P.T.M.
Healthcare Business Solutions


# 2022 External Quality Review

## Compliance

## UnitedHealthcare

**Measurement Period:** Calendar Year 2021
**Validation Period:** Feb-May 2022
**Publish Date:** Aug 3, 2022

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

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.

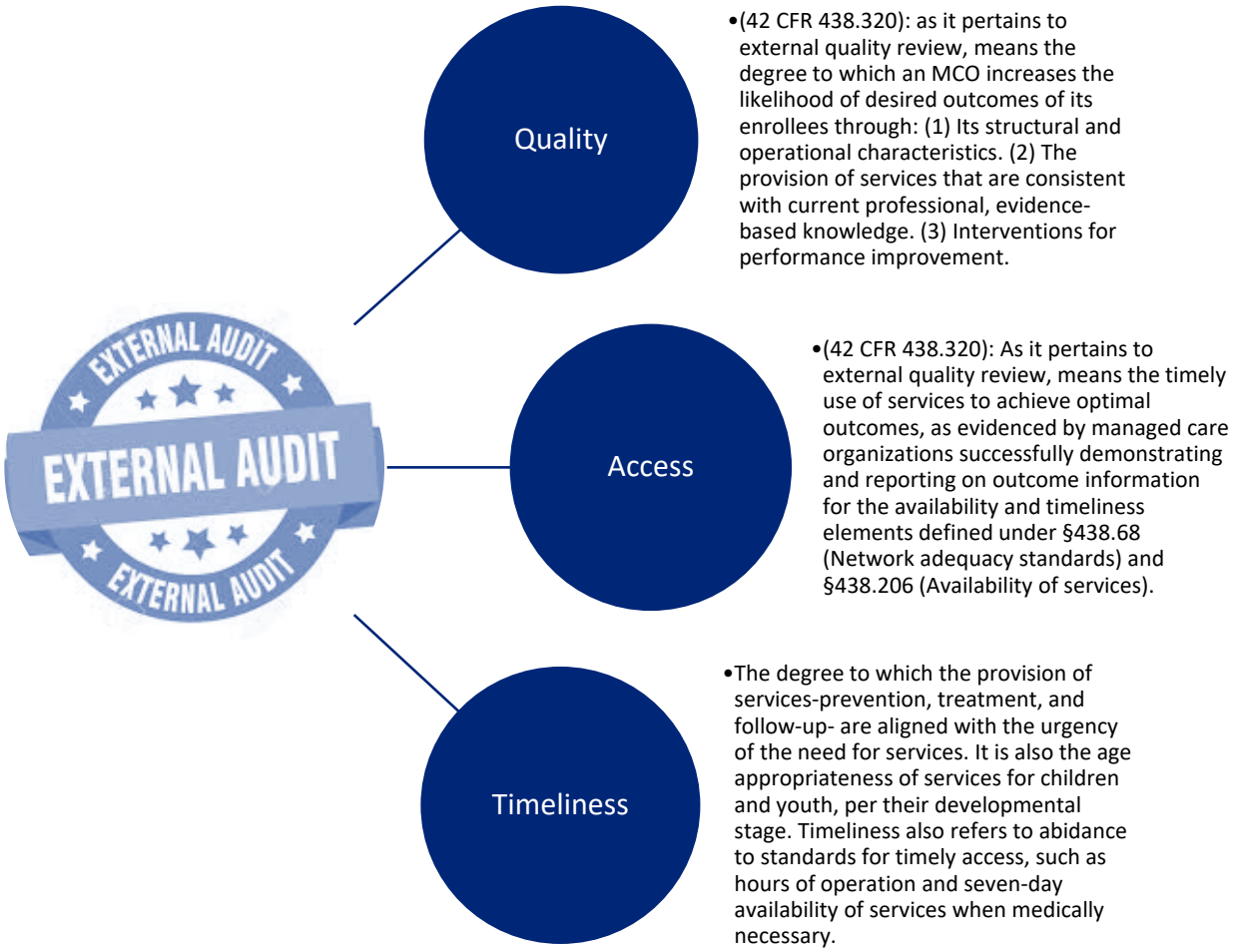


**Figure 1. External Quality Review**

## 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 UnitedHealthcare'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 |
|---|---|---|---|
| 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/UnitedHealthcare:

- 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 UnitedHealthcare'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 UnitedHealthcare in advance of the preliminary review, setting the expectations for the documents' submissions. The preliminary review findings and requirements were also submitted to UnitedHealthcare in writing before the site meeting.

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

*Availability of Services:* QA019 Accessibility of Services and Availability of Practitioners and Providers; 2022 Care Provider Manual; MO Member Handbook; MS-001 Member Services Overview; NC-65 UHN Monitoring for Community and State (C&S) Network Access and Adequacy; Member and Provider Complaints, Provider Availability and Accessibility; Dial America (survey); National Committee for Quality Assurance (NCQA) Network Access and Availability; C&S Standards-Analytic Results; Provider Turnover Report; MCM 004 Member Initiated Second and Third Opinion; Single Case Agreement Process; MCM 011 Cultural

Proficiency; MO-MK001 Marketing Guidelines; Advancing Health Equity to Improve Outcomes; Health Disparity Report 2021; Sustainability Report 2020; UnitedHealthcare Credentialing Plan 2021-2023; OB/GYN Provider Network; and MUM 003 Referrals.

*Assurances of Adequate Capacity and Services:* MO HealthNet Provider Directory; Enrolled Providers; MO-002 Primary Care Provider Responsibilities; UnitedHealthcare Credentialing Plan; Behavior Health Provider List; FQHC, RHC Provider List; OB/GYN Provider List; PCN Group (Children's Mercy Health Providers); Dental Provider List; Tertiary Care Specialists; Ranken Jordan Hospital and Shriners Hospital; Network Access Plan-Disposition; MO-PT001 State Notification of Provider Termination; PCP Notifications; and Expansion Readiness Approval.

*Coordination and Continuity of Care:* MOHNET ID Cards; UnitedHealthcare Welcome Letter; MCM 001 Identification of High-Risk Members for Care Management; MCM 013 Transition of Care; MCM 002 Care Management Process; NCM 002 Case Management Process; Disclosure to Third Parties; MCM 013 Transition of Care; UnitedHealth Group Policy Summary; P17 Privacy Training; MDM 001 Disease Management Process; UCSMM.ALL.06.14.IP-G3 Referral to Discharge Care Management; UCSMM.ALL.06.14.IP-G Discharge Care Management Review Workflow; UCSMM.ALL.06.14.IP-I Post-Discharge Outreach Process; Genoa's Meds to Bedside Program; MCM 0012 Risk Stratification Process; and PCP Care Plan Letter.

*Coverage and Authorization of Services:* UCSMM.06.10 Clinical Review Criteria; UCSMM 2017 002 Management of Behavioral Health Benefits Addendum; QA017 MO HCY/EPSDT; Radiology and Cardiology Prior Authorization Program; Participating Plan Addendum; MOUM001 Emergency Care and Post-Stabilization; UCSMM.08.10 Mental Health Parity Program Quality and Compliance Monitoring; UCSMM.07.10 Appeal Peer Reviewer Qualifications; UCSMM.06.15 Peer Clinical Review; CL.001 Payment of Custom Items; UCSMM.06.14 Initial Clinical Review; UCSMM 06.16 Initial Review Timeframes; and UCSMM.02.12 Performance Assessment and Incentives.

*Provider Selection:* Missouri State Programs Regulatory Requirements Appendices (Medical and Non-Medical) Subcontractors; State and Federal Regulatory Addendum E to the UnitedHealthcare Credentialing Plan; Clinician Credentialing Process; Optum Physical Health Credentialing Risk Management Plan 2021; Missouri Addendum to Credentialing Policies; CRD001 Provider Credentialing and Recredentialing; Ongoing Monitoring of Sanctions and Complaints; Organizational Provider Credentialing and Recredentialing (Behavioral Health); Reporting Requirements for Credentialing Decisions-NPDB and Licensing Agencies; POL.17267538 Vision Credentialing and Recredentialing Policy; POL.17701055 Vision Ongoing Sanction Monitoring; MO HealthNet Demographic File

Layout; Missouri Contract Risk Assessment; CSQ 01 Advance Directives Medical Record Review; Missouri Facilities MRR Instructions; MMAC Ownership and Disclosures-Provider Enrollment; Enrolled Provider List MMAC; Provider Disclosure; Missouri Initial Credential to Load (ICL) Reporting Dashboard 2021; MO Fraud Waste Abuse Report Log; PROVDIR 001 Provider Directory Creation and Distribution; IT Flow Chart-Provider; MO-EE-001 Non-Discrimination in Hiring; Supplier Code of Conduct; and WBE Expense Report.

*Confidentiality:* PP-01 MO Privacy and Confidentiality; UnitedHealth Group 2022 Privacy and Security Program Overview; Privacy Policy Manual; Security Training and Awareness Overview; 5B Mobile Device Security; 10A External Party Security; Confidentiality and Non-Disclosure; 13A Data Classification and Protection Standard; Electronic Communication Gateway Overview; How UnitedHealth Group Protects Customer Data; Information Security/Privacy Incident Response Process Overview-Jan 2022; Enterprise Information Security (EIS) Supplier Information Risk Governance; P14 Authorizations; UnitedHealth Group Personal Information Privacy and Data Protection; 13A Data Classification and Protection Standard; P22 Business Associate Contracting; P9 Disclosures to Third Parties; P13 De-Identification; P3 Minimum Necessary; 10A External Party Security; P8 Accounting of Disclosures; P6 Right to Inspect and Obtain Copy of DRS; ID 5924 Enterprise Records and Information Management; Records Retention Summary; P15 Document Retention; P6 Right to Inspect and Obtain Copy of Designated Record Set; and P12 Marketing.

*Grievance and Appeal System:* MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy; MO HealthNet Member Appeals and Grievances (Inquiry-Process); Grievance and Appeals Flyer; UCSMM.06 Initial Adverse Determination Notices; Notice of UnitedHealthcare Community Plan of Missouri Adverse Benefit Determination; and MO Issue Logs 2021 (Open and Closed).

**Site Interviews:** PTM conducted a site meeting with UnitedHealthcare on May 4, 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.

| **Table 2: MCO Information** |
|---|
| MCO Name: UnitedHealthcare |
| MCO Location: 13655 Riverport Drive, Maryland Heights, MO, 63043 |
| Audit Contact: Katherine Whitaker, Associate Director Compliance |

UnitedHealthcare team included: Chief Executive Officer; Vice President, Clinical Programs; Associate Director, Compliance; Senior Medical Director; Appeals Analyst; Senior Research

Consultant; Associate Director, General Management; Network Program Consultant; Director, Clinical Quality; Director, Medical Clinical Operations; and Associate General Counsel.

**Compliance Rating**

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

**Table 3. Compliance Rating Scale**

| | |
|---|---|
| ● | **Fully Met**: All documentation listed under a regulatory provision, or component thereof, is present. MCO staff provide responses to reviewers that are consistent with each other and with the documentation. A State-defined percentage of all data sources–either documents or MCO staff–provides evidence of compliance with regulatory provisions. |
| ● | **Partially Met**: All documentation listed under a regulatory provision, or component thereof, is present, but MCO staff are unable to consistently articulate evidence of compliance; or MCO staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice; or any combination of "Met," "Partially Met" and "Not Met" determinations for smaller components of a regulatory provision would result in a "Partially Met" designation for the provision as a whole. |
| ● | **Not Met**: No documentation is present, and MCO staff have little to no knowledge of processes or issues that comply with regulatory provisions; or<br>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 UnitedHealthcare 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, UnitedHealthcare did not receive points for the updated documents. However, PTM allowed updating inconsistent/inaccurate information, and those changes were considered for scoring.

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

**Table 4: Compliance Level**

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

**Corrective Action Process**

PTM initiates a corrective action plan (CAP) after submitting the final report to the MHD. The CAP will be recommended for all weaknesses identified, including the Not Met/Partially Met criteria. The CAP must detail the interventions UnitedHealthcare plans to implement to comply with the regulations, including how UnitedHealthcare measures the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. UnitedHealthcare must submit the CAP to the MHD within 10 calendar days of its initiation. When deemed sufficient, the MHD, in consultation with PTM, will approve UnitedHealthcare's CAP. Within 90 calendar days of CAP approval, UnitedHealthcare must submit its documentation to close the identified gaps. The results of the corrective actions taken by UnitedHealthcare 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 UnitedHealthcare achieving a compliance score of 87.9%. Table 5 summarizes the findings from the first (EQR 2021) and second year (EQR 2022) of the current three-year review cycle (EQR 2021-2023).

**Table 5: Compliance Summary for EQR 2021-2022**

| | | Number of Sections | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 42 CFR 438/457 | Medicaid/CHIP Regulation | Total | Fully Met | Partially Met | Not Met | Score | Score % | Confidence Level |
| 438.206 457.1230(a) | Availability of services | 10 | 10 | 0 | 0 | 20 | 100 | High |
| 438.207 457.1230(b) | Assurances of adequate capacity and services | 14 | 3 | 11 | 0 | 17 | 60.7 | Low |
| 438.208 457.1230(c) | Coordination and continuity of care | 19 | 16 | 3 | 0 | 35 | 92.1 | High |
| 438.210 457.1230(d) | Coverage and authorization of services | 19 | 10 | 9 | 0 | 29 | 76.3 | Moderate |
| 438.214 457.1233(a) | Provider selection | 14 | 12 | 2 | 0 | 26 | 92.9 | High |
| 438.224 457.1110 | Confidentiality | 22 | 21 | 1 | 0 | 43 | 97.7 | High |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 438.228<br>457.1260 | Grievance and appeal system | 34 | 28 | 6 | 0 | 62 | 91.17 | High |
| **Overall Result EQR 2022 (Year 2)** | | **132** | | | | **232** | **87.9** | **Moderate** |
| 438.56<br>457.1212 | Disenrollment: Requirements and limitations | 18 | 18 | 0 | 0 | 36 | **100** | High |
| 438.100<br>457.1220 | Enrollee rights | 18 | 13 | 05 | 0 | 31 | **86.1** | Moderate |
| 438.114<br>457.1228 | Emergency and post-stabilization services | 12 | 11 | 01 | 0 | 23 | **95.8** | High |
| 438.230<br>457.1233(b) | Subcontractual relationships and delegation | 12 | 08 | 04 | 0 | 20 | **83.3** | Moderate |
| 438.236<br>457.1233(c) | Practice guidelines | 06 | 06 | 0 | 0 | 12 | **100** | High |
| 438.242<br>457.1233(d) | Health information systems | 16 | 05 | 08 | 3 | 18 | **56.3** | Low |
| **Overall Result EQR 2021 (Year 1)** | | **82** | | | | **140** | **85.4** | **Moderate** |

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

UnitedHealthcare'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. UnitedHealthcare 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. During the interview, the staff was knowledgeable about the geographical access reporting system UnitedHealthcare utilized to track the provider member ratio and geographic distribution of providers and members.

b. UnitedHealthcare educates providers on the accessibility of services and availability of practitioners' requirements through written notification when an opportunity is identified and about standards requirements in the provider manual. Member education is provided through the member handbook, which outlines the standards for provider appointment availability.

c. UnitedHealthcare monitors compliance with appointment standards using one or more of the following and shall have a corrective action plan when appointment standards are not met:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) and supplemental questions.
- Key Member Indicators Survey questions.
- Qualified Health Plan Survey questions.
- Primary Care Practitioner and Specialists Accessibility Surveys.
- PCP After-hours Access Survey.
- Member access complaints.
- Out-of-network service requests and claim utilization.
- Behavioral Health satisfaction survey questions, complaints, treatment record reviews, appointment tracking, and claims data.

d. UnitedHealthcare provides second opinions both in-network and out-of-network when requested by a member are provided at no cost to the enrollee.

e. UnitedHealthcare adequately and timely covers services out-of-network for the enrollee for as long as its provider network cannot provide them.

f. UnitedHealthcare prioritizes its engagement with qualified providers who promote a culturally sensitive environment and embrace the health care provider's role in minimizing health care disparities. Care Provider Manual informs the providers that UnitedHealthcare has developed a Cultural Competency Program to meet its membership needs.

g. UnitedHealthcare meets the provision of physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities by the providers.

h. UnitedHealthcare allows female members direct access to in-network Obstetrics/Gynecology (OB/GYN) services of their choice for covered services (women's routine and preventive healthcare services) if her PCP is not a women's health specialist.

### *4.2.2 Weaknesses and Recommendations.*

No areas of concern were identified regarding the regulation.

## 4.3 Regulation II- Assurances of Adequate Capacity and Services

A detailed evaluation is provided in Appendix B.

### *4.3.1 Strengths*

a. 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). UnitedHealthcare has contracted with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), Local Public Health Agencies, Tertiary Care centers, pediatric hospitals, family planning, and sexually transmitted disease treatment providers and dentists. UnitedHealthcare is prepared to implement the Local Community Care Coordination Program (LCCCP) model that focuses on providing care management, care coordination, and disease management through local healthcare providers. UnitedHealthcare contracts with Children's Mercy Health for LCCCP.

b. UnitedHealthcare 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 is currently carried out by the MHD.)

c. The MHD is notified of any change in the provider network or UnitedHealthcare'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 6.

**Table 6. Assurances of Adequate Capacity and Services**

| Weakness | EQRO Recommendation |
|---|---|
| a. None of the policies specified the range of services and provider types that UnitedHealthcare ensures to include in its network. | Update the policy, "NC-65 UHN Monitoring for Community and State (C&S) Network Access and Adequacy," to specify the range of services and provider types that UnitedHealthcare ensures to include in its network. |
| b. UnitedHealthcare did not submit documentation to show that it does not require an exclusive relationship or not advertise/hold itself out with any provider. | Update the policy, "Accessibility of Services and Availability of Practitioners and Providers," and subcontracts based on the deficiency identified by PTM. |
| c. The provider manual does not include all the required responsibilities of primary | Update the provider manual to include all the responsibilities of a PCP based on the |

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| care providers (PCP). Revisions to the policy, "Primary Care Provider Responsibilities," were made during the review process after PTM identified the deficiency. | MHD contract, section 2.4.2(a). The revised policy, "Primary Care Provider Responsibilities," must be submitted to the MHD for approval. |
| d. A policy for eligible providers serving as PCPs in institutions with teaching programs and specialists serving as PCPs for members with chronic and disabling conditions was not submitted. Revisions to the policy, "Primary Care Provider Responsibilities," were made during the review process after PTM pointed out the deficiency. | Same comment as above. |
| e. Policy/procedure to comply with the requirement that UnitedHealthcare shall include in its network a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults was not submitted. | Submit a policy to include the guidelines about the inclusion of behavioral health professionals, Community Behavioral Health Organizations (CCBHOs), and Community Mental Health Centers (CMHCs) in the provider network. |
| f. Policy/procedure to show that UnitedHealthcare 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 was not submitted. | Submit a policy to comply with requirements pertaining to FQHCs and RHCs. |
| g. UnitedHealthcare did not submit a policy/procedure to include Title X and STD providers. UnitedHealthcare did not submit documentation to show its contract agreement with Family Planning and STD treatment providers not in the network describing, at a minimum, care coordination, medical record management, and billing procedures. | Submit a policy and an agreement template for out-of-network providers to include the minimum requirements describing care coordination, medical record management, and billing procedures. |
| h. A policy and the list of dental providers were not submitted to support the | Submit documents to support that UnitedHealthcare contracts with and reimburses any licensed dental provider |

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|---|---|
| provision of dental services in a school setting. | who provides preventive dental services (i.e., dental exams, prophylaxis, and sealants) in a school setting. |
| i. Policy/guidelines on providing tertiary care services and a process for providing such services, including transfer protocols and arrangements with out-of-network providers, were not submitted. | Submit documentation. |
| j. UnitedHealthcare did not submit policy/guidelines to include specialty pediatric hospitals in its provider network. | Submit documentation. |
| k. Policy and procedure were not submitted to comply with the requirement that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP). UnitedHealthcare reported that there are no IHCPs in Missouri, so they do not have any documentation for submission. | PTM noted information about Native Americans' access to care in UnitedHealthcare's provider manual. However, UnitedHealthcare must comply with all the requirements for access to care per the MHD contract, section 2.4.18 in its policies and procedures. |
| l. Policy/procedure to include enrollment of a new population impacting UnitedHealthcare's operations was not submitted. | Incorporate procedure for assessing UnitedHealthcare's readiness for accommodating a newly enrolled population. |

## 4.4 Regulation III- Coordination and Continuity of Care

A detailed evaluation is provided in Appendix C.

### *4.4.1 Strengths*

a. All members select or are assigned to a single practitioner responsible for coordinating care and making referrals to specialists for the enrolled population.

b. UnitedHealthcare has a policy and procedure that addresses the transition of care requirements for newly enrolled members from other MCOs or Fee-For-Service (FFS) programs.

c. UnitedHealthcare ensures that relevant enrollee information is transferred between the subcontractors in a timely manner before transitioning to the new subcontractor if UnitedHealthcare changes subcontractors.

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

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

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

g. Prior authorization during the transition of care for inpatient and residential treatment days is not required.

h. UnitedHealthcare’s Privacy and Security Programs are designed to comply with federal and state privacy laws and regulations, including, as applicable, the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the Gramm-Leach-Bliley Act (GLBA), Children's Online Privacy Protection Rule (COPPA), and state privacy laws including but not limited to the California Consumer Privacy Act (CCPA).

i. UnitedHealthcare may use a Section 2703 designated health home provider to perform disease management functions if the health home provider is a member of the UnitedHealthcare's network.

j. UnitedHealthcare 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. UnitedHealthcare coordinates the services to the enrollees between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

k. UnitedHealthcare provides services for enrollees with special health care needs. The care manager reviews the referral source and risks stratification data to identify complex or special needs, current risks as well as the utilization history of a member. All new members entering UnitedHealthcare are screened for care management programs via a health risk assessment (HRA) tool or may receive a more comprehensive assessment based on program need. A person-centered, evidence-based plan of care (POC) is developed by the care manager in collaboration with the member, caregiver/family (with member's consent), and the interdisciplinary care team. The team includes the member's PCP, other medical and behavioral health providers, and external care managers involved in the member's care.

i. UnitedHealthcare permits direct access and standing referrals for a specialist or specialty care center in case of a member's chronic or life-threatening condition. Also, a standing referral to an out-of-network provider is provided if UnitedHealthcare does not have a provider with the required training and experience within its network.

j. During the interview, UnitedHealthcare reported that in the fall of 2020, they launched a pilot program focusing on providing homeless people housing, shelters, and food.

### *4.4.2 Weaknesses and Recommendations*

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

**Table 7. Coordination and Continuity of Care**

| Weakness | EQRO Recommendation |
|---|---|
| a. UnitedHealthcare did not submit information on the timeframe (90 days) within which they are required to screen all new enrollees to assess their needs. | Update the policy, "Identification of High-Risk Members for Care Management," to mention the timeframe for compliance. |
| b. UnitedHealthcare did not submit documentation to show that each provider furnishing services to enrollees maintain and shares, as appropriate, an enrollee health record in accordance with professional standards to prevent duplication of those activities. | Submit policy and ensure that the requirement of maintaining and sharing enrollee health records is met. |
| c. Hospital Care Transition (HCT) plan does not include onsite coordinators to work directly with the hospital staff to assist members in their care transition. | Update Discharge Care Management Review Workflow to include the coordinator's presence onsite at the facility. When members are identified with |

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|---|---|
| | an admission requiring HCT management services, the coordinators must work directly with the hospital staff to assist members in their care transition. This requirement can be implemented after the Covid-19 pandemic restrictions are no longer necessary. |
| d. UnitedHealthcare's "Case Management Process" policy has incorrect information on completing the assessment within 60 days. | Update policy, "Case Management Process," to reflect the completion time of care management assessment within 30 calendar days of receiving a notification/identification. |

## 4.5 Regulation IV- Coverage and Authorization of Services

A detailed evaluation is provided in Appendix D.

