P.T.M.
Healthcare Business Solutions

2022 External Quality Review

Compliance

Home State Health

Measurement Period: Calendar Year 2021
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MoHealthNet

THE GREAT SEAL OF THE STATE OF MISSOURI

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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. Home State Health is one of the three MCOs operating in Missouri. The MHD works closely with Home State Health to monitor quality, enrollee satisfaction, and contract compliance. Quality is monitored through various ongoing methods, including MCO's Healthcare Effectiveness Data and Information Set (HEDIS®) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and an annual external quality review (EQR).

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.

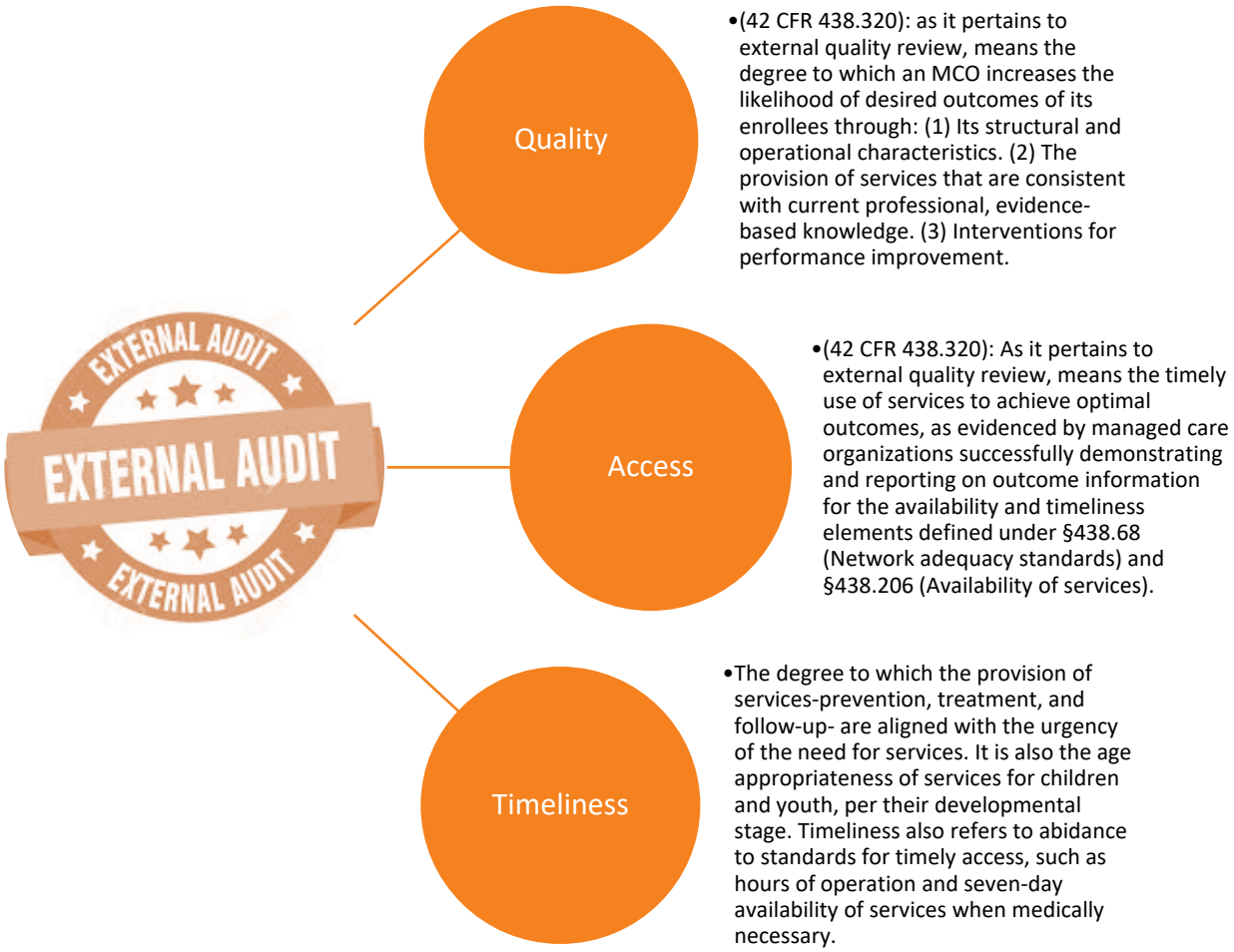

Figure 1. External Quality Review

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 Home State Health'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/Home State Health 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 Home State Health'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 Home State Health in advance of the preliminary review, setting the expectations for the documents' submissions. The preliminary review findings and requirements were submitted to Home State Health in writing before the site meeting.

Documents' Submissions: Home State Health uploaded its documents to the 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: MO.CONT.01 Network Adequacy; Welcome to Home State Health (Provider Orientation); MO.PRVR.04 Provider Appointment and Accessibility Standards; Provider Reference Manual; Measurement Results and Comparison to Performance Goal by Appointment Type-Medicaid; Appointment Access-Corrective Action Plan; After-Hours Access Survey; After-Hours Accessibility Corrective Action Plan; MO.CONT.02 Network Selection and Retention; Access Questions; MO.PRVR.04 Provider Appointment and Accessibility Standards; Member Handbook; MO.UM.01.01 Covered Benefits and Services;

MO.UM.01 Utilization Management Program; MO.UM.01 Utilization Management Program; Single Case Agreement; MO.QI.21 Cultural Competency Program; and MO.PRVR.19 Provider Directory updates.

Assurances of Adequate Capacity and Services: 2021 December Full Network Medicaid Providers; 2021 Network Access Plan Approval Letter; Participating Provider Agreement (Attachment A-Medicaid); MO.UM.23 Utilizing the Specialist as the PCP; 2021 Behavioral Health Providers; 2021 FQHCs and RHCs Providers; Out-of-Network Single Case Agreement; Out-of-Network Providers (website); 2021 Family Planning and STD Network Providers; 2021 Local Health Public Agencies; 2021 School-Based Dental Providers; 2021 Tertiary Care Network Providers; 2021 Specialty Pediatric Hospitals; 2021 Network Access Plan (Outline); Home State Health Plan-Network Access Plan Report; and System for Electronic Rate and Form Filing Submission.

Coordination and Continuity of Care: MO.ELIG.03 Primary Care Provider Selection and Change; Primary Care Provider Auto-Assignment; MO.MBRS.04 Distribution of New Member Materials; MO.MBRS.43 Member Services; New Member Outreach Report 2021; MO.CM.17 Transition of Care; MO.CM.16 Continuity and Coordination of Services; MO.QI.13 Medical Record Review; Privacy and Confidentiality Training; CC.COMP.PRVC.03 Authorization and Revocation of Protected Health Information; Hospital Care Transition Management; MO.CM.01 Case Management Program Description; and CP.CPC.05 Clinical Policy-Medical Necessity Criteria.

Coverage and Authorization of Services: MO.QI.20 HCY/EPSDT; MO.UM.05 Timeliness of UM Decisions and Notifications; MO.UM.02 Clinical Decision Criteria and Application; MO.UM.04 Medical Management; MO.UM.06 Clinical Information and Documentation; MO.UM.05 Timeliness of UM Decisions and Notifications; and MO.UM.04.01 Affirmative Statement About Incentives.

Provider Selection: CC.CRED.06 Ongoing Monitoring of Sanctions & Complaints; CC.CRED.01 Practitioner Credentialing and Recredentialing; Provider Directory (Central Region); 2021 Credentialing Turn-Around-Time Report; CC.CM.10 Advance Directives; Provider Compliance Audit Tool; Disclosure of Ownership and Control Interest Statement; Provider Exclusion Attestation; Credentialing Report 2021 (Denials and Terminations); CC. CRED.07 Practitioner Disciplinary Action and Reporting; OIG Monthly Exclusion Audit 2021; Preclusion Lists; 2021 Date Maintenance Turn-Around-Time Report; CC.PDM.03 Practitioner Affiliation Start Date; Credentialing TAT Data Dec 2021; 2021 Enrollment Turn-Around-Time Report; MO.HUMR.32 Anti-Harassment and Non-Discrimination; CC.HUMR.02 Equal Employment Opportunity & Affirmative Action; CC.HUMR.75 Disability Accommodations; Inclusive & Responsible Workplace-(Anti-Harassment & Non-

Discrimination); and MO HealthNet Managed Care Contract Administrative Requirements.

Confidentiality: Centene Business Ethics and Code of Conduct; Compliance-Privacy and Confidentiality Annual Learning; 2021 Privacy and Confidentiality Training-Authorization to Disclose; 2021 Privacy and Confidentiality Training-Confidential Information; CC.COMP.04 Confidentiality and Release of PHI; CC.COMP.PRVC.01 Privacy Program Description; CC.COMP.PRVC.11 Allowable Disclosures; MO.COMP.09 Compliance; Data Loss Prevention Program; CC.COMP.PRVC.02 Privacy Compliance Administrative Policy; CC.SECR.7.2A Information Security; CC.SECR.8.3A Information Security; CC.SECR.9.4A Information Security; Cryptography Standard- Cryptographic Controls; CC.SECR.13.2A Information Security; CC.SECR.18.1A Information Security; Business Associate Agreement; CC.COMP.PRVC.03 Authorization and Revocation of Protected Health Information; MO.COMP.28 Providing Member Medical Records to State Agency; MO.COMP.PRVC.60 Managing Substance Use Disorder Records; CC.COMP.PRVC.10 Individual Rights to Protected Health Information; CC.COMP.PRVC.04 Assurances from Business Associates to Safeguard PHI; CC.COMP.PRVC.11 Allowable Disclosures; CC.COMP.PRVC.09 Disclosing and Requesting only the Minimum Amount of PHI Necessary; MO.COMP.PRVC.17 Individual Rights to Protected Health Information–Granting Access to Inspect and Obtain a Copy; MO.COMP.PRVC.54 Managing Unauthorized Uses/Disclosures, Security Incidents, and Breaches; and MO.COMP.PRVC.04 MO HealthNet Business Associate Provision Requirements.

Grievance and Appeal System: MO.QI.11 Member Grievance and Appeals System Description; Home State Health-MO Grievance and Appeals Flyer; Acknowledgement of Grievance; Acknowledgement of Appeal; Notice of Home State Health Adverse Benefit Determination; MO.UM.07 Adverse Determination (Denial) Notices; Notice of Grievance Resolution; Notice of Appeal Resolution; Out-of-Network Provider Information; Member Appeals-Closed (Log-Jan 2021); and Member Grievance-Closed (Log-Jan 2021).

Site Interviews: PTM conducted a site meeting with Home State Health on May 2, 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.

Home State Health team included: Vice President, Compliance; Vice President, Quality and Process Improvement; Vice President, Operations; Senior Director, Operations; Senior Director, Utilization Management; Senior Director, Case Management; Senior Director, Provider Network; Senior Director, Provider Network Operations; Senior Manager, Credentialing and Provider Data Management; Senior Compliance Analyst; Director, Compliance; Senior Manager, Credentialing; Compliance Auditor; and Process

Improvement Specialist (Clinical).

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

Compliance Ratings

PTM analyzed the information provided by Home State Health and assigned a score for each regulation. Then an overall compliance score for all the regulations was also 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 Home State Health 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, Home State Health 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 in 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 Home State Health plans to implement to comply with the regulations, including how Home State Health measures the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. Home State Health must submit the CAP to the MHD within 10 calendar days of its initiation. When deemed sufficient, the MHD, in consultation with PTM, will approve Home State Health's CAP. Within 90 calendar days of CAP approval, Home State Health must submit its documentation to close the identified gaps. The results of the corrective actions taken by Home State Health 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 Home State Health achieving a compliance score of 90.9%. Table 5 summarizes 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	8	2	0	18	90	High
438.207 457.1230(b)	Assurances of adequate capacity and services	14	9	5	0	23	82.1	Moderate
438.208 457.1230(c)	Coordination and continuity of care	19	19	0	0	38	100	High
438.210 1230(d)	Coverage and authorization of services	19	17	2	0	36	94.7	High
438.214 457.1233(a)	Provider selection	14	12	2	0	26	92.9	High
438.224 457.1110	Confidentiality	22	20	1	1	41	93.2	High

438.228 457.1260	Grievance and appeal system	34	24	10	0	58	85.3	Moderate
Overall Result EQR 2022 (2-Year)		**132**				**240**	**90.9**	**High**
438.56 457.1212	Disenrollment: Requirements and limitations	18	16	2	0	34	94.4	High
438.100 457.1220	Enrollee rights	18	11	6	1	28	77.8	Moderate
438.114 457.1228	Emergency and post-stabilization services	12	12	0	0	24	100	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	06	0	0	12	100	High
438.242 457.1233(d)	Health information systems	16	14	2	0	30	93.8	High
Overall Result EQR 2021 (1-Year)		**82**				**150**	**91.5**	**High**

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

Home State Health'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. Home State Health complies with the geographic distribution (distance travel) standards and the appointment standards required by the MHD for all enrollees, including those with limited English proficiency or physical or mental disabilities. The services included in the contract are available 24 hours a day, seven days a week, when medically necessary. Home State Health analyzes its network adequacy monthly by running Geo Access Maps for all contracted network providers. During the interview, the staff was knowledgeable about the geographical access reporting system Home State Health utilized to track the provider member ratio and geographic distribution of providers and members.

b. Home State Health disseminates the appointment and after-hours standard requirements to its in-network providers and members via Home State Health's provider orientation presentation, provider reference manual, at least annually in the provider and member newsletters, member handbook, and ongoing provider education materials.

c. Home State Health monitors compliance with appointment and after-hours standards and will have a CAP when appointment and after-hours standards are not met. Calls from Home State Health's contracted vendor verify the contracted providers' appointment availability and confirm whether the provider's panel is open or closed. Phantom after-hours calls by the contracted vendor are made to monitor the provider has adequate 24/7 service availability.

d. Authorization for a second opinion is granted to a network provider (or an out-of-network provider if there is no in-network provider available) when there is a question concerning diagnosis, options for surgery, or other treatment of a health condition, or when requested by any representative of the member's health care team, the member, or a parent/guardian(s).

e. Home State Health provides for the availability of transfer protocols and arrangements with out-of-network providers for services that are not available from a qualified in-network practitioner.

f. The providers are encouraged to complete the U.S. Department of Health and Human Services Physician Practical Guide to Culturally Competent Care. During the interview, Home State Health described measures taken to help members with limited English proficiency and low literacy: care managers explain written materials to the members; educational videos are posted on the website; KRAM library is utilized for member education; call center staff is educated and trained using Empathy Tools; and member services connect directly with provider offices for translation services if needed.

g. The provider network operations, contracting and network development, and provider relations departments select and recruit the providers to the network by regularly monitoring and considering various factors, including whether the location provides physical access for members with disabilities. Home State Health will provide accommodation, if needed, to ensure all members have equal access to 24 hours per day health care coverage.

h. Female members may self-refer to an OB/GYN for routine women's health services regardless of whether the PCP (general practitioner, family practitioner, or internist) provides such women's health services, including routine gynecological exams.

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 policy, "Provider Appointment and Accessibility Standards," does not include behavioral health providers for all appointment-related standards.	Update policy, "Provider Appointment and Accessibility Standards," to include behavioral health providers for the appointment availability standards.
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 policies to include: • Strategies to recruit, retain, and promote diverse staff and leadership that are representative of the demographic characteristics of regions covered by the contract at all levels of the organization. • Provision of member materials in their preferred language, verbal offers and written notices when required, informing them of their right to receive language assistance services. • 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. • 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.

4.3 Regulation II- Assurances of Adequate Capacity and Services

A detailed evaluation is provided in Appendix B.

4.3.1 Strengths

a. Home State Health's provider network consists of hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, safety-net hospitals, and all other provider types necessary to ensure sufficient capacity, in accordance with the accessibility service standards consistent with State requirements.

b. The provider network includes a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults, including Community Mental Health Centers (CMHCs) and Community Behavioral Health Organizations (CCBHOs). Home State Health has contracted with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), Local Public Health Agencies, Tertiary Care centers (trauma centers, burn centers, stroke centers, high-risk nurseries, cardiac hospitals), pediatric hospitals, family planning, and sexually transmitted disease treatment providers and dentists providing school-based dental services.

c. Home State Health 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.)

d. The MHD is notified of any change in the provider network or Home State Health's operations that would affect the adequacy of capacity, services, benefits, and geographic service areas within 5 business days of identification of the issue.

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. A policy describing the responsibilities of a PCP as per the MHD contract, section 2.4.2(a) was not submitted.	Develop a policy to include the responsibilities of PCPs.
b. A policy for eligible providers serving as PCPs in institutions with teaching programs was unavailable during the review period. Home State Health revised	Submits the revised policy, "Utilizing the Specialist as the PCP," for the MHD's approval.

its policy, "Utilizing the Specialist as the PCP," after PTM identified the deficiency.	
c. The member handbook does not include information on freedom of choice for family planning services.	Update member handbook
d. The Single Case Agreement template for out-of-network providers has information on care coordination and billing procedures but does not include information on medical record management.	Update Single Case Agreement template for out-of-network providers.
e. A policy to include contracting and reimbursing dental providers for services in the school setting was not submitted. Policy, "Network Adequacy," was revised to incorporate the school-based dental services after PTM identified the deficiency.	Submit revised policy, "Network Adequacy," for the MHD's approval.
f. Home State Health did not address the requirement that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP). Home State Health informed PTM that there are no Indian Reservations in Missouri. However, Home State Health's Provider Reference Manual states that Home State Health's American Indian/Alaskan Natives have a right to receive care from Indian Health Care Providers (IHCP).	Address requirements related to American Indian/Alaskan Natives per the MHD contract 2.4.18.

4.4 Regulation III- Coordination and Continuity of Care

A detailed evaluation is provided in Appendix C.

4.4.1 Strengths

a. Due to Home State Health's processes of PCP auto-assignment, there are no barriers to members receiving access to care in or out of the Home State Health's provider network upon entry into Home State Health.

b. Home State Health begins Welcome Calls upon a member's enrollment and is completed within the first 90 days in accordance with state or federal contract. The outreach staff conducts a brief Health Risk Screening (HRS) to identify whether the member is pregnant, has a chronic condition, and has special health care needs.

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

d. Relevant enrollee information is transferred between the subcontractors in a timely manner before transitioning to the new subcontractor if Home State Health changes subcontractors.

e. Home State Health coordinates with out-of-network providers 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 who is not in Home State Health's network. Home State Health will 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.

f. Home State Health 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.

g. 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.

h. Home State Health does not require prior authorization during the transition of care for inpatient and residential treatment days is not required.

i. Home State Health's Integrated Care Team (ICT) will facilitate communication and coordination between the PCPs and specialists, including behavioral health providers, Federally Qualified Health Centers, and Rural Health Clinics, to ensure continuity of care and prevent duplication of services.

j. For all uses and disclosures of a member's protected health information (PHI), Home State Health will obtain a signed authorization from the member unless the use or disclosure is required or otherwise permitted without authorization, by 45 CFR Part 164 Subparts A and E (the Privacy Rule).

k. Home State Health includes Section 2703 designated health home treating physician, clinical practice, or advance practice nurse in their provider network for members in a Section 2703 designated health home if the provider meets Home State Health's minimum credentialing standards.

l. Home State Health has policies and procedures that 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. Home State Health coordinates the services to the enrollees between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

m. Home State Health provides services for enrollees with special health care needs. Members are identified for care management through several data sources, e.g., claims and encounter data, predictive modeling software, hospital discharge data, and State enrollments. An assessment for care management is completed within 30 days of enrollment for new members with a diagnosis that needs complex care management/care management. The care plan is developed in conjunction with the member, the member's authorized representative or guardian, authorized family members, the managing physician, and other members of the health care team. Behavioral health care coordination is incorporated into the care plan as needed. The care plan is created utilizing clinical practice guidelines (including the use of CyberAccess™ to monitor and improve medication adherence and prescribing practices consistent with practice guidelines).

n. Members may have a standing referral from a specialist if the member has a condition that requires ongoing care from a specialist. In cases where services cannot be reasonably obtained by a network provider, services can be rendered by an out-of-network provider if the services are medically necessary, a covered benefit, and authorized by Home State Health.

