continuation of benefits as specified in 42 CFR. §438.420(b)(5).		
Findings: Healthy Blue's policies comply with the requirement of persons who have the authority to file a grievance, appeal, or a State Fair Hearing. The policy, "Member Appeals-MO," acknowledges that providers cannot request for continuation of benefits. **Required Actions:** None.		
iv. Deemed exhaustion of appeals processes: If an MCO fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's appeals process. The enrollee may initiate a State Fair Hearing.	Member Appeals-MO: page 4	Fully Met
Findings: Healthy Blue's policy, "Member Appeals-MO," complies with the requirement of this section. **Required Actions:** None.		
vi. Timing for filing. An enrollee may file a grievance with the MCO at any time whereas an enrollee has 60 calendar days from the date of the adverse benefit determination notice, to file a request for an appeal to the MCO.	Health Care Management Denial Core Process-MO: page 13 Member Appeals-MO: page 7 Member Handbook-page 58 Member Inquiries and Grievances-MO: page 2	Partially Met
Findings: Healthy Blue's policies are compliant with the timing for filing grievance and appeal. A grievance can be filed any time and an appeal request must be filed by members or their authorized representatives within 60 calendar days of the date on the adverse benefit determination notice. However, the member handbook does not mention the timing for filing a grievance. **Required Actions:** PTM recommends that Healthy Blue updates its member handbook to reflect the time of filing for a grievance.		
vii. Procedures:	Member Appeals-MO: page 7 Member Handbook: page 58	Partially Met

a. Grievance-The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with MCO. b. Appeal-The enrollee may request an appeal either orally or in writing.	Member Inquiries and Grievances-MO: pages-2, 7	
Findings: a. Healthy Blue's member handbook states that the members can file a grievance on the telephone, in person, fax, or in writing. Healthy Blue policy "Member Inquiries and Grievances-MO" states that a grievance can be filed verbally or in writing and may be filed with the State or Healthy Blue. b. Healthy Blue's policy "Member Appeals-MO" and its Member Handbook states that an appeal may be requested verbally or in writing. Unless an expedited appeal is requested, a verbal appeal must be followed by a written, signed appeal. PTM noted that the member handbook and the policy statement about a verbal appeal to be followed by a written and signed appeal is incorrect. **Required Actions:** PTM recommends that Healthy Blue updates its policy "Member Appeals-MO" and member handbook regarding correct procedure for filing an appeal.		
C. Timely and adequate notice of adverse benefit determination (42 CFR 438.404). i. The notice must explain the following: a. The adverse benefit determination the MCO has made or intends to make. b. The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria,	Health Care Management Denial Core Process-MO: pages-10, 11 Notice of Healthy Blue Adverse Benefit Determination Member Handbook: page 57	 Fully Met

and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The enrollee's right to request an appeal of the MCO's adverse benefit determination, including information on exhausting the MCO's one level of appeal described at §438.402(b) and the right to request a State Fair Hearing consistent with §438.402(c). d. The procedures for exercising the rights to appeal and request a State Fair Hearing. e. The circumstances under which an appeal process can be expedited and how to request it. f. The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services.		
Findings: Healthy Blue's policy, "Health Care Management Denial Core Process-MO," and the information provided in the member handbook complies with the components that must be included in the notice for adverse benefit determination. Healthy Blue uses a template provided by the MHD. **Required Actions:** None.		
ii. Timing of notice (MHD contract 2.15.4(c): a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 calendar days before the date of adverse benefit determination.	Health Care Management Denial Core Process-MO: pages-11, 12	Fully Met

b. No later than the date of adverse benefit determination in case of the following: beneficiary's death; withdrawal from services; and unknown whereabouts-the post office returns MCO's mail directed to the member indicating no forwarding address; member's physician prescribes a change in the level of medical care; member's admission to an institution where he is ineligible for further services; and member has been accepted for the MHD services by another local jurisdiction. c. In cases of probable fraud-notice will be 5 calendar days before the date of adverse benefit determination. d. For denial of payment, at the time of any action affecting the claim. e. For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1). (Not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days.) f. For service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.		
Findings: Healthy Blue's policy, "Health Care Management Denial Core Process-MO," complies with the timing for the notice of adverse benefit determination.		