### *4.5.1 Strengths*

a. UnitedHealthcare coordinates services with child-serving agencies and providers, provision of all medically necessary individualized Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (called as Healthy Children and Youth-HCY program in Missouri), and arrangements for necessary follow-up care regardless of whether the required service is a covered benefit.

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

c. UnitedHealthcare conducts and supports ongoing quality monitoring of MHP regulatory requirements as defined by the Mental Health Parity and Addiction Equity Act (MHPAEA), 21st Century Cures Act, 2021 Consolidated Appropriations Act (CAA), and all applicable federal or state-specific MHP laws and regulations.

d. UnitedHealthcare’s denial of a service authorization request or authorizing service in an amount, duration, or scope that is less than requested is made by an individual with appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and support needs.

e. UnitedHealthcare 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) delivered or placed within six months of approval, even if the member's enrollment in UnitedHealthcare ends.

f. Prior Authorization decisions are made within 36 hours, which shall include one working day of obtaining all necessary information for routine services. UnitedHealthcare notifies the requesting provider and gives the enrollee written notice of any decision by UnitedHealthcare to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested.

g. Staff members and practitioners involved in clinical or administrative review will not be given the incentive to make determinations that result in underutilization nor rewarded for issuing non-approval or non-certification determinations.

h. During the interview, UnitedHealthcare reported that they have an emergency backup plan for critical members in the event of a natural disaster. The senior leadership conducts mock exercises and the disaster plan is updated annually. Providers are contracted for after-hour service arrangements, e.g., online call staff and urgent care centers.

### *4.5.2 Weaknesses and Recommendations*

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

**Table 8. Coverage and Authorization of Services**

| Weakness | EQRO Recommendation |
|---|---|
| a. UnitedHealthcare did not identify, define, and specify the amount, duration, and scope of services required to offer categorically needy and medically needy members that are sufficient to achieve its purpose. | Submit documentation. |
| b. UnitedHealthcare's policies did not address that the services will be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS. | Address the missing element and create/update the policies to describe how it meets the requirements instead of presenting the contractual requirements "as is." |
| c. UnitedHealthcare did not submit a policy to meet the criterion regarding protecting | Submit documentation. |

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| and allowing members the freedom to choose family planning services. | |
| d. Policy, "Clinical Review Criteria," has two versions. The old version copied the MHD contract quoting sections about the requirements, such as: if an MCO requires a referral, assessment, or other requirements prior to the member accessing requested medical or behavioral health, such requirements shall not impede the timely delivery of the medically necessary service; and ensures uninterrupted medical supplies, oxygen, nutrition, and treatment regimens.<br>The new version does not have any information that complies with the above mentioned criteria. | Reconcile two versions of the policy, "Clinical Review Criteria," adopt the MHD's requirements and describe the process as applicable. |
| e. Documentation and adopting requirements from the MHD contract in UnitedHealthcare policies remains an issue.<br>The policy, "Initial Clinical Review," has two versions. The old version quotes the requirements from the MHD contract, such as: if an 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 (except under some circumstances-misinterpretation or omission of health information, contract termination, coverage termination); and MCO shall not deny physician requested continuing coverage of an inpatient hospital stay unless an alternative service is recommended by the MCO.<br>The new version of the policy does not meet the requirements. | Reconcile two versions of the policy, "Initial Clinical Review," adopt the MHD's requirements and describe the process as applicable. |
| f. Approval or denial of non-emergency services, when determined by emergency room staff, shall be provided by the MCO within 30 minutes of the request for | Reconcile the two versions of the policy, "Initial Review Timeframes," and adopt the MHD's requirements for all prior authorization decisions. |

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| behavioral health services. UnitedHealthcare did not submit its policy decision timeframe for physical health-related non-emergency services. | |

## 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. UnitedHealthcare monitors participating licensed independent practitioners (LIPs) and facilities for complaints, potential quality concerns, or identified adverse events. Identified concerns will be tracked and resolved in accordance with UnitedHealthcare's policy. The Universal Credentialing Data Source form (Form UCDS) by the Council for Affordable Quality Healthcare (CAQH) has been adopted and used by UnitedHealthcare and their agents when credentialing or re-credentialing health care professionals in compliance with the MHD contract, section 2.18.8(c).

b. UnitedHealthcare credentials and re-credentials all in-network providers listed within the MHD contract, section 2.18.8(c) within 60 business days of applying. UnitedHealthcare has submitted data showing provider credentialing turn-around-time as 100% for each month in CY 2021.

c. UnitedHealthcare monitors primary care physicians' compliance with advance directives through Medical Records Review (MRR). The MRR data, including advanced directives, are reviewed quarterly at the Quality Management Committee and the results are included in the re-credentialing process, as applicable, to determine whether the provider is following the policies and procedures related to advanced directives.

d. UnitedHealthcare requires all its subcontractors to make disclosures to UnitedHealthcare 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 UnitedHealthcare and the State for any or all of such information.

e. UnitedHealthcare reviews state and federal reports, as well as publicly available

health care entity reports within 30 calendar days of their release to identify and exclude Participating LIPs who have had Office of Inspector General (OIG) sanctions on Medicare or Medicaid participation, General Services Administration (GSA) debarments, or other sanctions or restriction on their ability to practice. Providers must represent that they are licensed and certified under applicable state and federal statutes and regulations and are eligible to participate in the Medicaid program.

f. The data for the newly credentialed providers attached to a new contract was loaded into the claim adjudication and payment system with the contractual timeframe of 10 business days (100% compliance).

g. UnitedHealthcare does not make credentialing and re-credentialing decisions based on a licensed independent practitioner's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the licensed independent practitioner or facility specializes. UnitedHealthcare also does not discriminate in terms of participation, reimbursement, or indemnification against any licensed independent practitioner acting within the scope of the applicable license or certification under State law, solely based on the license or certification. Every request for proposal (RFP) managed by the Enterprise Sourcing & Procurement (ES&P) team targets the inclusion of at least one diverse supplier, where available.

### *4.6.2 Weaknesses and Recommendations*

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

**Table 9. Provider Selection**

| Weakness | EQRO Recommendation |
|---|---|
| a. No documentation was submitted about notifying the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing process. | Submit documentation. (This is not the same as the quarterly report log fraud, waste, and abuse report log that UnitedHealthcare submitted.) |
| b. UnitedHealthcare's timeframe (5 business days) from credentialing to uploading the newly credentialed providers to the existing contract in the claims system was met only for four months in CY 2021. UnitedHealthcare's compliance was 78%-100% throughout the year. | UnitedHealthcare carried out root cause analysis for the months the target was missed. UnitedHealthcare should adhere to the contractual timeframes at all times. |
| c. UnitedHealthcare's Missouri State | Update the appendices for the |

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| Programs Regulatory Requirements Appendices for Medical and Non-Medical Subcontractors do not include a statement about including minorities in their company. | subcontractors communicating the policy statement on minority inclusion or provide a link to its webpage on Supplier Diversity-UHG.com. |

## 4.7 Regulation VI- Confidentiality

A detailed evaluation is provided in Appendix F.

### *4.7.1 Strengths*

a. UnitedHealthcare policies and procedures address privacy and security requirements: minimum necessary; use and disclosure; business associates; authorizations; individual rights; privacy notice; complaints; and safeguards. The UnitedHealthcare's Corporate Privacy Office (CPO) head leads Health Insurance Portability and Accountability Act (HIPAA) privacy compliance for UnitedHealthcare, including the development of enterprise-wide policies and procedures to safeguard the privacy of individuals PHI consistent with federal and state laws and regulations (as applicable).

b. UnitedHealthcare workforce members are responsible for safeguarding the privacy of Protected Health Information (PHI/electronic PHI): confidentiality of information concerning applicants and members of public assistance; 42 CFR Part 2, regarding confidentiality of substance use disorder member records; and records for adult and adolescent STDs and adolescent family planning services.

c. All UnitedHealthcare employees receive mandatory privacy and security training at the beginning of their employment (within 30 days of joining the workforce) and at least annually.

d. No disciplinary actions will be applied against a whistleblower Workforce Member (based on the fact that they were a whistleblower) or a workforce member who is a victim of a criminal act and Discloses PHI to law enforcement (subject to certain limitations).

e. Use and Disclosure of PHI are permitted without authorization only for treatment, payment, and day-to-day Healthcare operations. Disclosures of an individual's PHI to government entities are mandated by law and do not require the authorization or advance notification to an individual (but may still require an accounting. However, the authorization exceptions do not apply to uses and disclosures of psychotherapy notes and marketing.

f. UnitedHealthcare Business Associate may aggregate PHI of more than one Covered Entity to conduct analyses for the provision of data aggregation services to each Covered Entity (or Business Associate on the Covered Entity's behalf), provided that the analyses are related to the Healthcare Operations of each such Covered Entity, and data aggregation services are authorized by the relevant Business Associate Agreement (BAA).

g. The de-identified information that has been re-identified may not be disclosed or used except as permitted under the Privacy Rule and the Privacy Policy Manual for Disclosure and Use of PHI.

h. UnitedHealthcare enters BAA based on HIPAA privacy and security requirements, with any vendor/subcontractor who will have PHI access. UnitedHealthcare may disclose PHI to a Business Associate and allow the Business Associate to create, receive, maintain, or transmit PHI on its behalf, provided it obtains satisfactory assurances that the Business Associate will appropriately safeguard the information.

i. UnitedHealthcare 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 state agency by no later than five calendar days of requesting.

j. UnitedHealthcare shall report to the state agency's Privacy Officer any security incident, breech, unauthorized use, or disclosure of PHI immediately upon becoming aware of such incident. A written description of the breach, the 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, will be provided within five calendar days of notice.

k. Record retention policy for PHI under HIPAA is a minimum of six years from the date of creation or when it was last in effect, whichever is later. For CMS-regulated entities, such documentation must be retained for a minimum of 10 years.

l. Marketing is not a permissible use or disclosure of PHI under HIPAA. It requires Member authorization (except for face-to-face communication by the Covered Entity or promotional gifts of nominal value provided by a Covered Entity to a member). For marketing communications made by UnitedHealthcare that require written authorization and involve direct or indirect remuneration to a UnitedHealthcare member from a third party, the authorization must state that such remuneration is involved.

m. UnitedHealthcare 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).

### *4.7.2 Weaknesses and Recommendations*

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

**Table 10. Confidentiality**

| Weakness | EQRO Recommendation |
|---|---|
| UnitedHealthcare did not have a policy to 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 available to the state agency and to the Secretary of the Department of Health and Human Services or designee for purposes of determining compliance with the HIPAA Rules and the MHD contract within the timeframe of 10 calendar days. | UnitedHealthcare updated its policy, "Privacy and Confidentiality," after the preliminary review when PTM identified the noncompliance. The revised policy should be submitted to the MHD for approval. |

## 4.8 Regulation VII-Grievance and Appeal System

A detailed evaluation is provided in Appendix G.

### *4.8.1 Strengths*

a. UnitedHealthcare's Government Appeals Operations (GAO) processes appeals and grievances submitted by members and their authorized representatives, including providers submitting on behalf of members. The Resolving Analyst (RA) is the staff person responsible for investigating appeals and grievances and compiling the electronic record. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals. The RA assigned to the case on grievance and appeal is an individual not involved in the previous disposition and is not a subordinate of the individual who made the previous disposition.

b. Written policies and procedures detail the operation of the grievance and appeal system and provide simplified instructions on how and when to file a grievance or appeal and to request a State Fair Hearing, the timing of the notice of adverse benefit determination, the time frame for standard service decisions (36 hours includes one

business day) and extension (not more than 14 calendar days). Enrollees, a provider, or an authorized representative with the enrollee's written consent may request an appeal, file a grievance, or request a State Fair Hearing on behalf of an enrollee, with an exception that providers cannot request continuation of benefits. An enrollee can file a State Fair Hearing if an adverse benefit determination is upheld or the timeframe to resolve an appeal within 30 calendar days is exhausted.

c. UnitedHealthcare 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). UnitedHealthcare acknowledges receipt of each grievance and appeal in writing within 10 business days after receiving a grievance or appeal.

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 UnitedHealthcare (or at the direction of UnitedHealthcare) in connection with the appeal of the adverse benefit determination.

f. UnitedHealthcare complies with the timeframe for resolution of grievance (30 calendar days), appeal (30 calendar days), and expedited resolution for appeal (72 hours), and notices to the affected parties are provided. UnitedHealthcare does not take punitive or retaliatory actions against a member or provider supporting a member for filing an expedited appeal.

g. UnitedHealthcare maintains the records for grievances and appeals in the Escalation Tracking System (ETS) in an accessible manner to the CMS and the MHD and submits logs for grievances and appeals each month in the format required by the MHD. The records are maintained for a minimum of 10 years.

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

i. During the interview, UnitedHealthcare reported that the grievances filed in CY 2021 were 0.05-0.07 per 1000 members and appeals were 0.03-0.05 per 1000 members, which was within their target (4 per 1000 members). The number of adverse benefit determination notices was 12252, out of which 204 (1.7%) were appealed. (Note: The data for comparison from the last year was not provided.)

### *4.8.2 Weaknesses and Recommendations*

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

**Table 11. Grievance and Appeal System**

| Weakness | EQRO Recommendation |
|---|---|
| a. Even though the definitions of grievance, appeal, grievance and appeal system, inquiry, adverse benefit determination, and State Fair Hearing are accurately defined in the policies, the provider manual does not include an accurate definition of adverse benefit determination and appeal. | Update the provider manual with accurate definitions of adverse benefit determination, and appeal per 42 CFR 438.400. |
| b. The member flyer explaining the grievance and appeal system distributed to the members upon enrollment had incomplete and inaccurate information. | The flyer was updated after PTM identified the deficiencies in the preliminary review. PTM recommends that UnitedHealthcare submits the revised flyer for the MHD's approval and posts the MHD's approval date in the right lower corner of the flyer per the requirements of the MHD contract, section 2.14.6(e). |
| d. The policy, "Initial Adverse Benefit Determination Notices," did not address all the criteria required to be included in the notice of adverse benefit determination per 42 CFR 438.404. | UnitedHealthcare updated another policy, "Member Appeal, State Fair Hearing and Grievance," to comply with all the criteria required to be included in the notice of adverse benefit determination after PTM pointed out the deficiencies in the preliminary review. PTM recommends that the revised policy be submitted to the MHD for approval. |
| e. The policy, "Initial Adverse Benefit Determination Notices," states that a written notice of adverse determination | PTM noted that the provision of peer clinical review in the notice of adverse benefit determination is not in compliance with 42 CFR 438.404. The peer clinical |

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| includes the availability of peer clinical review before filing an appeal. | review can be held before the notice is mailed to the member/provider and must not be included in the notice of adverse benefit determination. The policy and procedure must be updated. |
| f. Policies, "Initial Review Timeframes," acknowledged the requirements listed in this section by posting the MHD contract/CFR sections. Another policy, "Appeal Process and Record Documentation," has the same issue. | PTM recommends that UnitedHealthcare adopt the MHD contract/CFR requirements to create its policies and procedures. |
| g. The member handbook does not provide information on applying for a State Fair Hearing when UnitedHealthcare does not resolve an appeal within 30 calendar days (deemed Exhaustion of appeal process). | Update the member handbook. |
| h. The provider manual has the following deficiencies/inaccuracies:<br>• Definition of an appeal and State Fair Hearing.<br>• All conditions in adverse benefit determination under which a provider on behalf of a member can file an appeal.<br>• The time frame for filing under which benefit would continue pending an appeal or a State Fair Hearing during the review period. | UnitedHealthcare incorporated the timeframe for filing an appeal or State Fair Hearing under which benefits would continue after PTM identified the deficiency. The remaining information should be updated in the provider manual. |

## 5.0 CONCLUSION

Table 12 presents the key findings from the evaluation of Quality, Timeliness, and Access to Healthcare services provided by UnitedHealthcare in the current review cycle: EQR 2021-2023.

**Table 12. Audit Results EQR 2021-2022**

| 42 CFR 438/457 Regulation | Key Finding | CAP (Yes/No) |
|---|---|---|
| 438.206/457.1230(a) Availability of services | No concerns | No |
| 438.207/457.1230(b) Assurances of adequate capacity and services | Concerns identified | Yes |

| | | |
|---|---|---|
| 438.208/457.1230(c) Coordination and continuity of care | Concerns identified | Yes |
| 438.210/457.1230(d) Coverage and authorization of services | Concerns identified | Yes |
| 438.214/457.1233(a) Provider selection | Concerns identified | Yes |
| 438.224/457.1110 Confidentiality | Concerns identified | Yes |
| 438.228/457.1260 Grievance and appeal system | Concerns identified | Yes |
| 438.56/457.1212 Disenrollment: Requirements and limitations | No concerns | No |
| 438.100/457.1220 Enrollee rights | Concerns identified | Yes |
| 438.114/457.1228 Emergency and post-stabilization services | Concerns identified | Yes |
| 438.230/457.1233(b) Subcontractual relationships and delegation | Concerns identified | Yes |
| 438.236/457.1233(c) Practice guidelines | No concerns | No |
| 438.242/457.1233(d) Health information systems | Concerns identified | Yes |

## 5.1 Improvement by UnitedHealthcare

UnitedHealthcare's overall score for compliance with Medicaid and CHIP managed care regulations in EQR 2022 is 87.9%, compared to 85.4% achieved in EQR 2021. UnitedHealthcare 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 13 shows the degree to which UnitedHealthcare 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 14). 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 13. Score for Degree of Response | | | | | | |
|---|---|---|---|---|---|---|
| Total | High | = | 24 | ×2 | = | 48 |
| | Medium | = | 1 | ×1 | = | 1 |
| | Low | = | 5 | ×0 | = | 0 |
| Numerator | Score Obtained | | | | | 49 |
| Denominator | Total Sections | = | 30 | ×2 | = | 60 |
| **Overall Score= Medium** | | | | | | **81.7%** |

**Table 14. UnitedHealthcare's Response to Previous Recommendations**

| Recommendations | Action by UnitedHealthcare | Degree of Response |
|---|---|---|
| **EQR 2021** | | |
| **1. Disenrollment: Requirements and Limitations** | | |
| UnitedHealthcare updates its Medicaid Disenrollment Standard Operating Procedure (SOP) by incorporating all the reasons a member can request disenrollment without cause. | UnitedHealthcare did not submit the document. | **Low** |
| **2. Enrollee Rights** | | |
| a. UnitedHealthcare should update its policy, MR-001 UHC MO Member Rights, to describe how UnitedHealthcare ensures Enrollee Rights. Primaris (PTM) suggested UnitedHealthcare survey members for the areas not addressed in the CAHPS survey to assess the extent to which the Enrollee's Rights are met. The providers should also be regularly educated on the state and federal requirements. | No action was taken. | **Low**<br>Ensuring enrollee rights are not addressed. The same recommendation applies. |
| b. UnitedHealthcare post the member rights and responsibilities on their website under member resources so that members are aware of these even without reading the member handbook. | UnitedHealthcare has directed its webpage to the MHD website, where members' rights are displayed. | **High** |

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| c. UnitedHealthcare update its policy, MO-MK001 Marketing Guidelines, with the font size requirement to "conspicuously visible size" of the taglines instead of "18 font size." UnitedHealthcare member materials should be readable at the sixth-grade level. | MO-MK001 Marketing Guidelines: page 5<br><br>No action was taken. | **Low**<br>The policy is not updated. Large print is defined as a print size no smaller than 18 points. The same recommendation applies. |
| d. UnitedHealthcare must explore different ways to notify changes impacting members at least 30 calendar days before the effective day of change and implement them. | MR-001 UHC MO Member Rights (revised): page 2<br>UnitedHealthcare updated its policy to include various member engagement platforms.<br><br>Members will also be informed of changes via the website and Health Talk Newsletters. (uhccommunityplan.com) Here For You-MO (Flyer informing Medicaid Expansion) | **High** |
| e. UnitedHealthcare must update its member handbook to meet all the 48 items listed in the MHD contract, section 2.12.16, even though the MHD provides a template. | MO Member Handbook 2022 | **Low**<br>The same recommendation applies. |
| **Findings:** Out of 48 criteria required in the member handbook per the MHD contract 2.12.16, nine were "Partially Met," and three were "Not Met" during EQR 2021. PTM re-reviewed the revised 2022 member handbook available at UnitedHealthcare's website (downloaded on Apr 15, 2022) and found that only three of nine "Partially Met" criteria were addressed. Thus, six criteria remain "Partially Met," and three remain "Not Met." (Alphabets used below refer to the criteria from EQR 2021 Compliance Report). The "Partially Met" criteria are as follows:<br><br>h. Information on how and where members can access benefits provided by the State is not mentioned.<br>i. A description of all available services outside the comprehensive benefits package, including information on where and how members may access benefits not available under the comprehensive benefit package, is not stated. | | |

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| t. All the conditions under which an enrollee can disenroll with or without cause are not listed.<br><br>a6. Information on how to access behavioral health when in crisis is not indicated.<br><br>a.18. In reference to the Advance Directives, UnitedHealthcare did not include a statement on "any limitation regarding the implementation of advance directives as a matter of conscience" as required per the MHD contract.<br><br>a.20. Information on how a member can request to obtain a free copy of their medical record annually is not provided.<br><br>The "Not Met" criteria are as follows:<br><br>k. A description of all prior authorization or other requirements for treatments and services is missing.<br><br>q. How a member with a life-threatening condition, disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, may request access to a specialty care center and the procedure by which such access may be obtained.<br><br>y. Information about disease management program is not provided. | | |
| f. UnitedHealthcare must update its policy, Rally-Online Directory, to include all the requirements about their network providers. The provider directory (PDF version) submitted to Primaris (now PTM) should be updated to consistently reflect all the criteria for every provider in the network per the 42 CFR 438.10h and the MHD contract, section 2.12.17. UnitedHealthcare should educate its providers about the contractual requirement for submitting their information to UnitedHealthcare. | Rally-Online Directory<br><br>Provider Directory (Introduction)<br><br>Snapshot from an online provider search tool showing URL and Interpreter, American Sign Language availability<br><br>Provider Directory Central Missouri<br><br>Snapshots (website/URL, panel status, footnote) | **High**<br>The policy "Rally-Online Directory" does not incorporate a field "URL/Website" for the providers. However, this information is presented in the online and PDF version of the provider directory.<br><br>Information on the panel status is not available in the PDF version for all providers, even though it is online. Information on the |

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| | | linguistic capabilities is not stated for all the providers. However, a footnote states that all providers accept new patients and are proficient in English unless noted otherwise. |
| g. UnitedHealthcare should update its policy, "Provider Directory Creation and Distribution," to clearly state what they mean by "processing the request within 48 hours." UnitedHealthcare is required to mail the directories to the members within 48 hours of their request. | Provider Directory Creation and Distribution: page 2<br><br>The policy is updated. | **High** |
| h. UnitedHealthcare should consider providing a notification for their members on the website about requesting a paper directory. | UnitedHealthcare informed PTM that the information is presented in the member handbook posted on the website. | **High**<br>PTM confirmed the information. |
| i. The only means of disseminating information to the members regarding Enrollee Rights, per 42 CFR 438.10, is via a member handbook. UnitedHealthcare should consider using its website to disseminate information about access to member-related information in a paper format. Newsletters, flyers, and blogs are suggested ways of communicating information on Enrollee Rights. | UnitedHealthcare's webpage has linked the information to the MHD website. Furthermore, they will provide the links in the summer newsletter. | **High** |
| **3. Emergency and Post-stabilization Services** | | |
| a. UnitedHealthcare must consistently update definitions of an emergency medical condition, emergency services, and post-stabilization services in its documents. UnitedHealthcare should update the policy, 2020F7012C Reimbursement, on the definition of an emergency medical condition. Also, | MO Member Handbook: page 85<br><br>The member handbook is not revised to update the definition of the emergency medical | **Low**<br>Same recommendation applies |