4.4.2 Weaknesses and Recommendations

No areas of concern were identified pertaining to criteria evaluated for this regulation. However, PTM identified a weakness in the submitted documents as stated in Table 8.

Table 8. Coordination and Continuity of Care

Weakness	EQRO Recommendation
The policy, "Medical Record Review," and the provider manual state that the practitioners must maintain all member records for at least seven years from the last professional service provided.	Update the medical record retention period to 10 years per 42 CFR 438.3u.

4.5 Regulation IV- Coverage and Authorization of Services

A detailed evaluation is provided in Appendix D.

4.5.1 Strengths

a. Home State Health provides 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. The services will be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same series furnished to beneficiaries under FFS Medicaid.

b. Home State Health's coverage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (called as Healthy Children and Youth-HCY program in Missouri) to all members under the age of 21 years in compliance with the terms of the MHD contract and the federal government to identify health and developmental problems. These services are sufficient in amount, duration, and scope to reasonably achieve their purpose and will only be limited by medical necessity.

c. Home State Health covers family planning services by any qualified provider whether or not the provider is in-network without referral/authorization. Home State Health allows full freedom of choice to provide these services.

d. Home State Health does not require 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.

e. Home State Health is in compliance with the Wellstone–Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), as applicable to the Medicaid MCOs. Home State Health will ensure that any benefit limitations for mental health or substance

use disorder (MH/SUD) benefits are comparable to those for medical/surgical benefits and will not impose less favorable benefit limitations on MH/SUD benefits compared to medical/surgical benefits, including annual and lifetime dollar limits, financial requirements, or treatment limitations.

f. Home State Health provides assistance to members in making necessary arrangements to fulfill prior authorization requirements. If such arrangements cannot be made timely, the requested services will be approved.

g. A decision to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and support needs. A Medical Director or qualified designee reviews all appeals and denials.

i. Home State Health ensures an 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.

j. Home State Health will not deny the physician's request for continuing coverage of an inpatient hospital stay unless an alternative service is recommended by Home State Health and scheduled within seven days of discharge that meets the medical needs of the member.

k. Home State Health complies 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. Home State Health notifies the requesting provider and gives the enrollee written notice of any decision by Home State Health to deny a service authorization request or authorize service in an amount, duration, or scope that is less than requested.

l. All individuals making Utilization Management (UM) decisions at Home State Health sign an 'Affirmative Statement about Incentives,' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that Home State Health does not offer financial incentives for UM decisions that result in underutilization.

m. During the interview, Home State Health reported about their emergency backup plan for its members in the event of a disaster. Simulation exercises are undertaken throughout the year per the business continuity disaster plan. Mass texting and emails are sent to the providers.

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. Documentation on the criterion that Home State Health will not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition, was not submitted.	Submit documentation to comply with the requirement.
b. "Clinical Policy-Medical Necessity Criteria" does not comply with the definition of Medical Necessity.	Update policy.
c. Home State Health shall not subsequently retract its authorization, revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of its receipt by a health care provider, 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).	The time limit of 45 days is stated in the policy, "Timeliness of UM Decisions and Notifications." However, there is no time limit set in the MHD contract. PTM recommends that Home State Health clarify the time limit of 45 days with the MHD.
d. Provider reference manual states that emergency room and post-stabilization services never require prior authorization, whereas Home State Health's policy, "Timeliness of UM Decisions and Notifications," states about determination within 60 minutes of receiving post-stabilization services. Furthermore, PTM noted that the response timeframe to the	Update the provider reference manual and the policy, "Timeliness of UM Decisions and Notifications," with a correct timeframe for authorization decisions on post-stabilization services.

post-stabilization service request in 60 minutes is also incorrect.	

4.6 Regulation V- Provider Selection

A detailed evaluation is provided in Appendix E.

4.6.1 Strengths

a. Credentialing and re-credentialing policies and procedures comply with the requirements of determining and assuring all in-network providers are licensed by the state where they practice and are qualified to perform their services. Home State Health has a policy and procedure to monitor practitioner sanctions, exclusions, complaints, and quality issues between re-credentialing cycles to maintain a network of participating practitioners who meet or exceed the standards for delivering high-quality, safe care to members. Home State Health utilizes Council for Affordable Quality Health Care (CAHQ) Universal Credentialing Data Source Form (UCDS) as the credentialing application for all practitioner credentialing in compliance with the MHD contract, section 2.18.8(c).

b. The average turnaround time for credentialing reported by Home State Health in CY 2021 is 19 calendar days (the timeframe set by the MHD is 60 business days).

c. Home State Health assesses the providers' medical record-keeping practices against the established standards. As part of re-credentialing, Home State Health reviews a sample of records from PCPs, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives. The elements scoring below 80% are considered deficient and need improvement.

d. Home State Health's Provider Agreement requires a provider to agree to furnish Home State Health a complete and accurate information necessary to permit Home State Health to comply with the collection of disclosures requirements specified in 42 CFR Part 455, Subpart B, or any other applicable state or federal requirements. Home State Health requires all its subcontractors to make disclosures to Home State Health of complete information regarding ownership, financial transactions, and persons convicted of criminal activity related to Medicaid: 1) upon execution of the subcontract; 2) within 35 calendar days of any change in ownership; and 3) at any time upon request by Home State Health and the State for any or all such information.

e. Home State Health notifies the MHD of any denial of provider credentialing or re-credentialing on time. It will report provider terminations as part of its quarterly fraud and

abuse report per the State provided forms.

f. Home State Health shall exclude providers from participation who have been identified as having a non-renewed license or certification registration, has a revoked professional license or certification, or have been terminated by the state agency. Home State Health will access information from the Professional Registration Boards Internet site to identify State initiated terminations. The List of Excluded Individuals/Entities (LEIE) will be queried through the Office of Inspector General's (OIG) website.

g. Data for the newly credentialed hospitals and facilities attached to a new or existing contract is loaded in the claims adjudication and payment system at the same time when credentialing is completed. The practitioner's par affiliation start date is the date on which the practitioner is eligible to submit a claim and receive contracted rates. It is not dependent upon the completion of credentialing.

h. Home State Health is committed to providing equal employment opportunities for all applicants and employees in all employment decisions. Provider and contracted providers recognize that, as a governmental contractor, company or payor may be subject to various federal laws, executive orders, and regulations regarding equal opportunity and affirmative action, which also may apply to subcontractors. Provider and each contracted provider agree to comply with such requirements described in the Participating Provider Agreement.

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. The list of providers in the policy, "Practitioner Credentialing and Recredentialing," does not include provisionally licensed psychologists and provisionally licensed professional counselors.	PTM recommends that Home State Health updates its documentation and ensures its credentialing process includes provisionally licensed psychologists and professional counselors in the provider network.
b. Documentation about minority inclusion and dissemination of information to its subcontractors was not submitted. The participating provider agreement does not specify the requirement.	Submit documentation about minority inclusion and dissemination of information to its subcontractors.

4.7 Regulation VI- Confidentiality

A detailed evaluation is provided in Appendix F.

4.7.1 Strengths

a. Employees are prohibited from any unauthorized access to, use, or disclosure of patient or health care provider information, Home State Health's proprietary information, including but not limited to medical records, claims, benefits, or other administrative data that is personally identifiable, in addition to quality improvement programs, reports, and disease management information. No member information shall be released to the public without the prior written consent of the MHD.

b. All employees, contractors, and designated contingent workers who are granted Home State Health information system and network access credentials must complete security training in accordance with established organization security training requirements. The users must complete training requirements within 30 days of receiving information system and network access credentials and at least annually. Health Insurance Portability and Accountability Act (HIPAA) privacy program sets the standards for employees in safeguarding confidential and protected health information (PHI) in any format: electronic, paper, or verbal.

c. Home State Health may not use or disclose members' identifiable Part 2 records to any third party, including the member's PCP or family members, unless Home State Health has received a Part 2 compliant Authorization to Use and Disclose Health Information form from the member, or their legal guardian or representative.

d. Home State Health may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR 164.502(j)(1) (Disclosures by whistleblowers and workforce member crime victims). It shall notify the state agency no later than 10 calendar days after Home State Health becomes aware of the disclosure of the PHI.

e. Use and Disclosure of PHI are permitted without authorization only for treatment, payment, and day-to-day Healthcare operations. Home State Health may disclose PHI without member authorization in compliance with and as limited by the relevant requirements of a court order, court-ordered warrant, subpoena, or summons issued by a judicial officer or a grand jury subpoena.

f. MCO may use PHI to provide data aggregation services to the MHD. Home State Health may not use PHI to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the MHD to do so.

g. When using or disclosing PHI or requesting PHI from a third party, Home State Health employees shall make reasonable efforts to limit the PHI used, disclosed, or requested to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

h. Home State Health will execute a Business Associate Agreement (BAA) that complies with 45 CFR 164.504(e) with any entity that creates, receives, maintains, or transmits PHI on behalf of Home State Health. The business associate contracted with Home State Health must agree to the same restrictions and conditions that apply to Home State Health for such information.

i. The business associate will make its internal practices, books, and records available to the Covered Entity, the Secretary, or the state agency and complete any written attestation within 10 calendar days of a written request.

j. Home State Health 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. Home State Health and its subcontractors will report any incident (security incident, unauthorized use or disclosure of PHI not permitted or required, breach of PHI, or loss, destruction, alteration, or other events in which PHI cannot be accounted for) within five days of discovering the incident.

l. The Privacy Officer will maintain HIPPA required documentation, in written or electronic form, of policies, procedures, communications, and other administrative documents for additional years than required by 45 CFR 164.530 (i) and (j), for a period of at least 10 years from the date of creation or the date when last in effect, whichever is later.

m. Prior to any use or disclosure of PHI for marketing, Home State Health will obtain authorization from the member. If the marketing involves financial remuneration to Home State Health from a third party, the authorization must state that such remuneration is involved.

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. 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, were not submitted.	Submit documentation.
b. Documentation to show that Home State Health 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 available during the review period. A new policy, "MO HealthNet Business Associate Provision Requirements," was developed after the preliminary review.	Submit the new policy, "HealthNet Business Associate Provision Requirements," for the MHD's approval.

4.8 Regulation VII- Grievance and Appeal System

A detailed evaluation is provided in Appendix G.

4.8.1 Strengths

a. Home State Health maintains procedures for the receipt and prompts internal resolution of all grievances, appeals, and State Fair Hearing processes that comply with all applicable state and federal requirements and accreditation standards. Home State Health refers all members who are dissatisfied with Home State Health or its subcontractors in any respect to contact the Member Services Department and, when applicable, the expression of dissatisfaction is forwarded to Home State Health's grievance and appeals coordinator (GAC) to review.

b. Oral inquiries seeking to appeal an adverse determination are treated as appeals (to establish the earliest possible filing date for the appeal).

c. Home State Health has policies and procedures to comply with the timeframe of filing a grievance (any time), an appeal (within 60 calendar days of adverse benefit

determination notice), and State Fair Hearing (within 120 calendar days of notice of resolution of an appeal), timings of notice of adverse benefit determination, acknowledgment of receipt of each grievance and appeal in writing (within 10 business days after receiving a grievance or appeal) and timely filing (within 10 calendar days of notification) for the continuation of benefits when an appeal or State Fair Hearing is pending.

d. Enrollees are provided any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. The assistance includes, but is not limited to, auxiliary aids and services upon requests, such as providing interpreter services and toll-free numbers with adequate TTY/TTD and interpreter capability.

e. The member and 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 Home State Health in connection with the appeal of the adverse benefit determination.

f. Home State Health complies with the timeframe for resolution of grievance (30 calendar days), appeal (30 calendar days), expedited resolution for appeal (72 hours), and an extension of the timeframe for appeals (not more than 14 calendar days), and notice to the affected parties. Home State Health does not take punitive or retaliatory actions against a member or provider supporting a member for filing an expedited appeal.

g. Home State Health is knowledgeable of its role after the final resolution of appeal or State Fair Hearing. If the decision is against the enrollee, Home State Health may recover the cost of services furnished to the enrollee for the period appeal, or State Fair Hearing was pending. Home State Health 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.

h. During the interview, Home State Health reported that the grievances filed in CY 2021 were < 1% per 1000 members and appeals were 0.03 per 1000 members, which was within their target. All appeals were resolved within the timeframe.

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. The policy, "Adverse Determination (Denial) Notices," provider manual, and the member handbook does not accurately define adverse benefit determination.	Update definition of adverse benefit determination in all documents.
b. The policy, "Member Grievance and Appeals System Description," states that appeal rights may not be applicable for some grievances (e.g., member grievances about Emergency Room wait times, staff conduct, or physician conduct, where there is no adverse decision to appeal). PTM remarked that there is no appeal process for grievances per the CFR/MHD contract.	Update policy.
c. The member flyer explaining the grievance and appeal process has incomplete information: State Fair Hearing in case of deemed exhaustion of appeal process is missing, and the date of approval by the MHD on the flyer is not indicated.	Update flyer
d. An exception that a provider cannot file for a continuation of benefit is not stated in the policy "Member Grievance and Appeals System Description."	Update the policy.
e. The policy, "Member Grievance and Appeals System Description," states that a member, member's authorized representative or a provider with the member's written consent may request a State Fair Hearing after Home State Health's internal grievance or the appeal process has been exhausted. PTM noted that a Home State Health has erroneously provided an option of State Fair Hearing for a grievance.	Update policy.
f. Provider manual does not mention: • A provider can file an appeal on behalf of the member with their written consent.	Update provider manual.

• Home State Health's assistance to providers in case of filing an appeal and State Fair Hearing on behalf of members. The provider manual inaccurately mentions: • Appeals must be requested orally or in writing by the member or the member's representative within 120 days of the Home State Health's notice of resolution of the appeal unless an acceptable reason for delay exists. (Home State Health has erroneously stated "appeals" instead of "State Fair Hearing.") • The term "notice of action" is used instead of "notice of adverse benefit determination." • A copy of verbal complaint logs and disposition or written grievances records shall be retained for seven years. (PTM remarked that the record retention duration should be 10 years).	
g. The policy, "Member Grievance and Appeals System Description," states that if Home State Health fails to adhere to the notice and timing requirements under section 2.12.16 c(22) of the MHD contract, the member is deemed to have exhausted Home State Health's internal level of appeal and may initiate a State Fair Hearing. PTM advised that the MHD contract, section 2.12.16c(22), does not mention the timeframe requirements for an appeal.	Update policy.
h. The member handbook does not mention filing of State Fair Hearing when the Home State Health does not meet the timeframe for an appeal resolution. This information is not provided in the Acknowledgement of Appeal.	Update member handbook and letter used for acknowledgment for an appeal.

i. An oral appeal must be followed by a written request in the member handbook, and the provider reference manual is incorrect.	Update member handbook and provider manual to reflect the correct procedure for filing an appeal.
j. The Notice of Adverse Benefit Determination has information on scheduling a peer-to-peer call allowing the treating practitioners to discuss any medical or behavioral health UM decisions with the Medical Director of Home State Health within two business days of this notification. PTM noted that the peer-to-peer call is not in compliance with the 42 CFR 438.404, where there is a provision for filing an appeal after an adverse benefit notification is sent to a member instead of initiating a discussion between the treating provider and Home State Health after the notice. PTM advised that a peer-to-peer discussion should be held before the notice is mailed to the member/provider and must not be included in the notice of adverse benefit determination.	Update the procedure in Notice of Adverse Benefit Determination consistent with the information in two policies, "Member Grievance and Appeals System Description, and "Adverse Determination (Denial) Notices."
k. If additional clinical information is received with an appeal request and meets the criteria for coverage, the practitioner who made the initial adverse determination may review the case and overturn the previous decision. PTM remarked that Home State Health allows the same professional who made the initial adverse determination to review the additional documents if any, after an appeal is filed. This does not comply with the CFR 438.406(b): those who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual should decide on an appeal or grievance.	Update documentation and procedure on who should make decisions after an appeal is filed.

l. The policy, "Member Grievance and Appeals System Description," incorrectly mentions the provision of an appeal after a notice of resolution to appeal is provided to a member (one level appeal only).	Update policy.
m. The following inaccuracies were noted in the document "Out-of-Network Provider Information:" • "Adverse action" is used instead of "adverse benefit determination." • Appeal: The review may be requested in writing or orally. However, oral requests must be followed up in writing unless an expedited resolution is requested.	Update document.

5.0 CONCLUSION

Table 13 presents the key findings from the evaluation of Quality, Timeliness, and Access to Healthcare services provided by Home State Health 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	No concerns	No
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	No concerns	No
438.230/457.1233(b) Subcontractual relationships and delegation	Concerns identified	Yes
438.236/457.1233(c) Practice guidelines	No concerns	No
438.242/457.1233(d) Health information systems	Concerns identified	Yes

5.1 Improvement by Home State Health

Home State Health's overall score for compliance with Medicaid and CHIP managed care regulations in EQR 2022 is 90.9%, compared to 91.5% achieved in EQR 2021. Home State Health is placed on a CAP for 6 of 7 regulations in the EQR 2022. During the previous EQR 2021, 4 of 6 regulations were included in the CAP.

5.2 Response to Previous Year's Recommendations

Table 14 shows the degree to which Home State Health 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	=	16	×2	=	32
	Medium	=	4	×1	=	4
	Low	=	3	×0	=	0
Numerator	Score Obtained					36
Denominator	Total Sections	=	23	×2	=	46
Overall Score= Medium						**78.2%**

Table 15. Home State Health's Response to Previous Recommendations

Recommendations	Action by Home State Health	Degree of Response
EQR 2021		
1. Disenrollment: Requirements and Limitations		
a. Home State Health updates its policy, MO.ELIG.02 Disenrollment, and implement the member's right to request disenrollment if Home State Health does not cover services the member seeks because of moral or religious objections.	Town Hall Meeting (Sept 14, 2021) MO.ELIG.02 Disenrollment: page 2	**High** Home State Health educated its employee's on the requirement not to deny services regarding any moral or religious objections during the Home State Health Town Hall meeting on Sept 14, 2021. The policy was also updated.
b. Home State Health should specify in their policy, MO.ELIG.01 Eligibility Guidelines that Fee-For-Service members will remain in Fee-For-Service until an appropriate acute inpatient hospital discharge.	Town Hall Meeting (Sept 14, 2021) MO.ELIG.01 Eligibility Guidelines: page 3	**Medium** Home State Health educated its employees regarding the requirements related to hospitalization at the time of enrollment during the Home State Health Town Hall meeting on Sept 14, 2021. However, the updated in the policy, "Eligibility Guidelines," does not comply with the requirement.
2. Enrollee Rights		
a. During the interview, Home State Health reported that they do not monitor whether their providers explain various treatment options to the members. EQRO suggested that Home State Health educate their providers on explaining the provision in the CFR about providing treatment options to their members. Additionally, Home State Health can conduct member surveys internally to seek information from the members regarding various treatment options offered by the treating doctor.	CAHPS Survey Report 2021 (Medicaid Child): pages-10, 13	**High** The score on question 20 in CAHPS-Doctor informed about care was 93.2% (93rd percentile), and question 12-Doctor explained things was 96.2% (66th percentile) as estimated by the Home State Health's vendor.

b. Home State Health must have a policy based on 42 CFR 438.10 for disseminating member information. There is no requirement for taglines to be in font size 18, per CFR, effective Dec 14, 2020. Home State Health should update its policy to reflect this change after discussing with the MHD for amending their contract.	Town Hall Meeting (Sept 14, 2021) MO.MBRS.06 Member Handbook and ID Cards: page 5 Member Handbook: page 48 The information on Auxiliary aids and services will be made available upon request at no cost. Home State Health educated its employees regarding the requirements related to requests for materials in an alternative format during the Home State Health Town Hall meeting on Sept 14, 2021.	**Medium** Home State Health has not submitted its policy, "Marketing Member-Facing Material Submission to the MHD," to show if the requirement on the font size 18 is updated. PTM recommends that the taglines do not need to be font 18 in the member materials per the CFR.
c. Home State Health update their policy, MO.MBRS.06 Member Handbook and ID Cards based on the MHD contract section 2.12.16.	MO.MBRS.06 Member Handbook and ID Cards: page 4	**High**
d. Home State Health should have a policy/procedure of notifying their enrollees of any significant change in the member handbook at least 30 calendar days before the intended effective date of the change. Supporting evidence (mail letters, newsletters) should be submitted.	MO.MBRS.06 Member Handbook and ID Cards: page 5 Home State Health reported no significant updates or changes to the member handbook during the year 2021.	**High** PTM visited the Home State Health website and found the information about AEG and the member handbook 2022 (page 15). PTM noted that the staff was unaware of a significant change to the member handbook. PTM recommends that the staff be updated when significant changes are made and know the regulations and how to address the requirements.

e. Home State Health updates its member handbook to meet all the 48 items listed in the MHD contract, section 2.12.16, even though the MHD provides a template.	Member Handbook 2022: page 48	**Low** Home State Health informed PTM about their changes to the member handbook-July 2021 version. However, PTM downloaded the most recent 2022 version on their website and noted the findings (see notes below).

