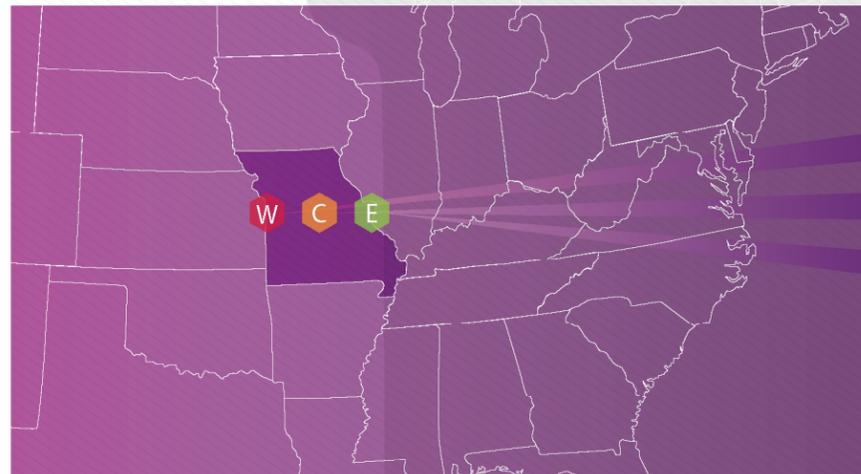
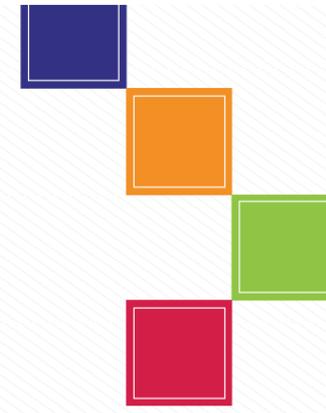


Building on 16 Years of Service and Caring



MO HealthNet Managed Care

- W** Western Region
- C** Central Region
- E** Eastern Region

RFP No. B3Z12055
December 13, 2011
2:00 PM Central Time

Volume 1 of 2
Copy





December 13, 2011

Ms. Laura Ortmeyer
Office of Administration
Division of Purchasing and Materials Management
301 West High Street, Room 630
Jefferson City, MO 65101

RE: MO HealthNet Managed Care RFP #B3Z12055

Dear Ms. Ortmeyer:

On behalf of HealthCare USA of Missouri, LLC (HealthCare USA), I am pleased to submit this response to your request for proposal regarding MO HealthNet's Managed Care Program. This proposal represents a statewide bid for all three regions.

HealthCare USA has partnered with the State of Missouri for 16 years on its journey to provide high-quality, cost effective health care to its members. With offices located in all three of MO HealthNet's managed care regions and staffed by local teams, HealthCare USA's impact goes beyond that of a strong health care partner. We also provide strong community partnerships and leadership with substantial economic impact to the State of Missouri.

HealthCare USA is a managed care organization and wholly owned subsidiary of Coventry Health Care, Inc. (Coventry). Coventry is a national managed care company providing a full range of products and services – including group and individual health insurance, Medicare and Medicaid programs, and coverage for specialty services such as workers' compensation – to nearly 5 million members. HealthCare USA's affiliate companies – Coventry Health Care of Missouri (formerly Group Health Plan) and Coventry Health Care of Kansas – provide group, individual and Medicare Advantage health insurance to over 500,000 Missourians. Collectively, HealthCare USA and its affiliates serve nearly 700,000 state residents.

Coventry currently operates full risk/capitated Medicaid MCOs in nine states, covering nearly 690,000 TANF, ABD, Foster Children and CHIP beneficiaries. This vast experience, including the longstanding, local experience in the State of Missouri, will allow us to demonstrate in this proposal how HealthCare USA will be able to continue serving MO HealthNet members and help achieve its three goals:

1. Improve access to needed services
2. Improve quality of healthcare services
3. Control program rate-of-cost increases

As other Managed Care Organizations have come and gone in the State of Missouri over the years, HealthCare USA has and shall remain a constant partner. We respectfully ask for your continued business and look forward to continuing our collaboration to meet the needs of MO HealthNet's members. If you have any questions regarding this proposal, please feel free to call Pam Victor, Director of Government Relations at (573) 681-9742 or me at (314) 444-7253.

Sincerely,

A handwritten signature in cursive script that reads "Kimberly Covert". The signature is written in black ink and is positioned above the printed name and title.

Kimberly Covert
Chief Executive Officer



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GENERAL MATTERS AND REQUIRED FORMS



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Amendment No. 2 to RFP B3Z12055



**STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR PROPOSAL (RFP)**

AMENDMENT NO.: 2
RFP NO.: B3Z12055
TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions
ISSUE DATE: 12/02/11

REQ NO.: NR 886 25751202126
BUYER: Laura Ortmeyer
PHONE NO.: (573) 751-4579
E-MAIL: laura.ortmeyer@oa.mo.gov

RETURN PROPOSAL NO LATER THAN: DECEMBER 13, 2011 AT 2:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type RFP Number and Return Due Date on the lower left hand corner of the envelope or package. Delivered sealed proposals must be in DPMM office (301 W High Street, Room 630) by the return date and time.

RETURN PROPOSAL AND AMENDMENT(S) TO:

(U.S. Mail)	or	(Courier Service)
DPMM		DPMM
PO BOX 809		301 WEST HIGH STREET, ROOM 630
JEFFERSON CITY MO 65102-0809		JEFFERSON CITY MO 65101-1517

CONTRACT PERIOD: July 1, 2012 through June 30, 2013

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Department of Social Services, MO HealthNet Division
Post Office Box 6500
Jefferson City MO 65102-6500

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements, and specifications of the original RFP as modified by this and any previously issued RFP amendments. The offeror should, as a matter of clarity and assurance, also sign and return all previously issued RFP amendment(s) and the original RFP document. The offeror agrees that the language of the original RFP as modified by this and any previously issued RFP amendments shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME		LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS TAX ID NO.	
MAILING ADDRESS		HealthCare USA of Missouri, LLC	
10 South Broadway, Suite 1200		IRS FORM 1099 MAILING ADDRESS	
CITY, STATE, ZIP CODE		10 South Broadway, Suite 1200	
St. Louis, MO 63102		CITY, STATE, ZIP CODE	
St. Louis, MO 63102		St. Louis, MO 63102	
CONTACT PERSON		EMAIL ADDRESS	
Pamela Victor		psvictor@cvty.com	
PHONE NUMBER		FAX NUMBER	
(573) 681-9742		(573) 761-7380	
TAXPAYER ID NUMBER (TIN)	TAXPAYER ID (TIN) TYPE (CHECK ONE)	VENDOR NUMBER (IF KNOWN)	
431702094	<input checked="" type="checkbox"/> FEIN <input type="checkbox"/> SSN		
VENDOR TAX FILING TYPE WITH IRS (CHECK ONE)			
<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> State/Local Government <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> IRS Tax-Exempt <input checked="" type="checkbox"/> Other LLC			
AUTHORIZED SIGNATURE		DATE	
		12/6/2011	
PRINTED NAME		TITLE	
Kimberly Covert		Chief Executive Officer	



AMENDMENT #2 to RFP B3Z12055

TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions

CONTRACT PERIOD: July 1, 2012 through June 30, 2013

RFP B3Z12055 is hereby revised as follows:

1. The following items in the RFP contain changes:
 - 1.3.1 k. and o.
 - 2.2.1 h.
 - 2.5.9 a.
 - 2.5.9 c.
 - 2.5.9 c. 2)
 - 2.6.3 b.
 - 2.6.5
 - 2.11.1 d. 1) fifth bulletpoint
 - 2.12.16 c. 6)
 - 2.16.4 c. 2)
 - 2.16.5
 - 2.16.5 a. through d.
 - 2.18.8 c.
 - 2.18.8 c. 2)
 - 2.23.1 c.
 - 2.27.3
 - 2.29.3 a.
 - 2.32.5 a. 1) first and fourth bulletpoint
 - 3.12.6
 - 4.4.1
 - 4.4.3 a. 1) and 4)
 - 4.4.4 a, including sub items 1) through 3)
 - 4.4.5 e., f., g.,(including sub items 2) through 4) h., and i.
 - 4.4.6 a. and b.
 - 4.4.7 b.
 - 4.4.8
 - 4.4.11
 - 4.4.16
2. The numbering of Section 2.7 has been corrected.
3. Attachment 6a, Attachment 6c, and Attachment 12 are revised.
4. Exhibit A is available in an Excel format. Exhibit A can be downloaded from the Division of Purchasing and Materials Management’s Internet web site at: <https://www.moolb.mo.gov>.
5. Portions of Attachment 9 are available in an Excel format. In addition, corrections have been made to sections of Attachment 9 in regard to correct references to the regions. These documents can be downloaded from the Division of Purchasing and Materials Management’s Internet web site at: <https://www.moolb.mo.gov>.





Amendment No. 1 to RFP B3Z12055



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR PROPOSAL (RFP)

AMENDMENT NO.: 1
RFP NO.: B3Z12055
TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions
ISSUE DATE: 11/07/11

REQ NO.: NR 886 25751202126
BUYER: Laura Ortmeier
PHONE NO.: (573) 751-4579
E-MAIL: laura.ortmeier@oa.mo.gov

RETURN PROPOSAL NO LATER THAN: DECEMBER 13, 2011 AT 2:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type RFP Number and Return Due Date on the lower left hand corner of the envelope or package. Delivered sealed proposals must be in DPMM office (301 W High Street, Room 630) by the return date and time.

RETURN PROPOSAL AND AMENDMENT(S) TO:

(U.S. Mail) DPMM PO BOX 809 JEFFERSON CITY MO 65102-0809	or	(Courier Service) DPMM 301 WEST HIGH STREET, ROOM 630 JEFFERSON CITY MO 65101-1517
---	----	---

CONTRACT PERIOD: July 1, 2012 through June 30, 2013

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Department of Social Services, MO HealthNet Division
Post Office Box 6500
Jefferson City MO 65102-6500

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements, and specifications of the original RFP as modified by this and any previously issued RFP amendments. The offeror should, as a matter of clarity and assurance, also sign and return all previously issued RFP amendment(s) and the original RFP document. The offeror agrees that the language of the original RFP as modified by this and any previously issued RFP amendments shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME		LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS TAX ID NO.	
MAILING ADDRESS		HealthCare USA of Missouri, LLC	
10 South Broadway, Suite 1200		IRS FORM 1099 MAILING ADDRESS	
CITY, STATE, ZIP CODE		10 South Broadway, Suite 1200	
St. Louis, MO 63102		CITY, STATE, ZIP CODE	
St. Louis, MO 63102		St. Louis, MO 63102	
CONTACT PERSON		EMAIL ADDRESS	
Pamela Victor		psvictor@cvtv.com	
PHONE NUMBER		FAX NUMBER	
(573) 681-9742		(573) 761-7380	
TAXPAYER ID NUMBER (TIN)	TAXPAYER ID (TIN) TYPE (CHECK ONE)	VENDOR NUMBER (IF KNOWN)	
431702094	<input checked="" type="checkbox"/> FEIN <input type="checkbox"/> SSN		
VENDOR TAX FILING TYPE WITH IRS (CHECK ONE)			
<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> State/Local Government <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> IRS Tax-Exempt <input checked="" type="checkbox"/> Other <input type="checkbox"/> LLC			
AUTHORIZED SIGNATURE		DATE	
		12/6/2011	
PRINTED NAME		TITLE	
Kimberly Covert		Chief Executive Officer	



AMENDMENT #1 to RFP B3Z12055

TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions

CONTRACT PERIOD: July 1, 2012 through June 30, 2013

RFP B3Z12055 is hereby revised as follows:

1. The following item in the RFP contains changes:
 - 1.3.1 b.
2. The Pricing Pages are revised.
3. Attachments 5 and 13 are revised.





RFP B3Z12055 (Original)



**STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR PROPOSAL (RFP)**

RFP NO.: B3Z12055	REQ NO.: NR 886 25751202126
TITLE: MO HealthNet Managed Care – Central, Eastern, and Western Regions	BUYER: Laura Ortmeier
ISSUE DATE: 11/01/11	PHONE NO.: (573) 751-4579
	E-MAIL: laura.ortmeier@oa.mo.gov

RETURN PROPOSAL NO LATER THAN: DECEMBER 13, 2011 AT 2:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type **RFP Number** and **Return Due Date** on the lower left hand corner of the envelope or package. Delivered sealed proposals must be in DPMM office (301 W High Street, Room 630) by the return date and time.

(U.S. Mail)	or	(Courier Service)
RETURN PROPOSAL TO: DPMM		DPMM
PO BOX 809		301 WEST HIGH STREET, RM 630
JEFFERSON CITY MO 65102-0809		JEFFERSON CITY MO 65101-1517

CONTRACT PERIOD: July 1, 2012 through June 30, 2013

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Department of Social Services, MO HealthNet Division
Post Office Box 6500
Jefferson City MO 65102-6500

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all requirements and specifications contained herein and the Terms and Conditions Request for Proposal (Revised 10/05/11). The offeror further agrees that the language of this RFP shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED

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CONTACT PERSON		EMAIL ADDRESS	
Pamela Victor		psvictor@cvty.com	
PHONE NUMBER		FAX NUMBER	
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AUTHORIZED SIGNATURE		DATE	
		12/6/2011	
PRINTED NAME		TITLE	
Kimberly Covert		Chief Executive Officer	

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Proposal Security Deposit Documentation [4.7.5]

For further information, refer to Attachment 26 in Volume 2 of our response.



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EXECUTIVE SUMMARY



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HealthCare USA is the longest-running MO HealthNet plan, and the only plan that has served the Missouri Medicaid population since program inception 16 years ago, a loyal, constant partner to the state as other providers have come and gone.

The 22 improvements we propose for access, quality, and cost reductions reflect our deep knowledge of, enduring commitment to, and ongoing success with MO HealthNet in improving the lives of our fellow Missourians. What we propose to retain is our service of caring, true partnership, and leadership.

We are so deeply committed to this program and each of its members that we include performance guarantees. Those, along with our \$1.5 billion economic impact over the contract, assure the state and its tax payers that the MO HealthNet program is viable for all members' needs today and tomorrow.

Sara's Story

This is the story of Sara and Angela.

Sara went into labor at 31 weeks. She delivered her new daughter, Angela, successfully (Angela was put in the neonatal intensive care unit). But thinking she still had weeks to prepare before delivery, Sara didn't have baby clothes, a crib, or a car seat for Angela. And now she had her daughter's health to worry about, too.

But Denise knew how to help, and she did. A HealthCare USA NICU Manager, Denise contacted Sara after she learned that Angela was in the NICU. She identified a local nonprofit to provide a car seat for Sara. She contacted other community resources to get Sara and Angela the baby supplies they needed. And perhaps equally important, she contacted Sara frequently to check on her and the baby, and provide the new mother with reassurance that things would be OK.

And they are. Angela is at home now and thriving. "She's a little chubby baby," Sara says fondly, adding, "Although I've never met Denise, I consider her a real friend."



HealthCare USA Cares

This is also the story of HealthCare USA.

Sara's story is just one of literally scores our members can tell from over the 16 years we have been serving and caring for MO HealthNet's Medicaid members. The continuity of service, of partnership, and of commitment we have made to MO HealthNet and its members is deeper and longer than any other plan: We are the only plan who has been with MO HealthNet every day of the program from Day One.



Today, our commitment to MO HealthNet and the Missouri Medicaid community is as strong as it was in 1995. In this bid, we commit to continuing our steadfast service and to implementing improvements in all three regions for the next contract—22 improvements for the upcoming contract, seven of them, uniquely ours.

Commitment is more than competency, more than dedication to doing the job right. It is devotion to doing the right thing. In addition to Sara’s story, other examples of HealthCare USA’s commitment to caring and service include:

- **Quality Accreditation:** HealthCare USA was the first MO HealthNet plan to obtain URAC quality accreditation— even when it wasn’t required—and today we also hold NCQA *Commendable* accreditation status. We commit in the new contract to obtaining NCQA *Multicultural Health Care Distinction* designation to support cultural competency and reduce healthcare disparities.
- **Welfare to Work:** HealthCare USA commits in this bid to hiring MO HealthNet members in our new Welfare to Work program. Our hiring formula anticipates over the course of the contract we will hire 5 Medicaid members at an average salary of \$38,000/year (salary and benefits) in departments such as member services and community outreach . Some HealthCare USA’s employees are former public assistance recipients, including a former HealthCare USA vice president who now works in a Coventry corporate position.
- **Additional Benefits:** We propose 18 benefits more than required, worth nearly \$11 million over the contract period (or \$5 million more than in previous contracts) to remain current with evidence-based medicine and healthcare technology assessments, including CMS determinations. These range from diabetic foot care to significant contributions for local community organization memberships.
- **Transportation to Critical Non-Health Services:** Transportation benefits include arrangements with approximately a dozen community partners— including faith based organizations that utilize their church vans—in all three regions to provide transportation of members to *non-health* wraparound services such as WIC and Legal Aid, services that impact overall wellness for members and their families. We propose to continuing this service in the new contract.
- **In-home Visits:** To targeted populations, we deliver services *in the home*. This program was originally designed to target high-risk pregnant members and has resulted in an estimated savings of \$120,000 annually or \$360,000 over the contract period. We propose to continue this service in the new contract, as well to target an additional population – members with asthma whose condition is not controlled by their medications

Visiting members in their homes, driving them to services they need— these are things friends do for friends, as member Sara thinks of Denise. They are the right thing to do. And HealthCare USA does these things because we care.



HealthCare USA Partners

Doing the right thing also extends to the state and state providers. HealthCare USA has demonstrated our care for our MO HealthNet partners over the years by ensuring smooth operations in the face some challenging issues, as shown in Figure ES- 1.

Figure ES- 1: HealthCare USA Helps Missouri Solve Program Challenges

Initiative/Problem	Increased Access	Improved Quality	Reduced Costs	Smooth Contract Mgt
2010 COB reimbursements			X	
2011 Wraparound payments for FQHC/RHCs, reporting issues (a 2-year issue)				X (avoided unnecessary legislation)
2011: Proposed: Collaborate with MO HealthNet to implement an ED triage rate to reduce unnecessary ED utilization	X	X	X	

A proven partnership approach is more important than ever this contract period as the state grapples with the effects of the enactment of the Patient Protection and Affordable Care Act (ACA). Indeed, because of the undetermined nature of the ACA, MO HealthNet needs a partner who can be highly responsive to changes as they occur. HealthCare USA has proven we are that partner.

We’ve also proven to be a solid partner to providers, which in turn, supports smooth MO HealthNet operations. We know that like most states, Missouri is facing a shortage of Medicaid providers, particularly should the ACA expand enrollment by the up to 400,000 members as projected. With our current capacity, we can rapidly take on substantial number of new members, and with the solid provider relationships we’ve built over the last 16 years, we are confident we can expand our network to meet any further expansion, supporting the program’s solvency.

Figure ES- 2: HealthCare USA’s Provider Partnering Plan Supports MO HealthNet Goals

Provider Partnership Feature	Benefit to MO HealthNet
Pay for performance, including for improvements made under the home health program and for participation in expanded asthma DM program	Quality of services, program integrity,
Additional payment for expanded after-hours care at the PCP (newly proposed)	Cost reduction: reduce overuse of ED
Additional payment/provider incentives for HealthCare USA’s health home improvements (newly proposed)	Meets new program goals, federally matching funds



Provider Partnership Feature	Benefit to MO HealthNet
1-page snapshot report: identifies all care received inside & outside PCP, results, remaining gaps in that care for PCP and specialty provider coordination (newly proposed)	Cost reductions/no duplication
HEDIS scores reported at the practice level (newly proposed)	Quality of services, program integrity
Prompt claims payments Prompt Payments to Providers	Access: providers retained to serve members
HealthCare USA PCP/Member Ratio – Western: 1:65 HealthCare USA PCP/Member Ratio – Central: 1:43 HealthCare USA PCP/Member Ratio – Eastern: 1:137	Access, quality of services
HealthCare USA BH Provider/Member Ratio – Western 1:51 HealthCare USA BH Provider/Member Ratio – Central: 1:109 HealthCare USA BH Provider/Member Ratio – Eastern: 1:131	Access, quality of services
HealthCare USA Dental Provider/Member Ratio – Western 1:100 HealthCare USA Dental Provider/Member Ratio – Central 1:305 HealthCare USA Dental Provider Member Ratio – Eastern 1:433	Access, quality of services
24/7 access to education via Doc Bear University	Quality of services

HealthCare USA Leads

A strong, steady partner, HealthCare USA also has proven to be a true leader. A commitment to caring, to doing the right thing, means a commitment to leadership. Doing the right thing goes beyond doing the job right. It means doing the job so successfully that others emulate and set new standards by it.

We have demonstrated enduring program leadership innovation in our 16 years serving Missouri, and we commit to retaining our lead position for the new contract. Figure ES- 3 highlights our top initiatives, most of which have grown to become ongoing requirements in the state’s RFPs.



Figure ES- 3: HealthCare USA That Have Improved the MO HealthNet Program

Initiative	Increased Access	Improved Quality	Reduced Costs	Smooth Contract Management
<ul style="list-style-type: none"> Longest continuously running health plan offering continuity to state, members, providers 	X	X	X	X
<ul style="list-style-type: none"> COB reimbursements 			X	
<ul style="list-style-type: none"> Kick payments for newborns and low-birth weight babies 	X			
<ul style="list-style-type: none"> Statewide QI projects (instead of plan-specific projects) 		X	X	X
<ul style="list-style-type: none"> Reduced NICU hospital length of stay by 9 days 	X	X	X	
<ul style="list-style-type: none"> Accredited health plan (URAC first) 		X		X
<ul style="list-style-type: none"> Engage in community partnerships 	X	X	X	
<ul style="list-style-type: none"> Cover 17P 		X	X	
<ul style="list-style-type: none"> Offer additional physical therapy benefits 	X	X	X	
<ul style="list-style-type: none"> Introduction of new Integrated Pediatric Network (IPN) in WMO 	X			



A Team of Leaders

The entire HealthCare USA team embodies leadership. Specifically, HealthCare USA comprises us, our behavioral health affiliate, MHNet, and five subcontractors:

1. ***DentaQuest, our dental health provider***, is the largest Medicaid dental network in the state. DentaQuest's commitment to public health improvement is exemplified in their grants program, which over the past 12 years has administered \$25 million in grants supporting oral health, including two in Missouri.
2. ***March Vision, our vision provider***, was founded by two ophthalmologists with a passion for closing the health disparities gap for socioeconomically disadvantaged populations. They have met their mission by serving public health members in 16 states and the District of Columbia.
3. ***CareCore, our specialty care/diagnostic imaging provider***, is both URAC and NCQA-accredited and has nearly one million Missouri members, mostly Medicaid, demonstrating their commitment to the same mission as MO HealthNet.
4. ***MTM, our non-emergency medical transportation provider***, was founded for the sole purpose of managing Non-Emergency Medical Transportation (NEMT) for the medically fragile, disabled, underserved, elderly, and other transportation-disadvantaged populations served by state and county government programs and health plans. They also share MO HealthNet's commitment to member, serving 3 million members across half the nation.
5. ***McKesson, our Nurseline contractor***, is a recognized leader in the 24 hour-a-day, 7-day a week nurse triage service industry.



The HealthCare USA team, including subcontractors and affiliate, averages 13.5 years *each* of publicly-funded healthcare program experience throughout many regions and states across the country. That translates to both low-risk, best-practice contracting, as we leverage lessons learned and best practices from other states to our service in Missouri and a demonstrated commitment to supporting government health programs. Section 4.5.1 details other benefits to MO HealthNet of our highly experienced team including examples of best practices.



Our People

The HealthCare USA Team is led by our expert Health Plan Administrator, Kim Covert, CPA. Ms. Covert has more than 20 years of health care experience, including multiple roles in Medicaid managed care. Ms. Covert has served as COO and CFO for Coventry's other divisions and subsidiaries.

Ms. Covert is joined by equally accomplished personnel who each average nearly 18 years of health care industry experience each, and over 6 years on average working with Missouri Medicaid. Among these are our Compliance Officer and former Deputy Director of MO HealthNet, Pamela Victor, MPA and our Medical Director, William Rooney, MD, who is licensed in three states, Board-certified in Family Practice Medicine, and holds an Executive MBA.

The exemplary nature of our team enables us to maintain our leadership commitment in our proposal to MO HealthNet—something more critical now than ever, given today's economy and the potential impact of the ACA.

Like most states, Missouri is facing the most critical challenge of all: doing more with less. And to meet this challenge, the state needs a team of leaders experienced in overcoming such challenges.

HealthCare USA Proposes

Our proposal offers the opportunity to improve the health and wellbeing of our members and control costs through seven innovative initiatives—ideas we believe are ours alone—and 15 additional improvements. The one proposition that remains completely unchanged, however, is our commitment to continuing to serve and care for MO HealthNet members and help MO HealthNet achieve its three goals to

- Improve access to needed services
- Improve quality of healthcare services
- Control program rate-of-cost increases

We will strive to meet not only today's issues, but the many challenges of tomorrow in all three regions of the program:

Improve Access to Needed Services

HealthCare USA has maintained exemplary coverage statewide in all the three Missouri regions (Eastern, Western, and Central) for all provider types over the last contract. As Section 4.5.4 details, today, we have 12,945 providers, meeting our patient-provider ratio of 1:2000 for PCPs and 1:1000 for physician extenders.

Appropriate coverage is proven through state documentation, NCQA Commendable accreditation (attained in August 2011) and CAHPS scores that would gain maximum accreditation scores from NCQA.

We achieve these goals through innovative contracting, ongoing provider relations to grow and sustain our network, and leveraging our countless long-term relationships with community



partnerships to expand our reach We average 250 community partnerships per region, including faith-based organizations and others to attract various cultures.

Some of the unique ways we improve and propose to continue to improve access are:

- Dental:** Our dental network is the largest among all existing plans, across all regions. Dental services are further expanded via contracts outside our service areas. Also, we bring dental services into the schools through a Triads of Care approach (see Section 4.5.4(b)3), in which providers, community entities, and members come together.
- Targeted Populations:** High-risk populations—such as high-risk pregnancies and asthma patients—receive in-home visits, bringing services right to our members. Transportation benefits are tailored for high-risk populations: we transport substance abuse pregnant women to methadone treatments to protect the unborn child, and we provide enhanced transportation services to a provider’s office for high-risk asthma patients.
- Community Partnerships:** Community partnerships are developed to bring members to the services. We have arrangements with faith-based and other organizations to transport members to non-health wraparound services such as WIC and Legal Aid, services that meet needs that if not attended to, will affect a member’s health and that of their family.

Newly Proposed:

We will expand our Improve Access to Needed Services efforts and improve access to needed services even further. The most significant way is through our anticipated acquisition of Children’s Mercy Family Health Partners (FHP), to be completed pending regulatory approval and targeted for the first quarter of 2012. The acquisition will expand our network in the Western region, for example, by adding, 10 Rural Health Clinics.

Figure ES- 4 lists and describes the other new proposals. These initiatives prepare us for expansions, should they occur as a result of the ACA’s implementation (although significant changes will result in contract modifications).

Figure ES- 4: HealthCare USA’s Proposal Increases Access

Area	Proposed Expanded Access
Behavioral health	MH Net will recruit an increased number of CMHCs and allied health professionals, including physician assistants, to increase access
Telemedicine/rural areas	Performance guarantee ranging up to \$25,000 in Year 1
ED utilization	Reduced via an increase in after-hours at PCPs via financial incentives
Preventive health	Mammvans to bring services to members via a QI project
Additional benefits	Add 18 additional benefits, ranging from diabetic foot care to a member mobile app that both expand access to care and improve



Area	Proposed Expanded Access
	quality of services
Special Needs Children	Establish networks of “gold” practices for referral of special needs children by our internal health services staff

Improve Quality of Health Care Services

HealthCare USA has an exceptional commitment to quality, as demonstrated URAC’s certification that we operate within the highest standards—even when no requirement to do so exists. Since we’ve been mandated to achieve NCQA accreditation, we’ve attained a commendable status.

Our HEDIS scores—almost half in the 75th percentile nationally for effectiveness of care—also improved health in non-HEDIS measures, such as:

- Reduced low birth weight babies by 3%
- Reduced asthma-related ED visits per 1000 from 23.3% to 22.5% in the last contract period
- Achieved NCQA CAHPS scores of 12.82 out of 13

Some unique features of how we support improved health outcomes are:

- **Identifying Gaps in Care at Every Touch-point:** Our Member Services representatives have tools to identify gaps in care by member so that at every time a member calls, we can use that as a touch-point for highly-personalized reminders for immunizations, considering case management or disease management, seeking out the next health fair or Mammvan, and more.
- **Early ID for Management:** Using our proprietary Case Management Tool software, we identify potential candidates for case management and disease management after a first claim is initiated, improving health outcomes.
- **Corporate Commitments:** Annually, Coventry’s corporate leadership defines commitments to improve certain health issues. This year, every plan is committed to improving - three scores: breast cancer screening, diabetic eye exams and post partum visits - making better health for our membership truly everyone’s responsibility.

Newly Proposed

Ongoing improvement is what our commitment to quality for MO HealthNet is all about. We propose numerous quality enhancements for the new contract, as detailed in Section 4.5.2 and 4.5.3 and summarized in Figure ES- 5

Figure ES- 5: HealthCare USA’s Proposal Will Improve Quality of Service

Area	Proposed Improvement
Physical Health (PH) and Behavioral Health (BH)	<ul style="list-style-type: none"> • Case managers physically side by side • Same system platform • BH screening tools disseminated to PCPs and community



Area	Proposed Improvement
Integration	partners to id issues early, treat holistically
Care Coordination	<ul style="list-style-type: none"> • Financial incentives for home health providers; • 1-page care report to use at each visit • Expanded and new DM programs
Cultural Competency	<ul style="list-style-type: none"> • Obtain NCQA Multicultural Health Care Distinction status; • Members as a part of our organization and on our Board of Managers • New community partners to reflect cultures; • QI project focused on prevention targeted through community partners
HEDIS improvements	<ul style="list-style-type: none"> • Results analyzed and disseminated at more granular, practice level • Strategies for improving HEDIS measures • Performance guarantees for HEDIS measures ranging up to \$100,000 annually

- ***Tighter Physical Health and Behavioral Health Integration.*** HealthCare USA is already structurally designed to support integration of physical and behavioral health—we deliver our behavioral health services via our company affiliate, MHNet.

This contract period, we are improving on that integration in three ways.

- **First, we are expanding physical co-location from the Eastern region into all regions.** While today’s technologies make it easy for workers to associate without physical proximity, when it comes to healthcare, there is nothing more effective than simply being there. Physical Health (PH) and Behavioral Health (BH) case managers will work side by side to initiate, monitor, and re-evaluate a member’s status. This will occur upon contract award.
- **Second, we have redesigned our systems so that our PH and BH systems communicate more easily and transparently** than in the past by facilitating closer integration and oversight of member holistic health. This systems integration will allow case managers and customer service representatives to see claims activity for all of a member’s health care services.
- **Third, we will be more proactive in providing integrated screening tools for our providers and community partners** to ensure a holistic approach to health at every turn. We will disseminate for PH providers a BH screening tool and educate them on its use. We will also do the same (with less clinical language) for our community partners, such as pastors and school counselors, who are often the front line in recognizing issues. And we will monitor the effectiveness of these tools ongoing.

- ***Improved Care Coordination.*** Like the federal and state initiatives for more care coordination via health homes and other avenues, HealthCare USA has focused most recently on improving care coordination.



Related to health homes, we will provide incentives to health home providers to increase provider participation and improve care coordination. We have developed a Snapshot one-page report that helps coordinate care between the PCP and specialty providers by identifying quality gaps in care, medication compliance, Emergency Department (ED) use (including avoidable visits) and hospitalizations (including ambulatory sensitive conditions). The report can be accessed online through the provider portal and used at the point of care.

Also for care coordination, we are expanding our disease management programs. We are

- Expanding the existing asthma program through in-home visits, targeting those members whose medications do not control their illness. We anticipate this will broaden the program to serve 50 more asthma patients across all regions, resulting in fewer ED visits and thus producing cost savings of \$234,000 over the three-year contract period
- Adding a rheumatoid arthritis program with a performance guarantee of up to \$50,000 per year. From our evidence-based research, we anticipate this will improve health outcomes as evidenced by improvements in HEDIS scores by 3% in each region each year.
- ***Improve Cultural Competency.*** As introduced at the beginning of this *Executive Summary*, HealthCare USA's commitment to reducing healthcare disparities resulting from socioeconomic or racial factors starts with the very composition of our team—several subcontractors were selected because of their mission to this goal. It is executed in daily operations through the diversity of our operations team which is comprised of 33% minority team members, and the 300 community partnerships across all 3 regions that we have targeted to help us best reach Hispanic, Russian, Vietnamese cultures, to name a few. The pursuit of this designation is backed by a performance guarantee of \$75,000 in Year 1 and \$100,000 in Year 2.

We strengthen our commitment to and accountability of cultural competency in the new contract with:

- ***Application for NCQA to obtain the Multicultural Health Care Distinction designation.*** The Multicultural Health Care Distinction evaluates organizations through an evidence-based set of requirements. Organizations that obtain this distinction are equipped to fulfill federal and state mandates. We will submit an application in Year 1 of the contract and obtain the Distinction in Year 2.
- ***Addition of new community partners as avenues for preventive health services*** including Mammvans for breast cancer screenings (a proposed QI project in the Western region),
- ***Incorporation of members into our structure,*** so we reflect culture in order to meet competency needs. As mentioned earlier, we propose hiring up to 5 members in our Welfare-to-Work program over the course of the contract in departments such as Member Services and Community Outreach roles. We also propose adding a member to our Board of Managers, so that members truly have a say in how we run our operations, help make policies that will better reflect their needs, and act as an advocate for MO HealthNet services. We do this successfully in another plan now.



We will start with one member serving a one-year term; and rotate membership throughout the contract to reflect all regions. We also will include a provider on our Board for the same reasons, and rotate them as well to reflect all regions and specialties.

- **Improved HEDIS Scores.** All the above measures are proposed to improve healthcare outcomes.

With already strong scores, we aim to maintain and improve in two ways. Most effective will be our deeper analyses of HEDIS scores at the practice level, so that we can offer more focused provider education and share best practices. We will also continue to do what has worked well in sustaining our ranking in the 75% percentile for prenatal visits, and commit to that with a performance guarantee of up to \$100,000 per year.

Control Program Rate-of-Cost Increase

The significant fiscal challenges that MO HealthNet faces now and in the coming contract—a budget shortfall coupled with the potential of a substantially expanded membership as a result of the ACA—means successful contractors must also implement stronger-than-ever fiscal responsibilities. And while the plans themselves cannot control the rate of cost increases, we can create efficiencies that contribute to the economic welfare of the state.

We have always aided the state in this regard. HealthCare USA assisted the state to identify and collect COB reimbursements, resulting in cost avoidance of \$17 million, including \$7 million in recoveries, one year alone, protecting Medicaid funds. In addition, our subrogation specialist identifies on average \$800,000 in savings.

Our corporate-wide, national contracts with many providers and subcontractors, such as McKesson, offer the lowest-price contracting, so that we have more funds through our capitated payments to provide more services to MO HealthNet members. We also leverage our corporate national call center for disease management, a cost-saving to MO HealthNet.

Finally, our financial stability was rated in 2011 at B++ from AMBest, Baa3 from Moody's and BBB- from Standard & Poor's, enabling us to continue to better weather the revenue cycles that are simply part of managing care on this scale. As a multi-line business with strong financial standing, we are less sensitive to the dips and sways in revenue, and short-term drops have no effect on our ability to support our providers and serve our members.

Through our services, we have also helped MO HealthNet reduce the rate of program increase through our utilization management (UM) efforts which have save an estimated \$15 million in 2010 alone. Through our offer of ten additional benefits in the last contract period valued at \$1.5 million per year, resulting in reduced costs as a result of improved healthcare outcomes.

Newly Proposed

Continuing with all the above cost-minimization efforts, HealthCare USA also proposes four new ways to minimize costs. Listed in Figure ES- 6 and detailed after it and in Section 4.5.2 and Section 4.5.3, these initiatives enable us to do more within a capitated setting.



Figure ES- 6: HealthCare USA’s Proposal Will Help Minimize Program Costs

Area	Proposed Improvement
Accountability	Performance guarantees in 8 areas totaling up to \$1.4 million over the term of the contract.
Economic Impact	\$1.5 billion over the contract
Healthcare Outcome Improvements	Better quantification of cost savings results Performance guarantees on key improving key HEDIS measures
Lower Provider Rates	Global capitation with Children’s Mercy’s IPN Potential implementation of ED triage rates.

- **Accountability through Performance Guarantees.** HealthCare USA enhances our commitment to quality through performance guarantees. Totaling up to \$550,000 annually and addressing everything from operational management/smooth implementation of the Family Health Partners (FHP) merger to maintaining our CAHPS and HEDIS scores, we attach performance guarantees to:
 1. Smooth implementation of FHP merger
 2. Ensure Child CAHPS overall scores will exceed Quality Compass Medicaid National Average
 3. Maintain HEDIS prenatal scores in the 75th percentile
 4. Obtain the NCQA Multicultural Distinction
 5. Improve HEDIS scores in breast cancer screening, and post-partum visits by 2% each year, every year of the contract
 6. Increase use of anti-rheumatoid drugs by 3% each year
 7. Increase the use of telemedicine by 5% year over year

In addition to the performance guarantee, HealthCare USA will also work with Missouri Telehealth Network to provide grant funding up to \$100,000 over the term of our state contract to assist participating rural practices in all three regions with the procurement of telehealth devices. By offering these grants, HealthCare USA's goal is to expand the use of non traditional service delivery methods in order to improve improve the quality of care of members who live in rural areas by increasing access to specialty care and improving patient outcomes by decreasing delays in diagnosis and treatment

- **Economic Impact.** Our projected economic impact for the next contract period is \$1.5 billion This includes everything from tax obligations to purchased/rented supplies and space, and much more, as detailed in Section 4.5.2. Among the elements included in this figure is our newly proposed Welfare-to-Work program, as introduced in the beginning of this summary. We project that five new hires will result in about \$570,000 in compensation over the contract (including salary and benefits). The \$1.5 billion figure does not allocate for the positive economic impact our employees have just by living and working here daily.



- ***Savings From Improved Health Outcomes.*** HealthCare USA commits to quantifying savings from healthcare outcome activities beyond HEDIS, disease management (DM), and case management (CM) so that we can more accurately forecast, for both ourselves and the state, what works well in order to help control the rate of cost increases. For the next contract, we anticipate our proposed QI projects, CM, DM and health home activities, and performance guarantees as cited above will result in at least \$45 million over the contract. These are calculated from reduced ED visits and inpatient admissions and readmits, preventive measures that identify issues early on, and more integrated PH and BH programs, among other activities.
- ***Savings Provider Rates.*** We will enter into a global capitation agreement with Children’s Mercy Hospital upon acquisition of FHP. Additionally, savings as a result of our commitment to increased use of telemedicine are projected at \$850, based on calculations from a report out of the Center for Information Technology Leadership.

Finally, as introduced earlier in Figure ES- 1 (page ES-13), we propose working with the state to implement ED triage rates in the state hospital fee schedule: We project this could save up to \$287, 000 for every 1000 cases—yet another example of how HealthCare USA will partner with the state to improve the program and support MO HealthNet’s objectives through this contract.

Conclusion

For 16 years, HealthCare USA and MO HealthNet have worked together, every day, to improve the lives of Missourians needing help in hard times.

We have been an enduring and unwavering partner to the state, expanding our caring service as other plans have exited the state, taking on members as we did in the Eastern region in 2000 when Prudential exited the market , in the Central region in 2002 when Care Partners declined to continue, and in the Western region in 2007 when Centene subsidiary FirstGuard left Missouri.

We remain bold and energetic in serving and caring for MO HealthNet’s members and in partnering with MO HealthNet solely because we have such a strong foundation to our commitment. Our offer today of more services, improvement activities, access, and accountability is, for this reason alone, innovative and forward-thinking, yet low-risk.

HealthCare USA will do what is right for our fellow Missourians, our coworkers, our partners—our friends—leading in innovation and building on our 16 years of service and caring.



2. PERFORMANCE REQUIREMENTS



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HealthCare USA's policies and procedures that fulfill the requirements of specified sections, or are mentioned as a point of reference in this section, are available upon request.

For reference, HealthCare USA's Provider Manual and Member Handbook are included in the Attachments Binder, Volume 2 of our response.

2.1 General Requirements [4.4.8]

- 2.1.1 The contractor (hereinafter referred to as the "health plan") shall provide a managed care medical service delivery system for the Department of Social Services, MO HealthNet Division (hereinafter referred to as the "state agency"), located in the State of Missouri in accordance with the provisions and requirements stated herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.1.1.

For 16 years, HealthCare USA has provided a managed care medical service delivery system for the Department of Social Services, MO HealthNet Division (MHD). We currently serve all three regions and will continue to do so in the next contract period.

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- 2.1.2 The health plan shall adhere to all applicable local, State and Federal requirements regarding operation of the MO HealthNet Managed Care Program.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.1.2.

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- 2.1.3 The health plan shall cooperate with the state agency, as directed, in the implementation of the requirements of the Patient Protection and Affordable Care Act (ACA). ACA implementation will result in the expansion of the MO HealthNet member population to approximately 1.2 million individuals. Any ACA requirements altering the obligations of the health plan under the contract shall be accomplished through contract provisions, which may differ from the terms of the contract, to the extent that relevant Federal guidance is issued after the effective date of the contract; or through a contract amendment, as required herein, to the extent that relevant Federal guidance is issued during the term of the contract. The state agency may implement ACA requirements that impact the health plan's operations, but do not directly alter its contractual obligations, through the issuance of a provider bulletin.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.1.3.



- 2.1.4 Prior to performing services in each of the counties, the health plan shall:
- a. Have and maintain a certificate of authority from the Department of Insurance, Financial Institutions & Professional Registration to establish and operate a health maintenance organization (HMO) in all the counties specified herein by no later than April 3, 2012 so that the state agency can proceed with open enrollment with only health plans that are appropriately licensed. In the event the health plan is awarded a contract and fails to achieve appropriate licensure by April 3, 2012, the contract shall be cancelled in its entirety.

4.4.8 Certificate of Authority

The offeror shall submit proof that the offeror has a Certificate of Authority from the Missouri Department of Insurance, Financial Institutions & Professional Registration to operate a HMO in each county specified herein. (2.1.3a)

- a. If the offeror does not currently have a certificate for a certain county, the offeror shall provide documentation that the offeror has or will submit an application to the Department of Insurance, Financial Institutions & Professional Registration for such certification.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.1.4(a) and 4.4.8.

HealthCare USA maintains a Certificate of Authority (COA) from the Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP), see Attachment 1, to perform as an HMO in all counties specified in 2.1.4 (a). Figure 2- 1 shows a complete list from DIFP’s website of the counties where we hold a current license.

Figure 2- 1: HealthCare USA Licensed Counties Obtained from DIFP Website

Western Region		Central Region		Eastern Region	
• Bates	• Lafayette	• Audrain	• Marion	• Franklin	• St. Francois
• Cass	• Platte	• Benton	• Miller	• Jefferson	• St. Louis
• Cedar	• Polk	• Boone	• Moniteau	• Lincoln	• St. Louis City
• Clay	• Ray	• Callaway	• Monroe	• Madison	• Ste. Genevieve
• Henry	• St. Clair	• Camden	• Montgomery	• Perry	• Warren
• Jackson	• Vernon	• Chariton	• Morgan	• Pike	• Washington
• Johnson		• Cole	• Osage	• St. Charles	
		• Cooper	• Pettis		
		• Gasconade	• Phelps		
		• Howard	• Pulaski		
		• Laclede	• Ralls		
		• Linn	• Randolph		
		• Macon	• Saline		
		• Maries	• Shelby		

HealthCare USA’s subcontractors and affiliate also maintain documentation COAs from DIFP which are available upon request.



2.1.4b Understand that Federal approval is required prior to commitment of the Federal financing share of funds under the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.1.4(b).

2.1.4c Participate in readiness reviews. If the health plan is new to the MO HealthNet Managed Care Program, the state agency shall conduct on-site readiness reviews of the health plan in order to document the status of the health plan with respect to meeting the Performance Requirements outlined herein. If the health plan has an established relationship with the state agency, the state agency may either (1) conduct off-site readiness reviews of the health plan in order to document the status of the health plan with respect to meeting any new Performance Requirements from previous contracts, or (2) conduct on-site readiness reviews at the state agency's discretion. The implementation plan, as submitted in the contractor's awarded proposal, and adherence to the implementation plan shall be monitored by the state agency as part of readiness review activities.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.1.4(c).

HealthCare USA will coordinate and participate in any readiness reviews to document compliance with the performance requirements.

- 2.1.5 The health plan awarded a contract for the Eastern region shall provide services to individuals determined eligible by the state agency for the MO HealthNet Managed Care Program in all of the following thirteen areas in the State of Missouri, unless otherwise specified in the health plan's awarded proposal and as approved by the State of Missouri at the time of award of the contract:
- a. Franklin County
 - b. Jefferson County
 - c. Lincoln County
 - d. Madison County
 - e. Perry County
 - f. Pike County
 - g. St. Charles County
 - h. St. Francois County
 - i. Ste. Genevieve County
 - j. St. Louis County
 - k. Warren County
 - l. Washington County
 - m. St. Louis City

HealthCare USA understands and shall comply with requirements set forth in Section 2.1.5.

Since the start of managed care in the Eastern region, we have been successfully working with the State to provide convenient access to cost-effective medical care and to improve clinical outcomes for members in all 13 areas listed above.

2.1.6 The health plan awarded a contract for the Central region shall provide services to individuals determined eligible by the state agency for the MO HealthNet Managed Care Program in all of the



following twenty-eight areas in the state of Missouri, unless otherwise specified in the health plan's awarded proposal and as approved by the State of Missouri at the time of award of the contract:

- a. Audrain County
- b. Benton County
- c. Boone County
- d. Callaway County
- e. Camden County
- f. Chariton County
- g. Cole County
- h. Cooper County
- i. Gasconade County
- j. Howard County
- k. Laclede County
- l. Linn County
- m. Macon County
- n. Maries County
- o. Marion County
- p. Miller County
- q. Moniteau County
- r. Monroe County
- s. Montgomery County
- t. Morgan County
- u. Osage County
- v. Pettis County
- w. Phelps County
- x. Pulaski County
- y. Ralls County
- z. Randolph County
- aa. Saline County
- bb. Shelby County

HealthCare USA understands and shall comply with requirements set forth in Section 2.1.6.

HealthCare USA has been successfully working with the State for more than 15 years to provide convenient access to cost-effective medical care and to improve clinical outcomes for members in the Central region in all 28 areas listed above.





- 2.1.7 The health plan awarded a contract for the Western region shall provide services to individuals determined eligible by the state agency for the MO HealthNet Managed Care Program in all of the following thirteen areas in the State of Missouri, unless otherwise specified in the health plan's awarded proposal and as approved by the State of Missouri at the time of award of the contract:
- a. Bates County
 - b. Cass County
 - c. Cedar County
 - d. Clay County
 - e. Henry County
 - f. Jackson County
 - g. Johnson County
 - h. Lafayette County
 - i. Platte County
 - j. Polk County
 - k. Ray County
 - l. St. Clair County
 - m. Vernon County

HealthCare USA understands and shall comply with requirements set forth in Section 2.1.7.

HealthCare USA has been successfully working with the State for more than 8 years to provide convenient access to cost-effective medical care and to improve clinical outcomes for members in the Western region in all 13 areas listed above.

- 2.1.8 Contingent upon CMS approval, the state agency will implement a health home program designated by Section 2703 of the ACA for eligible MO HealthNet members

HealthCare USA understands and shall comply with the requirements of Section 2.1.8.

We strongly support the efforts of the state to develop a health home and look forward to working with the state and the health home providers to make this successful.

- 2.1.8a. The health plan is required to provide coordination with a primary care provider.

HealthCare USA understands and shall comply with the requirements of Section 2.1.8(a).