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| update the definition of "emergency services" in the member handbook. | condition, and the policy is not submitted. | |
| b. UnitedHealthcare must update the Provider Manual that states, "After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable." The duration for approval must be updated to 30 minutes instead of one hour. | 2022 Care Provider Manual: page 32<br><br>The provider manual on the website is updated. | **High**<br>PTM confirmed the information. |
| c. UnitedHealthcare must provide documentation on the payment agreement with its providers on emergency and post-stabilization services. | MOUM001 Emergency Care and Post Stabilization: page 3<br><br>MO Medicaid State-Specific Payment Appendix: pages-5, 6<br><br>Single Case Letter of Agreement: page 5 | **High**<br>All documents comply with the requirements. |
| **4. Subcontractual Relationships and Delegation** | | |
| a. UnitedHealthcare explicitly and consistently writes in all the subcontracts that UnitedHealthcare shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract. UnitedHealthcare must have a policy, guidelines, or Master Service Agreement that meets this criterion. | MO State Program(S) Regulatory Requirements Appendix: page 4 | **High**<br>The document is compliant. |
| b. UnitedHealthcare must update all their contracts other than the Dental Benefit Providers' contract, with the requirements set under the MHD contract, section 3.9.6. (The MHD contract, section 3.9.6 requires an MCO to specify the delegated activities, obligations, and related reporting | Children's Mercy Integrated Care Solutions, Inc: page 36<br><br>CareCore National, LLC (Participating Plan Addendum # 28): pages-3, 7 | **High**<br>All the documents are compliant with the requirements. |

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| responsibilities in the subcontract or written agreement.) | Medical Transportation Management (MTM): pages-3, 4<br>March Vision Care Group, Inc. Exhibit B/F: pages 21, 53<br><br>Rose International, Inc: pages-2, 3, 22 | |
| c. UnitedHealthcare should update its contract with Rose International, Inc. and include Missouri Medicaid on the "right to audit." | MO State Program(S) Regulatory Requirements Appendix: page 4<br><br>UnitedHealthcare submitted an Appendix specific to MO State Program and stated that UnitedHealthcare will amend identified vendors' contracts to include the Appendix as needed to comply. | **High**<br>The document complies with the requirement. PTM recommends that UnitedHealthcare ensures this Appendix is incorporated in the subcontract with Rose International, Inc. |
| d. UnitedHealthcare should consistently update the duration of record retention for 10 years at all places in all subcontracts. | MO State Program(S) Regulatory Requirements Appendix: page 4<br><br>UnitedHealthcare informed PTM that the revised Appendix will be added to all the subcontracts. | **High**<br>PTM recommends that UnitedHealthcare ensures this Appendix is incorporated with all subcontracts. |
| e. UnitedHealthcare must update the Rose International, Inc., Master Services Agreement, and March Vision Care Group, Inc. contract to ensure the MHD consistently is indemnified, saved, and held harmless from and against all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract. | MO State Program(S) Regulatory Requirements Appendix: page 3<br>UnitedHealthcare informed PTM that the revised Appendix will be added to all the subcontracts. | **High**<br>PTM recommends that UnitedHealthcare ensures this Appendix is incorporated with Rose International, Inc, March Vision Care Group, Inc., and all other subcontractors. |

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| f. UnitedHealthcare should update its subcontract with Rose International, Inc. to indemnify the State in case of any dispute between UnitedHealthcare and its providers. CareCore National, LLC's contract should be updated to mention that the State will not be involved in any dispute between UnitedHealthcare and the subcontractor. | MO State Program(S) Regulatory Requirements Appendix: page 3<br><br>UnitedHealthcare informed PTM that the revised Appendix will be added to all the subcontracts. | **High**<br>PTM recommends that UnitedHealthcare ensures this Appendix is incorporated with Rose International and all other subcontractors. |
| **5. Practice Guidelines** | | |
| UnitedHealthcare informs its members via any medium, e.g., member handbook, mailers, newsletters, about the availability and access to evidence-based practice guidelines. | MO-AMC-Medicaid-Newsletter-Spring-2022-EN.pdf<br><br>A member newsletter is posted on the website, informing them about CPGs. | **High** |
| **6. Health Information Systems** | | |
| a. UnitedHealthcare must explain/describe their process of how the health information system provides information on Utilization management (UM), claims, grievances and appeals, and disenrollment. | Escalation Tracking System: page 2<br>MO_MIS001 Management Information System (MIS): Pages-1 to 3<br><br>Encounter Data Completeness, Accuracy, and Timeliness: page 1<br><br>Manual Updates in Facets CSP: pages 1 to 4<br><br>MO-ENR-01 Disenrollment Effective Dates: page 5<br><br>Data Entry Medical SOP (Medical Claims into Facets): page 8<br><br>CSP Facets Source (Systems Access, Transactions Processing, | **High**<br>Documents meet the requirements. |

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| | Adjustment Processing Guidelines): page 71 | |
| b. UnitedHealthcare must have documentation about how their claims processing and retrieval system detects fraud and abuse necessary for program integrity, oversight, and administration. | Compliance Committee Report (CCR) (Jun-Jul-Aug 2021)<br><br>Encounter Data Completeness, Accuracy and Timeliness: page 1<br><br>CSP Facets Source: pages-54, 55<br><br>Anti-Fraud, Waste, and Abuse Program 2022-2023: pages-3, 5, 6<br><br>UnitedHealthcare Compliance Program: page 8 | **High**<br>Documents meet the requirements. |
| c. UnitedHealthcare must have Electronic Claims Management (ECM) policies and provide phone-based capabilities to obtain claims processing status information. | Provider IVR High-Level Call Flow (embedded in policy-MO PS-001)<br><br>Optum Pay UHCprovider.com: pages 3 to 5<br><br>Health Insurance Claim Form 1500/UB-04<br><br>Standard Companion Guides-Professional/Institutional (Embedded in policy MO_MIS001 MIS) | **High**<br>Documents meet the requirements. |
| d. Adherence to Key Transaction Standards: UnitedHealthcare must have policies and procedures to address HIPAA standards related to claims processing and electronic transaction standards. | Standard Companion Guides-Professional /Institutional (embedded in policy MO_MIS001 MIS): page: 14<br><br>EDI Claim Edits (embedded in policy | **High**<br>Documents meet the requirements. |

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| | MO_MIS001 MIS): pages-1 to 6 | |
| e. UnitedHealthcare must have policies and detailed process/procedures describing their HIS System flow charts' functional/operational aspects. Also, they must address how they verify the timeliness of the reported provider data and collect data from providers in standardized formats, including secure information exchanges and technologies utilized for the MHD quality improvement and care coordination efforts. | Electronic Communication Gateway (ECG) Overview: pages-1, 2<br><br>Standard Companion Guides-Professional (embedded in policy MO_MIS001 MIS): pages-8, 9<br><br>Encounter Data Completeness, Accuracy, and Timeliness: pages-1, 2<br><br>CSP Facets Source: pages 35 to 90 | **High**<br>Documents meet the requirements. |
| f. UnitedHealthcare must implement an Application Programming Interface (API) as specified in 42 CFR 438.242, in reference to 42 CFR 431.60 and 431.70. EQRO will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item. | API Procedure: pages-1, 2<br><br>API is developed and implemented. | **High** |
| g. UnitedHealthcare must have a detailed description of its process and data elements captured to identify the providers delivering services or items to enrollees. | EDI Claim Edits (embedded in policy MO_MIS001 MIS): pages-1 to 6<br><br>Encounter Data Completeness, Accuracy, and Timeliness: pages-1, 2 | **High**<br>Documents meet the requirements. |
| h. UnitedHealthcare should have a policy and submit evidence to show that their encounter data submitted to the MHD includes the allowed and paid amounts per 42 CFR 438.818. | Encounter Data Completeness, Accuracy, and Timeliness: page 2 | **Medium**<br>The policy complies with the requirement; however, the encounter data |

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| | Monthly Encounters Self-Reporting (Excel-July 2021) | submitted to the MHD includes only the paid amounts. The MHD's Encounter Data process is not yet updated to capture and submit the allowed amounts. |
| i. UnitedHealthcare must submit sufficient documentation to show that encounter data submitted to the MHD comply with standardized Accredited Standards Committee (ASC) X12N 837 and has implemented version 5010 transaction set. | Encounter Data Completeness, Accuracy, and Timeliness: page 2<br><br>Standard Companion Guide (embedded in policy MO_MIS001 MIS) | **High**<br>Documents meet the requirements. |
| **EQR 2020 (Action item pending)** | | |
| Grievances and Appeals: UnitedHealthcare reported Member Appeals under categories such as Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. EQRO finds these categories not aligned with the definition of adverse benefit determination & appeals per 42 CFR 438.400. EQRO recommends that UnitedHealthcare seek written clarification on expectations from the MHD. UnitedHealthcare should update data in the 2019 QAPI report and comply with the MHD's instructions for future reporting. | Addendum QAPI Non-Behavioral Health Member Appeals Data 2019-2021 (snapshot) | **High**<br>PTM noted that categories for Appeals are rectified in the snapshot submitted. Details will be evaluated next year when the regulation (QAPI) is reviewed. |

## 6.0 RECOMMENDATIONS

### 6.1 UnitedHealthcare

PTM recommends that UnitedHealthcare submits its CAP and include all the weaknesses listed for regulations in sections 4.3 to 4.8. PTM's recommendations are provided in the same sections. UnitedHealthcare must also address "Low" and "Medium" response items from section 5.2 on the previous year's recommendations (Table 14). UnitedHealthcare must proactively develop its policies and procedures for all the regulations covered in the compliance review and not post snapshots/tabulate contents "as is" from the MHD contract

and CFR.

## 6.2 MHD

The following recommendations would improve the EQR process and findings.
1. The MHD contract with UnitedHealthcare should include the 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 UnitedHealthcare on ways to increase the significance of the EQR.

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

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

5. Identify ways the PTM can assist UnitedHealthcare 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. Per the MHD contract, section 2.18.8(c), regarding the credentialing and re-credentialing process, the MCOs are required to provide the state agency with the Social Security Number (SSN) of the providers.
UnitedHealthcare informed PTM that the MHD does not require SSN of the providers as the providers are identified using their National Provider Identifier (NPI). They clarified the requirement from the MHD telephonically. The MO HealthNet Demographic Layout (Excel) submitted by UnitedHealthcare does not have an SSN field. If the information provided by UnitedHealthcare is correct, then PTM recommends that the MHD provides written clarification on the requirement and amend the contract to replace SSN with NPI.
(Note: PTM noted that the Council for Affordable Quality Health Care (CAHQ) Universal Credentialing Data Source Form (UCDS) utilized by UnitedHealthcare for credentialing the providers has a field for SSN).

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

6. 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 1–42 CFR: 438.206, 457.1230(a)-Availability of Services | | |
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| **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.<br><br>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). | QA019 Accessibility of Services and Availability of Practitioners and Providers: pages-4 to 6 | Fully Met |
| **Findings:** UnitedHealthcare will ensure that services are geographically accessible and are distributed so that no member residing in the service area must travel an unreasonable distance to obtain covered services. The policy, "Accessibility of Services and Availability of Practitioners and Providers," complies with the geographic distribution (distance travel) standards of this section.<br><br>**Required Actions:** None. | | |
| B. Appointment standards (MHD contract 2.5.3):<br><br>i. The MCO shall have policies and procedures in accordance with these appointment standards:<br><br>a. Waiting times defined as time spent both in the lobby and in the examination | QA019 Accessibility of Services and Availability of Practitioners and Providers: pages-9 to 11<br><br>2022 Care Provider Manual: page 19 | Fully Met |

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| room prior to being seen by a provider) for appointments do not exceed one hour from the scheduled appointment time.<br><br>b. Urgent care appointments for physical or behavioral illness injuries which require care immediately but do not constitute emergencies- available within 24 hours.<br><br>c. Routine care with physical or behavioral symptoms-available within 1 week or 5 business days whichever is earlier.<br><br>d. Routine care without physical or behavioral symptoms-within 30 calendar days.<br><br>e. Aftercare appointments-within 7 calendar days after hospital discharge.<br><br>f. For maternity care:<br>First trimester-within 7 calendar days of first request.<br>Second trimester-within 7 calendar days of first request.<br>Third trimester-within 3 calendar days of first request.<br>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. | MO Member Handbook: page 23 | |
| **Findings:** UnitedHealthcare's policy, "Accessibility of Services and Availability of Practitioners and Providers," complies with the appointment and wait timing requirements of this section.<br><br>**Required Actions:** None. | | |
| ii. The policies and procedures should address the following:<br><br>a. The methods for educating both the providers and the members about appointment standards. | QA019 Accessibility of Services and Availability of Practitioners and Providers: pages-7, 8, 11, 12 | Fully Met |

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| b. The MCO shall disseminate the appointment standard policies and procedures to its in-network providers and to its members.<br><br>c. The MCO shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met. | 2022 Care Provider Manual: page 19<br><br>MO Member Handbook: page 23<br><br>MS-001 Member Services Overview: pages-2, 3 | |
| **Findings:** a, b. Provider and Member Education: Providers are educated on accessibility of services and availability of practitioners requirements through written notification when an opportunity is identified, as well as educated about requirements of standards in provider manual. Member education is provided through the member handbook which outlines the standards for provider appointment availability.<br><br>c. Performance against appointment access standards will be measured by analysis of one or more of the following:<br>• CAHPS questions and supplemental questions.<br>• Key Member Indicators Survey questions.<br>• Qualified MCO Survey questions.<br>• Primary Care Practitioner and Specialty care Practitioner Accessibility Surveys.<br>• PCP After-hours Access Survey.<br>• Member access complaints.<br>• Out-of-network service requests and claim utilization.<br>• Behavioral Health satisfaction survey questions, complaints, treatment record reviews, appointment tracking and claims data.<br><br>Results from survey questions and complaints related to the access standard are compared to benchmarks, thresholds, or goals as applicable and opportunities are identified and prioritized annually. Interventions are developed and implemented on at least one opportunity as applicable.<br><br>**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. | QA019 Accessibility of Services and Availability of Practitioners and Providers: pages-1, 7, 8<br><br>NC-65 UHN Monitoring for Community and State (C&S) | Fully Met |

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| | Network Access and Adequacy: page 3<br><br><u>Onsite Submission</u><br>Member and Provider Complaints, Provider Availability and Accessibility (Presentation)<br><br>Dial America (Survey-PCPs and Specialists)<br><br>NCQA Network Access and Availability<br><br>C&S Standards-Analytic Results<br><br>Provider Turnover Report (Excel) | |
| **Findings:** UnitedHealthcare maintains standards for the numeric and geographic availability of participating practitioners and providers based on State contractual requirements, and analyzes their networks against the established standards at least annually. At least biennially, UnitedHealthcare conducts an assessment of how well the network meets members' cultural needs and preferences. Interventions related to both analyses are identified and implemented to improve availability when needed. Assessments are conducted in accordance with state, federal and regulatory requirements.<br><br>UnitedHealthcare will monitor its provider network to ensure that service accessibility standards are being met and the provider listings of panel status (open and closed) are accurate. United Healthcare produces monthly PCP capacity reports which identify the current number of members assigned, as well as the percentage of panel capacity.<br><br>**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 | 2022 Care Provider Manual: page 45<br><br>MCM 004 Member Initiated Second and Third Opinion: pages-1, 2<br><br>MO Member Handbook: page 24 | Fully Met |

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| elective surgical procedures require a second medical opinion be provided prior to the surgery. A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion (MHD contract 2.8). | | |
| **Findings**: UnitedHealthcare stated in its Provider manual that if a member asks for a second opinion about a treatment or procedure, UnitedHealthcare will cover that cost. Scheduling an appointment for the second opinion should follow the access standards established by the MHD as stated in the Provider manual. The care provider giving the second opinion must not be affiliated with the attending care provider. The member's PCP refers the member to an in-network care provider for a second opinion. PCPs will forward a copy of all relevant records to the second opinion care provider before the appointment. The care provider giving the second opinion will then forward his or her report to the member's PCP and the treating care provider, if different. The member may help the PCP select the care provider. All second and third medical opinions, whenever possible, should be provided in-network and must be authorized by the member's Network Medical Group or UnitedHealthcare Medical Director. Out-of-network second/third medical opinions will be considered if there is no available or appropriate in-network provider and must be authorized by the member's Network Medical Group or UnitedHealthcare Medical Director.<br><br>**Required Actions:** None. | | |
| iii. If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO must adequately and timely cover these services out-of-network for the enrollee, for as long as the MCO's provider network is unable to provide them.<br><br>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. | Single Case Agreement Process: page 1<br><br>NC-65 UHN Monitoring for Community and State C&S Network Access and Adequacy: page 3 | Fully Met |

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| **Findings:** Single Case Agreements will be created and negotiated with out- of-network providers for services needed to be provided to a member that are not available with a participating provider. If UnitedHealthcare cannot establish contracts with care providers who meet State accessibility or adequacy requirements, the members are permitted to utilize medically necessary care for covered benefits from out-of-network providers at the in-network cost-sharing levels while UnitedHealthcare continues variance (accessibility or adequacy gap) remediation work.<br><br>**Required Actions:** None. | | |
| D. Timely access: Each MCO must do the following:<br><br>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.<br><br>b. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.<br><br>c. Establish mechanisms to ensure compliance by network providers.<br><br>d. Monitor network providers regularly to determine compliance.<br><br>e. Take corrective action if there is a failure to comply by a network provider. | 2022 Care Provider Manual: page 18<br><br>QA019 Accessibility of Services and Availability of Practitioners and Providers: pages-7 to 10<br><br><u>Onsite Submission</u><br>Dial America (Survey-PCPs and Specialists) | Fully Met |
| **Findings:** a. The Provider manual requires providers to have the same office hours of operation to UnitedHealthcare members as those hours offered to commercial members.<br>During the interview, UnitedHealthcare stated that they conduct appointment availability and after hours availability surveys to check any issues related to work hours or appointments and retake surveys for providers out of compliance within 90 days after educating the providers on the requirements.<br><br>b. UnitedHealthcare will ensure that emergency medical/behavioral health services are available 24 hours per day, seven days per week to treat an emergency medical/behavioral health condition. | | |

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| c. Performance against appointment access standards will be measured by analysis of one or more of the surveys and other sources stated earlier in section B(ii)(c) of this evaluation tool (Appendix A).<br><br>d, e. Annually, the assessment and analysis of network availability is reported to the Service Quality Improvement Sub-Committee (SQIS) or Quality Management Committee (QMC). Opportunities for improvement are identified and interventions are implemented, if applicable. Where there are deficiencies, staff will work with the UnitedHealthcare network management team to develop and implement improvement actions.<br><br>Providers are educated on accessibility of services & availability of practitioners requirements through written notification when an opportunity is identified, as well as educated about requirements of standards in provider manual. Member education is provided through member handbook which outlines the standards for provider appointment availability.<br><br>**Required Actions:** None. | | |
| 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.<br><br>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):<br><br>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.<br><br>ii. The MCO shall implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff | 2022 Care Provider Manual: page 6<br><br>MCM 011 Cultural Proficiency: pages-1 to 3<br><br>MO-MK001 Marketing Guidelines: pages-5, 6<br><br>MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-4, 5, 6, 14<br><br>MS-001 Member Services Overview: pages-4, 5<br><br><u>Onsite Submission</u><br>Advancing Health Equity to Improve Outcomes: pages-2, 5, 6<br><br>Health Disparity Report 2021 (posted on website: Advancing Health Equity - UnitedHealth Group)<br><br>Sustainability Report 2020 | Fully Met |

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| and leadership that are representative of the demographic characteristics of regions covered by the contract.<br><br>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.<br><br>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.<br><br>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.<br><br>vi. The MCO shall develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.<br><br>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.<br><br>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 | | |

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| cultural and linguistic characteristics of regions covered by the contract.<br><br>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.<br><br>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.<br><br>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. UnitedHealthcare prioritizes its engagement with qualified providers that promote a culturally sensitive environment and embrace the role of the health care provider in minimizing health care disparities. The provider manual informs the providers that UnitedHealthcare has developed a Cultural Competency Program to meet its membership needs.<br><br>ii. Per the document, "Advancing Health Equity to Improve Outcomes," UnitedHealthcare works across its business to promote equity and diversity in the healthcare work force. UnitedHealthcare formed culture, inclusion and diversity councils to create strategies focusing on three key priorities: diverse leadership advancement; reducing the impact of unconscious bias; and improving health equity and equitable access in addition to being stewards and champions of their servant-leader culture.<br><br>iii. Ongoing training regarding cultural proficiency is conducted for staff and providers that address the cultural and linguistic characteristics and special health care needs of the population. | | |

iv, v. The percentage of member-preferred languages other than English is monitored by reports generated from the enrollment information, reviewing census data, and Medicare and Medicaid eligibility files. UnitedHealthcare provides simplified materials for members with limited English proficiency and who speak languages other than English or Spanish. They also provide materials for visually impaired members. UnitedHealthcare will make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in a service area.

vi. UnitedHealthcare's policy "Cultural Proficiency" meets the requirements of this criterion.

vii, viii. UnitedHealthcare determines the cultural and linguistic needs of its members by using available community demographics, focus groups, survey data and other forums of key information sources. The members enrolled in a care management program receive an individualized assessment of their cultural and linguistic needs or limitations. UnitedHealthcare identifies key issues and best practice approaches to facilitate cultural proficiency in managing, coordinating, and delivering health care and services across the continuum of care settings.

ix. UnitedHealthcare initiates and develops relationships with culturally diverse community groups, associations, and key community contacts to develop responsive care approaches. UnitedHealthcare will engage culturally appropriate social service agencies as indicated in the member's plan of care to address social/environmental barriers to care and/or non-covered health care services.

x. upon enrollment, UnitedHealthcare distributes to its members, a flyer explaining the grievance system. The grievance system flyer is readily available in the member's primary language. In addition, UnitedHealthcare has procedures in place to notify all members in their primary language of grievance dispositions and appeal resolutions. There is a provision for written notices at appropriate reading levels and in a culturally and linguistically appropriate manner. The Resolving Analyst (RA) will provide reasonable assistance to the member in completing forms and taking other procedural steps related to an 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, American Sign Language and interpreter capability, and providing written notices in a secondary language per a member's request that are culturally and linguistically appropriate.

xi. UnitedHealthcare posted Health Disparity Report, Sustainability Report on its website: https://www.unitedhealthgroup.com/what-we-do/health-equity.html. These reports address how UnitedHealthcare is committed to help build a workforce reflective of community it serves, improve health of historically marginalized communities, and leverage data to uncover and combat health disparities.