Findings: Out of 48 criteria required in the member handbook, per the MHD contract 2.12.16, seven were "Partially Met," and one was "Not Met" during EQR 2021. PTM re-reviewed the revised member handbook 2022 available at Home State Health's website and found that only one of seven "Partially Met" criteria were addressed. Thus, six criteria remain "Partially Met," and one remains "Not Met." (Alphabets used below refer to the criteria from EQR 2021 Compliance Report). The "Partially Met" criteria are as follows:

i. The information on where and how members may access benefits not available under the comprehensive benefits package, is not presented in the member handbook for all the services.

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

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

v. The timeframe for filing a grievance is not written.

a.18. The MHD provides the language for Advance Directives as a template. Home State did not include a statement of "any limitation regarding the implementation of advance directives as a matter of conscience" as required in the MHD contract. During the interview, Home State Health informed EQRO that they impose no limitations.

a19. A description of the additional information available upon request and information on Home State Health structure is missing.

a.22. Home State Health must inform members how they can obtain information from the state agency about accessing the services MCO does not cover because of moral or religious objections not mentioned in the member handbook.

There is one criterion (q), which is scored as "Not Met" in the member handbook: How a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, may request access to a specialty care center and how such access may be obtained.

f. Home State Health updates its policy, "MO.PRVR.19 Provider Directory	MO.PRVR.19 Provider Directory Updates: page 1	**High**

Updates," to include all the requirements about their network providers. The provider directory (PDF version) submitted to Primaris (PTM) should be updated to consistently reflect all the criteria for every provider and hospital in the network per the 42 CFR 438.10h and the MHD contract, section 2.12.17. Home State Health should educate its providers about the contractual requirement for submitting their information to Home State Health.	Provider Directory-Central MO (PDF-10/19/21)	Information on panel, linguistic capabilities, availability of sign language services, and URLs (as applicable) are not available for all hospitals and physicians in the PDF version. Icons/abbreviations used for physicians are not explained (e.g., B, CT) in the provider directory (PDF). However, all the required elements are addressed on the website search tool for the providers. PTM recommends that Home State Health continues its efforts to capture all the information required per the MHD contract/CFR for all its network providers.
g. Home State Health uploads its provider directory on its website in a machine-readable format (computer/mobile readable). Thus, the members will have access to them once downloaded on their computer or mobile, even without internet accessibility/availability.	https://www.homestatehealth.com/find-a-doctor/find-a-provider-guide.html Email communication	**High** PTM noted sufficient evidence in support of compliance with this section.
3. Emergency and Post-stabilization Services		
Home State Health must update their Participating Provider Agreement for Medicaid with medical records retention to 10 years from the last date of the contract period or from the date of completion of any audit, whichever is later (ref. 42 CFR 438.230).	Business Associate Agreement (Revised Template 2021-04.1): page 6 Participating Provider Agreement (Revised Sample): page 23	**High**

	The documents are updated with accurate information.	
4. Subcontractual Relationships and Delegation		
a. Home State Health explicitly includes language regarding "legal and financial aspects" of their responsibility/accountability in their policy. Also, Home State Health must incorporate it in the subcontract with TurningPoint Healthcare Solutions and all other subcontracted vendors.	Amendment 1 to Addendum 8 (Turning Point)	**High** The subcontractor (Turning Point) agreement is updated. PTM recommends that Home State Health uses the revised template (as applicable) for all the other subcontractors.
b. Home State Health has a policy/procedure regarding establishing new subcontracting arrangements or changing subcontractors. The MHD's approval is required before any subcontract is effective.	MO.COMP.21 Oversight of Delegated Vendors: page 1	**High**
c. Home State Health update their policy, MO.COMP.21 Oversight of Delegated Vendor, to require its providers to maintain the records for a minimum of 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.	MO.COMP.21 Oversight of Delegated Vendors: page 2	**High**
5. Practice Guidelines		
a. Home State Health must update the immunization schedule posted on their website with the most current version.	https://www.homestatehealth.com/members/medicaid/health-management/get-vaccinated.html	**High**
b. Home State Health follows its policy regarding informing its members about the practice guidelines. The information about practice guidelines and the members' right to request these may be disseminated via member handbook, newsletters, mailers, and website. Currently, the care managers at Home State Health inform the members	Home State Health did not submit any documentation.	**Medium** PTM visited Home State Health's website and found Krames Online patient education resource, which is an extensive library of evidence-based, peer-reviewed information written specifically for

enrolled in the care management program about the availability of these guidelines.		patients and covers diseases and conditions, diagnoses and treatments, surgeries and procedures, and wellness and safety for people of all ages and walks of life. However, PTM recommends that Home State Health post information about the availability of clinical practice guidelines to its members on its website, member handbook, or any other feasible method.
6. Health Information Systems		
a. Home State Health must address signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. Also, EQRO suggested that Home State Health align its claims processing deadlines per RSMo 376.383.	Provider Manual 2022: pages-58, 69, 84 Provider Manual 2022 is updated to align claims processing deadlines. Code for rejecting a claim if a signature is not present is documented, and signature requirements are addressed.	**High**
b. Submit information on the "allowed amount" in the encounter data submitted to the MHD and Primaris for evaluation.	Home State Health informed PTM that the MHD's Encounter data process does not yet accept the "allowed amount field." As a result, this item is not resolved.	**Medium** PTM recommends that the MHD updates its Encounter Data process so that MCO can comply with the CFR requirement.
c. Home State Health must implement an Application Programming Interface (API) as specified in 42 CFR 438.242, in reference to 42 CFR 431.60 and 431.70. EQRO will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.	My Health Application Centene (Home State Health's parent company) implemented Interoperability capabilities, including supporting API interfaces	**High**

	for member claims, provider data, and more.	
EQR 2020		
3. Home State Health should present analysis, evaluation, trends, and recommendations for the future year regarding information related to cultural competence and requests to change practitioners. QAPI 2020 did not include the trends related to cultural competence and change requests for PCPs.	Home State Health submitted the most recent QAPI 2022 (evaluation period-CY 2021) for reviewing the ERQO recommendations. QAPI 2022: pages-102 to 104	**High**
4. Home State Health is required to provide analysis and evaluation of a summary of services provided to members with visual or hearing impairments or who are physically disabled (e.g., Braille, large print, cassette, sign interpreters); an inventory of member materials available in alternative formats. QAPI 2020 did not include data for trends and analysis and a future action plan for improvement.	QAPI 2022: pages-104 to 108	**High**
5. Trends, analysis, and evaluation of information systems in relation to membership and providers must be provided in QAPI.	QAPI 2022: page 142 Process and procedures to meet member and provider needs are described.	**Low** Data analysis about membership and providers is not presented in the QAPI. The same recommendation applies.
6. Home State Health should evaluate and analyze integrated physical and behavioral health CM data.	QAPI 2022: pages-82, 83 Reduction in member cost pre-care coordination, and post-intervention is reported. Description of Pregnancy/Substance Use Disorder (SUD) Program is provided as in QAPI 2020 previously.	**Low** No trends or analyses for the integrated CM services for Behavioral and physical health are presented. The same recommendation applies.

7. Home State Health has not provided analysis and evaluation of Average Length of Stay (ALOS); Readmissions/1000 members; Emergency Department Utilization (EDU)/1000 members; Outpatient Visits (OPV)/1000 members; Inter-Rater Reliability; Timeliness of Prior Authorization/Certification Decision Making.	QAPI 2022: Pages-116, 117, 119 to 131 The readmission rate is not presented per 1000 members.	**High** PTM recommends that Readmissions data be presented per 1000 members (not in %)as required in the MHD contract.

6.0 RECOMMENDATIONS

6.1 Home State Health

PTM recommends that Home State Health submits its CAP and include all the weaknesses listed for regulations in sections 4.2 to 4.8. Home State Health must also address "Low" and "Medium" response items from section 5.2 on the previous year's recommendations (Table 15). Home State Health 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 Home State Health 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 Home State Health on ways to increase the significance of the EQR.

3. Include PTM in quality-related meetings with Home State Health and EQR as a standing agenda item.

4. The MHD should recommend to Home State Health 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 Home State Health on conducting member surveys, provider surveys in addition to Consumer Assessment of Healthcare Providers and Systems (CAHPS).

5. Identify ways PTM can assist Home State Health 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 Home State Health 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).	MO.CONT.01 Network Adequacy: page 2	Fully Met
Findings: Home State Health's policy, "Contracting and Network Development," complies with the requirement of this section. **Required Actions:** None.		
B. Appointment standards (MHD contract 2.5.3): 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	Welcome to Home State Health (Provider Orientation Presentation-PDF): pages-54 to 56 MO.PRVR.04 Provider Appointment and Accessibility Standards: pages-1, 2 Provider Reference Manual: page 18	Fully Met

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: a. Home State Health's policy, "Provider Appointment and Accessibility Standards," states that Home State Health will ensure that waiting times for appointments do not exceed one hour from the schedule appointment. PTM noted that Home State Health's policy, "MO.PRVR.04 Provider Appointment and Accessibility Standards," does not address criteria b, c, and d for behavioral health conditions, whereas criterion e is addressed only for behavioral health/Substance Abuse conditions. Home State Health clarified that the criteria b, c, d apply to the behavioral health providers as well. The provider manual incorporates all the appointment availability requirements for physical and behavioral health providers.		

Required Actions: PTM recommends that Home State Health updates its policy "Provider Appointment and Accessibility Standards," to include behavioral health providers for all appointment availability requirements.		
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.	Measurement Results and Comparison to Performance Goal by Appointment Type-Medicaid (PCPs, OB/GYN, Specialists, Behavioral Health (BH) providers, After-hours Access): Tables-1, 3, 6, 9, 12 Appointment Access-Corrective Action Plan (CAP)(Templates for BH providers, OB/GYN, PCPs, Specialists) After-Hours Access Survey (Template) After-Hours Accessibility CAP (Template) MO.CONT.02 Network Selection and Retention: page 3 Access Questions: pages-1 to 5 MO.PRVR.04 Provider Appointment and Accessibility Standards: page 3 Welcome to Home State Health (Provider Orientation Presentation-PDF): pages-54 to 56 Member Handbook: pages-35, 36 Provider Reference Manual 2021: page 18	 Fully Met

Findings: a, b. Home State Health disseminates the appointment and after-hours standard requirements to its in-network providers and to its members. Home State Health's appointment and after-hours standards are included in Home State Health's provider orientation presentation, provider manual, at least annually in the provider and member newsletters, member handbook, and in ongoing provider education materials.

c. Home State Health assesses its appointment and after-hours standards and ensures that these service standards are being met by conducting one or more of the following:

- Calls from Home State Health's contracted vendor to verify contracted providers' appointment availability and confirm whether the provider's panel is open or closed.
- Phantom after-hours calls from Home State Health's contracted vendor to monitor that the provider has adequate 24/7 service availability.

Home State Health monitors compliance with appointment and after-hours standards and has a corrective action plan when appointment and after-hours standards are not met. The results of the surveys and the calls described above are tracked by the provider relations department and used to identify providers who may need education and/or CAP to bring them into compliance with Home State Health's appointment and after-hours standards. The results of the surveys and the calls are presented to Home State Health's quality management team and shared with the regulatory bodies both internal and external to Home State Health such as the State of Missouri and Home State Health's Quality Improvement Committee.

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.	MO.CONT.01 Network Adequacy: pages-1, 4 MO.CONT.02 Network Selection and Retention: page 2	Fully Met

Findings: Home State Health will establish, maintain and monitor a network of affiliated providers sufficient to provide adequate access to all covered services taking into consideration: the anticipated number of members for Home State Health, the expected utilization of services, the number and types of providers necessary to furnish the covered services, the number of affiliated providers with closed panels; and the geographic location of the affiliated providers and Home State Health members. Through its contracted provider network, Home State Health will ensure that all Home State Health covered members receive equitable and effective treatment in a culturally and linguistically appropriate manner. Home State Health will facilitate linking of its members with practitioners who can meet members' cultural, ethnic, racial and

linguistic needs and preferences. Home State Health shall analyze its network adequacy monthly by running Geo Access Maps for all contracted network providers. **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 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).	MO.UM.01.01 Covered Benefits and Services: page 3 MO.UM.01 Utilization Management Program: page 13	Fully Met
Findings: Authorization for a second opinion is granted to a network provider (or an out-of-network provider if there is no in-network provider available) when there is a question concerning diagnosis, options for surgery, or other treatment of a health condition, or when requested by any representative of the member's health care team, the member, or a parent and/or guardian(s). Certain elective surgical procedures require a second medical opinion be provided prior to the surgery. Second opinions, from an in-network or an out-of-network provider, are provided at no cost to the members. A third surgical opinion will be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operations, and if the member desires the third opinion. Second opinions are subject to the referral requirements. PCPs can refer a member to a specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, paper referrals are not required. To better coordinate a members' healthcare, Home State Health encourages specialists to communicate with PCP the consultation outcome and treatment plan. A social worker exercising a custodial responsibility may also request a second 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	MO.CONT.01 Network Adequacy: page 2	Fully Met

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 the services were furnished within the network.	MO.UM.01.01 Covered Benefits and Services: pages-1, 3 MO.UM.01 Utilization Management Program: pages-13, 14 Single Case Agreement (Template)	
Findings: If a member requires services that are not available from a qualified network practitioner, the decision to authorize use of an out-of-network practitioner will be based on continuity of care, availability and location of an in-network practitioner of the same specialty and expertise, and complexity of the case. Home State Health has transfer protocols and will make appropriate arrangements with out-of-network providers. When it is necessary to utilize out-of-network providers to provide reasonable and necessary care, staff will educate out-of-network providers at the time of interaction on how to access information on covered services, member eligibility verification, prior authorizations, claims submission, and other general questions about Home State Health's program. Home State Health will coordinate payment with the out-of-network provider and ensure the cost to the member is not greater than it would be if the services were furnished by an in-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, seven days a week, when medically necessary. c. Establish mechanisms to ensure compliance by network providers. d. Monitor network providers regularly to determine compliance.	Welcome to Home State Health (Provider Orientation Presentation-PDF): page 56 Measurement Results and Comparison to Performance Goal by Appointment Type-Medicaid (PCPs, OB/GYN, Specialists, BH providers, After-hours Access): Tables-1, 3, 6, 9, 12 Appointment Access-Corrective Action Plan (CAP)(Templates for BH providers, OB/GYN, PCPs, Specialists)	Partially Met

e. Take corrective action if there is a failure to comply by a network provider.	After-Hours Access Survey (Template) After-Hours Accessibility CAP (Template) Provider Reference Manual: page 15	
Findings: a. PTM noted that Home State Health has not addressed this criterion in its policy. However, during the interview, Home State Health stated that workhours requirements are given to the providers at the time of contracting, education of providers at the time of orientation, and included in the provider manual. Home State Health stated that the providers are not audited for ensuring work hours related discrimination to its Medicaid enrollees; however, member satisfaction survey is conducted and analyzed for any issues. PTM confirmed the information is provided in the provider manual. b. Home State Health's PCPs, behavioral health providers, and Specialty providers are required to maintain sufficient access to covered physician services and will ensure that such services are accessible to members as needed 24 hours a day, seven days a week. c. Home State Health monitors provider compliance through after-hours calls. Primary Care Providers and Specialists must adhere to the following response time for telephone call back waiting times: • After-hours telephone care for non-emergent, symptomatic issues within 30 minutes. • Same day for non-symptomatic concerns. d, e. Home State Health has submitted sample results of their surveys conducted to monitor network providers for compliance on appointment availability, after-hours access, CAP and thus meet the requirements of these sections. **Required Actions:** PTM recommends Home State Health addresses criteria "a" in its policy and has a procedure to ensure no discrimination related to the work hours 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.		
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.	MO.CONT.02 Network Selection and Retention: page 2 MO.QI.11 Member Grievance and Appeals System Description: pages-5, 6	Partially Met

The MCO shall exhibit congruent behaviors, attitudes, and policies that come together in a system that enables 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	MO.QI.21 Cultural Competency Program: page 3 Welcome to Home State Health (Provider Orientation Presentation-PDF): page 49 Provider Reference Manual: page 22 Member Handbook: pages-3 to 6	

accountability/oversight mechanisms to 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: i. Home State Health will ensure in-network providers do not intentionally segregate members in any way from other patients receiving care in the provider's office. In addition, Home State Health will ensure in-network providers provide care without regard to the member's race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status or physical or mental disability. Home State Health believes its members are entitled to dignified, appropriate, and quality care and expects this of its providers and their staff serving Home State Health members. Providers are encouraged to complete the U.S. Department of Health and Human Services Physician Practical Guide to Culturally Competent Care. iii. Home State Health staff and subcontractors will be educated about the regulations during their regular training related to the Cultural Competency Plan. Refresher training will also be offered periodically. Network providers must ensure that office staff who routinely interact with members have access to and participate in cultural competency training and development. x. Home State Health gives members any reasonable assistance in completing forms and taking other procedural steps for filing Grievances and Appeals. This includes, but is not limited to, auxiliary aides and services, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD, American Sign Language, and interpreter capability. The notice of resolution is in an easily understood language and format, be available in alternative formats, and in a culturally and linguistically appropriate manner that takes into consideration those with special needs. PTM noted that Home State Health has not addressed criteria ii, iv, ix, and xi, in its policies and procedures. However, criterion iv is addressed in the member handbook. During the interview Home State Health informed about measures taken to help members with limited English proficiency and low literacy: care managers explain written materials to the members; educational videos are posted on the website; KRAM library is utilized for member education; call center staff is educated and trained using Empathy Tools; and member services connect directly with provider offices for translation services, if needed. **Required Actions:** PTM recommends that Home State Health develops a policy to address the missing elements and describes methods to ensure congruent behaviors and attitudes that enables effective work in cross-cultural situations.		
F. Accessibility considerations: Each MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid	MO.CONT.02 Network Selection and Retention: page 1 MO.PRVR.04 Provider Appointment and	Fully Met

enrollees with physical or mental disabilities.	Accessibility Standards: page-1 MO.PRVR.19 Provider Directory updates: page 1 MO.QI.21 Cultural Competency Program: page 3	
Findings: The provider network operations, contracting and network development, and provider relations departments select and recruit the provider network by regularly monitoring and considering various factors including whether a provider's facility provides physical access for members with disabilities. Home State Health will provide an accommodation, if needed, to ensure all members have equal access to 24 hours per day health care coverage. Home State Health maintains a web-based provider directory that allows members to search for a provider/practitioner or a Health Centers/Clinic/Hospitals/ Ancillary, Vision or Dental providers. The information received from the provider on accommodations for people with physical disabilities including offices, exam rooms, and equipment is available to view in the provider directory. PTM determined that Home State Health's four policies combined, meet the requirements of this section. **Required Actions:** None.		
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.	MO.UM.01.01 Covered Benefits and Services: pages-2, 5	Fully Met
Findings: Female members may self-refer to an OB/GYN for routine women's health services regardless of whether the PCP (general practitioner, family practitioner or internist) provides such women's health services, including routine gynecological exams. In accordance with the State law, Home State Health allows members direct access to the services of the in-network OB/GYN of their choice for the provision of covered services. • For pregnant members at high risk for complications, particularly those with serious mental illness or developmental disabilities, Home State Health's policy emphasizes the		

critical importance of consistent prenatal and postnatal care for the health of women and their children.