HealthCare USA understands and will provide coordination with the primary care provider through our nurse case managers working with the primary care provider's designated contact. We will also provide the health home with claims-based utilization information. This will aid the health home in engaging the member and ensuring appropriate medical or behavioral health follow-up. In addition, HealthCare USA will provide the health home demographics of members with missing preventative services, excessive utilization of potentially unnecessary medical care, or situations that can lead to health care disparity, such as:

- Missing EPSDT examinations
- Missing Lead screenings
- Missing HEDIS related encounters



- Missing dental care
- Missing vision care
- Adolescent immunization rates
- Missing annual influenza/flu vaccines
- Excessive Emergency Department utilization
- Hospital readmission
- Identify members whose primary language is not English
- Identify members that have been found, through HealthCare USA concurrent review or social worker staff, to have unique case management needs based on ethnic, cultural or religious identities.

2.1.8b. On a monthly basis, the state agency will notify the health plan which of its members are receiving health home services and a contact person will be provided for each health home to allow for coordination of a member's services.

HealthCare USA understands and shall comply with the requirements of Section 2.1.8(b). HealthCare USA understands the state will notify us on a monthly basis of health home members.

2.1.8c. The health plan must identify a single point of contact for the Section 2703 designated health home practice.

HealthCare USA understands and shall comply with the requirements of Section 2.1.8(c). HealthCare USA has identified a single person as the “contact point” for the State’s Health Home sites. Brenda McHenry, Health Home Coordinator, will review the monthly State reports of the HealthCare USA members who are receiving health home services through the State program and will coordinate with each health home practice.

2.1.8d. The health plan is not required to provide case management services that duplicate those reimbursed to the Section 2703 designated health home.

HealthCare USA understands and shall comply with the requirements of Section 2.1.8(d). To prevent duplication of services and maximize the coordination of care for our members, HealthCare USA will coordinate with the State-designated Health Homes on the care and case management strategies of the HealthCare USA members enrolled in such a program.





2.1.8e. The health plan must inform the health home of any inpatient admission or discharge of a health home member within twenty-four hours.

HealthCare USA understands and shall comply with the requirements of Section 2.1.8(e).

HealthCare USA will inform health home providers of inpatient admissions, over-night observation stays, and hospital (medical and behavioral health) discharges of the HealthCare USA health home member within twenty-four hours of our receipt of notification. HealthCare USA will support the medical home in all aspects of care transition. HealthCare USA will provide timely and accurate utilization data including hospital admissions and readmissions and emergency department utilization. An “ambulatory sensitive hospitalization” report will be available for the health home provider, based on the current daily HealthCare USA inpatient census. This will aid in the timely notification of hospitalizations to health home providers.

2.1.8f. The health plan should include any Section 2703 designated health home treating physician, clinical practice, or advance practice nurse in their provider network for members in a Section 2703 designated health home.

HealthCare USA understands and shall comply with the requirements of Section 2.1.8(f).

HealthCare USA has reviewed the MO HealthNet division and the Department of Mental Health’s lists of enrolled health home providers. We invite all Section 2703-designated health home treating physicians to become part of the HealthCare USA provider network. The following tables demonstrate the current network status of these providers.

Figure 2- 2: CMHC Health Home Providers

	Within 54 County Service Area			
Provider Type	CMO	EMO	WMO	Total
Par	1	4	6	11
Non-Par	1	3	0	4
Total	2	7	6	15

Figure 2- 3: Primary Care Health Home Providers

	Within 54 County Service Area			
Provider Type	CMO	EMO	WMO	Total
FQHC	3	4	2	9
RHC	2	1		3
PCP Clinic	3		2	5
Non Par				
Total Par	8	5	4	17



2.2 Health Plan Administration

2.2.1 The health plan shall have in place sufficient administrative personnel and organizational structure to comply with all requirements described herein. The health plan shall provide qualified persons in numbers appropriate to the health plan's size of enrollment. At a minimum, the health plan shall have the following personnel to perform the responsibilities listed. Unless otherwise specified, the health plan may combine or split the listed responsibilities among the health plan's personnel as long as the health plan demonstrates that the responsibilities are being met. Similarly, the health plan may contract with a third party (subcontractor) to perform one or more of these responsibilities.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.1 (a-p).

Kim Covert, Plan Administrator, has clear authority over the general administration and implementation of the requirements set forth herein. Under her leadership, the health plan shall have in place sufficient administrative and organizational structure to ensure compliance with all requirements. She directs a dynamic team of healthcare professionals each averaging over 7 years of Medicaid experience and nearly 18 years in the healthcare industry. This team possesses an array of degrees/certifications as listed below.

For further details on Section 2.2.1, see Section 4.4.11.

2.2.1a. A full time Health Plan Administrator with clear authority over the general administration and implementation of the requirements set forth herein.

Kim Covert serves as a full-time Plan Administrator and has ultimate responsibility over the general administration and implementation of the requirements set forth in this RFP. Employees located in our Kansas City, Jefferson City and St. Louis, Missouri offices report directly to Ms. Covert, and she has dotted line responsibility and oversight for corporate/subcontractor functions as demonstrated in the organization chart provided in Figure 2- 4.

Ms. Covert has 21 years of progressive health care experience, including multiple roles in Medicaid managed care and 11 years with Coventry. She began her career working as a CPA for various nationally recognized accounting firms. As part of Coventry Health Care, she has held such titles as Chief Financial Officer and Chief Operating Officer for various subsidiaries and divisions, including three years in the Missouri market with Coventry Health Care of Kansas. Ms. Covert holds a Bachelor of Science Business Administration degree from West Virginia State College and is also a Certified Public Accountant (CPA).

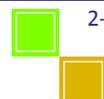
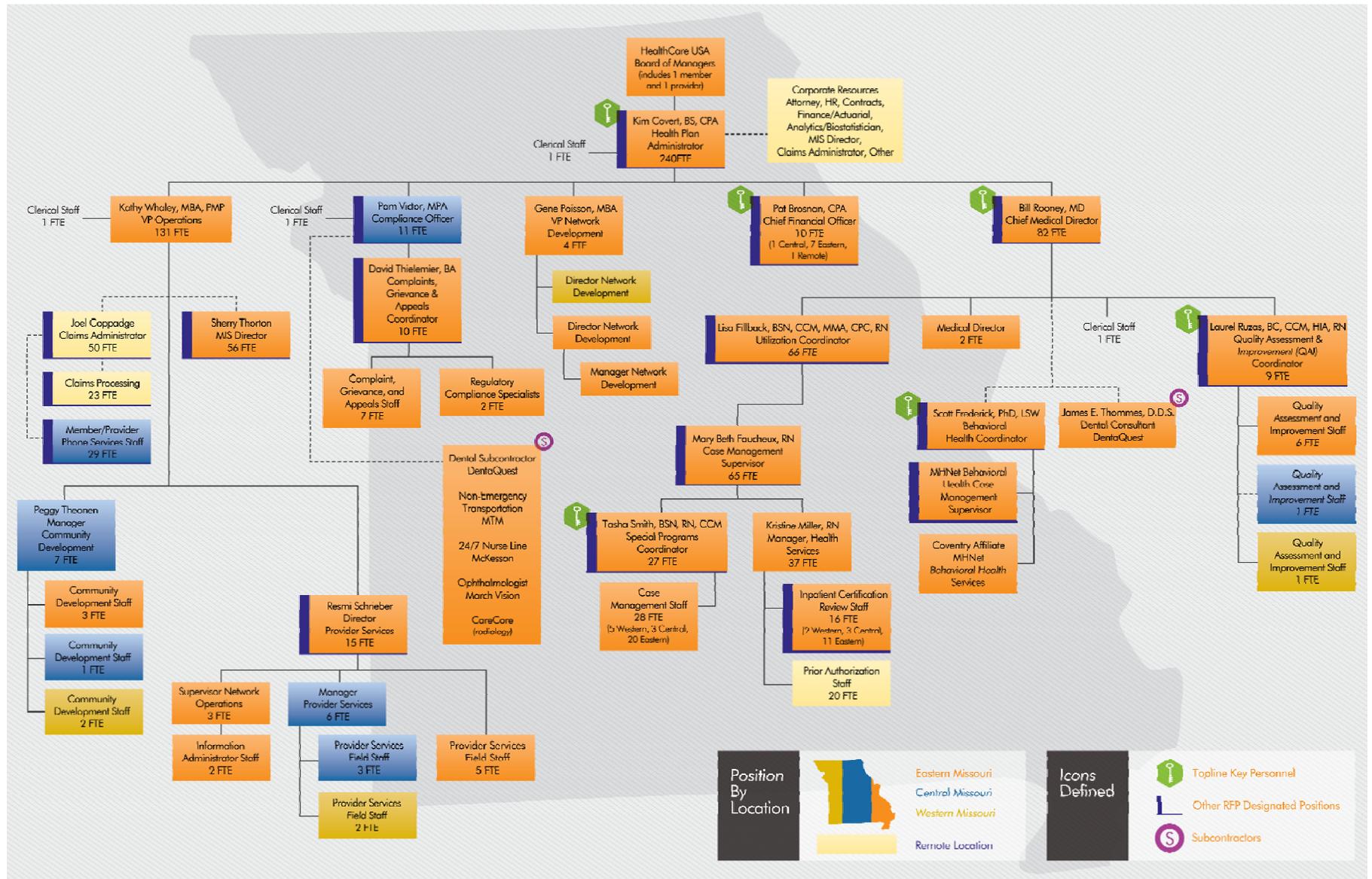


Figure 2-4: HealthCare USA Organization Chart



Position By Location

- Eastern Missouri
- Central Missouri
- Western Missouri
- Remote Location

Icons Defined

- Topline Key Personnel
- Other RFP Designated Positions
- Subcontractors

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2.2.1b. Clerical and support staff to ensure appropriate functioning of the health plan's operation.

HealthCare USA has sufficient administrative staff and an organizational structure that is compliant with all RFP requirements, as demonstrated in Figure 2- 4 above. HealthCare USA employs people who are qualified by their education, training, work experience and interpersonal/professional skills, ensuring appropriate functioning of the health plan's operations. Our team addresses the health care needs of MO HealthNet members and ensures our operations function efficiently.

2.2.1c. A Medical Director, for physical and behavioral health, who is a Missouri-licensed physician, has or does practice medicine in the United States, and is in good standing with the State Board of Medical Licensure, has not had his/her license revoked or suspended under 20 CSR 2150.2. The Medical Director shall sign any denial letter required under the Missouri regulation. He/she must be board-certified, board-eligible, or have sufficient experience in his/her field or specialty to be determined competent by the health plan's Credentials Committee. The Medical Director shall be a primary leader of the organization, being actively involved in all clinical and quality program and shall be responsible for the treatment policies, protocols, quality assurance activities, and utilization management decisions of the health plan. The Medical Director shall devote sufficient time to the health plan to ensure timely medical decisions, including after hours consultation as needed. The Medical Director shall report to the Health Plan Administrator and be responsible for the sufficiency and supervision of the health plan provider network; oversee the development of clinical care standards, practice guidelines, and protocols; and maintain current medical information pertaining to clinical practice and guidelines. The Medical Director must be available to the health plan's medical staff for consultation on referrals, denials, grievances and appeals, and problems. The following department staff shall report to the Medical Director: the Quality Assessment and Improvement and Utilization Management Coordinator and the Case Management Supervisor. The Medical Director shall ensure compliance with the National Committee for Quality Assurance (NCQA), and all Federal, State and local reporting laws on communicable diseases, child abuse, neglect, etc.

William Rooney, M.D. serves as HealthCare USA's full-time Medical Director for both physical and behavioral health.

Licensed to practice medicine in three states (Missouri, Kansas and Oklahoma) Dr. Rooney is board certified by the American Board of Family Practice Medicine. He holds a Doctorate of Medicine, Bachelors of Science and an Executive Masters in Business Administration. Dr. Rooney has over 25 years clinical experience in both private practice and managed care settings. During his tenure with Coventry Health Care he has held titles including Medical Director, Chief Medical Officer and Vice President of Medical Affairs. He has participated in hospital and health plan committees on Quality Assurance, Utilization Review, Peer Review and Credentialing.

In his current role, Dr. Rooney's broad experience affords him a well-rounded management perspective in fulfilling his responsibilities for:

- Maintaining the adequacy of and supervising HealthCare USA's provider network
- Developing and maintaining clinical care standards, practice guidelines and protocols
- Overseeing the medical management team.



Dr. Rooney has direct responsibility for the Quality Assessment and Improvement Coordinator, Utilization Management Coordinator and the Case Management Supervisor. All health plan denials are issued under his name and he is available to the health plans medical staff for consultation on referrals, denials grievances, appeals and any other issues that may arise. He also ensures compliance with the National Committee for Quality Assurance (NCQA) and all Federal, State and local reporting laws on communicable diseases, child abuse and neglect.

2.2.1d. A Dental Consultant who is a Missouri-licensed dentist. The Dental Consultant shall devote sufficient time to the health plan to ensure timely dental decisions and claim review.

Since 1999, James E. Thommes, D.D.S., has served as HealthCare USA's Dental Consultant. Dr. Thommes has been a practicing dentist for the past 28 years and is licensed in the State of Missouri as well as ten other states.

Dr. Thommes has held several consulting and directing positions and is a certified Dental Consultant with over 25 years of dental consulting experience. Dr. Thommes devotes sufficient effort to HealthCare USA to ensure timely dental decision and claim review to promote the most effective and efficient care and service to our members

Dr. Thommes graduated from Loyola University Dental School in 1983. He is a member of professional organizations including the American Dental Association and the American Association of Dental Consultants.

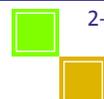
Pursuant to Section 2.2.2 of the RFP, DentaQuest is actively recruiting a Dental Consultant, with comparable qualifications. This consultant will be located in and operate from the State of Missouri no later than March 1, 2012.

2.2.1e. A full-time Chief Financial Officer to oversee the budget and accounting systems implemented by the health plan.

Patrick W. Brosnan CPA, the full time Chief Financial Officer. is a licensed Certified Public Accountant (CPA) and is a member of the American Institute of CPAs. He directly oversees the budgeting, financial reporting and accounting systems implemented by HealthCare USA.

Mr. Brosnan has over 25 years of progressive financial and accounting experience. Prior to this position, Mr. Brosnan was Finance Director for Health Net of the Northeast, where he was responsible for internal and external financial reporting and compliance for the Medicaid line of business. In addition Mr. Brosnan has extensive internal control experience as well as experience ensuring financial compliance with state regulatory agencies.

2.2.1f. A Quality Assessment and Improvement and Utilization Management Coordinator who is a registered nurse, nurse practitioner, or physician. The registered nurse or nurse practitioner must be licensed in the State of Missouri. The Quality Assessment and Improvement and Utilization Management Coordinator must have formal certification in quality improvement, risk management, or another parallel field. The physician must be Missouri licensed and has or does practice medicine in the United States. He/she must be board-certified, board-eligible, or have





sufficient experience in his or her field or specialty to be determined competent by the health plan's Medical Director or the Credentials Committee.

Quality Assessment and Improvement Coordinator

As HealthCare USA's full-time Quality Assessment and Improvement Coordinator, Laurel Ruzas is a Missouri-licensed Registered Nurse who is involved in all major clinical and quality program components of HealthCare USA. Ms. Ruzas oversees HealthCare USA's quality improvement program which promotes the most effective and efficient care and service to our members.

Ms. Ruzas has more than 20 years of health care experience in both non-profit and commercial sectors. She has experience developing health care quality improvement programs and operational assessments as well as direct member care and other management experience. Prior to joining HealthCare USA in September 2010, Laurel held the positions of Director of Quality, Vice President of Quality and Case Management, and Vice President of Health Services at Group Health Plan of Missouri. Laurel's credentials include:

- Formal certification in a parallel field as a Certified Case Manager (CCM)
- Health Insurance Associate (HIA) designation from the Health Insurance Association of America
- Bachelors degree in HealthCare Administration

Utilization Management Coordinator

As our full-time Utilization Management Coordinator, Lisa Fillback oversees prior-authorization, concurrent review, complex case management, disease management and our health and wellness programs. Ms. Fillback is a Missouri-licensed Registered Nurse and has been with HealthCare USA since 2002. Prior to her appointment as Vice President, she was HealthCare USA's Director of Health Services.

Ms. Fillback has more than 21 years of nursing experience. She earned a Bachelor of Science in Nursing and holds several certifications:

- Case management certification (CCM)
- Medical management associate certification (MMA)
- Professional coder certification (CPC)

2.2.1g. A Special Programs Coordinator who is either (1) a Missouri-licensed social worker; (2) a Missouri-licensed registered nurse including advanced practice nurse, physician, or physician's assistant; or (3) has a Master's degree in health services, public health, or health care administration. In addition, the Special Programs Coordinator should be familiar with the variety of services available through the Missouri human services agencies that interface with health care. The duties of the Special Programs Coordinator shall include care coordination with all stakeholders and providers involved in the care of members. These stakeholders and providers may include, but not be limited to, the state agency, the Department of Health and Senior Services (DHSS), local public health agencies, the Department of Mental Health (DMH), the



Department of Elementary and Secondary Education (DESE), the Family Support Division (FSD), Children’s Division (CD), hospitals, the judicial system, schools, and Community Mental Health Centers (CMHCs). The Special Programs Coordinator shall provide timely and comprehensive facilitation of the identification of medically necessary services and implementation of such when included in a member’s Individualized Education Program/Individual Family Service Plan. The Special Programs Coordinator is the main point of contact for members, their representatives, providers, the state agencies, and local public health agencies.

Special Programs Coordinator

Our full-time Special Programs Coordinator, Tasha Smith, oversees the case and disease management departments. Ms. Smith is a Missouri-licensed Registered Nurse and has been employed by HealthCare USA since 2004. She has served as Manager of Health Services since 2010. Prior to her appointment as Manager of Health Services, she was part of HealthCare USA’s Disease Management team.

Due to Ms. Smith’s seven year’s of experience with MO HealthNet, she ensures that the case and disease management staff access services available through various Missouri human service agencies. She oversees care coordination with all stakeholders and providers, including schools and social services.

Ms. Smith has more than 15 years of nursing experience and holds a Bachelor of Science in Nursing. In addition to her degree, she holds formal certification as a certified case manager (CCM). Ms. Smith is a member of the St. Louis Professionals for HealthCare Quality, Case Management Society of America and St. Louis, and the St. Louis Asthma Consortium.

Health Home Coordinator

In addition to our Special Programs Coordinator, HealthCare USA created a Health Home Coordinator position. Brenda McHenry is a Missouri-licensed Registered Nurse with over 24 years in the health care industry. Brenda has 10 years experience in managed care and is currently perusing a CCM.

Brenda’s current title is Complex Case Manager. On a daily basis Brenda coordinates care for our members with the PCPs, Specialists, Behavioral Health Providers and the Member/Family. The coordination and collaboration that Brenda facilitates helps to assure a positive outcome for the member.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2.2.1h. A Case Management Supervisor for behavioral health services is either a Missouri-licensed registered nurse or a Missouri licensed psychologist. A Case Management Supervisor for medical services is a Missouri-licensed registered nurse. The Case Management Supervisor shall be responsible for all staff and activities related to the case management program.

Mary Beth Faucheux has been employed by HealthCare USA since 2011 and currently services as a full-time Case Management Supervisor. Ms. Faucheux is responsible for all staff and activities related to the case management program. She oversees the health services staff, which include:



- Case Management
- Disease Management
- Social Workers
- Clinical Health Coordinators

Ms. Faucheux is a Missouri-licensed Registered Nurse and currently serves as Director of Health Services. She holds a Bachelor of Science in Nursing and a Masters of Science in Nursing. In addition to her degrees, Ms. Faucheux holds formal certification as a certified case manager (CCM). She has over 22 years of nursing experience including 13 years in the managed care industry.

2.2.1.i. A Behavioral Health Coordinator, who is licensed in the State of Missouri, is a qualified behavioral health professional (QBHP) as specified herein, and possesses, at a minimum, a master's degree.

Scott Frederick, HealthCare USA's full-time Behavioral Health Coordinator, has been employed with MHNet Behavioral Health, our subcontracted managed behavioral health organization (MBHO) and affiliate, since November 2009.

Mr. Frederick oversees the Missouri regional service center daily operations, including:

- Behavioral health hotline
- Customer service activities
- Clinical services
- Case management programs.

He also ensures adoption of an integrated care management approach for members with primary behavioral health diagnosis, and coordination of behavioral health network and provider servicing activities for MHNet.

With more than 25 years of experience in managed behavioral health, Mr. Frederick has held various roles of increasing responsibility including Utilization Management Director, Director of Operations. Mr. Frederick holds a Ph.D. in Counseling and is licensed in Missouri as a Professional Counselor and a Clinical Social Worker.

2.2.1.j. Prior Authorization Staff that are available to authorize services twenty-four (24) hours per day, seven (7) days per week. Prior Authorization Staff shall be directly supervised by a Missouri-licensed registered nurse, physician, or physician's assistant. Prior authorization functions for behavioral health services shall be performed and/or supervised by a licensed QBHP.

Lisa Fillback, a Missouri-licensed Registered Nurse, is Vice President of Health Services and supervises a staff of Missouri-licensed nurses. Ms. Fillback oversees all prior authorization services, including those delegated to our subcontractors and affiliate. HealthCare USA's Health Services staff is experienced in all common clinical specialties, and Ms. Fillback and her staff are available to review cases and authorize covered services 24 hours a day, seven days a week. Additionally, the department is supported by non-clinical administrative staff.



Prior authorization for behavioral health services are delegated to HealthCare USA's behavioral health subcontractor and affiliate, MHNNet. MHNNet's prior authorization staff is comprised of only qualified behavioral health professionals as defined in Section 2.4.8 of this RFP. Prior authorization for radiology services are delegated to HealthCare USA's radiology benefits subcontractor, CareCore National. CareCore employs a staff of Missouri-licensed nurses for all clinical decisions supported by non-clinical administrative staff. Prior authorizations for dental services are delegated to HealthCare USA's dental benefits subcontractor, DentaQuest. DentaQuest employs a staff of Missouri-licensed dentists for all clinical decisions supported by non-clinical administrative staff.

2.2.1k. Inpatient Certification Review Staff to conduct inpatient initial, concurrent, and retrospective reviews. The Inpatient Certification Review Staff shall consist of registered nurses, physicians, physician's assistants, and/or licensed practical nurses experienced in inpatient reviews and be under the direct supervision of a registered nurse, physician, or physician's assistant. Inpatient Certification Review Staff functions for behavioral health services shall be performed by licensed QBHPs.

Kristine Miller RN, is a Missouri-licensed Registered Nurse and Manager of Health Services, overseeing 15 full-time Missouri-licensed Registered Nurses for Inpatient Certification Review. Our Inpatient Certification Review staff is located in each of our three regional offices—St. Louis, Jefferson City and Kansas City. HealthCare USA's Inpatient Certification Review staff has an average of 21 years of managed care experience.

Inpatient Certification Review for behavioral health services is performed by HealthCare USA's behavioral health affiliate, MHNNet Behavioral Health. MHNNet employs only qualified behavioral health professionals as defined in Section 2.4.8. MHNNet employs a staff of 15 full-time Qualified Behavioral Health Professionals (QBHP) with an average of nearly 20 years Medicaid experience.

Inpatient Certification Review staff performs both on-site and telephone reviews, with a focus on proactive communications with the hospital staff and attending physicians. The concurrent nurses participate in daily rounds with our Medical Directors, discussing "every case, every day." This collaborative approach assists us in identifying and preventing potential delays in care, lack of progression of an established inpatient care plan, and post-discharge access issues. The concurrent nurses also ensure:

- Timely initiation of discharge planning
- Identification of any special discharge needs
- Review of benefits available to support discharge
- Referrals to case or disease management
- Referrals to behavioral health and substance abuse case management
- Early identification of outpatient management concerns to avoid medically unnecessary care
- Identification of potential quality of care issues



-
- 2.2.1l. Member Services Staff to coordinate communications with members and act as member advocates. The health plan shall provide sufficient Member Services Staff to enable members to receive prompt resolution to their problems or inquiries.
-

During the past 15 years of our contract, HealthCare USA has employed dedicated Member Services staff who coordinate communications with members and act as member advocates. These staff are supervised by a Director of Service Operations, Manager of Service Operations and Supervisors of Service Operations. Actual staffing is based on enrollment and Coventry's service indicators.

Our staffing ratio approximates the national benchmark, as reported in the Warren Survey Managed Care Staffing Ratios, one full-time employee (FTE) per 6,000 members. Additionally we hire at least one full-time supervisor for every 15 Customer Communications Specialists. The Manager of Service Operations, Supervisors of Service Operations and the Customer Communications Specialists positions will be located in Missouri by April 1, 2012. All of these positions will be overseen by HealthCare USA, VP of Operations.

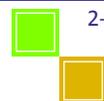
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- 2.2.1m. Provider Services Staff to coordinate communications between the health plan and providers. The health plan shall provide sufficient Provider Services Staff to enable providers to receive prompt resolution to their problems or inquiries.
-

Resmi Schrieber, Director of Provider Services, manages HealthCare USA's Provider Services team. Recognizing the importance of a local presence to support our extensive network of providers throughout Missouri and to meet our members' needs, the Provider Services representatives are located in our three regional offices in St. Louis, Jefferson City and Kansas City, enabling providers to receive prompt resolution to their problems or inquiries.

The Provider Services team is comprised of Provider Services field representatives augmented by Network Operations staff and dedicated telephone Customer Communications Specialists. Interfacing with our providers on a daily basis, our 10 full-time Provider Services field representatives are the backbone to our provider services approach. Our team of 3 full-time Network Operations staff assist the field representatives by managing credentialing, provider data administration, written provider communications support such as provider manual updates, bi-monthly newsletters and newsflashes, and other administrative functions. The team is further supported by a dedicated team of Customer Communications Specialists that manage our Provider Services phone line. By March 19, 2012, the Customer Communications Specialists will join the rest of the Provider Services department in Missouri.

-
- 2.2.1n. A Complaint, Grievance, and Appeal Coordinator to manage and adjudicate member and provider complaints, grievances, and appeals in a timely manner.
-

David Thielemier, Complaint, Grievance and Appeals Coordinator manages HealthCare USA's Member Grievance System and the Provider Appeals Grievance Systems. He leads seven full-time employees with an average of over 10 years of Medicaid experience and an average of over 7 years of appeals and grievance experience to achieve timely and fair resolution of all complaints, grievances and appeals. Mr. Thielemier ensures that all concerns and appeals are





reviewed by appropriate personnel, including physicians and other medical personnel with the same or similar specialty to the provider requesting the service. Grievances are also investigated with the appropriate departments for research and timely response. Complaints, grievances and appeals are tracked in order to identify trends or systemic issues that need to be addressed. As an important part of HealthCare USA's management team, Mr. Thielemier frequently addresses the senior leadership team collectively or individually, as well as the QMC to report trends or areas requiring attention. His team follows any such trends or issues to full resolution.

Mr. Thielemier has more than 10 years of managed care experience and holds a Bachelor of Arts in Anthropology with in minors Spanish and African Studies.

2.2.1o. A Claims Administrator/Management Information System (MIS) Director.

Claims Administrator

Joel Coppadge, Claims Administrator, oversees HealthCare USA's Medicaid Claims Department. This department is staffed by full-time individuals dedicated to processing claims for Coventry's entire Medicaid line of business, including 23 full-time employees dedicated to HealthCare USA.

Mr. Coppadge has been employed by Coventry Health Care, HealthCare USA's parent company, for over 11 years. His previous work experience includes more than 18 years of managed care service as Workers Compensation Finance Manager, Information Systems Project Manager, Business Analyst and Assistant Manager. Prior to joining Coventry, Mr. Coppadge was an Operations Supervisor with a large national insurance company. Mr. Coppadge holds a Bachelor of Science in Business Administration.

Management Information System Director

Sherry Thornton, Management Information System Director, is responsible for the planning, development and maintenance of core transactional systems for HealthCare USA. Her applications experience encompasses claims, customer service, finance, sales and marketing, provider relations and medical management.

Ms. Thornton also leads integrated MIS projects for HealthCare USA that coordinate the activities of more than 20 internal departments and outside vendors. Additionally, she supports more than a dozen Coventry internal systems for government programs and new business initiatives. She has been with Coventry Health Care since April 2009 and has more than 10 years of managed care and MIS experience. She holds a Bachelor of Science/Management degree.

2.2.1p. A Compliance Officer to oversee and manage all fraud and abuse and compliance activities.

Pamela Victor has been employed by HealthCare USA since 2005 as Director of Governmental Relations and Regulatory Compliance. As HealthCare USA's Compliance Officer, Ms. Victor oversees and manages fraud and abuse by serving as the liaison with Coventry's Special Investigation Unit (SIU), which reviews potential fraud and abuse activities. Ms. Victor's



compliance activities include monitoring state and federal regulatory changes, ensuring compliance and overseeing of the MO HealthNet contract.

Ms. Victor has over 23 years of federal and state government experience. She spent over five years auditing Medicaid and Medicare programs at the federal level for the Office of Inspector General. At the state level, Ms. Victor previously held various roles for MO HealthNet including Chief Operating Officer, Deputy Director and Chief Financial Officer. She holds a Bachelor of Science Degree in Accounting and a Master in Public Administration Degree.

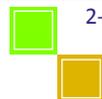
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- 2.2.2 The health plan must have a physical presence in Missouri by having one or more offices located in the State. Additionally, the following personnel, at a minimum, shall be located in and operate from the State of Missouri:
- a. Health Plan Administrator;
 - b. Clerical and support staff;
 - c. Medical Director;
 - d. Dental Consultant
 - e. Chief Financial Officer;
 - f. Quality Assessment and Improvement and Utilization Management Coordinator;
 - g. Special Programs Coordinator;
 - h. Case Management Supervisor;
 - i. Behavioral Health Coordinator;
 - j. Inpatient Certification Review Staff;
 - k. Member Services Staff;
 - l. Provider Services Staff;
 - m. Compliance Officer; and
 - n. Complaint, Grievance, and Appeal Coordinator.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.2.

HealthCare USA currently maintains three regional offices located in St. Louis, Jefferson City and Kansas City allowing quick resolution to various situations across the state of Missouri.

The Health Plan Administrator, clerical and support staff, Medical Director, Chief Financial Officer, Quality Assessment and Improvement and Utilization Management Coordinator, Special Programs Coordinator, Case Management Supervisor, Behavioral Health Coordinator, Inpatient Certification Review staff, most of its Provider Services staff, Compliance Officer and Complaint, Grievance and Appeals Coordinator have been and will continue to be located in and operated from one of our three offices in Missouri.

By March 1, 2012, HealthCare USA will also locate and operate its Dental Consultant and Member Services staff in Missouri. Additionally our telephonic support for Provider Services will join the other portions of our Provider Relations team physically in Missouri.





- 2.2.3 The health plan shall inform the state agency in writing within seven (7) calendar days of staffing changes in the key positions listed below. The health plan shall fill vacancies in any of these key positions with permanent qualified replacements within ninety (90) calendar days of the departure of the former staff member.
- a. Health Plan Administrator;
 - b. Medical Director;
 - c. Quality Assessment and Improvement and Utilization Management Coordinator;
 - d. Special Programs Coordinator;
 - e. Behavioral Health Coordinator; and
 - f. Chief Financial Officer.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.3. HealthCare USA's Compliance Department monitors adherence to the personnel requirements contained within this proposal. Our Human Resources Manager notifies the Compliance Department when key personnel leave the organization, including the:

- Health Plan Administrator
- Medical Director
- Quality Assessment and Improvement and Utilization Management Coordinator
- Special Programs Coordinator
- Behavioral Health Coordinator
- Chief Financial Officer

HealthCare USA notifies the state within seven calendar days of the vacancy and provides the name, qualifications and credentials of the substitute personnel that meet or exceed the original individual's qualifications. If the substitute is an interim solution until a more intensive employment search can be conducted, HealthCare USA also indicates that the person named is interim and provides the State with a succession plan timeline.

Once the position is filled, HealthCare USA provides the name, qualification and credentials of the new employee to demonstrate compliance with this requirement.

For further details on Section 2.2.3, see Section 4.4.11.

- 2.2.4 The health plan shall ensure that all staff has appropriate training, education, experience, liability coverage, and orientation to fulfill the requirements of the positions and have met all appropriate licensure requirements.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.4.

HealthCare USA is committed to hiring the best staff for the job. Prior to hiring staff, our leadership team, in conjunction with Human Resources, use a multi-step process to vet candidates including employment screens, multi-step interviews, background checks, credentials verification and e-verify eligibility screen. Prior to hiring clinical employees, Human Resources also verifies with the Missouri Division of Professional Registration Web site to ensure current licensure. Licensure for clinical staff is verified annually.



All HealthCare USA new hires complete a Human Resources orientation prior to receiving department-specific training. HealthCare USA conducts ongoing training within each department in the form of “Lunch and Learns” and online presentations and quizzes to enhance the knowledge of our employees. Annually, all employees are required to complete Compliance and Ethics and Unlawful Harassment refresher training. Completion of training is documented. As noted in Section 3.4, HealthCare USA maintains Errors & Omissions coverage of \$2 million per claim to cover potential liabilities. Insurance coverage is reviewed annually and appropriate action is taken to ensure adequacy of coverage.

Figure 2- 5: – HealthCare USA Employee Education

Type of Certification/Degree	Number of Certifications/Degrees
Juris Doctorate	2
Masters Degree	16
Bachelors Degree	41
Associates Degree	10
Medical Doctors (MD)	3
Registered Nurses (RN)	38
Licensed Practical Nurses (LPN)	2
Project Management Professional (PMP)	1
Certified Public Accountant (CPA)	3
Certified Professional HealthCare Quality (CPHQ)	2
Certified Professional Coder (CPC)	8
Academy for Healthcare Management (AHM)	1
Fellow Academy for Healthcare Management (FAHM)	1
Professional Academy for Healthcare Management (PAHM)	1
Medical Management Associate (MMA)	2
Doctor of Philosophy (PhD)	1
Licensed Professional Counselor (LPC)	1
Health Information Administrator (HIA)	1
Certified Case Managers (CCM)	8
Oncology Certified Nurse (OCN)	1
Certified Diabetes Educator (CDE)	1



Type of Certification/Degree	Number of Certifications/Degrees
Legal Nurse Consultant (LNC)	1

For further details on Section 2.2.4, see Section 4.4.11.

2.2.5 The health plan shall not knowingly employ as a director, officer, partner, or employee with beneficial ownership of more than five percent (5%) of the health plan’s equity; a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or is an affiliate (as defined in such Act) of such a person. In addition, the health plan shall not have an employment, consulting, or other agreement with such a person described above for the provision of items and services that are significant and material to the health plan’s obligations required herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.5. As a wholly owned subsidiary of Coventry Health Care, HealthCare USA adopts and enforces all Coventry conflict of interest policies including Coventry’s Code of Business Conduct and Ethics and Policy for Querying the Excluded Parties Listing System for Employees.

In adherence with those policies, we have not and will not knowingly employ as a director, officer, partner or employee an individual with ownership of more than 5% of the health plan’s equity or our parent company’s equity. Additionally we have not and will not knowingly enter into an employment, consulting or other agreement with any such person for the provision of items and services that are significant and material to HealthCare USA’s obligations.

For further details on Section 2.2.5, see Section 4.4.4 and 4.4.11.

2.2.6 In accordance with 45 CFR § 162.410, the health plan shall require each ordering and referring professional providing services to health plan members to have a national provider identifier (NPI). The health plan shall require that the NPI be included in each claim for payment for services submitted to the health plan by an ordering or referring professional with dates of service beginning January 1, 2013.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.6. As documented in our Provider Manual, HealthCare USA has required and will continue to require each ordering and referring professional providing services to our members to have a national provider identifier (NPI). We further require that the NPI be included on each claim for services submitted to the health plan as indicated in the *HealthCare USA Provider Manual*, p. 70



2.2.7 Non-Discrimination in Hiring and Provision of Services:

- a. Non-Discrimination and ADA: The health plan shall comply with all federal and state statutes, regulations and executive orders relating to nondiscrimination and equal employment opportunity to the extent applicable to the contract. These include but are not limited to:
1. 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;
 2. Equal Pay Act of 1963 (P.L. 88 -38, as amended, 29 U.S.C. Section 206 (d));
 3. 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;
 4. 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;
 5. The Age Discrimination Act of 1975, as amended (42 U.S.C. 6101-6107) which prohibits discrimination on the basis of age;
 6. Equal Employment Opportunity – E.O. 11246, “Equal Employment Opportunity”, as amended by E.O. 11375, “Amending Executive Order 11246 Relating to Equal Employment Opportunity”;
 7. Missouri State Regulation, 19 CSR 10-2.010, Civil Rights Requirements;
 8. Missouri Governor’s E.O. #94-03 (excluding article II due to its repeal);
 9. Missouri Governor’s E.O. #05-30; and
 10. The requirements of any other nondiscrimination federal and state statutes, regulations and executive orders which may apply to the services provided via the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.7(a).

HealthCare USA maintains a continuing policy of nondiscrimination in employment as outlined in our policy HR-1 *Affirmative Action*.

Our policy is to provide equal opportunity in all phases of employment, and in compliance with applicable federal, state, and local laws and regulations, including all those cited within this RFP. We are committed to providing an equal employment opportunity to all employees and applicants. HealthCare USA values diversity and a workplace free from harassment and discrimination. As a condition of employment, all new hires must complete and pass an online training course on Unlawful Harassment and Compliance & Ethics, and must then re-take the training annually thereafter. This training includes tests to ensure knowledge and understanding of the materials and our Human Resources department ensures compliance with the annual re-education for every employee.

2.2.7b. The health plan shall incorporate in its policies, administration, and delivery of services the values of:

1. Honoring member's beliefs;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.7(b).

Honoring members’ beliefs is an integral element of our approach to health care delivery for our members. A central element of our new employee orientation is a review and discussion



regarding members' rights and responsibilities, including being treated with respect and dignity and recognizing and honoring a members' cultural differences. A copy of these rights and responsibilities is given to each new hire., and during quarterly walk-throughs, our Compliance Department ensures that copies of these member rights are prominently displayed at each employee's desk as a reminder of their importance during our daily interactions. This approach, coupled with formal diversity training, is the backbone of ensuring compliance with this requirement.

2.2.7b2. Being sensitive to cultural diversity; and

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.7(b)2.

We also incorporate diversity into our formal policies, administration and delivery of services. We believe that diversity and fostering an inclusive workforce are not only the right thing to do, but are also critical to maintaining a competitive advantage in today's marketplace. We embrace the differences among people and the variety of perspectives and values inherent in those differences, and managing diversity involves recognizing and respecting those differences to make them a powerful resource to achieve business goals. A formal training program called "Footprints—A Guide to Respecting Others in the Workplace" is mandatory for all employees.

Additionally, as part of Human Resources new hire orientation, all new hires are trained on cultural competence and quizzed at the completion of the training to confirm understanding and adherence. HealthCare USA has augmented our formal training with innovative, in-service programs to help our employees better understand cultural competency from the member's perspective. These programs include:

- **Poverty Simulation** exercise conducted by the Community Action Agency of St. Louis County (CAASTLC) for 35 HealthCare USA management and staff employees
- **Joint staff and community provider in-service on Cultural Diversity and its Impact on Health Care Delivery**—This session was conducted by Joseph Betancourt, M.D., Director of the Disparities Solutions Center, program director for Multi-cultural Education at Massachusetts General Hospital, and an assistant professor of medicine at Harvard Medical School
- **An all-clinician pain management beliefs in-service** about the impact of personal beliefs and culture on treatment of chronic pain. The in-service was presented by Dr. Elliott Gellman, Medical Director for BJC Healthcare Palliative Care Program.

2.2.7b3. Fostering in staff and providers attitudes and interpersonal communication styles which respect the member's cultural backgrounds

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.7(b)3.

HealthCare USA recognizes that our providers play an integral role in our cultural competency program. A key component of our new provider orientation includes reviewing the essential



elements for delivering culturally competent care. Refresher training on these elements is provided upon request or when member grievances of other service complaints warrant. Cultural competency is an annual topic for our Provider newsletters and is incorporated in the *HealthCare USA Provider Manual*, pp 66-67.

2.2.7c. The health plan shall have specific policy statements on minority inclusion and non-discrimination and procedures to communicate the policy statements and procedures to subcontractors.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.7(c).

For further details, see:

- HealthCare USA policy HR-1 *Affirmative Action*



Subcontractor Agreement Language

Oversight Committee Meeting. DentaQuest and HealthCare USA shall each designate representatives who shall attend regularly scheduled Oversight Committee meetings to discuss performance, delivery of services and on-going policy changes to monitor and ensure adherence to Federal, State and HealthCare USA policies and procedures related to this Agreement.

2.2.7d. The health plan 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 a health plan declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. The health plan's provider selection policies and procedures cannot discriminate against particular providers that serve high risk populations or specialize in conditions that require costly treatment. This section may not be construed to:

1. Require the health plan to contract with providers beyond the number necessary to meet the needs of its members;
 2. Preclude the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
 3. Preclude the health plan from establishing measures that are designed to maintain quality of services, control costs, and are consistent with its responsibilities to members.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.7(d).

We do not discriminate against providers as established in HealthCare USA policies *CRED-9 Practitioner Credentialing* p. 1, *CRED-10 Practitioner Re-credentialing* p. 1, and *CR-15 Practitioner Discrimination* pp. 1-2 for provider selection standards that are approved and on file with the Missouri Department of Insurance, Financial Institutions and Professional Registration.

These selections standards are available through our:

- Public Web site (www.hcusa.org)





- Provider portal (www.directprovider.com)
- Provider relations field services representative
- Provider recruitment packet sent out to new providers

These procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

Credentialing

Our credentialing policies and procedures comply with NCQA, state and federal regulations and require that all applications be submitted and reviewed by a credentialing committee comprised of high volume specialties physicians that participate in our network. The Credentialing Committee makes all decisions for approval or denial to participate in the network. If HealthCare USA declines to include individual or groups of providers in our network, we give the affected providers written notice of the reason for the denial.

2.2.8 All services and functions provided by the health plan or its subcontractors under the contract shall be performed in the United States.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.2.8.

2.3 Cultural Competency

2.3.1 The health plan shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. The health plan shall exhibit congruent behaviors, attitudes, and policies that come together in a system that enables effective work in cross-cultural situations. The health plan shall adhere to the following standards:

HealthCare USA understands and shall comply with the requirements set forth in Section Section 2.3.1.

HealthCare USA’s membership is comprised of individuals, who upon enrollment, may declare languages other than English and individuals with visual or hearing impairment. The principal languages as defined by the State contract are English and Spanish. HealthCare USA policy QI-7 *Cultural Competency* outlines our procedures.

For further details on Section 2.3.1, see Sections 4.4.11, and 4.5.2(b-d).

2.3.1a. The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(a).



HealthCare USA's membership includes individuals with visual or hearing impairment and individuals who upon enrollment may declare languages other than English. The principal languages as defined by the State contract are English and Spanish; other languages with a significant membership include Arabic, Vietnamese, and Russian.

This diverse membership requires translation of written materials and interpreter services for both telephone and face-to-face contacts. HealthCare USA employs Spanish-speaking staff in the customer service department, and we provide telephone interpretation services through Language Line, which also tracks the languages requested and reports this data to HealthCare USA.

Face-to-face interpretation services are available throughout all three regions through agencies that include:

- Language Access Metro Project (LAMP),
- Jewish Vocational Services
- International Institute
- A-Z Translating Services
- AAA Translation

Interpreter services for hearing impaired members are provided through:

- Deaf Inter-Link
- Deaf Expression, Inc.
- DEAF Way

2.3.1b. The health plan shall implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff and leadership that are representative of the demographic characteristics of the region.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(b).

HealthCare USA Human Resources (HR) processes assure that recruitment, retention and promotion of staff at all levels—including leadership—assures that our staff is representative of the demographic characteristics of the region. HealthCare USA policy HR-1 *Equal Employment Opportunity/Affirmative Action* further details these processes. Over 30% of our employees are minority and 86% are female.

2.3.1c. The health plan shall ensure that staff, at all levels and across all disciplines, receives ongoing education and training in culturally and linguistically appropriate service delivery.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(c).



HealthCare USA recognizes the differences among people and the variety of perspectives and values that are inherent in those differences.

Managing diversity involves recognizing and respecting those differences and making them a powerful resource to achieve business goals.

A formal training program called “Footprints—A Guide to Respecting Others in the Workplace” is mandatory for all employees. Additionally, as part of Human Resources new hire orientation, all new hires are trained on cultural competence. A quiz is administered to confirm understanding and adherence.

HealthCare USA has augmented this formal training with innovative, in-service programs to help our employees better understand cultural competency from the member’s perspective. HealthCare USA has a Cultural Committee composed of employees from multiple departments. The committee is responsible for continuous employee education about different cultures, holiday observances, and beliefs. The committee also facilitates employee and provider education and will be instrumental in the NCQA program.

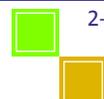
These programs include:

- Thirty-five management and staff employees participating in a Poverty Simulation exercise for HealthCare USA employees conducted by the Community Action Agency of St. Louis County (CAASTLC).
- Hosting a joint staff and community provider in-service on Cultural Diversity and its Impact on Health Care Delivery. This session was conducted by Joseph Betancourt, M.D., Director of the Disparities Solutions Center and the program director for Multi-cultural Education at Massachusetts General Hospital, and an assistant professor of medicine at Harvard Medical School.
- Completed an all-clinician (nurses and medical directors) pain management beliefs assessment and followed up with an in-service about the impact of personal beliefs and culture on treatment of chronic pain. The in-service was presented by Dr. Elliott Gellman, Medical Director for BJC Healthcare Palliative Care Program.

2.3.1d. The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(d).

In accordance with our Oct. 1, 2009 contract with the state of Missouri, a language block has been added to all member literature. This block reads: *"To receive a translated copy of this document, call Member Services at 1.800.566.6444. Para recibir una copia traducida de este documento, llame al servicio para miembros al 1.800.566.6444."*





2.3.1e. The health plan shall make available easily-understood member-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the region.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(e).

HealthCare USA provides easily understood, state approved, member related materials by assuring that all members materials are written at the sixth grade reading level and all materials have the language block as described above. HealthCare USA's member website has an English *and* Spanish version. HealthCare USA posts signage in Spanish in a variety of locations which includes:

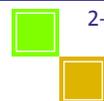
- Signs on Metro buses in English and Spanish
- Spanish posters are posted in the following locations:
 - FQHC offices
 - WIC offices
 - FSD offices
 - Homeless Shelters
 - Safe Havens
 - Resource Centers
 - Wellness Centers
 - Women/Children Battered & Abused Centers
 - Provider Representatives provide posters to physician offices

2.3.1f. The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(f).

HealthCare USA has a written strategic plan that outlines the goals, policies, operational plans and management oversight to provide culturally and linguistically appropriate services. The strategic plan is presented and approved by the HealthCare USA Executive staff and Quality Management Committee.

HealthCare USA continues to expand our efforts to improve the quality of care and services provided to members. Improvement efforts include on-going research and evaluation of current programs and initiatives. To further demonstrate our commitment to ensure our methods result in positive outcomes for participants we are seeking the eminent and premiere NCQA Multicultural Health Care Distinction recognition. Obtaining this gold standard certification demonstrates that we are positioned and prepared to fulfill all current and future State and





Federal mandates to reduce health care disparities and provide the best service possible regardless of race, ethnicity, language, or physical ability.

2.3.1g. The health plan shall ensure that data on the individual member's race, ethnicity, and spoken and written language are collected in health records, integrated into the health plan's management information systems, and periodically updated.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(g).

HealthCare USA maintains the reports provided by MO HealthNet regarding each member's race, ethnicity and spoken and written language and does a population assessment to assure that we have accurate and updated member information. The case managers also note this information in the case management system as part of the case management process. The language line utilization report is reviewed quarterly and monitored for trends in language utilization.

2.3.1h. The health plan shall maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the region.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(h).

2.3.1i. The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(i).

HealthCare USA has established strong partnerships with agencies and organizations dedicated to improving the lives of minority cultures and disparate populations in Missouri.

Not only do we recognize and support ethnic communities within our regions, but we also acknowledge the differences between urban and rural communities. HealthCare USA has strengthened our partnerships in many rural areas by regularly attending monthly Community Action Agency meetings and participating in their local events, including Back-To-School Fairs in counties throughout the state.

HealthCare USA's Member Advisory Committee and community partners provide suggestions for meeting the needs of our diverse membership.





2.3.1j. The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(j).