**Required Actions:** None.

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| F. Accessibility considerations:<br><br>Each MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities. | UnitedHealthcare Credentialing Plan 2021-2023: page 23<br><br>2022 Care Provider Manual: pages-70, 71 | Fully Met |
| **Findings:** Physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped is one of the site assessment criteria for credentialing/recredentialing a provider.<br><br>The provider manual requires providers and their facilities meet the following site standards:<br>• Clean and orderly overall appearance.<br>• Available handicapped parking.<br>• Handicapped accessible facility.<br>• Available adequate waiting room space.<br>• Adequate exam room(s) for providing member care.<br>• Privacy in exam room(s).<br>• Clearly marked exits.<br>• Accessible fire extinguishers.<br>• Post file inspection record in the last year.<br><br>**Required Actions:** None. | | |
| G. Direct Access to Female Enrollees:<br><br>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. | OB/GYN Provider Network (Excel)<br><br>Onsite Submission<br>MUM 003 Referrals: page 2 | Fully Met |
| **Findings:** UnitedHealthcare's policy, "MUM 003 Referrals," is compliant with the requirements of this section.<br><br>**Required Actions:** None. | | |

Compliance: UnitedHealthcare

| Compliance Score – Availability of Services | | | | | | |
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| Total | Fully Met | = | 10 | ×2 | = | 20 |
| | Partial Met | = | 0 | ×1 | = | 0 |
| | Not Met | = | 0 | ×0 | = | 0 |
| Numerator | Score Obtained | | | | | 20 |
| Denominator | Total Sections | = | 10 | ×2 | = | 20 |
| **Score** | | | | | | **100%** |

**Appendix B**

| **Standard 2-42 CFR: 438.207, 457.1230(b)-Assurances of Adequate Capacity and Services** | | |
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| **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:<br><br>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.<br>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 HealthNet Provider Directory (Excel)<br><br>Enrolled Providers (Feb 2022-Excel)<br><br><u>Onsite Submission</u><br>NC-65 UHN Monitoring for Community and State (C&S) Network Access and Adequacy: page 1 | Partially Met |
| **Findings:** Per UnitedHealthcare's policy, "Monitoring for Community and State (C&S) Network Access and Adequacy," UnitedHealth ensures that it complies with individual state-specific requirements for Medicaid/Temporary Assistance to Needy Families (TANF), Long Term Care (LTC/LTSS), Children's Health Insurance Program (CHIP), and other programs related to Centers for Medicare & Medicaid Services (CMS) services for network adequacy and accessibility to services.<br><br>PTM noted that UnitedHealthcare submitted the list of providers in its network and the provider directory that met the requirements of this section. However, none of the policies specified the range of services and provider types that UnitedHealthcare strives to include in its network. | | |

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| **Required Actions:** PTM recommends that UnitedHealthcare updates its policy to specify the range of services and provider types that UnitedHealthcare strives to include in its network. | | |
| 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.<br>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)). | QA019 Accessibility of Services and Availability of Practitioners and Providers: pages-1, 4, 6<br><br>MO HealthNet Provider Directory | Partially Met |
| **Findings:** UnitedHealthcare maintains standards for the numeric and geographic availability of participating practitioners and providers based on State contractual requirements.<br><br>PTM noted that UnitedHealthcare has not submitted documentation regarding not having an exclusive relationship or not advertise/hold itself out with any provider.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare updates its policy and subcontracts based on the deficiency identified. | | |
| B. Primary Care Providers (PCPs):<br><br>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.<br><br>i. The PCPs responsibilities must include at a minimum (MHD contract 2.4.2(a)): | MO-002 Primary Care Provider Responsibilities: page 4<br><br>Care Provider Manual: page 22 | Partially Met |

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| a. Maintaining continuity of each member's health care.<br><br>b. Making referrals for specialty care and other medically necessary services to both in-network and out-of-network providers.<br><br>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.<br><br>d. Conducting a behavioral health screen to determine whether the member needs behavioral health services.<br><br>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:** UnitedHealthcare's policy "Primary Care Provider Responsibilities" meets the requirements of this section.<br><br>UnitedHealthcare's provider manual does not include all the responsibilities listed in this section-b, c, d are not addressed, criterion e is partially addressed. Thus, a score of "Partially Met" is assigned to this section.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare updates its provider manual based on PTM's findings. | | |
| ii. PCP (Eligible Specialties):<br><br>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 | Care Provider Manual: page 21<br><br>UnitedHealthcare Credentialing Plan: page 4 | Partially Met |

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| 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).<br><br>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).<br><br>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.<br><br>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). | MO Member Handbook: page 89<br>QA019 Accessibility of Services and Availability of Practitioners and Providers: page: 1<br><br><u>Onsite Submission</u><br>MO-002 Primary Care Provider Responsibilities (revised): page 4 | |
| **Findings:** a. Provider Manual and Credentialing Plan meets this requirement.<br><br>d. UnitedHealthcare's member handbook informs its members that they can ask for a specialist to be their PCP. | | |

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| PTM noted that UnitedHealthcare did not have a policy that met criteria b, c, and d during the review period. However, UnitedHealthcare revised its policy, "Primary Care Provider Responsibilities" after PTM identified deficiencies during the preliminary review.<br>**Required Actions:** No further action is needed. However, PTM recommends that UnitedHealthcare submits its revised policy "Primary Care Provider Responsibilities" for the MHD's approval. | | |
| C. Behavioral Health Providers:<br><br>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)-<br><br>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.<br><br>ii. The majority of Community Mental Health Centers (CMHC), within each county where the MCO provides coverage and the majority of Certified Community Behavioral Health Organizations (CCBHO). If there is not a CMHC in that county, the MCO must contract with a CMHC within 30 miles | <u>Onsite Submission</u><br>Behavior Health Provider List (Excel) | Partially Met |

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| 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:** UnitedHealthcare submitted supporting documentation, i.e., a list of BH providers and BH facilities that included mix of providers listed in criterion i.<br><br>PTM noted that UnitedHealthcare did not submit a policy to comply with requirements pertaining to behavioral health professionals, CCBHOs, and CMHCs as stated in this section.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare submit a policy to include all the guidelines pertaining to behavioral health professionals, CCBHOs, and CMHCs. | | |
| D. Federally Qualified Health Centers and Rural Health Clinics.<br><br>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). | Onsite Submission<br>FQHC, RHC Provider List (Excel) | Partially Met |
| **Findings:** UnitedHealthcare submitted supporting documentation, i.e., a list of contracted FQHCs and RHCs.<br><br>PTM noted that UnitedHealthcare did not submit a policy to comply with requirements pertaining to FQHCs and RHCs stated in this section.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare submits a policy to include the guidelines pertaining to FQHCs and RHCs. | | |
| E. Family Planning and Sexually Transmitted Disease (STD) Treatment Providers.<br><br>The MCO shall include Title X and STD providers in its provider network to serve members covered under the comprehensive and extended family | MO Member Handbook: page 46<br><br>Onsite Submission<br>OB/GYN Provider List (Excel) | Partially Met |

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| planning, women's reproductive health, and sexually transmitted diseases benefit packages. The MCO shall establish an agreement with each Family Planning and STD treatment provider not in the provider network describing, at a minimum, care coordination, medical record management, and billing procedures. The MCO shall allow for full freedom of choice for the provision of these services (MHD contract 2.4.10). | | |
| **Findings:** Member handbook states that a member can go to any provider who offers family planning services without any referral even to out of network providers. UnitedHealthcare submitted supportive documentation, i.e., a list of providers practicing obstetrics and gynecology included in its provider network.<br><br>PTM noted that UnitedHealthcare did not submit a policy incorporating guidelines related to Title X and STD providers. UnitedHealthcare did not submit documentation to show its contract agreement with Family Planning and STD treatment providers not in the network describing, at a minimum, care coordination, medical record management, and billing procedures.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare submits a policy and an agreement template for out-of-network providers to include the minimum requirements describing care coordination, medical record management, and billing procedures. | | |
| F. Local Public Health Agencies.<br><br>The MCO shall include local public health agencies in its provider network for the local public health agency services described in the MHD contract and for other services such as care management and services provided under the Local Community Care Coordination Program (LCCCP). The MCO should establish an agreement with each local public health agency not in the provider network describing, at a minimum, care coordination, medical record management, and billing procedures (MHD contract 2.4.11). | Proposed Model: LCCCP for MO HealthNet: pages 1 to 11<br><br><u>Onsite Submission</u><br>PCN Group (Children's Mercy Health Providers-Excel) | Fully Met |

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| **Findings:** UnitedHealthcare is prepared to implement LCCCP model focusing on providing care management, care coordination, and disease management through local healthcare providers. UnitedHealthcare contracts with one LCCCP (Children's Mercy Health).<br><br>As PTM pointed out the deficiency in the prior section E that a contract agreement template for out-of-network provider is not submitted by UnitedHealthcare, so it was not scored in this section.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare submits an agreement template for out-of-network providers to include the minimum requirements describing care coordination, medical record management, and billing procedures. | | |
| G. School Based Dental Services.<br><br>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). | <u>Onsite Submission</u><br>Dental Provider List (Excel) | Partially Met |
| **Findings:** UnitedHealthcare submitted supporting documentation, i.e., a list of dental providers included its network.<br><br>PTM noted that the list of dental providers do not inform about provision of dental services in a school setting. Neither has UnitedHealthcare submitted its policy or guidelines that meet the requirement of this section.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare submits a policy to include the guidelines related to school based dental services. | | |
| H. Tertiary Care.<br><br>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 have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements | MO HealthNet Provider Directory (Excel)<br><br><u>Onsite Submission</u><br>Tertiary Care Specialists (Excel) | Partially Met |

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| with out-of-network providers (MHD contract 2.4.16). | | |
| **Findings:** UnitedHealthcare submitted their provider directory and a list of specialists providing tertiary care.<br><br>PTM noted that UnitedHealthcare did not submit its policy/guidelines on provision of tertiary care services/centers and a process for providing such services including transfer protocols and arrangements with out-of-network providers.<br><br>**Required Actions:** PTM recommends UnitedHealthcare submits documentation based on the deficiency identified regarding tertiary care services. | | |
| I. Specialty Pediatric Hospitals.<br>The MCO shall include specialty pediatric hospitals as defined in 13 CSR 70-15.010(2)(Q), as amended, in its provider network. | <u>Onsite Submission</u><br>Ranken Jordan Hospital and Shriners Hospital (Excel) | Partially Met |
| **Findings:** UnitedHealthcare submitted a list of specialties in the two pediatric hospitals. PTM noted that UnitedHealthcare did not submit policy/guidelines to meet the requirement of this section.<br><br>**Required Actions:** PTM recommends UnitedHealthcare submits documentation based on the deficiency pointed out by PTM regarding pediatric services. | | |
| J. American Indian/Alaskan Natives:<br><br>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).<br><br>i. The MCO must demonstrate that there are sufficient IHCPs participating in the provider network of the MCO to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.<br><br>ii. Permit any Indian who is enrolled in a MCO entity that is not an IMCE and eligible to receive services from a | 2022 Care Provider Manual MO: page 59 | Partially Met |

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| 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.<br><br>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:** UnitedHealthcare reported that there are no IHCPs in Missouri, so they do not have any documentation for submission. However, PTM noted that the UnitedHealthcare's provider manual states that the Native American members can access care to tribal clinics and Indian hospitals without approval.<br><br>**Required Actions:** Since the requirement is part of the MHD contract, UnitedHealthcare must have policy and procedure that addresses service requirements for Indian enrollees. | | |
| K. Timing of documentation.<br>Each MCO must submit the documentation as specified by the MHD, but no less frequently than the following: | | |
| i. On an annual basis.<br>Access Plan: In accordance with State requirements specified at 20 CSR 400-7.095, the MCO shall file an annual access plan, by March 1 of each year, with the Department of Commerce and Insurance, that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues (MHD contract 2.5.4).<br><br>(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 | Network Access Plan-Disposition: pages 1 to 3 | Fully Met |

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| services, as set forth in § 438.68 and § 438.206.) | | |
| **Findings:** UnitedHealthcare submitted a disposition letter dated Mar 29, 2021, from the State showing a status as "approved."<br><br>**Required Actions:** None. | | |
| ii. Network Changes.<br><br>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.<br><br>a. A decrease in the total number of primary care providers by more than five percent (5%).<br><br>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.<br><br>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.<br><br>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 | MO-PT001 State Notification of Provider Termination<br><br>PCP Notifications (1 to 4)<br><br>Expansion Readiness Approval (Email documentation) | Fully Met |

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| reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity (MHD contract 2.4.12 (a)).<br><br>e. Enrollment of a new population in the MCO. | | |

**Findings:** UnitedHealthcare's policy, "State Notification of Provider Termination," complies with all the requirements except for criterion e listed in this section.

c. UnitedHealthcare submitted a letter sent to the MHD dated Feb 4, Oct 23, 2020, informing termination of a hospital from its network.

d. UnitedHealthcare submitted documents consisting of email communications with the MHD dated Jan 4, May 4, July 6, Oct 6, 2021, to show that UnitedHealthcare had informed the MHD when its PCPs reached 85% capacity.

e. UnitedHealthcare submitted an email communication with the MHD showing its readiness for new members enrollment (Medicaid Expansion).

**Required Actions:** PTM scored this section as "Fully Met." However, it is recommended that UnitedHealth updates its policy by addressing the criterion e.

| **Compliance Score – Assurances of Adequate Capacity and Services** | | | | | | |
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| Total | Met | = | 3 | ×2 | = | 6 |
| | Partial Met | = | 11 | ×1 | = | 11 |
| | Not Met | = | 0 | ×0 | = | 0 |
| Numerator | Score Obtained | | | | | 17 |
| Denominator | Total Sections | = | 14 | ×2 | = | 28 |
| **Score** | | | | | | **60.71 %** |

**Appendix C**

| **Standard 3–42 CFR: 438.208, 457.1230(c)-Coordination and Continuity of care** | | |
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| **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. | MOHNET ID Cards: pages-1, 2<br><br>UnitedHealthcare Welcome Letter<br><br><u>Onsite Submission</u><br>MO-002 Primary Care Provider (PCP) Responsibilities: page 1 | Fully Met |
| **Findings:** All members select or are assigned to a single practitioner responsible for coordinating care and making referrals to specialists for the enrolled population. Members are offered the opportunity to select from several available participating PCPs or is auto-assigned in compliance with all applicable State rules and regulations. The PCP is responsible for the provision of initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to the members.<br><br>**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. | MCM 001 Identification of High Risk Members for Care Management: page 1 | Partially Met |
| **Findings:** All new members entering the UnitedHealthcare will be screened for care management programs via a health risk assessment (HRA) tool or may receive a more comprehensive assessment based on program need.<br><br>PTM noted that UnitedHealthcare has not submitted a guideline regarding the timeframe within which they are required to screen all new enrollees. | | |

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| **Required Actions:** PTM recommends that UnitedHealthcare updates its policy to mention the timeframe as required in this section. | | |
| C. Coordination of services/Transition of care:<br><br>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-<br><br>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.<br><br>b. If a member enrolls with the MCO from another MCO, the new MCO, within 5 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.<br><br>c. The MCO will provide for the transfer of relevant member information, including medical records and other pertinent materials, to another MCO within 5 | MCM 013 Transition of Care: pages-1, 2 | Fully Met |

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| business days of receiving the request.<br><br>d. If the MCO receives new members who were previously members in the Fee-For-Service program, the MCO must contact the member's provider within five business days of the state agency's notification to the MCO of the member's anticipated enrollment date, to request the necessary medical records and information. | | |
| **Findings:** UnitedHealthcare adopted all the requirements in its policy, "Transition of Care," thus complies with this section.<br><br>**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.<br>If the MCO changes subcontractors, the MCO shall ensure that relevant member information is transferred between the subcontractors within a timely manner prior to transitioning to the new subcontractor. | MCM 002 Care Management Process: page 2<br><br>NCM 002 Case Management Process: pages-2, 5<br><br>Disclosure to Third Parties: pages-1 to 4<br><br>MCM 013 Transition of Care: page 2 | Fully Met |
| **Findings:** If the member is transitioning from another MCO or the MHD Fee-For-Service (FFS), and has been previously engaged in care management, the care manager will also request and review information provided by the previous MCO, as available, to support the transition of care management services. This will include notifying the physical health or behavioral health primary care provider of the change in the MCO and care management contact.<br><br>To ensure continuity of care, if a member transitions to another MCO or the MHD FFS, the care manager will facilitate transition to the new MCO/or FFS. The care manager will share | | |

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| the member care plan and historical utilization data, upon request, with the new MCO. This data will be shared per HIPAA guidelines.<br><br>UnitedHealthcare may disclose PHI to a Business Associate and may allow the Business Associate to create, receive, maintain, or transmit PHI on its behalf, provided it obtains satisfactory assurances that the Business Associate will appropriately safeguard the information. The broker, agent, or consultant must first sign a third-party disclosure agreement (or other agreement with adequate confidentiality assurances) with UnitedHealthcare and the affected employer group, fully insured plan sponsor, or self-funded plan administrator prior to the disclosure of PHI.<br><br>If UnitedHealthcare changes subcontractors, UnitedHealthcare will ensure that relevant enrollee information is transferred between the subcontractors within a timely manner prior to transitioning to the new subcontractor.<br><br>**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.<br><br>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. | MCM 013 Transition of Care: page 2 | Fully Met |
| **Findings:** UnitedHealthcare adopted all the requirements in its policy "Transition of Care" and thus complies with this section.<br><br>**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 | MCM 013 Transition of Care: pages-2, 3 | Fully Met |

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| 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.<br><br>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.<br><br>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.<br><br>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:** UnitedHealthcare adopted all the requirements in its policy "Transition of Care" and thus complies with this section.<br><br>**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 | MCM 013 Transition of Care: page 3 | Fully Met |

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| providers, for- the lesser of 60 calendar days or until the member has been seen by the assigned primary care provider who has authorized a course of treatment. | | |
| **Findings:** UnitedHealthcare's policy "Transition of Care" complies with the requirements of this section.<br><br>**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). | MCM 013 Transition of Care: page 3 | Fully Met |
| **Findings:** UnitedHealthcare's policy "Transition of Care" complies with the requirements of this section.<br><br>**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. | MCM 013 Transition of Care: page 3 | Fully Met |
| **Findings:** UnitedHealthcare's policy "Transition of Care" complies with the requirements of this section.<br><br>**Required Actions:** None. | | |
| D. Ensure that inpatient and residential treatment days are not prior authorized during transition of care. | MCM 013 Transition of Care: page 3 | Fully Met |
| **Findings:** UnitedHealthcare's policy "Transition of Care" complies with the requirements of this section.<br><br>**Required Actions:** None. | | |

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| 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. | Onsite Submission<br>MO-002 Primary Care Provider Responsibilities: page 4 | Partially Met |
| **Findings**: PCP is responsible for 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.<br><br>PTM noted that UnitedHealthcare has not submitted documentation requiring PCPs to share the enrollee's health record per the professional standards to prevent duplication of services.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare updates its policy and ensures that the medical records are shared per requirement of this section. | | |
| 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. | UnitedHealth Group 2022 Privacy and Security Program Overview: pages-1, 2<br><br>UnitedHealth Group Policy Summary: pages-1 to 3<br><br>P17 Privacy Training: pages-1, 2 | Fully Met |
| **Findings:** UnitedHealthcare Privacy and Security Programs are designed to comply with federal and state privacy laws and regulations, including as applicable, the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH), the Gramm-Leach-Bliley Act (GLBA), Children's Online Privacy Protection Rule (COPPA), and state privacy laws including but not limited to the California Consumer Privacy Act (CCPA).<br><br>At a high level, UnitedHealthcare policies and procedures address, for example, the following privacy and security requirements: Minimum Necessary; Use and Disclosure; Business Associates; Plan Sponsors; Authorizations; Individual Rights; Privacy Notice; Complaints; and Safeguards. In addition, before releasing any information, individuals must be properly identified and authenticated by providing their name, member ID number or address, date of birth, their relationship to the member if applicable, and affirmation that they have appropriate permission and authority to speak on behalf of the member. Information is only provided to individuals calling about themselves, parents of unemancipated minor children, and to individuals with a valid authorization. "Sensitive | | |

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| information" (as defined by more stringent state laws) is only provided to individuals calling about themselves or to individuals with a valid authorization.<br><br>**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). | MDM 001 Disease Management Process: page 1<br><br>MCM 002 Care Management Process: page 5 | Fully Met |
| **Findings:** UnitedHealthcare may use a Section 2703 designated health home provider to perform disease management functions if the health home provider is a member of the UnitedHealthcare network. If a member has a disease for which UnitedHealthcare has a disease management program and the member is not receiving education regarding the disease by the health home, UnitedHealthcare may enroll the member in disease management. In<br>the event of such, UnitedHealthcare will have processes in place to monitor service delivery and ensure that all requirements, as described herein, are adequately performed. The care managers will collaborate with the interdisciplinary care team (i.e., PCP, pharmacy, medical director, behavioral health, social work, health home, external care manager), as appropriate to address and coordinate care needs of the member across the continuum.<br>(Note: Disease management program is concurrently managed with care management program at UnitedHealthcare.)<br><br>**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.<br>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. | | |

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| i. HCT Management: The MCO shall have written policies and procedures that address all HCT requirements herein (MHD contract 2.11.4).<br><br>a. HCT coordinators will collaborate with facility staff responsible for discharge planning to understand the discharge risk assessment, patient and caregiver and goals of care, and provider recommendations. The HCT coordinators will assist the member in the transition of members' care by providing education about in-network care providers, programs they may be eligible for, and community-based resources. In doing so, HCT coordinators will abide by facility policies and procedures, and other applicable federal and state laws governing access to patients and secure patient data.<br><br>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.<br><br>c. HCT coordinators shall be onsite at the facility, when MCO members are identified with an admission requiring HCT management services, in order to work directly with the hospital staff to assist members in their care transition. | <u>Onsite Submission</u><br><br>UCSMM.ALL.06.14.IP-G3 Referral to Discharge Care Management: pages-1 to 4<br><br>UCSMM.ALL.06.14.IP-G Discharge Care Management Review Workflow: pages-1 to 3, 6, 7<br><br>UCSMM.ALL.06.14.IP-I Post-Discharge Outreach Process: page 6 | Partially Met |

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| **Findings:** The Discharge Care Management Program (DCMP) was developed to standardize the discharge planning process to positively impact clinical and client audit outcomes, timely and appropriate patient transition to a lower level of care, patient education, member satisfaction and experience, as well as efficient and effective utilization of resources. Scope-of-care includes Acute Inpatient (IP), non-Neonatal Resource Services (NRS) and referrals from Facilities/Providers. This applies to cases with Adverse Determinations and/or Coordination of Benefits (COB).<br><br>a. The care manager collaborates with the Facility discharge planner to coordinate transition to a lower level of care or for discharge home. (Refer to the list of activities in the section H(ii) below.<br><br>b, c. The care manager coordinates with the facility discharge planner or case manager/social worker and finalize the member's discharge plan. A member will be outreached via hospital phone or member cell phone.<br><br>PTM noted that criteria b and c requires coordinators to be present onsite. This is not addressed in the workflow. During the interview, UnitedHealthcare informed PTM that due to Covid-19 pandemic restrictions, the care managers are not allowed in the hospital. While PTM understands these restrictions, UnitedHealthcare should address the necessity of an onsite HCT coordinator.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare updates its Discharge Care Management Review Workflow to include the coordinators presence onsite at the facility, when members are identified with an admission requiring HCT management services, to work directly with the hospital staff to assist members in their care transition. This requirement can be implemented after the Covid-19 pandemic restrictions are no longer necessary. | | |
| ii. Services provided by HCT coordinators include, but are not limited to:<br><br>a. Obtaining discharge disposition/location, including post-discharge contact information.<br><br>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.) | <u>Onsite Submission</u><br>Genoa's Meds to Bedside Program (Presentation-Behavioral Health facility and Pharmacy Integration)<br><br>UCSMM.ALL.06.14.IP-G Discharge Care Management Review Workflow: pages-3, 6 | Fully Met |

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| c. Coordinating home care services (e.g., home health, home infusion, durable medical equipment, pharmacy).<br>d. Coordinating community services (e.g., transportation, other resources and services to address social determinants, etc.).<br><br>e. Providing member benefit education (prescriptions, member concerns, chart/medical history).<br><br>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.<br><br>g. Ensuring the member has an assigned primary care physician.<br><br>h. Maintaining continuum of care by helping to ensure connections and communications with post-discharge programs.<br><br>i. Helping members and caregivers understand discharge plans, current medication lists, transfer plans, and instructions. | | |
| **Findings:** The care manager will conduct and coordinate for the following services:<br>• Review the discharge plan with the member and assess for understanding.<br>• Contact PCP to inform the member's admission. If the member does not have a PCP or Specialist identified, the care manager will provide a list of In-Network providers. If the member does have a PCP or Specialist and needs assistance with scheduling an appointment, coordinate the scheduling of the follow-up visit.<br>• Identification of resources.<br>• Activities of Daily Living needs.<br>• Other required post-discharge program referrals, e.g., referrals to internal partners.<br>• Psychosocial barriers, e.g., Instrumental Activities of Daily Living (IADL), poor social support, family dynamics, no familial support. | | |

- Legal Assistance, e.g., guardianship, Power of Attorney, advance directives, protective services.
- Coordination of additional state/federal financial resource eligibility.
- Financial prescription medication needs/eligibility.
- Behavioral Health resource guidance.
- Regional/Community support groups.
- Alternative housing, e.g., homeless shelters, group home, assisted living, domestic violence, shelters, family lodging for member medical treatments.
- Home modifications due to complex medical conditions.
- Community resources.
- Transportation access.
- Inform the member that a post-discharge call will be made and confirm the best time to outreach.