Required Actions: None.		
iii. If the MCO meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii), it must— a. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. b. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.	Member Appeals-MO: page 8 Member Inquiries and Grievances-MO: page 3	Fully Met
Findings: Healthy Blue's policies meet the requirements in case of extension of the timeframe for standard service authorization. **Required Actions:** None.		
D. Handling of grievances and appeals (42 CFR 438.406): i. The MCO must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. ii. Acknowledge receipt of each grievance and appeal. The MCO shall acknowledge receipt of each grievance and appeal in writing within 10 business days after	Member Appeals-MO: page 7 Member Inquiries and Grievances-MO: page 3 <u>Onsite Submission</u> Member Inquiries and Grievances-MO (revised): page 3	Fully Met

receiving a grievance or appeal (MHD contract 2.15.5c, 2.15.6j).		
Findings: i. Healthy Blue will give members any reasonable assistance in completing forms and taking other procedural steps related to grievance or an appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services for members/authorized representatives with limited English proficiency and toll-free numbers that have adequate TTY/TTD (Teletypewriter/Telecommunications Device for the Deaf) and interpreter capability and American Sign Language services for members and authorized representatives with visual or other communicative impairments/challenges. Upon a member's request, appeal notices will be provided that meet their cultural and linguistic needs in a format that is easy to understand, readily accessible and consistent with state and federal requirements. Healthy Blue will comply with HIPAA policies and procedures regarding the sharing of information with and verification of the member's authorized representative. ii. Healthy Blue will mail an acknowledgement letter to the member or the member's authorized representative within 10 calendar days of receipt of the verbal or written grievance. All appeals are acknowledged in writing within 5 calendar days of receipt. **Required Actions:** None.		
iii. Ensure that the individuals who make decisions on grievances and appeals are individuals— a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues.	Member Appeals-MO: page 5 Member Inquiries and Grievances-MO: page 3	Partially Met

c. Who takes into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.		
Findings: a. The policy, "Member Appeals-MO," states that an appeal will be reviewed by qualified Healthy Blue associate, including any aspects of clinical care involved. In cases of clinical care, a medical director reviews the appeal. However, the medical director or the practitioner who made the initial decision may review the case and overturn their initial decision. The policy also states that Healthy Blue will ensure that the individuals who make decisions on appeals are individuals who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual. PTM noted that the above two statements in the policy are not consistent with each other to meet the criterion "a" of this section. An appeal is not to be reviewed by a medical director/practitioner who had made an initial decision. The policy, "Member Appeals-MO," complies with the requirements listed in b and c of this section. The policy "Member Inquiries and Grievances-MO" complies with all the three criteria, a, b, and c of this section. **Required Actions:** PTM recommends that Healthy Blue updates its policy "Member Appeals-MO" based on the above findings.		
iv. Include the enrollee and his/her representative, or legal representative of a deceased enrollee's estate as parties to the appeal and provide: a. A reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The MCO must inform the enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in 42 CFR 438.408 (b)	Member Appeals-MO: page 6	Fully Met

and (c) in case of expedited resolution. b. Enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals specified in 42 CFR 438.408.		
Findings: Healthy Blue policy "Member Appeals-MO" complies with the requirements of this section. **Required Actions:** None.		
E. Resolution and notification-grievance and appeals (42 CFR 438.408): i. Standard resolution of grievances may not exceed 90 calendar days from the day the MCO receives the grievance. The MCO shall resolve each grievance and provide written notice of the resolution of the grievance, as expeditiously as the member's health condition requires but shall not exceed 30 calendar days of the filing date (MHD contract 2.15.5(e). ii. Standard resolution of appeals and notice to the affected parties must be made no longer than 30 calendar days from the day the MCO receives the appeal. This timeframe may be extended as stated below.	Member Handbook: page 59 Member Appeals-MO: page 7 Member Inquiries and Grievances-MO: page 5 <u>Onsite Submission</u> Member Inquiries and Grievances-MO (revised): page 5	Partially Met