HealthCare USA assures that interpretation services are available to members either by phone or in person should they wish to appear in person for an appeal. If a member advocate or the member identifies a cross-cultural issue, the HealthCare USA appeal committee takes this into consideration when making their decision.

2.3.1k. The health plan shall regularly make information available to the public about the health plan'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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.3.1(k).

HealthCare USA shall provide public notice in the community about the availability of this information, employing various methods to provide public notice such as:

- Member and Provider portals
- Posters
- Member and Provider newsletter
- Language block on member correspondence
- Member Handbook
- Provider Manual

For further information, refer to:

- HealthCare USA *Provider Manual* pp. 66-67
- HealthCare USA *Member Handbook* pp. 4-5



2.4 Health Plan Provider Networks

2.4.1 General:

- a. The health plan shall establish and maintain health plan provider networks in geographically accessible locations, in accordance with the travel distance standards specified herein. The health plan's network shall consist of, at minimum, hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified herein. In order to maintain geographically accessible locations for members, the health plan shall look to providers in contiguous and other counties for full development of the network
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.1(a).

HealthCare USA's has established network compliance in meeting travel distance standards as indicated by the Missouri Department of Insurance, Financial Institutions and Professional Regulation (DIFP). Network adequacy per DIFP requirements have been met as well.

Our diverse network includes geographically accessible providers who provide the full range of covered services in the 54 counties in the Western, Central and Eastern regions. Further, HealthCare USA has contracted providers in 94 of Missouri's 114 counties. Ongoing expansion of our networks, both providers, subcontractors and affiliate, are done to meet the needs of our members for today and in the future.

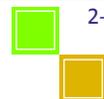
Provider network adequacy is reviewed at a minimum of twice a year. Review of network adequacy is accomplished through Geo Access analysis. The reviews are done to assure members have access to the provider resources needed.

-
- 2.4.1b. In order to ensure that members have access to a broad range of providers and to limit the potential for disenrollment due to lack of access to providers or services, the health plan shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another health plan or in which the health plan represents or agrees that it will not contract with another provider. The health plan shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.1(b).

HealthCare USA **does not** hold any exclusive contractual relationships with any service provider.

-
- 2.4.1c. The health plan shall regularly monitor its provider network to ensure that service accessibility standards described herein are being met, that provider listings of panel status (open and closed) are accurate, that members have and use their primary care providers (PCPs), and that emergency rooms are not being used unnecessarily. As part of the monitoring, the health plan shall, at a minimum, require that its providers report on the number of members they will take as patients or the limitations to the number of referrals accepted and report to the health plan when they have reached eighty-five percent (85%) of capacity. The health plan shall have and





implement policies and procedures that describe its network development and monitoring activities, including methods for ensuring adequate capacity for members.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.1(c).

The HealthCare USA Provider Services team randomly audits provider capacity and accessibility standards across all regions. Education is also done with providers concerning the reporting of their panel size. Any network provider who is found to be out of compliance will be educated on the standard by their provider relations representative and re-surveyed within three months.

Primary care providers must provide care or direct access to care 24 hours per day, seven days per week. Audits are conducted to determine provider after hour phone lines to not automatically direct members to the emergency department.

Non-compliant providers are forwarded to the HealthCare USA Medical Director to determine additional action.

The following policies outline our procedure, and are available upon request:

- *PS-47 Provider Access - Appointment Availability*
- *PS-48 Provider Access - 24-Hour Access*
- *PS-49 Provider Access - Travel Distance*
- *PS-50 Provider Access – PCP Capacity Monitoring*

2.4.2 Primary Care Provider Responsibilities

The health plan shall have written policies and procedures for all its primary care provider activities required herein. At a minimum, these policies and procedures shall provide for the linking of every member to a primary care provider; the monitoring of primary care providers to ensure they are performing the duties described below and are operating in compliance with health plan policies and procedures described herein; the use of specialists as primary care provider; and notifying primary care providers of their assigned member(s) prior to the member's effective date with the primary care provider.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.2.

HealthCare USA's Provider Manual and policy SO-7 *Primary Care Provider (PCP) Assignment* govern the processes used to ensure all members are linked with a health home, ensure that primary care providers (PCP) understand and comply with their health home responsibilities, allow for a specialist to serve as a member's a PCP, notify the PCP of member assignments prior to the member's effective date, ensure and ensure member's are informed on a timely basis provider demographic changes.





2.4.2.a. The primary care provider shall serve as the member's initial and most important contact. As such, primary care provider responsibilities must include at a minimum:

1. Maintaining continuity of each member's health care;
2. Making referrals for specialty care and other medically necessary services to both in-network and out-of-network providers;
3. Working with health plan case managers in developing plans of care for members receiving case management services;
4. Conducting a behavioral health screen to determine whether the member needs behavioral health services; and
5. 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, etc.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.2(a)1-5.

The *HealthCare USA Provider Manual*, p. 15 includes information about primary care provider (PCP) responsibilities and is centered around the PCP serving as the cornerstone for a member's health home needs. Those responsibilities include:

- Ensuring continuity of care
- Making specialty care and case and disease management referrals and coordinating medically necessary specialty care and services including case management
- Developing case management plans in coordination with HealthCare USA case managers
- Conducting behavioral health screenings
- Maintaining comprehensive medical records
- Providing preventative services
- Developing treatment plans

2.4.2.b. Primary care providers may have formalized relationships with other primary care providers to see their members for after hours care, during certain days, for certain services, or other reasons to extend their practice. However, the primary care providers shall be ultimately responsible for the above listed activities for the members assigned to them.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.2(b).

HealthCare USA requires our PCPs to provide access 24/7 to direct members health care needs, which is monitored thru our after hours access surveys with our PCP network. Our PCPs accomplish this using a variety of methods including but not limited to:

- Extending office hours to evenings and weekends



- After hours call coverage solutions, which include:
 - Nurse Triage Line
 - Covering physician
 - Answering Service
 - Direct access to physician (in rural areas)

HealthCare USA PCPs are encouraged to contact new members assigned to their panel and to schedule an initial visit.

2.4.3 Primary Care Providers - Eligible Specialties: The health plan shall limit its primary care providers to licensed physicians specializing in family and general practice, pediatrics, obstetrics and gynecology (OB/GYN), and internal medicine; and registered nurses who are advanced practice nurses with specialties in family practice, pediatric practice, behavioral health, and OB/GYN practice. To the maximum extent possible, the health plan shall include all of these specialties in its health plan provider network.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.3. In compliance with Section 2.4.3, Healthcare USA limits its primary care providers to licensed family and general practice, pediatrics and internal medicine physicians and advance practice nurse practitioners in the specialties of family practice, general practice, pediatrics.

As indicated in Section 2.4.2, members may request to use a specialist, including licensed obstetrics and gynecology (OB/GYN) physicians, as their PCP. As of October 2011, HealthCare USA maintains an extensive network of over 2,196 primary care practitioners across the state of Missouri who practice in 3476 locations.

2.4.4 Primary Care Provider Teams and Primary Care Clinics: The responsibilities of a primary care provider team and a primary care clinic shall be the same as the responsibilities listed herein for primary care providers.

a. If the health plan 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. If primary care provider teams are included within the health plan's provider network, the primary care provider 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. In both instances, the health plan shall organize its primary care provider 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.4(a).

For further information, refer to:

- *HealthCare USA Provider Manual*, p. 9



2.4.4b. The health plan may elect to make clinics available to serve as primary care providers. The primary care clinic must provide the range of services required of all primary care providers. A centralized medical record shall be maintained on each member enrolled with the primary care clinic.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.4(b).

For further information, refer to:

- *HealthCare USA Provider Manual*, p. 9

2.4.5 Primary Care Providers - Selection and Assignment: The health plan shall offer its members freedom of choice in selecting a primary care provider. The health plan shall decrease the number of members assigned to a primary care provider if necessary to maintain the appointment availability standards described herein. To the degree possible, the health plan shall adjust the primary care provider's member assignments prospectively (before care has been initiated) and the health plan shall take steps to minimize the need for such adjustment to the primary care provider's member assignments.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.5.

HealthCare USA policy SO-8 *Primary Care Assignment* details selecting and assigning primary care providers that has been approved by MO HealthNet. This policy describes the processes for:

- New and/or established members to select a PCP
- New and/or established members to change their PCP
- Assigning a PCP to a member who has not selected a PCP.
- Assisting members whose PCP is no longer participating to select and transition to a new PCP
- Allowing members to request a specialist as their PCP.

HealthCare USA ensures appointment accessibility requirements are met through ongoing monitoring of primary care availability and capacity. Our monitoring includes:

- An annual appointment and availability access survey
- Review of PCP to Member ratio and capacity review
- PCP Panel Study
- Secret shopper surveys
- Quarterly appeals and grievance trend and analysis reviews

Though our policy PS-50 *Provider Access PCP Capacity*, which has been approved by MO HealthNet, we can also adjust a PCP panel maximum if any access issues are identified for members. To the extent possible, these adjustments are performed prospectively, to minimize care disruption.



2.4.6 Specialists as Primary Care Providers: The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.6. We allow specialty care providers to serve as a primary care provider (PCP) for members with disabling or chronic conditions, provided the specialty care provider agrees to accept all the responsibilities of acting as PCP.

The responsibilities of a PCP are outlined in the *HealthCare USA Provider Manual*, pp. 9-10. Any specialty care provider taking care of a member with a disabling or chronic condition—such as an oncologist or psychiatrist—must accept these terms and requirements in order to act as a PCP for any member. Our systems are then capable of quickly setting up the specialist as a PCP, whenever the need arises.

2.4.7 Physician Specialists: The health plan shall employ or contract with physician specialists in sufficient numbers to ensure specialty services are available in accordance with travel distance and appointment standards described herein. The health plan shall have protocols for coordinating care between primary care providers and specialists. These protocols shall include the expected response time for consults between primary care providers and specialists.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.7.

Full Range Physician Specialists in Over 18,000 Locations

As of October 31, 2011, we have 7,383 provider specialists across the state of Missouri practicing in 18,778 locations, covering a full range of provider specialties including 641 specialists in contiguous counties outside of the MO HealthNet service area.

COUNT of UNIQUE Providers						
Counts based on UNIQUE PROVIDERS						
Provider Type	In the 54 MO HealthNet Counties				In MO Counties outside of MO HealthNet Services	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Specialist	1284	4187	1271	6742	641	7383

SOURCE OF PROVIDER NUMBERS IS HEALTHCARE USA'S DATABASE FOR DEMOGRAPHIC AND CREDENTIALING INFORMATION - COVENTRY PROVIDER DATABASE (CPD) AS OF 10/31/2011



COUNT OF PROVIDER LOCATIONS						
Provider Type	In the 54 MO HealthNet Counties				In MO Counties outside of MO HealthNet Services	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Specialist	2,534	11,013	2,605	16,152	2,626	18,778

SOURCE OF PROVIDER NUMBERS IS HEALTHCARE USA'S DATABASE FOR DEMOGRAPHIC AND CREDENTIALING INFORMATION - COVENTRY PROVIDER DATABASE (CPD) AS OF 10/31/2011

Leading Specialists From All the Academic and Healthcare Institutions

In addition to a wide selection of independent, community-based specialists, HealthCare USA offers our members access to specialists from all the leading academic and healthcare institutions in Missouri who are at the forefront of medical advances. We have long standing relationships with:

- Western region
 - Children's Mercy
 - University Physician Associates
 - Truman
- Eastern region
 - Washington University
 - BJC Health System
 - Mercy Health System—St Louis
 - St Louis University
 - SSM Health System,
- Central region
 - Mercy Health System – Springfield
 - University of Missouri Hospitals and Clinics

Full Compliance with Network Capacity and Travel Distance Standards

As required in Section 2.5.2 of the RFP, HealthCare USA files an annual network access plan on March 1 with DIFP as required by 20 CSR 400-7.095 and which includes specialty care providers. The attached documentation (attachments from 2.5.2 and/or 4.5.4 a 1) from the DIFP demonstrates HealthCare USA's 2011 compliance with network capacity and travel distance standards for specialty care providers. As noted in the approval letter, no exceptions were required to meet these DIFP requirements.



In addition, HealthCare USA monitors appointment access and travel distance to ensure adequate access to and timely appointments for specialists using:

- Bi-annual Geo-Access reviews
- Appointment Access Surveys
- Provider-to-member ratios for high-volume specialties
- Review of member grievance and appeals for quality-of-service

HealthCare USA Provider Manual, p. 20 outlines our protocols for coordination of care between PCP and specialty providers, including best practices for communication and response time.

For additional details, see our responses to Section 2.4.7 and Section 4.5.4(a)1-2.





- 2.4.8 Behavioral Health and Substance Abuse Providers -To ensure a broad range of treatment options are available, the health plan shall include in its network a mix of behavioral health and substance abuse providers with experience in treating children, adolescents, and adults.
- a. The health plan shall include at least one Community Mental Health Center (CMHC) in the health plan provider network located in the contracted region. To the maximum extent possible, the health plan shall include additional CMHCs in its network. A listing of CMHCs is provided in Attachment 5.
 - b. The behavioral health provider network may include licensed psychiatrists, provisionally licensed psychologists, licensed psychologists, licensed psychiatric advance practice nurses, provisional licensed professional counselors, licensed professional counselors, licensed master social workers, licensed clinical social workers, licensed psychiatric clinical nurse specialists, licensed psychiatric mental health nurse practitioners, licensed home health psychiatric nurse, licensed psychiatric nurse, Missouri certified substance abuse counselors, and State certified behavioral health or substance abuse programs. To be considered adequate, the behavioral health provider network shall, at a minimum, include QBHPs, Qualified Substance Abuse Professionals (QSAP), licensed psychiatrists, licensed psychologists, licensed psychiatric nurses, licensed professional counselors, licensed clinical social workers, and licensed clinical nurse specialists.
1. A QBHP shall be one of the following and provide services within their defined scope of practice:
 - A physician, licensed under Missouri State law to practice medicine or osteopathy who has either specialized training in behavioral health services or one (1) year of experience, under supervision, in treating problems related to behavioral health or specialized training.
 - A psychiatrist licensed under Missouri State law, who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association, or other training program identified as equivalent by the state agency.
 - A psychologist licensed under Missouri State law to practice psychology with specialized training in behavioral health services.
 - A professional counselor licensed under Missouri State law to practice counseling who has specialized training in behavioral health services.
 - A clinical social worker licensed under Missouri State law with a Master's Degree in social work from an accredited program who has specialized training in behavioral health services.
 - A psychiatric nurse, a registered professional nurse, licensed under Missouri State law who has at least two (2) years of experience in a psychiatric setting or a Master's Degree in psychiatric nursing.
 - An individual possessing a Master's Degree or Doctorate Degree in counseling and guidance, rehabilitation counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling, family therapy, social work, or a related field, who has successfully completed a practicum or has one (1) year of experience under the supervision of a QBHP.
 - An advanced practice nurse, as set forth in Section 335.011, RSMo, who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the Board of Nursing.
 2. A QSAP shall demonstrate substantial knowledge and skill regarding substance abuse by being one of the following and must provide services within their defined scope of practice:
 - A physician or QBHP who is licensed in Missouri with at least one year of full time experience in the treatment of persons with substance abuse disorders.



- A person who is certified or registered as a substance abuse professional by the Missouri Substance Abuse Counselors Credentialing Board.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.8(a-b).

HealthCare USA (through its contract with MHNNet) meets and exceeds the requirement to contract with at least one CMHC in each region. MHNNet contracts with five CMHCs in the Central region, five CMHCs in Eastern region and six CMHCs in the Western region.

HealthCare USA utilizes MHNNet’s comprehensive provider network of rigorously screened mental health and substance abuse professionals to ensure a broad range of treatment services is provided to our members. Network providers must complete a specialty checklist indicating their expertise in treating age groups (child, adolescent, adult, and geriatric), socio-cultural groups and over 30 clinical specialty areas in which they are trained and have treatment experience. MHNNet has serviced Missouri HealthNet enrollees through its agreement with HealthCare USA since 1997 and its network includes over 2,100 behavioral health and substance abuse providers.

For additional details, see our responses to Section 2.4.8 and Section 4.5.4(a)1.

2.4.9 Federally Qualified Health Centers and Rural Health Clinics: In accordance with Federal law, the health plan shall include at least one Federally Qualified Health Center (FQHC) in the health plan’s provider network. (A description of FQHC/RHC services is included in Attachment 2. A listing of FQHCs and RHCs is provided in Attachment 5.) The health plan shall have protocols for coordinating care between the primary care provider and the FQHC and RHC providers. The protocols shall indicate the expected response time for consults between the FQHC and RHC and the primary care provider.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.9.

For 16 years HealthCare USA has contracted with FQHCs and RHCs and we exceed the requirement to contract with at least one Federally Qualified Health Center (FQHC) in each region.

As of October 31, 2011 HealthCare USA has 193 contracted FQHC and RHC providers in the state of Missouri. As demonstrated in Figure 2- 6, our network includes 31 FQHC’s and 107 RHC’s within the MO HealthNet Managed Care service area and 55 FQHC/RHC’s outside of the service area. A complete listing of our contracted FQHCs and RHCs is provided in the Attachments Binder, Exhibit A.

Figure 2- 6: HealthCare USA Provider Network

Provider Type	In the 54 MO HealthNet Counties				In MO Counties outside of MO HealthNet Services	Total Across MO Counties
	CMO	EMO	WMO	Totals		
FQHC	8	18	5	31	55	193



Provider Type	In the 54 MO HealthNet Counties				In MO Counties outside of MO HealthNet Services (RHC/FQHC)	Total Across MO Counties
	CMO	EMO	WMO	Totals		
RHC	65	29	13	107		
Behavioral Health	313	955	615	1,865	261	2,126
HealthCare USA Family Planning/STD Treatment Contracts	2	5	1	8	3	8
Total in Attachment 5	2	6	1	9	0	9
Contracted Missouri Family Health Council Directory Other Title X Providers						
Local Public Health	10	7	2	21	3	43
FQHC's	0	6	1	7	0	7
PCP Clinics	N/A	N/A	2	2	0	2
HealthCare USA Contracted Public Health Agencies						
Local Public Health	25	13	13	51	4	55

SOURCE OF PROVIDER NUMBERS: HEALTHCARE USA'S DATABASE FOR DEMOGRAPHIC AND CREDENTIALING INFORMATION - COVENTRY PROVIDER DATABASE (CPD) AS OF 10/31/2011

HealthCare USA allows FQHC and RHC clinics to participate as Primary Care Providers (PCPs), eliminating the need for care coordination and information transfer between FQHCs/RHCs and the PCP.

All our contracted FQHCs and RHCs have signed agreements to function as PCPs for our members. If an FQHC or RHC wants to act only as a specialty care provider, HealthCare USA has existing policies and protocols for coordinating care and transferring information between the provider and the member's PCP. The *HealthCare USA Provider Manual* p .5 and p.20 explains protocols for coordinating care and transferring information between PCPs and Specialty care providers including communications best practices and recommended response times.

During the orientation process, HealthCare USA's provider relations representatives educate the providers and their office staff on these protocols. These procedures are reviewed upon request or when HealthCare USA determines that procedures are not being followed by the practice.

Figure 2- 7, Figure 2- 8and Figure 2- 9 are letters of support from three of our current partners in the Western, Central and Eastern regions, indicating their positive experiences with HealthCare USA and their belief in the strides we can make together in bringing quality and affordable health care to our Missouri populations.



Figure 2- 7: Letter of Support from Swope Medical Center (Western Region)



November 4, 2011

Daniel Paquin, CEO
HealthCare USA of Missouri
10 S. Broadway, Ste 1200
St Louis, MO 63102

To: Missouri Department of Social Services
MO HealthNet Division

Swope Health Services wishes to continue its support of HCUSA as a MO HealthNet provider for the rebid of the MO Medicaid Managed Care Program for 2012. We remain strong business partners in serving the patients/members who are enrolled with HCUSA. There have been several collaborations with HCUSA for community events between us demonstrating our mutual commitment to the Western region MO HealthNet recipients. Swope Health Services greatly values this partnership and fully intends to renew a contract if awarded and encourage your prudent consideration of their application.

Sincerely,

A handwritten signature in black ink, appearing to read "William A. Pankey, MD".

William A. Pankey, MD
Chief Medical Officer
Swope Health Services

816 | 923-5800 | FAX 816 | 448-2908
3801 BLUE PARKWAY | KANSAS CITY, MO 64130-2807 | WWW.SWOPEHEALTH.ORG

Accredited by The Joint Commission on Accreditation of Health Care Organizations





Figure 2- 8: Letter of Support from Hallsville Area Clinic (Central Region)



Hallsville Area Family Clinic

501 N Route B
Hallsville, MO 65255
Phone: 573-696-0500
Fax: 573-696-0509

Dr. Jerry Bruggeman, MD

Ruth Threlkeld, FNP-BC

November 11, 2011

Kim Covert, CEO
Healthcare USA
10 South Broadway, Suite 1200
St. Louis, MO 63102

To: Missouri Department of Social Services
MO Healthnet Division

We are a rural health clinic in Boone County that delivers health care to our rural community and beyond. We have been in Hallsville Missouri for a little over 2 years and our proud to serve the people. Healthcare USA has been very helpful to us as we got up to speed with credentialing, billing and even our VFC program. The provider representatives are very attentive to our needs and keep us up to date with newsletters regarding any changes to the program.

I would like to recommend Healthcare USA be re contracted as a managed care company with MO Healthnet. In the Mid Missouri area, this is by far the most helpful and attentive MC+ plan.

Sincerely,

Luann Roberts
Director of Business Operations
MedChoice Clinics
P O Box 478
Mexico, MO 65265
573-581-8127



Figure 2- 9: Letter of Support from Pike Medical Clinic (Eastern region)

Oct. 6. 2011 4:00PM

No. 1064 P. 2

PIKE MEDICAL CLINIC, INC.
211 SOUTH THIRD STREET
LOUISIANA, MO 63353

211 SOUTH THIRD STREET
LOUISIANA, MO 63353
PHONE: 573-754-5555
FAX: 573-754-4677

PHILLIP W. PITNEY, M.D.
JAN F. ONIK, D.O.
CASEY A. JENNINGS, D.O.
SEAN L. WEAVER, RN,MSN,FNP-C

905 BUS. HWY. 181 SOUTH
BOWLING GREEN, MO 63334
PHONE: 573-324-2241
FAX: 573-324-5137

October 6, 2011

To Whom It May Concern:

We are participating providers under HealthCare USA. During our contract period with HealthCare USA we have had a great experience. They are always very helpful with any customer service issues. HealthCare USA has very good turn around time on claim process. They provide us with a report on their members focused on health conditions / preventative care issues on a regular basis. The reports assist us in providing the best care possible for those members. We find the tools they provide to us very useful and helpful. The HealthCare USA support staff keeps us up to date on any changes or new material for providers. They are always willing to assist. I believe their goals are patient focused. We would recommend any Physician to participate with HealthCare USA.

Respectfully

Lisa Lindsay, Office Manager

10/06/2011 06:06 PM Eastern Daylight Time



2.4.10 Family Planning and Sexually Transmitted Disease (STD) Treatment Providers: The health plan shall include Title X and STD providers in its provider network to serve members covered under the comprehensive and extended family planning, women's reproductive health, and sexually transmitted diseases benefit packages. The health plan 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 health plan shall allow for full freedom of choice for the provision of these services. A listing of Family Planning and STD treatment providers is provided in Attachment 5.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.10.

Title X and STD Providers in Our Provider Network

Partnering with Title X and STD clinics and agencies since 1995, we have long recognized the important role played by providers of reproductive health care and education. Making these services available and accessible to all—with particular concern for disadvantaged and underserved groups—these providers are part of the core of HealthCare USA's approach of increasing access to family planning and related health services for our membership. Figure 2- 6 illustrates HealthCare USA's contracts with 8 of the 9 Family Planning and STD clinics listed in Attachment 5 of this RFP.

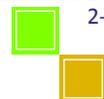
Additional Choices

Given our longevity in the market, HealthCare USA further recognizes that the traditional patterns of care for receiving Title X services extend beyond the Family Planning and STD clinics listed in Attachment 5. To ensure our members have access to these vital services we have also contracted with 31 additional Missouri Title X providers in the MO HealthNet Managed Care service area that are listed in the Missouri Family Health Council Directory to provide our members with choice.

2.4.11 Local Public Health Agencies: The health plan shall include local public health agencies in its provider network for the public health agency services described herein and for other services. (A listing of local public health agencies is provided in Attachment 5.) The health plan shall 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. The health plan shall comply with requirements for reimbursement for certain services provided by local public health agencies as specified herein. The health plan shall comply with all statutorily mandated disease and condition reporting requirements, regardless of the site of the service. Attachment 4 lists the conditions for which the health plan shall report to or cooperate with local public health agencies.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.11. We have long included local public health agencies in our statewide network, recognizing the integral role they play in improving the health of Missourians. They provide invaluable services such as:

- Lead testing





- VFC immunizations
- Controlling communicable diseases
- Increasing public awareness of chronic health conditions that affect Missourians

Collaborating with many of these local public health departments is an essential part of our case and disease management programs.

We have partnered with local public health agencies since 1995. We have 55 contracted in all counties; with 51 located in the MO HealthNet service area and 4 outside the service area.

Figure 2-6 lists, by region, the number of local public health agencies with whom HealthCare USA holds a contract.

2.4.12 Network Changes:

- a. The health plan shall notify the state agency within five (5) business days of first awareness/notification of changes to the composition of the health plan provider network or the health care service subcontractors' provider network that materially affect the health plan's ability to make available all covered services in a timely manner. At a minimum, this means the health plan shall notify the state agency when there is:
 1. A decrease in the total number of primary care providers by more than five percent (5%);
 2. A loss of providers that will result in the health plan failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095;
 3. A loss of any hospital regardless of whether the loss will result in the health plan failing to meet the service accessibility standards defined herein and in 20 CSR 400-7.095; or
 4. Any other adverse change to the composition of the provider network which impairs or denies the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity
- b. If a primary care provider ceases participation in the health plan's provider network, the health plan shall send written notices to the members who have chosen or are assigned to that provider as their primary care provider. The health plan shall mail this notice, with information about how to select a new primary care provider, at least thirty (30) calendar days prior to the effective date of the termination and no more than fifteen (15) calendar days after receipt or issuance of the termination notice.
- c. If a member is in a prior-authorized, ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services, the health plan shall notify the member in writing within fifteen (15) calendar days from the date the health plan becomes aware of such unavailability.
- d. The requirements to provide notice prior to the effective dates of termination shall be waived in instances where a provider (1) becomes physically unable to care for members due to illness, (2) dies, (3) relocates outside of the region, (4) fails to notify the health plan, or (5) fails credentialing. Under these circumstances, the health plan shall issue the notice immediately upon becoming aware of the circumstances.
- e. The health plan shall have procedures to address changes in its provider network that negatively affect the ability of members to access services, including access to a culturally diverse provider network. Material changes in network composition that negatively affect member access to services may be grounds for contract cancellation or State determined sanctions.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.12(a-e).

HealthCare USA's policy PS-30 *Network Changes Notification to the State* and a streamlined processes that are compliant with this provision on timely notification to the state agency and



members regarding network provider changes that could affect providing adequate access to a full range of in-network providers. Our subcontractor networks for vision and dental and our affiliates network for behavioral health, we have established similar processes to comply with this notification requirement.

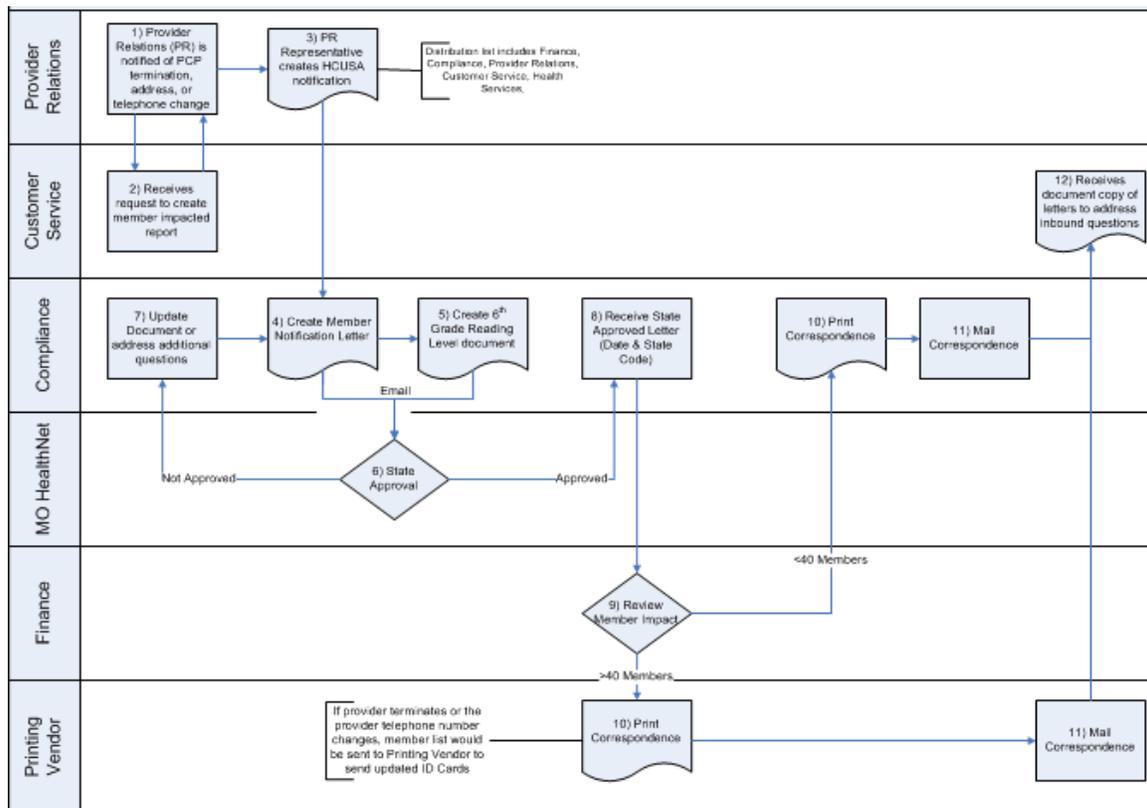
Process Outline

When HealthCare USA is notified of a PCP termination, our provider relations team initiates the established workflow to:

- Notify applicable inter-company departments
- Initiate process to seek MO HealthNet approval on member notifications
- Send state-approved written communication to affected members
- Identify any members with transition of care issues and the issue new id cards (in the case of primary care provider terminations)

In addition, if a PCP changes location or phone number, HealthCare USA notifies members and issues a new ID card so our members can stay connected with their health care home. Figure 2-10 illustrates our process.

Figure 2- 10: PCP Termination, Address Change, or Telephone Change Process





2.4.13 Mainstreaming: The state agency considers mainstreaming of MO HealthNet Managed Care members into the broader health delivery system to be important. The health plan therefore shall ensure that all of the in-network providers accept members for treatment and that in-network providers do not intentionally segregate members in any way from other persons receiving services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.13.

2.4.13a. To ensure mainstreaming of members, the health plan shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

1. Denying or not providing to a member any covered service or availability of a facility;
 2. Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large; and
 3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.13 (a).

We have several processes in place supporting the MO HealthNet's position on mainstreaming to ensure members are treated fairly and provided the same level of access and services as any other members.

The *HealthCare USA Provider Manual* outlines requirements to provide the same level of care and access to members for covered services that providers give other members. These are explained in several sections of the *Healthcare USA Provider Manual*, pp. 5, 10, 15-16, 66-67.

2.4.13b. If the health plan knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract are more restrictive than the contract), the State shall consider the health plan to have breached the provisions and requirements of the contract. In addition, if the health plan becomes aware of any of the health plan's existing subcontractors' failure to comply with this section and does not take action to correct such within thirty (30) calendar days, the State shall consider the health plan to have breached the provisions and requirements of the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.13 (b).

Should we would become aware that any of our providers, subcontractors or affiliate have violated of these provisions, we immediately correct the situation, up to and including termination. HealthCare USA does not and will not hold any contracts with any providers, subcontractors or affiliates with provisions that allow, or with any intent to, implement barriers



to care or where the terms of the subcontract are more restrictive than our current contract with MO HealthNet.

2.4.14 Home Health Agencies: The health plan shall comply with any applicable Federal requirements with respect to home health agencies, as amended.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.14.

2.4.15 School Based Dental Services: The health plan 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. The health plan shall ensure that dental providers who participate in the health plan's provider network are qualified under the credentialing criteria of the health plan and are willing to accept the health plan's operating terms, including but not limited to, the health plan's fee schedule, covered expenses, and quality standards. Nothing shall prevent a health plan from instituting reasonable credentialing criteria for school-based dental services or establishing other reasonable measures designed to maintain quality of care or control costs.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.15.

Our dental subcontractor, DentaQuest, provides preventive dental services in school-based settings, contracting with and reimbursing licensed dental providers who perform services in a school setting.

HealthCare USA delegates dental provider credentialing to DentaQuest, who credentials and recredentials dental providers in compliance with Section 2.18.8(c) – Provider Credentialing and HealthCare USA policy CRED-II *Delegated Credentialing*. To ensure DentaQuest dental provider credentialing and recredentialing is in compliance with all state requirements, HealthCare USA monitors DentaQuest based on the oversight process described in HealthCare USA policy CRED-II *Delegated Credentialing*

The decision to delegate the credentialing responsibility is solely at the discretion of HealthCare USA, and we have the final authority to approve and terminate any practitioner from a delegate's network. The subcontractor agreement between HealthCare USA and DentaQuest includes the provisions of this section to ensure compliance with Section 2.4.15.

2.4.16 The decision to delegate the credentialing responsibility is solely at the discretion of HealthCare USA, and we have the final authority to approve and terminate any practitioner from a delegate's network. The subcontractor agreement between HealthCare USA and DentaQuest includes the provisions of this section to ensure compliance with Section 2.4.15. HealthCare USA Community Development staff use their local relationships to work with the providers and local school districts to facilitate greater access to school-based dental services for MO HealthNet enrollees. 2.4.16 Tertiary Care: Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists. These services frequently require complex technological and support facilities. The health plan shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the region. If the health plan does not have a full range of tertiary care services, the health plan shall



have a process for providing such services including transfer protocols and arrangements with out-of-network providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.16.

The State of Missouri is home to nationally-recognized tertiary hospitals. HealthCare USA contracts with, and is proud to offer HealthCare USA members, access to the highest quality of care provided at the tertiary hospitals located within the managed care service area. Whether they live within walking distance of a facility or in the farthest corners of the rural counties, by providing transportation to these hospitals HealthCare USA provides our members access to tertiary hospitals. Figure 2- 11 shows the tertiary hospitals located within our managed care service area.

Figure 2- 11—Tertiary Hospitals Located Within Healthcare USA’s Managed Care Service Area, by region lists all HealthCare USA participating tertiary care hospital facilities available and accessible to members.

Figure 2- 11: Tertiary Hospitals Located Within Healthcare USA’s Managed Care Service Area, by Region

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TABLE SOURCE: MARCH 2011 DIFP FILING

In addition, our contracted facilities are staffed with all necessary medical subspecialty providers to provide all necessary tertiary care services 24 hours a day. HealthCare USA has agreements with the following university-affiliated physician groups that provide care at these tertiary care hospital facilities, NICUs, trauma centers, burn centers and rehabilitation facilities.

Figure 2- 12: Participating University-Affiliated Physician Groups

Western Region	Central Region	Eastern Region
<ul style="list-style-type: none"> University Physician Associates Children’s Mercy Physicians 	<ul style="list-style-type: none"> University of Missouri Physicians 	<ul style="list-style-type: none"> Washington University School of Medicine SLUCare Physicians

HealthCare USA also maintains and monitors the participating provider network in accordance with DIFP network adequacy criteria. We are in compliance with these tertiary care requirements and maintains a full-range of tertiary care providers in all three regions.

HealthCare USA also understands the importance of providing primary, secondary and tertiary levels of care at hospitals that are out-of-area (“out-of-network”). If a member requires specialty care from a tertiary hospital that cannot be provided by Missouri-based tertiary hospital, HealthCare USA has written protocols for allowing members to obtain tertiary level services out of network. HealthCare USA manages these cases whether care is provided in Missouri or outside the state.



On an emergent basis, HealthCare USA members do not need to obtain authorization for care at a non-participating facility. After members are stabilized, HealthCare USA employs established transfer protocols or makes arrangements with the non-participating hospital in order to address member health care needs at no cost to the member.



Children's Hospital of Boston has been used for a case of complex esophagus and fistula repair. HealthCare USA has also authorized ongoing follow-up care at the Children's Hospital of Pittsburgh for post-transplant services when the services were not available in Missouri. Our case management nurses and a medical director coordinate services to ensure members receive all medically necessary covered services in a timely manner, including post-hospitalization care and follow-up.

2.4.17 Specialty Pediatric Hospitals: The health plan shall include specialty pediatric hospitals as defined in 13 CSR 70-15.010 (2) (P), as amended, in its provider network.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.4.17.

Ranken Jordan, the only specialty pediatric hospital in the State of Missouri as defined in 13 CSR 70-15.010 (2) (P) has been a participating provider with HealthCare USA since 1998.

2.5 Service Accessibility Standards

2.5.1 Twenty-Four Hour Coverage:

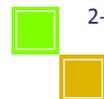
- a. The health plan shall ensure that emergency medical/behavioral health services are available twenty-four (24) hours seven (7) days per week to treat an emergency medical condition.
 - b. The health plan shall provide an accommodation, if needed, to ensure all members equal access to twenty-four (24) hours per day health care coverage.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.1(a-b).

HealthCare USA members for emergent care and behavioral health can access care at **any hospital**, in network or out of network, 24 hours a day, seven days a week. To assist members, we have behavioral health and nurse toll-free lines.

We encourage providers to use their best judgment when referring patients to the emergency room, and we have not created any artificial barriers to members for accessing emergency medical services. We have developed a network of urgent care and convenience clinics across Missouri that treat urgent conditions, and our members also have access to a 24-hour Nurse Line that employs physician-directed protocols for assessing and triaging members.

HealthCare USA requires all medical and behavioral providers to be available to direct care for our members 24 hours a day, seven days a week for treating an emergency medical condition. HealthCare USA and our behavioral health affiliate conduct random surveys of providers to confirm their after-hours access meets our standards for 24-hour access to care.





- Providers are required to maintain telephone access for after-hours access to care
- Providers are required to provide direct access, use a call coverage service or utilize a nurse triage line
- Providers must refrain from directing members to call 9-1-1 as the only option for after-hours access

HealthCare USA Member Handbook, p. 41 explains for members how, in case of emergency, they can go to the nearest emergency room, in network or out.

2.5.2 Travel Distance- The health plan shall comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 as amended and in Attachment 14. For those providers not addressed under 20 CSR 400-7.095, the health plan shall ensure that members have access to those providers within thirty (30) miles, unless the health plan can demonstrate to the state agency that there is no such licensed provider within thirty (30) miles, in which case the health plan shall ensure members have access to those providers within sixty (60) miles. For those providers addressed under 20 CSR 400-7.095 but not applicable to the MO HealthNet Managed Care Program (e.g. chiropractors), the health plan shall not be held accountable for the travel distance standards for those providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.2.

Documentation of Travel Distance Standards

On March 1 of each year, HealthCare USA files an annual network access plan with DIFP as required by 20 CSR 400-7.095. The attached documentation from the DIFP shows that HealthCare USA complies with network capacity and travel distance standards for all provider types and specialties as required by 20 CSR 400-7.095. Specifically, this is evidenced by the first paragraph in the DIFP Network Adequacy Approval letter, dated June 6, 2011, indicating that the 2010 Network Access Plan for HealthCare USA was approved. See Attachment 3, DIFP Network Adequacy Approval Documentation.

As the DIFP documentation illustrates, our networks have achieved **100% compliance** with network capacity and travel distance standards.

Note: HealthCare USA submits a provider file to DIFP of our dental provider network for evaluation, (which is a MO HealthNet requirement and not actually a part of the DIFP regulation) Because distance standards do not exist in the DIFP regulation for Dental providers, the following standards are used to evaluate the dental network:

- Urban county: 15 miles
- Basic county: 30 miles
- Rural county: 60 miles

Attachment 3 further illustrates, DIFP has also evaluated our dental network and we have achieved **100% compliance** for dental network capacity and travel distance standards.



2.5.3 Appointment Standards:

- a. The health plan shall ensure that waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments do not exceed one hour from the scheduled appointment time.
- b. In accordance with State requirements specified at 20 CSR 400-7.095, Exhibit A, the health plan shall adhere to appointment standards for all provider types. The health plan shall have in its network the capacity to ensure that the time elapsed between the request for appointments and the scheduled appointments does not exceed the following:
 1. Urgent care appointments for illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services): Appointments within twenty-four (24) hours.
 2. Routine care with symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): Appointments within one (1) week or five (5) business days whichever is earlier.
 3. Routine care without symptoms (e.g. well child exams, routine physical exams): Appointments within thirty (30) calendar days.
 4. Behavioral health and substance abuse services: Aftercare appointments within seven (7) calendar days after hospital discharge.
- c. For maternity care, the health plan shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:
 1. First trimester appointments must be available within seven (7) calendar days of first request.
 2. Second trimester appointments must be available within seven (7) calendar days of first request.
 3. Third trimester appointments must be available within three (3) calendar days of first request.
 4. Appointments for high risk pregnancies must be available within three (3) calendar days of identification of high risk to the health plan or maternity care provider, or immediately if an emergency exists.
- d. The health plan shall have policies and procedures in accordance with these appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The health plan shall disseminate these appointment standard policies and procedures to its in-network providers and to its members. The health plan shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.3(a-d).

Appointment standards are published in the *HealthCare USA Member Handbook* and *HealthCare USA Provider Manual*, p. 17, reviewed with providers during orientations and routine provider visits and sent at least annually via the Provider Newsletter.

HealthCare USA monitors our directly contracted providers and subcontractors and affiliate to ensure compliance with these standards. All providers who do not meet standards are educated and re-surveyed within three months of the initial survey to ensure compliance with appointment standards.

On a quarterly basis our Appeal and Grievance department reviews and analyzes member grievances to identify potential access and availability issues, including appointment times, for root cause analysis and intervention opportunities. Provider-specific corrective action plans are implemented as necessary.

Additional information can be found in our response to Section 2.4.1(c) and Section 4.5.4(a)2 and 4.5.4(b)4.



2.5.4 Access Plan: In accordance with State requirements specified at 20 CSR 400-7.095, the health plan shall file an annual (March 1 of each year) access plan with the Department of Insurance, Financial Institutions and Professional Registration that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.4. Each year HealthCare USA files an Network Access Plan with the Department of Insurance, Financial Institutions and Professional Registration. HealthCare USA reviews the adequacy of the provider network by county by specialty to assure adherence to the access standards and address any potential access issues.

2.5.5 Prior Authorization:
a. The health plan is prohibited from requiring prior authorization for emergency medical/behavioral health or substance abuse services as defined herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5(a).

As documented in the *HealthCare USA Member Handbook*, p. 56, and *HealthCare USA Provider Manual*, p. 37, HealthCare USA continues to not require prior authorization for emergency medical/behavioral health or substance abuse services.

2.5.5b. The health plan shall specify, in writing, the procedures for prior authorization of non-emergency services and the timeframes in which authorizations will be processed (approved or denied) and providers and members are notified.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5(b).

HealthCare USA documents its procedures for prior authorization of non-emergency services and the timeframes in which authorizations are processed and providers and members notified in the following:

- *HealthCare USA Provider Manual*, pp. 42-43
 - *HealthCare USA Member Handbook*, pp. 54-57
 - HealthCare USA policy HS-27 *Requests for Authorization*
 - HealthCare USA policy HS-92 *Timeliness of Decision Making and Notification*,.
-

2.5.5c. If the health plan requires a referral, assessment, or other requirement prior to the member accessing requested medical, behavioral health, or substance abuse services, such requirements shall not be an impediment to the timely delivery of the medically necessary service. The health plan shall assist the member to make any necessary arrangements to fulfill such requirements





(e.g. scheduling appointments, providing comprehensive lists of available providers, etc). If such arrangements cannot be made timely, the requested services shall be approved.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5(c).

As documented in HealthCare USA's policy HS-27 *Request for Authorization* the prior authorization process does not impede timely delivery of medically necessary services. HealthCare USA assists members in making necessary arrangements to fulfill these requirements. If these arrangements cannot be made timely, HealthCare USA approves the request.

2.5.5d. The health plan shall have and implement prior authorization policies and procedures that meet the following minimum requirements:

1. All appeals and denials must be reviewed by a professional with experience or expertise comparable to the provider requesting the authorization.
 2. 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.
 3. Reasons for decisions are clearly documented and assigned a prior authorization number which refers to and documents approvals and denials.
 4. Documentation shall be maintained on any alternative service(s) approved in lieu of the original request.
 5. There is a well-publicized review process for both providers and members.
 6. The review process is completed and communicated to the provider in a timely manner, as indicated below, or the denials shall be deemed approved. For the purpose of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.
- Approval or denial of non-emergency services, when determined as such by emergency room staff, shall be provided by the health plan within thirty (30) minutes of request.
 - Approval or denial shall be provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider.
 - Approval or denial shall be provided within two (2) business days of obtaining all necessary information for routine services. The health plan shall notify the requesting provider within two business days following the receipt of the request of service regarding any additional information necessary to make a determination. In no case shall a health plan exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial.
 - Involuntary detentions (ninety-six (96) hour detentions or court ordered detentions) or commitments shall not be prior authorized for any inpatient days while the order of detention or commitment is in effect.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5(d).

HealthCare USA's policy HS-27 *Request for Authorization* outlines the following minimum requirements:



- All appeals and denials are reviewed by a professional with experience or expertise comparable to the provider requesting the authorization.
- 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. HealthCare USA uses nationally-established InterQual® criteria, Coventry technology assessments, internally-developed guidelines and contractually-developed guidelines to make review determinations.
- Reasons for decisions are clearly documented and assigned a prior authorization number which refers to and documents approvals and denials.
- Documentation is maintained on any alternative service approved in lieu of the original request.
- There is a well-publicized review process for both members and providers. This is documented in the *HealthCare USA Member Handbook*, pp.54-57, and *HealthCare USA Provider Manual*, pp.42-43.

HealthCare USA's timeframes for certification review (concurrent review) are compliant with both the state agency and NCQA. Timeframes for authorization determinations and notification to providers and members are housed in HealthCare USA's policy HS-92 *Timeliness of Decision Making and Notification*. (See Figure 2- 13 below.) HealthCare USA provides approval or denial of non-emergency services, when determined as such by an ED staff, within 30 minutes of the request. HealthCare USA determinations never exceed 14 calendar days following the receipt of the request of service.

Involuntary detentions or commitments are not prior-authorized for any inpatient days while the order detention or commitment is in effect.

2.5.5e. The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5(e).

HealthCare USA's prior authorization process, as documented in policy HS-27 *Request for Authorization*, ensures that members are not without necessary medical supplies, oxygen, nutrition, etc. A interim supply of an item is approved if necessary.

2.5.5f. The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5(f).



As documented in HealthCare USA's policy HS-27 *Request for Authorization*, HealthCare USA ensures that member's treatment regimens are not interrupted or delayed by the prior authorization process.

2.5.5g. The health plan 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 (6) months of approval, even if the member's enrollment in the health plan ends.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5.g.

HealthCare USA is responsible for payment of custom items, as documented in policy HS-27 *Request for Authorization*.

2.5.5h. If the health plan prior authorizes health care services, the health plan shall not subsequently retract its authorization after the services have been provided, or reduce payment for an item or service unless:

1. The authorization is based on material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
2. The health plan's contract terminates before the health care services are provided; or
3. The covered person's coverage under the health plan terminates before the health care services are provided.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5(h).

HealthCare USA policy HS-27 *Request for Authorization* documents how we authorize services and conditions for retracting authorization.

2.5.5i. The health plan shall not deny physician requested continuing coverage of an inpatient hospital stay unless an alternative service is recommended by the health plan and such alternative care is available and has been scheduled within seven (7) days of discharge and is appropriate to meet the medical needs of the member.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.5(i).

HealthCare USA policy HS-79 *Certification Review*, documents our physician-requested continuing coverage.





2.5.6 Certification Review

- a. The health plan shall have written policies and procedures that specify the steps for obtaining initial, concurrent, and retrospective reviews for inpatient admissions and the timeframes in which authorizations will be processed (approved or denied) and providers and members are notified. The health plan shall ensure that these policies and procedures meet the following minimum requirements:
 1. A professional with experience or expertise comparable to the provider requesting the authorization reviews all appeals and denials.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6(a).1.