**Required Actions:** None.

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| 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.<br><br>*LTSS is N/A per the MHD Contract | MCM 002 Care Management Process: page 2<br><br>MCM 001 Identification of High Risk Members for Care Management: pages-1, 2<br><br>MCM 0012 Risk Stratification Process: pages-1, 3 | Fully Met |

**Findings:** Prior to initiating contact with the member, the care manager will review the referral source and risk stratification data to identify complex or special needs, current risks as well as the utilization history of member.
All new members entering the UnitedHealthcare will be screened for care management program via a health risk assessment (HRA) tool or may receive a more comprehensive assessment based on program need. The purpose of this screening is to identify and refer members for care management and other specialized programs to meet their needs. The screening will identify and assign high risk members to a fully integrated interdisciplinary care team. Category of Aid 4 members are assigned a care manager with the Foster Care team.

Additional processes/sources are in place to continually evaluate for ongoing identification of members for referral to care management. These sources include but are not limited to the following:

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| a. Data sources (Predictive modeling tools). For example, claims or encounter data; hospital admission/discharge and or census data; pharmacy data; laboratory data; and data collected through UM Process.<br>b. Individuals identified with complex or special needs as defined by State, e.g., extended nursing hours, disability, ventilator dependence, developmental delay.<br>c. Medical management program referrals, which includes UM programs, disease management programs, NurseLine (health information line), and community programs.<br>d. Discharge planner referral.<br>e. State files (pregnancy flags, special needs individuals).<br>f. Member or caregiver referral.<br>g. Practitioner referral.<br><br>**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. | MCM 002 Care Management Process: pages-2, 3<br><br>NCM 002 Case Management Process: page 1 | Fully Met |
| **Findings:** The case manager will complete the initial comprehensive assessment as expeditiously as the member's condition requires within the timeframes established by regulatory requirements, but no later than 30 calendar days from identification of the member as appropriate for high risk case management and is completed within 60 days of identification. The care manager completes the initial comprehensive assessment based on information provided by the member and/or caregiver/authorized representative the member's PCP, other medical and behavioral health providers including external care managers involved in the members care. The assessment will be completed telephonically or face to face based on member condition and regulatory guidance.<br><br>PTM noted that UnitedHealthcare's policy, "Case Management Process," has an incorrect information on completing the assessment within 60 days (30 calendar days per the MHD contract).<br><br>**Required Actions:** PTM recommends that UnitedHealthcare updates its policy based on the inaccuracy identified. | | |
| iii. Treatment/service plans. MCOs must produce a treatment or | MCM 002 Care Management Process: pages-1, 3, 4, 6 | Fully Met |

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| service plan meeting the following criteria in for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan for the enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be:<br><br>a. Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee.<br><br>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.<br><br>c. Approved by the MCO, PIHP, or PAHP in a timely manner, if this approval is required by the MCO.<br><br>d. In accordance with any applicable State quality assurance and utilization review standards.<br><br>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). | <u>Onsite Submission</u><br>PCP Care Plan Letter | |
| **Findings:** a, b. A person-centered plan of care (POC) is developed by the care manager in collaboration with the member, caregiver/family (with member's consent), and the interdisciplinary care team including the member's PCP, other medical and behavioral | | |

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| health providers as appropriate and external care managers involved in the members' care.<br><br>c. UnitedHealthcare sends a letter to the member's PCP informing about a member's enrollment in care management program, health care goals, and how the care plan can be accessed by visiting UHCprovider.com and suggestions, notes be added for improving care services.<br><br>d. The POC is evidence based, person centered, and goals are measurable, time bound, and prioritized to meet the needs identified in the assessment. The POC is individualized in alignment with the member's wishes and preferences. The POC will be monitored, evaluated and updated as the member's care needs change through case closure.<br><br>e. The care manager will complete a comprehensive assessment at a minimum annually or within the timeframes established by regulatory requirements.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare submits documentation based on the guidelines for a care plan per the MHD contract, section 2.11.1. | | |
| J. Direct Access and standing referrals:<br><br>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):<br><br>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.<br><br>ii. A standing referral from a specialist if the member has a condition which requires on-going care from a specialist.<br><br>iii. Access to a specialty care center if the member has a life-threatening condition or disease | MO Member Handbook: pages 20, 48<br><br><u>Onsite Submissions</u><br>MUM 003 Referrals: page 1<br><br>MO-002 Primary Care Provider Responsibilities: page | Fully Met |

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| either of which requires specialized medical care over a prolonged period of time. | | |

**Findings:** UnitedHealthcare's policy, "Referrals" lists all the criteria in this section, but does not address how a member may request and obtain referrals. However, another policy, "Primary Care Provider Responsibilities" states that it is PCP's responsibility to make referrals for specialty care and other medically necessary services to both in-network and out-of-network providers. The member handbook states that UnitedHealthcare does not require a referral to see a specialist that is in-network. During the interview, the staff informed that the members do not need a referral for specialist services.

**Required Actions:** None.

| **Compliance Score – Coordination and Continuity of care** | | | | | | |
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| Total | Met | = | 16 | ×2 | = | 32 |
| | Partial Met | = | 3 | ×1 | = | 3 |
| | Not Met | = | 0 | ×0 | = | 0 |
| Numerator | Score Obtained | | | | | 35 |
| Denominator | Total Sections | = | 19 | ×2 | = | 38 |
| **Score** | | | | | | **92.10 %** |

**Appendix D**

| **Standard 4-42 CFR: 438.210 , 457.1230(d) Coverage and Authorization of Services** | | |
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| **Requirements and references** | **Evidence/documentation as submitted by the MCO** | **Score** |
| A. Coverage:<br><br>Each MCO must do the following:<br>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).<br><br>ii. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. | Onsite Submission<br>UCSMM.06.10 Clinical Review Criteria (old version): page 4 | Partially Met |
| **Findings:** UnitedHealthcare has not addressed the requirements of this section. The policy, "Clinical Review Criteria (old version)," has copied the section from the MHD contract that requires the MCO to provide a comprehensive benefit package sufficient in amount, duration, and scope to reasonably achieve its purpose.<br><br>In EQR 2019, EQRO had recommended that UnitedHealthcare creates its policies by adopting the contractual requirements and code of federal regulation describing details of how they will meet the MHD's requirements. PTM noted that UnitedHealthcare continued to copy the MHD contract "as is."<br><br>**Required Actions:** PTM recommends that UnitedHealthcare describes how it complies with criteria i, ii of this section. | | |
| iii. Services identified be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid as set forth in 440.230 of chapter IV and for enrollees under 21, as set forth in subpart B of part 441 of chapter IV (Early and Periodic Screening, Diagnosis, and Treatment-EPSDT-of individuals under age 21). (Note: These sections do not apply to CHIP per the CMS EQR protocol). | Onsite Submission<br>UCSMM.06.10 Clinical Review Criteria (old version): page 4<br><br>UCSMM 2017 002 Management of Behavioral Health Benefits Addendum: page 2 | Partially Met |

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| 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:** UnitedHealthcare's policy does not address the requirement that the services will be furnished in an amount, duration, and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS. All the other requirements are acknowledged from the MHD contract.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare addresses the missing element and also creates/updates its policy to describe how it meets the requirements of this section and not reiterate the contract language. | | |
| iv. EPSDT Services (known as Healthy Children and Youth-HCY-Program in Missouri) (MHD contract 2.7.5):<br><br>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.<br><br>The services will include:<br>• A comprehensive health and developmental history including assessment of both physical and behavioral health developments.<br>• A comprehensive unclothed physical exam.<br>• Health education (including anticipatory guidance).<br>• Laboratory tests as indicated (appropriate according to age | QA017 MO HCY/EPSDT: pages 1, 2, 4, 8 to 10 | Fully Met |

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| and health history unless medically contraindicated).<br>• Appropriate immunizations according to age.<br>• Annual verbal lead risk assessment beginning at age six months and through age seventy-two (72) months.<br>• 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.<br>• Hearing screening.<br>• Vision screening.<br>• Dental screening beginning at 6-12 months of age and repeated every 6 months.<br><br>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. UnitedHealthcare reaches out to each new member with a phone number within 30 days of enrollment to complete a welcome call. UnitedHealthcare conducts member and provider outreach and education to help members and their parents, or legally appointed representative, use resources appropriately. This outreach and education is designed to inform members of the MHD HCY (EPSDT) program, including the need for screening and treatment services in a timely manner, assistance in making an appointment for MHD HCY/EPSDT services, and/or assistance in scheduling transportation. The preventive screens include all the components listed in this section.<br><br>b. UnitedHealthcare coordinates services with child-serving agencies and providers, providing all medically necessary individualized HCY services, screening, vision, dental, and hearing services and makes arrangements for necessary follow-up care regardless of whether the required service is a covered benefit.<br><br>**Required Actions:** None. | | |

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| v. The MCO is permitted to place appropriate limits on a service:<br><br>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.<br>The MCO will specify what constitutes "medically necessary services." Services that-<br>• Prevents, diagnoses, or treats a physical or behavioral health condition or injury.<br>• Is necessary for the member to achieve age appropriate growth and development.<br>• Minimizes the progression of disability.<br>• Is necessary for the member to attain, maintain, or regain functional capacity.<br>(MHD contract 2.7.8) (Note: This section does not apply to CHIP). | <u>Onsite Submission</u><br>UCSMM.06.10 Clinical Review Criteria (old version): page 5<br><br>Radiology and Cardiology Prior Authorization Program: page 1<br><br>Participating Plan Addendum#28 (Exhibit A-page 3/Exhibit J-page 9) | Fully Met |
| **Findings:** UnitedHealthcare presented the excerpt from the MHD contract showing the definition of Medical Necessity. As UnitedHealthcare acknowledged the definition correctly, PTM scored this section as Fully Met.<br><br>The radiology and cardiology Notification protocol includes a prior authorization requirement when the member's benefit plan requires services to be Medically Necessary to be eligible for coverage.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare creates/updates its own policy to adopt the definition of Medical Necessity rather than reproducing the contract language. | | |
| b. For the purpose of utilization control, provided that—<br><br>• The services furnished can reasonably achieve their purpose, as required in section A of this evaluation tool.<br>• The services supporting individuals with ongoing or | MO Member Handbook: page 64<br><br><u>Onsite Submission</u><br>UCSMM.06.10 Clinical Review Criteria (old version): page 2 | Partially Met |

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| 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.<br>• 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. | | |
| **Findings:** UnitedHealthcare's staff who apply clinical review criteria will consider the member's age, comorbidities, complications, progress of treatment, psychosocial situation and, where applicable, the home environment or ability of the facility to deliver services. The staff also consider available services in the local delivery system and their ability to meet the member's specific health care needs.<br>The member handbook states that UnitedHealthcare allows family planning services that protects and enables the enrollee's freedom to choose the method of family planning.<br><br>PTM noted that UnitedHealthcare submitted generalized documentation to meet the requirements listed in bullet points 1 and 2. During the interview the staff had the knowledge about conducting assessments and management of the complex needs of members.<br><br>PTM noted that UnitedHealthcare did not addressed criterion regarding family planning services in its policy. However, during the interview, the staff informed that the claims system is set up not to deny any claim for family planning services.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare submits policy that addresses the deficiencies. | | |
| B. Authorization of services:<br><br>i. MCO is prohibited from requiring prior authorization for emergency medical/ behavioral health services (MHD contract 2.5.5(a)).<br><br>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 | <u>Onsite Submission</u><br>UCSMM 2017 002 Management of Behavioral Health Benefits Addendum: page 4<br><br>MOUM001 Emergency Care and Post-Stabilization: page 1 | Fully Met |

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| detention or commitment is in effect (MHD contract 2.5.5(e). | | |
| **Findings:** UnitedHealthcare submitted policies that meet the requirements of this section.<br><br>**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)). | Onsite Submission<br>UCSMM.08.10 Mental Health Parity Program Quality and Compliance Monitoring: pages-1 to 3 | Fully Met |
| **Findings:** UnitedHealthcare Mental Health Parity (MHP) team conducts and supports ongoing quality monitoring of MHP regulatory requirements as defined by the Mental Health Parity and Addiction Equity Act (MHPAEA), 21st Century Cures Act, the 2021 Consolidated Appropriations Act (CAA), and all applicable federal or state specific MHP laws and/or regulations. The MHP quality and compliance monitoring ensures ongoing maintenance and progression of the MHP infrastructure and processes as well as assessment and management of the MHP compliance program, including monitoring, detecting, facilitating correction, and reporting of MHP Improper Practices.<br><br>**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)). | Onsite Submission<br>UCSMM.06.10 Clinical Review Criteria (old version): page 3 | Partially Met |
| **Findings:** UnitedHealthcare acknowledged the requirements by copying the section from the MHD contract. | | |

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| **Required Actions:** PTM recommends that UnitedHealthcare creates its own policy by adopting the information and describing the process, as applicable. | | |
| 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:<br><br>a. All appeals and denials must be reviewed by a professional who has appropriate clinical expertise in treating the member's condition or disease.<br><br>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.<br><br>c. Reasons for decisions are clearly documented and assigned a prior authorization number which refers to and documents approvals and denials.<br><br>d. Documentation shall be maintained on any alternative service(s) approved in lieu of the original request.<br><br>e. There is a well-publicized review process for both providers and members (MHD contract 2.5.5e). | UCSMM.07.10 Appeal Peer Reviewer Qualifications: pages-1, 2<br><br>UCSMM.06 Initial Adverse Determination Notices: pages-2, 3<br><br>UCSMM.06.15 Peer Clinical Review: page 2<br><br>UCSMM.06.10 Clinical Review Criteria: pages-1, 2 | Fully Met |
| **Findings:** a. Only qualified individuals who are clinical peers with active, unrestricted licenses to practice in accordance with their license, will render appeal review determinations. The appeal reviewer is in the same profession, in a similar specialty, and has training and experience that includes treating the condition and treating complications that may result from the service or procedure, and is sufficient to determine if a service or | | |

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| procedure is medically necessary or clinically appropriate in accordance with applicable accreditation, state/federal law, contract or government program requirements.<br><br>b. UnitedHealthcare Clinical Services Medical Management (UCSMM) utilizes external and internal clinical review criteria that are evaluated annually by the applicable quality oversight committee and approved by the medical director or equivalent designee. External clinical review criteria are based on applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines such as Milliman Care Guidelines or InterQual. The Internal clinical review criteria are developed by UnitedHealthcare through review of current, new, and emerging medical technologies. For example, Internal review criteria such as Medical Policy, Coverage Determination Guidelines and Utilization Review Guidelines are available for staff access.<br><br>d. UnitedHealthcare staff considers available services in the local delivery system and their ability to meet the member's specific health care needs.<br>UnitedHealthcare informed PTM that it has not approved any alternative service in lieu of the requested services in CY 2021.<br><br>c, e. The peer clinical reviewer enters the principle reasons and clinical rationale for the adverse determination into the system case file. The peer clinical reviewer who rendered an adverse determination will document an electronic identifier in the medical management system.<br><br>**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. | UCSMM.06.15 Peer Clinical Review: pages-1, 2 | Fully Met |
| **Findings:** Cases are reviewed that were not approved/certified by initial screening or initial clinical review process, i.e., all cases in which medical necessity cannot be certified, or in which benefit determination is not explicitly excluded and cannot be approved based on information provided. Staff members who conduct peer clinical review will be qualified health professionals, with a current license to practice in accordance with their license, or current license in the same category as the treating/ordering provider or an administrative license to review UM cases. Only peer clinical reviewers will render adverse | | |

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| determinations for clinical review outcomes. In the case of clinical adverse determination, the peer clinical reviewer or their alternate will be available within one business day to discuss determinations with requesting providers.<br>**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). | Onsite Submission<br>UCSMM.06.10 Clinical Review Criteria (old version): page 3 | Partially Met |
| **Findings:** UnitedHealthcare acknowledged the requirements by copying the section from the MHD contract.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare creates its own policy by adopting the information and describing the process, as applicable. | | |
| 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). | Onsite Submission<br>UCSMM.06.10 Clinical Review Criteria (old version): page 3 | Partially Met |
| **Findings:** UnitedHealthcare acknowledged the requirements by copying the section from the MHD contract.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare creates its own policy by adopting the information and describing the process, as applicable. | | |
| 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). | CL.001 Payment of Custom Items: page 1 | Fully Met |
| **Findings:** UnitedHealthcare complies with the requirement of this section per its policy, "Payment of Custom Items."<br><br>**Required Actions:** None. | | |

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| 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:<br><br>a. The authorization is based on material misrepresentation or omission about the treated person's health condition or the cause of the health condition.<br><br>b. The MCO's contract terminates before the health care services are provided.<br><br>c. The covered person's coverage under the MCO terminates before the health care services are provided (MHD contract 2.5.5i). | Onsite Submission<br>UCSMM.06.14 Initial Clinical Review (old version): page 3 | Partially Met |
| **Findings:** UnitedHealthcare acknowledged the requirements by copying the section from the MHD contract.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare creates its own policy by adopting the information and describing the process, as applicable. | | |
| 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). | Onsite Submission<br>UCSMM.06.14 Initial Clinical Review (old version): page 3 | Partially Met |
| **Findings:** UnitedHealthcare acknowledged the requirements by copying the section from the MHD contract.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare creates its own policy by adopting the information and describing the process, as applicable. | | |
| C. Timeframe for authorization: | | |

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| 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.<br><br>ii. Approval or denial shall be provided within 24 hours of request for services determined to be urgent by the treating provider. | <u>Onsite Submission</u><br>UCSMM 06.16 Initial Review Timeframes (old version): page 5<br><br>UCSMM 2017 002 Management of Behavioral Health Benefits Addendum: page: 6 | Partially Met |
| **Findings:** i. UnitedHealthcare's policy, "Management of Behavioral Health Benefits Addendum," complies with the criterion.<br><br>PTM noted that UnitedHealthcare has not submitted documentation for physical health related non-emergency services.<br><br>ii. UnitedHealthcare acknowledged the requirement by copying the section from the MHD contract.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare creates its own policy by adopting the information from the MHD contract and describing the process, as applicable. Also, there should be documentation to meet the requirement based on the deficiency pointed out by PTM. | | |
| iii. Authorization decisions (Note: There are no separate criteria for standard/expedited authorization decisions time frames in the MHD contract.)<br><br>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 | <u>Onsite Submission</u><br>UCSMM 06.16 Initial Review Timeframes (old version): pages-5, 6<br><br>UCSMM 2017 002 Management of Behavioral Health Benefits Addendum: page: 6 | Fully Met |

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| second opinion that may be required.)<br><br>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.<br><br>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. | | |
| **Findings:** UnitedHealthcare acknowledged the requirements by copying the section from the MHD contract in its policy, "Initial Review Timeframes." UnitedHealthcare's policy, "Management of Behavioral Health Benefits Addendum," complies with the requirements from this section.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare creates its own policy by adopting the information and describing the process, as applicable. | | |
| D. Notice of adverse benefit determination:<br><br>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.) | UCSMM.06 Initial Adverse Determination Notices: page 1 | Fully Met |

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| **Findings:** Written notice of an adverse benefit determination will be given to the provider who is requesting coverage and/or providing the service as well to the member. To ensure timeliness, verbal and other acceptable electronic means of notice will be used in addition to written notices. Written notice of all adverse determinations will provide principle reasons for the determination, information about availability and how to contact a peer clinical reviewer, and a description of appeal rights.<br><br>Written notice of adverse determinations resulting from clinical review will contain the following information: the availability of and how to initiate a discussion with the peer clinical reviewer, reference to the criteria used, instructions for how to request clinical rationale, and how to request clinical review criteria upon which the decision was based.<br><br>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. PTM has noted this inaccuracy in the policy "Initial Adverse Determination Notices" under Grievance and Appeal Review (Appendix G) and has scored it as "Partially Met," thus PTM is not re-evaluating the same in this section.<br><br>PTM evaluated and scored the contents of the notice of adverse benefit determination letter utilized by UnitedHealthcare under Grievance and Appeal Review (Appendix G) and has not scored it again in this section.<br><br>**Required Actions:** Even though PTM assigned a score of "Fully Met" as UnitedHealthcare met the requirement of this section, PTM recommends that UnitedHealthcare updates the above mentioned policy based on PTM's finding. | | |
| E. Compensation for utilization management activities (consistent with §438.3(i), and 422.208 of 42 CFR chapter IV):<br><br>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)). | UCSMM.02.12 Performance Assessment and Incentives: page 2 | Fully Met |
| **Findings:** Staff members and practitioners involved in clinical or administrative review will not be given incentive to make determinations that result in underutilization nor rewarded for issuing non-approval or non-certification determinations.<br>**Required Actions:** None. | | |

| Compliance score-Coverage and Authorization of Services | | | | | | |
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| Total | Met | = | 10 | ×2 | = | 20 |
| | Partial Met | = | 9 | ×1 | = | 9 |
| | Not Met | = | 0 | ×0 | = | 0 |
| Numerator | Score Obtained | | | | = | 29 |
| Denominator | Total Sections | = | 19 | ×2 | = | 38 |
| **Score** | | | | | | **76.31%** |

**Appendix E**

| Standard 5– 42 CFR: 438.214, 457.1233(a)-Provider Selection | | |
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| **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):<br><br>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).<br><br>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.<br><br>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.<br><br>iv. Following the effective date of the contract, the MCO shall provide the state agency with the Social Security Number of the providers. | Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor: page 3<br><br>UnitedHealthcare Credentialing Plan 2021-2023: pages-8, 14, 16, 17, 31<br><br>State and Federal Regulatory Addendum E to the UnitedHealthcare Credentialing Plan: page 34<br><br>Clinician Credentialing Process: pages-3, 5<br><br>Optum Physical Health Credentialing Risk Management Plan 2021: pages-10 to 13, 18, 19, 28, 41<br><br>Missouri Addendum to Credentialing Policies: page 1<br><br>CRD001 Provider Credentialing and Recredentialing: page 1<br><br>Ongoing Monitoring of Sanctions and Complaints: page 3<br><br>Organizational Provider Credentialing and Recredentialing | Fully Met |

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| | (Behavioral Health): pages-2, 3<br><br>Reporting Requirements for Credentialing Decisions-NPDB and Licensing Agencies: page 2<br><br>POL.17267538 Vision Credentialing and Recredentialing Policy: pages-6, 8<br><br>POL.17701055 Vision Ongoing Sanction Monitoring: pages-1, 2<br><br>MO HealthNet Demographic File Layout (Excel) | |

**Findings:** i. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in UnitedHealthcare's Medicaid or CHIP network. Upon notification from the State that the provider's enrollment has been denied or terminated, UnitedHealthcare must terminate the provider immediately and will notify affected covered members that the provider is no longer participating in the network.

UnitedHealthcare (credentialing entity) will Primary Source Verify that the applicant maintains current, valid licensure or certification, without Material Restrictions, conditions, or other disciplinary action, in all states where the applicant practices. Any finding of sanctions or restrictions on the licensed independent practitioner (LIP) from any government agency or authority, including but not limited to a state licensing authority may result in denial of credentialing. If the LIP has a Material Restriction in a state in which the LIP does not practice, UnitedHealthcare has the discretion to recommend acceptance into the network after reviewing the circumstances of the Material Restriction.