iii. Expedited resolution of appeals and notice to the affected parties must be made no longer than 72 hours after the MCO receives the appeal. This timeframe may be extended as stated in the section below.		
Findings: i. Healthy Blue's member handbook complies with the requirement of timeframe for resolving a grievance. During the onsite submission, Healthy Blue updated its policy, "Member Inquiries and Grievances-MO," with the correct information based on the inaccuracies pointed out by PTM in the preliminary review, thus meeting the requirement of this criterion "i." ii, iii. Healthy Blue's member handbook states that Healthy Blue will decide within 30 calendar days after Healthy Blue receive the request for preservice appeals, within 60 calendar days after Healthy Blue receives the request for post service appeals, and within 72 hours for expedited appeal. However, the policy "Member Appeals-MO states that the standard and preservice appeals will be resolved within 30 calendar days and post service appeals will be resolved and members will be notified within 30 calendar days of receipt of the appeal request. PTM noted that the timeframe of post service appeal resolution within 60 days mentioned in the member handbook is not per the MHD contract/CFR. **Required Actions:** PTM recommends Healthy Blue update its member handbook to mention the correct timeframe within which a standard appeal (preservice/post service-not in the CFR/MHD contract) must be resolved and the member notified.		
iv. Extension of timeframes: The MCO may extend the timeframes by up to 14 calendar days if: a. The enrollee requests the extension; or the MCO shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest. b. If the MCO extends the timeframes not at the request of	Member Appeals-MO: page 8 Member Inquiries and Grievances-MO: pages-2, 3	Fully Met

the enrollee, it must complete all of the following: • Make reasonable efforts to give the enrollee prompt oral notice of the delay. • Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.		
Findings: Healthy Blue's policies comply with the extension of timeframe requirement in case of grievance or an appeal. **Required Actions:** None.		
v. Format of notice. i. The MCO will use an established method by the State to notify an enrollee of the resolution of a grievance. ii. For all appeals, the MCO must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10. iii. For an appeal for expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	Member Appeals-MO: page 8 Member Inquiries and Grievances-MO: page 2 <u>Onsite Submission</u> MOGR03 Member Grievance Resolution Letter Template	Fully Met
Findings: i. Healthy Blue provides written notice of resolution of the grievance to its members.		

ii. Appeal resolution notifications will be communicated timely and will include:
• The results of the resolution and completion date.
• The reason for the resolution in an easy-to-understand language.
• Reference to the criteria, benefit provision, guideline and/or protocol used for making the decision.
• The right to obtain a copy of the criteria, benefit provision, guideline and/or protocol used to make the appeal decision, upon request.
• The right to access and receive copies of all documents, upon request, used to make the appeal decision, free of charge.
• Identification of individuals who participated in the appeal review including:
  ○ For benefit decisions, the reviewer's title.
  ○ For medical necessity decisions, the reviewer's title, qualifications, and specialty.
 	
iii. For expedited Appeals, within 72 hours of receipt of the appeal request, Healthy Blue will make reasonable efforts to provide verbal notice.
 	
Required Actions: None.		

vi. Content of notice of appeal resolution: The written notice of the resolution must include the following: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the enrollees— • The right to request a State Fair Hearing, and how to do so (CHIP enrollees have the right to request a State External Review in accordance with the terms of 42 CFR 457, Subpart K.) • The right to request and receive benefits while the hearing is pending, and how to make the request. • That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's	Member Appeals-MO: pages-8, 9	Fully Met

adverse benefit determination.		
Findings: Healthy Blue's notice format of notice on appeal resolution to its members meets the requirements of this section. **Required Actions:** None.		
vii. Requirements for State Fair Hearings: An enrollee may request a State Fair Hearing (The CHIP enrollees have the right to request a State External Review in accordance with the terms of subpart K of 42 CFR 457, Subpart K (457.1260(b)(2)): a. After receiving a notice that the MCO is upholding the adverse benefit determination. b. If deemed to have exhausted the MCO's appeals processes. c. No less than 90 calendar days and no more than 120 calendar days from the date of the MCO's notice of resolution. d. The parties to the State Fair Hearing include the MCO as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.	Member Appeals-MO: pages-9, 10 Member Handbook: page 58	Partially Met
Findings: The state agency maintains an independent State Fair Hearing process as required by federal law and regulation, as amended. The State Fair Hearing process provides the members an opportunity before an impartial hearing officer**.** A member may request a State Fair Hearing no later than 120 calendar days from the date an adverse benefit determination is upheld through Healthy Blue's internal level of appeal and not resolved wholly in favor of the member. If Healthy Blue fails to adhere to the notice and timing requirements under the MHD contract, section 2.12.16 c.22 and in accordance with 42 CFR 438.408, the member is deemed to have exhausted Healthy Blue's internal level of		