- Home State Health may go beyond the minimum contract requirements to provide out-of-network prenatal and postpartum care to members in their third trimester of pregnancy, offering pregnant members the option to remain with their current out-of-network OB/GYN for the duration of their pregnancy and postpartum visit regardless of their current gestational age.
- Home State Health does not require a medical necessity review for prenatal or postpartum care.

Required Actions: None.

Compliance Score – Availability of Services						
Total	Met	=	8	×2	=	16
	Partial Met	=	2	×1	=	2
	Not Met	=	0	×0	=	0
Numerator	Score Obtained					18
Denominator	Total Sections	=	10	×2	=	20
Score						**90%**

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)).	MO.CONT.01 Network Adequacy: page 1 <u>Onsite Submission</u> 2021 Dec Full Network Medicaid Providers 2021 Network Access Plan Approval Letter (Disposition) MO.CONT.02 Network Selection and Retention (revised): pages-1, 2	Fully Met
Findings: Home State Health established and maintained credentialed provider networks in geographically accessible locations, in accordance with the travel distance standards consistent with State requirements. Home State Health's provider network consists of hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, safety net hospitals, and all other provider types necessary to ensure sufficient capacity, in accordance with the accessibility service standards consistent with State requirements. Home State Health submitted lists of the entire provider network that meets the requirement of this section. Home State Health submitted State's disposition on its provider network plan as "Approved."		

Required Actions: None.		
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)).	MO.CONT.02 Network Selection and Retention: pages-1, 2 <u>Onsite Submission</u> 2021 Dec Full Network Medicaid Providers (Excel)	Fully Met
Findings: Provider Network Operations, Provider Relations, and Contracting and Network Development will be proactive in selecting and maintaining a stable network through outreach, recruitment and retention activities to ensure an adequate and accessible provider network. Home State Health's policies and supporting network documentation met all the requirements of this section. **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 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.	Participating Provider Agreement (Attachment A-Medicaid): pages-18, 19 Provider Reference Manual: page 15 Member Handbook: pages 34, 35	Partially Met

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: PCP responsibilities are listed in the provider manual and the Provider Agreement template, which meets the compliance requirement of this section. However, PTM noted that Home State Health did not submit a policy which entails all the responsibilities of a PCP as per the MHD contract. **Required Actions:** PTM recommends that Home State Health develop a policy detailing the PCPs responsibilities.		
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).	MO.CONT.01 Network Adequacy: page 1 MO.UM.23 Utilizing the Specialist as the PCP: page 1 <u>Onsite Submission</u> MO.UM.23 Utilizing the Specialist as the PCP (revised): page 1	Partially Met

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).		
Findings: a. Home State Health's provider network includes primary care providers who are licensed physicians specializing in family and general practice, pediatrics, 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. d. Home State Health's policy, "Network Adequacy," is compliant with the requirement under this criterion. Qualified specialists who meet credentialing criteria to serve as the overall coordinator of all medically necessary care for members with complex conditions may serve as the PCP for that member when approved by Home State Health's Chief Medical Director, or designee. Home State Health's policy, "Medical Management" describes the procedure to allow specialists to serve as PCPs.		

PTM noted that Home State Health did not have documentation to the meet criteria b and c of this section during the review period. However, Home State Heath revised its policy after the deficiency was identified by PTM. Thus, PTM scored this section as "Partially Met." **Required Actions:** No further action is required. However, PTM recommends that Home State Health submits its revised policy, "Utilizing the Specialist as the PCP," for the MHD's approval.		
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 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	MO.CONT.01 Network Adequacy: page 2 <u>Onsite Submission</u> 2021 Behavioral Health Providers (Excel)	Fully Met

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: Home State Health's policy, "Network Adequacy," is compliant with the requirements of this section. Home State Health submitted its provider network of Behavioral Health providers as a supporting documentation. **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).	MO.CONT.01 Network Adequacy: page 2 <u>Onsite Submission</u> 2021 FQHCs and RHCs Providers (Excel)	 Fully Met
Findings: Home State Health's policy, "Network Adequacy," is compliant with the requirements of this section. Home State Health submitted its provider network of FQHCs, PBHCs, and IRHCs as a supporting documentation. **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	MO.CONT.01 Network Adequacy: page 2 Provider Reference Manual 2021: page 39 Member Handbook: page 20 <u>Onsite Submission</u> Out-of-Network Single Case Agreement: page 1	Partially Met

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).	Out-of-Network Providers (website PDF): pages-6 to 10 MO.CONT.01 Network Adequacy (revised): page 2 2021 Family Planning and STD Network Providers (Excel)	
Findings: Home State Health's policy, "Network Adequacy," meets the requirements of this section except for the requirement of allowing full freedom of choice for the family planning services to its members. Also, the member handbook does not include this information on freedom of choice for family planning services. However, it is mentioned in provider manual. PTM noted that Home State Heath updated its policy after the deficiency was identified by PTM. Home State Health submitted supporting documentation on its provider network that included Family Planning and STD treatment providers. The Single Case Agreement template for out-of-network providers submitted during onsite submission has information on care coordination and billing procedures but does not include information on medical record management. PTM checked Home State Health's website for information to out-of-network providers but did not find a description for medical record management in posted documents. **Required Actions:** PTM recommends that Home State Health incorporates the missing documentation as identified in its member handbook, Single Case Agreement, and in the PDF document posted on the website for out-of-network providers.		
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,	MO.CONT.01 Network Adequacy: page 2 <u>Onsite Submission</u> 2021 Local Health Public Agencies Out-of-Network Single Case Agreement: page 1 Out-of-Network Providers (website PDF): pages-6 to 10	 Fully Met

care coordination, medical record management, and billing procedures (MHD contract 2.4.11).		
Findings: Home State Health's policy "Network Adequacy" is compliant with the requirements of this section. Home State Health submitted supporting documentation on its provider network that included Local Public Health Agencies. As stated in the previous section "E," the Single Case Agreement template for out-of-network provider submitted during onsite submission does not include information on medical record management. As PTM has already scored this document in the prior section, it is not scored in this section. **Required Actions:** As recommended in the previous section, Home State Health should update its Single Case Agreement template to include information on medical record management.		
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).	2021 School Based Dental Providers (Excel) <u>Onsite Submission</u> MO.CONT.01 Network Adequacy (revised): page 9	Partially Met
Findings: Home State Health did not have a documentation to meet the requirements of this section during the review period. However, Home State Health updated its policy, "Network Adequacy," after PTM identified the deficiency. Home State Health submitted supporting documentation to show its network on dentists providing school based dental services. **Required Actions:** No further action is required. However, PTM recommends that Home State Health submits its revised policy, "Network Adequacy," for the MHD's approval.		
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	MO.CONT.01 Network Adequacy: page 2 <u>Onsite Submission</u> MO.CONT.01 Network Adequacy (revised): page 2 2021 Tertiary Care Network Providers (Excel)	Fully 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: Home State Health's provider network includes tertiary care providers consisting of highly-specialized providers available twenty-four (24) hours per day in all service areas. Tertiary care providers include trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists, and specialty pediatric hospitals as defined in 13 CSR 70-15.010(2)(P), or as amended. Home State Health has transfer protocols and will make appropriate arrangements with out-of-network providers. Home State Health revised its policy, "Network Adequacy" to include stroke centers and STEMI centers in medical sub-specialties as advised by PTM during the preliminary review. Home State Health submitted supporting documentation to show its Tertiary Care network providers. **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.	MO.CONT.01 Network Adequacy: page 2 <u>Onsite Submission</u> 2021 Specialty Pediatric Hospitals	Fully Met
Findings: Home State Health's policy, "Network Adequacy," is compliant with the requirements of this section. Home State Health submitted supporting documentation to show pediatric hospitals in the network. **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	MO.CONT.01 Network Adequacy: page 2 Provider Reference Manual: page 57	Partially Met

of the MCO to ensure timely access to services available under the contract 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 Indian Managed Care Entity (ICME) 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: i, ii. Home State Health did not address these requirements in its policy. Home State Health informed PTM that there are no Indian Reservations in Missouri. However, Home State Health's provider manual states that Home State Health's American Indian/Alaskan Natives have a right to receive care from Indian Health Care Providers (IHCP). iii. Due to no Indian Health Care Providers (IHCP) in the state, American Indian and Alaskan Natives are permitted to access out-of-State IHCPs. As IHCPs become available, Home State Health will offer an Agreement for Network participation. **Required Actions:** PTM recommends that Home State Health addresses criteria i, ii in its policy and procedure per the requirement of the MHD contract, even though there are no American/Alaskan Natives in MO.		
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	2021 Network Access Plan (Outline): pages 1 to 5	Fully Met

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, 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.)	Home State Health Plan-Network Access Plan Report (Feb 28, 2021): page 1 <u>Onsite Submission</u> 2021 Network Access Plan Approval Letter (Disposition) SERFF (System for Electronic Rate and Form Filing) Submission-Feb 28, 2022	
Findings: The Missouri Department of Social Services, the MHD has completed its review of Home State Health's 2021 Access Plan and assigned a status as "Approved." Home State Health has submitted documentation as an evidence of its submission of 2022 Access Plan. **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%).	MO.CONT.02 Network Selection and Retention: page 2	Fully 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: Home State Health's policy "Network Selection and Retention" complies with all the requirements of this section. **Required Actions:** None.		

Compliance Score – Assurances of Adequate Capacity and Services						
Total	Met	=	9	×2	=	18
	Partial Met	=	5	×1	=	5
	Not Met	=	0	×0	=	0
Numerator	Score Obtained					23
Denominator	Total Sections	=	14	×2	=	28
Score						**82.14%**

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.	MO.ELIG.03 Primary Care Provider (PCP) Selection and Change: page 1 PCP Auto-Assignment: page 2 MO.MBRS.04 Distribution of New Member Materials: page 1 MO.MBRS.43 Member Services: page 1 Member Handbook: pages-3, 34	Fully Met
Findings: Home State Health mails welcome packet/ID cards to all new members within 10 business days of receipt of the 834 enrollment file. Home State Health issues identity card before the member's effective date of coverage. The New Member Packet includes a notice informing members of the process for changing PCP assignments and encouraging members to make their own choices about the provider who will serve them. New members may either choose a PCP at the time they select Home State Health, or Home State Health auto-assigns a PCP to its members. Members may change PCPs with or without cause. Members who do not have PCP assigned to them from the 834 enrollment file, are outreached during the New Member Welcome Call to assist in scheduling an initial appointment with an auto-assigned PCP or assist the member in choosing a PCP of their preference. The intent of the call is to welcome new members, educate them on the program, assist them in establishing a relationship with their PCP, ensure they have access to services, and perform an initial health risk screen (HRS) to identify potential care management needs. Due to Home State Health's processes of PCP auto-assignment, there will be no barriers to members to receive access to emergency services, urgent services, or obtained care in or out of the Home State Health's provider network upon enrollment in Home State Health. **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 subsequent attempts if the initial attempt to contact the enrollee is unsuccessful.	MO.MBRS.43 Member Services: page 1 New Member Outreach Report 2021 (Excel sheet)	Fully Met
Findings: Home State Health begins Welcome Calls upon enrollment of a member and are completed within the first 90 days, or in accordance with state or federal contract. The outreach staff will conduct a brief HRS to identify whether the member is pregnant, has a chronic condition, and/or any special health care needs. The outreach staff will help make an appointment with their PCP to all members with such issues. Outreach staff will make a minimum of three attempts to contact each new member telephonically. Attempts will be made on separate days and at varying times to reach the member. Each attempt will be documented in the member's record in OMNI or TruCare (Clinical Documentation System). **Required Actions:** None.		
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. b. If a member enrolls with the MCO from another MCO, the new	MO.CM.17 Transition of Care: page 1	Fully Met

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 5 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: Home State Health's policy, "Transition of Care," meets all the 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. If the MCO changes subcontractors, the MCO shall ensure that relevant member information is transferred	MO.CM.17 Transition of Care: pages-1, 2	Fully Met

between the subcontractors within a timely manner prior to transitioning to the new subcontractor.		
Findings: Home State Health's policy, "Transition of Care," 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.	MO.CM.17 Transition of Care: page 2	Fully Met
Findings: Home State Health's policy, "Transition of Care," 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 regard to whether such services are being provided by in-network or out-of-network providers.	MO.CM.16 Continuity and Coordination of Services: page 2 MO.CM.17 Transition of Care: page 2	Fully Met

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: a. Home State Health will provide active assistance to members when transitioning into or out of Home State Health , including transition to another MCO or the MHD Fee-For-Service (FFS) program. In the event a member entering Home State Health is receiving medically necessary covered services at the time of enrollment, Home State Health will honor a transition period of up to 60 calendar days. Home State Health will allow continuation of such medically necessary services without regard to whether such services are being provided by contract or non-contract providers. Home State Health's policy, "Transition of Care," meets all the 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	MO.CM.17 Transition of Care: page 2	Fully Met

calendar days or until the member has been seen by the assigned primary care provider who has authorized a course of treatment.		
Findings: Home State Health's policy, "Transition of Care," 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).	MO.CM.17 Transition of Care: page 2	Fully Met
Findings: Home State Health's policy, "Transition of Care," meets the requirement of this section. **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.	MO.CM.17 Transition of Care: page 3	Fully Met
Findings: Home State Health's policy, "Transition of Care," 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.	MO.CM.17 Transition of Care: page 3	Fully Met
Findings: Home State Health's policy, "Transition of Care," 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.	MO.CM.16 Continuity and Coordination of Services: page 3 MO.QI.13 Medical Record Review: page 1 Provider Reference Manual: pages-69, 71	Fully Met

Findings: Home State Health's Integrated Care Team (ICT) will facilitate communication and coordination between the PCPs and specialists, including behavioral health providers, Federally Qualified Health Centers, and Rural Health Clinics, as needed to ensure continuity of care and prevent duplication of services. This is especially important for complex or special needs members as they often see several providers to manage their condition. Providers are educated on the importance of cross-communication in the Provider Handbook and ad-hoc training sessions.

In accordance with the Senate Bill No. 1024, enacted by the General Assembly of the State of Missouri, Section A, chapter 334, RSMO, amended to be known as Section 334.097, physicians shall maintain an adequate and complete medical record for each member and may maintain electronic records provided the record keeping format is capable of being printed for review. Home State Health shall require its providers to maintain medical records in a detailed and comprehensive manner which conforms to good professional, medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Standards include medical record content and organization, ease of medical record retrieval, and maintaining confidentiality of all PHI. These standards apply to all areas of service including inpatient, ambulatory, ancillary, and emergency care.

PTM noted that the policy, "Medical Record Review," and the provider manual states that the practitioners are required to maintain all member records for at least seven years from the date of when the last professional service was provided.

When a member changes PCPs, upon request, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of request or prior to the next scheduled appointment to the new PCP whichever is earlier.

PTM noted that the timeframe for transferring medical records to the new PCP does not correspond to the timeframe of 5 business days per the MHD contract, section 2.5.9.

Required Actions: PTM scored this section as "Fully Met." However, PTM recommends that Home State Health updates the duration of maintaining medical records to 10 years based on 42 CFR 438.3u and the provider manual with the correct timeframe for sharing medical records.

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.	Privacy and Confidentiality Training (Snapshot) CC.COMP.PRVC.03 Authorization and Revocation of Protected Health Information: page 1 MO.CM.16 Continuity and Coordination of Services: page 1	Fully Met
Findings: For all uses and disclosures of a member's protected health information, Home State Health will obtain a signed authorization from the member, unless the use or disclosure is required, or otherwise permitted without an authorization, by 45 CFR Part 164 Subparts A and E (the Privacy rule). Home State Health will ensure each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable when sharing information regarding the members. Home State Health will ensure each member's privacy is protected during all communications with external parties. Transfer of protected health information will be conducted by phone, secure fax or secure email in order to ensure maintenance of member privacy at all times. Home State Health's ICT will ensure appropriate referrals and linkages are made for the member to the applicable provider, Health Home or community resource, even if these services are outside of the required core benefits of Home State Health, are not available in the network, or the member has met the benefit limitation. This includes sharing information regarding members, especially those with special health care needs, or children who are out of EPSDT services, with other MCOs and other insurance payers as specified in contract and in accordance with 42 CFR 438-208(b). **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).	MO.CM.16 Continuity and Coordination of Services: pages-2, 3	Fully Met

Findings: Contingent upon CMS approval, Home State Health will support the State's implementation of a health home program designated by Section 2703 of the Affordable Care Act for eligible MHD members. • Home State Health's ICT will provide coordination with the PCP. • The Patient Centered Medical Home (PCMH) Manager will be the designated contact for the Section 2703 designated health home practices. • Upon receipt of State's monthly health home services notification, an ICT single point of contact will be provided for each health home to allow for coordination of a member's services. • Home State Health will coordinate with the health home providers to prevent duplication of services such as case management. • Home State Health will notify the health home of any inpatient admission or discharge of an assigned health home member within 24 hours. • Home State Health will include any Section 2703 designated health home treating physician, clinical practice, or advance practice nurse in their provider network for members in a Section 2703 designated health home as long as the provider meets Home State Health's minimum credentialing standards. **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	Hospital Care Transition (HCT) Management: pages-1 to 3	● Fully Met

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.		
Findings: Home State Health's policy "Hospital Care Transition (HCT) Management" complies with all the requirements of this section. Home State Health shall maintain and operate a formalized Hospital Care Transition (HCT) program that includes effective post-discharge HCT, including appropriate discharge planning for short-term and long-term hospital stays**.** Home State Health will facilitate transition from one care setting to another by engaging members at bedside where appropriate and providing transition of care assistance to ensure members receive quality secondary care and follow up. The HCT team will engage in discharge planning through collaboration with the member, caregivers, facility staff, and other resources to meet the goals for discharge. Activities and planning will focus on the member needs with consideration to the diagnosis, assessment, prognosis and recommendations for post-acute services. Services will include on-site management as deemed appropriate and will remain in alignment with the policies of the facilities. Members identified through the hospital discharge risk assessment and in need of transition of care assistance, will receive onsite HCT management services upon admission to a hospital.		

Required Actions: None.		
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, 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	HCT Management: pages-3 to 5	Fully Met

and communications with post-discharge programs. i. Helping members and caregivers understand discharge plans, current medication lists, transfer plans, and instructions.		
Findings: Home State Health's policy "HCT Management" complies with all the requirements of this section. **Required Actions:** None.		
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 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	Onsite Submission MO.CM.01 Case Management Program Description: pages-14, 15	Fully Met
Findings: Members are identified for care management through several data sources, including, but not limited to: • Claim or encounter data. • Predictive modeling software (e.g., Impact Pro™). • Hospital discharge data. • Pharmacy data (if available). • UM data, e.g., hospital admission data, NICU reports, inpatient census, precertification/prior authorization data, concurrent review data. • Emergency Department Utilization reports. • Laboratory data. • Readmission reports. • State Enrollment Process and other State supplied data. • State defined groups. • Information provided by members or their caregivers, such as data gathered from Health Risk Assessments. • Information provided by practitioners, such as Notification of Pregnancy. Reports identifying members for care management are run on at least a monthly basis and forwarded to the care management team for outreach and further appraisal for care management.		

Additional referral sources: Healthcare providers; nurse advice phone services; disease management program staff; hospital staff; UM staff; members and family members; community and social services agencies; and delegated entity staff. During the site meeting, Home State Health informed PTM that State sends a list of members with special healthcare needs monthly. **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.	<u>Onsite Submission</u> MO.CM.01 Case Management Program Description: pages-13, 15, 16, 21, 22	Fully Met
Findings: An assessment for care management is completed within 30 days of enrollment for new members who present with a diagnosis needing complex care management/care management. General standardized assessments have been developed internally to address the specific issues of Home State Health's unique populations. Standardized assessments allow for consistency in application of criteria and objective appraisal of appropriateness of members for care management. All assessments are documented in the central clinical documentation system which date/time stamps each activity, including documentation of the staff member completing the activity. When staff identifies a member with coexisting medical and behavioral health disorders, the identifying staff will notify the care manager of the member. If the member's primary diagnosis is a behavioral health condition, the case is referred a behavioral health care manager, working in tandem with the medical care team. Whether the member's primary diagnosis is physical or behavioral determines whether a medical or behavioral health care manager will serve as the lead care manager. **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	<u>Onsite Submission</u> MO.CM.01 Case Management Program Description: pages-10, 23 to 25	Fully Met

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 request of the enrollee per §441.301(c)(3).		
Findings: a. The care plan is developed in conjunction with the member, the member's authorized representative or guardian, authorized family members, and the managing physician and other members of the health care team. Behavioral health care coordination is incorporated in the care plan as needed. b. Once the plan of care is agreed to (by the member), agreement is documented in the clinical documentation system, and timelines are put into place to evaluate and monitor the effectiveness of the plan.		