The credentialing department obtains or queries prior to the credentialing/recredentialing decision date a copy of the license(s) from the organizational provider or verification of the licensure directly from the state agency and confirms that the facility holds valid current license(s) in the applicable state(s) where contracting for Optum. (UnitedHealthcare's behavioral health services operates under the brand Optum).
ii. UnitedHealthcare will monitor participating LIPs and facilities for complaints, potential quality concerns or identified adverse events. Identified concerns will be tracked and resolved in accordance with UnitedHealthcare's policy. An applicant for recredentialing must have demonstrated compliance with all terms of the Participation Agreement, specifically including successful participation in quality improvement initiatives or

completion of improvement action plans requested by UnitedHealthcare. As required by credentialing authority, UnitedHealthcare in conjunction with Quality of Care Department or its designee (collectively "QOC Department") monitors complaints concerning participating LIPs/facilities. Complaints about an office site and facilities are recorded, investigated and appropriate follow-up is conducted to assure that covered persons receive care in a clean, accessible, and appropriate environment. If an unwarranted variation does not improve, UnitedHealthcare may take actions up to and including termination of participation status. UnitedHealthcare may terminate a provider's participation in the network for failure to comply with certain contractual obligations or Quality Management requirements. Depending on the circumstances, termination may be immediate or allow for an appeals process.

Complaints about clinicians are tracked, investigated, resolved, and monitored daily. Clinician complaint histories are evaluated at the time of any complaint investigation. Additionally, clinicians' history of complaints is evaluated at least every six months and clinicians who have received two or more complaints during that period are reviewed by complaint manager. If any provider receives four or more substantiated complaints, the complaint manager will review details to determine if further action is need such as education of the provider by Provider Relations or referral to Credentialing Committee for further determination.

UnitedHealthcare has process and evidence in the file for committee review and monitoring, facility specific information such as, but not limited to, the following (at least two):
• Member complaints.
• Utilization data (drugs utilization, disease prevention).
• Performance measure rates (e.g., time-late opening clinic, after-hours office hours, medical record documentation compliance, immunization rates).
• Results of medical record review audits.
• Quality of care issues.
• On-site assessment.

iii. The Universal Credentialing Data Source form (Form UCDS), incorporated by reference and published on October 31, 2006, by the Council for Affordable Quality Healthcare (CAQH), has been adopted and will be used by UnitedHealthcare and their agents when credentialing or recredentialing health care professionals (20 CSR 400-7.180 (2011)). UnitedHealthcare is required to accept any application approved by the Missouri Director of Insurance and cannot require a provider to use any particular form to the exclusion of another form. If UnitedHealthcare demonstrates a need for additional information, the director of the Department of Insurance may approve a supplement to the standard credentialing form. All forms and supplements must meet all requirements as defined by NCQA (RSMo 354.442(15).

iv. UnitedHealthcare informed PTM that the MHD does not require Social Security Numbers (SSN) of the providers as they are identified using their National Provider Identifier (NPI).

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| They clarified the requirement from the MHD telephonically. The MO HealthNet Demographic Layout (Excel) submitted by UnitedHealthcare does not have an SSN field.<br><br>**Required Actions:** PTM will discuss the requirement in criterion iv with the MHD. If the information provided by UnitedHealthcare is correct, then PTM will recommend contract amendment to replace SSN with NPI. | | |
| 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)). | UnitedHealthcare Credentialing Plan 2021-2023: page 13<br><br>State and Federal Regulatory Addendum E to the UnitedHealthcare Credentialing Plan: page 34<br><br>Optum Physical Health Credentialing Risk Management Plan 2021: page 41<br><br>Missouri Addendum to Credentialing Policies: page 2<br><br>Missouri Contract Risk Assessment-Presentation: slide 1<br><br>CRD001 Provider Credentialing and Recredentialing: page 3<br><br><u>Onsite Submission</u><br>Missouri Addendum to Credentialing Policies (revised): page 3 | Fully Met |
| **Findings:** UnitedHealthcare Credentialing Plan 2021-2023 states that the applicants have the right to be notified of the credentialing decision within 60 calendar days of the UnitedHealthcare's National Credentialing Committee's decision and recredentialing denials within 60 calendar days of decision date, notwithstanding this provision, credentialing time frames and notification will not exceed timelines required by the Credentialing Authority. | | |

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| According to the UnitedHealthcare's policy "Clinician Credentialing Process," when a clinician has received initial approval from the credentialing committee, the clinician will be notified, in writing within 10 business days of the committee's decision to accept the clinician in the UnitedHealthcare network. If the clinician is not accepted as UnitedHealthcare participating clinician, the credentialing department will notify the clinician of this decision, in writing, within 10 business days of the committee's decision.<br><br>The State and Federal Regulatory Addendum E to the UnitedHealthcare Credentialing Plan specific to Missouri states that UnitedHealthcare is required to decide whether to approve or deny a practitioner's credentialing application within 60 business days of receipt of completed credentialing application (RSMo 376.1578(3)).<br><br>The 60 business day deadline will not apply if the credentialing application or subsequent verification indicates that the practitioner has a history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse; has licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction; had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or a judgment or judicial award [but not a settlement] against the practitioner arising from a medical malpractice liability lawsuit (RSMo 376.1578(3)(1-4)).<br><br>UnitedHealthcare has submitted data showing provider credentialing turn-around-time for as 100% for each month in CY 2021.<br><br>UnitedHealthcare's policy "Provider Credentialing and Recredentialing" states that they will meet the requirements with respect to health care professionals, such as physicians, chiropractors, dentists, and any other health care practitioners who are licensed, accredited or certified by the State of Missouri to perform specified health services consistent with state law.<br><br>During the onsite submission, UnitedHealthcare updated its "Missouri Addendum to Credentialing Policies" to include credentialing of provisionally licensed psychologists and provisionally licensed professional counselors after the deficiency was pointed out by PTM. UnitedHealthcare submitted a snapshot to show these behavioral health providers are included in license verification. The snapshot has old data from CY 2017-2019, but PTM has accepted it and score this section Fully Met.<br><br>During the interview, the staff confirmed including provisionally licensed psychologists and professional counselors in the network.<br><br>**Required Actions:** None. | | |
| C. As part of re-credentialing, the MCO shall audit records of primary care providers, hospitals, home health | CSQ 01 Advance Directives Medical Record Review (MRR): page 1 | Fully Met |

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| 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)). | Missouri Facilities MRR Instructions: page 1 | |
| **Findings:** It is the policy of UnitedHealthcare and State to monitor provider compliance with UnitedHealthcare's advanced directives. Whether credentialing is delegated or performed by the UnitedHealthcare's National Credentialing Committee, UnitedHealthcare will remain ultimately accountable for ensuring that advance directive requirements are being met. Practitioners should consult their administrative UnitedHealthcare guide for criteria regarding documentation requirements. UnitedHealthcare and the State monitors primary care physicians' compliance with advance directives through Medical Records Review (MRR). MRR data including advanced directives is reviewed quarterly at the Quality Management Committee. A notation that the practitioner has addressed advance directives, and if the member has executed an advance directive, should be prominently documented in every adult member's chart. The medical record review results will be included in the recredentialing process, as applicable, to determine whether the provider is following the policies and procedures related to advanced directives.<br><br>**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 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). | MMAC Ownership and Disclosures-Provider Enrollment: pages-2 to 10<br><br>Missouri State Programs Regulatory Requirements Appendix Non-Medical Subcontractor: page 6<br><br>Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor: pages-11, 12 |  Fully Met |

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| **Findings:** UnitedHealthcare submits a form required by Missouri Medicaid Audit and Compliance that requires providers' information on ownership, ownership interest (individual and organizational), security interest, partnerships, operational/managerial control, adverse legal history.<br><br>"Missouri State Programs Regulatory Requirements Appendices for Medical and Non-Medical Subcontractor" state that a subcontractor shall make disclosures to UnitedHealthcare of full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the Federal Title XX programs in accordance with Federal and State requirements, including Public Chapter 379 of the Acts of 1999 and 42 CFR 455.104-106 and 42 CFR 1001.1001-1002.<br><br>**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:<br><br>a. At the stage of provider credentialing and re-credentialing.<br><br>b. Upon execution of the provider agreement.<br><br>c. Within 35 days of any change in ownership of the provider.<br><br>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)). | Missouri State Programs Regulatory Requirements Appendix Non-Medical Subcontractor: page 6<br><br>Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor: pages-11, 12<br><br>Enrolled Provider List MMAC (Excel)<br><br>MMAC Ownership and Disclosures-Provider Enrollment: pages-2 to 10<br><br><u>Onsite Submission</u><br>Provider Disclosure (State Email) | ● Fully Met |
| **Findings:** "Missouri State Programs Regulatory Requirements Appendices for Medical and Non-Medical Subcontractor" states that a subcontractor shall provide such disclosures, 1) upon execution of the subcontract; 2) within 35 calendar days of any change in ownership; and 3) at any time upon request by UnitedHealthcare and/or the State for any or all information. These documents meet three criteria b, c, d, of this section. | | |

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| PTM noted that the appendix for Medical Subcontractor incorporates the requirement listed in criterion-a.<br><br>UnitedHealthcare informed PTM that they use the list provided by MMAC and has submitted documentation to the MHD.<br><br>**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)). | Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor: pages-11, 12<br><br>Missouri State Programs Regulatory Requirements Appendix Non-Medical Subcontractor: page 6 | Fully Met |
| **Findings:** "Missouri State Programs Regulatory Requirements Appendices for Medical and Non-Medical Subcontractor" comply with the requirements of this section. Refer to findings in section E and D above.<br><br>**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)). | Missouri Initial Credential to Load (ICL) Reporting Dashboard 2021 (Presentation): slide 3<br><br><u>Onsite Submission</u><br>MO Fraud Waste Abuse Report Log-Q4 2021 | Partially Met |
| **Findings:** UnitedHealthcare has submitted a quarterly report log fraud, waste, and abuse report log.<br>PTM noted that no documentation is provided about notification to the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing process. However, a presentation submitted to PTM showed number of providers denied credentialing each month.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare must submit documentation based on the deficiency pointed out by PTM in the findings. | | |

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| 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)). | Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor: pages-3, 4, 11<br><br>UnitedHealthcare Credentialing Plan 2021-2023: pages-8, 12, 16<br><br>State and Federal Regulatory Addendum E to the UnitedHealthcare Credentialing Plan: page 35<br><br>Clinician Credentialing Process: page 6<br><br>Clinician Recredentialing Process: pages-5, 6<br><br>Missouri Addendum to Credentialing Policies: page 2<br><br>CRD001 Provider Credentialing and Recredentialing: page 3<br><br>Ongoing Monitoring of Sanctions and Complaints: page 2<br><br>POL.17267538 Vision Credentialing and Recredentialing Policy: page 7 | Fully Met |
| **Findings:** UnitedHealthcare will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid, or CHIP program in any state. Providers must be currently licensed and/or certified under applicable state and federal statutes and regulations and be eligible to participate in the Medicaid program. Providers must represent that they do not have a Medicaid provider agreement with the State that is terminated, suspended, denied, or not renewed as a result | | |

of any action of the State, CMS, HHS, or the Medicaid Fraud Control Unit of the state's Attorney General. Providers shall always maintain throughout the term of the Agreement with UnitedHealthcare, all necessary licenses, certifications, registrations, and permits required to provide the health care services and/or other related activities delegated to providers by UnitedHealthcare under the Agreement. If at any time during the term of the Agreement, a provider is not properly licensed, the provider shall discontinue providing services to UnitedHealthcare members.

Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial, the applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration (GSA) and the CMS Preclusion list or other disciplinary action by any federal or state entities identified by CMS.

State and federal reports, as well as publicly available health care entity reports, will be reviewed within 30 calendar days of their release, or as soon as possible thereafter, in order to identify Participating LIPs who have had OIG sanctions on Medicare or Medicaid participations, GSA debarments, or other sanctions or restriction on their ability to practice. If UnitedHealthcare identifies a professional license that is not valid, an OIG sanction on Medicare or Medicaid participation, GSA debarment, Office of Personnel Management (OPM), CMS Preclusion and Revocation Lists or other Material Restriction on a LIP's ability to practice, action shall be taken to terminate the LIP from the Network in accordance with the authority established in the Credentialing Plan. Sanctions and restrictions monitoring, tracking and reporting will be done in accordance with UnitedHealthcare's policy.

UnitedHealthcare obtains a monthly list of Medicare/Medicaid sanctioned clinicians from the OIG website and Excluded Parties List System (EPLS) on the System for Award Management (SAM) website. These lists are reviewed to identify any UnitedHealthcare providers who have been sanctioned. On a monthly basis, UnitedHealthcare queries state licensing professional agencies to receive information on sanctions or limitations on clinician licensure. These reports are reviewed on a regular basis as determined by the frequency of the publication by the boards and a log of the reports kept by designated Credentialing Department staff. The designated Credentialing Department personnel also keep a listing of each licensing agency with the method utilized to obtain that agency's sanction information. If a licensing agency does not report sanctions to OptumInsight or Optum, the staff member contacts the agency directly to obtain sanction information.

**Required Actions:** None.

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| I. Claims and Payment System | | |
| i. Unless otherwise written in the subcontract, MCO shall load | State and Federal Regulatory | Fully Met |

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| 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:<br><br>a. Newly credentialed provider attached to a new contract within 10 business days after completing credentialing.<br><br>b. Newly credentialed hospital or facility attached to a new contract within 15 business days after completing credentialing.<br><br>c. Newly credentialed provider attached to an existing contract within five business days after completing credentialing.<br><br>d. Changes for a re-credentialed provider, hospital, or facility attached to an existing contract within 5 business days after completing re-credentialing.<br><br>e. Change in existing contract terms within ten 10 business days of the effective date after the change.<br><br>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)). | Addendum E to the UnitedHealthcare Credentialing Plan: 35<br><br>Optum Physical Health Credentialing Risk Management Plan 2021: page 41<br><br>Missouri Addendum to Credentialing Policies: page 2<br><br>Missouri Initial Credentialing to Load (ICL) Dashboard 2021: slide 4<br><br>CRD001 Provider Credentialing and Recredentialing: page 4<br><br>PROVDIR 001 Provider Directory Creation and Distribution: page 2<br><br><u>Onsite Submission</u><br>Missouri ICL Reporting Dashboard 2021 (revised Presentation): slide 5 | |
| **Findings:** UnitedHealthcare will load credentialed providers into the claim adjudication and payment system within the timeframe mentioned in this section in order to ensure timely denial or payment for a health care service or item already provided to a participant and billed to UnitedHealthcare by the provider. | | |

UnitedHealthcare has submitted data that met the timeframe requirement stated in criterion "a" 100% for each month in CY 2021.

PTM noted that additional information presented during onsite submission showed that even though the average time to meet the criterion "d" was within 5 business days, the longest time in the CY 2021 was 13 days in Aug 2021. UnitedHealthcare analyzed the root cause and TAT reduced to 5 business days by Dec 2021.

It is the policy of UnitedHealthcare to update provider data on a weekly basis. Provider Data is extracted from NDB (Database that houses provider data). Provider Data is input into the core claims processing system (CSP). Provider files are extracted from the CSP and sent to the State IT on a weekly basis. Provider file contains 173 data fields including 20 variable fields. Third party vendor data is aggregated outside of the claims platform and joined within the directory file in the Auxiliary database.

**Required Actions:** None.

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| 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)). | CRD001 Provider Credentialing and Recredentialing: page 1<br><br>IT Flow Chart-Provider: page 2 | Fully Met |

**Findings:** UnitedHealthcare uses State standards for credentialing, recredentialing, monitoring and loading providers to system to be available in directories and payments upon completion of the credentialing process. UnitedHealthcare will ensure providers are included in the network and eligible to receive payment immediately upon completion of the credentialing and re-credentialing process.

UnitedHealthcare explained their IT Flow Chart stating that once the provider credentials data are loaded into the information system, in an overnight feed, it loads into CSP Facets and will process the claims. The provider data is sent daily to the online provider directory.

**Required Actions:** None.

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| J. Upon request by the state agency, the MCO shall provide a report demonstrating the following:<br><br>i. Compliance with the credentialing requirements including but not limited to the average number of days taken to complete credentialing by provider | Missouri ICL Reporting Dashboard 2021 (Presentation): slides-3, 4<br><br><u>Onsite Submission</u><br>Missouri ICL Reporting Dashboard 2021 (revised Presentation): slide 5 | Partially Met |

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| type, and the number of providers who were not credentialed according to the requirements by provider type; and<br><br>ii. Compliance with the required timeframes for loading credentialed providers (MHD contract 2.18.8(c)). | | |
| **Findings:** i. UnitedHealthcare submitted a PowerPoint presentation showing 100% compliance with turn-around-time of 60 business days for credentialing process during CY 2021.<br><br>ii. The time frame (10 business days) for loading credentialed provider in the claims and payment system for a newly credentialed provider attached to a new contract was 100% compliant for the entire year CY 2021. However, UnitedHealthcare's timeframe (5 business days) from credentialing to uploading newly credentialed providers to existing contract was met only for four months in CY 2021. UnitedHealthcare's compliance was 78%-100% throughout the year.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare takes proactive steps to avoid delays and comply with the timeframe requirements per the MHD contract. | | |
| K. Nondiscrimination in hiring and provision of services (MHD contract 2.2.7):<br><br>i. The MCO network provider selection policies and procedures, consistent with §438.12, must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.<br>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. | Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor: page 14<br><br>UnitedHealthcare Credentialing Plan 2021-2023: page 6<br><br>MO-EE-001 Non-Discrimination in Hiring Policy: page 3 | Fully Met |

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| **Findings:** UnitedHealthcare's template "Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor" complies with the requirements of this section. UnitedHealthcare further clarifies that this provision will not be construed as prohibiting UnitedHealth from limiting a provider's participation to the extent necessary to meet the needs of its members. This provision also is not intended and will not interfere with measures established by UnitedHealthcare that are designed to maintain quality of care practice standards and control costs. When a licensed independent practitioner's or a facility's application for credentialing is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision.<br><br>**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):<br><br>a. Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color, or national origin (this includes individuals with limited English proficiency) in programs and activities receiving federal financial assistance and Title VII of the Act which prohibits discrimination on the basis of race, color, national origin, sex, or religion in all employment activities.<br><br>b. Equal Pay Act of 1963 (P.L. 88-38, as amended, 29 U.S.C. Section 206 (d)).<br><br>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.<br><br>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. | Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor: pages 9, 10<br><br>UnitedHealthcare Credentialing Plan 2021-2023: pages-1, 5, 6<br><br>Missouri State Programs Regulatory Requirements Appendix Non-Medical Subcontractor: page 4<br><br>MO-EE-001 Non-Discrimination in Hiring Policy: pages-1, 2<br><br>POL.17267538 Vision Credentialing and Recredentialing Policy: page 5 | Fully Met |

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| e. The Age Discrimination Act of 1975, as amended (42 U.S.C. 6101-6107) which prohibits discrimination on the basis of age.<br><br>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."<br><br>g. Missouri State Regulation, 19 CSR 10-2.010, Civil Rights Requirements.<br><br>h. Missouri Governor's E.O. #94-03 (excluding article II due to its repeal).<br><br>i. Missouri Governor's E.O. #05-30. | | |
| **Findings:** UnitedHealthcare does not make credentialing and recredentialing decisions based on a licensed independent practitioner's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or patients in which the licensed independent practitioner or facility specializes. UnitedHealthcare also does not discriminate in terms of participation, reimbursement, or indemnification, against any licensed independent practitioner who is acting within the scope of the applicable license or certification under state law, solely on the basis of the license or certification. This does not preclude UnitedHealthcare from including in its network licensed independent practitioners who meet certain demographic or specialty needs such as, but not limited to, cultural needs of its covered persons.<br><br>UnitedHealthcare's policy "Non-Discrimination in Hiring" complies with all the criteria listed in this section.<br><br>**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. | MO-EE-001 Non-Discrimination in Hiring Policy: page 3<br><br>Missouri State Programs Regulatory Requirements Appendix Medical Subcontractor: pages 9, 10<br><br>Missouri State Programs | Fully Met |

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| | Regulatory Requirements Appendix<br>Non-Medical Subcontractor: page 4<br><br><u>Onsite Submission:</u><br>Supplier Diversity-UHG.com (website)-Supplier Code of Conduct: page 3<br><br>WBE Expense Report-Sept 2021 | |

**Findings:** UnitedHealthcare acknowledged the requirements of this section in its policy "Non-Discrimination in Hiring."

PTM noted that UnitedHealthcare's Missouri State Programs Regulatory Requirements Appendices for Medical and Non-Medical Subcontractors includes statement on Equal Employment Opportunity but does not include a statement on inclusion of minorities in their organization. However, UnitedHealthcare directed PTM to its website showing Supplier Diversity web page. Every request for proposal (RFP) managed by the Enterprise Sourcing & Procurement (ES&P) team targets inclusion of at least one diverse supplier, where available. RFPs are evaluated through a balanced scorecard that considers supplier diversity alongside key factors such as cost, quality and service delivery. In addition, supplier diversity objectives are built into the development strategies and the annual performance objectives for all categories managed by the ES&P team. The Team works to identify opportunities for certified minority-owned, women-owned, veteran-owned, disability-owned, LGBTQ+-owned and other historically underutilized businesses. UnitedHealthcare also works with state and local governments, minority business groups and nonprofit organizations to identify sourcing opportunities for diverse suppliers where possible.