appeal and may initiate a State Fair Hearing. The parties to the State Fair Hearing include Healthy Blue, the member and his or her representative or the representative of a deceased member's estate. To request a review, the member must submit a written request, within the timeframe specified above to the state agency. PTM noted that the MHD contract, section 2.12.16(c)(22) does not mention timeframe requirements. Also, the member handbook does not meet criterion b of this section. **Required Actions:** PTM recommends that Healthy Blue updates its policy citing the correct section from the MHD contract and update its member handbook based on the deficiency identified by PTM.		
F. Expedited resolution of appeals (42 CFR 438.410): i. The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. ii. Punitive action: The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal. iii. Action following denial of a request for expedited resolution: a. Transfer the appeal to the timeframe for standard resolution. b. Follow the requirements for extension as stated in E(4)(b) of this evaluation tool or 42 CFR 438.408(c)(2).	Member Appeals-MO: pages-2, 9	Fully Met

Findings: i. Healthy Blue will establish and maintain an expedited appeal process for appeals related to urgent care, care for life-threatening conditions and continued stays for hospitalized patients who have not been discharged from a facility or any other situation when Healthy Blue determines (for a request from the member) or the provider indicates (in making the request on the member's behalf) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health or the ability to attain, maintain or regain maximum function. ii. Healthy Blue will ensure that members and authorized representatives acting on behalf of the member will not receive punitive action for requesting the appeal and have a full and fair process to appeal, either verbally or in writing, any adverse decision (e.g., benefit, coverage, quality of care, administrative). iii. If Healthy Blue denies a request for expedited appeal resolution, it must: • Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2). • Make reasonable efforts to give the member prompt verbal notice of the denial and follow up within two calendar days with a written notice that also informs the member of their right to file a grievance if they disagree with the decision. • Resolve the appeal as expeditiously as the member's health condition dictates and no later than the standard timeframe for resolution. **Required Actions:** None.		
G. Information about the grievance and appeal system to providers and subcontractors must be provided to them at the time they enter into a contract with the MCO (42 CFR 438.414). i. This information should be as per 42 CFR 438.10(g)(2)(xi), which includes: a. Right to file grievances and appeals. b. Requirements and timeframes for filing a grievance or appeal. c. Availability of assistance in the filing process, right to file State Fair Hearing if MCO has made a decision adverse to the enrollee.	MHD Managed Care Provider Manual: pages-44, 45, 127 DentaQuest (Ancillary Services Agreement): pages-58 to 72, 68 Member Appeals-MO: page 1 Member Inquiries and Grievances-MO: page 1 Medical Transportation Management (MTM) Statement of Work (SOW): pages-6, 36 March Vision Service Agreement: page 13	Partially Met

d. The fact that, when requested by the enrollee, benefits that the MCO seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the enrollee may, consistent with State policy, 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 enrollee.		

Findings: Healthy Blue's provider manual provides the following information to its providers:

a. A provider may act as the member's representative to file an appeal or grievance. To act as a member's representative, the provider must have the written consent signed by the member and follow the time frames and processes for member grievances and appeals.

b. Members have the right to file a grievance at any time orally by calling member services or a member may choose to file a grievance only by mail. Any supporting documents must be included. The member, or the member's representative, can file an appeal within 90 calendar days from the date on the Healthy Blue Notice of Action. A provider or authorized representative acting on behalf of the member and with the member's written consent, may file an appeal verbally, in writing or in person.

PTM noted that the 90 calendar days' timeframe for filing appeal is incorrect per the CFR and MHD contract.

c. If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for our member to request a State Fair Hearing and how to do it.
- The right to receive benefits while this hearing is pending and how to request it.

d. The notice to the member will include that the member may have to pay the cost of these benefits if the State Fair Hearing officer upholds the Healthy Blue action. Healthy Blue will continue a member's benefits while the appeals process or the State Fair Hearing is pending if all of the following are true:

- The appeal is submitted to us on or before the latter of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action but no more than 30 days.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.