As documented in HealthCare USA's policy HS-79 *Certification Review*, a professional with experience or expertise comparable to the provider requesting the authorization reviews all appeals and denials.

2.5.6a2. There are standard policies and procedures for inpatient hospital admissions, continued stay reviews, and retrospective reviews and for making determinations on certifications or extensions of stays based on sound medical evidence that is updated regularly and consistently applied and for consultations with the requesting provider when appropriate.

- For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, the health plan shall use the same criteria as MO HealthNet Fee-For-Service.
- For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, the health plan shall use LOCUS/CALOCUS. If the member scores less than an inpatient level of care on the LOCUS/CALOCUS but the services recommended are not available, the health plan shall continue to authorize inpatient care. In the event of disagreement, the health plan shall provide full detail of its scoring of the LOCUS/CALOCUS to the provider of service.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6(a).2.

As outlined in HealthCare USA's policy HS-28 *Medical Necessity Review Criteria* standard policies and procedures exist for making determinations on certification or extensions of stays based on sound medical evidence that is updated regularly and consistently applied and for consultations with the requesting provider when appropriate. HealthCare USA uses the following criteria:

- Nationally-established InterQual® criteria
- Coventry technology assessments
- Internally-developed guidelines
- Contractually-developed guidelines
 - For inpatient hospital admissions, continued stay reviews and retrospective reviews to specialty pediatric hospitals, the same criteria is used as MO HealthNet Fee-For-Service.



- For psychiatric inpatient hospital admissions, continued stay reviews and retrospective reviews, LOCUS/CALOCUS is used.

2.5.6a3. Reasons for decisions are clearly documented and assigned a certification number, which refers to and documents approvals and denials.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6(a)3.

HealthCare USA policy HS-79 *Certification Review* details our reason documentation for such decisions.

2.5.6a4. Documentation is maintained on any alternative service approved in lieu of the original request.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6.a.4.

HealthCare USA policy HS-79 *Certification Review* illustrates that HealthCare USA has and will continue to document any alternative service approved in lieu of an original request.

2.5.6a5. There are fair and unbiased policies and procedures for reconsideration requests when the attending physician, the hospital, or the member disagrees with the health plan's determination regarding inpatient hospital admission or continued stays.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6.a.5.

HealthCare USA policy HS-25 *Peer-to-Peer Review* establishes procedures for such reconsideration requests.

2.5.6a6. There are policies and procedures followed to address the failure or inability of a provider or a member to provide all necessary information for review. In cases where the provider or a member will not release necessary information, the health plan may deny certification of an admission.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6(a)6.

HealthCare USA has procedures to address the failure or inability of a provider or a member to provide all necessary information for review, as outlined in HealthCare USA Policy HS-78 *Administrative Denials*. If a provider or member will not release necessary information, HealthCare USA denies certification of the admission.





2.5.6a7. There is a well-publicized review process for both providers and members.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6(a)7.

For further details, see:

- *HealthCare USA Provider Manual*, pp. 42-43
- *HealthCare USA Member Handbook*, pp. 54-57

2.5.6a8. To the extent known, the health plan shall inform inpatient providers of the member's recent health care service history at the time of authorization of a psychiatric inpatient admission. Such information shall include psychiatric inpatient admissions and emergency room visits for the prior year, psychiatric outpatient services for the prior six (6) months, and medications for the prior ninety (90) calendar days. The date, diagnosis, provider, and procedure shall be provided for each episode of care. Services related to substance abuse or HIV disorders are exempt from this requirement. Claims history from CyberAccesssm may be used to fulfill this requirement.

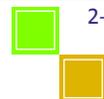
HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6(a)8.

HealthCare USA policy HS-79 *Certification Review* explains how HealthCare USA and MHNet work together to inform inpatient providers of the member's recent health care service history at the time of a psychiatric inpatient admission authorization.

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- 2.5.6b. The review process shall be completed and communicated to the provider and member in a timely manner, as indicated below or the denials shall be deemed approved. For the purpose of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.
1. Approval or denial for initial determinations shall be provided by the health plan within two (2) working days of obtaining all necessary information.
 2. Approval or denial for concurrent review determinations shall be provided by the health plan within one (1) working day of obtaining all necessary information.
 3. Approval or denial for retrospective review determinations shall be provided by the health plan within thirty (30) working days of receiving all necessary information.
 4. The health plan shall notify the requesting provider within two (2) working days following the receipt of the request of service regarding any additional information necessary to make a determination.
 5. In no case shall a health plan exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial for an initial or concurrent review.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.6(b).

HealthCare USA's timeframes for certification review (concurrent review) are compliant with both the state agency and NCQA. Timeframes for authorization determinations and notification to providers and members are housed in HealthCare USA's policy HS-92 *Timeliness of Decision*





Making and Notification. Determinations that are not made and communicated in a timely manner are deemed approved.

Figure 2- 13: HealthCare USA’s Determination and Notification Timeframes – Concurrent Review

Item	Decision Timeframe	Oral Notification	Written Notification of Adverse Determination
Concurrent Review (initial and continued stay)	24 hours of receipt of request	24 hours of receipt of request	1 business day
Post-service (Retrospective)	30 calendar days of receipt of request	30 calendar days of receipt of request	1 business day

Requests for additional information are made within two business days following the receipt of the request of service regarding any additional information necessary to make a determination. HealthCare USA determinations never exceed 14 calendar days following the receipt of the request of service.

2.5.7 Behavioral Health and Substance Abuse In-Network Self Referrals: The health plan shall have written policies and procedures that permit members to seek in-network behavioral health services and substance abuse services without a referral or authorization from the primary care provider. The policies and procedures shall permit members to contact an in-network behavioral health and substance abuse provider directly and shall provide for the authorization of at least four (4) visits annually without prior authorization requirements. The health plan shall require that the health plan’s behavioral health and substance abuse providers to complete a health status screen, at the initial point of contact and as part of the re-assessment process for members in treatment. The health plan shall require the health plan’s behavioral health and substance abuse providers to refer members with physical health conditions (as indicated by the screen) to their primary care provider for evaluation and treatment of the physical health condition.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.7. As documented by MHNNet policy 4.1.1 *Self-Referrals for Outpatient Assessment and Initiation of Treatment*, members can seek in-network behavioral health services and substance abuse services without a referral or authorization from a PCP. This is supported in our MHNNet contract under “Recitals” and in HealthCare USA Policy HS-91 *Direct Access and Standing Referrals*.



2.5.8 Direct Access and Standing Referrals:

- a. The health plan 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:
 1. A referral to an out-of-network provider when the health plan 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;
 2. A standing referral from a specialist if the member has a condition which requires on-going care from a specialist; and
 3. Access to a specialty care center if the member has a life-threatening condition or disease either of which requires specialized medical care over a prolonged period of time.
 - b. In accordance with State law, the health plan shall allow members direct access to the services of the in-network OB/GYN of their choice for the provision of covered services.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.8.

As indicated in HealthCare USA policy HS-91 *Direct Access and Standing Referral* we continue to provide direct access and standing referrals. A request for a standing referral is authorized when the request is for medically necessary treatment of any of the following conditions:

- Special health care needs.
- Chronic health condition.
- Life threatening, degenerative, or disabling condition.
- Major organ transplant.
- Any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

HealthCare USA authorizes referrals to out-of-network providers when there is not an in-network provider with appropriate training or experience to meet the health care needs of the member.

HealthCare USA allows members direct access to the services of an in-network OB/GYN provider of their choice.

2.5.9 Transition of Care: Regarding transition of care for newly enrolled members transitioning to the health plan from fee-for-service or another health plan and for members transitioning out of the health plan to another health plan or to fee-for-service, the health plan shall, at a minimum, carry out the following responsibilities:

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9.

HealthCare USA's policy HS-34 *Transition of Medical Services*, supports the transferring of information from one health plan to another for newly enrolled members transitioning to HealthCare USA from fee-for-service or another health plan and for members transitioning out of HealthCare USA to another health plan or to fee-for-service. HealthCare USA recognizes that the transition from one health plan to another is a critical time for many members. They frequently need assistance in accessing the health care system when there is a change.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- 2.5.9a. Provide for the transfer of relevant member information, including medical records and other pertinent materials, to another health plan such that the transition of care shall be smooth. Upon contract award, the health plan shall provide the state agency with a contact person for transition of care information.
1. If a member enrolls with the health plan from another health plan, the health plan shall, within five (5) business days from the date of the state agency’s notification to the health plan of the member’s anticipated enrollment date, contact the member to determine the name of the other health plan in order to request relevant member information from the other health plan.
 2. If the health plan is contacted by a member’s new health plan requesting relevant member information, the health plan shall provide such data to the health plan within five (5) business days of receiving the request.
 3. If the health plan becomes aware that a member will transfer to another health plan, the health plan shall contact the other health plan within five (5) business days of becoming aware of the member’s transfer and shall share relevant member information and respond to questions regarding the member’s care needs and services.
 4. If the health plan becomes aware that a member will transfer out of the MO HealthNet managed care program and into the MO HealthNet fee-for-service system, the health plan shall contact the state agency within five (5) business days of becoming aware of the member’s disenrollment to share relevant member information and to respond to questions regarding the member’s care needs and services.
 5. If the health plan changes subcontractors, the health plan shall ensure that relevant member information is transferred between the subcontractors within a timely manner prior to transitioning to the new subcontractor.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(a).

HealthCare USA policy provides for the transfer of relevant information, including medical records and other pertinent materials, to another health plan to ensure a smooth transition.

Figure 2- 14: Member Transfer Scenarios

Situation	Timeframe	HealthCare USA’s Action
Member transfers to HealthCare USA from another health plan	Five business days from notification	Contacts the member to determine what plan they transferred from. Contacts the previous health plan to obtain relevant member information.
HealthCare USA is contacted by a member’s new health plan	Five business days from the receipt of the request	Provides relevant member information to the member’s new health plan
HealthCare USA becomes aware of a member’s transfer to another plan	Five business days from notification	Contacts the new health plan to share relevant member information and responds to



Situation	Timeframe	HealthCare USA's Action
		questions regarding the member's care needs and services
HealthCare USA becomes aware of a member's transfer to MO HealthNet fee-for-service	Five business days from notification	Contacts the state agency to share relevant member information and responds to questions regarding the member's care needs and services

In the event HealthCare USA changes subcontractors, we will ensure that relevant member information is transferred between the subcontractors within a timely manner prior to transitioning to the new subcontractor.

2.5.9b. Work with an out-of-network provider and/or the previous health plan to effect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a medical health, behavioral health, or substance abuse provider that is not in the health plan's network. At a minimum, the health plan shall (1) facilitate in the securing of a member's records from the out-of-network providers as needed, and (2) pay rates comparable to fee-for-service for these records, unless otherwise negotiated.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(b).

As documented in HealthCare USA policy HS-34 *Transition of Medical Services* HealthCare USA works with out-of-network providers and/or the previous health plan to ensure a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a medical health, behavioral health or substance abuse provider that is a out-of-network provider. HealthCare USA also works at facilitating and securing the member's records from the out-of-network providers as needed and will pay rates comparable to that of MO HealthNet for these records unless otherwise negotiated.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- 2.5.9c. Facilitate continuity of care for medically necessary covered services. In the event a member entering the health plan is receiving medically necessary covered services, in addition to or other than prenatal services (see below for members in their third trimester receiving prenatal services), the day before enrollment into the health plan, the health plan shall be responsible for the costs of continuation of such medically necessary services, without any form of prior approval and without regard to whether such services are being provided by in-network or out-of-network providers.
1. The health plan shall provide continuation of such services for the lesser of (1) ninety (90) calendar days, or (2) until the member has transferred, without disruption of care, to an in-network provider.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2. For members eligible for case management, the new health plan shall provide continuation of services authorized by the prior health plan for up to thirty (30) calendar days after the member's enrollment in the new health plan and shall not reduce services until an assessment is conducted by the new health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(c).

HealthCare USA policy HS-34 *Transition of Medical Services* supports facilitation of continuity of care for medically necessary covered services. Members receiving medically necessary covered services on the day before enrollment into HealthCare USA continue to receive those services with HealthCare USA without any form of prior approval and without regard to where such services are being provided by participating providers or out-of-network providers until one of the following:

- The lessor of 90 calendar days
- The member has transferred, without disruption in care, to a participating provider

Members receiving case management will continue to receive services for at least 30 calendar days after the member's enrollment and will not have services reduced until an assessment is conducted by HealthCare USA.

- 2.5.9d. Ensure that any member entering the health plan is held harmless by the provider for the costs of medically necessary covered services except for applicable MO HealthNet cost sharing.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(d).

As documented by HealthCare USA policy HS-34 *Transition of Medical Services* any member entering the health plan is held harmless by the provider of the costs of medically necessary covered services except for applicable MO HealthNet cost sharing.



2.5.9e. Allow non-pregnant members receiving a physician authorized course of treatment to continue to receive such treatment, without any form of prior approval and without regard to whether such services are being provided by in-network or out-of-network providers for the lesser of sixty (60) days or until the member has been seen by the assigned primary care provider who has authorized a course of treatment.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(e).

HealthCare USA's long standing practice and policy HS-34 *Transition of Medical Services* support non-pregnant members receiving a physician authorized course of treatment to continue to receive such treatment, without any form of prior approval and without regard to whether such services are being provided by in-network or out-of-network providers for the lesser of 60 days or until the member has been seen by the assigned primary care provider (PCP) who has authorized a course of treatment.

2.5.9f. 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) through the postpartum period (defined as sixty (60) days from date of birth).

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(f).

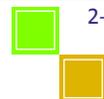
HealthCare USA's long standing practice and policy HS-34 *Transition of Medical Services* allow female members in their third trimester of pregnancy to continue to receive services, through the postpartum period (defined as 60 days from date of birth) from their prenatal care provider, even if the provider is out-of-network.

2.5.9g. Allow pregnant members to continue to receive services from their behavioral health and/or substance abuse treatment provider until the birth of the child, the cessation of pregnancy, or loss of eligibility.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(g).

HealthCare USA's long standing practice and policy HS-34 *Transition of Medical Services* allow pregnant members to continue to receive services from their behavioral health and/or substance abuse treatment provider until:

- The birth of the child
 - Cessation of pregnancy
 - Loss of eligibility
-





2.5.9h. Ensure that inpatient and residential treatment days are not prior authorized during transition of care.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(h).

HealthCare USA’s long standing practice and policy HS-34 *Transition of Medical Services* continue to ensure that inpatient and residential treatment days are not prior authorized during transition of care.

2.5.9i. Have written policies and procedures that address all transition of care requirements herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.5.9(i).

As outlined in HealthCare USA policy HS-34 *Transition of Medical Services* we will provide for the transfer of relevant member information, including medical records and other pertinent materials, to another health plan such that the transition of care shall be unencumbered.

2.6 Payments to Providers [4.4.9]

2.6.1 The health plan shall negotiate mutually acceptable payment rates and payment timeframes with providers so long as those rates and timeframes are in compliance with the requirements in RSMo 376.383 and RSMo 376.384, as amended. Regardless of the specific arrangements the health plan makes with providers, the health plan shall make timely payments to both in-network and out-of-network providers, subject to the conditions described below.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.1.

In addition to rates, HealthCare USA’s participating provider agreements require us to pay clean claims timely in accordance with the applicable Missouri Prompt Payment law. The participating provider agreements contain the same definition of a “clean claim” as required by law in the State of Missouri. We apply the State of Missouri prompt payment requirements to all in-network and out-of-network provider claims payments, resulting in 94% of claims paid within 15 days.

2.6.2 All disputes between the health plan and in-network and out-of-network providers shall be solely between such providers and the health plan. In the case of any disputes regarding payment for covered services between the health plan and providers, the member shall not be charged for any of the disputed costs except as allowed for below.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.2.

HealthCare USA’s participating provider agreements clearly state that members are to be held harmless for any disputed costs that are not associated with the applicable cost-sharing amounts for which members may be held responsible pursuant to the MO HealthNet benefit





plan. We also include this requirement in all letters of agreement with out-of-network providers to further ensure that our members are not improperly billed.

- 2.6.3 In accordance with 13 CSR 70-4.0301, the health plan shall ensure that providers accept payment from the health plan as payment in full (no balance billing) and not collect payment from members except for:
 - a. Applicable MO HealthNet cost sharing amounts; and

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- b. When services are not in the comprehensive benefit package and, prior to providing the services, the provider informed the member that the services were not covered. The provider shall inform the member of the non-covered service and have the member acknowledge the information. If the member still requests the service, the provider shall obtain such acknowledgement in writing (private pay agreement) prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills the health plan for the service that has been provided, the prior arrangement with the member becomes null and void. The health plan shall reference the contract provisions regarding payment to out-of-network providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.3(a-b).

HealthCare USA's participating provider agreements clearly state that providers shall accept payment from HealthCare USA only as payment in full for services rendered to HealthCare USA members. Providers are prohibited from collecting payment from members except for applicable cost-sharing amounts and in situations where a member has entered into a written private pay agreement with the provider that explicitly states the service is not a covered benefit. HealthCare USA also includes this requirement in all letters of agreement we enters into with out-of-network providers to further ensure that members are not improperly billed.

- 2.6.4 **Retroactive Eligibility Period:** Except for newborns, the health plan shall not be responsible for any payments owed to providers for services rendered prior to a member's enrollment with the health plan, even if the date of service fell within an established period of retroactive MO HealthNet eligibility.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.4.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2.6.5 Claims Processing Requirements: The claim processing requirements are set forth by RSMo 376.383 and RSMo 376.384, as amended. For the purposes of this contract, a clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.5. The participating provider agreements contain the same definition of a “clean claim” as required by law in the State of Missouri. HealthCare USA applies the State of Missouri prompt payment requirements to all in-network and out-of-network provider claims payments.

2.6.6 Payment Denials: If the health plan has a pattern of inappropriately denying or delaying payments for services, the health plan may be subject to suspension of new enrollments, withholding in full or in part the capitation payments, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where the state agency has ordered payment after appeal but to situations where no appeal has been made (i.e., the state agency is knowledgeable about the documented abuse from other sources).

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.6.





- 2.6.7 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): FQHCs and RHCs are entitled to reimbursement of reasonable costs from the state agency and any differential payment from the state agency.
- a. The health plan shall reimburse the FQHC/RHC at the same reimbursement level as other providers for the same services. The state agency shall perform reconciliation between the health plan reimbursement and the FQHC/RHC's reasonable costs for the covered services provided under the contract. The FQHC/RHC must fully comply with the state agency's payment and billing systems, and provide the state agency with all cost reporting information required by the state agency to verify reasonable costs and apply applicable reasonable cost reimbursement principles.
 - b. The health plan shall submit a list of its contracted FQHCs, RHCs, and CMHCs to the state agency annually at the start of each contract period. The report format is available in Exhibit A.
 - c. The health plan shall fulfill the following:
 1. Billing for Services provided by an FQHC or RHC: The FQHC/RHC must bill using a valid FQHC/RHC's NPI. The health plan shall include this NPI on FQHC/RHC claims as follows:
 - FQHC Medical and Dental Claims: The health plan shall submit the FQHC's NPI on the NSF layout, record 'FAO', within field number 23. This field is referenced as the Rendering Provider Number.
 - FQHC Home Health Claims: The health plan shall submit the FQHC's NPI on the UB92 layout, record '80', within field number 11. This field is referenced as the Other Provider.
 - RHC Claims: The health plan shall submit the RHC's NPI on the UB92 layout, record 80', within field number 11. This field is referenced as the Other Provider.
 2. The FQHC/RHC must bill its usual and customary amount for all payor classes. The health plan shall include the billed amount when the health plan submits the encounter claims to the state agency.
 - d. Health plan records applicable to a FQHC/RHC are subject to audit by the state agency or its contracted agent.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.7(a-d).

At the date of this submission, HealthCare USA has 193 contracted FQHC and RHC providers across Missouri at the same reimbursement levels as other providers.

- 2.6.8 Local Public Health Agencies: The health plan shall reimburse the local public health agency (both in-network and out-of-network) according to the most current MO HealthNet program fee schedule in effect at the time of service, unless otherwise negotiated.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.8.

At the date of this submission, HealthCare USA has contracts with 55 local public health agencies across Missouri. Our claims payment system reimburses both in-network and out-of-network local public health agencies at a rate no less than the current MO HealthNet program fee schedule at the time of service.



- 2.6.9 Payment for Emergency Services and Post-stabilization Care Services:
- a. The health plan shall cover and pay for emergency services regardless of whether the provider is an in-network or out-of-network provider.
 1. The state agency encourages the health plan and providers to reach agreement on payment for services.
 2. The health plan shall pay out-of-network providers for emergency services at the current MO HealthNet program rates in effect at the time of service.
 - b. The State and the health plan shall not reimburse for emergency services provided outside the United States.
 - c. The health plan shall not deny payment for treatment obtained under either of the following circumstances:
 1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition specified herein; or
 2. A representative of the health plan instructs the member to seek emergency services.
 - d. The health plan shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or the health plan of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.
 - e. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.
 - f. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan.
 - g. The health plan shall be financially responsible for post-stabilization care services, obtained within or outside the health plan, that are pre-approved by a health plan provider or other health plan representative.
 - h. The health plan shall be financially responsible for post-stabilization care services, obtained within or outside the health plan, that are not pre-approved by a health plan provider or other health plan representative, but are administered to maintain, improve, or resolve the member's stabilized condition if:
 1. The health plan does not respond to a request for pre-approval within thirty (30) minutes;
 2. The health plan cannot be contacted; or
 3. The health plan representative and the treating physician cannot reach an agreement concerning the member's care and a health plan physician is not available for consultation. In this situation, the health plan shall give the treating physician the opportunity to consult with a health plan physician and the treating physician may continue with care of the member until a health plan physician is reached or one of the criteria in the subparagraph below is met.
 4. The health plan's financial responsibility for post-stabilization care services which the health plan has not pre-approved ends when:
 - A health plan physician with privileges at the treating hospital assumes responsibility for the member's care;
 - A health plan physician assumes responsibility for the member's care through transfer;
 - A health plan representative and the treating physician reach an agreement concerning the member is transferred.
 5. The health plan shall limit charges to members for post-stabilization care services to an amount no greater than what the health plan would charge the member if he or she had obtained the services through the health plan.
 6. The health plan shall negotiate mutually acceptable payment rates with out-of-network providers for post-stabilization services for which the health plan has financial responsibility.



HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.9(a-g).

HealthCare USA policies PS-15 *Payment For Emergency Services to Out-of-Network Providers* and PS-46 *Access of Emergency Services* address the access and payment for Emergency Services that support compliance with Section 2.6.9.

As part of our comprehensive benefit package, we provide coverage and are financially responsible for emergency services, along with post-stabilization care services obtained at both in-network or out-of-network providers without prior authorization. Provisions related to compliance with this section are included in the HealthCare USA's participating provider agreements.

HealthCare USA pays for services furnished outside the service area to the same extent that we pay for services furnished within the service area if the services are furnished to a member and any of the following conditions are met:

- The member has an emergency medical condition, including cases in which the absence of immediate medical attention would have had the outcomes specified in the definition of emergency medical condition
- A HealthCare USA representative instructs the member to seek emergency services

If the services requested by an out-of-network provider are for emergency services to evaluate and/or stabilize an emergency medical condition

HealthCare USA reimburses the provider based on the current MO HealthNet program rates in effect at the time of service.

The attending physician actually treating a member determines when the member is sufficiently stabilized for transfer or discharge. This determination is binding on the part of HealthCare USA.

HealthCare USA is financially responsible for post-stabilization services obtained within or outside the network that are not pre-approved but administered to maintain, improve, or resolve the member's stabilized condition if:

- We do not respond to a request for pre-approval within 30 minutes
- We cannot be contacted
- A HealthCare USA representative and the treating physician cannot reach an agreement concerning the member's care and a HealthCare USA Medical Director is not available for consultation

HealthCare USA's financial responsibility for post-stabilization care services we have not pre-approved ends when:

- A HealthCare USA provider with privileges at the treating hospital assumes care
- A HealthCare USA provider assumes responsibility for the member's care through transfer
- A HealthCare USA representative and the treating physician reach an agreement concerning the member's care
- The member is transferred



HealthCare USA's policies and procedures address fully the access and payment for Emergency Services in full compliance with Section 2.6.9.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy PS-15 *Payment For Emergency Services to Out-of-Network Providers*
- HealthCare USA policy PS-46 *Access of Emergency Services*

For further details on Section 2.6.9, see Section 4.4.12.

2.6.10 Fee Schedule for Dental, Optical, and Physician Services: The Missouri 94th General Assembly approved a statutory change for the state agency to develop a four-year plan to achieve parity with Medicare reimbursement rates for physicians and approved a fee increase for the MO HealthNet dental and optical services. The statutory change affects MO HealthNet Managed Care health plans' reimbursement rates. Since the Missouri General Assembly appropriated funds expressly for the services required herein, the health plan shall pass fee increases to its providers commensurate with the Missouri General Assembly's intent. The health plan shall maintain the fee schedule for dental, optical, and physician services at no lower than the MO HealthNet Fee-For-Service fee schedule in effect at the time of service for the codes that had a fee effective date of July 1, 2007 or later in the programs described below. The MO HealthNet Online Fee-For-Service Fee Schedule is available electronically at the state agency's website: <http://www.dss.mo.gov/mhd/providers/pages/cptagree.htm>.

- a. The dental program includes examinations, evaluations, treatments, and preventive pediatric and adult dental health including but not limited to fluoride treatment, gingivectomy, pulp treatment, root canal therapy, sealants, x-rays, and children's orthodontia.
- b. The optical program provides eye examinations, serial tonometry, lenses and frames, a prosthetic eye, orthoptic and/or pleoptic training, and contact lenses.
- c. The physician program includes services provided by medical personnel in a physician's office, a hospital, an outpatient facility, or nursing home that include medical examinations, anesthesia services, surgery, radiology, transplants, psychiatry, dialysis, ophthalmology, otorhinolaryngology, cardiovascular, physical medicine, nervous system, digestive system, obesity, obstetrics, case management, diabetes self-management training, podiatry, and pathology.
- e. For calendar years 2013 and 2014, the MO HealthNet Fee-For-Service Fee Schedule will reflect a payment increase for primary care services by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. The rate will be not less than one hundred percent (100%) of the payment rate that would apply to such services under Medicare Part B. For purposes of this Section, the term "primary care services" is defined as provided in Section 1902(jj) of the Act.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.10(a-c).

We ensure that our subcontracted vendors understand and comply with these requirements.

2.6.11 Specialty Pediatric Hospitals: The health plan shall reimburse specialty pediatric hospitals as defined in 13 CSR 70-15.010 (2) (P) at no lower than the MO HealthNet Fee-For-Service fee schedule in effect at the time of service unless otherwise negotiated with the provider.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.11.



HealthCare USA has a participating hospital agreement with specialty pediatric hospital Ranken Jordan, the only specialty pediatric hospital in the state of Missouri as defined in 13 CSR 70-15.010 (2) (P). Our participating hospital agreement with Ranken Jordan stipulates that HealthCare USA shall reimburse Ranken Jordan at 100% of the MO HealthNet Fee-For-Service fee schedule. If the MO HealthNet Fee-For-Service schedule for Ranken Jordan changes, we will adjust the rates to comply with Section 2.6.11.

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- 2.6.12 Services Outside Health Plan's Region: The health plan shall pay for services furnished outside its region to the same extent that it would pay for services furnished within its region if the services are furnished to a member and any of the following conditions are met:
- a. Medical services are needed because of an emergency medical condition;
 - b. Medical services are needed and the member's health would be endangered if he or she were required to travel to his or her residence; or
 - c. On the basis of medical advice, the health plan determines that the needed medical services, or necessary supplementary resources, are more readily available outside the region. These services are subject to the health plan's prior authorization and concurrent review process.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.12(a-c).

HealthCare USA has established written protocols, and policies and procedures, for the circumstances listed in Section 2.6.12(a-c) as stated in HealthCare USA policy PS-40 *Out-of-Network Providers – Claims Payment and Timely Filing*. These services are reviewed by case management nurses and authorized by a Missouri-licensed Medical Director to ensure members receive all medically necessary covered services in a timely manner, including post-hospitalization care and follow-up.



2.6.13 Physician Incentive Plan (PIP) Requirements:

- a. The health plan may establish physician incentive plans (PIP) pursuant to Federal and State regulations, including 42 CFR § 422.208, 422.210 and 438.6. The health plan shall require all subcontractors, including any health care services subcontractors, comply with all PIP regulations. The PIP regulations do not apply outside the scope of incentive plans for healthcare providers providing services to Medicare or MO HealthNet managed care members.
- b. The health plan shall not offer financial incentives to induce physicians to limit or reduce medically necessary services to a specific member. The health plan shall not offer non-financial incentives to limit or reduce medically necessary services to a specific member.
- c. A physician group is at "substantial" financial risk if more than twenty-five percent (25%) of its potential payment is at risk for services it does not provide.
- 1. If a physician group is at "substantial" financial risk, the health plan shall provide adequate protection to limit financial losses. The health plan has the option of: (1) retaining the risk in its direct provider contracts, or (2) the Managed Care Organization (MCO), intermediate entity, physician, or physician group can reinsure the risk through a reinsurance carrier. Stop-loss protection must cover at least ninety percent (90%) of the costs of referral amounts that exceed twenty-five percent (25%) of the total potential payment on either a per member, per year or an aggregate basis.
- 2. For the purposes of the PIP regulation, the term "physician" is defined as: Doctors of medicine, doctors of osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, and any limited practice provider that provides services on State authority to perform such services.
- d. If the health plan chooses to establish a PIP, the health plan shall submit the PIP to the state agency for approval prior to implementation. The information to be disclosed shall include the following:
 - 1. Effective date of the PIP;
 - 2. The type of incentive arrangement;
 - 3. The amount and type of stop-loss protection;
 - 4. The patient panel size;
 - 5. If the patient panel is pooled, a description of the method;
 - 6. The computations of significant financial risk; and
 - 7. Name, address, phone number, and other contact information for a person from the health plan who may be contacted with questions regarding the PIP.
- e. Annually, the health plan shall submit a disclosure statement to the state agency indicating whether or not there have been changes to its PIP arrangements. If no changes were made to PIP arrangements, the health plan shall submit a statement certifying that no changes were made.
- f. The health plan shall maintain all PIP reporting and disclosures in their files for review by the state agency upon request.
- g. In compliance with the Federal regulation, the health plan shall disclose to the members, upon request, whether the health plan uses a PIP, what type of PIP it uses, and whether stop-loss insurance is provided.
- h. The health plan shall notify the state agency within five (5) business days of any change to the health plan or the subcontractors' PIPs.

4.4.9 Physician Incentive Plans

The offeror shall provide a minimum of the following information regarding each of the offeror's PIPs and each of the proposed subcontractor's PIPs with their downstream providers (provider of the subcontractor), if the PIPs place the providers at significant financial risk. (2.6.13)

- a. Effective date of the PIP;
- b. The type of incentive arrangement;
- c. The amount and type of stop-loss protection;
- d. The patient panel size;
- e. If the patient panel is pooled, provide a description of the method;
- f. The computations of significant financial risk; and



- g. The name, address, telephone number, and other contact information for a person from the offeror's organization who may be contacted with questions regarding the PIP.

If the offeror has no PIPs with the health care service providers, the offeror shall confirm in the proposal that no such arrangements exist. If the offeror's subcontractors do not have any PIPs with their downstream providers, the offeror shall confirm in the proposal that no such arrangements exist and maintain documentation that demonstrates that no such arrangements exist.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.13(a-h) and 4.4.9(a-g).

Currently, neither HealthCare USA nor its subcontractors or affiliate utilize any physician incentive plans that place providers at significant financial risk. However, HealthCare USA recognizes the importance of partnering with physicians to align incentives to best promote quality of care and positive health outcomes. Therefore, any physician incentive plans adopted by HealthCare USA in the future will be based on quality and performance.

We are constantly assessing the characteristics of our network and member needs to develop and implement unique ways to reimburse providers to reward them for the comprehensive care they provide to our members. Over the past several months, HealthCare USA has been working closely with various physician groups to explore and develop mutually agreeable payment programs to drive quality and focus on disease management, HEDIS, outcomes measurement, and collection of encounter data that is complete and accurate. Our Medical Home model addresses each of these facets.

HealthCare USA's Medical Home model is based upon a shared savings approach. There is no "downside" for the provider, and no significant financial risk but, rather, qualifying providers can receive additional compensation above the amount specified in the contracted fee schedule, by achieving pre-defined performance measures, and assuming the medical loss ratio is within a specified corridor. We believe this model will best incentivize our providers to invest in the care and services they provide to our members.

Critical areas of performance include:

- Assistance with enrolling eligible members into HealthCare USA's disease management programs.
- Active collaboration in case management and interventions associated with case management enrollees.
- Delivery of clinical interventions that can help improve quality of care and clinical outcomes.
- Measurement of goals and outcomes by reviewing known deficits in HEDIS quality of care standards and known barriers to improving access and care.
- Increase in level of ease required to obtain required claims and encounter data.
- Measuring improvements in the outcomes appropriate to EPSDT measures.

Refer to Attachment 4 – Physician Incentive Plan Attestations in the Attachment Binder.



2.6.14 Electronic Health Record (EHR) Incentives: Contingent upon Centers for Medicare & Medicaid Services (CMS) approval, the state agency will implement incentive payments for “eligible professionals” who adopt, implement, upgrade, or meaningfully use certified electronic health record technology. For purposes of this section, “eligible professional” will have the definition set forth in Section 1903(t)(3)(B) of the Act. In general, eligible professionals are physicians, pediatricians, dentists, certified nurse midwives, nurse practitioners, and some physician’s assistants who meet a minimum Medicaid patient volume threshold. Incentive payment amounts shall be determined by Section 1903(t)(5) of the Act.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.6.14.

HealthCare USA supports Missouri providers who are interested in transitioning to Electronic Health Record (EHR) technology.

We believe providers using an EHR are better positioned to

- Maximize opportunities to address the unique needs of their patients
- Coordinate effective methods of treatment for their patient population in an efficient manner

EHR Education and Solutions

To increase provider awareness of

- EHR
- How to access Healthcare Stimulus funds available for conversion or upgrade of EHRs
- Provide current information on “meaningful use”

We offer our network providers education on these current topics.

In October 2010, we partnered with the League of HealthCare Experts, a Missouri-based educational consulting organization comprised of companies with special expertise in the healthcare industry who provide healthcare-specific solutions in areas such as finance, technology, legal compliance and strategy for providers. At each of our 11 statewide provider seminars, experts from this organization presented key information regarding the HITECH Act, meaningful use, and how Medicaid and Medicare providers could qualify for future funding for converting to qualified EHRs.

Almost 300 providers, representing practices all three regions, who attended gave us consistent feedback on the value of the information presented in these seminars covering the Healthcare Stimulus and what resources are available to Missouri providers.



2.6.15 Coverage of Preventive Health Services: The state agency is not required to pay for preventive health services that are the responsibility of a third party payer. Federal Law, Section 2713 of the Affordable Care Act requires non-grandfathered health plans to provide, at a minimum, coverage without cost-sharing for preventive services rated 'A' or 'B' by the U.S. Preventive Services Force (<http://www.uspreventiveservicestaskforce.org>), recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. Therefore, effective for dates of service on or after September 23, 2010, MO HealthNet will not pay third party liability (TPL) claims for these services.

HealthCare USA understands and shall comply with the requirements set forth in 2.6.15.

IDX, our claims processing system, enables cost-avoidance on all claims lines when a primary carrier is identified. HealthCare USA understands we are not responsible for services categorized as immunizations, preventative care for infants, children and adolescents, and additional preventative care and screenings for women for dates of service on and after September 23, 2010, when a third party payor is identified. However, as noted in Section 2.23.1 (c) HealthCare USA will not cost avoid the services referenced in Section 2.6.15, but will provide payment for the service, and then recover payment from the third party health insurance carrier ("pay and chase") Therefore, acting as an agent of the state agency, we will ensure compliance with this requirement.

HealthCare USA has a long-standing contract with HMS, which provides regular updates regarding validated primary carrier additions, changes and deletions. The primary carrier information is then updated in our system and any affected claims are addressed. Members or providers disagreeing with the primary source information we have on file request a re-verification through Member Services or Provider Services.

AMENDMENT 2 CORRECTED THE NUMBERING OF SECTION 2.7.

2.7 Comprehensive Benefit Package [4.5.2.b6]

2.7.1 The health plan shall provide all covered medical and behavioral health services in the comprehensive benefit package for each member as of the effective date of coverage. The health plan shall provide covered services under this contract in the United States, including the District of Columbia, the Northern Mariana Islands, American Samoa, Guam, Puerto Rico, and the Virgin Islands. The health plan is prohibited from providing payments for items or services provided under the contract to any financial institution or entity located outside the United States. The health plan shall provide services according to the medical and behavioral health needs of the member.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.1.



2.7.2 The health plan's services shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR 146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.2. HealthCare USA continues to ensure there is parity between mental health/substance abuse disorder benefits and medical/surgical condition benefits.

2.7.3 The health plan may manage specific services as long as the health plan provides services that are medically necessary. The health plan shall have a process for allowing exceptions that are in accordance with 13 CSR 70-2.100. The health plan may develop criteria by which it reviews future treatment options, sets prior authorization criteria, or exercises other administrative options for the health plan's administration of medical and behavioral health care benefits. The health plan may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The health plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The health plan shall follow the requirements outlined in the policy statements found in Attachment 3.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.3. HealthCare USA ensures that the comprehensive benefit package is properly administered through our utilization management processes in accordance with medical necessity. We have designed our medical management program to focus on the unique and diverse needs of the individual, and we:

- Have an exception process in accordance with 13 CSR 70-2.100
- Develop criteria to:
 - Review future treatment options
 - Set prior authorization criteria
 - Exercise other administrative options administering medical and behavioral health care benefits
- All internally- developed criteria are reviewed with the Quality Management Committee prior to implementation and at least annually thereafter.
- Place appropriate limits on services on the basis of criteria (such as medical necessity) or utilization control, as long as the services furnished can reasonably be expected to achieve their purpose
- Maintain amount, duration or scope of a required service and never arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition.
- Follow the MO HealthNet Policy Statements



2.7.4 Preventable Serious Adverse Events Performed by Providers: Services falling in a preventable serious adverse event category shall be denied MO HealthNet reimbursement. The state agency will be following CMS guidelines regarding preventable serious adverse events. A member shall not be liable for payment for any item or service related to a preventable serious adverse event.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.4.

Adherence to State and Federal Guidelines, Including CMS Guidelines

In over 15 years of work in the state of Missouri, HealthCare USA has followed—and will continue to follow—all State and Federal guidelines, including CMS guidelines, surrounding services falling in a preventable serious adverse event category.

Rigorous Provider Credentialing

HealthCare USA has a rigorous credentialing process for contracted providers. It includes verification of credential as well as inquiry and verification of licensing and restrictions on State and Federal data bases. Once credentialed HealthCare USA paid claims are routinely monitored by the corporate Special Investigation Unit (SIU). The SIU is highly trained focused to identify fraudulent activity or other aberrant practice in provision of services.

Investigation of Unusual or Adverse Outcomes

HealthCare USA medical management staff is encouraged to report any unusual or adverse outcomes to the health plan Quality Improvement Department for investigation. The Quality Improvement staff review the outcomes with the plan Medical Director. If appropriate, the event is sent to the Peer Review Committee, which is made up of community physicians, for review, scoring and action.

2.7.5 The health plan shall include the following services within the comprehensive benefit package:
a. Adult day health care services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5 (a).

2.7.5b. Ambulatory surgical center, birthing center;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5 (b).

Ambulatory surgical center services are available to members through our contracted network which offers surgical procedures that can be performed safely in a convenient and cost-effective outpatient setting.



We also offer the benefit of birthing centers to members, but currently have no contracted facilities in the network. Requests for services to be performed at a birthing center will be handled appropriately as out-of-network service.

2.7.5c. Behavioral health and substance abuse services:

1. For children covered under MO HealthNet Managed Care within Category of Aid 4 and with dual diagnoses (physical and behavioral/substance use-related), the health plan shall be financially responsible for all inpatient hospital days if the primary, secondary, or tertiary diagnosis is a combination of physical and behavioral/substance use-related health. These admissions are subject to the prior authorization and concurrent review process identified by the health plan. The health plan shall not be responsible for all other behavioral health and substance abuse services for children within Category of Aid 4.
2. For all other members, the health plan shall provide all medically necessary behavioral health and substance abuse services included in the comprehensive benefit package. The state agency, in conjunction with the Department of Mental Health, has developed community-based services with an emphasis on the least restrictive setting. The health plan shall consider, when appropriate, using such services in lieu of using an out-of-home placement setting for members. Services which the health plan shall provide shall include, but not be limited to:
 - Inpatient hospitalization, when provided by an acute hospital, or private or state psychiatric hospital.
 - Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, provisional licensed clinical social worker, licensed counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric nurse, or State certified behavioral health or substance abuse program. These services must include outreach efforts on an as needed basis that recognize the unique behavioral health challenges of some members. These efforts may include phone contacts and home visits.
 - Crisis intervention/access services, including but not limited to (1) intake, evaluation, and referral services, including services that are alternatives to out of the home placements, and (2) mobile crisis teams for on-site interventions.
 - Alternative services which are reasonable, cost effective, and related to the member's treatment plan.
 - Referral for screening to receive case management services.
3. With the member's or the member's parent/guardian's consent, the health plan shall notify the member's primary care provider when a member is admitted for behavioral health or substance abuse services.
4. The health plan shall have and implement protocols for coordinating the diagnosis, treatment, and care between primary care providers, behavioral health and substance abuse providers, and assigned case managers. These protocols shall include the expected response time for consults between primary care providers and behavioral health and substance abuse providers.
5. The health plan shall provide behavioral health and substance abuse services defined herein that are court ordered, ninety-six (96) hour detentions, and for involuntary commitments.
6. Behavioral Health Out-of-Network Referrals: If the health plan believes that a child or youth may require residential services in order to receive appropriate care and treatment for a serious emotional disorder, the health plan may apply to the Missouri Division of Comprehensive Psychiatric Services (CPS) for placement in accordance with the state agency's Managed Care policy statement entitled, *Behavioral Health and Substance Abuse Fee-For-Service*.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(c).



2.7.5d. Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury, and dental services when the absence of dental treatment would adversely affect a pre-existing medical condition.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5 (d).

HealthCare USA provides dental services for our members through DentaQuest, our dental benefits subcontractor. We coordinate with DentaQuest to ensure both routine dental services, and dental services related to trauma or injury, are available to members. These services are covered by both in-network and out-of-network providers.

2.7.5e. Durable medical equipment including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, diabetic supplies and equipment, and medically necessary equipment and supplies used in connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP).

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(e).



- 2.7.5f. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT): The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid cover all medically necessary services listed in Section 1905 (a) of the Act to children from birth through age twenty (20). In Missouri, this program is known as the Healthy Children and Youth (HCY) Program. In accordance with the health plan's written policies and procedures, the health plan 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 twenty-one (21), and conduct and document well child visits (screenings) using the State HCY/EPSDT screening form as amended. (The HCY screening form may be found on the Internet at: <http://manuals.momed.com/> under MO HealthNet Manuals, Forms, Healthy Children and Youth Screening [HCY Screening].) The health plan shall provide the full scope of HCY/EPSDT services in accordance with the following:
1. The health plan shall ensure HCY/EPSDT well child visits are conducted on all eligible members under the age of twenty-one (21) to identify health and developmental problems. The state agency recognizes that the decision to not have a child screened is the right of the parent or guardian of the child. The health plan shall follow the state agency's Fee-For-Service policies for recognition of completion of all components of a full medical HCY/EPSDT well child visit service. A full HCY/EPSDT well child visits includes all of the components listed below. Segments of the full medical screen (partial screens) may be provided by different providers. An interperiodic screen is defined as any encounter with a health care professional acting within his or her scope of practice.
 - A comprehensive health and developmental history including assessment of both physical and behavioral health developments;
 - A comprehensive unclothed physical exam;
 - Health education (including anticipatory guidance);
 - Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);
 - Appropriate immunizations according to age;
 - Annual verbal lead assessment beginning at age six (6) months and continuing through age seventy-two (72) months;
 - Blood level testing is mandatory at twelve (12) and twenty-four (24) months or annually if residing in a high-risk area of Missouri as defined by Department of Health and Senior Services regulation 19 CSR 20-8.030;
 - Hearing screening;
 - Vision screening; and
 - Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommended that preventive dental services begin at age six (6) through twelve (12) months and be repeated every six (6) months.
 2. If a suspected problem is detected during a well child visit, the child must be evaluated as necessary, using the required assessment protocol, for further diagnosis. This diagnosis is used to determine treatment needs.
 3. HCY/EPSDT requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate (defined as "prevent from worsening") defects, physical and behavioral health issues, and conditions discovered by the screening services or correct a problem discovered during an HCY/EPSDT visit. All medically necessary diagnosis and treatment services 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.



4. The health plan shall establish a tracking system that provides information on compliance with HCY/EPSDT service provision requirements in the following areas:
 - Initial visit for newborns. The initial HCY/EPSDT well child visits shall be the newborn physical exam in the hospital.
 - Preventive pediatric visits according to the periodicity schedule inclusive of a verbal lead assessment and blood lead tests.
 - Diagnosis and/or treatment, or other referrals in accordance with HCY/EPSDT well child visit results.
 - The health plan shall ensure that the tracking system generates information consistent with the requirements regarding encounter data as specified elsewhere herein.

5. The health plan shall have an established process for reminders, follow-ups, and outreach to members. This process shall include, but not be limited to, notifying the parent(s) or guardian(s) of children of the needs and scheduling of periodic well child visits according to the periodicity schedule. The health plan shall contact new members within thirty (30) calendar days of health plan enrollment to provide assistance in accessing HCY/EPSDT well child visit services. The health plan shall provide assistance to members in accessing subsequent HCY/EPSDT well child visits in accordance with the periodicity schedule. At the time of notification, the health plan shall offer transportation and scheduling assistance if necessary. For members with ME Codes 73 through 75, non-emergency medical transportation is not a covered benefit.
6. The health plan shall provide written notification to its families with eligible children when appropriate well child visits are due. The health plan shall follow-up with families that have failed to access well child visits after one hundred and twenty (120) calendar days of when the well child visit was due. The health plan shall provide to each PCP, on a monthly basis, a list of the eligible children who are not in compliance with the periodicity schedule.
7. For those children who have not had well child visits in accordance with the periodicity schedule established by the state agency, the health plan shall document its outreach and educational efforts to the parent or guardian informing them of: the importance of well child visits; that a well child visit is due; how and where to access services including necessary transportation (except to those children with ME Codes 73 through 75) and scheduling services; and a statement that service are provided without cost.
8. The health plan shall seek innovative, cooperative ways to enhance care coordination and delivery of HCY/EPSDT. This may include the use of a standardized data base system among health plans.
9. The health plan shall report HCY/EPSDT well child visits through encounter data submissions in accordance with the requirements regarding encounter data as specified elsewhere herein. The state agency shall use such encounter data submissions and other data sources to determine health plan compliance with CMS requirements that eighty percent (80%) of eligible members under the age of twenty-one (21) are receiving HCY/EPSDT well child visits in accordance with the periodicity schedule. The state agency shall use the participant ratio as calculated using the CMS 416 methodology for measuring the health plan's performance.
 - The health plan shall report HCY/EPSDT well child visits in accordance with the appropriate well child visits codes established by the state agency. HCY/EPSDT screening codes are identified in the state agency's Managed Care Policy Statements. Services not reported as HCY/EPSDT well child visits in accordance with the appropriate codes will not be counted toward the health plan's participant ratio.
 - In the event the state agency uses other data sources submitted by the health plan, the health plan shall certify the data provided. The data must be certified by one of the following:
 - The health plan's Chief Executive Officer;
 - The health plan's Chief Financial Officer; or



- An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
 - The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness, and truthfulness of the data.
 - The health plan shall submit the certification concurrently with the data.
10. The health plan shall submit its HCY/EPSDT policies and procedures to the state agency for review and approval.