During the site meeting, Home State Health informed PTM that the care plan is sent to the PCPs for their input. c. The Chief Medical Director (CMD) provides clinical support and guidance to Home State Health's care management program. The CMD will be a currently practicing physician with an unrestricted state license in the State to practice medicine. A behavioral health practitioner is involved in the implementation, monitoring, and directing of behavioral health aspects of the care management program. A care management supervisor for behavioral health services is either a Missouri-licensed Mental Health Clinical Nurse Specialist, Mental Health Nurse Practitioner, or a Missouri licensed psychologist. A behavioral health coordinator, who is licensed in the State of Missouri, is a Qualified Behavioral Healthcare Professional (QBHP), and possesses, at a minimum, a master's degree. d. The care plan is based on medical necessity, appropriateness of the discharge plan as applicable, support systems to assist the patient in the home setting, community resources/services availability, and the potential for member adherence to the prescribed care plan. Care plan is created utilizing clinical practice guidelines (including the use of CyberAccess™ to monitor and improve medication adherence and prescribing practices consistent with practice guidelines). e. Care plans are updated as medically indicated or within 90 days of discharge from an inpatient stay or an emergency department visit. **Required Actions:** None.		
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 particular health care needs of the member.	MO.UM.01.01 Covered Benefits and Services: page 3 MO.UM.22 Out-of-Network Requests: pages-1, 2 MO.UM.23 Utilizing the Specialist as the PCP: pages-1, 2	Fully Met

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. Whenever possible, Home State Health will transition out-of-network care to a participating network provider to ensure initial and ongoing quality of care and services are provided. In cases where services cannot be reasonably obtained by a network provider, out-of-network services can be rendered if the services are medically necessary, a covered service, and authorized by Home State Health. The decision to authorize use of an out-of-network provider or specialty care center will be based on continuity of care, complexity of the case and the lack of availability of an in-network provider of the same specialty and expertise. Services will be authorized as long as the service is needed, or until the service can be provided by an in-network provider. Home State Health will coordinate payment with the out-of-network provider and ensure the cost to the member is not greater than it would be if the services were furnished by an in-network provider. Home State Health will coordinate communication between member's PCP and the out-of-network provider.

ii. Members may have a standing referral from a specialist if the member has a condition which requires on-going care from a specialist. Home State Health realizes that some members' needs may transcend the traditional capabilities of a PCP. Home State Health allows qualified specialists who meet credentialing criteria to serve as the overall coordinator of all medically necessary care for members with complex conditions. Home State Health's prior approval is required for the authorization of a specialist as a PCP on a case-by-case basis. Home State Health will determine whether or not services are available through the PCP as well as to identify any quality issues concerning PCP care. The specialist must initiate the request to be designated as the PCP for the member. The request is submitted in writing. The request is forwarded to the Care Manager and/or care management team designee for review. The care manager will conduct outreach calls to the member as well as the currently assigned PCP to ensure all parties are aware of and agreeable with the request for the specialist assignment as PCP. If this is not agreeable, the CM will work with all parties to ensure the member care is uninterrupted, any PCP change is agreeable to the member, and care delivery continues to be appropriate to meet the members' needs. All information is forwarded to the Chief Medical Director (CMD), or designee for review within five business days of the request. All urgent requests are referred within 24 hours of the request. If the CMD, or designee agrees with the need to

have the specialist act as the PCP, the member, original PCP, and specialist are notified of the decision telephonically.

iii. Home State Health shall provide access to a specialty care center if the member has a life-threatening condition or disease either of which require specialized medical care over a prolonged period.

Required Actions: None.

Compliance Score – Coordination and Continuity of care						
Total	Met	=	19	×2	=	38
	Partial Met	=	0	×1	=	0
	Not Met	=	0	×0	=	0
Numerator	Score Obtained					38
Denominator	Total Sections	=	19	×2	=	38
Score						**100%**

Appendix 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.	MO.UM.01.01 Covered Benefits and Services: pages-1 to 6 Member Handbook: pages-13 to 15	Fully Met
Findings: Home State Health will provide each member all covered medical and behavioral health services in the comprehensive benefit packet as in the MHD contract effective from the date of coverage. All services must be reasonable and medically necessary for the diagnosis or treatment of an illness or injury. Preventive care and certain screening tests are also covered under the benefit plan. In accordance with the MHD contract, if Home State Health wishes to offer additional health benefits, Home State Health will seek approval from the state agency for these benefits and notify the state agency no less than 30 calendar days prior to discontinuing such benefits. Home State Health shall not portray required health benefits or services as an additional health benefit. ii. Home State Health shall be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. **Required Actions:** None.		
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	MO.UM.01.01 Covered Benefits and Services: page 2	Partially Met

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 because of the diagnosis, type of illness, or condition.		
Findings: Services at Home State Health will be furnished in an amount, duration and scope that is no less than the amount, duration, and scope for the same series furnished to beneficiaries under FFS Medicaid. PTM noted that Home State Health has not submitted documentation on the criterion that Home State Health will not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition. However, during the site meeting Home State Health informed that its staff is aware of this requirement. Any denials are reviewed by medical directors for medical necessity criteria. Data for appeals is evaluated for service issues. **Required Actions:** PTM recommends Home State Health submits documentation for the deficiency noted in the findings.		
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:	MO.QI.20 HCY/EPSDT: pages-1, 2 Provider Reference Manual: page 37 Member Handbook: pages-16, 17	Fully Met

• A comprehensive health and developmental history including 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 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. Home State Health shall cover and provide HCY/EPSDT services to all members under the age of 21 years in compliance with the terms of the MHD contract and the federal government to identify health and developmental problems. A full HCY/EPSDT well-child visit includes all components listed in this section. Segments of the full medical screen (i.e., partial screens) may be provided by different providers.		

b. Home State Health shall provide medically necessary services to treat or ameliorate defects, physical or behavioral health issues, or conditions identified by an HCY/EPSDT screen. Services shall be sufficient in amount, duration, and scope to reasonably achieve their purpose and will only be limited by medical necessity. HSH shall follow the MHD's Fee-For-Service policies for recognition of completion of all components of a full medical HCY/EPSDT well-child visit, as well as follow the MHD Mandatory Language, the MHD Managed Care Policy Statements, and the MHD contract in relation to all HCY/EPSDT requirements. **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).	CP.CPC.05 Clinical Policy-Medical Necessity Criteria: page 2 MO.UM.01.01 Covered Benefits and Services: pages-1, 5	Partially Met
Findings: Home State Health's policy, "Covered Benefits and Services," complies with the definition of Medical Necessity. Medical necessity determinations are made on a case-by-case basis in situations where there are no viable non-experimental treatment options or all other treatment options have been exhausted. A service will not be considered reasonable and medical necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered. Home State Health may make exceptions to covered service benefit limits as deemed appropriate to provide for medically necessary care as allowed under 13 CSR 70-2.100.		

PTM noted that "Clinical Policy Medical Necessity Criteria" does not comply with all the requirements of this section. **Required Actions:** PTM recommends that Home State Health documents and complies with all the medical necessity criteria as required per this section.		
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.	MO.UM.01.01 Covered Benefits and Services: pages-1, 2, 4 Provider Reference Manual: page 39 Member Handbook: page 20	Fully Met
Findings: Services shall be furnished in the most appropriate setting. Services may be limited by medical necessity. Home State Health understands there are times when a covered service benefit limit should be exceeded to provide for medically necessary care. Home State Health shall allow for exceptions to covered benefit limitations that are in accordance with 13 CSR 70-2. 100. Under this rule, Home State Health may approve and authorize payment for the provision to a member of an essential medical service or item that would otherwise exceed the benefit limitations of the program. An exception may be made on a case-by-case basis to limitations and restrictions through the prior authorization process. This is not applicable to non-covered services. Individuals with Disabilities Education Act (IDEA) Services: IDEA established Medicaid as a legitimate funding source for health and related services provided to disabled students under their Individualized Education Plan (IEP) for children ages 3-21 or Individualized Family Service Plan (IFSP) for children under the age of three. Home State Health covers family planning services as defined by the MHD managed care policy statements, provided by any qualified provider, in-network or out-of-network.		

Referral/authorization is not required if a member chooses to receive family planning services and supplies from outside the network. Family planning services are also exempt from any out-of-pocket costs for the member. Home State Health 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. Home State Health shall allow for full freedom of choice for the provision of these services. **Required Actions:** None.		
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).	MO.UM.05 Timeliness of UM Decisions and Notifications: page 1 MO.UM.07 Adverse Determination (Denial) Notices: page 2 Provider Reference Manual: pages-31, 32 MO.UM.12 Emergency Services: page 1	Fully Met
Findings: i. In accordance with the MHD contract, Home State Health will ensure that emergency medical/behavioral health and Substance Abuse Services are available 24 hours per day seven days a week to treat an emergency medical/behavioral and substance abuse condition. Home State Health will provide an accommodation, if needed, to ensure all members equal access to 24 hours per day health care coverage. Home State Health will not require prior authorization for emergency medical/behavioral health or substance abuse services. ii. The policy "Utilization Management" complies with the requirement of this section. **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)).	MO.UM.01 Utilization Management Program: page 20	Fully Met

Findings: Home State Health complies with the MHPAEA as it applies to its Medicaid Managed Care Organizations as described in section 1903(m) of the Social Security Act (the Act); Medicaid Alternative Benefit Plans (ABPs) as described in the Act; and CHIP under title XXI of the Act. Home State Health will ensure that any benefit limitations for mental health or substance use disorder (MH/SUD) benefits are comparable to those for medical/surgical benefits and will not impose less favorable benefit limitations on MH/SUD benefits compared to medical/surgical benefits, including with respect to annual and lifetime dollar limits, financial requirements, or treatment limitations. **Required Actions:** None.		
iv. If the MCO requires a referral, assessment, or other requirement prior to the member accessing requested medical or behavioral health, such requirements shall not be an impediment to the timely delivery of the medically necessary service. The MCO shall assist the member to make any necessary arrangements to fulfill such requirements (e.g., scheduling appointments, providing comprehensive lists of available providers). If such arrangements cannot be made timely, the requested services shall be approved (MHD contract 2.5.5(d)).	MO.UM.05 Timeliness of UM Decisions and Notifications: page 2	Fully Met
Findings: A "referral," is a request to Home State Health for authorization of services as listed on the Authorization Guidelines. PCPs are not required to issue paper referrals. Home State Health shall assist the member to make any necessary arrangements to fulfill prior authorization requirements. If such arrangements cannot be made timely, the requested services shall be approved. **Required Actions:** None.		
v. For the processing of requests for initial and continuing authorizations of services, each MCO must have in place, and follow, written policies and procedures and practices that meet the following minimum requirements: a. All appeals and denials must be reviewed by a professional who has	CP.CPC.05 Clinical Policy-Medical Necessity Criteria: page 1 MO.UM.02 Clinical Decision Criteria and Application: pages-1 to 4 MO.UM.04 Medical Management: page 1	Fully Met

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. 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).	MO.UM.07 Adverse Determination (Denial) Notices: page 2 MO.UM.06 Clinical Information and Documentation: page 1 MO.UM.05 Timeliness of UM Decisions and Notifications: pages-1, 2	

Findings: a. Level I review is conducted by a clinical UM designee (Prior Authorization Nurse, Concurrent Review Nurse) who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. At no time will a Level I review result in a reduction, denial or termination of a service. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review.

Level II review is conducted by an appropriately licensed practitioner or other health care professional. If the request is for behavioral health service, a qualified behavioral health practitioner will be consulted during the review. If the request is for dental services, a qualified dental practitioner will conduct the Level II review. All Level II reviews shall be conducted utilizing McKesson's InterQual criteria, Milliman Care Guidelines or applicable medical policy with consideration given to continuity of care, individual member needs at the time of the request and the local delivery system available for care. A board-certified consultant may also be used in making a medical necessity determination.

b. Home State Health uses evidence-based, nationally recognized clinical support tools and guidelines to make medical necessity decisions on a case-by-case basis, based on the information provided on the member's health status. For example, McKesson's InterQual

Level of Care Planning Criteria, Milliman Care Guidelines, local state and/or regulatory guidelines, for psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, Home State Health shall use Level of Care Utilization System (LOCUS)/Child and Adolescent Level of Care Utilization System (CALOCUS). Two levels of UM clinical review are available for all authorization requests c, d, e. All requests for prior authorization/certification are assigned a prior authorization/certification number which refers to and documents associated approvals and denials. The policy, "Utilization Management," details procedure for determining approval or denial of a service request. The adverse decision and rationale for the determination, as well as any alternative service(s) approved in lieu of the original request, will be documented in event notes of the clinical documentation system. For medical services that Home State Health has determined to require referral, prior authorization and/or certification, only the minimally necessary information will be obtained. The information required will not be overly burdensome for the member, the practitioner, staff, or the health care facility. Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care will be documented and maintained in the clinical authorization system. **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.	CP.CPC.05 Clinical Policy-Medical Necessity Criteria: pages-1, 2 MO.UM.02 Clinical Decision Criteria and Application: pages-1 to 4 MO.UM.04 Medical Management: page 1	Fully Met
Findings: Home State Health's clinical policy, "Medical Necessity Criteria," states that only appropriate practitioners can make the decision to deny coverage of a requested service based on medical necessity guidelines. Appropriately licensed, qualified health professionals supervise the utilization management process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under Home State Health's medical benefits. Appropriate practitioners may include, but are not limited to: • Physicians • Behavioral health practitioners, including psychiatrists, doctoral level clinical psychologists or certified addiction medicine specialists		

• Chiropractors • Dentists **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).	MO.UM.05 Timeliness of UM Decisions and Notifications: page 2	Fully Met
Findings: Home State Health will ensure that members are not without necessary medical supplies, oxygen, nutrition, and will follow establish procedures to ensure that an interim supply of an item is made available while the authorization process is occurring. **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).	MO.UM.05 Timeliness of UM Decisions and Notifications: page 2	Fully Met
Findings: Home State Health's policy, "Timeliness of UM Decisions and Notifications," complies with the requirements 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).	MO.UM.05 Timeliness of UM Decisions and Notifications: page 3	Fully Met
Findings: Home State Health's policy, "Timeliness of UM Decisions and Notifications," 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. 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).	MO.UM.05 Timeliness of UM Decisions and Notifications: pages-3, 4	Fully Met
Findings: If a member is an enrollee of Home State Health and has prior authorized health care services, Home State Health will not subsequently retract its authorization, revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of its receipt by a health care provider, after services have been provided, or reduce payment for an item or service unless the three conditions listed in this section are met. PTM noted the time limit of 45 days is stated in the policy. However, there is no time limit set in the MHD contract. **Required Actions:** Home State Health should clarify the time limit of 45 days with the MHD.		
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).	MO.UM.07 Adverse Determination (Denial) Notices: page 2	Fully Met

Findings: Home State Health will not deny physician requested continuing coverage of an inpatient hospital stay unless an alternative service is recommended by Home State Health 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. **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. ii. Approval or denial shall be provided within 24 hours of request for services determined to be urgent by the treating provider.	MO.UM.05 Timeliness of UM Decisions and Notifications: page 1 MO.UM.07 Adverse Determination (Denial) Notices: page 1	Fully Met
Findings: Home State Health has timelines in place to notify the utilization management decisions to the providers following a service request. Notifications are provided to both providers and the members. Decision on non-emergency services as determined by emergency room staff will be made within 30 minutes of request. Determination on emergency post-evaluation or stabilization services will be made within 60 minutes of receiving the request. If the review process is not completed and communicated within the timeframes specified, the request shall be deemed approved. PTM noted that Home State Health's provider manual states that emergency room and post-stabilization services never require prior authorization. On the contrary, Home State Health's policy, "Timeliness of UM Decisions and Notifications," states UM determination is required within 60 minutes of receiving a request for post-stabilization services. PTM further noted that the response timeframe to the post-stabilization service request in 60 minutes is also incorrect. All urgent requests will be approved or denied within 24 hours of the request.		

Required Actions: Even though PTM scored this section, "Fully Met," as Home State Health complied with this section, PTM recommends that Home State Health updates its provider manual and its policy based on the identified inaccuracies.		
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 extension is in the enrollee's best interest.	MO.UM.05 Timeliness of UM Decisions and Notifications: pages-1 to 3 MO.UM.07 Adverse Determination (Denial) Notices: pages-1, 2 Provider Reference Manual: page 32	Fully Met
Findings: a. For standard/non-urgent preservice request, Home State Health will notify the providers and members within 36 hours which shall include one-work day of obtaining all necessary information regarding a proposed admission, procedure, or service. Determinations for urgent pre-service prior authorization requests are made within 24 hours of receipt of the request. Determinations for retrospective prior authorization		

requests are made within 30 calendar days of receipt of the request. When notifying by telephone, the nurse reviewer documents the date and time of the notification in the authorization system, as well as who was notified of the decision. The nurse reviewer provides written notification of all determinations within 24 hours of making the decision. The nurse reviewer will also attempt to provide verbal notification to the requesting provider for any denial determination by close of business on the day the determination is made. b. If a determination cannot be made due to lack of necessary information, the UM designee will notify the requesting provider within 36 hours, inclusive of one working day following the receipt of the request of service, regarding any additional information necessary to make a determination. If additional information is received, a decision is made within 36 hours to include one working day. At no time shall the entire process exceed 14 calendar days from the original receipt of request. c. The provider manual states that Home State Health 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 Home State Health justifies a need (to the state agency, upon request) for additional information and shows how the extension is in the enrollee's best interest. PTM noted that Home State Health's policies, "Timeliness of UM Decisions and Notifications," and, "Utilization Management," state that determinations for retrospective prior authorization requests are made within 30 calendar days of receipt of the request. This is not compliant with the criterion c listed in this section. Home State Health clarified that retrospective prior authorization determination within 30 days is required by National Committee for Quality Assurance (NCQA) and in order to be compliant with both, the MHD and NCQA requirements, Home State Health has incorporated the criterion in its policies. **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.)	MO.UM.05 Timeliness of UM Decisions and Notifications: pages-2, 3 MO.UM.07 Adverse Determination (Denial) Notices: pages-1, 2	Fully Met

Findings: If the determination results in a denial, reduction or termination of coverage, notification will include the right to a peer-to-peer discussion and/or appeal. A written or electronic notice of the decision, including the right to appeal and appeal process, is issued to the member and treating practitioner, and/or facility within 24 hours of making the decision. Once the provider is notified of his/her peer-to-peer rights, they have two working days to initiate a peer-to-peer discussion from the time of notification. PTM noted that once a written notification of adverse benefit determination is sent to a provider, there should not be an option of peer-to-peer review. There is only one level of appeal permitted after a notification of adverse benefit determination (42 CFR 438.402(b)). Peer-to-peer review can be an option before a written notification is sent to the provider. Additionally, PTM noted that Home State Health's policy "The adverse determination (denial) Notices" is not fully compliant with the definition of adverse benefit determination per the 42 CFR 438.400 (b). Home State Health's policy, "Adverse Determination (Denial) Notices," complies with the requirement of 42 CFR 438.402(b) as it states that at the time of verbal notification to the requesting practitioner/facility of an adverse determination, the nurse reviewer of Home State Health designee will notify the requester of the opportunity for the treating physician to discuss the case directly with Home State Health's Medical Director or applicable practitioner reviewer making the determination. PTM evaluated and scored the contents of the notice of adverse benefit determination letter utilized by Home State Health and inaccurate definition of adverse benefit determination is scored under Grievance and Appeal Review (Appendix G). **Required Actions:** PTM recommends that Home State Health updates its policies based on the inaccuracies identified in this section.		
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)).	MO.UM.04.01 Affirmative Statement About Incentives: pages-1 to 3 MO.UM.04 Medical Management: page 3	Fully Met
Findings: All individuals involved in UM decision making at Home State Health sign an 'Affirmative Statement about Incentives' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or		

care and that Home State Health does not offer financial incentives for UM decisions that result in underutilization. Members, staff, practitioners and providers will be provided a written copy of the 'Affirmative Statement about Incentives' at any time, upon request. Additionally, Home State Health distributes at least annually the 'Affirmative Statement about Incentives' to practitioners, providers, staff, and members. The information may be distributed: in a newsletter; in a broadcast letter; or on the internet with written notification.