• The member requests an extension of benefits. DentaQuest Ancillary Services Agreement: Regarding member related grievances and appeals, the agreement states that Healthy Blue retains the responsibility, and the subcontractors will direct the inquiries, complaints, grievance and appeals to Healthy Blue. It also states that a provider may file a verbal or written complaint or a written appeal within 90 days or within contractual specified time frame of adverse benefit determination. PTM noted that the appeals filing timeframe and procedure for filing is incorrect. MTM SOW: In the event of a dispute regarding Medically Necessary Covered Services, vendor shall refer the complaining party to Healthy Blue's grievance/complaint process, including providing written notice of such process whenever such notice is required by law or Agency. Should the vendor receive a member complaint, grievance, or appeal directly from a member or from a contracted provider on behalf of a member, vendor will submit a copy of the written complaint, grievance or appeal to Healthy Blue within one business day of vendor's resolution of complaint, grievance, or appeal. Should an appeal be marked or deemed expedited, vendor will send it to Healthy Blue within one business day of receipt. PTM noted that the MTM, SOW does not consist of information about criteria b, c, and d of this section. March Service Agreement: Provider will cooperate and participate in Healthy Blue's applicable appeal, grievance, and external review procedures, including government program appeals and expedited appeals, provide Healthy Blue with necessary information to resolve the same and abide by the decisions of the applicable appeals, grievances and review committees. **Required Actions:** PTM recommends that Healthy Blue updates its documents per the deficiencies identified by PTM.		
ii. The information about the grievance and appeal system as described in the above section may be distributed to providers via the member flyer, a flyer designed for providers, or the grievance and appeal system policies and procedures. The information to out-of-network providers shall be distributed by the MCO within 10 calendar days of prior approval of a service or the date of receipt of a claim whichever is earlier (MHD contract 2.15.2 f).	Member Appeals-MO: pages-1, 2 Member Inquiries and Grievances-MO: pages 1, 2	Partially Met

Findings: Healthy Blue's policies, "Member Appeals-MO," and "Member Inquiries and Grievances-MO," comply with the requirement of this section. The information on grievance and appeal system is distributed annually through provider newsletters, the Healthy Blue's provider web site and the provider manual and may also be distributed to providers via the member flyer, a flyer designed for providers, or the grievance and appeal system policies and procedures. PTM noted that Healthy Blue's website for provider resources does not provide information on grievance and appeal system. The Quick Reference Guide posted on the website for providers also does not incorporate information. Healthy Blue has not submitted a member flyer or provider flyer (if designed) or any newsletter for review. **Required Actions:** PTM recommends that Healthy Blue make the grievance and appeals system information available to out-of-network providers on their website and upon the submission of an out-of-network claim.		
H. Recordkeeping requirements (42 CFR 438.416): i. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The MCO shall submit the log sheets for all inquiries, grievances, and appeals to the state agency monthly and upon request. If the MCO does not have a separate log for the MHD Managed Care members, the log shall distinguish the MHD Managed Care members from other MCO members (MHD contract 2.15.3).	Member Appeals-MO: page 7 Member Inquiries and Grievances-MO: page 6 Complaint Issue (Log-Jan 2022)	Partially Met
Findings: Healthy Blue logs and tracks all inquiries, grievances and appeals and accurately maintains in a manner accessible to the State and available to CMS upon request. Healthy Blue submits logs for grievances and appeals to the MHD. Healthy Blue submitted a complaint log Jan 2022 as a sample. PTM noted that Healthy Blue did not submit logs of closed and open cases of grievances and appeals for the review period. Thus, PTM could not determine compliance. **Required Actions:** Healthy Blue should submit a sample of the logs in the format requested by the MHD for the EQR so that compliance could be ascertained.		
ii. The record of each grievance or appeal must contain, at a minimum, all of the following information:	Member Appeals-MO: page 7	Fully Met