**Required Actions:** PTM recommends that UnitedHealthcare updates the requirement of minority inclusion in the appendices provided for the subcontractors or provide a link to its website.

| **Compliance Score - Provider Selection** | | | | | | |
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| 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 6–42 CFR: 438.224, 457.1110-Confidentiality** | | |
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| **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). | PP-01 MO Privacy and Confidentiality: page 1 | Fully Met |
| **Findings:** UnitedHealthcare's policy, "MO Privacy and Confidentiality," complies with the requirement of this section.<br><br>During the site meeting UnitedHealthcare informed PTM that they do not disclose member information to public.<br><br>**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). | PP-01 MO Privacy and Confidentiality: page 1 | Fully Met |
| **Findings:** UnitedHealthcare's policy, "MO Privacy and Confidentiality," complies with the requirement of this section.<br><br>**Required Actions:** None. | | |
| C. The MCO shall provide safeguards that restrict the use or disclosure of information concerning members to | UnitedHealth Group 2022 Privacy and Security Program Overview: page 1 | Fully Met |

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| purposes directly connected with the administration of the contract (MHD contract 3.16.3, 2.38.3(b)).<br>Such safeguards shall include, but not be limited to:<br><br>a. Workforce training on the appropriate uses and disclosures of Protected Health Information pursuant to the terms of the contract.<br><br>b. Policies and procedures implemented by the MCO to prevent inappropriate uses and disclosures of PHI by its workforce and subcontractors, if applicable.<br><br>c. Encryption of any portable device used to access or maintain PHI or use of equivalent safeguard.<br><br>d. Encryption of any transmission of electronic communication containing PHI or use of equivalent safeguard.<br><br>e. Any other safeguards necessary to prevent the inappropriate use or disclosure of PHI. | Privacy Policy Manual: pages-viii, 1, 2, 6<br>P17 Privacy Training: page 1<br><br>Security Training and Awareness Overview: pages-1 to 9<br><br>5B Mobile Device Security: pages-2, 3<br><br>10A External Party Security: page 2<br><br>Confidentiality and Non-Disclosure: pages-1, 2<br><br>13A Data Classification and Protection Standard: pages-7 to 12<br><br>Electronic Communication Gateway Overview: pages-1, 2<br><br>How UnitedHealth Group Protects Customer Data: pages-1, 2<br><br>Information Security/Privacy Incident Response Process Overview-Jan 2022: page 1<br><br>Enterprise Information Security (EIS) Supplier Information Risk Governance (SIRG): pages-1 to 4 | |
| **Findings:** a. All UnitedHealthcare workforce members are responsible for safeguarding the privacy of PHI. All UnitedHealthcare employees receive mandatory privacy and security training at the beginning of their employment (within 30 days of joining the workforce) and at least annually thereafter. Training is offered through UnitedHealthcare's corporate Privacy and Enterprise Information Security offices and through business training | | |

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| programs. Training will, at a minimum, include completion of the computer-based training module(s) regarding privacy. In addition, various resources, including policies and procedures and periodic reminders are available to employees to provide proactive guidance and address issues to support ongoing compliance with privacy and security requirements.<br><br>b. At a high level, UnitedHealthcare policies and procedures address the following privacy and security requirements: minimum necessary; use and disclosure; business associates; plan sponsors; authorizations; individual rights; privacy notice; complaints; and safeguards. The UnitedHealthcare's Corporate Privacy Office (CPO) head leads HIPAA privacy compliance for UnitedHealthcare, including the development of enterprise-wide policies and procedures to safeguard the privacy of individuals' PHI consistent with federal and state laws and regulations (as applicable).<br><br>c. Workforce members who conduct UnitedHealthcare's work on their personal mobile devices must use an approved secure mobile device/application management solution for that purpose. Software and applications downloaded from the Internet or online application sites may not meet Enterprise Information Security (EIS) standards and must not be used. Mobile devices used to conduct UnitedHealthcare business must always be PIN/passcode protected. Mobile devices with biometric authentication capabilities can be used if the PIN/passcode is still enabled. Mobile device/application management solutions must comply with, and be able to demonstrate compliance with the password requirements of UnitedHealthcare. Multi-Factor Authentication (MFA) must be enforced during registration of UnitedHealthcare-approved mobile device/application management solutions and during any password change processes. UnitedHealthcare's data stored on a mobile device must be encrypted using a method approved by EIS. Keys used for encryption and decryption must meet complexity requirements described in the EIS standards and UnitedHealthcare's encryption policy.<br><br>d. In accordance with UnitedHealthcare's Risk Management approach to privacy and security, numerous policies and procedures, and technical controls have been established to manage access to systems and information, and to limit such access to that which is minimally necessary. Secure Transmission Standards are used and corresponding controls have been implemented to ensure the confidentiality, integrity, and availability of electronic PHI transmitted via public networks. Controls utilize appropriate encryption and authentication or equivalent means to protect the transmitted information.<br><br>**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). | PP-01 MO Privacy and Confidentiality: page 1<br><br>UnitedHealth Group 2022 Privacy and Security Program Overview: page 2 | Fully Met |

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| | P14 Authorizations: page 1<br><br>Privacy Policy Manual: pages-36, 37<br><br>UnitedHealth Group Personal Information Privacy and Data Protection: page 3 | |
| **Findings:** UnitedHealthcare's policy, "MO Privacy and Confidentiality," complies with the requirement of this section.<br><br>Before releasing any information, individuals must be properly identified and authenticated by providing their name, member ID number or address, date of birth, their relationship to the member if applicable, and affirmation that they have appropriate permission and authority to speak on behalf of the member. Information is only provided to individuals, parents of unemancipated minor children, and to individuals with a valid authorization. "Sensitive information" (as defined by more stringent state laws) is only provided to individuals or to individuals with a valid authorization. UnitedHealthcare requires a signed authorization from an individual (or a Personal Representative, prior to using or disclosing PHI, unless otherwise indicated under exceptions for use and disclosure.<br><br>**Required Actions:** None. | | |
| E. MCO shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance and 42 CFR Part 2, as amended, regarding confidentiality of substance use disorder member records (MHD contract 3.16.5). | Privacy Policy Manual: pages-51, 52<br><br>13A Data Classification and Protection Standard: pages-3 to 5 | Fully Met |
| **Findings:** Federal and state privacy laws often impose additional Use and Disclosure restrictions on data that identifies an Individual with Sensitive Conditions, e.g., Alcohol and Substance Abuse. 42 CFR. Part 2 Confidentiality of Substance Use Disorder Patient Records ("Part 2") protects the confidentiality of certain records containing the identity, diagnosis, prognosis, or treatment of any individual, as they relate to Substance Use Disorder ("SUD"). Its purpose is to ensure that Part 2 patients are not made more vulnerable than individuals with a SUD who did not seek treatment. Part 2 is also meant to prevent:<br>• Individuals from not seeking SUD care.<br>• Loss of employment, housing, and child custody due to having been treated for SUD.<br>• Discrimination by medical professionals and insurers.<br>• Arrest, prosecution, and incarceration because an individual sought treatment for SUD. | | |

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| Part 2 Data is data maintained by or obtained from a Part 2 Program (generally a federally assisted entity or person that holds itself out as providing, and provides, SUD diagnoses, treatment, and or referrals for treatment).<br>Part 2 generally requires an individual's consent prior to using or disclosing SUD data from a Part 2 treatment program. UnitedHealthcare may not disclose Part 2 Data without an individual's consent unless exception applies, e.g., medical emergencies, research, audit and evaluation, court orders, direct administrative control, qualified service organizations, child abuse/neglect. Part 2 also requires that UnitedHealthcare provides notice to members about the data that is subject to Part 2 and that UnitedHealthcare maintains safeguards to prevent unintended Disclosure.<br><br>The policy "Data Classification and Protection Standard" lists identifiers which are considered as protected information and complies with 45 CFR 431.305.<br><br>**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). | Privacy Policy Manual: pages-50, 51 | Fully Met |
| **Findings:** Most states have statutes or regulations that preclude the disclosure of disease status and test results without an individual's prior consent in cases of HIV/AIDS/Communicable Diseases/Sexually Transmitted Diseases.<br><br>**Required Actions:** None. | | |
| G. The MCO uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. | | |
| i. The MCO must comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH)(PL-111-5) (collectively HIPAA) and all regulations promulgated pursuant to authority | Privacy Policy Manual: pages-i, ix<br><br>How UnitedHealth Group Protects Customer Data: page 2<br><br>Onsite Submission | Fully Met |

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| granted therein. The MCO constitutes a "Business Associate" of the state agency (MHD contract 2.38.1). | P22 Business Associate Contracting: page 1 | |

**Findings:** UnitedHealthcare Covered Entities, Business Associates and Subcontractors, as well as other Business Organizations, as applicable, will comply with the Health Insurance Portability and Accountability Act ("HIPAA") and adhere to HIPAA Privacy Policy Manual. This Manual operates in conjunction with the UnitedHealthcare's Personal Information Privacy and Data Protection Policy, which broadly describes UnitedHealthcare's approach to the protection of information about individuals under applicable laws and other privacy policies of UnitedHealthcare and its business organizations. UnitedHealthcare can be both a United Covered Entity and a United Business Associate. The Privacy Policy Manual applies to all UnitedHealthcare Covered Entities and to all United Business Associates, as applicable, and to all Workforce Members performing work for UnitedHealthcare Covered Entities and United Business Associates.

UnitedHealthcare is compliant with HIPAA/HITECH requirements. UnitedHealthcare's security program is designed to satisfy all applicable security requirements and regulations, including the HIPAA Security Rule.

PHI may be disclosed by UnitedHealthcare, functioning as either a Covered Entity or Business Associate, only if UnitedHealthcare and the other entity first execute a Business Associate Agreement ("BAA") that details how the Business Associate will safeguard the privacy of the PHI it receives from UnitedHealthcare.

**Required Actions:** None.

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| 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). | Privacy Policy Manual: page vi<br><br>13A Data Classification and Protection Standard: page 2, 8, 11, 12 | Fully Met |

**Findings:** "Protected Health Information" (PHI) means individually identifiable health information (IIHI) transmitted by electronic media, maintained in any form or electronic media, or transmitted or maintained in any other form or medium.

PHI or ePHI is individually identifiable information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual that is created, received, transmitted, or stored by UnitedHealthcare, provider, or their supplier. PHI and ePHI includes any health information in the foregoing context used to identify an individual.

**Required Actions:** None.

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| 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)). | PP-01 MO Privacy and Confidentiality: pages-1, 2<br><br>Privacy Policy Manual: page 3 | Fully Met |
| **Findings:** UnitedHealthcare's policy, "MO Privacy and Confidentiality," complies with the requirement of this section.<br><br>Privacy Policy Manual states that no disciplinary actions will be applied against a whistleblower Workforce Member (because he or she was a whistleblower) or a workforce Member who is a victim of a criminal act and Discloses PHI to law enforcement (subject to certain limitations). It is the responsibility of UnitedHealthcare to review and determine whether one of the above exceptions is applicable.<br><br>**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)). | Privacy Policy Manual: page 12 | Fully Met |
| **Findings**: Use and Disclosure of PHI is permitted without an authorization in the course of day-to-day Healthcare operations to conduct the following activities:<br>• Quality-Assessment and Improvement activities, including certain outcomes, evaluation and development of clinical guidelines, patient-safety activities, population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of healthcare providers and patients with information about treatment alternatives, and related functions that do not include treatment.<br>• Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, UnitedHealthcare's performance, conducting training programs to improve skills of healthcare providers and students/trainees, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities.<br>• Underwriting (except the use of genetic information as prohibited under the Privacy Rule), premium rating, and other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a | | |

contract for reinsurance of risk relating to claims for health care (including stop-loss insurance), provided that certain requirements under the Privacy Rule related to the Use and Disclosure of PHI for underwriting and related purposes are met.
• Conducting or arranging for medical review, legal services, and auditing functions, including fraud-and-abuse detection and compliance programs.
• Business planning and development, such as cost-management and planning related to managing and operating UnitedHealthcare, including formulary development and administration, development of improvement of methods of payment or coverage.
• Business management and general administrative activities, such as customer service, resolution of internal grievances, due diligence in connection with the sale or transfer of assets, creating de-identified health information or a limited data set, and fundraising.

(Note: The authorization exception for Treatment, Payment, and Health Care Operations Uses and Disclosures of PHI does not apply with respect to Uses and Disclosures of psychotherapy notes and marketing).

**Required Actions:** None.

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| 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)). | P9 Disclosures to Third Parties: pages-2, 3<br><br>Privacy Policy Manual: pages-13, 14, 15 | Fully Met |

**Findings:** The following disclosures of an individual's PHI to government entities is mandated by law and does not require the authorization or advance notification to an individual (but may still require an accounting):
1. Disclosure of PHI to public health authorities for purposes of compiling vital statistics (e.g., births and deaths), providing information to prevent or control diseases, injury, or disability, or for communicable disease intervention or investigation.
2. Disclosure of abuse, neglect, or domestic violence to a state or local child abuse and neglect authority, public health authority, or social services or protective services agency.
3. Disclosure of PHI to law enforcement, only if the request is accompanied by a court order, court-ordered warrant, subpoena or summons, or similar legal process, as required or permitted by law.
4. Disclosure of PHI to health oversight agencies, such as state licensing agencies responsible for administering public health programs (e.g., Medicare and Medicaid) or state licensing agencies for auditing purposes.
5. Disclosures related to legal actions, if the information is required by law, has been requested in a court order or an order of an administrative tribunal, or the information has been requested by means of a subpoena, discovery request, or other legal process.
6. Disclosure of PHI to coroners, medical examiners, and funeral directors to carry out their duties with respect to the decedent.
7. Disclosure of PHI to organ procurement agencies or other organizations engaged in the procurement, banking, or transplantation of organs or tissue.

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| 8. Disclosure of PHI for purposes of research if the appropriate requirements have been met.<br>9. Disclosure of PHI needed to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.<br><br>**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)). | Privacy Policy Manual: page 26<br><br><u>Onsite Submission</u><br>P22 Business Associate Contracting: page 1 | Fully Met |
| **Findings:** A UnitedHealthcare Business Associate may aggregate PHI of more than one Covered Entity to conduct analyses for the provision of data aggregation services to each Covered Entity (or Business Associate on the Covered Entity's behalf), provided that the analyses are related to the Healthcare Operations of each such Covered Entity and data aggregation services are authorized by the relevant BAA.<br><br>**Required Actions:** None. | | |
| vii. The MCO may not use Protected Health Information to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the state agency to do so (MHD contract 2.38.2(g)). | PP-01 MO Privacy and Confidentiality: page 2<br><br>P13 De-Identification: page 1 to 3<br><br>Privacy Policy Manual: pages-24 to 26 | Fully Met |
| **Findings:** UnitedHealthcare's policy, "MO Privacy and Confidentiality," complies with the requirement of this section.<br><br>UnitedHealthcare's policy, "De-Identification," states that UnitedHealthcare may de-identify PHI by changing such information so that it cannot (1) subsequently be used to identify an Individual or (2) create a reasonable basis to believe an individual can be identified. If PHI is properly de-identified, it is not subject to the requirements of the HIPAA Privacy Rule and may thus be used and disclosed by UnitedHealthcare without restriction.<br><br>A UnitedHealthcare may assign a unique code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified. The code or other means of record identification cannot be derived from or related to individuals and cannot otherwise be capable of being translated to identify individuals. The code or other means of record identification may not be disclosed. De-identified information that has been re-identified may not be disclosed or used except as permitted under the Privacy Rule and the Privacy Policy Manual for Disclosure and Use of PHI. | | |

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| **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)). | P3 Minimum Necessary: page 1<br><br>P13 De-Identification: Pages 2, 3<br><br>Privacy Policy Manual: pages-9, 10 | Fully Met |
| **Findings:** When disclosing or requesting PHI for routine and recurring disclosures or requests, limit PHI to the minimum amount necessary to accomplish the purpose of the disclosure or request. For all other disclosures or requests:<br>• Develop criteria to limit the PHI disclosed to the minimum amount of information necessary to accomplish the purpose of the disclosure or request; and<br>• Review disclosures or requests on an individual basis under the criteria.<br><br>UnitedHealthcare will use, disclose or request the minimum necessary amount of PHI, except for the following:<br>• Disclosures to a Health Care Provider for Treatment.<br>• Uses or Disclosures made to the Individual who is the subject of the PHI.<br>• Uses or Disclosures made pursuant to the Individual's valid authorization.<br>• Disclosures to the Secretary of HHS.<br>• Uses or Disclosures that are required by law.<br>• Uses or Disclosures that are required for a UnitedHealthcare's compliance with applicable provisions of the Privacy Rule.<br><br>**Required Actions:** None. | | |
| H. Obligations and activities of MCO:<br><br>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)). | UnitedHealth Group 2022 Privacy and Security Program Overview: page 4<br><br>P9 Disclosures to Third Parties: page 1<br><br>Privacy Policy Manual: page 4<br><br>10A External Party Security: page 2<br><br>EIS/SIRG: pages-1 to 4 | Fully Met |
| **Findings**: UnitedHealthcare enters into BAA (that meet HIPAA privacy and security requirements) with any vendor/subcontractor who will have access to PHI. UnitedHealthcare may disclose PHI to a Business Associate and may allow the Business Associate to create, receive, maintain, or transmit PHI on its behalf, provided it obtains | | |

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| satisfactory assurances that the Business Associate will appropriately safeguard the information. These assurances are to be documented in a written Business Associate Agreement.<br><br>External parties (contractors, vendors, suppliers, business venture parties, auditors or assessors, cloud service providers, research agreements, government entities, or others who are involved in this Scope of Services) must acknowledge their responsibility for safeguarding the UnitedHealthcare's information technology systems and information via a formally written and legally binding agreement. Such agreements must follow applicable UnitedHealthcare policies, including Enterprise Sourcing & Procurement and Delegation of Authority policies. UnitedHealthcare maintains a standardized Security Exhibit template when protected information is in scope for the business engagement. Any negotiated modifications to the Security Exhibit must be approved by the UnitedHealthcare's Corporate Legal Department and EIS.<br><br>**Required actions:** None. | | |
| ii. By no later than 10 calendar days after receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the MCO shall make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by, or received by the MCO on behalf of the state agency available to the state agency and/or to the Secretary of the Department of Health and Human Services or designee for purposes of determining compliance with the HIPAA Rules and the contract (MHD contract 2.38.3(e)). | Onsite Submission<br>PP-01 MO Privacy and Confidentiality: page 3 | Partially Met |
| **Findings:** UnitedHealthcare did not have a policy to meet the requirements of this section. However, UnitedHealthcare revised its policy to incorporate the requirements after PTM pointed out the deficiency during the preliminary review.<br><br>During the site meeting, the staff was knowledgeable about this requirement when PTM inquired about the timeframe. | | |

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| **Required Actions:** No further action required. However, PTM recommends that UnitedHealthcare submits its policy to the MHD for approval. | | |
| 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)). | UnitedHealth Group 2022 Privacy and Security Program Overview: page 3<br><br>P8 Accounting of Disclosures: page 5<br><br>PP-01 MO Privacy and Confidentiality: page 2 | Fully Met |
| **Findings:** UnitedHealthcare's policy, "UnitedHealth Group 2022 Privacy and Security Program Overview," states that upon request, UnitedHealthcare must provide individuals with an accounting of certain disclosures of PHI. Disclosures made in the course of normal healthcare operations are exempt from this HIPAA accounting requirement. Similar to the process for access requests, a Customer Care Professional provides a request form to the individual to verify the identity and authority of the requestor. Upon receipt of the completed request form, an accounting of disclosures report is mailed to the individual.<br><br>UnitedHealthcare's policy, "Accounting of Disclosures," states Requests made pursuant to this policy must be processed within 60 calendar days of receipt of a written request. If unable to complete the request within that timeframe, UnitedHealthcare may extend the time to provide the accounting by no more 30 calendar days, provided that the member is given a written statement of the reasons for the delay and is informed of the date it will be provided.<br><br>The policy, "MO Privacy and Confidentiality," complies with the timeframe requirement of this section.<br><br>**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 | PP-01 MO Privacy and Confidentiality: page 2<br><br>UnitedHealth Group 2022 Privacy and Security Program Overview: page 3<br><br>Privacy Policy Manual: pages- 39, 40 | Fully Met |

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| designated record set (MHD contract 2.38.3(g)). | P6 Right to Inspect and Obtain Copy of DRS: pages-1, 2 | |
| **Findings:** UnitedHealthcare's policy, "MO Privacy and Confidentiality," complies with the requirement of this section.<br><br>Under the HIPAA Privacy Rule, individuals have a right to access the health information about them that UnitedHealthcare maintains. UnitedHealthcare is required to maintain this information in a "Designated Record Set" (DRS) and to provide these records to individuals upon request, with very few exceptions. The right to access does not apply to psychotherapy notes, or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. Individuals can exercise this right by contacting the toll-free customer care number on their identity card. A customer care professional will send a request form to the member that will be used to verify the identity and authority of the requestor and describe the records being requested. Upon receipt of the completed request form, UnitedHealthcare will review and respond to the request within the timeframes required by the HIPAA Privacy Rule.<br><br>UnitedHealthcare's policy, "Right to Inspect and Obtain Copy of Designated Record Set," states that requests made for the DRG must generally be processed within 30 calendar days of receipt of a written request. Within that time limit, UnitedHealthcare may extend the time for fulfilling a request by 30 calendar days provided the individual is given a written statement of the reasons for the delay and the date by which the request will be completed. If PHI is not available on-site, action must be taken within 60 calendar days after receiving a written request. If an access request is received from an Individual residing in a state with a more stringent requirement, the state timing requirement will be followed.<br><br>**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 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 | PP-01 MO Privacy and Confidentiality: page 2<br><br>Privacy Policy Manual: page 6 | Fully Met |

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| 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:** UnitedHealthcare's policy, "MO Privacy and Confidentiality," complies with the requirement of this section.<br><br>The Privacy Policy Manual states that if UnitedHealthcare becomes aware of a pattern of activity or a practice by a Business Associate that constitutes a material breach or violation of its obligations under the Business Associate Agreement between the parties, UnitedHealthcare should mitigate consequences and damages arising from the breach. UnitedHealthcare must take reasonable steps to cure the breach or end the violation, and if such steps are unsuccessful, it must terminate the contract, if feasible.<br><br>**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)). | ID 5924 Enterprise Records and Information Management: page 1<br><br>Records Retention Summary: pages 1, 2, 3<br><br>P15 Document Retention: page 1<br><br>Privacy Policy Manual: page 8<br><br>P6 Right to Inspect and Obtain Copy of Designated Record Set (DRS): page 6 |  Fully Met |
| **Findings:** UnitedHealth's policy "Enterprise Records and Information Management" requires assigning a retention period according to legal, regulatory, and contractual obligations as well as a maximum retention period for operational information not subject to legal requirements or audits.<br><br>Beginning April 14, 2003, all documentation related to PHI must be retained for a minimum of six years from the date of creation or the date when it was last in effect, whichever is later. For CMS regulated entities, such documentation must be retained for a minimum of 10 years. Upon termination of a business associate contract, a Business Associate must continue to extend the contractual protections within the Business Associate Agreement to | | |

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| the PHI that the Business Associate maintained on behalf of UnitedHealthcare and must limit further use and disclosure of the PHI.<br><br>**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)). | P12 Marketing: pages-3, 4<br><br>Privacy Policy Manual: pages-16, 17 | Fully Met |
| **Findings:** Marketing is not a permissible use or disclosure of PHI under HIPAA and requires Member authorization, except in the following circumstances:<br>• Face-to-face communications from a Covered Entity to the individual or member; and<br>• Promotional gifts of nominal value provided by a Covered Entity to an individual.<br>If the intended use and disclosure is for marketing purposes, then UnitedHealthcare requires the Covered Entity, or a Business Associate provide such marketing materials to UnitedHealthcare Legal and Compliance Departments for review and approval. An authorization from all the affected Individuals is necessary.<br>For marketing communications made by UnitedHealthcare that requires a written authorization and involve direct or indirect remuneration to a UnitedHealthcare from a third party, the authorization must state that such remuneration is involved.<br><br>**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 | PP-01 MO Privacy and Confidentiality: page 2 | Fully Met |

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| wrongful actions or inactions or violations of this Agreement (MHD contract 2.38.3(p)). | | |
| **Findings:** UnitedHealthcare's policy, "MO Privacy and Confidentiality," complies with the requirement of this section.<br><br>**Required Actions:** None. | | |

| **Compliance Score-Confidentiality** | | | | | | |
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| Total | Met | = | 21 | ×2 | = | 42 |
| | Partial Met | = | 1 | ×1 | = | 1 |
| | Not Met | = | 0 | ×0 | = | 0 |
| Numerator | Score Obtained | | | | = | 43 |
| Denominator | Total Sections | = | 22 | ×2 | = | 44 |
| **Score** | | | | | | **97.72%** |

**Appendix G**

| Standard 7–42 CFR: 438.228 , 457.1260-Grievance and Appeal System | | |
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| **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).<br><br>i. Adverse benefit determination means:<br><br>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.<br><br>b. The reduction, suspension, or termination of a previously authorized service.<br><br>c. The denial, in whole or in part, of payment for a service (applies for clean claims only.)<br><br>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). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-1, 2<br><br>2022 Care Provider Manual MO: page 85 | Partially Met |

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| 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.<br><br>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).<br><br>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:** The definition of adverse benefit determination as describe in the policy, "Member Appeal, State Fair Hearing and Grievance" meets all the requirements of this section.<br><br>PTM noted that the provider manual does not include/specify criteria a, f, and g.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare updates the definition of adverse benefit determination in its provider manual based on the deficiencies pointed in this section. | | |
| ii. Appeal means a review by an MCO of an adverse benefit determination. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 2<br><br>2022 Care Provider Manual MO: page 85 | Partially Met |
| **Findings:** The definition of an appeal as describe in the policy, "Member Appeal, State Fair Hearing and Grievance," meets the requirement of this section.<br><br>PTM noted that the provider manual inaccurately defines an appeal as a formal way to share dissatisfaction with a benefit determination.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare updates the definition of an appeal in its provider manual. | | |

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| 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 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.<br>Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 3<br>2022 Care Provider Manual MO: page 86 | Fully Met |
| **Findings:** The definition of grievance as described in the policy, "Member Appeal, State Fair Hearing and Grievance," and the provider manual meets the requirement of this section.<br><br>**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. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 3 | Fully Met |
| **Findings:** The definition of grievance and appeal system as describe in the policy, "Member Appeal, State Fair Hearing and Grievance," meets the requirement of this section.<br><br>**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)). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 3 | Fully Met |
| **Findings:** The definition of inquiry as describe in the policy, "Member Appeal, State Fair Hearing and Grievance," meets the requirement of this section. | | |

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| **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. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 4 | Fully Met |
| **Findings:** The definition of State Fair Hearing as describe in the policy, "Member Appeal, State Fair Hearing and Grievance," meets the requirement of this section.<br><br>**Required Actions:** None. | | |
| B. General requirements (42 CFR 438.402).<br><br>i. The grievance and appeal system:<br><br>a. The MCO must have a grievance and appeal system in place for enrollees.<br><br>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)).<br><br>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)).<br><br>d. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (42 CFR 406). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-1, 4, 5, 6, 8<br>Grievance and Appeals (Flyer)<br><br><u>Onsite Submission</u><br>MO HealthNet Member Appeals and Grievances (Inquiry-Process): pages-1 to 9<br><br>Grievance and Appeals (Flyer-revised) | Partially Met |
| **Findings:** a. UnitedHealthcare's Government Appeals Operations (GAO) processes, appeals and grievances submitted by members and by their authorized representatives, including | | |

providers submitting on behalf of members, in accordance with applicable state and federal regulatory requirements, and the member's plan coverage documents. Resolving Analyst (RA) is the person responsible for investigating appeals and grievances and compiling the electronic record.

b. Upon enrollment, UnitedHealthcare distributes a flyer to members explaining the grievance system. The Grievance and Appeals flyer is a standalone document and is distributed along with the member handbook.