Required Actions: None.

Compliance score-Coverage and Authorization of Services						
Total	Met	=	17	×2	=	34
	Partial Met	=	2	×1	=	2
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	36
Denominator	Total Sections	=	19	×2	=	38
Score						**94.73%**

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.	CC.CRED.06 Ongoing Monitoring of Sanctions & Complaints: page 1 CAHQ Form <u>Onsite Submission</u> CC.CRED.01 Practitioner Credentialing and Recredentialing: pages-12, 14, 15, 70, 71	Fully Met
Findings: i. Home State Health validates a practitioner's a current and valid license at the time of credentialing decision in all states where the practitioner provides care to its members. The verification is directly from the state license or certification agency (or it's website). Because medical specialty boards verify education and training, verification of the board certification fully meets the requirement for verification of education and training, unless otherwise noted. Home State Health may execute network provider agreements pending the outcome of Medicaid enrollment of up to 120 days, but must terminate a network provider immediately		

upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected enrollees as of January 1, 2018 per 42 CFR 438.602(b) and 438.608(b). ii. Home State Health has a policy and procedure to implement an ongoing process of monitoring practitioner sanctions, exclusions, complaints, and quality issues between re-credentialing cycles in order to maintain a network of participating practitioners who meet or exceed the standards for delivery of high-quality, safe care to members. Home State Health adheres to requirements that no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished by excluded individuals or entities. Home State Health evaluates the history of all practitioner-specific complaints for all practitioners every six months. Complaints are reviewed and categorized by the Quality Improvement (QI) department. Adverse events and/or significant trends in type or volume of complaints for a particular practitioner are also evaluated at least every six months. Ongoing monitoring is performed by Home State Health monthly. Home State Health communicates the evaluation of complaints and sentinel/adverse events to the Credentialing Committee (CC) for review and follow-up as indicated. The findings and follow-up action are reported at the next Credentialing Committee meeting and recorded in committee minutes, credentialing files, and other documentation of actions taken against a practitioner. iii. Home State Health utilizes Council for Affordable Quality Health Care (CAHQ) Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1(15) and 20 CSR 400.7.180 (as amended), as the credentialing application for all practitioner credentialing in compliance with section 2.18.8c of the contract. iv. PTM noted that Home State Health submitted a blank CAHQ form which requires information on provider's social security number information. **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)).	Provider Reference Manual: page 113 Provider Directory (Central Region-Excel) <u>Onsite Submission</u> CC.CRED.01 Practitioner Credentialing and Recredentialing: pages-2, 3, 70	Partially Met

	2021 Credentialing Turn-Around-Time Report (Excel)	
Findings: The re-credentialing process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the Home State Health network. PTM noted that the list of providers stated in the policy, "Practitioner Credentialing and Recredentialing," does not include provisionally licensed psychologists and provisionally licensed professional counselors. The provider directory submitted by Home State Health shows psychologists and professional counselors included in the network, but does not distinguish from the provisionally licensed ones. As per Missouri 376.1578, Home State Health shall assess a health care practitioner's credentialing information and determine to approve or deny the practitioner's credentialing application within 60 business days of the date of receipt of the completed application. The average turnaround time for credentialing reported by Home State Health in CY 2021 is 19 calendar days. **Required Actions:** PTM recommends that Home State Health updates its documentation and ensures its credentialing process includes provisionally licensed psychologists and professional counselors in the provider network.		
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)).	Provider Reference Manual: pages-23, 114 CC.CM.10 Advance Directives: page 2 MO.QI.13 Medical Record Review: pages-1 to 4 Provider Compliance Audit Tool: page 1	Fully Met
Findings: The provider manual states that the PCPs and providers delivering care to the members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record. As part of the re-credentialing process, Home State Health will review records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine if the provider is adhering to Home State Health's advance directive policy as stated in the provider manual.		

Home State Health's policy, "Advance Directives," states that the providers identified as noncompliant with a member's advance directive or treatment decision are reviewed by the Peer Review committee, in accordance with the Peer Review Process Policy & Procedure. Home State Health will require its providers to maintain medical records in a detailed and comprehensive manner which conforms to good professional, medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Practitioners must keep accurate, detailed, and comprehensive medical records with documentation including, but not limited to: • Identification of the member's name, date of birth, address and telephone number. • The date(s) member was seen. • The current status of the member, including reason for the visit. • Observation of pertinent physical findings. • Assessment and clinical impression of diagnosis. • Plan of care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the medical record the medication and dosage of any medication prescribed, dispensed, or administered. • Any informed consent for office procedures. • Results of any x-rays, laboratory tests, or other diagnostic procedures. • Each entry legible, signed, and dated. • Discussion about advanced directives with patients 18 years of age and older. Home State Health will assess the providers' medical record keeping practices against the established standards. As part of re-credentialing, Home State Health will review a sample of records from PCPs, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives. The elements scoring below 80% are considered deficient and in need of improvement. **Required Actions:** None.		
D. As part of credentialing and re-credentialing, the MCO shall collect from providers directly contracted with the MCO, full and complete information, as described herein, regarding ownership and control, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, CHIP, or any other Federal health care program, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1051. The MCO shall provide this information to the state	Disclosure of Ownership and Control Interest Statement: pages-1, 2 Participating Provider Agreement: page 6 <u>Onsite Submission</u> CC.CRED.01 Practitioner Credentialing and Recredentialing: pages-73, 74	Fully Met

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: Home State Health's Provider Agreement states that a provider agrees to furnish to Home State Health a complete and accurate information necessary to permit Home State Health to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455, Subpart B, or any other applicable state or federal requirements, within such time period as is necessary to permit Home State Health to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five-year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime. PTM noted an inaccurate information in the Participating Provider Agreement regarding the medical record retention period. It was reported as seven years as opposed to 10 years. Home State Health corrected it during the onsite submission, as advised by PTM. **Required Actions:** None.		
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.	<u>Onsite Submission</u> CC.CRED.01 Practitioner Credentialing and Recredentialing: page 74	Fully Met

b. Upon execution of the provider agreement. 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: Home State Health's policy meets the requirements of this section. **Required Actions:** None.		
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)).	Participating Provider Agreement: page 6	Fully Met
Findings: Home State Health's Participating Provider Agreement complies with the requirements of this section (refer to the notes in section D). **Required Actions:** None.		
G. MCO shall promptly notify the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing process. This requirement is in addition to the requirement for the MCO to report provider terminations as part of its quarterly fraud, waste, and abuse report (MHD contract 2.18.8(c)).	CC.CRED.06 Ongoing Monitoring of Sanctions & Complaints: pages-4, 12 Provider Reference Manual: page 114 <u>Onsite Submission</u> Provider Exclusion Attestation (Email notification to State)	Fully Met

	Credentialing Report 2021 (Denials and Terminations-Excel)	
Findings: Home State Health will notify the state agency of any denial of provider credentialing or re-credentialing in a timely manner and will report provider terminations as part of its quarterly fraud and abuse report using the State's forms. **Required Actions:** None.		
H. As part of credentialing and re-credentialing, the MCO shall screen all health care service subcontractors to determine whether the subcontractor or any of its employees or subcontractors has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care program (as defined in Section 1128B (f) of the Act); has failed to renew license or certification registration; has revoked professional license or certification; or has been terminated by the state agency. The screening shall consist of, at a minimum, consulting the following databases on at least a monthly basis: The List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS) and the National Plan and Provider Enumeration System (NPPES), located in the Missouri Professional Registration Boards website, and any such other State or Federal required databases. MCO shall deny/terminate credentialing or re-credentialing to any subcontractor that falls within this section (MHD contract 2.18.8(c)).	CC.CRED.06 Ongoing Monitoring of Sanctions & Complaints: pages-2, 3, 12 CC. CRED.07 Practitioner Disciplinary Action and Reporting: pages-3, 4, 27 MO.CONT.02 Network Selection and Retention: pages-2, 4 OIG Monthly Exclusion Audit 2021 <u>Onsite Submission</u> Preclusion Lists (Excel)	Fully Met
Findings: Home State Health will exclude providers from participation who have a non-renewed license or certification registration, have a revoked professional license or certification, or has been terminated by the state agency. Home State Health will access information from the Professional Registration Boards Internet site (http://pr.mo.gov) to identify State initiated terminations. Ongoing monitoring is performed by Home State Health monthly. Published information is reviewed within 30 calendar days of release by the reporting entity. Reviews include:		

• Medicare/Medicaid-specific exclusions or National Practitioner Data Bank (NPDB) reports: LEIE will be queried through the Office of Inspector General's (OIG) website. This review includes all practitioners/providers listed in the Provider Data Management system, regardless of participation status. • Sanction information from all state licensing boards, Medicare and Medicaid sources monthly, provided through a delegated agreement with CAQH Universal Provider Data Source Sanctions Track. Specific sources include: the System for Awards Management (SAM), formerly EPLS; and State Specific Exclusion Lists, as applicable. Sanction information may warrant immediate restriction, suspension or termination of network participation. In cases where a practitioner is found to be excluded from participating in Medicare/Medicaid and/or federal procurement activities, network privileges are terminated immediately and do not require consultation with the Medical Director or Credentialing Committee (Administrative Termination). Written notification of the administrative termination is mailed to the practitioner via certified mail within 24 hours of the determination of non-compliance. **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.	<u>Onsite Submission</u> CC.CRED.01 Practitioner Credentialing and Recredentialing: pages-75, 76 2021 Date Maintenance Turn-Around-Time Report (Excel)	Fully Met

d. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within 5 business days after completing re-credentialing. 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: Home State Health's policy, "Practitioner Credentialing and Recredentialing," meets the requirements of this section. Home State Health submitted Data Maintenance Report 2021 showing compliance with criterion f of this section, with an average time of 14 calendar days taken to update information in claim adjudication and payment system. Home State Health informed PTM that newly credentialed providers, newly credentialed hospitals and facilities attached to a new or existing contract are loaded at the same time that credentialing is being completed. **Required Actions:** None.		
ii. Payment should be made on the next payment cycle following the requirement outlined in I (i) above. In no case shall a provider be loaded into the provider directory which cannot receive payment on the MCO's current payment cycle (MHD contract 2.18.8(c)).	CC.PDM.03 Practitioner Affiliation Start Date: page 1	Fully Met
Findings: The practitioner affiliation start date shall be the date input by the submitter of the practitioner enrollment when adding a practitioner to an existing group. The practitioner's par affiliation start date is the date on which the practitioner is eligible to submit a claim and receive contracted rates. It is not dependent upon completion of credentialing. However, if credentialing is denied/closed, the practitioner's participating affiliations will be made non-par. The practitioner affiliation start date is subject to the following rules:		

• Practitioner's affiliation start date cannot precede the contract effective date established via the contracted agreement with the provider organization for the product/network specified in the enrollment request. • Practitioner's contracted payment eligibility cannot precede state Medicaid eligibility. • Practitioner's affiliation start date should be the date the provider group or practitioner notified Home State Health they have joined a contracted group. **Required Actions:** None.		
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 ii. Compliance with the required timeframes for loading credentialed providers (MHD contract 2.18.8(c)).	CC.CRED.01 Practitioner Credentialing and Recredentialing: page 76 <u>Onsite Submission</u> Credentialing TAT Data Dec 2021 2021 Credentialing Report (Denials and Terminations-Excel) 2021 Credentialing Turn-Around-Time Report (Excel) 2021 Enrollment Turn-Around-Time Report (Excel)	Fully Met
Findings: i. Home State Health's policy, "Practitioner Credentialing and Recredentialing," meets the requirement of this section. Home State Health has submitted data for Dec 2021 showing 100% compliance with the turn-around-time (TAT) for credentialing practitioners within 60 business days. The average turnaround time for credentialing reported by Home State Health in CY 2021 is 19 calendar days. No providers were denied initial credentialing or found not to meet credentialing standards during re-credentialing. ii. The average provider enrollment (loading) turnaround time submitted by Home State Health is 22 calendar days. **Required Actions:** None.		
K. Nondiscrimination in hiring and provision of services (MHD contract 2.2.7): i. The MCO network provider selection policies and procedures, consistent	MO.CONT.02 Network Selection and Retention: page 1	Fully Met

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.	MO.HUMR.32 Anti-Harassment and Non-Discrimination: pages-1, 4	
Findings: Home State Health's policy, "Anti-Harassment and Non-Discrimination," meets the requirement of this section. However, the policy clarifies that compliance with this section may not be construed to: • Preclude Home State Health from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or • Preclude Home State Health from establishing measures that are designed to maintain quality of services, control costs, and are consistent with its responsibilities to members. **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,	CC.HUMR.02 Equal Employment Opportunity & Affirmative Action: page 1 CC.HUMR.75 Disability Accommodations: page 1 Inclusive & Responsible Workplace-(Anti-Harassment & Non-Discrimination): page 1 <u>Onsite Submission</u> MO HealthNet Managed Care Contract	Fully Met

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. 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.	Administrative Requirements: pages-3, 4	
Findings: Home State Health's policy, "MO HealthNet Managed Care Contract Administrative Requirements," complies with all the regulations listed in this section. Home State Health is committed to providing equal employment opportunity for all applicants and employees in all employment decisions. Home State Health does not unlawfully discriminate on the basis of race, color, religious creed (including religious dress and grooming practices), citizenship status, sex (including pregnancy, childbirth,		

breastfeeding and related medical conditions), national origin, ancestry, marital status, sexual orientation, gender, gender expression and gender identity, age (40 and over), genetic information, physical or mental disability (including AIDS and HIV), medical condition (including cancer), request for Pregnancy Disability, Family Care, or Medical Leave, past, present or future membership in a uniformed service of the United States including status as a disabled veteran, recently separated veteran, active wartime or campaign badge veteran, armed forces service medal veteran or other covered veteran. Home State Health also makes reasonable accommodations for qualified applicants and employees with disabilities, disabled veterans, and for employees' religious observances and practices. **Required Actions:** None.		
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.	Participating Provider Agreement: page 5 <u>Onsite Submission</u> MO.QI.21 Cultural Competency Program: page 1	Partially Met
Findings: Each contracted provider will provide covered services to covered persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Contracted providers recognize that, as a governmental contractor, company or payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and providers. Home State provides educational information and resources to participating providers offering support to providers as they endeavor to foster equitable treatment of their clients and to prevent discrimination. PTM noted that Home State Health did not submit documentation about minority inclusion and dissemination of information to its subcontractors. The participating provider agreement does not specify the requirement. **Required Actions:** PTM recommends that Home State Health submits documentation about minority inclusion and dissemination of information to its subcontractors.		

Compliance: Home State Health

Compliance Score - Provider Selection						
Total	Met	=	12	×2	=	24
	Partial Met	=	2	×1	=	2
	Not Met	=	0	×0	=	0
Numerator	Score Obtained					26
Denominator	Total Sections	=	14	×2	=	28
Score						**92.85 %**

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).	Centene Business Ethics and Code of Conduct: pages-26, 27 Compliance: Privacy and Confidentiality Annual Learning 2021 Privacy and Confidentiality Training-Authorization to Disclose (screenshot) 2021 Privacy and Confidentiality Training-Confidential Information (screenshot) CC.COMP.04 Confidentiality and Release of PHI: page 7 CC.COMP.PRVC.01 Privacy Program Description: page 2 CC.COMP.PRVC.11 Allowable Disclosures: page 3 MO.COMP.09 Compliance: page 2	Fully Met
Findings: Any work product conceived, created, or changed by an employee, individually or jointly, during the period of employment belongs to Home State Health. This includes writings, models, processes, technologies, inventions, discoveries, ideas, and other work product of any nature. Employees may not share, publish, claim, or further develop any Home State Health work product during or after their employment unless they have express, written permission to do so from the Corporate Legal Department. Customers' sensitive information (e.g., pricing data, member information, audit results, or strategic planning documents) must not be shared with or made available to anyone who might use it for any purpose other than to serve the customer to whom the information belongs.		

Inappropriately sharing such information may put our customers at a competitive disadvantage, and may also violate legal or contractual requirements, placing Home State Health at risk. Home State Health has access to protected and confidential personal data (e.g., health information, personally identifiable information, etc.) of members, patients, providers, and employees. Home State Health is committed to handling this data responsibly and to respecting the rights of all data subjects. Home State Health and every employee has a responsibility to safeguard personal data maintained by the organization. Whenever working with personal data, employees must ensure that they follow applicable business unit policies and procedures, and comply with local laws and regulations. Home State Health receives authorization from patients and members in writing to use or disclose their protected health information (PHI) outside of treatment, payment, and healthcare operation activities. Employees are prohibited from any unauthorized access to, use or disclosure of patient or health care provider information, the corporations proprietary information, including but not limited to, medical records, claims, benefits, or other administrative data that is personally identifiable, in addition to quality improvement programs, reports and disease management information (collectively, "confidential information"). Home State Health may disclose PHI for public health activities to public health authorities, entities, and persons authorized by law to receive such information. Home State Health agrees and understands that all discussions between Home State Health and the MHD and all information gained by Home State Health as a result of its 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 MHD. **Required Actions:** None.		
B. If required by the state agency, MCO and any required MCO personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request. Failure of MCO and any required personnel to sign such documents shall be considered a breach of contract and subject to the cancellation provisions of this document (MHD contract 3.16.2).	MO.COMP.09 Compliance: page 1	Fully Met

Findings: Home State Health policy, "Compliance," meets the requirements of this section. **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.	Compliance: Privacy and Confidentiality Annual Learning 2021 Privacy and Confidentiality Training-Authorization to Disclose (screenshot) 2021 Privacy and Confidentiality Training-Confidential Information (screenshot) CC.COMP.04 Confidentiality and Release of PHI: pages-11, 12, 15, 17 Data Loss Prevention Program: page 1 CC.COMP.PRVC.01 Privacy Program Description: pages-1, 2 CC.COMP.PRVC.02 Privacy Compliance Administrative Policy: page 5, 6, 7 CC.SECR.7.2A Information Security: page 1, 2 CC.SECR.8.3A Information Security: pages-1, 2, 3 CC.SECR.9.4A Information Security: pages-1 to 4 Cryptography Standard-Cryptographic Controls: pages-1, 2, 3	Fully Met

	CC.SECR.13.2A Information Security: pages-1, 2 CC.SECR.18.1A Information Security: pages-1, 2 Business Associate Agreement: page 7, 12 to 24	

Findings: a. All employees are required to complete training on Home State Health's privacy program policies annually and are required to perform their work duties with a conscious regard for the privacy rights of Home State Health's members. All new employees will receive training regarding the privacy and confidentiality of individual health information within 10 days of initial employment. Under the direction of the Home State Health Privacy Officer, the privacy program focuses on educating employees on their ongoing responsibility to protect member and associate privacy and secure member and associate information. The Privacy Officer manages and updates our privacy policies and procedures, which are available to all Home State Health employees via RSA Archer (Home State Health's policies and procedure management software).