a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. Resolution at each level of the appeal or grievance, if applicable. d. Date of resolution at each level, if applicable. e. Name of the covered person for whom the appeal or grievance was filed.	Member Inquiries and Grievances-MO: page 6	
Findings: Healthy Blue's policies are compliant with the record keeping requirements of this section. **Required Actions:** None.		
iii. The MCO shall retain member grievance and appeal records for a period of no less than 10 years. (MHD contract 2.15.3f).	Member Appeals-MO: page 7 Member Inquiries and Grievances-MO: page 6 MHD Managed Care Provider Manual: page 62	Partially Met
Findings: Healthy Blue's policies are compliant with the record retention requirements of 10 years. Healthy Blue's provider manual requires member records to be retained for at least seven years after the last product, service, or supply has been provided to a member or an authorized agent unless those records are subject to review, audit or investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government. **Required Actions:** PTM recommends that Healthy Blue updates its provider manual to reflect the record retention duration to 10 years.		
I. Continuation of benefits while the MCO appeal and the State Fair Hearing are pending (42 CFR 438.420) (The continuation of	Member Appeals-MO: page 10	Fully Met

benefits while an appeal is pending does not apply to CHIP): i. Timely files means the enrollee files for continuation of benefits on or before the later of the following: a. Within 10 calendar days of the MCO sending the notice of adverse benefit determination. b. The intended effective date of the MCO's proposed adverse benefit determination.		
Findings: Healthy Blue's policy, "Member Appeals-MO," meets the requirements of this section. During the interview, Healthy Blue clarified that they do not distinguish between Medicaid and CHIP members and continuation of benefits are applicable to both the programs as no distinction is stated in the MHD contract. **Required Actions:** None.		
ii. Continuation of benefits (N/A CHIPS): The MCO must continue the enrollee's benefits if all of the following occur: a. The enrollee files the request for an appeal timely in accordance with §438.402(c)(1)(ii), i.e., who can file and (c)(2)(ii), i.e., within 60 calendar days of notice of adverse benefit determination. b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider.	Member Appeals-MO: page 11	Fully Met

d. The period covered by the original authorization has not expired. e. The enrollee timely files for continuation of benefits.		
Findings: Healthy Blue's policy, "Member Appeals-MO," meets the requirements of all the criteria in this section. However, the policy states that a member or provider seeking to have continuation of benefits while pending an appeal process must file timely. PTM noted that provider seeking for continuation of benefits is inaccurate and inconsistently presented in the policy. During the interview, Healthy Blue clarified that they do not differentiate between Medicaid and CHIP members regarding continuation of benefits. **Required Actions:** PTM recommends that Healthy Blue updates its policy, "Member Appeals-MO," stating that a provider cannot file for continuation of benefits on behalf of the member.		
iii. Duration of continued or reinstated benefits: If the MCO continues or reinstates the enrollee's benefits while the appeal or State Fair Hearing is pending, the benefits must be continued until one of following occurs: a. The enrollee withdraws the appeal or request for State Fair Hearing. b. The enrollee fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the MCO sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2). c. A State Fair Hearing office issues a hearing decision adverse to the enrollee.	Member Appeals-MO: page 11	Fully Met

Findings: Healthy Blue's policy, "Member Appeals-MO," meets the requirements related to duration of continued benefits. **Required Actions:** None.		
iv. If the final resolution of the appeal or State Fair Hearing is adverse to the enrollee, that is, upholds the MCO's adverse benefit determination, the MCO may recover the cost of services furnished to the enrollee while the appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section (42 CFR438.420).	Member Appeals-MO: page 11	Fully Met
Findings: Healthy Blue's policy, "Member Appeals-MO," complies with the requirement of this section. **Required Actions:** None.		
J. Effectuation of reversed appeal resolutions (42 CFR 438.424): i. Services not furnished while the appeal is pending: If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. ii. Services furnished while the appeal is pending. If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the	Member Appeals-MO: page 11	Fully Met

appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations. (Note: CHIP does not require a State to pay for disputed services furnished while an appeal is pending).		
Findings: Healthy Blue's policy, "Member Appeals-MO," complies with the requirement of this section. During the interview, Healthy Blue clarified that they do not differentiate between Medicaid and CHIP members regarding continuation of benefits. **Required Actions:** None.		

Compliance Score- Grievance and Appeal System						
Total	Met	=	22	×2	=	44
	Partial Met	=	12	×1	=	12
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	56
Denominator	Total Sections	=	34	×2	=	68
Score						**82.35%**