We ensure that HCY/EPSDT well-child visits are conducted on eligible members under the age of 21 to identify health and developmental problems. HealthCare USA covers an EPSDT visit in addition to a sick visit, sports physical or a visit for another purpose or procedure on the same day. Full HCY/EPSDT visits include:

- A comprehensive unclothed physical examination
- A comprehensive health and developmental history including assessment of both physical and behavioral health developments
- Health education
- Appropriate immunizations according to age
- Laboratory tests as indicated
- Lead screening at every EPSDT visit from six months to six years of age
- Hearing screening
- Vision screening
- Dental screening, beginning with the first tooth eruption but no later than one year of age

We recognize it is not always possible to complete all components of the full medical HCY screening service. Segments of the full HCY/EPSDT may be completed by different providers.

If a problem is identified during a well child visit, the problem can be treated at that time or the parents can be referred to providers, programs or agencies that are qualified to treat the condition.

We educate members about the importance of HCY/EPSDT screening. We contact new members within 30 days of enrollment to offer assistance in accessing HCY/EPSDT well child visit services in accordance with the periodicity schedule. We also provide scheduling assistance and transportation assistance or mileage reimbursement for those members who are eligible for the benefit.

We use claims and encounter data to track compliance of HCY/EPSDT services. For members we send "birthday reminders" and "missed appointment" mailings to parents/guardians of members to remind them of necessary age-specific services, including well-care visits and immunizations. We also send monthly mailings to providers with panel members that are overdue for an EPSDT visit.



We have enhanced our Navigator and Navigator Care documentation system used by our Member Services and Care Management staff to include “flags” to alert our staff when a member is missing an HCY/EPDST service. These flags enable the staff member to discuss the overdue service with the parent/guardian in addition to the original reason for the call. This enhancement has improved collaboration and efficiency between the departments and decreased outbound calls to the parents/guardians resulting in improved compliance with HCY/EPDST requirements.

We report well child visits through encounter data submissions in accordance with the requirements regarding encounter data and appropriate well child codes established by the state agency. Should other data be used in place of encounter data, appropriate certification of the data occurs.

HealthCare USA policy *QI-4 Healthy Children and Youth (HCY)/Early and Periodic Screening, Diagnosis and Treatment (EPDST) Compliance Program* further defines our procedure.

2.7.5g. Emergency Medical, Behavioral Health, and Substance Abuse Services, and Post-stabilization Care Services:

1. Emergency medical, behavioral health, or substance abuse services means covered inpatient and outpatient services that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
 - Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - Serious impairment to bodily functions;
 - Serious dysfunction of any bodily organ or part;
 - Serious harm to self or others due to an alcohol or drug abuse emergency;
 - Injury to self or bodily harm to others; or
 - With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn.
 2. The health plan shall not limit what constitutes an emergency medical condition as defined herein on the basis of lists of diagnoses or symptoms.
 3. Post-stabilization care services means covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member’s condition.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(g)

HealthCare USA provides coverage, and is financially responsible for, emergency medical/behavioral/substance abuse services, along with post-stabilization care services obtained in-network or out-of-network without prior authorization based upon the prudent layperson standard.



We define emergency medical services in HealthCare USA Policy HS-27 *Request for Authorization* in compliance with the contract.

For further details, refer to:

- *HealthCare USA Provider Manual*, pp. 53-54
- *HealthCare USA Member Handbook*, pp.41-42

We will not limit what constitutes an emergency medical condition on the basis of lists, diagnoses or symptoms.

We accept financial responsibility for post-stabilization care services that are necessary following an emergency medical condition to assure that a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

2.7.6h. Family Planning Services: The health plan shall be financially liable for payment to providers, whether in-network or out-of-network, in accordance with Federal freedom of choice provisions.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(h).

2.7.6i. Home Health Services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(i).

We cover medically-necessary, physician-ordered home health services that are sufficient in amount, duration and scope to reasonably achieve their purpose.

2.7.5j. Hospice Services: Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(j).

We provide hospice services when requested for terminally ill members. To be eligible for hospice services, a member must be certified by a physician as being terminally ill with a life expectancy of six months or less. Hospice services for members less than 21 years of age may be concurrent with care related to curative treatment for the terminal condition.

2.7.6k. Inpatient Hospital Services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(k).



2.7.6l. Laboratory, Radiology, and Other Diagnostic Services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(1).

We have a comprehensive network of contracted laboratory, radiology and other diagnostic providers to provide these medically necessary services. Radiology services are managed by our subcontractor CareCore National.





2.7.5m. Local Public Health Agencies Services: The health plan is responsible for the following services provided by in-network providers and at local public health agencies whether in-network or out-of-network:

1. Sexually Transmitted Disease Services: All sexually transmitted disease (STD) services including screening, diagnosis, and treatment. In-network providers shall follow current Centers for Disease Control and Prevention (CDC) Sexually Transmitted Diseases Treatment Guidelines. The STD guidelines may be found on the Internet at: <http://cdc.gov/std/treatment/> STD screening, diagnosis, and treatment services shall include:

- STD screening exam.
- Screening, diagnosis, and treatment for the following STDs: gonorrhea, syphilis, chancroid, granuloma inguinale, lymphogranuloma venereum, genital herpes, genital warts, trichomoniasis, chlamydia (cervicitis), chlamydia (urethritis), hepatitis B, and others as may be designated by the state agency.
- Screening, diagnosis, and treatment of vaginal or urethral discharge including non-gonococcal urethritis and mucopurulent cervicitis.
- Evaluation and initiation of treatment of pelvic inflammatory disease (PID).
- Diagnosis and preventive treatment of members who are reported as contacts/sex partners of any person diagnosed with a STD. The member shall be given the option of seeing an in-network provider first.
- The local public health agency shall encourage members to follow-up with their primary care provider; however, if the member chooses follow-up care at the local public health agency for confidentiality reasons, the health plan shall reimburse the local public health agency for follow-up office visits (not to exceed three (3) visits per episode).

2. Human Immunodeficiency Virus (HIV) Services: Human immunodeficiency virus (HIV) services relating to screening and diagnostic studies. In-network providers shall use The Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health –Care Settings. The HIV guidelines may be found on the Internet at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

3. Tuberculosis Services: Tuberculosis services include screening, diagnosis, and treatment. In-network providers shall follow current American Thoracic Society/CDC/Infectious Diseases Society of America Guidelines: Treatment of Tuberculosis MMWR 2003; 52 (No. RR-11), including the use of Mantoux PPD skin test or FDA-approved Interferon Gamma Release Assays (IGRAs) to screen for Tuberculosis. The Tuberculosis guidelines may be found on the Internet at: <http://cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm>.

- All members diagnosed with tuberculosis infection or tuberculosis disease shall be reported to the local public health agency.
- All members receiving treatment for tuberculosis disease shall be referred to the local public health agency's tuberculosis contact person for directly observed therapy (DOT). The health plan shall communicate with the local public health agency's tuberculosis contact person to obtain information regarding the member's health status. The health plan shall communicate this information to the in-network provider. The health plan shall be responsible for care coordination and medically necessary follow-up treatment.
- All laboratory tests for tuberculosis shall meet the standards established by the CDC and the Missouri Department of Health and Senior Services. Sensitivity tests shall be performed on all initial specimens positive for M. Tuberculosis. The Department of Health and Senior Services encourage all sputum specimens to be submitted to the Department of Health and Senior Services' Tuberculosis



Reference Laboratory at the Missouri Rehabilitation Center. Positive cultures for M Tuberculosis isolated at private laboratories must be sent to the TB Reference Laboratory (Required by Missouri Rule 19 CSR 20-20.080).

4. Childhood Immunizations: The health plan shall ensure that in-network providers fully immunize their members according to the most recent immunization recommendations designated by the state agency. The state agency shall provide the health plan's Medical Director with copies of the most recent recommendations upon contract award, upon request, and when the recommendations change.
 - The health plan and its in-network providers shall enroll and obtain vaccines through the Missouri Department of Health and Senior Services Vaccines for Children (VFC) Program or any such vaccine supply program as designated by the state agency. Any time a member receives immunizations from a local public health agency, or at a Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) site, the health plan shall reimburse only the cost for administration at the current MO HealthNet program rates in effect at the time of the service, unless otherwise negotiated.
 - The health plan shall reimburse governmental public health agencies for the cost of both administration and vaccines not available through the VFC program or vaccine supply program as designated by the state agency when the vaccine is deemed medically necessary.
 - The health plan shall collaborate with the state agency and the Missouri Department of Health and Senior Services to determine the health plan's aggregate immunization level. The Missouri Department of Health and Senior Services, Immunization Program will offer consultation to the health plan to foster the exchange of immunization information, and to in-network providers for purposes of assessment, reminder/recall, and reporting.
 - The health plan shall establish, as a quality assessment and improvement measure, a target rate of ninety percent (90%) for the number of two (2) year olds immunized.
5. Childhood lead poisoning prevention services shall include screening, diagnosis, treatment, and follow-up as indicated. In-network providers shall follow the CMS guidelines in effect for the specific time period and CDC guidelines: Screening Young Children for Lead Poisoning and Managing Elevated Blood Lead Levels Among Young Children. The Department of Health and Senior Services shall provide the health plan's Medical Director with copies of current protocols and guidelines upon contract award or at any time upon request. If there is a discrepancy between guidelines, the state agency requires use of the HCY/EPSTDT Lead Risk Assessment Guide developed in accordance with CMS guidelines. The HCY/EPSTDT Lead Risk Assessment Guide may be used separately or in conjunction with the HCY Screening form.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(m).



2.7.5n. Maternity Benefits for Inpatient Hospital and Certified Nurse Midwife:

1. The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo, as amended.
2. The health plan may authorize a shorter length of hospital stay for services related to maternity and newborn care if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with Federal and State law, as amended. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization, and is documented in the member's medical record.
3. The health plan shall provide coverage for post-discharge care to the mother and her newborn. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests, and submission of a metabolic specimen satisfactory to the State laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care", or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(n).

As documented in the *HealthCare USA Provider Manual*, p. 45, we cover a minimum 48 hours of inpatient services after a vaginal delivery and 96 hours of inpatient services after a cesarean delivery.

Any shorter length in stay is with the approval of the attending physician and the member and may include the provision of home health services.

Our members also have the benefit of post-discharge home care visits after delivery, which include:

- Physical assessment of the newborn and mother
- Parent education
- Assistance and training in breast or bottle feeding
- Childhood immunization education
- Clinical testing



2.7.5o. Optical services include one (1) comprehensive or one(1) limited eye examination every two (2) years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), and one (1) pair eyeglasses every two (2) years (during any twenty-four (24) month period of time);

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(o).

Through March Vision (our vision benefit subcontractor), we provide optical services sufficient in amount, duration and scope to reasonably achieve their purpose and are only limited by medical necessity. We also cover medically necessary optical procedures performed in an inpatient or outpatient hospital facility, Emergency Department or ambulatory surgical center.

For details, refer to:

- *HealthCare USA Member Handbook*, p. 19.

2.7.5p. Outpatient Hospital Services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(p).

Our provider network covers outpatient services for all members' medically necessary health needs.

2.7.5q. Personal Care Services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(q).

We cover medically necessary personal care services as an alternative to nursing home placement. These services include:

- Basic personal care
- Advanced personal care
- Nurse visits

We understand that Federal law does not require a physician to prescribe personal care services.



2.7.5r. Physician, Advanced Practice Nurse, and Certified Nurse Midwife Services:

1. The health plan shall provide certified nurse midwife services that are medically appropriate either in- network or out-of network at the health plan's expense.
 2. If the member elects a home birth, the health plan shall notify the state agency so that the member can be disenrolled from MO HealthNet Managed Care and enrolled in the MO HealthNet Fee-For-Service program.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(r).

2.7.5s. Podiatry services with the exception of trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s), one (1) to five (5); debridement of nail(s) by any method(s), six (6) or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and/or foot;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(s).

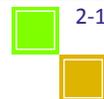
We provide podiatry services that are within the scope of a podiatrist practice. Services are sufficient in amount, duration and scope to reasonably achieve their purpose, and may only be limited by medical necessity. We understand that there are limitations, as listed in the MO HealthNet policy statements, to the benefit for adult members 21 years of age and over except for specified adult pregnant women.

2.7.5t. Transplant Related Services:

The health plan shall permit and authorize and shall be financially responsible for any inpatient, outpatient, physician, and related support services including presurgery assessment/evaluation prior to the date of the actual bone marrow/stem cell or solid organ transplant surgery. The bone marrow/stem cell or solid organ transplant will be prior authorized by the state agency and must be performed at a state agency's approved transplant facility in accordance with the MO HealthNet member's freedom of choice. The health plan shall be responsible for pre-transplant and post-transplant follow-up care. To ensure continuity of care, the health plan shall permit and authorize follow-up services and the health plan shall be responsible for the reimbursement of such services. The primary care provider shall be allowed to refer a transplant patient to the performing transplant facility for follow-up transplant care. The health plan shall reimburse out-of-network providers of transplant support services no less than the current MO HealthNet program rates in effect at the time of the services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(t).

We cover the pre-surgery evaluation and care (excluding the solid organ procurement or bone marrow/stem cell harvest) and post-transplant discharge follow-up care. We continue to permit the PCP to refer a transplant patient to the performing transplant facility for follow-up transplant care. All members identified as transplant recipients or potential recipients are





enrolled in our complex case management program where a case management nurse coordinates care and services between the member, provider and the state agency.

2.7.5u. Transportation Services:

1. The health plan shall provide emergency transportation (ground and air) for its members.
2. The health plan shall provide non-emergency medical transportation to members (except for children in ME Codes 73 - 75 (Refer to Attachment 1, Category of Aid 5) and children in State custody with the following ME Codes 08, 52, 57, and 64 (Refer to Attachment 1, Category of Aid 4) who do not have the ability to provide their own transportation (such as their own vehicle, friends, or relatives) to and from services required herein as well as to and from MO HealthNet Fee For Service covered services not included in the comprehensive benefit package.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.5(u).

Non-emergency Medical Transportation

We cover non-emergency medical transportation (NEMT) for members, excluding those with ME codes 08, 52, 57, and 64, who do not have the ability to provide their own transportation to and from health care services including ancillary services and those services that are carved out of the MO HealthNet Managed Care contracts. We ensure that public transit is not used for members with:

- High-risk pregnancy
- Pregnancy after the eighth month
- High-risk cardiac conditions
- Severe breathing problems
- Longer than a three-block walk to the nearest bus stop

Emergency Air and Ground Transportation

HealthCare USA covers emergency air and ground transportation for all members regardless of ME code.

2.7.6 **Cancer Screenings:** In accordance with State law, the health plan shall notify all members on an annual basis, in writing, of cancer screenings covered by the health plan and provide the current American Cancer Society guidelines for all cancer screenings.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.6. We notify all members annually, in writing, of covered cancer screenings through the *HealthCare USA Member Handbook* and through mailings such as our member newsletter articles and specific





cancer screening reminder postcards. We also educate our members on the current American Cancer Society guidelines for all cancer screenings.

For further details, refer to:

- *HealthCare USA Member Handbook* pp. 50- 53
- *Bear Facts* member Newsletter, Volume 1, dated 4/14/2011 (Attachment 5)

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- 2.7.7 Additional Services: In addition to the services listed in the comprehensive benefit package, herein, the health plan shall provide the following services to children under twenty-one (21) years of age and pregnant women with ME codes 18, 43, 44, 45, and 61.
- a. Comprehensive Day Rehabilitation (for certain persons with disabling impairments as the result of a traumatic head injury)
 - b. Dental Services – All preventative, diagnostic, and treatment services as outlined in the Medicaid State Plan
 - c. Diabetes self management training for persons with gestational, Type I, or Type II diabetes
 - d. Hearing aids and related services
 - e. Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses per year, and, for children under age twenty-one (21), HCY/EPST optical screen and services
 - f. Podiatry services.
 - g. Services that are included in the comprehensive benefit package, medically necessary, and identified in the IFSP or IEP (except for physical therapy, occupational therapy, speech therapy, hearing aid, personal care, private duty nursing, or psychology/counseling services)
 - h. Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all other therapies.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.7.

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- 2.7.8 Services for Children in the Custody of the Jackson County Office of the Missouri Children's Division: Children in the custody of the Jackson County office of the Missouri Children's Division (CD) and residing in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, or St. Clair counties receive additional medical care services.
- a. In addition to the services outlined herein, the health plan shall provide the following services following the effective date of enrollment with the health plan. If the child is already enrolled with the health plan and enters custody, the health plan shall provide the following services from the time the child enters CD custody. The timeframes for these examinations begin with the time and date the child enters CD custody.
 - 1. In initial physical examination is due the next working day following entry into custody. (This initial physical examination shall be paid by the state agency on a fee-for-service basis and arranged by CD if the child is not enrolled in a health plan at the time of the initial



physical examination.) In all cases, if a child is enrolled with the health plan, the health plan shall be responsible for payment of the initial physical examination. CD, the Medical Case Management Agency, and the health plan shall work together to establish a notification process so that the health plan receives notification of the enrollment of a covered child who is under the jurisdiction of the court in Jackson County in a timely manner.

2. Follow-up examinations recommended by the provider during the initial physical examination; shall be done within thirty (30) calendar days.

b. The health plan shall follow the periodicity schedule for children up to and including age five (5) with annual examinations after age five (5) unless the child has physical health, behavioral health, or developmental health problems identified by the provider that require medically necessary treatment on a more frequent basis.

c. The health plan shall be responsible for determinations regarding medically necessary treatments, medically necessary appointments, and medically necessary services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.8. Children in custody of the Jackson County Family Support Division (FSD) office and residing in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray or St. Clair counties are managed by the assigned HealthCare USA Special Needs Coordinator to promote timely access to medically necessary services and assist in the coordination of care for eligible members. HealthCare USA understands the initial physical examination is due the next working day following entry into custody and the follow-up examination is due within 30 calendar days.

We continue to follow the periodicity schedule for children up to and including age five with annual examinations after age five unless the child has health problems identified by the provider that require medically necessary treatment more frequently. The HealthCare USA Special Needs Coordinator works closely with the Children's Division caseworkers, the Medical Case Management Agency, MHNet, and the foster family to ensure notification of enrollment, facilitation and coordination of care and completion of the aforementioned examinations for the member.

2.7.9 Medically Necessary: The health plan shall be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. Services may be limited by medical necessity. A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health condition or injury; (2) is necessary for the member to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity. A service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered.

a. In reference to medically necessary care, behavioral health services shall be provided in accordance with a process of behavioral health assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of behavioral health assessment shall include distinct criteria for children and adolescents.

b. The health plan shall provide medically necessary services to children from birth through age twenty (20), which are necessary to treat or ameliorate defects, physical or behavioral health, or



conditions identified by an HCY/EPST screen. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.9 (a-b). Medically necessary services are covered in the HealthCare USA Policy HS-28 *Medical Necessity Review Criteria*.

For further details, see:

- *HealthCare USA Provider Manual*, p. 42 and

2.7.10 Additional Health Benefits: The health plan may offer additional health benefits not included in the comprehensive benefit package to their members. If the health plan offers additional health benefits, the health plan shall notify the state agency of these benefits no later than ten (10) calendar days prior to their offering and must notify the state agency no less than thirty (30) calendar days prior to discontinuing such benefits. The health plan shall not portray required health benefits or services as an additional health benefit.

4.5.2b. Program Administration - The offeror shall:

6. Provide a listing, description, and conditions under which the offeror will offer additional health benefits to its members. Examples of such additional health benefits are non-emergency transportation (NEMT) for those members who do not have NEMT as part of their benefit package; or sponsorship in youth programs such as Boy Scouts or YMCA. This is not an exhaustive list of such services but only provides examples of the types of services that may qualify as an additional health benefit. (2.7.11)

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.10 and 4.5.2(b)6.

HealthCare USA's 17 Additional Benefits Include 6 Newly Proposed Ones. In total, we commit to providing more than \$8.6 million in additional benefits over the next three year contract period. This value and the fact that we have increased additional benefits by about 40% for the new contract demonstrates that our commitment to MO HealthNet and its members remains as strong today as it has over the last 16 years.

This response is applicable to all regions.

At HealthCare USA, we understand the importance of engaging members in their health care. Some members need encouragement to embrace proactive health care activities that can prevent their illnesses from getting worse or result in trips to the ED. For some members, an incentive, such as the asthma or high-risk pregnancy incentives discussed below, motivate them to seek the right care in the right place at the right time. For other members, the availability of online mobile services helps them track when they need care, such as EPST visits or annual dental visits.

Additionally, as we look forward to the possibility of a membership expansion from a health insurance exchange, we realize certain additional Medicaid benefits are standard in commercial benefit packages. In preparation for changes related to the exchange, we are making the following commercial-type benefits available to all of our members. These include My Online Services, the mobile application for My Online Services and WellBeing Solutions, a brand new online coaching tool.



To enhance the health and wellbeing of our members, HealthCare USA offers 17 benefits that are either not available or go beyond the amount, duration and scope of the benefits required in Sections 2.7.10 and 4.5.2(b)6. This includes six new benefits which contribute to more than half the dollar value of proposed \$8.6 million of additional benefits over the life of the contract; nearly doubling the number of additional benefits offered. Figure 2- 15 highlights our full additional benefits list.

Note that upon the successful acquisition of Children’s Mercy Family Health Partners, our additional benefits will be valued at another \$2.5 million over the life of the contract (on top of the \$8.6 million) as a result of new members who would take advantage of these additional services.

Figure 2- 15: HealthCare USA’s 17 Additional Member Benefits Address Health with a Range from Transportation to Prevention to Disease Management to Improved Outcomes for Targeted Populations

Benefit	Description	Conditions for Offering	Value of Benefit over Life of Contract
Physical Therapy	Evaluation and limited physical therapy visits for adults	<ul style="list-style-type: none"> For adult members who do not have a physical therapy benefit but have significant, defined orthopedic injuries or procedures Authorized coverage for a physical therapy evaluation and up to 8 physical therapy visits when medically appropriate 	\$303,735
Circumcisions	Newborn circumcisions	<ul style="list-style-type: none"> Performed while the infant is hospitalized Also cover circumcisions if the procedure is performed post-hospitalization during the member’s first 30 days of life and is performed in the physician’s office For infants who have been hospitalized in NICU or special care nursery, covered during first 30 days post-discharge if performed in the physician’s office 	\$2,823,960
Health Fairs	Annual Back-to-School Fairs <ul style="list-style-type: none"> Includes free health screenings for the entire family such as 	<ul style="list-style-type: none"> Open to members and general public 	\$4,908



Benefit	Description	Conditions for Offering	Value of Benefit over Life of Contract
	<p>mammograms, HIV, vision, dental, lead, blood pressure, height, weight, body mass index, blood sugar, and immunizations for children.</p> <ul style="list-style-type: none"> • Also includes free back pack and school supplies donated by community partners. Children collect one supply from each partner which gives parents the opportunity to learn about the resources each community partner has to offer. • Partners include mental health vendors, Legal Aide, Family Support Division, Parents as Teachers, Services for Independent Living, faith based groups/ churches, Prevention Resource Center, etc. • Total value of donated items or services each child may receive is \$360+. See below. <ul style="list-style-type: none"> ○ Hair cut \$10 ○ Dental kit \$5 ○ Dental exam \$50 - \$75 ○ Vision exam \$50 - \$75 ○ Blood pressure – free like in grocery ○ BMI \$30 - \$50 ○ Blood sugar testing \$20 ○ Hearing test \$50 ○ Mammograms \$300 (adults only) ○ HIV testing \$10 ○ Immunizations \$100 ○ Back pack \$8 ○ School Supplies from partners \$18 ○ Free lunch while at fair \$7 ○ Entertainment per child \$5 		



Benefit	Description	Conditions for Offering	Value of Benefit over Life of Contract
Enhanced Transportation Benefits	<p>Members picking up a prescription</p> <p>Parents visiting baby or child in hospital</p> <p>Members attending WIC appointments</p> <p>Members attending Lamaze or similar birthing classes</p>	<ul style="list-style-type: none"> • Must occur after the member's appointment and as part of the return trip home. • Baby or child must be a HealthCare USA member • Limited to one trip per day. • Member must be current member of HealthCare USA without means to otherwise attend the appointment. • Pregnant member and one adult (member's coach during delivery) who is without means to otherwise attend the classes 	\$404,967
Peak Flow Meters	Provision of peak flow meters	<ul style="list-style-type: none"> • 2 meters per asthmatic member per year without prior authorization 	\$12,261
Asthma Incentive Program	Incentive gift card program to educate and empower members with asthma to proactively take care of their health condition.	<ul style="list-style-type: none"> • \$30 Incentive gift card available to asthmatic members who <ol style="list-style-type: none"> 1. have regular checkups or asthma visits 2. fill prescribed asthma medicines at a local pharmacy or clinic 3. select a rescue person at school, child care or work 4. have brochure signed by PCP, pharmacist and rescue person 5. mail signed and completed card to HealthCare USA. 	\$10,110
High Risk OB Incentive	Incentive gift card program to encourage moms-to-be to have	<ul style="list-style-type: none"> • \$30 gift card available to HealthCare USA moms- 	\$37,980



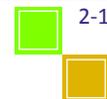
Benefit	Description	Conditions for Offering	Value of Benefit over Life of Contract
Program	regular prenatal visits.	to-be who go to their OB provider for five (5) prenatal visits and mail their signed card to us.	
***Post Partum Incentive Program	Quality improvement program to encourage new moms to get their post partum visit	<ul style="list-style-type: none"> • Available to our new moms who have recently given birth • Members who get their post partum care between the 21st to 56th day after birth of baby and get visit documented by OB/GYN attestation, will receive a \$30 gift card. 	\$474,630
***Limited adult dental benefit	One cleaning, x-ray and exam	<ul style="list-style-type: none"> • Non-pregnant members • Limited to once a year • Does not include fillings 	\$3,316,764
***WellBeing Solutions	Online, interactive coaching support for members wishing to stop smoking, lose weight, exercise more, or improve their mental well-being	<ul style="list-style-type: none"> • Open to all members • Available on-line through My On-line Services 	\$259,767
Kids Health	Online education and wellness site written by doctors for children, teens and parents 	<ul style="list-style-type: none"> • Available to all HealthCare USA members • Website and articles available in Spanish and English in 3 portals in one website with each portal written specifically to the targeted age groups — child, teen and parent. 	\$40,407
Doc Bear Club	Education and wellness club for children 	<ul style="list-style-type: none"> • All HealthCare USA children automatically enrolled in the Doc Bear Club. • Bear Facts member newsletters • Newsletter birth day card in month of their birthday. 	\$141,162



Benefit	Description	Conditions for Offering	Value of Benefit over Life of Contract
<p>My Online ServicesSM including My Online Services mobile application</p>	<p>Member-specific online portal including free Apple, Android or Blackberry app that allows on-the-spot access to ID card, vitals (such as medications, immunizations, allergies) via mobile application</p> <ul style="list-style-type: none"> Portal is tied to each individual member and provides member with alert or reminder when they are due for an annual preventive well care visit, immunization, cancer screening or dental check up among others! Also provides member with some brief educational information about why the screening is important to maintaining good health. 	<ul style="list-style-type: none"> Available to all HealthCare USA members 	<p>\$69,271</p>
<p>***Girls on the Run, Kansas City</p>	<p>Participation in new after-school program within Kansas City school; provides physical fitness, nutrition,</p>	<ul style="list-style-type: none"> Participation fee provided to be included in program Pilot in the Kansas City 	<p>\$45,000</p>



Benefit	Description	Conditions for Offering	Value of Benefit over Life of Contract
	mental wellness to help ensure EPSDT, BMI, Immunizations, and dental visits	area <ul style="list-style-type: none"> • Pilot entails 12-15 girls in Spring and Fall for 10-12 week program; ages 13 to 19 • If member participates in this after-school program, member would not be eligible for membership assistance in participation of other after-school programs or clubs such as Girl Scouts or 4-H. • We will case manage the girls in this program to tie to our obesity PIP 	
***YMCA, Kansas City	\$30 per month membership fee in targeted YMCAs in the Kansas City area	<ul style="list-style-type: none"> • Target YMCA's in Kansas City area located near high concentration of HealthCare USA membership • Member must be working in collaboration with their PCP health home to achieve weight loss or other health initiative 	\$540,000
***Diabetic Foot Care	Routine Trimming of Nails & Corns and Calluses	<ul style="list-style-type: none"> • Limited to Adult Members with Diabetes 	\$108,357
After School Programs	Membership to one of the following programs:  4-H  Girls, Inc.,  BOYS & GIRLS CLUB Boys and Girls Clubs',	<ul style="list-style-type: none"> • Registration fee is paid for one program per child • Child must be current member of HealthCare USA. 	\$91,140





Benefit	Description	Conditions for Offering	Value of Benefit over Life of Contract
	 <p>Girl Scouts, Girl Scouts</p>  <p>Boy Scouts,</p>  <p>Discovering Options and Local Investment Commission's</p>  <p>Caring Communities</p>		
Total value over three year contract period			\$8,684,419

***INDICATES NEWLY PROPOSED BENEFIT

2.8 Second Opinion

The health plan shall provide for a second opinion, at no cost to members, from qualified health care professionals. The health plan shall have and implement policies and procedures for rendering second opinions both in-network and out-of-network when requested by a member. These policies and procedures shall address whether there is a need for referral by the primary care provider or self-referral. Missouri Revised Statutes Section 208.152 states that certain elective surgical procedures require a second medical opinion be provided prior to the surgery. A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.7.9.

As documented in HealthCare USA's policy HS-35 *Second and Third Opinion* HealthCare USA provides for a second opinion from qualified health care professionals, at no cost to the member, whether in-network or out-of-network when requested by the member. A third surgical opinion is also provided, if requested by the member, when the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical procedure.

HealthCare USA requires prior authorization for second and third opinions and documents each step of the process in our referral system. The process of recording second and third opinion requests in the referral system allows for coordination of members' health care needs.



2.9 Release for Ethical Reasons [4.4.15]

- 2.9.1 As a condition to participating in its provider network, the health plan may not:
- Require a provider to perform any treatment or procedure which is contrary to the provider's conscience, religious beliefs, or ethical principles or policies; or
 - Prohibit a provider from making a referral to another health care provider licensed to provide care appropriate to the member's medical condition.

4.4.15 Release for Ethical Reasons

The offeror shall state if reimbursement for, or provider coverage of, a counseling or referral service will be objected to based on moral or religious grounds. (2.9)

HealthCare USA understands and shall comply with the requirements set forth in Sections 2.9.1 and 4.4.15.

We do not exclude any covered benefits or services to our members, including reimbursement to providers, based upon moral or religious grounds. We have procedures in place to allow a provider to refer to another health care provider or withdraw from a specific case and have the member reassigned to another provider when providing requested care is against that provider's religious or ethical beliefs.

Members are notified at least 30 days prior to any change in policy regarding coverage of a counseling or referral service for any benefit that the health plan would decide not to reimburse based on a moral or ethical reason. Notification includes how and where to obtain the service.

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- 2.9.2 The health plan shall have a process by which the provider may refer a member to another health care provider licensed to provide care appropriate to the member's medical condition, or withdraw from the case and the health plan shall assign the member to another provider licensed to provide care appropriate to the member's medical condition.
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HealthCare USA understands and shall comply with the requirements set forth in Sections 2.9.2.

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- 2.9.3 The health plan may object, on moral and religious grounds, to providing or reimbursing for a service for which it is otherwise required to provide or reimburse. If the health plan objects to providing or reimbursing for a service on moral or religious grounds, the health plan shall notify the state agency. Additionally, the health plan shall notify the state agency whenever the health plan adopts the policy during the term of the contract. The health plan agrees that such an objection and subsequent release from providing, reimbursing for, or providing coverage of a counseling or referral service shall result in a reduction to the applicable capitation rates paid to the health plan to reflect such a release as outlined in paragraph 2.30.6. The health plan shall also:
- Provide information to potential members prior to enrollment regarding the health plan's release of provision of such service;
 - Notify its members thirty (30) calendar days prior to any change in its policy regarding coverage of a counseling or referral service; and
 - Notify its members of how and where to obtain the service.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.9.3.



HealthCare USA provides information to potential members prior to enrollment regarding the release of provision of such service. Members are notified at least 30 days prior to any change in policy regarding coverage of a counseling or referral service for any benefit that the health plan would decide not to reimburse based on a moral or ethical reason. Notification includes how and where to obtain the service.

2.10 Coordination With Services not Included in the Comprehensive Benefit Package

The health plan is not obligated to provide or pay for any services not included in the comprehensive benefit package. This section provides additional information about some of the services not in the comprehensive benefit package. The health plan is responsible for coordinating the provision of services in the comprehensive benefits package with services not included within the comprehensive benefit package.

- 2.10.1 Abortion Services: Abortion services subject to MO HealthNet program benefits and limitations shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.1.

2.10.2 Autism Waiver Services:

- a. Home and community based waiver services including behavioral analysis services, personal assistant, in-home respite, out-of-home respite, environmental accessibility adaptations, specialized medical equipment and supplies (adaptive equipment), support broker, and transportation for persons in the Autism waiver are carved out of the MO HealthNet Managed Care Program. The state agency shall identify the Autism waiver participants to the health plan.
- b. The health plan shall be responsible for MO HealthNet Managed Care comprehensive benefit package services for Autism waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the Autism waiver. Information regarding Autism waiver services may be located on the Department of Mental Health website at <http://dmh.mo.gov/dd/progs/waiver/autism.htm>.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.2.

HealthCare USA covers comprehensive benefit package and coordinates services for autism waiver clients identified by the state agency. Members are assessed for possible enrollment into HealthCare USA's complex case management program. Our case managers collaborate with co-located MHNet case managers to ensure the health care needs of the member are met.

2.10.3 Comprehensive Substance Treatment Abuse and Rehabilitation (C-STAR) Services

- a. Services provided by a C-STAR MO HealthNet provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.
- b. In order to ensure quality of care, the health plan and its behavioral health/substance abuse treatment providers shall maintain open and consistent dialogue with C-STAR providers. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and C-STAR services in accordance with the MO HealthNet Managed Care



policy statement entitled *Behavioral Health and Substance Abuse Fee-For-Service Coordination and the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care*.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.3.

We acknowledge that C-STAR services shall be reimbursed by the State agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program. MHNet continues to support referrals to the C-STAR program whenever appropriate for the member.

When our members are receiving services, we receive notification from CSTAR providers. Our nurse case managers and social workers collaborate with the CSTAR providers, MHNet, behavioral health, and case managers to ensure the member's needs are met.

2.10.4 Behavioral Health Services:

- a. Services provided by a Community Psychiatric Rehabilitation provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.
- b. Targeted case management services for behavioral health services shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.
- c. Smoking cessation pharmacologic and behavioral intervention services shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet fee-for-service program.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.4 (a-c).

We understand that services provided by

- Community Psychiatric Rehabilitation provider
- Targeted case management services
- Smoking cessation pharmacologic and behavioral intervention services

will be reimbursed by the State agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.



- 2.10.5 Behavioral Health Services for Category Of Aid (COA) 4 Children:** For children within the COA 4 group, the health plan shall not be financially responsible for the following medically necessary behavioral health and substance abuse services:
- Inpatient Behavioral Health and Substance Abuse Services shall be any psychiatric stay in an acute care hospital, or in a private or State psychiatric hospital. Admissions must be in accordance with established guidelines of the Department of Social Services in conjunction with the Department of Mental Health. The Department of Social Services in conjunction with the Department of Mental Health will determine the appropriateness of inpatient placement, the appropriate facility, alternative placement, and psychiatric diversion. The state agency's Medical Review Agency must certify medically necessary inpatient days for behavioral health and substance abuse services (billable on an inpatient hospital claim form) beyond the days deemed medically necessary for physical health. The health plan shall ensure that the member's primary care provider and the child's caseworker coordinate services.
 - Outpatient Behavioral Health and Substance Abuse Services are those services not provided in an inpatient setting. Examples of appropriate settings are outpatient facility, office, or clinic settings. These services must be provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, licensed master social worker, licensed counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric nurse, Missouri-certified substance abuse counselor, or State certified behavioral health or substance abuse program. The services will be provided subject to MO HealthNet program benefits and limitations.
 - Comprehensive Community Support Services: Comprehensive Community Support Services are provided to children in the custody of the Children's Division and are found to have behavioral conditions which require rehabilitative services at a residential treatment or specialized foster care level of care or who are being discharged from these two treatment levels, and who require comprehensive community support services in order to maintain the rehabilitation treatment outcome in a less restrictive environment. The Children's Division identifies children in the custody of the Children's Division qualifying for these services and authorizes provision of comprehensive community support. Comprehensive community support services include any medical or remedial service reasonable and necessary for maximum reduction of a behavioral disability and restoration of the child to his or her best possible functional level. Examples include, but are not limited to: Intake, Assessment, Evaluation and Treatment Planning; Community Support; Specialized Sexual Abuse Treatment: 24-hour Crisis Intervention and Stabilization; Intensive In-Home Services; Medication Management and Monitoring; Day Treatment/Psychosocial Rehabilitation; Therapeutic Counseling or Consultation Services not Covered Separately through the HCY or Physician's Services Program; Supported Independent Living and Transitional Living Services; and School-Based Behavioral Support Services not included in the IEP. The services shall be provided subject to MO HealthNet program benefits and limitations.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.5 (a-c).

HealthCare USA and MHNet are able to identify children within COA 4 and will work with the member's primary care provider and caseworker to coordinate services. HealthCare USA acknowledges that it is not financially responsible for the following services for children within the COA 4 group:

- Inpatient behavioral health and substance abuse services
- Outpatient behavioral health and substance abuse services
- Comprehensive community support services



2.10.6 Developmental Disabilities (DD) Waiver Services:

- a. Home and community-based waiver services for persons in the DD waiver are carved out of the MO HealthNet Managed Care Program. The state agency shall identify the DD waiver participants to the health plan.
 - b. The health plan shall be responsible for MO HealthNet Managed Care comprehensive benefit package services for DD waiver clients enrolled in MO HealthNet Managed Care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the comprehensive benefit package and the DD waiver. Information regarding DD waiver services may be found in Section 19 of the MO HealthNet DD Waiver Provider Manual and the MO HealthNet Provider Bulletins located on the internet at <http://www.dss.mo.gov/mhd/providers/pages/bulletins.htm>.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.6 (a-b).

We acknowledge that the home- and community-based waiver services for persons in the DD waiver are carved out of the MO HealthNet Managed Care Program and will be identified by the state agency.

HealthCare USA covers all services listed within the comprehensive benefit package. HealthCare USA and MHNNet will work coordinate services with the member's primary care provider and caseworker.

2.10.7 Pharmacy Services

- a. Pharmacy services (including physician injections) shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.7(a).

We acknowledge that pharmacy services, including all medications and pharmaceuticals administered on an outpatient basis, are reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet Program.

- 2.10.7.b. The health plan shall coordinate with the state agency as necessary to ensure that members receive pharmacy services without interruption. In addition, the health plan shall provide information to members about appropriate prescription drug usage and shall monitor and manage providers' prescribing patterns through activities such as educating providers regarding practice patterns and intervening with providers whose practice patterns appear to be operating outside industry or peer norms.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.7(b).

HealthCare USA educates members on the state agency's formulary and regarding appropriate prescription drug usage. HealthCare USA's Medical Management Department and Fraud and Abuse Committee monitor and manage provider's prescribing patterns, as well as educating and intervening when necessary.



2.10.7.c. The carve out of pharmacy services is defined to include all medications and pharmaceuticals administered on an outpatient basis, including physician-administered drugs, covered over-the-counter (OTC) products, all drugs dispensed by outpatient pharmacies, medications administered in the outpatient department of a hospital, or other outpatient clinics, according to the terms and conditions of the MO HealthNet Pharmacy Program. The MO HealthNet Pharmacy Program covers a select list of OTC products. The list of covered OTC products may be found on the internet at http://dss.mo.gov/mhd/cs/pharmacy/pdf/otc_coveredproducts.pdf . The MO HealthNet Pharmacy Program will cover diabetic medication (oral and injectable), syringes, and diabetic testing equipment and directly related supplies such as strips, calibration solution, lancets, and alcohol pads For pharmacy services provided in a home health setting, the MO HealthNet Pharmacy Program will cover the pharmacy service when billed on a pharmacy claim form including all of the appropriate information such as, but not limited to, the National Drug Code, quantity, and dosage form. The health plan shall be responsible for the home health visit and all supplies incidental to the administration of the medication. The MO HealthNet Pharmacy Program covers smoking cessation, pharmacologic and behavioral intervention services for MO HealthNet Managed Care participant. The carve out of pharmacy services does not include pharmacy services provided during or incident to an inpatient hospital stay or during or incident to an observational unit status.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.7(c).

2.10.7.d. CyberAccesssm is a web-based, HIPAA-compliant tool which provides all paid pharmacy claims data submitted for the members over the most recent thirty-six (36) contiguous months (including, but not limited to, submitted managed care encounter medical, inpatient and outpatient hospital, and dental claims data). In addition to member health information, CyberAccesssm provides the health plans access to the clinical rules engine used to jury prior authorization or clinical edit criteria for prescription drugs. A Medicaid Possession Ratio (MPR) calculation for maintenance medications is displayed in the tool which notifies prescribers and the health plan of a member's adherence to prescribed medications. CyberAccesssm will allow the health plan to view drug utilization information in near real time, and pharmacy claims data extracts will be available for the health plan to integrate into its existing decision support tools to promote medical management.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.7(d).

We use CyberAccessSM to assist in promoting appropriate medical management, case management and disease management of the members. Our case/disease managers are able to view diagnosis and prescription refill data in real-time to assist in management of the member.

2.10.8 Public Health Programs: Services offered by the Department of Health and Senior Services and local public health agencies and the method of reimbursement shall include:

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.8.



2.10.8.a. Environmental Lead Assessments for health plan children with elevated blood levels shall be reimbursed directly by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.8(a).

HealthCare USA acknowledges that it is not financially responsible for environmental lead assessments for members with elevated blood levels.

2.10.8.b. State Public Health Laboratory Services to Members: In cases where the health plan is required by law to use the State Public Health Laboratories (e.g., metabolic testing for newborns) and in cases where the State Public Health Laboratory and Department of Health and Senior Services designated local public health agency laboratories perform tests, other than those services listed herein, on members for public health purposes, the laboratory shall be reimbursed directly by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program. Such costs shall not be included in the Medicaid State plan capitated rates.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.8(b).

We continue to follow children with elevated lead blood levels through our lead case management program. Case managers routinely work with members to educate them regarding the need for environmental lead assessments and assist them in accessing these services.

2.10.8.c. Newborn Screening Collection Kits: According to RSMo 191.331, health care providers must purchase pre-paid newborn screening collection kits from the Department of Health and Senior Services. The Department of Health and Senior Services sells the kit to providers. When the provider submits a specimen to the State Department of Health and Senior Services Laboratory, the laboratory shall process the test, determine if the member is MO HealthNet eligible, and bill the state agency for the test.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.8(c).

In accordance with RSMo 191.331, we continues to educate providers that they must purchase pre-paid newborn screening collection kits from DHSS.

2.10.8.d. Special Supplemental Nutrition for Women, Infants and Children (WIC) Program

1. Sections 1902(a)(11)(C) and 1902(a)(53) of the Act and Title 42, CFR 431.635 require coordination between the state agency and the WIC program. Title 7 CFR 246.7 states that members of a family in which a pregnant woman or an infant is certified eligible to receive assistance under Medicaid are automatically income eligible for the WIC program. The health plan shall be familiar with the WIC eligibility criteria found on the Department of Health and Senior Services WIC web page at: <http://health.mo.gov/living/families/wic/wiclwp/eligibilitylwp.php>.
2. The health plan shall require its in-network providers to document and refer eligible members for WIC services. As part of the initial assessment of members, and as a part of the initial evaluation



of newly pregnant women, the in-network providers shall provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five, as indicated, to the WIC Program. (Local WIC provider locations, contact information, and hours of operations can be found on the Department of Health and Senior Services WIC web page at: <http://health.mo.gov/living/families/wic/>.)

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.8(d).

We are familiar with the WIC eligibility criteria. HealthCare USA works with our providers to refer eligible members for WIC services by providing information on the referral process to providers at the time of orientation to the network and via the Provider Manual.

HealthCare USA recognizes that members benefit from aggressive coordination of services with the public health program. In addition to educating and encouraging the providers to work with the members to access these health services, our case managers routinely screen for the need and refer members to these public health programs.

2.10.9 SAFE-CARE Exams: Sexual Assault Forensic Examination and Child Abuse Resource Education (SAFE-CARE) examinations and related diagnostic studies which ascertain the likelihood of sexual or physical abuse performed by SAFE-CARE trained providers shall continue to be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program. The state agency shall define which services will continue to be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program when performed or requested by a SAFE-CARE trained provider. Other medically necessary services may be ordered by the SAFE-CARE provider by referring to an in-network provider when possible. The health plan shall be responsible for these services, regardless of whether the SAFE-CARE provider is in or out of the health plan network.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.9. SAFE-CARE examinations and related diagnostic studies, performed by SAFE-CARE-trained providers, will continue to be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the MO HealthNet program and issued policy statements. HealthCare USA covers other medically necessary services, not listed in the MO HealthNet policy statements, that may be ordered by the SAFE-CARE provider whether they are in-network or out-of-network.

2.10.10 Services in a Public School Setting:

- a. School Based Direct Services:
 - 1. The health plan shall not be financially liable for physical therapy (PT), occupational therapy (OT), speech therapy (ST), hearing aid, personal care, private duty nursing, or psychology/counseling services included in an IEP developed by the public school. IEPs will include services which are needed due to developmental and educational needs. The health plan shall be financially liable and shall not delay the provision of school based direct services that are medically necessary pending completion of the IEP.
 - 2. The health plan shall coordinate the provision of school based clinic services with comprehensive benefit services that are the responsibility of the health plan. In addition, the health plan shall



have a written process for coordination and collaboration with school based clinics, for promptly transferring medical and developmental data, and for coordinating ongoing care with special education services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.10(a).

As addressed in HealthCare USA policy HS-15 *Coordination with School-Based Services*, services that are identified to be our responsibility and are determined to be medically necessary are coordinated with the current school based services to promote the best long term outcome for the member.

2.10.10b. First Steps:

1. The health plan shall not be financially liable for services included in an IFSP developed under the First Steps Program. IFSPs include services which are needed due to developmental and educational needs.
2. First Steps is an early intervention program required by the Individuals with Disabilities Education Act (IDEA) - Part C (34 CFR 303) Early Intervention Program for Infants and Toddlers with Disabilities) which also defines the IFSP. IEP services are required by the IDEA Part B (34 CFR 300 and 301). The First Steps program serves children from birth to age three (3) who have a fifty percent (50%) or greater delay in development or a diagnosed medical condition known to cause developmental delay. Enrollment in the First Steps program is voluntary at the choice of the child's parent or guardian. The intent of the program is, through early identification and intervention, to improve functioning in order to better prepare the child to participate in school. The Missouri Department of Elementary and Secondary Education (DESE) operates the First Steps program. Service Coordinators, employed by the System Point of Entry (SPOE) agency that contracts with DESE are responsible for determining program eligibility based on multi-disciplinary evaluation of the child. The IFSP team determines the child's service needs. With the parent/guardian consent, the health plan shall refer children who are potentially eligible for First Steps services to the local First Steps office (System Point of Entry) or call the state-wide toll-free number, 866-583-2392, to make a referral.
3. The health plan shall coordinate the provision of First Step services with comprehensive benefit services that are the responsibility of the health plan. In addition, the health plan shall have a written process for coordination and collaboration with First Step, for promptly transferring medical and developmental data, and for coordinating ongoing care with special education services. The health plan shall not delay the provision of therapies that are medically necessary pending completion of the IFSP.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.10(b).

HealthCare USA understands that we are not financially liable for counseling services included in an:

- Individualized Educational Program (IEP) developed by the public schools
- Individualized Family Service Plan (IFSP) developed under the First Steps program as outlined in the *HealthCare USA-Member Handbook*, p. 68

HealthCare USA coordinates medically necessary services beyond the IEP benefit in collaboration with a child's PCP, therapy provider or school-based clinics. HealthCare USA is



financially liable and we will not delay school-based direct services that are medically necessary pending completion of an IEP or IFSP.

Case Management

When children are identified with developmental delays or their medical history is such that developmental delays are expected, HealthCare USA initiates a case management assessment. The case manager coordinates services that may include referrals to the First Steps Program after obtaining parental consent is. If records are required, HealthCare USA obtains written parental consent for the school to release to us records relevant to the therapy the case requires.