All employees, contactors, and designated contingent workers who are granted Home State Health information system and network access credentials must complete security training in accordance with established organization security training requirements. The users must complete training requirements within 30 days of receiving information system and network access credentials. Employees and designated contingent workers must complete security awareness training annually.

b. Access to the offices of Home State Health and its subsidiaries shall be limited to individuals having a legitimate business reason for such access as specified in Home State Health's physical access policies. It is the policy of Home State Health to protect and safeguard PHI, personally identifiable information (PII), confidential company information, internal work product, and other sensitive data (collectively, "Confidential Data") by preventing or mitigating its disclosure to unauthorized external individuals, entities, and locations. Through Data Loss Prevention (DLP) program controls and processes, Home State Health will monitor Confidential Data leaving the internal information technology (IT) environment and respond to any such instances or attempts in accordance with the established DLP procedures.

c. To protect the confidentiality, integrity, and availability of Home State Health data, the transfer, copy or download of any Home State Health data to storage capable, removable media of any kind (e.g., external hard drives, USB flash drives, DVDs/CDs) is not permitted without a completed risk assessment and approved exception. All data stored on removable media must be encrypted regardless of its data classification (e.g., PHI, PII, Confidential, publicly available information). The Infrastructure Storage Media must be encrypted, destroyed, or wiped prior to transport.

d. PHI transmitted externally must be encrypted and sent securely. The individual members name or any personal health or identification information will not be included in the subject line of the e-mail. When an outbound email or web transmission is identified as containing, or potentially containing Confidential Data, Forcepoint will prevent the transmission from leaving Home State Health's internal IT Environment by quarantine or block. The employee attempting to transmit the data will receive an email notification of the quarantine or block instructing him or her to contact his or her Compliance Department to resolve the DLP event. e. Records or other documents containing PHI must be secured in a locked file drawer or cabinet when such records or documents are not being used. Access to PHI while on a computer or electronic device is strictly limited to Home State Health issued or approved devices, systems, and applications, including internal Home State Health network email. The use of unauthorized computers or electronic devices to access, store, or transport PHI without prior approval is strictly prohibited. If PHI is being accessed or viewed via computer, a password-protected screen saver must be used when the work area is vacant or when a computer workstation is not in use. Mobile devices that store or are used to access PHI must be kept secure. Leaving a mobile device unattended for an extended period is strictly prohibited. **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).	CC.COMP.PRVC.03 Authorization and Revocation of Protected Health Information: page 1 MO.COMP.28 Providing Member Medical Records to State Agency: page 1	Fully Met
Findings: For all uses and disclosures of a member's PHI, Home State Health will obtain a signed authorization from the member, unless the use or disclosure is required, or otherwise permitted without an authorization, by 45 CFR. Part 164 Subparts A and E (the Privacy rule). Home State Health will make medical records available to duly authorized representatives of the state agency and the United States Department of Health and Human Services to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed. **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	MO.COMP.PRVC.60 Managing Substance Use Disorder Records: pages-1 to 3	Fully Met

members of public assistance and 42 CFR Part 2, as amended, regarding confidentiality of substance use disorder member records (MHD contract 3.16.5).	CC.COMP.04 Confidentiality and Release of Protected Health Information: page 6 CC.COMP.PRVC.10 Individual Rights to Protected Health Information: pages-2, 3	
Findings: Home State Health will comply with the regulations in Part 2 related to the use and disclosure of members' Substance Use Disorder (SUD) records obtained from a Part 2 program, person, or entity (collectively, a "Part 2 Provider"). Home State Health may not use or disclose members' identifiable Part 2 records to any third party, including the member's PCP or family members, unless Home State Health has received a Part 2 compliant Authorization to Use and Disclose Health Information form from the member, or their legal guardian or representative. This form must be valid at the time of the use or disclosure. Home State Health does not generate SUD records that are subject to the use and disclosure restrictions specified in Part 2. Home State Health is a lawful holder of SUD information that it receives from Part 2 Providers, non-Part 2 providers, members, or other outside parties. Home State Health maintains "Designated Record Set" that includes a group of records maintained by or for Home State Health, or health care provider: • The medical records and billing records about the member. • The enrollment, payment, claims adjudication and case or medical management record systems maintained by or for the health care plan. • Used, in whole or in part, by or for Home State Health or health care provider to make decisions about members. The Designated Record Set includes all the information listed in 42 CFR Part 431, Subpart F that is safeguarded. **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).		Not Met
Findings: Home State Health did not submit policy specific to the requirements of this section.		

Required Actions: PTM recommends that Home State Health submit a policy meeting the requirements of this section.		
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).	CC.COMP.PRVC.01 Privacy Program Description: page 2 Centene Business Ethics and Code of Conduct: page 27	Fully Met
Findings: Health Insurance Portability and Accountability Act (HIPAA) privacy program sets the standards for employees in safeguarding confidential and protected health information. Home State Health is committed to complying with applicable laws, regulations, and policies related to privacy of health and individually identifiable information. **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).	CC.COMP.04 Confidentiality and Release of PHI: page 12 CC.COMP.PRVC.01 Privacy Program Description: page 1 CC.COMP.PRVC.02 Privacy Compliance Administrative Policy: page 2 CC.COMP.PRVC.10 Individual Rights to Protected Health Information: page 2	Fully Met

Findings: Home State Health's policy "Privacy Program Description" states that PHI is individually identifiable health information in any format (electronic, paper, or oral) that is created or received by a covered entity (health care provider, health plan, or health care clearinghouse that conducts standard electronic transactions). When PHI is maintained in electronic format, access to databases containing PHI will be secured through IS programming and limited to those employees of the Home State Health having a need to access such PHI as part of their job functions. Home State Health considers electronic records housed within its claims payment, medical/utilization management, and enrollment/billing systems for the purpose of utilization review, as part of "designated record set." These electronic records include authorizations, referrals, care management/disease management notes, phone logs, reports and consents/authorization forms. **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 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)).	Business Associate Agreement: page 3	Fully Met
Findings: Home State Health's Business Associate Agreement template complies with the requirements of this section. **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 disclose Protected Health Information, if necessary, for the proper management and administration of MCO's business (MHD contract 2.38.2(d)).	CC.COMP.PRVC.03 Authorization and Revocation of PHI: page 3 CC.COMP.PRVC.04 Assurances from Business Associates to Safeguard PHI: page 3	Fully Met
Findings: When Home State Health initiates an authorization to use or disclose PHI for its own purposes, Home State Health will provide members with any facts they need to make an informed decision regarding the release of the information. Home State Health's Business Associate may use and disclose PHI for those purposes set forth in the Services Agreement between Home State Health and the Business Associate, provided such uses and disclosures would not violate the Privacy Rule if such use or disclosure was made by Home State Health.		

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)).	CC.COMP.04 Confidentiality and Release of PHI: page 11 CC.COMP.PRVC.11 Allowable Disclosures: page 5, 6	Fully Met
Findings: Home State Health employees shall comply with written or verbal requests for written or verbal disclosure of PHI relating to a member, whether from a law enforcement officer, a government agency, a legislative office, an employer of one or more members, a State Agency, or a third party who is not the member or the member's personal representative, only if such disclosure would constitute a Permitted Use or Disclosure under Home State Health's Policy "Confidentiality and Release of Protected Health Information." Home State Health may use or disclose PHI to the extent that such use or disclosure is required by law including, but not limited to: • For public health activities required by law. • For disclosures about victims of abuse, neglect, or domestic violence. • To comply with judicial request. • To comply with law enforcement. • For health oversight release. • To avert a serious threat to health or safety. • To comply with special government functions or requests. Home State Health may disclose PHI without member authorization in compliance with and as limited by the relevant requirements of a court order, court-ordered warrant, subpoena or summons issued by a judicial officer, or a grand jury subpoena. **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)).	Business Associate Agreement: page 3 MO.COMP.28 Providing Member Medical Records to State Agency: page 2	Fully Met
Findings: Home State Health's Business Associate Agreement (BAA) template and the policy "Providing Member Medical Records to State Agency" complies with the requirement of this criterion. **Required Actions:** None.		
vii. The MCO may not use Protected Health Information to de-identify or re-	Business Associate Agreement: page 3	Fully Met

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)).	MO.COMP.28 Providing Member Medical Records to State Agency: page 2	
Findings: Home State Health's Business Associate Agreement template and policy listed above complies with this criterion. Home State Health may not use PHI to de-identify or re-identify the information in accordance with 45 C.F.R. 164.514(a)-(c) without specific written permission from the state agency to do so. **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)).	CC.COMP.04 Confidentiality and Release of PHI: pages-9, 10 CC.COMP.PRVC.09 Disclosing and Requesting only the Minimum Amount of PHI Necessary: page 1 Business Associate Agreement: page 3	Fully Met
Findings: When using or disclosing PHI or when requesting PHI from a third party, Home State Health employees shall make reasonable efforts to limit the PHI used, disclosed or requested to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. Requests for disclosures that are made on a routine and recurring basis, Home State Health must limit the PHI disclosed pursuant to such request to the Minimum Necessary amount, in accordance with the Home State Health's privacy policies and procedures. For all other requests for disclosures, Home State Health must review the requests for disclosure on an individual basis to determine whether, in accordance with criteria identified in the Home State Health's privacy policies and procedures, the PHI to be disclosed pursuant to such request is the Minimum Necessary amount. **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)).	CC.COMP.04 Confidentiality and Release of Protected Health Information: pages-11, 13 CC.COMP.PRVC.04 Assurances from Business Associates to Safeguard Protected Health Information: pages-2 to 4 Business Associate Agreement: pages-3 to 5	Fully Met
Findings: Healthcare professionals and facilities who participate in the Home State Health's provider networks must comply with all applicable laws regarding PHI. With respect to participating facilities, compliance with applicable laws shall be evaluated during the facility site review in the credentialing process. Home State Health will execute a Business Associate Agreement that complies with 45 CFR 164.504(e) with any entity that creates, receives, maintains or transmits PHI on behalf of Home State Health. The Business Associate Agreement will contain language to ensure that any subcontractors who create, receive, maintain, or transmit protected health information on behalf of the business associate contracted with Home State Health agree to the same restrictions and conditions that apply to the Home State Health with respect to such information. Home State Health's Business Associate Agreement template states that a Business Associate must comply with the requirements of the Privacy Rule that apply to Home State Health to the extent Business Associate is carrying out one or more of the Home State Health's obligations under the Privacy Rule. A Business Associate must ensure that, before a subcontractor (including any affiliate that is a subcontractor) creates, receives, maintains, or transmits PHI on behalf of Business Associate, the subcontractor enters into a written agreement with the Business Associate (the "Subcontractor Agreement") obligating the subcontractor: (i) to comply with the same HIPAA Authorities that apply to Business Associate under the Primary Agreement; and (ii) to comply with the same restrictions and conditions that apply to Business Associate through a Business Associate Agreement with respect to such PHI. **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	Business Associate Agreement: page 6 MO.COMP.28 Providing Member Medical Records to State Agency: page 2	Fully Met

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)).		
Findings: The Business Associate Agreement template meets the requirement of this section. It states that by no later than 10 calendar days after receipt of a written request from Covered Entity (Home State Health), the Secretary, or the state agency, the business associate will make its internal practices, books and records available to Covered Entity, the Secretary, or the state agency, and complete any written attestations required by Covered Entity, in each case for purposes of determining Covered Entity's compliance with the HIPAA Authorities, in a time and manner designated by Covered Entity, the Secretary, or the state agency, as applicable. **Required Actions:** None.		
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)).	Business Associate Agreement: page 6 MO.COMP.28 Providing Member Medical Records to State Agency: page 2	 Fully Met
Findings: The Business Associate Agreement template requires the Business Associates to document all disclosures of PHI (other than those expressly exempted from documentation requirements under the HIPAA Authorities) and information related to such disclosures (i.e., (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably states the basis for the disclosure) as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR		

164.528. The Business Associate will provide an accounting of disclosures of PHI to Home State Health (Covered Entity), the state agency, or an Individual within five calendar days of the applicable request and in a reasonable manner designated by Home State Health or the state agency, as necessary to permit Home State Health or the state agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528 or other applicable provision of the HIPAA Authorities. Home State Health's policy, "Providing Member Medical Records to State Agency," complies with the requirements of this section. **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)).	CC.COMP.PRVC.04 Assurances from Business Associates to Safeguard Protected Health Information: page 3 Business Associate Agreement: page 6 MO.COMP.PRVC.17 Individual Rights to Protected Health Information–Granting Access to Inspect and Obtain a Copy: page 2	Fully Met
Findings: Business Associate Agreement template states that at the request of Home State Health and within five calendar days after such request, the Business Associate must make available PHI in a Designated Record Set to Home State Health or as directed by Home State Health, to an individual, in a manner acceptable to Home State Health in compliance with 45 CFR 164.524 and/or other applicable provisions of the HIPAA Authorities. Home State Health's policies meet the requirement of this section. **Required Actions:** None.		
v. The MCO shall report to the state agency's Privacy Officer any security 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	Business Associate Agreement: page 4 MO.COMP.PRVC.54 Managing Unauthorized Uses/Disclosures, Security Incidents, and Breaches: page 4	Fully Met

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)).		
Findings: Home State Health requires its subcontractors to report any incident (security incident, unauthorized use or disclosure of PHI not permitted or required, breach of PHI, or loss, destruction, alteration, or other event in which PHI cannot be accounted for) no later than 5 calendar days of discovering the incident and all the documentation requirements to be submitted to Home State Health as required in this section. The subcontractor will fully cooperate, coordinate with, and assist Home State Health in gathering information necessary to notify the affected individuals and government agencies following an incident to ensure that any notices sent in connection with the incident are sent without unreasonable delay, and in no case more than 60 days after discovery of the Incident, and perform such notifications if required by Home State Health in its sole discretion. Home State Health's policy "Managing Unauthorized Uses/Disclosures, Security Incidents, and Breaches" complies with the requirements of this section. **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)).	CC.COMP.PRVC.02 Privacy Compliance Administrative Policy: page 1 Business Associate Agreement: page 6	Fully Met
Findings: Home State Health's Privacy Officer will maintain HIPPA required documentation, in written or electronic form, of policies, procedures, communications, and other administrative documents for additional years than required by 45 C.F.R. §164.530 (i) and (j), for a period of at least 10 years from the date of creation or the date when last in effect, whichever is later.		

Home State Health's Business Associate Agreement template requires a Business Associate maintain any Designated Record Set for a period of 10 years and make such Designated Record Set available to Home State Health upon request in an electronic and written format so that Covered Entity may meet its Disclosure accounting obligations under 45 CFR 164.528. **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)).	CC.COMP.PRVC.03 Authorization and Revocation of Protected Health Information: page 1 to 3	Fully Met
Findings: Prior to any use or disclosure of PHI for marketing, Home State Health will obtain authorization from the member. If the marketing involves financial remuneration to Home State Health from a third party, the authorization must state that such remuneration is involved. **Required Actions:** None.		
viii. The MCO shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s) or subcontractor(s). The MCO shall reimburse the state agency for any and all actual and direct costs and/or losses, including those incurred under the civil penalties implemented by legal requirements, including but not limited to HIPAA as amended by the Health Information Technology for Economic and Clinical Health Act, and including reasonable attorney's fees, which may be imposed upon the state agency under legal requirements, including but not limited to HIPAA's Administrative Simplification Rules, arising from or in connection with the MCO's negligent or wrongful actions or inactions or violations of this Agreement (MHD contract 2.38.3(p)).	Business Associate Agreement: page 8 <u>Onsite Submission</u> MO.COMP.PRVC.04 MO HealthNet Business Associate Provision Requirements: page 4	Partially Met

Findings: The Business Associate Agreement template incorporates the requirement of indemnifying Home State Health by its Business Associate or subcontractor or vendor.

PTM noted that Home State Health did not mention that it will indemnify the State as same requirements apply to Home State Health.

Home State Health did not have a policy to meet the requirements of this section during the review period. They submitted a new policy meeting the requirements of this section after the deficiency was identified by PTM. Thus, the score remains "Partially Met."

Required Actions: No further action is required. However, PTM recommends that the new policy, "HealthNet Business Associate Provision Requirements," be submitted to the MHD for approval.

Compliance Score-Confidentiality						
Total	Met	=	20	×2	=	40
	Partial Met	=	1	×1	=	1
	Not Met	=	1	×0	=	0
Numerator	Score Obtained				=	41
Denominator	Total Sections	=	22	×2	=	44
Score						**93.18%**

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).	MO.QI.11 Member Grievance and Appeals System Description: page 1 MO.UM.07 Adverse Determination (Denial) Notices: page 1 Provider Reference Manual: page 60 Member Handbook: page 59	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: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the definition of adverse benefit determination. The policy, "Adverse Determination (Denial) Notices," does not incorporate criteria f and g listed in this section. The provider manual does not include/specify criteria d, e, and g. The member handbook does not comply with criterion f entirely. **Required Actions:** PTM recommends that Home State Health updates the definition of adverse benefit determination in its documents based on the deficiencies identified.		
ii. Appeal means a review by an MCO of an adverse benefit determination.	MO.QI.11 Member Grievance and Appeals System Description: page 1 Provider Reference Manual: page 60 Member Handbook: page 60	Fully Met
Findings: Home State Health's documents comply with the definition of an appeal. **Required Actions:** None.		
iii. Grievance means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services	MO.QI.11 Member Grievance and Appeals System Description: page 1 Provider Reference Manual: page 59	Fully Met

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.		
Findings: Home State Health's policy, "Member Grievance and Appeals System Description," complies 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.	MO.QI.11 Member Grievance and Appeals System Description: page 1	Fully Met
Findings: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the definition of grievance. **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)).	MO.QI.11 Member Grievance and Appeals System Description: page 1	Fully Met
Findings: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the definition of grievance. **Required Actions:** None.		
vi. State Fair Hearing is the process set forth in the MHD contract 2.12.16(c)(22) and in 42 CFR part 431, subpart E.	MO.QI.11 Member Grievance and Appeals System Description: page 1	Fully Met

Findings: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the definition of grievance. **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).	MO.QI.11 Member Grievance and Appeals System Description: page 2, 4, 5, 6 Home State Health-MO Grievance and Appeals Flyer Member Handbook: pages-46 to 49	Partially Met
Findings: a. Home State Health maintains procedures for the receipt and prompt internal resolution of all grievances, appeals, and State Fair Hearing processes that comply with all applicable state and federal requirements and accreditation standards. Home State Health refers all members who are dissatisfied with Home State Health or its subcontractors in any respect to contact the Member Services Department and, when applicable, the expression of dissatisfaction is forwarded to Home State Health's grievance and appeals coordinator (GAC) to review. The content and substance of a grievance or appeal, including all clinical care aspects involved, are fully investigated, and documented according to applicable		

statutory, regulatory, and contractual provisions and Home State Health's policies and procedures.

PTM noted that the policy, "Member Grievance and Appeals System Description," states that appeal rights may not be applicable for some grievances (e.g., member grievances about Emergency Room wait times, staff conduct or physician conduct, where there is no adverse decision to appeal). PTM determined that there is no appeal process for grievances per the CFR/MHD contract.

b. Home State Health members are notified upon enrollment of the procedure for requesting, processing, and resolving, grievances, appeals, and State Fair Hearing. The notification is provided by a separate flyer, which explains specific instructions about how to contact Home State Health's Member Services Department and identifies the GAC as the designated staff who process grievances, appeals, and State Fair Hearing. The flyer will be readily available in the member's primary language. The member handbook distributed to all members upon enrollment includes information of grievance and appeal system. This information is also posted on the Home State Health's website.

PTM verified that the flyer identified the member services' contact address where the members are required to report in cases of grievances and appeals. The information on language assistance services is provided in 15 languages other than English. However, PTM noted that some information presented in the flyer is incorrect or incomplete:

- Incomplete information (page 3 of 8)-State Fair Hearing in case of deemed exhaustion of appeal process is missing.
- The date of approval by the MHD is not identified in the flyer.

c. All inquiries received by the Member Services Department are probed to validate the possibility of any inquiry being a grievance or appeal. The GAC may also be notified of a grievance and complete the appropriate form.

d. Home State Health requires oral inquiries seeking to appeal an adverse determination are treated as appeals (to establish the earliest possible filing date for the appeal).

Required Actions: PTM recommends that Home State Health comply with the requirements of filing an appeal and grievance to comply with the CFR/MHD contract. Home State Health must update its flyer based on the deficiencies identified.

ii. Level of appeals: The MCO may have only one level of appeal for enrollees.	MO.QI.11 Member Grievance and Appeals System Description: page 3	Fully Met

Findings: Home State Health's policy, "Member Grievance and Appeals System Description," states member's right to request an appeal of adverse benefit determination and provides information on exhausting one level of appeal.