PTM verified that the flyer identifies the member services' contact address where the members are directed 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 4 of 15)-State Fair Hearing in case of deemed exhaustion of appeal process is missing.
- Incorrect information (page 4 of 15)-"In order for medical care not to stop you must ask for a State Fair Hearing within 10 days of the date the written notice of action was mailed and tell us not to stop the service while you appeal." (Notice of action should be the replaced with notice of appeal resolution).
- Incomplete information (page 5 of 15)-Adverse benefit determination (definition). One of the points includes the denial of a member's request to exercise his or her right to obtain services outside the network (under what situation is not mentioned).
- Date of approval by the MHD on the flyer is not mentioned.

During onsite submission, UnitedHealthcare revised its Grievance and Appeal flyer after PTM identified the deficiencies. As the flyer was non-compliant during the review period the score remains "Partially Met."

c. The RA probes inquiries to validate the possibility of any inquiry actually being a grievance or appeal and identifies and monitors any inquiry pattern. During onsite, UnitedHealthcare submitted its process of handling member calls regarding grievances (complaints) and appeals.

d. The policy "Member Appeal, State Fair Hearing and Grievance" is compliant with criterion d listed in this section.

**Required Actions:** PTM recommends that UnitedHealthcare submits the revised flyer for the MHD's approval and posts the MHD's approval date in the right lower corner of the flyer per the requirements of the MHD contract, section 2.14.6(e).

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| ii. Level of appeals:<br>The MCO may have only one level of appeal for enrollees. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 5 | Fully Met |

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| **Findings:** The "MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy" states that the members/authorized representatives are offered single level of appeal, which complies with the requirement of this section.<br><br>**Required Actions:** None. | | |
| iii. Authority to file:<br>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). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-6, 14 | Fully Met |
| **Findings:** The policy, "Member Appeal, State Fair Hearing and Grievance," complies with the requirements regarding authority to file grievance, appeals, and State Fair Hearing.<br><br>**Required Actions:** None. | | |
| iv. Deemed exhaustion of appeals processes:<br>If an MCO fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's appeals process. The enrollee may initiate a State Fair Hearing. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 12 | Fully Met |
| **Findings:** The member, and with the written consent of the member, a provider or an authorized representative may request a State Fair Hearing after receiving notice that UnitedHealthcare is upholding the adverse benefit determination or if UnitedHealthcare fails to adhere to the notice and timing requirements (42 CFR 438.408(f)(1)).<br><br>**Required Actions:** None. | | |
| vi. Timing for filing. An enrollee may file a grievance with the MCO at any time whereas an enrollee has 60 calendar days from the date of the adverse benefit | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-6, 14 | Fully Met |

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| determination notice, to file a request for an appeal to the MCO. | | |
| **Findings:** The policy, "Member Appeal, State Fair Hearing and Grievance," complies with the timely filing requirements of this section.<br><br>**Required Actions:** None. | | |
| vii. Procedures:<br><br>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.<br><br>b. Appeal-The enrollee may request an appeal either orally or in writing. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-6, 14<br><br>2022 Care Provider Manual: page 86<br><br>MO Member Handbook: page 80 | Fully Met |
| **Findings:** The policy, "Member Appeal, State Fair Hearing and Grievance," the provider manual, and the member handbook comply with the procedure for filing grievance and appeals as stated in this section.<br><br>**Required Actions:** None. | | |
| C. Timely and adequate notice of adverse benefit determination (42 CFR 438.404).<br><br>i. The notice must explain the following:<br><br>a. The adverse benefit determination the MCO has made or intends to make.<br><br>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, | UCSMM.06.18 Initial Adverse Determination Notices: page 2<br><br>MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 4<br><br>Notice of UnitedHealthcare Community Plan of Missouri Adverse Benefit Determination (Letter)<br><br><u>Onsite Submission</u><br>MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy (revised): pages-5, 6 | Partially Met |

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| and any processes, strategies, or evidentiary standards used in setting coverage limits.<br><br>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).<br><br>d. The procedures for exercising the rights to appeal and request a State Fair Hearing.<br><br>e. The circumstances under which an appeal process can be expedited and how to request it.<br><br>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:** PTM noted that the policy, "Initial Adverse Benefit Determination Notices," does not address all the criteria listed under this section (criteria a, f are not addressed, and b, c, d are partially addressed). Also, the policy states that a written notice of adverse determination includes the availability of peer clinical review before filing an appeal. PTM identified that the provision of peer clinical review in the notice of adverse benefit determination is not in compliance with 42 CFR 438.404.<br><br>The policy, "Member Appeal, State Fair Hearing and Grievance," states that a written notice of any decision by UnitedHealthcare to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested 42 CFR 438.210(c) is sent to the requesting provider and member.<br><br>The notice of adverse determination letter submitted by the UnitedHealthcare meets the requirements of this section. | | |

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| During onsite submission, UnitedHealthcare updated its policy, "Member Appeal, State Fair Hearing and Grievance" to comply with all the criteria listed in this section after PTM pointed out the deficiency. PTM scored this section as "Partially Met" as UnitedHealthcare was not fully compliant during the review period.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare submits the revised policy, "Member Appeal, State Fair Hearing and Grievance" to the MHD for approval. Also, the policy, "Initial Adverse Benefit Determination Notices," needs to be updated based on the remarks by PTM. The peer clinical review can be held before the notice is mailed to the member/provider and must not be included in the notice of adverse benefit determination. | | |
| ii. Timing of notice (MHD contract 2.15.4(c):<br><br>a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 calendar days before the date of adverse benefit determination.<br><br>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.<br><br>c. In cases of probable fraud-notice will be 5 calendar days before the date of adverse benefit determination.<br><br>d. For denial of payment, at the time of any action affecting the claim. | UCSMM.06.16 Initial Review Timeframes: pages-7, 8<br><br><u>Onsite Submission</u><br>MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy (revised): page-7 |  Fully Met |

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| e. For standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1). (Not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days.)<br><br>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:** In the policy, "Initial Review Timeframes," UnitedHealthcare acknowledged the requirements listed in this section by posting the sections from the MHD contract/CFR. UnitedHealthcare resubmitted a revised policy, "MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy," based on the suggestion by PTM to adopt the requirements instead of copying the MHD contract/CFR sections.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare adopts the requirements from the MHD contract/CFR to create its own policies and procedures in the future. | | |
| 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—<br><br>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.<br><br>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. | UCSMM.06.16 Initial Review Timeframes: page 8<br><br><u>Onsite Submission</u><br>MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy (revised): page 8 | Fully Met |

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| **Findings: :** In the policy, "Initial Review Timeframes," UnitedHealthcare acknowledged the requirements listed in this section by posting the sections from the MHD contract/CFR. UnitedHealthcare resubmitted a revised policy, "MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy," based on the suggestion by PTM to adopt the requirements instead of copying the MHD contract/CFR sections.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare adopts the requirements from the MHD contract/CFR and create its own policies and procedures. | | |
| D. Handling of grievances and appeals (42 CFR 438.406):<br><br>i. The MCO must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.<br><br>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). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-6, 15 | Fully Met |
| **Findings:** The RA provides reasonable assistance to the member in completing forms and taking other procedural steps related to an 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, American Sign Language, interpreter capability, and providing written notices in a secondary language per a member's request that are culturally and linguistically appropriate.<br><br>A written acknowledgment of the receipt of an appeal and grievance is sent upon case entry into the tracking system within 10 calendar days of receipt.<br><br>**Required Actions:** None. | | |
| iii. Ensure that the individuals who make decisions on grievances and appeals are individuals— | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-8, 9, 15, 16 | Fully Met |

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| a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.<br><br>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:<br>An appeal of a denial that is based on lack of medical necessity.<br>A grievance regarding denial of expedited resolution of an appeal.<br>A grievance or appeal that involves clinical issues.<br><br>c. Who takes into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. | | |

**Findings:** a. The RA assigned to the case on grievance and appeal is an individual not involved in the previous disposition and is not a subordinate of the individual who made the previous disposition.

b. Individuals who make dispositions on grievances and appeals on matters related to clinical issues, medical necessity, denial of expedited resolution of appeals, are individuals who have the appropriate clinical expertise.

c. In conducting the review, the RA and/or decision-maker(s) conduct(s) a full investigation of the substance of the grievance and appeal to include review of the member's applicable governing plan documents and medical records. The RA thoroughly investigates each grievance using applicable statutory, regulatory, and contractual provisions, and UnitedHealthcare's written policies and procedures. Pertinent facts from all parties are collected during the investigation.

**Required Actions:** None.

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| iv. Include the enrollee and his/her representative, or legal representative of a deceased enrollee's estate as parties to the appeal and provide:<br><br>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.<br><br>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. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-5, 8 | Fully Met |
| **Findings:** a. UnitedHealthcare allows an authorized representative to act on behalf of the member. A member may present evidence, or submit written comments, documents, records and other information relevant to the appeal. Submission of additional information does not affect the timeframe within which an appeal decision must be rendered. When the appeal is expedited, the RA informs the member of the limited time available for this sufficiently in advance of the resolution timeframe. The RA or other staff may request additional information and if not received by the due date will document lack of receipt in the tracking system.<br><br>b. The member or the member's representative may request the member's case file free of charge, including medical records, other documents, records, and any new or additional evidence considered, relied upon, or generated by UnitedHealthcare (or at the direction of UnitedHealthcare) in connection with the appeal of the adverse benefit determination. This information is provided free of charge and sufficiently in advance of the resolution | | |

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| timeframe for the appeal.<br><br>**Required Actions:** None. | | |
| E. Resolution and notification-grievance and appeals (42 CFR 438.408):<br><br>i. Standard resolution of grievances may not exceed 90 calendar days from the day the MCO receives the grievance.<br>The MCO shall resolve each grievance and provide written notice of the resolution of the grievance, as expeditiously as the member's health condition requires but shall not exceed 30 calendar days of the filing date (MHD contract 2.15.5(e).<br><br>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.<br><br>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. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-9, 16 | Fully Met |
| **Findings**: i. The timeframe from UnitedHealthcare's receipt to resolve a grievance is 30 calendar days, or when clinically urgent five business days or as expeditiously as the member's health condition requires.<br><br>ii. The timeframe to resolve an appeal (including notification) is 30 calendar days from the date of UnitedHealthcare's receipt, or as expeditiously as the member's health condition requires. | | |

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| iii. Expedited resolution and notice to affected parties is completed no longer than 72 hours or as expeditiously as the member's health condition requires. (Notice means written notice and making reasonable efforts to provide oral notice to affected parties.)<br><br>**Required Actions:** None. | | |
| iv. Extension of timeframes:<br><br>The MCO may extend the timeframes by up to 14 calendar days if:<br><br>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.<br><br>b. If the MCO extends the timeframes not at the request of the enrollee, it must complete all of the following:<br>Make reasonable efforts to give the enrollee prompt oral notice of the delay.<br>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.<br>Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-10, 16 | Fully Met |
| **Findings:** The policy, "Member Appeal, State Fair Hearing and Grievance," meets the requirements of this section.<br><br>**Required Actions:** None. | | |
| v. Format of notice. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-9, 10, 16 | Fully Met |

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| i. The MCO will use an established method by the State to notify an enrollee of the resolution of a grievance.<br><br>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.<br><br>iii. For an appeal for expedited resolution, the MCO must also make reasonable efforts to provide oral notice. | | |
| **Findings:** i. UnitedHealthcare's policy, "Member Appeal, State Fair Hearing and Grievance," states, "When required, written grievance dispositions are issued within applicable regulatory timeframe requirements and must include the following elements, as applicable: The letter is addressed to the grieving party, and where applicable, the provider or facility; the specific reason(s) for the disposition, in easily understandable language; and only when there is an adverse decision, the right to appeal."<br><br>ii, iii. A written notice of appeal resolution that is linguistically and culturally appropriate is provided making reasonable efforts to provide oral notice to the affected parties.<br><br>**Required Actions:** None. | | |
| vi. Content of notice of appeal resolution:<br><br>The written notice of the resolution must include the following:<br><br>a. The results of the resolution process and the date it was completed.<br>b. For appeals not resolved wholly in favor of the enrollees—<br>The right to request a State Fair Hearing, and how to do so (CHIP enrollees have the right to request a State External Review in accordance with the terms of 42 CFR 457, Subpart K.) | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 10 | Fully Met |

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| The right to request and receive benefits while the hearing is pending, and how to make the request.<br>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:** The policy, "Member Appeal, State Fair Hearing and Grievance," includes all the components required in the notice of resolution for appeals.<br><br>**Required Actions:** None. | | |
| vii. Requirements for State Fair Hearings:<br><br>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)):<br><br>a. After receiving a notice that the MCO is upholding the adverse benefit determination.<br><br>b. If deemed to have exhausted the MCO's appeals processes.<br><br>c. No less than 90 calendar days and no more than 120 calendar days from the date of the MCO's notice of resolution.<br><br>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. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 12<br><br>MO Member Handbook: page 80 | Partially Met |

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| **Findings:** The policy, "Member Appeal, State Fair Hearing and Grievance," includes all the requirements listed in this section for State Fair Hearing.<br><br>PTM noted that the member handbook does not meet criterion b of this section.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare update its member handbook to meet the identified deficiency. | | |
| F. Expedited resolution of appeals (42 CFR 438.410):<br><br>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.<br><br>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.<br><br>iii. Action following denial of a request for expedited resolution:<br>a. Transfer the appeal to the timeframe for standard resolution.<br>b. Follow the requirements for extension as stated in E(4)(b) of this evaluation tool or 42 CFR 438.408(c)(2). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-9, 10, 11 | Fully Met |
| **Findings:** i. UnitedHealthcare has an expedited appeal resolution process when a UnitedHealthcare's clinician determines (for a request from a member) or the member's treating provider indicates (in making the request on the member's behalf or supporting the member's request) taking the time for a standard resolution could seriously jeopardize | | |

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| the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.<br><br>ii. UnitedHealthcare does not take punitive or retaliatory actions against a member, or provider supporting a member, for filing an expedited appeal.<br><br>iii. When a request to expedite an appeal resolution is received from the member or authorized representative without the support of the member's treating provider, a clinical reviewer will determine if the information provided meets the expedited criteria. If the clinical reviewer denies the request to expedite an appeal resolution, the RA will:<br>• Transfer the appeal to the standard resolution process. The timeframe for resolution begins on the original date UnitedHealthcare received the request for appeal; and<br>• Make reasonable efforts to give the member prompt oral notice of the denial and follow up with a written notice within two calendar days for the reasons for the decision and the right to file a grievance.<br><br>UnitedHealthcare processes an expedited appeal when an appeal concerns admission, continued stay or other health care service for a member who has received emergency services, but has not been discharged from a facility.<br><br>**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).<br><br>i. This information should be as per 42 CFR 438.10(g)(2)(xi), which includes:<br><br>a. Right to file grievances and appeals.<br><br>b. Requirements and timeframes for filing a grievance or appeal.<br><br>c. Availability of assistance in the filing process, right to file State Fair Hearing if MCO has made a decision adverse to the enrollee.<br><br>d. The fact that, when requested by the enrollee, benefits that the MCO | 2022 Care Provider Manual MO: pages-85 to 87<br><br><u>Onsite Submission</u><br>2022 Care Provider Manual MO (revised): page 87 | Partially Met |

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| seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State Fair Hearing is pending if the final decision is adverse to the enrollee. | | |
| **Findings:** The provider manual, chapter 12, addresses the requirements listed under G(i)(a, b, c). However, it did not address the timeframe specified for filing under which benefit would continue pending an appeal or a State Fair Hearing during the review period.<br><br>UnitedHealthcare updated its provider manual to include the timeframe as stated in criterion "d" after PTM pointed out the deficiency during the preliminary review.<br><br>Weaknesses noted in the Provider Manual:<br>1. The definitions of member appeals (an appeal is a formal way to share dissatisfaction with a benefit determination) and State Fair Hearing (A State Fair Hearing lets the members share why they think MO Medicaid services should not have been denied, reduced, or terminated) were not per the MHD contract/CFR.<br>2. Only four of the eight conditions were listed in the provider manual under which a member (or a provider on behalf of the member) can file an appeal: When the MCO lowers, suspends or ends a previously authorized service; refuses, in whole or in part, a clean claim payment for services; fails to provide services in a timely manner, as defined by the State or CMS; and doesn't act within the time frame CMS or the State requires. The remaining four conditions (a, e, f, g of section A(i) of this Appendix G) is not addressed.<br><br>**Required Actions:** PTM recommends that UnitedHealthcare updates its provider manual on the following deficiencies:<br>1. Definitions of appeals and State Fair Hearing based on the 42 CFR 438.400.<br>2. List all the conditions under which a provider on behalf of a member can file an appeal (42 CFR 438.400). | | |
| 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 | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 5<br><br><u>Onsite Submission</u><br>Grievance and Appeals Flyer (revised) | Fully Met |

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| 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). | | |
| **Findings:** The policy, "Member Appeal, State Fair Hearing and Grievance," meets the requirement of this section. UnitedHealthcare uses the same flyer for members and providers.<br><br>**Required Actions:** None. | | |
| H. Recordkeeping requirements (42 CFR 438.416):<br><br>i. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The MCO shall submit the log sheets for all inquiries, grievances, and appeals to the state agency monthly and upon request. If the MCO does not have a separate log for MHD Managed Care members, the log shall distinguish MHD Managed Care members from other MCO members (MHD contract 2.15.3). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-12, 17<br><br>  | Fully Met |
| **Findings:** UnitedHealthcare maintains the records for grievance and appeals in Escalation Tracking System (ETS) in an accessible manner to the CMS and State and submits logs for grievance and appeals each month in the format required by the MHD (snapshot of the logs is posted).<br><br>**Required Actions:** None. | | |
| ii. The record of each grievance or appeal must contain, at a minimum, all of the following information:<br><br>a. A general description of the reason for the appeal or grievance.<br><br>b. The date received.<br><br>c. The date of each review or, if applicable, review meeting. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-12, 17 | Fully Met |

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| Resolution at each level of the appeal or grievance, if applicable.<br><br>d. Date of resolution at each level, if applicable.<br><br>e. Name of the covered person for whom the appeal or grievance was filed. | | |
| **Findings:** The policy, "Member Appeal, State Fair Hearing and Grievance" includes all the components mentioned in this section for maintaining the grievance and appeals records. PTM verified the information in two of the logs (records) submitted by UnitedHealthcare.<br><br>**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). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-12, 17<br><br>2022 Care Provider Manual: page 70 | Fully Met |
| **Findings:** UnitedHealthcare maintains grievance and appeals records for a minimum of 10 years as stated in the policy, "Member Appeal, State Fair Hearing and Grievance."<br><br>UnitedHealthcare's provider manual states that records must be kept for at least 10 years from the close of the managed care program agreement between the MHD and UnitedHealthcare or another period as required by law.<br><br>**Required Actions:** None. | | |
| 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):<br><br>i. Timely files means the enrollee files for continuation of benefits on or before the later of the following:<br><br>a. Within 10 calendar days of the MCO sending the notice of adverse benefit determination. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages-6, 7 | Fully Met |

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| b. The intended effective date of the MCO's proposed adverse benefit determination. | | |
| **Findings:** At UnitedHealthcare, a member, and with the written consent of the member, an authorized representative (but not a provider) may be entitled to request continuation of benefits while the appeal and State Fair Hearing are pending if a request for continuation of benefits occurs on or before the later of the following timely filing requirements: within 10 calendar days of UnitedHealthcare sending the notice of adverse benefit determination; or on the intended effective date of UnitedHealthcare's proposed adverse benefit determination.<br><br>During the site meeting, PTM inquired UnitedHealthcare the distinction between Medicaid and CHIP managed care members regarding continuation of benefits while an appeal is pending. UnitedHealthcare stated that they apply same rules for both programs as there is no distinction stated in the MHD contract.<br><br>**Required Actions:** None. | | |
| ii. Continuation of benefits (N/A CHIPS):<br><br>The MCO must continue the enrollee's benefits if all of the following occur:<br><br>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.<br><br>b. The appeal involves the termination, suspension, or reduction of previously authorized services.<br><br>c. The services were ordered by an authorized provider.<br><br>d. The period covered by the original authorization has not expired. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 7 | Fully Met |

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| e. The enrollee timely files for continuation of benefits. | | |
| **Findings:** UnitedHealthcare's policy, "Member Appeal, State Fair Hearing and Grievance" lists all the conditions required for compliance of this section.<br><br>**Required Actions:** None. | | |
| iii. Duration of continued or reinstated benefits:<br><br>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:<br><br>a. The enrollee withdraws the appeal or request for State Fair Hearing.<br><br>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).<br><br>c. A State Fair Hearing office issues a hearing decision adverse to the enrollee. | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 7 | Fully Met |
| **Findings:** UnitedHealthcare's policy, "Member Appeal, State Fair Hearing and Grievance," lists all the conditions required for compliance of this section.<br><br>**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 | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: page 7 | Fully Met |

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| pending, to the extent that they were furnished solely because of the requirements of this section (42 CFR438.420). | | |
| **Findings:** UnitedHealthcare's policy, "Member Appeal, State Fair Hearing and Grievance," states that if the adverse benefit determination is upheld, a member may be required to pay for the cost of the services furnished pending the outcome of the appeal and State Fair Hearing.<br><br>**Required Actions:** None. | | |
| J. Effectuation of reversed appeal resolutions (42 CFR 438.424):<br><br>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.<br><br>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.<br><br>(Note: CHIP does not require a State to pay for disputed services furnished while an appeal is pending). | MOAG-001 Member Appeal, State Fair Hearing and Grievance Policy: pages 13, 14 | Fully Met |

**Findings:** When an appeal resolution is reversed, as expeditiously as the member's health condition requires but no later than 72 hours from the date UnitedHealthcare staff receives notice, the authorization will be updated to provide the service or services. If the service or services were provided pending the outcome of the appeal, UnitedHealthcare will pay for those services, in accordance with State policy and regulations.

**Required Actions:** None.

| **Compliance Score- Grievance and Appeal System** | | | | | | |
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| Total | Met | = | 28 | ×2 | = | 56 |
| | Partial Met | = | 6 | ×1 | = | 6 |
| | Not Met | = | 0 | ×0 | = | |
| Numerator | Score Obtained | | | | = | 62 |
| Denominator | Total Sections | = | 34 | ×2 | = | 68 |
| **Score** | | | | | | **91.17 %** |