2.10.10c. Parents as Teachers (PAT):

1. PAT is a home-school-community partnership which supports parents in their role as their child's first and most influential teachers. Every family who is expecting a child or has a child under the age of kindergarten entry is eligible for PAT. PAT services include personal visits from certified parent educators, group meetings, developmental screenings, and connections with other community resources. PAT programs collaborate with other agencies and programs to meet families' needs, including Head Start, First Steps, the Women Infants and Children Program (nutrition services), local health departments, the Family Support Division, etc. Independent evaluations of PAT show that children served by this program are significantly more advanced in language development, problem solving, and social development at age three (3) than comparison children, ninety-nine point five percent (99.5%) of participating families are free of abuse or neglect, and early gains are maintained in elementary school, based on standardized tests. The PAT program is administered at the local level by the public school districts in the State of Missouri. Families interested in PAT may contact their local district directly. PAT also accepts referrals from other sources including medical providers. (Additional information about PAT is available at the Department of Elementary and Secondary Education's website at <http://www.dese.mo.gov/>. (To navigate to the web page, follow the links: A-Z Index, "E," "Early Childhood Education," and then "Parents as Teachers.")
2. PAT is not a Medicaid covered service. The health plan shall encourage in-network pediatric providers to make referrals to the PAT program.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.10(c).

HealthCare USA is fully aware of the mission and vision of Parents as Teachers (PAT) program and the program's goals to:

- Increase parent knowledge of early childhood development and improve parenting practices
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

We promote opportunities for child development and one outstanding way is by encouraging in-network pediatric providers to make referrals to the PAT program, as documented in the *HealthCare USA Provider Manual*, p. 95. We promote the program to members, too, informing parents on how PAT helps parents to be their child's best "first" teacher. PAT parent educators



visit families in their homes to share child development information and offer suggestions and ideas for activities parents can do with their child to encourage developmental skills.

2.10.11 Services for Children in the Custody of the Jackson County Office of the Missouri Children's Division: Children in the custody of the Jackson County Office of the Missouri Children's Division (CD) and residing in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, or St. Clair counties receive additional medical care services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.II.

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- 2.10.11.a. The health plan is not responsible for targeted medical case management services. Medical case management services are intended to facilitate access to medical services for the targeted children. Per the contract with Medical Case Management agencies, children are followed at three different levels: Category 1, well children; Category 2, children with behavioral health needs; and Category 3, children with medical needs. Children identified as Category 2 and Category 3 will remain in targeted medical case management during the entire time they are in custody. Category 1 children will be enrolled for targeted medical case management only during the first 30 calendar days of custody. The medical case management services provided by the Medical Case Management Agency include, but are not limited to:
1. Promoting the effective and efficient access to comprehensive medical services for the targeted children;
 2. Facilitating the coordination of medical services;
 3. Maintaining confidential centralized files for each child;
 4. Assisting in the education of CD staff, caregivers, and health care providers regarding the child's medical care;
 5. Providing information regarding the need for specialized health services; and
 6. Coordinating and monitoring all primary and specialty care necessary for the child.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.II(a).

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- 2.10.11.b. The health plan and its providers shall cooperate with the Medical Case Management Agency in securing medical histories and providing medical records. The health plan shall allow case managers to file an appeal immediately (or within 12 hours if a concern arises after regular business hours) to the health plan's Medical Director if a case managed child is denied services or has difficulty accessing services covered in the contract.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.II(b).



2.10.11.c. The health plan shall designate a person within the health plan as a primary contact for CD staff, caregivers, and health care providers for issues involving these targeted children. The health plan shall also participate and attend medical oversight meetings.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.11(c).

The HealthCare USA Special Needs Coordinator serves as the primary contact for Children's Division staff, caregivers, and health care providers for issues involving these targeted children. HealthCare USA participates and attends medical oversight meetings such as the Alternative Care Children's Oversight Committee meeting.

2.10.12 Transplant Services: Solid organ and bone marrow/stem cell transplant services are not included in the comprehensive benefit package as covered benefits. These services will be delivered for all populations through separate arrangements. Transplant services are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with both procurement and the transplant procedure.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.12.

2.10.12.a. The health plan shall be responsible for any services before and after this admission, including the evaluation that may be related to the condition, even though these services may be delivered out-of-network.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.12(a).

HealthCare USA covers the pre-surgery evaluation, care (excluding the solid organ procurement or bone marrow/stem cell harvest), and post-transplant discharge follow-up care whether in-network or out-of-network. We understand that members have freedom of choice of providers when services are paid on a fee-for-service basis outside of the plan. In recent year, several HealthCare USA members have received transplants in out-of-state locations, including Nebraska and Kansas.

2.10.12.b. According to 42 CFR 431.51, Medicaid must ensure freedom of choice of providers for services provided to Medicaid beneficiaries when those services are paid on a fee-for-service basis outside the health plan. When in-network providers identify a member as a potential transplant candidate, the member must be referred to a transplant facility of their choice without regard to health plan preference.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.10.12(b).

We recognize that members receiving a transplant typically require substantial coordination of their care, as well as support before, during and after the transplant procedure. Once



HealthCare USA is notified by MO HealthNet of a member who is a transplant recipient or potential recipient, the member is enrolled into our complex case management program. One of our nurse case managers then assists the member through the experience, working with HealthCare USA's concurrent review nurse, the facility, and the member and/or member's family to coordinate care and services with the member, provider and state agency.

2.11 Case Management and Disease Management

2.11.1 Case Management: The health plan shall provide case management to selected members. The health plan case management service shall focus on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality cost impact; and creating opportunities and systems to enhance outcomes. The health plan may use a Section 2703 designated health home providers to perform case management functions if the health home practice is a member of the health plan network. In this event, the health plan shall have processes in place to monitor service delivery and ensure that all requirements, as described herein, are adequately performed.

- a. Case management record documentation must include, but not be limited to, the following:
 1. Referrals;
 2. Assessment/Reassessment;
 3. Medical History;
 4. Psychiatric History;
 5. Developmental History;
 6. Medical Conditions;
 7. Care Planning;
 8. Provider Treatment Plans;
 9. Testing;
 10. Progress/Contact Notes;
 11. Discharge Plans;
 12. Aftercare;
 13. Transfers;
 14. Coordination/Linking of Services;
 15. Monitoring of Services and Care; and
 16. Follow-up.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.1(a).

Our Case Management Program focuses on:

- Enhancing and coordinating a member's care across either an episode or continuum of care
- Negotiating, procuring and coordinating services and resources needed by members/families with complex issues
- Ensuring and facilitating achieving quality, clinical and cost outcomes
- Intervening at key points for individual members
- Addressing and resolving patterns of issues that have negative quality cost impact



- Creating opportunities and systems to enhance outcomes
- Coordinating with the 2703 designated health home providers

As documented in HealthCare USA policy HS-55 *Care Management*, we have processes in place to ensure proper documentation in accordance with state agency and NCQA requirements.





2.11.1b. General Overview:

1. The health plan shall conduct case management services in order to achieve the following outcomes:
 - Improved patient care;
 - Improved health outcomes;
 - Reduction of inappropriate inpatient hospitalization;
 - Reduction of inappropriate utilization of emergent services;
 - Lower total costs; and
 - Better educated providers and members.
2. The health plan shall inform members selected for case management of the following:
 - The nature of the case management relationship;
 - Circumstances under which information will be disclosed to third parties;
 - The availability of a complaint process; and
 - The rationale for implementing case management services.
3. The case managers shall verify that the information listed in Section 2.11.1 b. 2) has been provided to the member and record the verification in the member's care plan.
4. The health plan shall notify members via the member handbook that they may request case management services at any time.
5. The health plan shall have policies and procedures for case management. The policies and procedures shall include:
 - A description of the system for identifying and screening members for case management services;
 - Provider and member profiling activities;
 - Procedures for conducting provider education on case management;
 - A description of how claims analysis will be used;
 - A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in the development of the care plan;
 - A process to ensure integration and communication between physical and behavioral health;
 - A description of the protocols for communication and responsibility sharing in cases where more than one case manager is assigned;
 - A process to ensure that care plans are maintained and up-dated as necessary;
 - A description of the methodology for assigning and monitoring case management caseloads that ensures adequate staffing to meet case management requirements;
 - Timeframes for reevaluation and criteria for case management closure; and
 - Adherence to any applicable State quality assurance, certification review standards, and practice guidelines as described in herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.1(b).

We place the member at the center of the case management process by addressing the needs of the whole person. Members are informed of available case management services in the *HealthCare USA Member Handbook*, p. 33, and through our member newsletters.



HealthCare USA policy HS-55 *Care Management*, outlines the case management processes, which include but are not limited to:

- Identifying of members for case management
- Profiling activities
- Provider education procedures
- Claims analysis
- Collaborating with the PCP, member/parent/guardian and specialists to develop the member's care plan
- Integration and communication between physical and behavioral health
- Co-management of a member by multiple health plan staff
- Initial and follow-up assessments
- Monitoring staff case loads
- Case closure criteria
- Adherence to state and accreditation guidelines

2.11.1c. General Eligibility and Assessment:

1. The health plan shall offer case management to all pregnant members. The health plan shall offer case management within fifteen (15) days of confirmation of pregnancy. The initial case management and admission encounter is required to be face-to-face and to include an assessment of the member's needs.
2. The health plan shall offer case management within the following timeframes to all children when knowledge of elevated blood lead levels is present:
 - 10 to 19 ug/dL within 1–3 days
 - 20 to 44 ug/dL within 1–2 days
 - 45 to 69 ug/dL within 24 hours
 - 70 ug/dL or greater - immediately
3. The health plan shall perform an assessment for case management within thirty (30) days of enrollment for new members who present with a diagnosis listed below. The health plan shall perform an assessment for case management within thirty (30) days of diagnosis for existing members who receive a new diagnosis listed below:
 - Cancer;
 - Cardiac Disease;
 - Chronic Pain;
 - Hepatitis C;
 - HIV/AIDS;
 - Individuals with special health care needs including those with Autism Spectrum Disorder. Individuals with special health care needs are those individuals that without services such as private duty nursing, home health, durable medical equipment/supplies, and case management may require



hospitalization or institutionalization. The following groups of individuals are at high risk of having a special health care need:

- Individuals with Autism Spectrum Disorder;
 - Individuals eligible for Supplemental Security Income (SSI);
 - Individuals in foster care or other out-of-home placement;
 - Individuals receiving foster care or adoption subsidy; and
 - Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the State agency in terms of either program participant or special health care needs.
- Sickle Cell Anemia;
 - Anxiety Disorders; and
 - Pervasive Developmental Disorder.
4. The health plan shall provide an assessment for case management for all members experiencing one (1) of the events listed below. The health plan shall conduct such assessments within thirty (30) days of:
- The date upon which a member receives the projected discharge date from hospitalization or rehabilitation facilities:
- After a stay of more than two (2) weeks; or
 - If they will be discharged with medications that require state agency prior authorization.
- The last day of the month following the end of a quarter in which a member has had three (3) or more emergency department visits as identified through analysis of utilization data;
 - Receipt of a diagnosis of co-occurring behavioral health and substance abuse as identified through analysis of utilization data;
 - Receipt of a diagnosis of a chronic or debilitating physical health condition including but not limited to the disease states listed in the Disease Management section herein and a behavioral health condition as identified through analysis of utilization data;
5. The health plan shall assess members for case management within five (5) days of admission to a psychiatric hospital or residential substance abuse treatment program.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.1(c).

HealthCare USA policies HS-55 *Care Management* and HS-60 *Lead Case Management* outline the timeframes and conditions in which staff offer and/or assess members for case management services.



2.11.1d. Care Plans:

1. For all eligible members, the health plan shall use the initial assessment to identify the issues necessary to formulate the care plan. All care plans shall have the following components:

- Use of clinical practice guidelines (including the use of CyberAccesssm to monitor and improve medication adherence and prescribing practices consistent with practice guidelines);
- Use of transportation, community resources, and natural supports (e.g. friends, family, neighbors, acquaintances, co-workers, volunteers, peers, church members);
- Specialized physician and other practitioner care targeted to meet member's needs;
- Member education on accessing services and assistance in making informed decisions about care;

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- Prioritized based on the assessment of the member's needs that are measurable and achievable;
- Emphasis on prevention, continuity of care, and coordination of care. The system shall advocate for and link members to services as necessary across providers and settings; and
- Reviews to promote achievement of case management goals and use of the information for quality management.

2. In addition to the requirements listed above, the health plan shall include the following in the care plans of pregnant women:

- A risk appraisal form must be a part of the member's record. The health plans may use the state agency form or any form that contains, at a minimum, the information required in the MHD Risk Appraisal form. These forms may be obtained from the Physician Provider manual on the state agency's website: www.dss.mo.gov/mhd.
- Intermediate referrals to substance-related treatment services if the member is identified as being a substance user. If the member is referred to a C-STAR program, care coordination should occur in accordance with the Substance Abuse Treatment Referral Protocol for Pregnant Women Under MO HealthNet Managed Care.
- Referrals to prenatal care (if not already enrolled), within two (2) weeks of enrollment in case management;
- Tracking mechanism for all prenatal and post-partum medical appointments. Follow-up on broken appointments shall be made within one (1) week of the appointment;
- Methods to ensure that EPSDT/HCY screens are current if the member is under age twenty-one (21);
- Referrals to WIC (if not already enrolled), within two (2) weeks of enrollment in case management;
- Assistance in making delivery arrangements by the twenty-fourth (24th) week of gestation;
- Assistance in making transportation arrangements for prenatal care, delivery, and post partum care;
- Referrals to prenatal or childbirth education where available;
- Assistance in planning for alternative living arrangements which are accessible within twenty-four (24) hours for those who are subject to abuse or abandonment;
- Assistance to the mother in enrolling the newborn in ongoing primary care (EPSDT/HCY services) including provision of referral/assistance with MO HealthNet application for the child, if needed;
- Assistance in identifying and selecting a medical care provider for both the mother and the child;
- Identification of feeding method for the child;



- Notifications to current health care providers when case management services are discontinued;
 - Referrals for family planning services if requested; and
 - Directions to start taking folic acid vitamin before the next pregnancy.
3. If the health plan wants to use local public health agencies to provide services, the health plan shall enter into written contracts with the local public health agencies. However, the health plan is not required to contract with outside entities for prenatal case management services.
4. In addition to the requirements listed above, the health plan shall:
- Include the following services in the care plans for children with elevated blood lead levels.
- Ensure confirmation of capillary tests using venous blood according to the timeframe listed below:
- 10-19 μ g/dL – Within two (2) months.
 - 20-44 μ g/dL – Within two (2) weeks.
 - 45-69 μ g/dL – Within two (2) days.
 - 70 μ g/dL – Immediately.
- Ensure that the Childhood Blood Lead Testing and Follow Up Guidelines are followed as required:
- 10-19 μ g/dL – 2-3 month intervals.
 - 20-70+ μ g/dL – 1-2 months intervals, or depending upon the degree of the elevated lead level, by physician discretion until the following three conditions are met:
 - i. BLL remains less than 15 μ g/dL for at least 6 months;
 - ii. Lead hazards have been removed; and
 - iii. There are no new exposures.

When the above conditions have been met, proceed with retest intervals and follow-up for BLLs 10-19 μ g/dL.

- A minimum of three (3) member/family encounters, all face-to-face. Initial visit must be performed within two (2) weeks of receiving a confirmatory blood lead level that met the lead case management requirements. This visit must include the following:
- A member/family assessment;
 - Provision of lead poisoning education offered by health care providers;
 - Engagement of member/family in the development of the care plan; and
 - Delivery of the case manager's name and telephone number.
- Follow-up visit or second (2nd) encounter within three (3) months following the initial encounter. Assessment and review of the child's progress, parental compliance with recommended interventions, reinforcement of lead poisoning education, member education, and the medical regime should be performed at that time.
- An exit evaluation or third (3rd) encounter is required to be performed prior to discharge between the sixth (6th) to seventh (7th) month after the initial encounter unless there is a medically necessary need for further follow-up. If the child meets the criteria for discharge, this encounter must include,



but not limited to, discharge counseling regarding current blood lead level status, review of ongoing techniques for prevention of re-exposure to lead hazards, as well as nutrition, hygiene, and environmental maintenance.

- Document the following in the member record:
 - Initial visit: The admission progress note must document contact with child's PCP and any planned interventions by the health plan or subcontractor case manager. The notes must also include the plan of care and include, at a minimum, blood lead level/s, assessment of the member/family including resulting recommendations, and lead poisoning education that includes acknowledgement of parental understanding of this education.
 - The health plan shall use the web-based Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC) Lead Application to document lead case management activities. The health plans may use the DHSS Childhood Lead Poisoning Prevention Program Nurse's Lead Case Management Questionnaire and the Nutritional Assessment forms to assist them in capturing all the required case management elements for documentation. Both forms are found in the Lead Poisoning Prevention Manual at <http://health.mo.gov>.
 - Follow-up visit(s): The documentation must include the most recent laboratory results, member status, any interventions by case manager, contacts with the child's primary care provider and progress made to meet plan of care goals.
 - Exit visit: The discharge documentation must include the date of discharge, reason for discharge, lab results, member status, and exit counseling. The exit counseling documentation must include a telephone number for member questions and assistance, and status of plan of care goal completion. The documentation must include member/family and primary care provider notification of discharge from case management and continued care coordination plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.1(d).

HealthCare USA's policy HS-55 *Care Management*, outlines the required components of the member care plan, which is in accordance with the state agency and NCQA guidelines.

We will follow services in the care plans and documentation requirements for children with elevated blood lead levels, as outlined in HealthCare USA policy HS-60 *Lead Case Management*.



2.11.1e. Case Management Closure:

1. The health plan shall have criteria for terminating case management services. These criteria shall be included in the care plans. Acceptable reasons for case closure for case management (excluding case management for elevated lead levels) include:
 - Achievement of goals stated in care plan including stabilization of the member's condition, successful links to community support and education, and improved member health;
 - Member request to withdraw from either case management or the health plan; and
 - Lack of contact with the case manager or compliance with case management must be documented in the care plan. At least three (3) different types of attempts to locate and engage the member should be made to contact the family prior to closure for this reason. Examples of contact attempts include:
 - Making phone call attempts before, during, and after regular working hours;
 - Visiting the family's home;
 - Sending letters with an address correction request; and
 - Checking with primary care provider, Women, Infants, and Children (WIC), and other providers and programs.
 - The health plan shall review cases for closure from prenatal case management no sooner than sixty (60) days from the date of delivery.
 - For children receiving case management due to elevated blood lead levels, the health plan shall review cases for closure using the following occurrences:
 - When current blood lead level is less than 10 ug/dL; or
 - When the child is disenrolled and referral to a new health plan, local public health agency, or health care provider has been completed.
 - The PCP must be notified in writing of all instances of children discharged from case management and the reason for discharge. The discharge notification must include a history of the child's condition.
 - The health plan shall provide quarterly and yearly outcome measurement and reporting. The reporting requirements specified herein will satisfy this component.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.1(e).

HealthCare USA policy HS-55 *Care Management* summarizes the criteria for terminating case management services. These criteria are also included in the care plans.



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- 2.11.2 Disease Management (DM): Disease management is the process of intensively managing a particular disease or syndrome. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. It is similar to case management, but more focused on a defined set of programs relative to an illness or syndrome. (Definition used with permission of Center for Health Care Strategies, Inc., Princeton, New Jersey, "Case Management in Managed Care for People with Developmental Disabilities: Models, Costs and Outcomes, January, 1999".)
- a. The health plan shall have disease management programs for major depression, asthma, and at least one of the following: obesity, diabetes, hypertension, or Attention Deficit Hyperactivity Disorder (ADHD). The health plan may use a Section 2703 designated health home providers to perform disease management functions if the health home practice is a member of the health plan network. In the event of such, the health plan shall have processes in place to monitor service delivery and ensure that all requirements, as described herein, are adequately performed.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.2(a).

HealthCare USA has the following disease management programs:

- Major depression (required)
- Asthma (required)
- Diabetes (selection)
- High-risk OB
- NICU



2.11.2b. The DM programs shall:

1. Have systematic methods of identifying and enrolling members in each program. As such, the health plan shall utilize the information gathered upon initial enrollment into the health plan and the MO HealthNet program and use of clinical diagnosis codes. In addition, the health plan shall offer disease management to members as early in the development of the disease state as possible. The health plan shall operate its disease management programs using an “opt out” methodology, meaning that disease management services shall be provided to eligible members unless they specifically ask to be excluded.
2. Utilize evidence-based clinical practice guidelines (hereafter referred to as the guidelines) that have been formally adopted by the health plan’s Quality Management/Quality Improvement (QM/QI) committee or other clinical committee and member empowerment strategies to support the provider-member relationship and the plan of care.
3. Emphasize the prevention of exacerbation and complications of the conditions as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.
4. Classify eligible members into stratification levels according to condition severity or other clinical or member-provided information. The DM programs shall tailor the program content, education activities, and benchmarks and goals for each risk level.
5. Take a member-centered approach to providing care by addressing psychological aspects, caregiver issues, and treatment of disease using nationally recognized standards of care.
6. Incorporate culturally appropriate interventions including, but not limited to, taking into account the multi-lingual, multi-cultural nature of the member population.
7. Have program content that includes the development of treatment plans that serve as the outline for all of the activities and interventions in the program. At a minimum, the activities and interventions associated with the treatment plan shall address condition monitoring, member adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues.
8. Have methods for informing and educating members and/or their caregivers regarding their particular condition(s) and needs. This information shall be provided upon enrollment in the DM program. The DM programs shall educate members to increase their understanding of their condition(s), the factors that impact their health status (e.g., diet and nutrition, lifestyle, exercise, medication compliance), and to empower members to be more effective in self-care and management of their health so they:
 - Are proactive and effective partners in their care;
 - Understand the appropriate use of resources needed for their care;
 - Identify precipitating factors and appropriate responses before they require more acute intervention; and
 - Are compliant and cooperative with the recommended treatment plan.
9. Have methods for informing and educating providers regarding the clinical practice guidelines. The health plan shall distribute the guidelines to providers who are likely to treat members with the DM conditions. This includes, but is not limited to, PCPs and specialists involved in treating that particular condition. The health plan shall also provide each PCP with a list of their members enrolled in each DM program upon the member’s initial enrollment and at least annually thereafter. The health plan shall provide specific information to the provider concerning how the program(s) works. The DM’s provider education shall be designed to increase the providers’ adherence to the guidelines in order to improve the members’ conditions.
10. Have established measurable benchmarks and goals for each DM program that are used to evaluate the programs. These benchmarks and goals shall be specific to each condition and should include:



- Performance measured against at least two important clinical aspects of the guidelines associated with each DM program;
- The rate of emergency department utilization and inpatient hospitalization for asthma;
- Appropriate HEDIS measures;
- The passive participation rates (as defined by the National Committee for Quality Assurance (NCQA) and the number of individuals participating in each level of each of the DM programs;
- Cost savings;
- Member adherence to treatment plans; and
- Provider adherence to the clinical practice guidelines.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.2(b).

HealthCare USA state-approved policies HS-55 *Care Management* and HS-97 *Disease Management* summarizes the criteria of Section 2.11.2(b).

2.11.2c. The health plan shall develop and maintain DM program policies and procedures that describe how the programs will incorporate all components listed above. These policies and procedures shall address how the DM programs will coordinate with case management activities, in particular for members who would benefit from both.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.2(c).

HealthCare USA's state-approved policies HS-55 *Care Management* and HS-97 *Disease Management* outline the processes and procedures for our disease management programs.

2.11.2d. The health plan shall submit the disease management program reports as required herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.11.2(d).

2.12 Eligibility, Enrollment, and Disenrollment

2.12.1 The Missouri Department of Social Services, the Family Support Division (FSD) is responsible for eligibility determinations. The state agency will conduct enrollment activities for MO HealthNet Managed Care eligibles. The health plan or its subcontractors shall not conduct or participate in eligibility or enrollment activities.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.1.

2.12.2 Enrollment Counseling: The state agency will operate a toll-free telephone line to make helpline operators available to all MO HealthNet Managed Care eligibles to provide assistance in selecting and enrolling into a health plan. Helpline operators also will be available by telephone to assist



MO HealthNet Managed Care eligibles who would like to change health plans. The health plan shall refer MO HealthNet Managed Care eligibles and members to the toll-free helpline when needed. The helpline operator responsibilities will include the following:

- a. Educating the eligible and family about Managed Care in general, including the requirement to enroll in a health plan, the way services typically are accessed under Managed Care, the role of the primary care provider, the health plan member's right to choose a primary care provider subject to the capacity of the provider, the responsibilities of the health plan member, and the member's rights including the right to file grievances and appeals and to request a State fair hearing.
- b. Educating the eligible and family about benefits available through the health plan, both in-network and out-of-network.
- c. Informing the eligible and family of available health plans and outlining criteria that might be important when making a choice (e.g., presence or absence of existing provider(s) in the health plan provider network).
- d. Identifying any sources of Third Party Liability that were not identified by the FSD eligibility specialist.
- e. Administering a health plan screen when possible, as designated by the state agency that collects baseline health status data to be used as part of the health plan program evaluation. Any baseline health status data shall be made available to the health plan. (See Attachment 8 for the most current version.)
- f. Inquiring and recording primary language information.
- g. Explaining options for obtaining services outside the health plan network.
- h. Providing a listing of the health plan primary care providers generated from the provider demographic electronic file submitted by the health plan to the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.2(a-h).

2.12.3 Voluntary Selection of Health Plan: MO HealthNet Managed Care eligibles will be given fifteen (15) calendar days from the date the FSD determines them eligible for Managed Care to select a health plan. All members of a family shall be encouraged to select the same health plan. If a family does not select a health plan within the fifteen (15) calendar day window, the state agency will automatically assign the family to a health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.3.



- 2.12.4 Automatic Assignment Into Health Plans: The state agency will employ an algorithm to assign to the health plan, on a prorated basis, any MO HealthNet Managed Care eligibles who do not make a voluntary selection of a health plan during open enrollment. The algorithm shall be based on the following:
- a. If the MO HealthNet Managed Care eligible's case head is enrolled with a health plan, the MO HealthNet Managed Care eligible shall be assigned to that health plan. If not, the next step in the algorithm will be followed.
 - b. If the MO HealthNet Managed Care eligible is included in a MO HealthNet eligibility case where another member is enrolled with a health plan, the MO HealthNet Managed Care eligible shall be assigned to that health plan. If not, the MO HealthNet Managed Care eligible will be assigned randomly.
 - c. Within each region, the health plans will share equally forty percent (40%) of the random auto assignments.
 - d. The remaining sixty percent (60%) of the random auto assignments in each region shall be based on the total performance score for each health plan for that region. The performance score for each region will be calculated on the following measures:
 1. The total evaluation score determined by the State of Missouri (see Proposal Submission Information section);
 2. The health plan's Missouri regional score on the HEDIS 2010 measure of annual dental visits;
 3. The health plan's Missouri regional score on the HEDIS 2010 measure of adolescent well care visits;
 4. The health plan's Missouri regional score on the HEDIS 2010 measure of mental health utilization;
 5. The number of FQHCs, RHCs, and CMHCs the health plan has in its network (beyond the minimum of one (1) in the region); and
 6. The inclusion of an acute care safety net hospital, (as defined in 13 CSR 70-15.010 of the Code of State Regulations, as amended) in its network. (A listing of safety net hospitals is provided in Attachment 5.)
 - e. The health plan shall receive a total number of points based on these six (6) measures; the total of these points will be the performance score earned by the health plan. The performance score will translate into a percent of the performance auto assignment. For the first year of the contract, health plans that are new to the MO HealthNet Managed Care Program or new to a region will receive the average score of all health plans in the awarded region for its proxy HEDIS 2010 measures.
 - f. Each year of the contract, the state agency will change the performance measures included, recalculate the performance score, and the performance auto assignment for each health plan. At a minimum, the state agency will make the following changes to the algorithm:
 1. In the second year of the contract, there will be a measurement of Emergency Department Visits which is a component of Ambulatory Care and an additional HEDIS measure and the total evaluation score will be replaced by a measure based upon encounter data and the extent to which it matches with health plan financial data submissions.
 2. In the third year of the contract, there will be one (1) additional HEDIS measure (for a total of six (6) HEDIS measures) and the total evaluation score will again be replaced by a measure based upon encounter data and the extent to which it matches with health plan financial data submissions.
 3. The state agency will conduct meetings with stakeholders and the health plans to solicit input on appropriate measures to be used during the second and third years of the contract. The state agency will inform the health plans of the measures to be used at least six (6) months prior to the implementation of the changed performance auto assignment algorithm.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.4(a-f).



2.12.5 Automatic Re-Assignment Into Health Plans:

- a. Following Resumption of Eligibility: The state agency will automatically enroll members who are disenrolled from a health plan due to loss of eligibility into the same health plan and to the same primary care provider should they regain eligibility within sixty (60) calendar days. The member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason. If more than sixty (60) calendar days have elapsed, the member shall be permitted to select a health plan and primary care provider through the enrollment process.
 - b. Members Relocating to Another Region: The state agency will automatically enroll members who move from one region to another into the same health plan if the health plan is operational in that region. The member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.5(a-b).

2.12.6 Health Plan Lock-In:

- a. All members will have a twelve (12) month lock-in to provide a solid continuum of care. Once a member chooses a health plan or is assigned to a health plan, the member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason. This applies to the member's initial enrollment and to any subsequent enrollment periods where the member changed health plans. All transfers between health plans that members request during the first ninety (90) calendar days following initial enrollment shall be granted without review by the state agency. Both the 90-day and the 12-month enrollment period begin on the same day.
 - b. Children in COA 4 shall be allowed automatic and unlimited changes in health plan choice as often as circumstances necessitate.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.6(a-b).

2.12.7 Open Enrollment:

- a. The state agency may conduct an open enrollment for the contract period. The state agency may at its sole option adjust enrollment during the transition between contract periods.
 - b. Annual Open Enrollment: The state agency will give members an annual open enrollment period prior to their 12-month enrollment anniversary date with the health plan. The state agency shall provide an open enrollment notice to members at least sixty (60) calendar days before each annual enrollment opportunity.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.7(a-b).

- 2.12.8 Suspension of and/or Limits on Enrollments: The state agency reserves the right to suspend or limit enrollment into a health plan. In the event the health plan's enrollment reaches sixty-five (65) percent of the total enrollment in the region, the health plan will not be offered as a choice for enrollment nor will the health plan receive members through the automatic assignment algorithm.
-



However, the health plan may receive new members as a result of: newborn enrollments; reassignments when a member loses and regains eligibility within a sixty (60) day period; assignments/selection when other family or case members are members of the health plan; the need to ensure continuity of care for the member; or determination of just cause by the state agency. The state agency's evaluation of a health plan's enrollment market share shall take place on a calendar quarter.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.8.

2.12.9 During the enrollment process, members will be asked if English is their main language. If English is not the member's main language, the member will be asked to identify that language. The information gathered by the state agency will be shared with the health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.9. We use member demographic information received on the Daily 834 Eligibility and Weekly 834 Reconciliation Files, and update any pertinent information, including the member's primary language.

2.12.10 Health Plan Enrollment Procedures:

- a. The health plan shall have and implement written policies and procedures for enrolling members within five (5) business days after receiving notification of the member's anticipated enrollment date from the state agency (e.g., if the health plan is informed of a new member on a Wednesday, it must contact (in writing, by phone, or in-person) the member by the following Tuesday).
- b. The health plan shall enroll any MO HealthNet Managed Care eligible that selects the health plan or is assigned with the health plan. The only exceptions shall be if:
 1. The health plan's specified enrollment limit has been reached.
 2. The member was previously disenrolled from the health plan as the result of a request for disenrollment by the health plan, as allowed herein.
- c. Services for New Members: The health plan shall make available the full scope of benefits to which a member is entitled immediately upon his or her enrollment.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.10(a-c).

HealthCare USA policy E-4 *Member Enrollment and Disenrollment* outlines procedures to ensure that all eligible members who select HealthCare USA or are auto-assigned by MO HealthNet to HealthCare USA are enrolled within five business days after receiving notification of the enrollment date. Daily, when the eligibility file is received from InfoCrossing (the State of Missouri's Fiscal Intermediary), it is loaded within 24 hours, and eligible members are simultaneously queued for new member kits.



From November 1, 2010 to October 31, 2011, HealthCare USA's Enrollment Department received and loaded more than ten million records from the Daily 834 Eligibility and Weekly 834 Reconciliation files.



- 2.12.11 Newborn Enrollment: The health plan shall have and implement written policies and procedures for enrolling the newborn children of members effective to the date of birth. Newborns of members enrolled at the time of the child's birth shall be automatically enrolled with the mother's health plan. The health plan shall have a procedure in place to refer newborns to the FSD to initiate eligibility determinations. A mother of a newborn may choose a different health plan for her child; unless a different health plan is requested, the child shall remain with the mother's health plan.
- a. The mother's health plan shall be responsible for all medically necessary services provided under the comprehensive benefit package to the newborn child of an enrolled mother. The child's date of birth shall be counted as day one (1). The health plan shall provide services to the child until the child is disenrolled from the health plan. When the newborn is enrolled by FSD and entered into the eligibility system, the health plan shall receive capitation payment for the month of birth and for all subsequent months the child remains enrolled with the health plan.
 - b. In the case of an administrative lag in enrolling the newborn and costs are incurred during that period, the health plan shall hold the member harmless for those costs. The health plan shall be responsible for the cost of the newborn including medical services provided prior to completion of the State enrollment process.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.11(a-b).

HealthCare USA policy HS-39 *Newborn Notification and Enrollment*, outlines our policies and procedures for enrolling newborns from their date of birth.

2.12.12 Enrollment and Disenrollment Updates:

- a. Daily: Every business day, the state agency shall make available, via electronic media, updates on members newly enrolled into the health plan, or newly disenrolled. The health plan shall have and implement written policies and procedures for receiving these updates and incorporating them into the health plan and health care service subcontractors' management information system each day.
- b. Weekly Reconciliation: On a weekly basis, the state agency shall make available, via electronic media, a listing of current members. The health plan shall reconcile this membership list against the health plan internal records within thirty (30) business days of receipt and shall notify the state agency of any discrepancies.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.12(a-b).

HealthCare USA policy E-4 *Member Enrollment and Disenrollment* promotes timely eligibility updates of enrolled and disenrolled members reported by the State agency to HealthCare USA.



From November 1st, 2010 to October 31st, 2011, HealthCare USA received and loaded 301 Daily 834 Eligibility and Weekly 834 Reconciliation files, all of which were loaded into IDX within twenty-four (24) hours, upon receipt from MO HealthNet.



2.12.13 New Member Orientation: The health plan shall have and implement written policies and procedures for: orienting new members to their benefits; the role of the primary care provider; how to utilize services; what to do in an emergent or urgent medical situation; how to file a grievance or appeal; how to report to the Family Support Division any changes in the status of families or members, including changes in family size, income, insurance coverage, and residence; and how to report suspected fraud and abuse.

HealthCare USA understands and will comply with the requirements set forth in Section 2.12.13. HealthCare USA has implemented written policies and procedures for orientating new members that include the following:

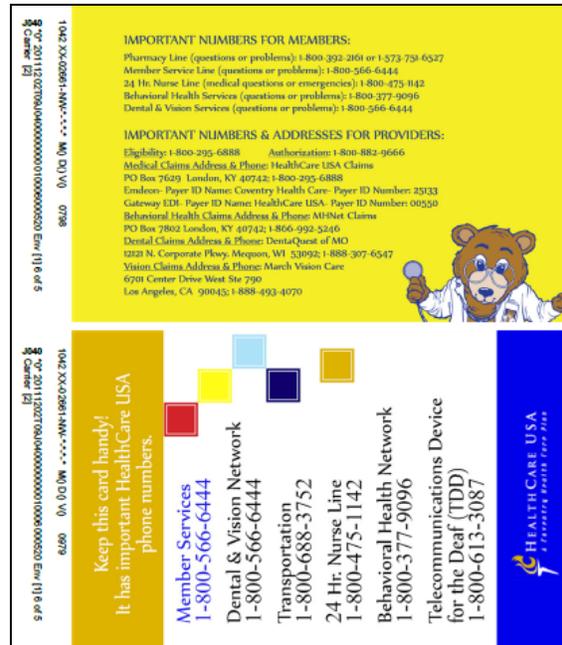
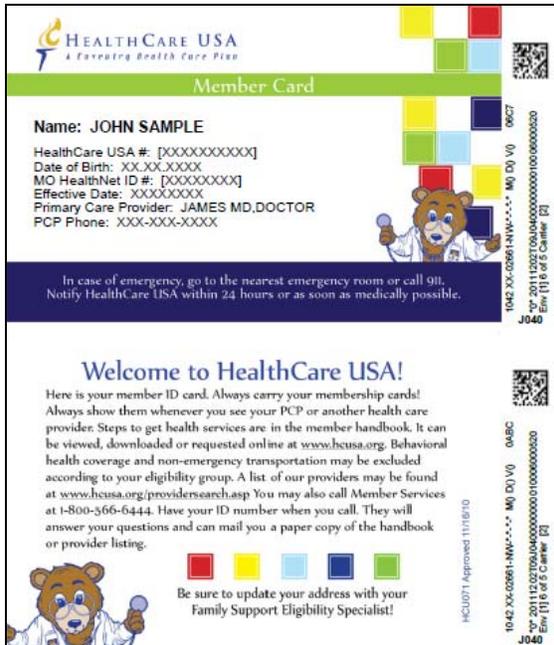
- Choosing a Primary Care Provider (PCP)
- Changing a Primary Care Provider (PCP)
- Understanding Member Rights and Responsibilities
- Service Availability and Appointment Standards
- Member Transportation
- Member Inquiry Grievance and Appeal Process
- Ensuring Early Periodic Screening Diagnostic Training (EPSDT)

HealthCare USA has written policies and procedures for orienting new members about HealthCare USA benefits through telephonic, written and personal outreach methods.

Our goal is to be available and accessible to members in order to provide reliable and timely information to keep our families healthy.

New HealthCare USA members will receive a Member Handbook and in ID card that explains HealthCare USA's benefits, the importance and role of their Primary Care Provider, what to do in case of an emergent or urgent medical situation, how to file an appeal or grievance, how to report suspected fraud and abuse and a listing of our most important telephone numbers as well as the 24-Hour Nurse Hotline.

At HealthCare USA, all new members receive a "sticker" on their ID card, encouraging them to call our member services department to learn about their benefits. HealthCare USA *welcomes* them to the HealthCare USA family, *informs* them of their benefits, *ensuring* they understand why a Primary Care Provider is beneficial and how to choose their Primary Care Provider, updates demographics and answers any additional questions our new members may ask in order to ensure a healthy family.



HealthCare USA’s Community Development Team and Member Services Department encourages our members to contact the Family Support Division in their area to report changes in their address or phone number, change in the size of their household or income. They are also encouraged to be sure to open any mail from the Family Support Division to allow processing time and avoid an interruption in their health care.

HealthCare USA’s Community Development Team also offers our new members an opportunity to be a part of “Doc Bear’s Membership Team.” Doc Bear’s Membership Team includes new members as well as existing members in all regions. This orientation process provides an opportunity for new members to learn about their benefits, educational opportunities, how to access care, how to avoid using the ED and how to keep an appointment when your ride does not show up.

HealthCare USA ensures all written materials are available to new members in a variety of formats to ensure all languages are represented as well as the hearing and visually impaired or those with limited literacy.

For further details on Section 2.12.13, see Section 4.5.2(d).

2.12.14 Assignment of Primary Care Provider: The health plan shall have and implement written policies and procedures for ensuring that each of the health plan’s members are assigned to a primary care provider. The process must include at least the following features:

- The health plan shall contact the member within five (5) business days from the date of the state agency’s notification to the health plan of the member’s anticipated enrollment date. To the extent provider capacity exists, the health plan shall offer freedom of choice to members in making a primary care provider selection.
- At the time of the state agency’s notification to the health plan, the health plan may assign a primary care provider taking into consideration factors such as current provider relationships, language needs (to the extent they are known), and area of residence. When contacting the member, the health plan shall provide the member with (1) the primary care provider’s name,



- location, and telephone number, and (2) options for selecting a primary care provider other than the primary care provider assigned to the member. The health plan shall inform the member that he/she has fifteen (15) calendar days to choose another primary care provider if they do not approve of the primary care provider assigned to them, and if they have not notified the health plan of their preferred primary care provider within that timeframe, the member will remain with the primary care provider previously assigned to the member.
- c. Prior to becoming effective with the health plan, if a member does not select a primary care provider or the health plan has not already assigned a primary care provider to the member at the time of notification from the state agency of the member's anticipated enrollment date, the health plan shall make an automatic assignment, taking into consideration such known factors as current provider relationships, language needs (to the extent they are known), and area of residence. The health plan shall then notify the member in writing of his or her primary care provider's name, location, and office telephone number. The member must have a primary care provider assigned by the time the member is effective with the health plan. If circumstances are such that the member does not have a primary care provider assigned on the effective date with the health plan, the health plan shall not deny services or payment of any service.
- d. The health plan shall submit to the state agency the methodology utilized by the health plan to assign primary care providers to members.
-

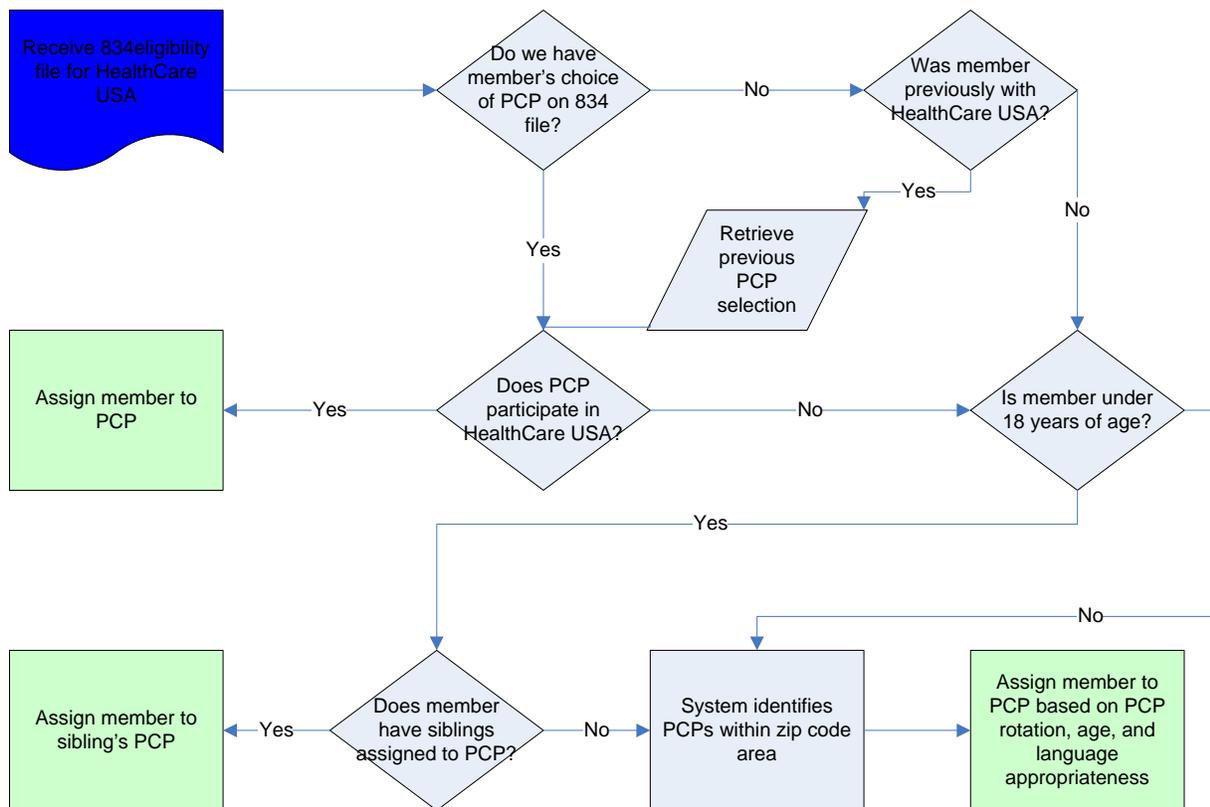
HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.14(a-d).

HealthCare USA has established policies and procedures to ensure that each of the health plan's members are assigned to a Primary Care Provider (PCP). Key details of the HealthCare USA process are as follows:

- The health plan contacts the member within five (5) business days from the date of the State agency's notification to the health plan of the member's anticipated enrollment date.
- The health plan assigns a Primary Care Provider (PCP) at the time of the State agency's notification to the health plan. Specific member factors are taken into consideration including, but not limited to the following: current provider relationships, language needs and area of residence. The health plan provides the name, location and telephone number of the PCP on the members ID card.
- The health plan explains that the member may select a different PCP within fifteen (15) calendar days.
- The health plan shall submit to the State agency the methodology utilized to assign PCPs to members prior to implementation of the contract. See Figure 2- 16.



Figure 2- 16: Primary Care Provider Assignment Process



2.12.15 Identification Cards: The member will receive two (2) identification cards.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.15.

For further details on Section 2.12.15, see Section 4.5.2(d).

2.12.15.a. The state agency will issue an identification card to all MO HealthNet eligibles. This card is not proof of eligibility, but to be used as a key for accessing the State's electronic eligibility verification systems by MO HealthNet enrolled providers. These systems will contain the most current information available to the state agency, including specific information regarding health plan enrollment. There will be no health plan specific information printed on the card.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.15 (a).



Through welcome packets, the web site and Doc Bear Facts Member Newsletter articles, HealthCare USA reminds members to present their MO HealthNet Identification card to their health care providers when accessing care.

2.12.15b. The health plan shall issue a membership card that contains information more specific to the health plan. At a minimum, the health plan issued membership card must contain the member's name, identification number, primary care provider name and telephone number, instructions for emergencies, and other relevant toll free lines for access such as behavioral health, dental, and nurse advice lines. The health plan issued membership card must be issued to the member prior to the member's effective date of coverage with the health plan. Upon selection of or assignment to a health plan, the member's effective date shall be fifteen (15) calendar days in the future. Exceptions apply to this policy for newborns and emergency enrollments. The state agency recognizes those exceptions and such enrollment materials may be produced as expeditiously as possible, but no later than fifteen (15) calendar days from the notification of the enrollment.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.15 (b).

HealthCare USA's membership ID card includes all the following information required information:

- Members Name
- Health Plan number
- Date of Birth
- MO HealthNet ID Number
- Medicaid Eligibility code
- Primary care provider's name and telephone number
- Effective date
- Pharmacy group number
- Members Services toll free number
- 24- Hour nurse hotline
- Mental Health services toll free number
- Dental Health toll free number
- Instructions for emergencies

HealthCare USA also provides an additional ready reference card to members listing important HealthCare USA phone numbers such as:

- Member Services
- Dental Network
- Transportation



- 24 Hour Nurse Hotline
- Mental Health Network
- After School programs
- Wellness check ups
- Vision and Dental coverage

HealthCare USA members receive their membership ID card prior to their effective date of coverage.

HealthCare USA's Community Development Team educates members on the importance of having both cards easily accessible and to present both cards when accessing care.





- 2.12.16 Member Handbook: The health plan shall mail a member handbook, and other written materials with information on how to access services, to all members within ten (10) business days of being notified of their future enrollment with the health plan.
- a. The member handbook shall be written in compliance with the requirements for written materials specified herein.
 - b. On an annual basis, the health plan shall review the member handbook, revise as necessary, and document that such review occurred.
 - c. At a minimum, the member handbook shall include the information and items listed below. The health plan may include some of the following information as inserts to the member handbook. The health plan shall include certain passages and language provided by the state agency in the member handbook. The health plan shall comply with all changes regarding member handbook content specified by the state agency in the time period defined by the state agency.
 1. Table of contents.
 2. Information about choosing and changing primary care providers, types of providers that serve as primary care providers (including information on circumstances under which a specialist may serve as a primary care provider), and the roles and responsibilities of primary care providers.
 3. Information about the importance of and how to report status changes such as family size changes, relocations out of county or out of state, etc.
 4. A listing of the members' rights and responsibilities as described herein.
 5. Appointment procedures and the appointment standards described herein.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

6. Notice that the adult member must present the MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility), as well as the health plan membership card, in order to access non-emergency services, and a warning that any transfer of the identification card or membership card to a person other than the adult member for the purpose of using services constitutes a fraudulent act by the adult member. Prior to seeking non-emergency services, the adult member must have a health plan issued membership card. If the adult member does not have a health plan issued membership card, the adult member must request one from the health plan they are enrolled in.
7. A description of all available health plan services, an explanation of any service limitations or exclusions from coverage, and a notice stating that the health plan shall be liable only for those services authorized by the health plan.
8. A description of all available services outside the comprehensive benefit package. Such information shall include information on where and how members may access benefits not available under the comprehensive benefit package.
9. The definition of medical necessity used in determining whether benefits will be covered.
10. A description of all prior authorization or other requirements for treatments and services.
11. A description of utilization review policies and procedures used by the health plan.
12. An explanation of a member's financial responsibility for payment when services are provided by an out-of-network provider or by any provider without required authorization or when a procedure, treatment, or service is not covered by the MO HealthNet Managed Care Program.
13. Notice that a member may receive services from an out-of network provider when the health plan does not have an in-network provider with appropriate training and experience to meet the particular health care needs of the member and the procedure by which the member can obtain such referral.
14. Notice that a member with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral.