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 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).	MO.QI.11 Member Grievance and Appeals System Description: pages-4, 6, 10 Provider Reference Manual: page 59	Partially Met
Findings: A grievance may be filed by an authorized representative (including a legal representative of a deceased member's estate), or provider on behalf of the member with implied or express consent (verbal or written approval). If a member would like an authorized representative, the member must complete the form authorizing the person to act on their behalf. Home State Health's policy, "Member Grievance and Appeals System Description," states that a provider or authorized representative may request an appeal on behalf of a member with the member's written consent. PTM noted that the policy, "Member Grievance and Appeals System Description," does not provide information that a provider cannot file for a continuation of benefit. The member, member's authorized representative, or provider with the member's written consent may request a State Fair Hearing after Home State Health's internal grievance or appeal process has been exhausted, as applicable, and defined by the State regulations. PTM noted that a Home State Health has erroneously provided an option of State Fair Hearing for a grievance. PTM noted that the provider manual does not mention that a provider can file an appeal on behalf of the member with their written consent. **Required Actions:** PTM recommends that Home State Health updates its policy and provider manual based on the deficiencies/inaccuracies identified.		
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	MO.QI.11 Member Grievance and Appeals System Description: page 10 Acknowledgement of Appeal	Partially Met

process. The enrollee may initiate a State Fair Hearing.		
Findings: The policy, "Member Grievance and Appeals System Description," states that if Home State Health fails to adhere to the notice and timing requirements under section 2.12.16 c(22) of the MHD contract the member is deemed to have exhausted Home State Health's internal level of appeal and may initiate a State Fair Hearing. PTM noted that the MHD contract, section 2.12.16c(22) does not identify the timeframe requirements for an appeal. The member handbook does not mention about filing a State Fair Hearing when the Home State Health does not comply with the timeframe for an appeal resolution. Neither is this information provided in the Acknowledgement of Appeal. **Required Actions:** PTM recommends that Home State Health updates it documents based on the deficiencies identified.		
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.	MO.QI.11 Member Grievance and Appeals System Description: pages-3, 6 Provider Reference Manual: page 60 Member Handbook: page 48	Fully Met
Findings: Home State Health's policy, "Member Grievance and Appeals System Description," and other documents listed above are compliant with the requirements of this section. **Required Actions:** None.		
vii. Procedures: 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.	MO.QI.11 Member Grievance and Appeals System Description: page 4, 6 Member Handbook: page 48 Provider Reference Manual: page 60	Partially Met
Findings: a. A member may file a grievance at any time with either the state agency or Home State Health. The grievance may be filed orally or in writing.		

b. Home State Health's policy, "Member Grievance and Appeals System Description," states that an appeal request may be submitted in several ways: • The member may call in to the Member Services Department through HSH's toll-free customer service line. All inquiries received by the Member Services Department are probed to validate the possibility of any inquiry being a grievance or appeal. The GAC is notified of the appeal and obtains the information from the member relations documentation system and/or documents the information in the clinical documentation system. • The member may submit the appeal by mail, fax, email, or phone. • If a member would like an authorized representative or a provider to act on behalf of a member, the member must complete the Authorized Representative Form and/or Member Appeal Form, authorizing the person to act on their behalf, or provide another form of written authorization. The Member Handbook states that a member may file an appeal orally or in writing to Home State Health. Unless a member needs an expedited review, the member must complete a written request even if he/she filed orally. The same is mentioned in the provider manual. PTM noted that the member handbook and the provider manual states an oral appeal must be followed by a written request, is incorrect. **Required Actions:** PTM recommends that Home State Health updates its member handbook and provider manual to reflect the 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,	MO.QI.11 Member Grievance and Appeals System Description: page 3 Notice of Home State Health Adverse Benefit Determination MO.UM.07 Adverse Determination (Denial) Notices: pages-2, 3	Partially 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: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the requirements of this section.

PTM noted that Notice of Adverse Benefit Determination has information on scheduling a peer-to-peer call allowing the treating practitioners to discuss any medical or behavioral health UM decisions with the Medical Director of Home State Health within two business days of this notification. This is not in compliance with the 42 CFR 438.404 where there is a provision of filing an appeal after an adverse benefit notification is sent to a member, instead of initiating a discussion between the treating provider and Home State Health after the notice.

During onsite review, Home State Health explained that they use the words "peer-to-peer" and "informal reconsideration" interchangeably. The opportunity to discuss the case between physicians helps to reduce barriers, facilitate conversation between the physicians

to understand the clinical situation of the member. The peer-to-peer conversation helps to reduce unnecessary appeals and ensure the member has timely access to care. PTM acknowledged the clarification provided by Home State Health. However, PTM reiterated that peer-to-peer discussion should be held before the notice is mailed to the member/provider and must not be included in the notice of adverse benefit determination. **Required Actions:** PTM recommends that Home State Health updates its Notice of Adverse Benefit Determination based on the inaccuracy identified.		
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. 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 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	MO.QI.11 Member Grievance and Appeals System Description: page 3 MO.UM.07 Adverse Determination (Denial) Notices: page 3	Fully Met

§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: Home State Health's policies comply with the requirements of this section. **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.	MO.QI.11 Member Grievance and Appeals System Description: page 3	Fully Met
Findings: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the requirements of this section. **Required Actions:** None.		
D. Handling of grievances and appeals (42 CFR 438.406): i. The MCO must give enrollees any reasonable assistance in	MO.QI.11 Member Grievance and Appeals System Description: pages-5 to 7	Fully Met

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 receiving a grievance or appeal (MHD contract 2.15.5c, 2.15.6j).	Provider Reference Manual: page 60 Acknowledgement of Grievance (Template) Acknowledgement of Appeal (Template)	
Findings: i. Home State Health gives members any reasonable assistance in completing forms and taking other procedural steps for grievance and appeal. This includes, but is not limited to, auxiliary aides and services, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD, American Sign Language, and interpreter capability. ii. The Complaint and Grievance Coordinator (CGC) will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within 10 calendar days of receipt. A copy of the member-specific grievance acknowledgement letter is attached to the member's file in the member relations documentation system. Home State Health acknowledges all oral and written standard appeals in writing within 10 calendar days of the receipt of a request for an appeal. Acknowledgement for expedited appeal occurs at the same time the resolution is determined. The member appeal acknowledgement letter for a standard appeal is attached to the member's file in the clinical documentation system utilized at Home State Health. **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.	MO.QI.11 Member Grievance and Appeals System Description: pages-2, 5, 7, 9	Partially Met

b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. c. Who 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: Home State Health states that the individuals who make decisions on grievances and appeals are the individuals who meet all the criteria listed in this section as per its policy, "Member Grievance and Appeals System Description." However, if additional clinical information is received and meets criteria for coverage, the practitioner who made the initial adverse determination may review the case and overturn the previous decision. A nurse, pharmacist, or other appropriate qualified licensed health professional may also overturn the prior adverse decision if additional clinical information is received with the appeal request and the additional information meets criteria for coverage. PTM noted that Home State Health allows the same professional who made the initial adverse determination to review the additional documents after an appeal is filed. This does not comply with criterion "a" of this section. However, during the interview, the staff stated that they look at the initial prior authorization for the decision maker and do not involve the same person in the appeals or grievance process. **Required Actions:** PTM recommends that Home State Health comply with the requirement of criteria "a" and update its policy.		
iv. Include the enrollee and his/her representative, or legal representative of a deceased	MO.QI.11 Member Grievance and Appeals System Description: page 6	Fully Met

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) 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: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the criteria listed under 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	MO.QI.11 Member Grievance and Appeals System Description: pages-5, 7, 8 Acknowledgement of Grievance (Template) Acknowledgement of Appeal (Template) Member Handbook: page 48	Fully Met

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. 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: The policy, "Member Grievance and Appeals System Description," complies with the timeframe resolution and notice to the affected parties for standard resolution of grievances and appeals and expedited resolution of appeals. The acknowledgment templates for grievance and appeals mention the timeframe for standard resolutions. **Required Actions:** None.		
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 the enrollee, it must complete all of the following:	MO.QI.11 Member Grievance and Appeals System Description: page 9 Acknowledgement of Grievance (Template) Acknowledgement of Appeal (Template) Provider Reference Manual: pages-60, 61	Fully Met

• 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: Home State Health's policy, "Member Grievance and Appeals System Description," meets the requirements of this section. **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.	Provider Reference Manual: page 60 MO.QI.11 Member Grievance and Appeals System Description: page 6, 7, 8 Notice of Grievance Resolution Notice of Appeal Resolution	Fully Met
Findings: i. The Complaint and Grievance Coordinator (CGC) will provide written resolution to the member, representative or provider within the timeframes and per the MHD. The grievance response will include, but not be limited to, the decision reached by Home State Health, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the member in accordance with the MHD policies.		

Per the policy, "Member Grievance and Appeals System Description," the notice of resolution includes the results of the resolution process, the date it was completed, and further appeal rights, if applicable; it is in an easily understood language and format, be available in alternative formats, and in a culturally and linguistically appropriate manner that takes into consideration those with special needs; it includes any information required by the State relating to Home State Health's notice of grievance resolution determination; and the procedures by which the member may appeal Home State Health grievance resolution. PTM noted that Home State Health mentions that its members may appeal to the grievance resolution. This is not per the CFR/MHD contract. The Notice of Grievance Resolution complies with the requirements of this section. It has information presented in 15 languages other than English. ii. When the adverse decision is upheld in whole or in part, the notice of resolution is provided to the member in easily understood language. Easily understandable notification includes a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand. iii. Once a resolution to the expedited appeal is made, the member is called to discuss the resolution decision. A Notice of Appeal Resolution Letter (which also documents the acknowledgement) is sent out after calling the member to confirm the conversation of the resolution decision. **Required Actions:** PTM has scored this section as Fully Met. However, PTM recommends that Home State Health updates its policy "Member Grievance and Appeals System Description," based on the above inaccuracy identified.		
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	MO.QI.11 Member Grievance and Appeals System Description: page 7, 8, 9 Notice of Appeal Resolution	Fully Met

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 adverse benefit determination.		

Findings: a. Home State Health's policy "Member Grievance and Appeals System Description" states that the notice of resolution includes the following:

- The results of the resolution process.
- The date it was completed.
- Further appeal rights, if any.

PTM noted that the policy incorrectly mentions about further appeals rights (if any) in the notice of appeal resolution. There is only one level of appeal and thereafter a member can file for State Fair Hearing.

b. When the adverse decision is upheld in whole or in part, the notice of resolution includes:

- Specific reason for the appeal decision, in easily understood language.
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based.
- Notification the member can obtain, upon request and free of charge, a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based with any new or additional evidence.
- Notification that the member is entitled to receive, upon request and at no cost, reasonable access to and copies of all documents relevant to the appeal including any new or additional evidence. Relevant documents include documents and records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
- For medical necessity appeals, a list of titles (e.g., Medical Director, external physician reviewer), and qualifications (e.g., MD, DO), including specialty (e.g., predications, neurology, etc.) of the individual(s) conducting the medical necessity review, of individuals participating in the appeal review. (Participant names do not need to be included in the written notification to members but must be provided to members upon request.) For benefit appeals, only the reviewer's/reviewer's title is required.
- The right to request a State Fair Hearing and how to do so.
- The right to request a continuation of benefits while the hearing is pending and how to make the request.

• Notification that the member may be held liable for the cost of the benefits if the hearing decision upholds HSH's adverse benefit determination. **Required Actions:** PTM assigned a score of Fully Met for this section as the policy incorporated all the criteria in the notice of resolution. However, PTM recommends Home State Health update its policy, "Member Grievance and Appeals System Description," based on the findings identified: there is no provision of an appeal after a notice of resolution to appeal is provided to a member (one level appeal only).		
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.	MO.QI.11 Member Grievance and Appeals System Description: page 10	Fully Met
Findings: Home State Health's policy, "Member Grievance and Appeals System Description," meets all the criteria for State Fair Hearing listed in this section. **Required Actions:** None.		
F. Expedited resolution of appeals (42 CFR 438.410):	Provider Reference Manual: pages-59, 61	Fully Met

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).	MO.QI.11 Member Grievance and Appeals System Description: page 4, 8 Member Handbook: page 47	

Findings: i. Home State Health's policy, "Member Grievance and Appeals System Description," complies with the requirements. An expedited appeal request must be granted to all requests concerning admissions, continued stay, or other health care services for a member who has received emergency services but has not been discharged from the facility.

ii. Home State values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf. No punitive action will be taken against a provider who requests an expedited resolution or supports a member's appeal.
iii. If Home State Health denies a request for an expedited appeal, the appeal must automatically be transferred to the standard timeframe. A reasonable attempt must be made to provide oral notification of the expedited request denial and followed up with written notice within two calendar days.

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. 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.	Provider Reference Manual: pages-59 to 62	Partially Met
Findings: The provider manual includes the following information: a**.** The grievance process allows the member, (or the member's authorized representative (family member, etc.) acting on behalf of the member or provider acting on the member's behalf with the member's written consent), to file a grievance either orally or in writing. Members may request that Home State Health review the adverse action to verify if the right decision has been made. A review may be requested in writing or orally, however oral requests must be followed up in writing unless an expedited resolution is requested.		

PTM noted that the requirement of filing an appeal is incorrect. Oral requests need not be followed-up in writing. Also, a provider can file an appeal on behalf of a member with member's written consent is not stated in the provider manual.

b. The provider manual states that grievance resolution will occur as expeditiously as the member's health condition requires, not to exceed 30 calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the CGC, in coordination with other Home State Health staff as needed. Expedited grievance reviews will be available for members in situations deemed urgent and will be resolved within 72 hours.

Appeals must be made within 60 calendar days from the date on Home State Health's notice of action. Home State Health shall acknowledge receipt of each appeal in writing within 10 calendar days after receiving an appeal. Home State Health shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Home State Health receives the appeal. Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Home State may extend the timeframe for disposition of a grievance or an appeal for up to 14 calendar days if the member requests the extension or the Home State Health demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest.

PTM noted an inaccurate usage of term "notice of action" in the provider manual instead of "notice of adverse benefit determination." PTM also noted an error: the provider manual states (page 62 of 72) that appeals must be requested orally or in writing by the member or the member's representative within 120 days of the Home State Health's notice of resolution of the appeal unless an acceptable reason for delay exists. PTM noted that Home State Health has erroneously stated "appeals" instead of "State Fair Hearing."

c. Home State Health will assist the members and providers with filing a grievance by contacting our Member/Provider Services Department at 1-855-694- HOME (4663).

PTM noted that the provider manual does not mention about Home State Health's assistance to providers in case of filing an appeal and State Fair Hearing on behalf of members.

d. Members have the right to request continuation of benefits during an appeal or State Fair Hearing filing. If Home State Health's actions are upheld in a hearing, the member may be liable for the cost of any continued benefits.

The subcontractors are notified of the Member Grievance and Appeal Policy prior to delegation or implementation and their requirements to comply with the related requirements.

Required Actions: PTM recommends that Home State Health updates its provider manual per the deficiencies/inaccuracies identified.		
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).	MO.QI.11 Member Grievance and Appeals System Description: page 2 Provider Reference Manual: pages-59 to 62 Out-of-Network Provider Information: pages-13 to 16	Partially Met
Findings: The providers are notified of the Member Grievance and Appeals System in the following ways: • Home State Health providers are provided access to a copy of the provider manual at the time Home State Health enters into provider agreements. • Member Grievance and Appeal System information is posted on Home State Health's website. • Out-of-network providers are provided information within 10 calendar days of prior approval of a service or the date of receipt of a claim, whichever is earlier. "Out-of-Network Provider Information" document provides information regarding Home State Health's grievance and appeal system and includes information listed in the previous section (Gi). However, PTM noted the following inaccuracies in the: • Term "Adverse action" is used instead of "adverse benefit determination." • Appeal: The review may be requested in writing or orally, however oral requests must be followed up in writing unless an expedited resolution is requested. **Required Actions:** PTM recommends that Home State Health update information presented in the document for out-of-network providers based on the deficiencies noted above.		
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	MO.QI.11 Member Grievance and Appeals System Description: page 4 <u>Onsite Submission</u> Member Appeals-Closed (Log-Jan 2021)	Fully Met

to the state agency monthly and upon request. If the MCO does not have a separate log for MHD Managed Care members, the log shall distinguish MHD Managed Care members from other MCO members (MHD contract 2.15.3).	Member Grievance-Closed (Log-Jan 2021)	
Findings: Home State Health will submit to the MHD monthly and upon request, a Member Grievance and Appeal Report with template and instructions located on the MHD website at MCO Reporting Schedule and Templates. Home State Health submitted logs for the grievances and appeals in Jan 2021 as an example. **Required Actions:** None.		
ii. The record of each grievance or appeal must contain, at a minimum, all of the following information: 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.	MO.QI.11 Member Grievance and Appeals System Description: page 3	Fully Met
Findings: Home State Health maintains a record/log of all grievances and appeals received verbally or in writing. At a minimum, the records/log will include the following information: • The member's name and member ID number. • The name of the grievant or appellant if not the member. • The date of filing/receipt. • Description of the grievance or appeal. • The date and description of the review resolution at each level. • Whether the grievance was determined valid. • The date of the related member grievance and appeal notifications.		

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).	MO.QI.11 Member Grievance and Appeals System Description: page 4 Provider Reference Manual: page 60	Partially Met
Findings: Home State Health maintains records of all grievances and appeals. A copy of grievance logs and records of disposition of appeals will be retained for 10 years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the 10 year period, the records will be retained until completion of the action and resolution of issues which arise from it or until the end of the regular 10 year period, whichever is later. The provider manual states that a copy of verbal complaint logs and records of disposition or written grievances shall be retained for seven years. PTM noted that the duration of record retention stated in the provider manual is incorrect. **Required Actions:** PTM recommends that Home State Health updates its provider manual to reflect the record retention duration of 10 years.		
I. Continuation of benefits while the MCO appeal and the State Fair Hearing are pending (42 CFR 438.420) (The continuation of 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.	MO.QI.11 Member Grievance and Appeals System Description: page 10	Fully Met
Findings: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the timely filing requirement of appeals for continuing the benefits.		

During the site meeting, Home State Health reported no distinction between Medicaid and CHIP managed care members regarding continuation of benefits while an appeal is pending. Home State Health applies same rules for both programs as there is no distinction 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. d. The period covered by the original authorization has not expired. e. The enrollee timely files for continuation of benefits.	MO.QI.11 Member Grievance and Appeals System Description: page 10	Fully Met

Findings: Home State Health will continue the member's benefits if all of the following are true:
• The member files the appeal in a timely manner, meaning on or before the later of the following:
  ○ Within 10 calendar days of the date on Home State Health's adverse benefit determination notice; or
  ○ The intended effective date of Home State Health's proposed adverse benefit determination.
• The action involves the termination, suspension, or reduction of a previously authorized course of treatment.		

• The services were ordered by an authorized provider. • The authorized period has not expired. • The member requests continuation of benefits. **Required Actions:** None.		
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.	MO.QI.11 Member Grievance and Appeals System Description: pages-10, 11	Fully Met
Findings: Home State Health's "Member Grievance and Appeals System Description" complies with the requirements of this section. **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	MO.QI.11 Member Grievance and Appeals System Description: page 11	Fully Met

the requirements of this section (42 CFR438.420).		
Findings: Home State Health's policy, "Member Grievance and Appeals System Description," complies with the requirements 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 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).	MO.QI.11 Member Grievance and Appeals System Description: page 11	Fully Met
Findings: Home State Health's "Member Grievance and Appeals System Description" complies with the requirements of this section. **Required Actions:** None.		

Compliance: Home State Health

Compliance Score- Grievance and Appeal System						
Total	Met	=	24	×2	=	48
	Partial Met	=	10	×1	=	10
	Not Met	=	0	×0	=	0
Numerator	Score Obtained				=	58
Denominator	Total Sections	=	34	×2	=	68
Score						**85.29**