15. Notice that a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the member's medical care and the procedure for requesting and obtaining such a specialist.
16. Notice that a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained.
17. A description of the mechanisms by which members may participate in the development of the policies of the health plan.
18. Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization.
19. Procedures for disenrollment, including an explanation of the member's right to disenroll with and without cause.
20. Information on how to contact member services and a description of its function.
21. Information on grievance, appeal, and State fair hearing procedures and timeframes. Such information shall include:

- The right to file grievances and appeals;
- The requirement and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the member can use to file a grievance or an appeal by phone;
- The procedures for exercising the rights to appeal or request a State fair hearing;

- That the member may represent himself or use legal counsel, a relative, a friend, or other spokesperson;
- The specific regulations that support or the change in Federal or State law that requires the action; and
- The fact that, when requested by the member -

- Benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and
- The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

- The following information about the member's right to request a State fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted:

- A member may request a State fair hearing within ninety (90) calendar days from the health plan's notice of action; and
- The state agency must reach its decisions within the specified timeframes:

- For standard resolution: within ninety (90) calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
- For expedited resolution (if the appeal was heard first through the health plan appeal process): within three working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process but was not resolved using the health plan's



- expedited appeal timeframes, or was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
- For expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the health plan appeal process): within three working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.
-
- Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
-
22. How to report suspected fraud and abuse activities, including the Medicaid Fraud Control Unit (MFCU) fraud and abuse hotline number.
 23. Information about the case management program to include that the member may request case management at any time.
 24. Information about the disease management programs.
 25. Pharmacy dispensing fee requirements (if applicable), including a statement that care shall not be denied due to lack of payment of pharmacy dispensing fee requirements.
 26. Information on how to access the provider network directory on the health plan's website and how to request a hard copy of the directory.
 27. A description of after-hours and emergency coverage. This description shall include the extent to which, and how, after-hours and emergency coverage are provided, including the following: (a) What constitutes an emergency medical condition, emergency services, and post-stabilization services; (b) The fact that prior authorization is not required for emergency services; (c) The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; (d) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; (e) The fact that the member has a right to use any hospital or other setting for emergency care; and (f) The post-stabilization care services rules specified herein.
 28. Information on how to obtain emergency transportation and non-emergency medically necessary transportation.
 29. Information on EPSDT services including immunization and lead guidelines designated by the state agency.
 30. Information on maternity, family planning, and sexually transmitted diseases services.
 31. Information on behavioral health and substance abuse services, including information on how to obtain such services, the rights the member has to request such services, and how to access services when in crisis, including the toll free number to be used to access such services.
 32. Information on travel distance standards.
 33. Information on how to obtain services when out of the member's geographic region and after-hours coverage.
 34. A statement that the health plan shall protect its members in the event of insolvency and that the health plan shall not hold its members liable for any of the following:
 - The debts of the health plan in the case of health plan insolvency;
 - Services provided to a member in the event the health plan failed to receive payment from the state agency for such service;
 - Services provided to a member in the event a health care provider with a contractual referral, or other type arrangement with the health plan, fails to receive payment from the state agency or the health plan for such services; or
 - Payments to a provider that furnishes covered services under a contractual referral, or other type arrangement with the health plan in excess of the amount that would be owed by the member if the health plan had directly provided the services.
-



35. A statement that any member that has a worker's compensation claim, or a pending personal injury or medical malpractice law suit, or has been involved in an auto accident, should immediately contact the health plan.
36. A statement that if a member has another health insurance policy, all prepayment requirements must be met as specified by the other health insurance plan and that the member must notify the health plan of any changes to their other health insurance policy. The member can contact the health plan with any questions.
37. Information on the Health Insurance Premium Payment (HIPP) program which pays for health insurance for members when it is determined cost effective.
38. Information on contributions the member can make towards his or her own health, appropriate and inappropriate behavior, and any other information deemed essential by the health plan or the state agency including the member's rights and responsibilities.
39. Information on the availability of multilingual interpreters and translated written information, how to access those services, and a statement that there is no cost to the member for these services.
40. Information on the procedures that will be utilized to notify members affected by termination or change in benefits, services, or service delivery office/site.
41. A statement that the health plan shall provide information on the health plan's PIP to any member upon request. Enrollment materials/member handbooks should annually disclose to members their right to adequate and timely information related to physician incentives.
42. With respect to advance directives, language describing:
 - The members' rights under the law of the State;
 - The health plan's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience; and
 - That complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.
43. A description of the additional information that is available upon request, including the availability of information on the structure and operation of the health plan.
44. A statement that the member has the right to obtain one free copy of his or her medical records annually and how to make the request.
45. Information on how to request and obtain an Explanation of Benefits (EOB).
 - d. The health plan shall submit the member handbook to the state agency for approval prior to distribution to members. The health plan shall make modifications in member handbook language if ordered by the state agency so as to comply with the member handbook requirements.

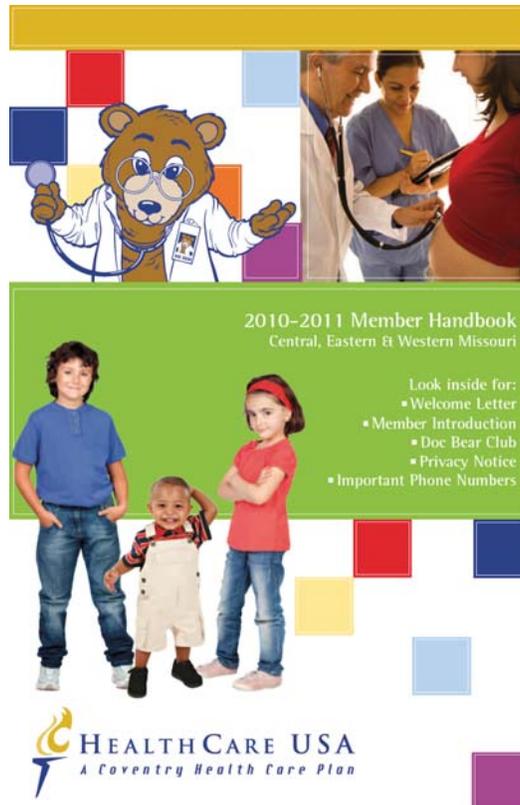
HealthCare USA understands and shall comply with the requirements set forth in 2.12.16 (a-d). HealthCare USA mails new member materials within 10 days of receipt of notification of new members. In addition, our member handbook and other member materials, are available online. Also, at any time, members may request a paper copies of online materials, such as the member handbook. Our Member Services Department processes those requests and mails member requested documents to the updated address provided by the member at the time of the request. HealthCare USA's member handbook is user-friendly and easy to understand. The Member Handbook includes, but is not limited to, the information listed in Section 2.12.16 (c) 1-45.



HealthCare USA reviews the Member Handbook on an annual basis and is revised as necessary in order to keep membership up to date and to comply with MO HealthNet requirements. The Member Handbook is also available on the HealthCare USA website, www.hcusa.org.

In addition, when a member receives their HealthCare USA membership card in the mail, they will be directed to contact Member Services to request a hard copy or on the website and request a Member Handbook or Provider Directory.

Figure 2- 17: Member Handbook



For further details on Section 2.12.16, see Section 4.5.2(d) and the *HealthCare USA Member Handbook* in the Attachments Binder.

2.12.17 Provider Directory: The health plan shall make available on its website an up-to-date searchable provider directory. The directory on the website shall be updated at least monthly. The directory shall include the names, specialty, telephone numbers, service site address(es), panel status (accepting new patients or not accepting new patients), and languages spoken of all providers. For physicians, this listing shall also include board certification status. The health plan shall have printed hard copies available of the directory which shall be mailed within forty-eight (48) hours of a member request for a hard copy version of the provider directory.

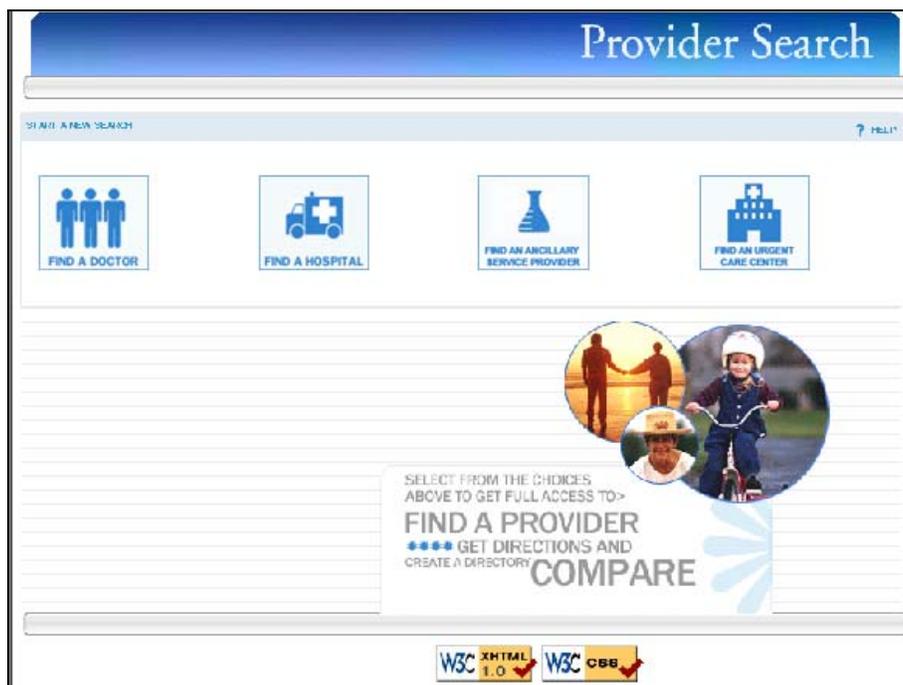
HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.17.



HealthCare USA has a complete and up-to-date list of our in-network providers available on our website. We update the website weekly, offering our members a current and complete listing for optimal access. Members and providers can search for providers by:

- Name
- Specialty
- County
- Zip code

A provider list is available in printed format (hardcopy directory requests are mailed to the member within 48 hours of the request) or by e-mail. The list can also be viewed simply by using the online provider function. This list contains names, specialties, telephone numbers, service site addresses, panel status, languages spoken and board certification information for based on specified search criteria.



For further details on Section 2.12.17, see Section 4.5.2(d).



2.12.18 Disenrollment:

- a. The state agency shall monitor, and approve or disapprove all transfer requests for just cause, within sixty (60) calendar days subject to a medical record review. The state agency may disenroll members from a health plan for any of the following reasons:
 1. Selection of another health plan during open enrollment, the first ninety (90) calendar days of enrollment, or for just cause.
 2. Change of residence that places the member outside of the health plan's region.
 3. To implement the decision of a hearing officer in a grievance proceeding by the member against the health plan, or by the health plan against the member.
 4. Loss of eligibility for either MO HealthNet Fee-For-Service or MO HealthNet Managed Care.
 5. Member exercises choice to voluntarily disenroll, or opt out, as specified herein under MO HealthNet Managed Care Program eligibility groups.
- b. Member Requests: A member may request to disenroll from a health plan for reasons that include, but are not limited to:
 1. Member requests health plan transfer during open enrollment.
 2. Member requests health plan transfer during the first ninety (90) days enrolled in the health plan.
 3. Just cause reasons that include:
 - Transfer is the resolution to a grievance or appeal;
 - Primary care provider or specialist with whom the member has an established patient/provider relationship does not participate in the health plan but does participate in another health plan;
 - Member is pregnant and her primary care provider or obstetrician does not participate in the health plan but does participate in another health plan;
 - Member is a newborn and the primary care provider or pediatrician selected by the mother does not participate in the health plan but does in another health plan;
 - Transfer to another health plan is necessary to ensure continuity of care;
 - An act of cultural insensitivity that negatively impacts the member's ability to obtain care and cannot be resolved by the health plan;
 - Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs;
 - Transfer to another health plan is necessary to correct an error made by the enrollment broker or the state agency during the previous assignment process; and
 - May also request transfer in order for all family members to be enrolled with the same health plan.
- c. Member Requests from Children in COA 4: Children in COA 4 will be allowed automatic and unlimited changes in health plan choice as often as circumstances necessitate. Foster parents will normally have the decision making responsibility for which health plan shall serve the foster child residing with them; however, there will be situations where the Social Service worker or the courts shall select the health plan for a child in State custody or foster care placement.
- d. Health Plan Requests:
 1. The health plan may request disenrollment of members, subject to the conditions described below:
 - Member persistently refuses to follow prescribed treatments or comply with health plan requirements that are consistent with Federal and State laws and regulations, as amended.
 - Member consistently misses appointments without prior notification to the provider.



- Member fraudulently misuses the MO HealthNet Managed Care Program or demonstrates abusive or threatening conduct. Giving or loaning a member's membership card to another person, for the purpose of using services, constitutes a fraudulent action that may justify a health plan's request to disenroll the member.
 - Member requests a home birth service.
2. The health plan shall not initiate disenrollment:
- Because of a medical diagnosis or the health status of a member;
 - Because of the member's attempt to exercise his or her rights under the grievance system;
 - Because of pre-existing medical conditions or high cost medical bills or an anticipated need for health care; or
 - Due to behaviors resulting from a physical or behavioral health condition.
3. Prior to requesting a disenrollment or transfer of a member, the health plan shall document at least three (3) interventions over a period of ninety (90) calendar days which occurred through treatment, member education, coordination of services, and case management to resolve any difficulty leading to the request, unless the member has demonstrated abusive or threatening behavior in which case only one (1) attempt is required. The health plan shall cite at least one (1) of the above examples of good cause before requesting that the state agency disenroll that member. If the health plan intends to proceed with disenrollment during the ninety (90) calendar day period, the health plan shall give a notice citing the appropriate reason to both the member and the state agency at least thirty (30) calendar days before the end of the ninety (90) calendar day period. The health plan shall document all notifications regarding requests for disenrollment.
- Members shall have the right to challenge a health plan initiated disenrollment to both the state agency and the health plan through the appeal process within ninety (90) calendar days of the health plan's request to the state agency for disenrollment of the member. When a member files an appeal, the process must be completed prior to the health plan and the state agency continuing disenrollment procedures.
 - Within fifteen (15) working days of the final notification (after no appeal or a final hearing decision), members shall be enrolled in another health plan or transferred to another provider.
 - If the health plan recommends disenrollment or transfer for reasons other than those stated above, the State shall consider the health plan to have breached the provisions and requirements of the contract and may be subject to sanctions as described herein.
- e. Disenrollment Effective Dates: Member disenrollments outside of the open enrollment process shall become effective on the date specified by the state agency. The health plan shall have written policies and procedures for complying with state agency disenrollment orders.
- f. Hospitalization at the Time of Enrollment or Disenrollment:
1. With the exception of newborns, the health plan shall not assume financial responsibility for members who are hospitalized in an acute setting on the effective date of coverage until an appropriate acute inpatient hospital discharge. If the member is in the MO HealthNet Fee-For-Service Program at the time of acute inpatient hospitalization on the effective date of coverage, the member shall remain in the fee-for-service program until an appropriate acute inpatient hospital discharge. Members, including newborn members, who are in another health plan at the time of acute inpatient hospitalization on the effective date of coverage, shall remain with that health plan until an appropriate acute inpatient hospital discharge. Members, including newborn



- members, who are hospitalized in an acute setting, shall not be disenrolled from a health plan until an appropriate acute inpatient hospital discharge, unless the member is no longer MO HealthNet Fee-For-Service or MO HealthNet Managed Care eligible or opts out.
2. For the purpose of a member moving from one health plan to another health plan, in addition to acute inpatient hospitalizations, admissions to facilities that provide a lower level of care in lieu of an acute inpatient admission may be considered as an acute inpatient hospitalization for purposes of this section. The state agency reserves the right to determine if such an admission qualifies as an acute inpatient hospitalization. Only acute inpatient hospitalization shall apply when a new member moves from the MO HealthNet Fee-For-Service Program to MO HealthNet Managed Care. The health plan shall provide timely notification to the state agency of a member's acute inpatient hospitalization on the effective date of coverage to effect a retroactive/prospective adjustment in the coverage dates for MO HealthNet Managed Care.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.18(a-f).

These procedures are outlined in HealthCare USA policy E-4 *Member Enrollment and Disenrollment* and addressed in the *HealthCare USA Member Handbook*, p.18.

2.13 Marketing and Member Education

- 2.13.1 MO HealthNet Managed Care Marketing and Member Education Guidelines: The health plan shall educate MO HealthNet Managed Care members, subject to the restrictions and definitions outlined herein. Education activities are efforts directed to current members to provide knowledge or skills. The health plan may conduct marketing activities for MO HealthNet Managed Care members, subject to the restrictions and definitions outlined herein. Marketing campaigns are efforts directed to an audience of members and potential health plan members to retain or increase health plan membership. The health plan shall comply with all marketing and member education requirements stated herein.
 - a. The health plan shall advise the health plan's subcontractors of these marketing guidelines and ensure that subcontractors adhere to them. No subcontractor shall operate to relieve the health plan of its obligations. The health plan shall have and implement written procedures to ensure subcontractor notification and compliance with these marketing guidelines.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.1 (a).

HealthCare USA advises all subcontractors and affiliates of the marketing guidelines to ensure compliance. HealthCare USA reviews all subcontractor and affiliate marketing materials annually, at minimum, to ensure compliance.

- 2.13.1b. The health plan shall use pre-approved MO HealthNet Managed Care information and materials for presentations or interviews with print and electronic media.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.1 (b).



2.13.1c. The health plan shall make an effort to ensure that presentations shall be available to maximize consumer access to information, including presentation after normal work hours, and at sites other than the FSD offices, such as WIC sites, Head Start centers, health fairs, etc.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.1 (c).

HealthCare USA's Community Development Team provides continual formal education presentations to the general public in the western, central and eastern regions to all populations including culturally diverse groups, religious groups and local community groups. Our Community Development Team is very flexible and will conduct educational presentation after normal working hours to maximize consumer access to information. Power point presentations are used to educate community influencers and the general public about the MO HealthNet application processes and HealthCare USA services and benefits. The Community Development Team provides presentations to early childhood centers, faith based institutions, teen parenting programs, pregnancy resource centers, school counselors, school nurses as well as Children's Division and Family Support Division.



2.13.1d. The health plan shall market to the entire region.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.1 (d).

HealthCare USA's Community Development Team continues to provide educational information and opportunities to the MO HealthNet population in all counties in all three regions. In building strong partnerships with community influencers, HealthCare USA maintains its visibility and ability to provide support and services within all regions.

2.13.1e. The health plan shall ensure that in-network providers provide equal representation of all contracted health plans and shall not favor one health plan over another in displayed information. The in-network providers may display brochures and other materials from one health plan even though all health plans have not provided similar materials.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.1 (e).



2.13.1f. The health plan shall only distribute approved material to local FSD offices. The health plan shall supply current materials and remove their out-dated materials in public areas at the FSD offices.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.1 (f).

2.13.1g. The health plan shall request state agency prepared mandatory MO HealthNet Managed Care materials from the state agency. The health plan and its subcontractors shall make the general public aware of the MO HealthNet program by providing any of the following:

1. General MO HealthNet eligibility information;
 2. MO HealthNet applications to complete and mail; or
 3. Links to web applications.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.1 (g).

2.13.2 State Review: The health plan shall:

- a. Submit its proposed marketing plan, all marketing materials, and member education materials to the state agency for written approval prior to use. The state agency shall only consider the marketing plan and materials submitted by the health plan (not subcontractors). The health plan shall submit all materials in mock camera-ready form. When submitting marketing and education materials for approval, the health plan shall indicate how and when the material will be used, the timeframes for the use, and the media to be used for distribution if approved. The state agency shall approve, disapprove, or require modifications of education and marketing materials. The state agency shall review and respond as soon as possible, but within thirty (30) calendar days of receipt by the state agency. Marketing and education materials are deemed approved if a response from the state agency is not returned within thirty (30) calendar days following receipt of the materials by the state agency. The health plan shall engage in only those marketing activities which are prior approved in writing.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.2(a).

2.13.2 b. Submit to the state agency all materials used by in-network providers to advise members of the health plans with which they have contracts. The health plan shall provide the following listing of what constitutes approved material to in-network providers:

1. A list of all health plans with which they have contracts;
 2. A letter to previous fee-for-service recipients who may be eligible for MO HealthNet Managed Care, informing them of all health plan(s) with which the provider has contracted;
 3. A display of all contracted health plan provided marketing and health education materials in an equal fashion;
 4. A listing of all contracted health plan phone numbers; and
 5. Displaying enrollment helpline phone number.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.2(b).



For further information, refer to:

- *HealthCare USA Provider Manual*, p. 35.

2.13.2 c. Correct problems and errors with the marketing plan and/or materials as identified by the state agency. The health plan shall submit to the state agency a written, corrected marketing plan or revised material within ten (10) business days following receipt date of the written notice from the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.2 (c).

2.13.2 d. Provide notice to the state agency, or have prior written approval from the state agency, in certain situations to sponsor or participate in community activities, programs, or events.

1. Community activities are defined for the purpose of this document as: activities where people come together to learn or ask questions about health care benefits, responsibilities, and procedures. These community activities require no notice to the state agency, except when held at provider sites. At community activities, the health plan shall only use materials approved by the state agency and must adhere to the ban on engaging in enrollment activities required herein.
2. Community activities at provider sites require a seven (7) calendar day notice to the state agency prior to sponsoring or participating in an activity. Provider sites may include, but are not limited to pharmacies in discount or grocery stores if the pharmacies are in an MO HealthNet Managed Care network, local public health agency, provider clinics, hospitals, etc.
3. The health plan may offer the availability of gifts no greater than \$10 in value, and only if such gifts are offered during any community activity (e.g. health fair). The nominal items must be offered to all individuals attending the community activity. The gifts must be directly and obviously health related or limited to printed materials (e.g. T-shirts, pens or pencils, caps, mugs, key chains, etc). All items must have prior written approval by the state agency and written proof of cost per unit must be provided by the health plan to the state agency prior to approval. Once an item is approved, the item does not have to be re-approved for additional community activities. Advertising the availability of such gifts through mailings, TV or radio, posters, and other promotions or publicity is prohibited.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.2 (d).

2.13.3 Prohibited Activities: The health plan shall not:

- a. Use the state agency's or the Department of Social Services' name, logo, or other identifying marks on any of the materials produced or issued without the prior written approval of the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.3 (a).



2.13.3b. Use any report, graph, chart, picture, or other document produced and included in whole or in part under the MO HealthNet Managed Care contract which is subject to copyright or the subject of any application for copyright by or on behalf of the health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.3 (b).

2.13.3c. Practice door-to-door, face-to-face, telephonic, or other "cold call" marketing. Cold call marketing means any unsolicited personal contact by the health plan with a potential member for the purpose of marketing as defined in this paragraph. The offerings of cash, prizes, other items for material gain, or other insurance products as an award for enrollment are prohibited, though the health plan may offer additional health benefits as described herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.3 (c).

2.13.3d. Offer raffles or conduct lotteries. Door prizes may be offered within the parameters and limits specified for participation in community activities, programs, or events.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.3 (d).

2.13.3e. Conduct or participate in health plan enrollment, disenrollment, transfer, or opt out activities. The health plan, any subcontractors, and the providers shall not influence a member's enrollment. Prohibited activities include:

1. Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care;
2. Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits;
3. Mailing or faxing MO HealthNet Managed Care enrollment forms;
4. Aiding the member in filling out health plan enrollment forms;
5. Aiding the member in completing on-line health plan enrollment;
6. Photocopying blank health plan enrollment forms for potential members;
7. Distributing blank health plan enrollment forms;
8. Participating in three-way calls to the MO HealthNet Managed Care enrollment helpline;
9. Suggesting a member transfer to another health plan; or
10. Other activities in which the health plan, its representatives, or in-network providers are engaged in activities to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan (their own or another).

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.3 (e).



2.13.3f. Use testimonial materials and/or celebrity endorsements of the health plan or as an enrollment inducement.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.3 (f).

2.13.3g. Describe or list covered benefits in any way other than according to the current MO HealthNet Managed Care contract. The health plan may not verbally or in writing identify or portray covered benefits as enhanced, additional, or free.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.3 (g).

2.13.3h. Develop marketing materials that are inaccurate or mislead, confuse, defraud, or deceive MO HealthNet Managed Care eligibles, or otherwise violate Federal or State consumer protection laws or regulations or contain any assertion or statement (whether written or oral) that:

1. The participant must enroll with the health plan in order to obtain MO HealthNet benefits or in order not to lose benefits. (The health plan may include information on any additional health benefits the health plan provides.)
 2. The health plan is endorsed by CMS, the Federal or State government, or similar entity.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.13.3 (h).

HealthCare USA reviews annually and revises as necessary the Marketing and Communications Plan, which includes the prohibited marketing activities. HealthCare USA develops marketing materials that are clear, concise and ‘member friendly’ in order to provide the member a factual outline of the benefits. The HealthCare USA Community Development Team are required to attend trainings regarding the Marketing and Communications Plan, prohibitive activities and any additional health benefits.

2.14 Member Services [4.4.13]

The health plan shall provide all member services as described herein. The health plan shall have and implement member services policies and procedures that address all member services activities.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.

2.14.1 Member Services Staff: The health plan shall provide adequately trained member services staff to operate at least nine (9) consecutive hours during the hours of 7:00 a.m. through 7:00 p.m. (e.g., 8:00 a.m. through 5:00 p.m.), Monday through Friday. The health plan may observe State designated holidays or the holidays designated in the health plan’s awarded proposal for its operation of member services. If the health plan observes holidays different than the State’s, the



health plan shall obtain the prior written approval of the state agency. The health plan's member services staff shall be responsible for the following:

4.4.13 Member Services and Provider Services

The offeror shall describe the hours of operation, holiday schedule, member and provider communication and education plans, and staff training plans for member services and provider services. (2.14 and 2.16)

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1 and 4.4.13.

The following response for Section 4.4.13 focuses on Section 2.14.1 Member Services. For Provider Services, see Section 2.16.1.

HealthCare USA recognizes our Customer Service is instrumental in ensuring the satisfaction of our Medicaid members. To reflect our commitment to continuous improvement and to deliver optimal service, HealthCare USA utilizes a dedicated Medicaid Customer Service Organization (CSO), which will have a dedicated team to service the Missouri Medicaid Program.

Operation Hours

Customer Service Specialists are available Monday through Friday, 8:00 a.m.–5:00 p.m. (CT), except on our designated holidays:

- Martin Luther King Day
- Memorial Day
- Independence Day (Observed day)
- Labor Day
- Thanksgiving
- Day after Thanksgiving
- Christmas (Observed day)
- New Years Day (Observed day)

The Member Services team also observes the following state-designated holidays for staff training and development:

- Lincoln Day
- Truman Day
- Columbus Day





Comprehensive 18-Month Training Program

Member Service Specialists participate in a comprehensive training curriculum conducted over an 18-month period. The first eight weeks incorporates classroom-based training facilitated by three dedicated trainers that includes:

- **New Hire Orientation**

E-mail usage, internet usage, attendance, office tour and code of conduct. Each employee is provided with all required documentation, policies, procedures, HealthCare USA plan benefits, Member Handbooks and directories.
- **HIPAA Regulations**

Standards to protect the privacy and confidentiality of an individual's Protected Health Information and anonymous reporting of violations. All employees are required to take yearly assessments on HIPAA guidelines.
- **Fraud and Abuse**

Identify intentional deception, concealment or misrepresentation that could result in unauthorized benefit to an individual or entity. Identify how to report and handle suspected fraud and abuse. All employees are required to take annual assessments on fraud and abuse guidelines.
- **Member Rights and Responsibilities**

Education for member service specialists on benefits, various health initiatives, Doc Bear programs and state guidelines and regulations and educating members on their rights and responsibilities, including but not limited to, the right to be treated with respect, the right to receive information on available treatment options and alternatives, the right to participate in decisions, the right to receive a copy of their medical records and the right to participate in decisions regarding their health care.
- **Advance Directives**

Ensure members are informed of their rights to refuse any medical treatment, including life-prolonging procedures in accordance with the Patient Self Determination Act of 1990.
- **System Training**

Access and carry out all tasks and features of all navigational and functional key systems on the Medicaid Specific Platform. Learn to navigate through all HealthCare USA systems, including Navigator, IDX (claim system), provider search and HealthCare USA's internet sites.
- **Primary Care Provider Changes**

Process for allowing new and/or established members to select a primary care provider; assign a primary care provider to new members that have not selected a provider, assist in the selection and transition of members whose primary care provider is no longer participating with HealthCare USA and review the process for members to request a specialist as their primary care provider.
- **Primary Care Provider Addresses**



Listing of addresses for all participating or non-participating primary care providers with directions, maps and mileage.

- **Provider Look Up**
Online provider search that selects providers by name, zip code, county, specialty and gender. Updates are made available every 48 hours via the internet (including supplying directions to all locations).
- **Benefits Training**
Review of documents and interpretation of benefits.
- **Grievance, Complaints and Appeals**
Identification, documentation, investigation, resolution and closure of all grievances, complaints and appeals for members and providers by representatives.
- **Member Look Up**
Complete member information such as claims, referrals, invoices, other insurance coverage information, eligibility, benefit plan usage, plan information and ID card history.
- **Coding**
Basic comprehension on Current Procedural Terminology (CPT), International Classification of Diseases, 9th Revision (ICD9), Health Care Common Procedure Coding System (HCPCS), Revenue and Disease Related Group (DRG) codes and terms for identifying medical services for providers and facilities.
- **Telephone Etiquette**
Ensure consistent, high-quality service to our members and have a major impact on the accuracy and effectiveness of our customer interactions.
- **Online Documentation**
Intranet Web-based central repository of company-wide information—from Legislative to HealthCare USA-specific policies and procedures.
- **HealthCare USA Policies and Procedures**
Education for member service specialists on benefits, various health initiatives, Doc Bear programs and state guidelines and regulations.
- **Soft Skills Training**
Customer service skills through courses entitled Foundation of Service, Customer Care, Attitude Adjusting, Diffusing Anger, Empathetic Listening and Exceeding Expectations. Annual training is provided to all member and provider service specialists.
- **Cultural Competency**
Describes our requirement to provide care to members with diverse values, beliefs, and behaviors, including tailoring delivery to meet members' social, cultural and linguistic needs.
- **Early, Periodic Screening, Diagnosis & Treatment Services (EPSDT)**
Review of the EPSDT services and benefits available to members under 21 years old.



- **Contract Overview**

Review of HealthCare USA provider contracts for interpretation.

Throughout the course and again upon completion of the program, each new Member Service Specialist completes detailed assessments and simulated calls to ensure they are retaining information and fulfilling established job requirements. New hires who fail to meet required benchmarks or demonstrate their ability to perform job functions within HealthCare USA's stringent quality requirements are evaluated for additional training needs or terminated if outcomes continue to be below acceptable performance norms.

To augment the initial classroom-based training, the Providing Employees with Education and Resources (PEER) program is an in-house program developed specifically for our Customer Service Operation (CSO). PEER uses experienced customer service representatives to support and guide new hires as they begin their employment. Following the formal training, PEERs are seated near the new hire and are required to follow a pre-determined checklist of tasks and assignments to ensure continuous learning and coaching outside of the classroom environment. Supervisors meet with new staff daily throughout their classroom training and follow a weekly curriculum to assess basic understanding of materials, review training objectives and address additional training opportunities.

Ongoing Training

Training does not stop with initial training. Our approach reflects our effort for continuous improvement and to deliver optimal service to our members. Upon hire, we add new employees into SABA, our learning management system. SABA is an advanced online tool that supports growth and development by linking employees to all types of learning activities, including instructor-led classes, online training, webinars and local career center resources. SABA also maintains records of all completed learning activities, assessments, events and other curriculum.

Ongoing training ensures continued success of our programs and performance. Training targets both new and modified policies and procedures and areas that we identify as warranting additional training. All Service Specialists must attend at least two service development training courses a year. Specific courses enhance the staff's knowledgebase and service ability. The following courses are part of a formal training curriculum, conducted over an 18 month period:

- **Claims Interpretation**

Understanding claims, including code types, dictionaries, terminology, workflows, coordination of benefits (COB), adjustment procedures and provider alerts.

- **Correct Coding System Edits Interpretation**

Correct coding initiatives, and how to interpret affected claims with system coding edits.

- **Service Recovery**

Soft skills including how to identify and meet caller expectations and turnaround.

- **Benefit Interpretation**

Refresher course designed to improve interpretation of plan-specific benefits.

- **COB Claims Interpretation**



Identification and validation of COB information as well as a refresher on interpreting claims payments when other insurance is involved.

- **IN TOUCH**

The knowledge and skills necessary to deliver exceptional service to all customers, focusing on internal customer service.

essentials

The Member Services team also has access to essentials, a company intranet site with subject matter reference tools and education aids to assist with ongoing training.



What is essentials?

essentials is an intranet web-based central repository of HealthCare USA information – from Legislative to plan-specific policy and procedures.

essentials allows users to move beyond the borders previously established by paper, into an electronic environment where all of the tools needed are at their fingertips.

Plan-specific details included in essentials are:

- Customer Service Handbook, including an alphabetized list of policies and procedures
- Member Handbook
- Provider Directory
- Inquiry, complaints and appeals processes
- Legal calls, correspondence and subpoenas policy
- Important contact names and numbers, including workflows
- Maps—state and service area
- Telephone scripts—inbound and outbound
- Claims processing manuals and information
- Check run calendars
- Online forms
- Eligibility information
- Provider alerts
- Breaking HealthCare USA news

Other essentials features beneficial to Member Service Specialists include:

- Google search function





- Reference tools, including code manuals and online reference books
- COB information
- Terminology
- Julian date calendar
- Electronic submission guidelines

All content is controlled through a content management system. Only those designated by management may update essentials policies. Member Service Specialists have online access to bank draft images, online images of remittance advices and provider contract summaries.

Quality and Accuracy

Reinforcing our commitment to providing quality service and increasing member loyalty, HealthCare USA maintains a formal call quality program for all staff. Internal Quality Auditors (QA), along with our service supervisors, monitor quality and attend monthly calibration sessions to “audit the auditor” and ensure accuracy and consistency. Monitoring is based on our “Come On In!” call quality program, where audits address the specialist’s ability to follow appropriate processes, communicate effectively and provide a solution.

Verint® Quality Management System

The Verint® Witness Actionable Solutions™ quality management system is a state-of-the-art system, which enables efficient monitoring by capturing and analyzing customer interactions, maximizing workforce performance and optimizing CSO processes. The system records 100 percent of voice interaction between the Member Service Specialist and the caller, along with a 30 percent capture of the corresponding computer desktop activity. The system then synchronizes voice and data capture during replay, thus allowing our leadership to observe and analyze complete customer interactions as they actually occurred. The Verint system stores corresponding audit and screens for 365 days and all audio is stored for four years.

Quality Foundation, Quality Goals

Our goal is to monitor at least 1% of all calls answered— approximately two to three calls per Member Service Specialist per week. We adjust the frequency of monitoring as necessary, based on call volume fluctuations and individual audit results.

To establish a quality foundation, our new hires meet on weekly with our quality staff to listen to calls, review program guidelines and receive coaching. This takes place for at least one month or until quality scores are favorable. Following these quality sessions, Member Service Specialists meet with QAs on a monthly basis to review scores and receive coaching. QAs are responsible for providing immediate feedback, fostering self-correcting techniques and promoting continuous improvement opportunities.

Monitoring for Adherence to Performance Standards

HealthCare USA is committed to ensuring our staff has the training, tools and systems to deliver first-class service to our members.



To ensure an optimal level of performance, HealthCare USA has developed and implemented stringent standards and metrics. These standards reflect leading industry standards as well as contract-mandated measures of performance. Our service leadership monitors productivity and availability reports to ensure contract obligations are met or exceeded.

Performance is monitored using Symposium's™ Real-time Statistical Display feature. This system allows our leadership, as well as staff, to view real-time and historical call center performance and resource usage through a desktop Web browser. Throughout the day, we review and analyze performance to identify service gaps, and management can configure call routing to ensure calls are answered in order of their priority. For example, a caller who indicates that he or she has a crisis is routed with highest priority to a trained representative with a skill set to address their needs.

Business Continuity Plan for Uninterrupted Transition of Call Response

In the event of a service disruption, HealthCare USA is integrated into the company-wide business continuity plan. Member services have an uninterrupted transition of call response.

2.14.1a. Explaining the operation of the health plan and assisting members in the selection of a primary care provider.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(a).

Quality Customer Service

Our Member Services department provides quality customer service in a timely, professional manner to current and potential members by answering questions regarding health care benefits, physician network and general information. After enrollment, members receive Information Packets, Welcome Calls and Member Handbooks. The education provided to the members includes, but is not limited to:

- Available benefits and benefit limitations
- Provider availability and office limitations
- Member rights and responsibilities
- Referral and prior authorization requirements
- Appointment and transportation scheduling
- Selecting and/or changing Primary Care Provider
- Roles of the Primary Care Provider
- Initiating the complaint, grievance and appeal process
- Advance Directives
- Online Services
- Boys and Girls Club Membership



- Eligibility
- Interpreter Services
- HealthCare USA ID Cards
- Managed Care Principles

2.14.1b. Educating the family about Managed Care including the way services typically are accessed under the Managed Care and the role of the primary care provider.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(b).

Members can receive current eligibility information by accessing the State's toll-free Enrollment Line, 24 hours a day, seven days a week. Members are educated on the role of their primary care provider. Members have access to their primary care provider 24 hours a day, seven days a week by calling the primary care provider's phone number on the ID card. Primary care providers are required by contract to provide 24 hour access to care.

2.14.1c. Specifying member's rights and responsibilities.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(c).

To establish a process for orientating members on their rights and responsibilities as a HealthCare USA member. HealthCare USA complies with all applicable Federal and State laws that pertain to member rights and ensures that its staff and affiliated providers take those rights into account when furnishing services to members.

All members are informed of their rights and responsibilities via the Member Handbook. Member rights include, but are not limited to:

- Dignity and Privacy. Each member is guaranteed the right to be treated with respect and with due consideration for his/her dignity and privacy
- Receive Information on available treatment options. Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- Participate in decisions. Each member is guaranteed the right to participate in decisions regarding his/her health care, including the right to refuse treatment
- Be free from restraint or seclusion. Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Obtain a copy of medical records. Each member is guaranteed the right to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164



- Freely exercise these rights. Each member is free to exercise his/her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member
- Each member is provided with names, locations, telephone numbers, and any non-English languages spoken by current contracted providers in the members service area, including identification of providers that are not accepting new patients
- Each member is provided with information on grievance and fair hearing procedures
- Each member is provided with the amount, duration, and scope of benefits available under the contract to which they are entitled
- Each member is provided with information on how to obtain benefits, including authorization requirements
- Each member is provided with the extent to which, and how, they may obtain benefits including family planning services, from out-of-network providers
- Each member is provided with the extent to which, and how, after-hours and emergency coverage are provided including:
 - What constitutes emergency medical conditions, emergency services, and post-stabilization services
 - The fact that prior authorization is not required for emergency services
 - The process and procedures for obtaining emergency services, including the 911-telephone system or its local equivalent
 - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services
 - The fact that the member has the right to use any hospital or other setting for emergency care
- Each member is provided the post stabilization care services rules
- Each member is provided the policy on referrals for specialty care and for other benefits not furnished by the members primary care provider
- Each member is provided cost sharing information, if any
- Each member is provided information on how and where to access any benefits that are available
- Member responsibilities include, but are not limited to:
 - Each member must provide, to the extent possible, information needed by providers in caring for the member
 - Each member must contact their primary care provider as their first point of contact when needing medical care
 - Each member must follow appointment scheduling processes



- Each member must follow instructions and guidelines given by providers

A member may request a copy of the rights and responsibilities notice by contacting the Member Services Department at 1-800-566-6444, Monday through Friday 8:00 a.m. to 5:00 p.m. The Member Handbook is mailed to all new members within 10 business days of enrollment and annually once enrolled.

2.14.1d. Explaining covered benefits

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(d).

HealthCare USA's Member Services Department provides education to our members through Information Packets, Welcome Calls and Member Handbooks.

The education provided to members includes, but is not limited to:

- Available benefits and benefit limitations
- Provider availability and office limitations
- Member rights and responsibilities
- Referral and prior authorization requirements
- Appointment and transportation scheduling
- Selecting and/or changing Primary Care Providers (PCPs)
- Initiating the complaint, grievance and appeal process
- Advance directives
- Online services
- Boys and Girls Club and other Doc Bear memberships
- Eligibility
- Interpreter services
- HealthCare USA Identification (ID) cards
- Managed care principles
- Health care away from home
- Emergency Services
- Healthy Children and Youth/Early Periodic Screening Diagnosis and Treatment (HCY/EPSTD)

2.14.1e. Assisting members to make appointments and obtain services

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(e).





The Member Services Department provides member education or assists in making appointments by contacting the provider on behalf of the member, when necessary.

When a Member Service Specialist has contact with a member through the Outreach Department or CSO, there is an opportunity to educate the member and make a difference in their health and wellbeing. Educating our Medicaid members is built into the foundation of the Member Service Specialist.

At the end of the call or other most appropriate time during the call, the Member Service Specialist will educate the caller on Health Plan Employer Data and Information Set (HEDIS) measures specific to the member the caller is authorized to discuss. The Member Service Specialist will offer to assist with making an appointment and offer transportation assistance.

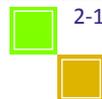
2.14.1f. Arranging medically necessary transportation for our members

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(f).

HealthCare USA provides non-emergency medical transportation through HealthCare USA's transportation subcontractor, Medical Transportation Management (MTM), to members who do not have the ability to provide their own transportation (such as their own vehicle, friends or relatives) to and from medical appointments and/or other approved visits. Routine transportation is available to and from approved medical appointments. HealthCare USA also provides emergency transportation (ground and air) for its members. When necessary, members are advised to call 9-1-1.

2.14.1g. Handling, recording, and tracking member inquiries promptly and timely

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(g).





HealthCare USA has a HIPAA-compliant tracking system (Navigator) used to assist Member Service Specialists explain benefits and provider network to our members. . This tracking system is used to track response time on member and provider inquiries, as well as, provide a means to document all member and provider communication. Member Service Specialists are required to track 100% of member inquiries. Documentation from this system is used for trending and reporting member issues. Random monitoring of Member Services Department telephone calls are conducted regularly to ensure that quality standards are met.

Resolution of member inquiries is usually provided during the initial contact. Calls not resolved upon initial contact are researched and the member is contacted within 48 hours with the resolution. Department response time and customer satisfaction indicators also are monitored and reported to the Quality Management and Health Plan Executive Team Meetings at least quarterly.

2.14.1h. [Assisting in changing primary care providers](#)

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(h).

Members are given the opportunity to request a change of providers. Member Service Specialists assist the member in changing PCPs in accordance with the member's expressed needs such as convenience, language spoken, office hours, travel distance, etc.

Members may request to change their PCPs by contacting HealthCare USA's Customer Service Operations (CSO). Children in state custody or foster care placements are allowed PCP changes as often as foster care changes necessitate. Excluding changes requested after the initial visit, members may change PCPs twice per year for any reason. Members may request a PCP change more than twice per year for good cause. As a general rule, routine changes made on or before the 15th day of the current month are made effective the 1st of the current month. Routine changes made after the 15th day of the current month are made effective the 1st of the following month.

All requests to change PCPs exceeding the two (2) allowed per year, are reviewed on a case by case basis. HealthCare USA may grant a member's request to change PCPs more than twice per year in certain circumstances in order to improve member's access or to remove any barriers that may hinder them from visiting the PCP. Possible reasons that are considered good cause include, but are not limited to, the following:



- a) Accessibility (appointment, telephone or waiting times): The member has difficulty in obtaining services due to transportation issues or office hours. Dissatisfaction with response or waiting times.
- b) Attitude (provider or provider's staff): The member is dissatisfied with the attitude of the provider or staff due to perceived lack of concern, lack of courtesy or lack of cultural sensitivity.
- c) Quality (care provided by the provider): The member is dissatisfied with the care provided or the provider does not explain the treatment or diagnosis.

The CSO identifies, documents and tracks the reasons for all PCP changes. The Quality Improvement Department monitors the trends. Any pattern or trend are followed up through the quality improvement process.

Members have the right to request a PCP change through the grievance process. When a PCP change is ordered as part of the resolution to a formal grievance proceeding, the change is not to be restricted.

In the event that the member's PCP has been terminated from HealthCare USA, and has given HealthCare USA advance notice, the member is notified in writing within fifteen (15) days advising they must select a new PCP. If the member does not select a new PCP by the date specified on the letter, a new PCP is assigned to them. The selection of a new PCP under these circumstances is not considered as one (1) of the two (2) changes allowed per year. There are only two (2) types of PCP changes: routine or immediate.

**2.14.1i. Providing the following information to members requesting the names of providers:
Whether the provider currently participates in the health plan**

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(i).

HealthCare USA understands the need to have an accurate and current provider listing for our members. Therefore, when members call inquiring about provider participation, our staff utilizes our online provider search reference tool to supply up-to-date provider in-network status. As a standard rule, the Member Service Specialists offer our members at least three participating providers to choose from, including their phone number, provider specialty and address. Our online provider search enables our staff to sort by provider specialty and zip code.

2.14.1i .1 Whether the provider is currently accepting new patients; and

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(i)l.

HealthCare USA's fully-integrated IDX claims system allows our Member Service Specialists to inform members immediately if a provider is accepting new members. Members are also educated on accessing HealthCare USA's Web site for up-to-date information relating to this inquiry.



2.14.1.i.2 Any restrictions on services, including any referral or prior authorization requirements the member must meet to obtain services from the provider.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(i)2.

When calling HealthCare USA's Member Services Department, members are educated on the role of their primary care provider. Primary care providers are the member's initial and most important contact. The member's primary care provider decides if the member needs a specialist and refers the member to someone for help.

Members are also informed on restrictions of services, including:

- Whether the provider participates with HealthCare USA
- The prior authorization requirements
- The frequency limits for services
- Whether these services are covered by HealthCare USA
- Whether the services are covered by MO HealthNet
- Rights to second opinions

2.14.1.j. Informing members about fraud and abuse policies and procedures and providing assistance in reporting suspected fraud and abuse.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.1(j).

All HealthCare USA employees are mandated to receive fraud and abuse training and education upon hiring. All employees complete the fraud and abuse training module online, including online quizzes. All employees are mandated to receive annual training. This training provides all employees guidance in assisting members with fraud and abuse questions and/or with reporting suspected fraud and abuse issues.

Specifically, HealthCare USA Member Services Department educates members concerning fraud and abuse policies and procedures. Each new HealthCare USA member receives a Member Handbook regarding information on fraud and abuse. This information includes terminology, how to identify fraud and abuse and specific examples. These examples are listed below:

- Member Fraud
- Letting someone else use your HealthCare USA card or your white/red MO HealthNet card
- Getting prescriptions with the intent of abusing or selling drugs
- Provider Fraud
- Billing for services not provided
- Member Abuse



- Going to the Emergency Department for a condition that is not an emergency

In addition to the above, members have 24 hour access to information about their benefits, provider directories, etc. through My Online Services. This HealthCare USA web site provides secured messaging options where members can e-mail questions to our Customer Service Organization. All e-mails received are recorded in Navigator as an activity. These contacts are managed daily to ensure all are worked within 48 hours from receipt.

All of HealthCare USA's dedicated Member Service Specialist have access to our Intranet-Web based central repository of company-wide information called essentials. This tool allows our staff to move beyond the borders previously established by paper into an electronic environment where all of the tools they need are right at their fingertips. essentials provides immediate and up-to-date information from legislative updates to plan specific policies and procedures in a format that makes documentation easy to use, organize, and maintain. This online tool is not only utilized by the Customer Service Organization, but by every business unit within the company, which ensures consistency in the application of our policies and procedures.

HealthCare USA efficiently manages member inquiries using Navigator. This single tool also enables CSO representatives the ability to automatically generate letters as required. All calls, as well as letters, e-mails and other contact types, are tracked from receipt through resolution.

Member Service Specialists are able to view a member's data in IDX (Coventry's claim payment system). Navigator generates activities (real-time internal notification to a user or department requesting assistance in resolving a customer issue) associated with contacts and sends them to other departments within the Customer Service Organization. Activities are categorized by type and managed daily to ensure timely resolution.

Navigator also provides Web links to Claim, Referral, and PCP information such as:

- WEBMD
- essentials
- Directprovider.com
- State Web sites
- Other health care industry sites

Navigator's reporting capacities encompass the Customer Service Organization's handling of member contacts, including grievances and appeals. Reports include:

- Time of resolution issues
- Issue Times
- Issue Trends
- Customer service representative level reports
- State specific customized reports



2.14.2 Toll-Free Telephone Line(s)/Call Center:

2.14.2a. The health plan shall maintain a toll-free member services telephone number to respond to member questions, comments, and inquiries. During non-business hours when the member service telephone number is not staffed, the health plan shall have an automated system or answering service. The automated system or answering service shall provide callers with: operating instructions on what to do in case of emergency, the MFCU fraud and abuse hotline number, an option to talk directly with a nurse or other clinician or behavioral health crisis worker, and instructions on how to leave a message and when that message will be returned. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.2(a).

HealthCare USA maintains a toll-free Member Services telephone number to respond to member questions, comments, and inquiries. During non-business hours, HealthCare USA provides an automated voice system to provide callers with instructions on what to do in case of emergency, an option to contact the MFCU fraud and abuse hotline, an option to talk directly with a nurse or other clinical specialist, and instructions on how to leave a message. Members may also utilize our behavioral health line during non-business hours, with the same options. The voice mailbox has adequate capacity to receive all messages. The messages are returned the next business day.

2.14.2b. The health plan shall operate a twenty-four (24) hours, seven (7) days per week toll-free nurse hotline to provide to its members direct contact with qualified licensed clinical staff. Recorded messages are not acceptable for this hotline.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.2(b).

HealthCare USA provides a 24-Hour Nurse Line in order to assist our members with answers to their medical questions. The number is conveniently located on the back of the member's ID card. This is a member-centric nurse line program staffed with qualified licensed clinical staff that provides high-touch call center services designed to direct the caller to the appropriate medical resource that may include self-care, physician office appointment, urgent care, the Emergency Department or to call 911. This program has demonstrated success by redirecting members that otherwise would have gone to the Emergency Department to either self-care or scheduling a provider office visit.

2.14.2c. The health plan shall operate a twenty-four (24) hours, seven (7) days per week behavioral health crisis line that is staffed by QBHPs. Recorded messages are not acceptable for this hotline.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.2(c).

Qualified behavioral health professionals are available twenty-four (24) hours, seven (7) days per week to handle both business hour as well as after-hour calls. After-hours services include





Crisis and Intervention Services with qualified behavioral health professionals available to assess emergent and urgent needed services. Our after-hours hotline allows for members and providers to speak directly to a MHNet Clinical Care Advocate to obtain precertification for both emergent and urgent services – giving twenty-four (24) hours, seven (7) days per week access to providers.

2.14.2d. The health plan may use the same number for all toll-free telephone lines/call centers or may develop different phone numbers. If the same number is used for all lines, the call prompts shall be clear so as to ensure that members reach the appropriate individual.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.2(d).

HealthCare USA uses the same toll-free telephone number, 1-800-566-6444, for all member calls. Prompt options are clear and understandable, directing the member to the appropriate individual who can assist them.

2.14.2e. All toll free telephone lines and call centers shall meet, at a minimum, the following call center standards:

1. Ninety (90) percent of calls are answered within thirty (30) seconds;
2. The call abandonment rate is five (5) percent or less;
3. The average hold time is two (2) minutes or less; and
4. The blocked call rate does not exceed one (1) percent.

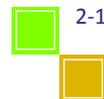
HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.2(e).

Department response time and customer satisfaction indicators are monitored and reported to the Quality Management and Health Plan Executive Team Meetings at least quarterly.

Specific management metrics are in place for all member and provider telephone service lines. HealthCare USA has the capability to track the call management metrics identified below:

- Answer Speed (Answered within 30 seconds)
- Abandonment Rate
- Average Hold Time
- Blocked Call Rate
- First Call Resolution Rate
- Talk Time

These reports are analyzed and the Member Service Specialists are assessed on their ability to accurately respond to questions. All calls are answered after the initial ring and placed in queue. The average speed to answer is monitored to ensure that all calls placed in queue are answered within 30 seconds or less. HealthCare USA does not block calls.





To demonstrate our ability to meet and exceed service standards, presented below is Figure 2-18: 2010/2011 YTD* Customer Service Performance Summary.

Figure 2- 18: 2010/2011 YTD Customer Service Performance Summary

Performance Measure	HealthCare USA Goal	MO HealthNet Requirement	HealthCare USA Result
% of Calls Answered in 30 seconds	90%	90%	90.5%
Abandonment Rate	< 3%	< 5%	1%
Average Hold Time	< 30 seconds	< 2 minutes	9 seconds
Blocked Call Rate	0%	1%	0%
Average First Call Resolution	90%	N/A	94.3%

* 2010/2011 YTD RESULTS MEASURE PERFORMANCE FROM JULY 2010 THROUGH JUNE 2011.

These metrics continue to be reviewed and monitored on a weekly basis by the HealthCare USA management team to ensure State obligations are met or exceeded.

2.14.2f. All toll-free telephone lines and call centers shall provide twenty-four (24) hours per day voice and telecommunications device services for hearing impaired members and language translation services in all languages, not just those languages that meet the threshold for written translation requirements.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.2(f).

HealthCare USA maintains toll-free TTY-Telecommunications Device for the Deaf (TDD) telephone numbers equipped to handle calls from customers who are deaf or hard of hearing.

HealthCare USA is committed to staff the Member Services Department with bi-lingual representatives to assure quality services for members who are not fluent in the English language. Members calling our Member Services Department are given the option to listen to all prompts in either English or Spanish, which are the prevalent languages spoken by our members. If additional assistance is required, members are assisted through the Language LineSM Translation line, HealthCare USA’s interpreter service provider. Our first attempt to handle non-English speaking callers is to utilize in-house bi-lingual resources since they best know and understand our business. However, if outside interpretation is necessary, Language LineSM Translation services provide interpreters for more than 190 languages, 24 hours a day, seven days a week.

Both our TTY/TDD line and the Language LineSM Translation are also utilized by our 24 Hour Nurse Line, providing members with these services, twenty-four (24) hours, seven (7) days per week.



2.14.2g. The health shall have policies and procedures regarding the operation of these toll-free telephone lines/call centers. The health plan shall make the policies and procedures available in an accessible format upon request.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.2(g).

HealthCare USA has implemented policies and procedures regarding the operations of our call center. All toll-free lines are tested on a weekly basis by the HealthCare USA management team to ensure compliance to the procedures.

2.14.3 Provider Listing: The health plan's member services staff must have available a complete and up-to-date list of the in-network providers in the health plan provider network. The health plan shall have and implement a policy and procedure for updating the provider listing at least monthly. This complete and up-to-date provider listing can be either hard copy or electronic.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.3.

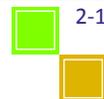
HealthCare USA has an existing policy and procedure for maintaining up-to-date In-Network Provider Listings and making them available both to members and to internal team members such as Member Services. The process includes our method for collecting, updating, verifying and maintaining provider directory listings of in-network providers at least monthly.

The Most Current Information Available

HealthCare USA ensures information included in the In-Network Provider Listings (Provider Directory) and in our member materials is the most current information available. Obtained from the provider's credentialing/re-credentialing application and credentialing delegate load sheet or from demographic updates we receive from our providers, provider demographic changes are loaded into HealthCare USA's database, CPD (Coventry Provider Database), our data source for all print, telephone and web-based directory information. CPD is updated daily for additions, deletions and changes to all practitioner or facility entries.

Weekly, CPD data extracts are automatically interfaced to update the web-based directory with the latest information and published to the HealthCare USA web site (www.hcusa.org) the following week.

Online or print copies of the current provider listing can be generated from our website by our members, providers, and HealthCare USA staff (including Member Services) at any time, 24 hours a day, 7 days a week. Members may also contact our Member Services team to request a hard copy of the provider listing, which Member Services generates on-demand from the website.





2.14.4 **Interpreter Services:** The health plan shall make interpreter services available as necessary to ensure that members are able to communicate with the health plan and providers and receive covered benefits. The health plan shall use certified interpreters. The health plan shall inform members of the availability of interpreter services, how to access them, and that there is no charge for the services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.4.

HealthCare USA makes interpreters available as necessary to ensure that members are able to communicate with HealthCare USA representatives, providers, and receive covered benefits, at no cost. In order to access interpreter services for general information, member benefits, and eligibility questions, the member or member's authorized representative and/or provider are instructed to call 1-800-566-6444 and ask for an interpreter. Telephone interpretation is available through the Language LineSM Translation Service. HealthCare USA also has on-site staff to service both English and Spanish-speaking members and we recruit fluent bi-lingual Member Service Specialists. We assist callers speaking on behalf of a member while maintaining HIPAA compliance. For our hearing impaired members, HealthCare USA maintains a toll-free TTY/TDD telephone relay function manned by specially trained specialists.

For our provider offices, over-the-phone interpretation is a quick, easy way to communicate with someone who does not speak English and their facility does not have bi-lingual resources. Over-the-phone interpretation helps us provide excellent service to members who have limited English speaking skills. Additionally, it helps eliminate the stress and frustration often experienced during language-complicated encounters.

Our first attempt to handle non-English speaking callers is to use in-house bi-lingual resources since they best know and understand our business. However, if outside interpretation is necessary, the Language LineSM Translation Service provides interpreters 24 hours a day, seven days a week.

With over 25 years of experience and translation available in over 190 languages, the Language LineSM Translation Service is a leader in telephone interpretation services. With a proprietary quality assurance program developed by leading academic experts in the field of language testing and interpreter training, the Language LineSM Translation Service reflects HealthCare USA's commitment to service excellence. Each request for telephonic translation is routed according to skill-based routing techniques, thus ensuring that each member is matched with a translator who speaks his/her requested language. HealthCare USA provides face-to-face interpretation to accompany members who need translation for medical appointments through third party vendors. Members or providers can request interpreters by calling the Member Services Department or faxing their requests directly to the agencies as directed below:

Region	Translation Source	Contact Telephone Number
Central	Language Access Metro Project (LAMP) Jewish Vocational Services (JVS)	1-314-842-0062 1-816-471-8356
Eastern	Language Access Metro Project (LAMP)	1-314-843-0062



Region	Translation Source	Contact Telephone Number
Western	Jewish Vocational Services (JVS)	1-816-471-8356

HealthCare USA also provides interpretation services for medical appointments for the hearing impaired through third party vendors. All interpreters are certified by the State of Missouri. Members or providers can request interpreters by calling the Member Services Department or by contacting the agencies as directed below:

Region	Translation Source	Contact Telephone Number
Central	Deaf Way	1-314-289-4294
Eastern	Deaf Way	1-314-289-4292 1-866-999-3929
	Deaf Inter-Link	1-314-837-7757, extension 2
Western	Deaf Expression, Inc.	1-913-268-3323

Members are informed of availability of interpreter services, at no charge, through the Member Handbook, Member Services Department toll-free number, educational presentations, HealthCare USA brochure entitled Interpretation Services-Habran Interpretes Disponibles and on our website under Member Rights & Responsibilities.

2.14.5 Internet Presence/Website: The health plan shall have a member portal on its website that is available to all members which contains accurate, up-to-date information about the health plan, services provided, the provider network, FAQs, and contact phone numbers and e-mail addresses. The section of the website relating to MO HealthNet shall comply with all marketing policies and procedures and requirements for written materials described herein. As part of the member services policies and procedures, the health plan shall describe its activities to ensure the website is updated regularly and contains accurate information.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.5. HealthCare USA's public website, www.hcusa.org, includes a member portal that is available to all members. All information on the website complies with MO HealthNet described herein. All information on the website is approved by the state before it is posted.

Available on the HealthCare USA Member Site is:

- a) **Member Handbook** that can be downloaded, printed or a request can be made to mail a handbook to a member
- b) **Provider Search** where members can search for a healthcare provider by specialty, name, zip code or distance
- c) **Contact information** to call or email HealthCare USA



- d) Member newsletter, *The Bear Facts* that can be viewed or printed; the current edition and two past editions are available
- e) Frequently Asked Questions (FAQs) with answers for commonly asked member questions
- f) Transportation Mileage Reimbursement Logs that can be downloaded and printed
- g) Announcements and News section to keep members up to date about important information
- h) Member Eligibility Information with links to MO HealthNet
- i) Community Events and Resources
- j) Staying Healthy Section with helpful resources to develop a healthy lifestyle, focus on children and women's care



Carefully Managed Content

To ensure that information displayed on the website about HealthCare USA and MO HealthNet is updated regularly and contains accurate information. HealthCare USA assigns staff to serve as website content managers. Content managers are subject matter experts and are also responsible for ensuring that the reading level is appropriate and all content is State approved before posting to the web.

Additionally, HealthCare USA's policy CD-14 *Website Communication* covers member communication on our website.

2.14.6 Requirements for Written Materials:

- a. The health plan shall develop appropriate methods for communicating with visual and hearing impaired members and accommodating the physically disabled. The health plan shall offer members standard materials, such as the member handbook and enrollment materials in alternative formats (i.e., large print, Braille, cassette, and diskette) immediately upon request from members with sensory impairments.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6.

HealthCare USA serves a diverse membership. Visually and hearing impaired members are made aware of specific benefits to assist them through our:

- Member Handbook
- Member website
- Member Services Department
- Community Development outreach events

To facilitate communication with the hearing impaired, we employ the Telecommunications Device for the Deaf (TDD— toll free at 1-800-613-3087). HealthCare USA members who are visually impaired can request the Member Handbook and in large print, Braille and audio formats.

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- 2.14.6.b If the health plan has more than two hundred (200) members or five (5) percent of its program membership (whichever is less) who speak a single language other than English as a primary language, the health plan shall make available general services and materials, such as the health plan's member handbook in that language. The health plan shall include, on all materials, language blocks in those languages that tell members that translated documents are available and how to obtain them.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(b).

HealthCare USA membership features individuals who, upon enrollment, may declare languages other than English as their primary language, as well as and those with visual or hearing impairments.





The principal languages of our membership, as defined by the state contract, are English and Spanish. Other languages with a significant membership include Arabic, Burmese, Nepali and Vietnamese (see Figure 2- 19—Face to Face Language Service Requests). This diverse membership requires both translation of written materials and oral interpretation services.

Figure 2- 19: Face to Face Language Service Requests

Face to Face Language Service Requests					
Language	FY11 1Q	FY11 2Q	FY11 3rdQ	FY11 4thQ	TOTALS
Spanish	574	612	587	546	2319
Nepali	234	179	143	210	766
Arabic	142	112	140	161	555
Somali	71	76	101	91	339
Burmese	85	98	90	41	314
Vietnamese	87	80	75	71	313
Bosnian	44	59	53	47	203
Russian	24	26	39	26	115
Swahili	6	12	15	30	63
Karen	3	2	31	19	55
Mandarin	15	17	8	14	54
Korean	3	13	20	15	51
Farsi	14	15	8	3	40
Cantonese	8	5	7	5	25
Albanian	4	4	3	13	24
Kirundi	1	3	13	5	22
Tigrinya	2	4	4	10	20
Kurdish	5	3	6	5	19
Dari	1	3	3	6	13
French	0	6	2	4	12
May May	0	2	6	1	9
Hindi	0	0	1	3	4



Face to Face Language Service Requests					
Language	FY11 1Q	FY11 2Q	FY11 3rdQ	FY11 4thQ	TOTALS
Pashtu	1	3	0	0	4
Uzbek	0	0	3	0	3
Chin	0	0	2	0	2
Kunama	0	0	0	1	1
Turkish	0	1	0	0	1
TOTALS	1324	1335	1360	1327	5346

SOURCE: LANGUAGE ACCESS METRO PROJECT DATA BASE

Interpretation Services Offered

HealthCare USA employs Spanish-speaking staff in the customer service department. Telephone interpretation services are provided through Language Line and face-to-face services throughout all three regions by contracting with:

- Language Access Metro Project (LAMP)
- Jewish Vocational Services
- International Institute
- A-Z Translating Services
- AAA Translation

Interpreter services for hearing impaired members are provided through Deaf Inter-Link, Deaf Expression, Inc. and DEAF Way. Figure 2-19— Face to Face Language Service Requests breaks down the face-to-face language service requests received.

Interpretation Services Offered

HealthCare USA offers our Member Handbook translated in Spanish, since Spanish is declared by more than 500 of our members. We distribute “Noodle Soups”, one-page educational information targeting specific health-related topics, to members through events and activities. Currently, HealthCare USA offers the following information in Spanish:

- *La importancia de Lavar tus manos* (Importance of Hand Washing)
- *Se sabia(o), vacune a sus hijos!* (Be Wise, Immunize)
- *Controlando el peso de su niño* (Controlling Your Child’s Weight)
- *Despues de las vacunas* (After Vaccinations)
- *Informacion sobre la salud Dental Infantil* (Children’s Oral Health Fact Sheet) published by the Centers for Disease Control and Prevention.



HealthCare USA also has *Los niños sanos son nuestra prioridad* (Healthy Kids are Our Business), an outline of HealthCare USA benefits and services, and *Instrucciones Anticipadas Sobre Atención Médica* (Advance Health Care Directive), explaining why members need a health care directive, and are available for our Spanish membership.

HealthCare USA’s Web site offers a fun, educational health and wellness-related program, KidsHealth®, to anyone with access to a computer. KidsHealth® offers a variety of physician-approved articles such as:

- Autism
- Dealing with Emotions
- Importance of Brushing Your Teeth
- Asthma
- Teen Depression
- How to Control Anger

Parents, teens and children can access hundreds of developmentally-appropriate articles, interactive games and healthy recipes, all of which can be translated into Spanish.

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- 2.14.6.c. All written materials shall be worded such that the materials are understandable to a member who reads at the sixth (6th) grade reading level. Suggested reference materials to determine whether this requirement is being met are the:
1. Fry Readability Index
 2. PROSE The Readability Analyst (software developed by
 3. Education Activities, Inc.)
 4. Gunning FOG Index
 5. McLaughlin SMOG Index
 6. The Flesch-Kincaid Index or other word processing software approved by the state agency.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(c).

HealthCare USA uses the Flesch-Kincaid readability formula to make certain our marketing materials meet the state-mandated sixth-grade reading level.

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- 2.14.6.d. The Health Plan shall:
1. Submit all materials, including changes or revisions, to the state agency for prior approval before being distributed. The health plan shall submit these changed materials at least thirty (30) days in advance of the scheduled distribution.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(d)l.

Our regulatory compliance analyst submits the materials to the State agency for approval. All member materials are written in accordance to the State contract. At least 30 days in advance of the scheduled distribution, our regulatory compliance analyst submits all materials to the State for approval and indicates how and when the material will be used, the timeframes for the use and the media to be used for distribution upon approval.



2.14.6.d2. Review all materials at least once a year. The health plan shall provide the state agency with copies of materials and documentation verifying the health plan reviewed their written materials.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(d)2.

Our Regulatory Compliance Analysts and Community Development Manager review all marketing and education materials at least once a year. Through this collaboration, we ensure all information either reviewed or created is accurate, easy-to-understand and compliant with the State's marketing guidelines.

2.14.6.d3. Insert new language in the written materials and substitute in a timely manner, as outlined by the state agency, any changes in Federal or State law or regulation, as amended, as the need arises.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(d)3.

HealthCare USA's Regulatory Compliance Analysts and Community Development Manager ensure that all modifications to written materials, including mandatory language or substitutions, are in a timely manner as explained by the state agency.

2.14.6.d4. Show the date the state agency approved the material in the lower right hand corner of all materials developed and printed by the health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(d)4.

All HealthCare USA documents and materials approved by the state agency show the agency's approval code and the approval date.

2.14.6.d5. Use mandatory education, marketing, and member notice language provided by the state agency. The state agency shall provide such language as it deems necessary. Any publicity given to the MO HealthNet Managed Care Program or the MO HealthNet Managed Care benefits shall be released only with prior written approval by the state agency, including but no limited to; notices, pamphlets, press releases, research, reports, signs and public notices prepared by or for the health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(d)5.

HealthCare USA uses mandatory education, marketing and member notice language provided by the state agency. Any publicity given to the MO HealthNet program or the MO HealthNet Managed Care benefits prepared by HealthCare USA are only released with prior written approval by the state agency.



2.14.6.d6. Maintain a member's right to confidentiality. In particular, post cards must be folded to protect the confidentiality of the member.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(d)6.

HealthCare USA ensures all member information is kept confidential, all post cards are folded to protect the confidentiality and identity information of our members.

- 2.14.7 Changing Primary Care Providers: The health plan shall have and implement written policies and procedures for allowing members to select or be assigned to a new primary care provider within the health plan when such a change is mutually agreed to by the health plan and member. The health plan shall allow members (except for children in COA 4) at least two (2) such changes per year; children in COA 4 may change primary care providers at will. The health plan shall inform members of the process for initiating primary care provider changes. Possible reasons for a member to change primary care providers include, but are not limited to:
- Accessibility - transportation problems, office hours, provider does not return phone calls, or waiting times.
 - Acceptability - is attended by too many different doctors at a clinic location, uncomfortable with surroundings or location, lack of courtesy, or provider or staff attitudes.
 - Quality - treatment (medical), referral related, or provider does not explain treatment plan/diagnosis. If this is a provider problem, the member may request a primary care provider change and a second opinion.
 - Enrollment - primary care provider with whom the member has an established patient/provider relationship no longer participates in the health plan. In cases where the primary care provider no longer participates, the health plan shall allow members to select another primary care provider or make a re-assignment within fifteen (15) calendar days of the termination effective date.
 - Cultural Insensitivity - an act of cultural insensitivity that negatively impacts the member's ability to obtain care.
 - Resolution of Grievance or Appeal Process - a primary care provider change is ordered as part of the resolution to the grievance and appeal process. A member's right to request a change in a primary care provider through the grievance and appeal process or other means shall not be restricted.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.6(d)7.

HealthCare USA members may request to change their Primary Care Provider by calling the HealthCare USA Member Services Department. HealthCare USA respects members' rights to change their PCP and assists them to ensure both timely transition and identify trends.

Members can choose a PCP upon enrollment and can change their PCP up to two times per year. Children in state custody or foster care placement can change their PCP as necessary.

HealthCare USA's Member Services Department assists members in choosing a different PCP. If a member feels they have been treated unfairly, experienced cultural insensitivity, received less than adequate care or access to the provider is difficult; they can request a change in PCP.

HealthCare USA will assist all members in finding the perfect fit for their families healthcare.



2.14.8 Member Rights and Responsibilities:

- a. Member Rights: The health plan shall include, in its member services policies and procedures, a description of how it will ensure that the rights of members are safeguarded and how the health plan will (1) comply with any applicable Federal and State laws that pertain to member rights, and (2) ensure that its staff and in-network providers take those rights into account when furnishing services to members. The members' rights include the right to:
1. Dignity and privacy. Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
 2. Receive information on available treatment options. Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
 3. Participate in decisions. Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
 4. Be free from restraint or seclusion. Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 5. Obtain a copy of medical records. Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164.
 6. Freely exercise these rights. Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.8(a).

HealthCare USA's Member Services staff is readily available to assist members with any questions they may have regarding their rights and responsibilities. Our Community Development Team also educates members regarding their rights and responsibilities at community events and activities as do the community partners who work hand-in-hand with our membership.

HealthCare USA also has policies and procedures on Member Rights and Responsibilities. To ensure member rights and responsibilities are enforced and providers are informed of these rights and responsibilities through our:

- Member Handbook
- Provider Directory
- Member and provider services toll free number
- Website

The policies and procedures are reviewed annually by HealthCare USA to ensure compliance with all state requirements.



- 2.14.8b. Member Responsibilities: The health plan shall also include in its member services policies and procedures, policies that address the members' responsibilities for cooperating with providers. These member responsibility policies must be supplied in writing to all providers and members and should address the member's responsibilities for:
1. Providing, to the extent possible, information needed by providers in caring for the member;
 2. Contacting their primary care provider as their first point of contact when needing medical care;
 3. Following appointment scheduling processes; and
 4. Following instructions and guidelines given by providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.8(b).

HealthCare USA has policies and procedures that address member's responsibilities in cooperating with providers. Members can refer to the Member Handbook for a list of rights and responsibilities. HealthCare USA's Community Development Team educates and encourages members to contact their PCP, schedule and keep appointments and contact the office if they cannot keep the appointment. All policies and procedures are reviewed annually.

- 2.14.9 Member Hold Harmless: The health plan shall not hold a member liable for the following:
- a. The debts of the health plan, in the event of the health plan's insolvency;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.9(a).

HealthCare USA will not hold a member liable in the event the health plan becomes insolvent.

- 2.14.9b. Services provided to the member in the event the health plan fails to receive payment from the state agency for such services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.9(b).

HealthCare USA will not hold a member liable in the event a health care provider with a contractual, referral or other arrangements with the health plan fails to receive payment from the state agency or health plan for such services.

- 2.14.9c. Services provided to the member in the event a health care provider with a contractual, referral, or other arrangement with the health plan fails to receive payment from the state agency or health plan for such services; or

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.9(c).

HealthCare USA will not hold a member liable in the event a health care provider with a contractual, referral, or other arrangement with the health plan fails to receive payment from the state agency or health plan for such services.



2.14.9d. Payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the health plan in excess of the amount that would be owed by the member if the health plan had directly provided the services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.9(d).

HealthCare USA will not hold a member liable for payment to a provider who furnishes covered services under a contractual, referral, or other arrangement with the health plan in excess of the amount that would be owed by the member if the health plan had directly provided the services.

2.14.9e. In the case of insolvency, the health plan shall continue to cover services to members during insolvency for the duration of period for which payment has been made by the state agency, as well as for inpatient admissions up until discharge.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.9(e).

In the case of insolvency, HealthCare USA will continue to cover services to members during insolvency for the duration of period for which payment has been made by the state agency, as well as for inpatient admissions up until discharge.

2.14.10 Changes in Information:

- a. The health plan shall ensure that members receive written notification of changes in health plan operations that affect them at least thirty (30) calendar days before the intended effective date of the change unless otherwise noted. Examples of such changes and the notification requirements are as follows:
1. Network changes such as a new behavioral health subcontractor or other major subcontractor. Notification is required to all members.
 2. Departure of an in-network primary care provider or other provider seen on a regular basis. Notification is required to the affected members within fifteen (15) calendar days after receipt or issuance of the termination notice.
 3. In network primary care provider moves from one in-network clinic or physician group to another. Notification is required to the affected members, seen on a regular basis, within fifteen (15) calendar days of the receipt of the move notice. The health plan must notify members of the primary care provider's new location and phone number. The member must receive new identification cards with the primary care provider's name and phone number.
 4. Comprehensive benefit package changes from what is explained in the member handbook. Notification is required to all members.
 5. Utilization management procedure(s) changes from what is explained in the member handbook. Notification is required to all members.
 6. Prior authorization procedure(s) changes from what is explained in the member handbook. Notification is required to all members.
 7. Advance directive policy changes as a result of changes in State law. Notification is required to all members.
- b. All written member notifications must be prior approved by the state agency and written according to the requirements for written materials stated herein. The health plan shall include certain passages and language provided to the health plan by the state agency in the member
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notification. The health plan shall comply with all changes regarding member notification content specified by the state agency within the time period defined by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.14.10 (a-b).

HealthCare USA requests approval from the state agency for all written member notifications. HealthCare USA ensures that members receive written notification of changes in health plan operations that affect them at least thirty (30) calendar days before the intended effective date of the change, unless otherwise noted.

2.15 Member Grievance System [4.4.14]

The health plan shall have a system in place for members which includes a grievance process, an appeal process, and access to the state agency's fair hearing system.

4.4.14 Member Grievance System

The offeror shall describe the offeror's member grievance system being sure to address the grievance process, the appeal process, expedited resolution process, and process for ensuring that members receive proper notice of action. (2.15)

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15 and 4.4.14. HealthCare USA maintains a Member Grievance system and reports quarterly, region-specific data to MO HealthNet.

For specific information on our grievance system, see to:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

For further details on Section 2.15, see Section 4.5.2(d).

Grievance System Overview

HealthCare USA understands that at times a member might disagree with a HealthCare USA action or a function of the health plan. In those instances the HealthCare Grievance System allows the member to voice their dissatisfaction. The member has the right to file either a grievance or appeal with HealthCare USA. We strive to address grievances and appeals promptly, making sure to address and assist member with any questions before, during, or after the process.

HealthCare USA members can access the Grievance System processes through various mechanisms. Available resources include member handbooks, grievance flyers, notice of action letters if a service is denied, and the HealthCare USA website. HealthCare USA develops these



materials in accordance with the appropriate state and federal regulations. In addition, members may decide to consult with staff they may already be comfortable in dealing with. Those staff members include case managers, social workers, appeals and grievances compliance analysts, customer service representatives, or community outreach coordinators. Our information and staff assist members with:

- Filing a grievance or appeal
- Answering any questions about the grievances or appeal process
- Assisting with completion of forms
- Requesting a state fair hearing
- Accessing the members ombudsman regarding grievances, appeals and state fair hearing

If a member decides to file a grievance or appeal, the designated compliance analyst acts as the member advocate to assist with guidance throughout the process. The compliance analyst's name and contact information is included in both the grievance and appeal acknowledgement letters. In addition, the compliance analyst assists with special needs assistance such as interpreter services, toll-free Telephone Typewriter (TTY) services, toll-free Telecommunication Devices for the Deaf (TTD), and translation services. There will be no retaliatory actions against members utilizing the Member Grievance process.

To ensure an impartial process for the member, the individual who reviews an appeal or grievance is neither the individual who made the initial determination or their subordinate. For grievances or appeals based in whole or in part on medical judgment, the reviewer(s) must:

- Hold an active, unrestricted license to practice medicine
- Be board-certified by a specialty approved by the American Board of Medical Specialties (Doctors of Medicine) or by the Advisory Board of Osteopathic Specialists from a major area of clinical services
- Be a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment (i.e., the same or similar specialty)

In addition, HealthCare USA does not subcontract member grievances or member appeals to any of our subcontractors or affiliates. Members receive a resolution letter directly from HealthCare USA that includes the name of a health plan representative who will serve as their advocate.

Member Grievances Process

HealthCare USA members may file a member grievance at any time. The grievance can be filed with HealthCare USA either in writing or verbally (telephone or in person). When filing a grievance verbally, HealthCare USA assists the member by obtaining the key details required to investigate or handle the grievance. If a member files the grievance in writing, the member can consult the member handbook or the grievance flyer to construct a detailed grievance.

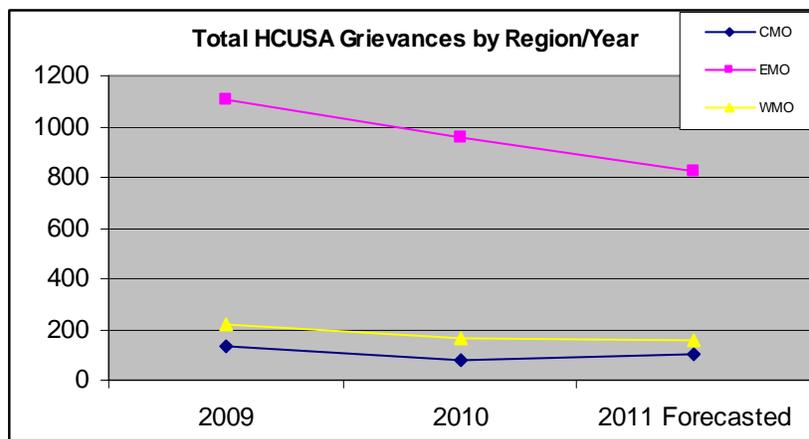
After a member files or an authorized representative of the member files a grievance, HealthCare USA documents the substance of the grievance in our online tracking system, Navigator. The substance of the grievance includes but is not limited to:



- Name of grievant
- Date grievance received
- Region of Missouri
- Type of grievance
- Substance of grievance
- Compliance due date

The compliance analyst uses these core details as the basis of their investigation into the grievance.

HealthCare USA resolves grievances as expeditiously as possible for our members. Since 2009 we processed 87.2% of all grievances (all three regions combined) in less than 10 business days.



DATA SOURCE: NAVIGATOR GRIEVANCE STATISTICS

Once the member’s grievance is documented and organized, the compliance analyst reviews the substance of the grievance. If the member’s issue requires consultation from an external vendor, the compliance analyst outreaches to the third party and collects additional information. Examples of a third party includes a provider’s office, a transportation vendor, or another HealthCare USA department. While additional facts concerning the member grievance are being collected, the compliance analyst reviews and documents the policy or procedure that applies to the grievances.

Once the member grievance documentation is complete, the compliance analyst evaluates the grievance using all member provided information, additional documentation gathered during the review, and the applicable HealthCare USA policies and procedures. The compliance analyst bases the grievance determination on applicable policies and procedures. In some instances, the compliance analyst requests a HealthCare USA professional to review and provide the determination on a grievance, including grievances related to medical decisions, access to care, or quality of service.

A member has the right to contact HealthCare USA to extend the review of their grievance. The compliance analyst acknowledges the extension request in writing through our online tracking system. The acknowledgement letter includes the reason for the extension.



The final steps in the Grievance process includes documenting the determination in writing to the member. The compliance analyst records the reason and rationale of the decision in our online tracking system including the final grievance determination. Finally, the compliance analyst uses our online letter writing program to respond to the member in simple and understandable language. The grievance determination letter includes:

- Assigned grievance number
- Grievance determination
- Reason and rationale for the decision
- Grievance reviewer
- Compliance analyst assigned to the grievance
- Contact information for any questions

Once the letter is given a final review, the compliance analyst saves the letter in our online tracking system, mails the letter, and closes the grievance. If the member contacts us in the future, the grievance would be visible in the on line tracking system for future customer service.

Member Appeal Process

Every HealthCare USA denial produces a Notice of Action letter that is mailed to the member. Each notice of action advises our member of their right to file an appeal, a state fair hearing, or both. To exercise their right to file an appeal, a member must contact HealthCare USA in ninety (90) days from the Notice of Action letter. A member may contact HealthCare USA by telephone, in writing or in person to file an appeal. A member appeal is processed in 30 days from the receipt of the appeal. A member may request a 14 day extension.

When HealthCare USA receives an appeal from a member or their authorized representative, the appeal is logged in our online tracking system and assigned a compliance analyst to serve as the member advocate for the duration of the appeal. The member receives a member appeal acknowledgement letter, an appeal form, and a stamped return envelope. If the member did not file their original appeal in writing, they must return the signed appeal form in the stamped return envelope. The acknowledgement information includes pertinent details such as date:

- Member appeal received date
- Member appeal number
- Substance of the member appeal
- Member appeal hearing date
- Compliance analyst name and contact information
- A checkbox for if they wish to attend their member appeal hearing

Once the appeal is acknowledged, the compliance analyst documents and researches the substance of the appeal. Each appeal is handled uniquely as it relates to the individual member. The compliance analyst works with the member to understand the intricate details of their specific appeal. From those discussions and descriptions, the compliance analyst outreaches to

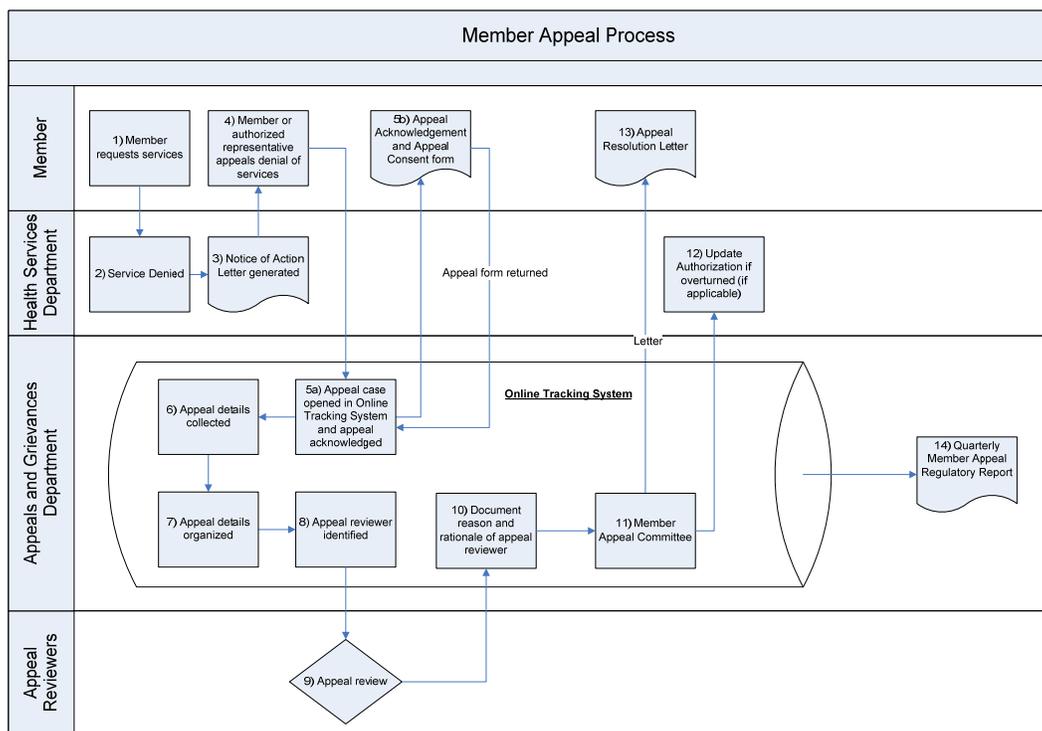


all of the appropriate medical professionals that have documentation (including medical records) that assist the member with their case. As the member advocate, the compliance analyst works to gather the documentation and assists with the member if there are any issues.

During the collection of data, the compliance analyst identifies and documents the clinical criteria used to deny the service. This information is combined and organized with the documentation for medical review. Before an appeal reviewer is identified, the compliance analyst reviews the denial information to assure the reviewer was not involved in the initial action, nor the subordinate or an individual that made the initial action decision. Based on the substance of the appeal, the compliance analyst identifies the appropriate appeal reviewer based on the same or similar medical specialty with an active, unrestricted license to practice medicine, and applicable board certified.

The compliance analyst sends the complete appeal record to the appeal reviewer.

Figure 2- 20: HealthCare USA Member Appeal Process



HealthCare USA sends member appeals to two appeal reviewers for member appeal determinations. As a Healthcare USA standard, a consensus among two board certified specialists is made that the medical decision is based on documented criteria. If the two appeal reviewers disagree, a third board certified specialist is consulted to break the tie. If an appeal is nonclinical in nature, management level staff at HealthCare USA reviews the administrative case. The appeal reviewer returns their signed determination to the compliance analyst in writing, including the specific reason and rationale for the decision.

Member appeal hearings occur weekly at HealthCare USA. The compliance analyst organizes the appeals for the hearing by detailing the substance of the appeal, the member statement, and the appeal reviewer determinations. A member has a right to attend the hearing in person at any



of the three HealthCare USA offices (Kansas City, Jefferson City, or St. Louis). The member provides their statement at the member appeal hearing. If the member does not choose to attend, the compliance analyst serves as the member representative and advocate. The member appeal committee takes all details and recommendations into consideration to determine the appeal outcome. The member appeal committee does not have authority to overturn decisions that have been recommended for approval by appeal reviewers.

The compliance analyst documents the reason and rationale of the decision in our online tracking system including the final appeal determination. Finally, the compliance analyst uses our online letter writing program to respond to the member in simple and understandable language. The appeal determination letter includes:

- Assigned appeal number
- Appeal determination
- Reason and rationale for the decision
- Criteria used for the decision
- Notification they have access to their appeal file
- Titles and qualifications of individuals involved in the appeal review
- Compliance analyst name and contact information
- Description of state fair hearing

Once the letter is given a final draft review, the compliance analyst saves the letter in our online tracking system, mails the letter, and closes the appeal. The member may contact the compliance analyst at any time after the appeal to assist them in filing for a state fair hearing.

Expedited Appeal Process

A member may request an expedited appeal at any time. The expedited appeal process is utilized when the standard Appeal timeframes could seriously jeopardize:

- (a) the life or health of the Member or in the case of a pregnant member, the member's unborn child; or
- (b) the Member's ability to attain, maintain or regain maximum function.

An expedited appeal will be reviewed in 72 hours from the time of receipt.

When a member or member's authorized representative requests an expedited appeal (written, verbally, or in person), the compliance analyst documents the substance of the appeal in our online tracking system. Due to the urgent nature of the request, a verbal appeal does not require written documentation. The compliance analyst contacts the member to notify them of receipt of the expedited appeal. By serving as the member advocate, the compliance analyst collects the appropriate appeal documentation for review.

Once the member's documentation is received, the compliance analyst presents the complete record to a HealthCare USA medical director. The medical director reviews the entire appeal documentation and determines if the member's case meets the criteria for an expedited review.



If denied as expedited, the member receives a letter from the compliance analyst notifying them of the decision and the right to file a grievance if they disagree. The compliance analyst documents the denial in our online tracking system and converts the appeal to a standard member appeal.

If approved as expedited, the member's case will be reviewed in 72 hours from the time of receipt. HealthCare USA sends member appeals to two appeal reviewers (appropriate board certified specialists in the like specialty). If the two appeal reviewers disagree, a third board certified specialist is consulted to break the tie. The appeal reviewer must return their signed determination to the compliance analyst in writing and include their specific reason and rationale for their decision.

As in the case of a standard member appeal, the compliance analyst documents the reason and rationale of the decision in our online tracking system including the final appeal determination. Finally, the compliance analyst uses our online letter writing program to respond to the member in simple and understandable language. The appeal determination letter includes:

- Assigned appeal number
- Appeal determination
- Reason and rationale for the decision
- Criteria used for the decision
- Notification they have access to their appeal file
- Titles and qualifications of individuals involved in the appeal review
- Compliance analyst name and contact information
- Description of state fair hearing

Once the letter is given a final review, the compliance analyst saves the letter in our online tracking system, mails the letter, and closes the appeal. The member may contact the compliance analyst at any time after the appeal to assist them in filing for a state fair hearing.

Process For Ensuring Members Receive Proper Notice Of Action

It is imperative that that a member receives a clear and concise Notice of Action letter from HealthCare USA. Each notice of action letter addresses any potential questions members may have about their grievance or member appeal.

Our online tracking system creates a form letter template that allows for effective repeatable processes for letter creation for both member grievances and member appeals. Key details that must be included each letter are flagged as required fields. Letters cannot be saved in our online tracking system unless the appropriate details are completed. This allows management to effectively audit staff to assure the appropriate letters are created at all times.

HealthCare USA achieved Commendable status for NCQA accreditation in August, 2011. Part of this rigorous process included a detail file audit of letters. Each letter was reviewed for the specific reason and rationale for the decision in easily understandable language.



In order to produce consistent letters, HealthCare USA adheres to documented policies and procedures for member grievances and member appeals. In addition, the Appeal and Grievance Department maintains an extensive library of responses for common appeals and grievances. This allows consistent management of approved language being sent to our members. Although we utilize templates, our goal is to make each letter personal to our individual members.

- 2.15.1 For purposes of the health plan's member grievance system, the following definitions shall apply:
- Action - The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure of the health plan to provide services in a timely manner as defined in the appointment standards described herein; or the failure of the health plan to act within timeframes for the health plan's prior authorization review process specified herein.
 - Appeal - A request for review of an action, as action is defined in this section.
 - Appeal Process - The health plan's process for handling of appeals that complies with the requirements specified herein, including, but not limited to, the procedural steps for a member to file an appeal, the process for resolution of an appeal, the right to access the State fair hearing system, and the timing and manner of required notifications.
 - Grievance - An expression of dissatisfaction about any matter other than an action, as action is defined in this section. Possible subjects for grievances 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 member's rights.
 - Grievance Process - The health plan process for handling of grievances that complies with the requirements specified herein, including, but not limited to, the procedural steps for a member to file a grievance, the process for disposition of a grievance, and the timing and manner of required notifications.
 - Grievance System - The overall system in place for members that includes a grievance process, an appeal process, and access to the State fair hearing system.
 - Inquiry - A request from a member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function but does not express dissatisfaction.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.1. HealthCare USA has policies and procedures that include the definitions of *Action*, *Appeal*, *Appeal Process*, *Grievance*, *Grievance Process*, and *Grievance System*. These policies are reviewed annually by the HealthCare USA Policy and Procedure Work Group—Quality Management Committee, and are then submitted to the State annually for review and approval.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*



2.15.2 General Requirements: The health plan shall develop and implement written policies and procedures that detail the operation of the grievance system and provides simplified instructions on how to file a grievance or appeal and how to request a state fair hearing.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2. HealthCare USA has state-approved policies and procedures detailing the process used to resolve grievances and appeals. HealthCare USA provides members with simplified instructions on how to file a grievance or appeal, or how to request a state fair hearing. In addition a member can contact a Member Service Representative to assist with the submitting a grievance or appeal. Additional resources available to the member include:

- HealthCare USA website
- HealthCare USA Member Handbook
- Notice of Action letters
- HealthCare USA Member Services
- HealthCare USA Appeal and Grievance Department Compliance Analysts

For specific information, see to:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.2a. The policies and procedures must be approved by the state agency prior to implementation.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (a).

Member Grievance policies and procedures are reviewed by HealthCare USA’s Quality Management Committee annually, and all applicable policies are sent to the state.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*



2.15.2b. The policies and procedures shall be approved by the health plan's governing body and be the direct responsibility of the governing body.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (b).

HealthCare USA's Board of Managers delegates the authority to approve and be responsible for the grievance system policies and procedures to the Quality Management Committee (QMC).

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.2c. The policies and procedures shall identify specific individuals who have authority to administer the grievance system policies.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (c).

HealthCare USA's member grievance system identifies compliance analysts as the staff who administer, research, resolve, and respond to member grievances and member appeals. Our compliance analysts serve as the member's advocate to resolve grievances and appeals. They investigate grievances and appeals thoroughly in order to notify the member of the reason and rationale for the decision.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.2d. The health plan shall distribute to members upon enrollment a flyer explaining the grievance system. This flyer shall contain specific instructions about how to contact the health plan's member services, and shall identify the person from the health plan who receives and processes grievances and appeals. This flyer can be distributed with the member handbook but it must be a stand-alone document. The grievance system flyer shall be readily available in the member's primary language. In addition, the health plan shall demonstrate that they have procedures in place to notify all members in their primary language of grievance dispositions and appeal resolutions.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (d).



HealthCare USA distributes a grievance flyer to members upon enrollment and upon request. This document defines the grievance system for the member, including how to file a grievance or an appeal.

Compliance Analysts function as member advocates, and the way they will assist the member through the grievance and appeal process is included. Phone numbers are also included, in case a member needs additional assistance with filing a grievance or appeal.

The flyer is available in any language required by a member. Translation of written grievance and appeal responses are provided by our contracted translation service business partners.

Specific information is outlined in HealthCare USA policy C3 *Member Grievance System Process—Grievances*.

¿No está satisfecho? Llámenos...

Es posible que no siempre esté satisfecho con HealthCare USA. Queremos escuchar su opinión.

En HealthCare USA hay personas que pueden ayudarlo. Hay dos maneras de informarle a HealthCare USA acerca de un problema. Puede presentar una queja o solicitar una apelación. HealthCare USA no puede retirarles sus beneficios porque usted presente una queja, una apelación, o solicite una audiencia estatal imparcial.

¿Qué es una queja?

Una "queja" es una manera de mostrar su insatisfacción sobre cosas como:

- La calidad de la atención médica o los servicios que recibió.
- La manera en que lo trató un proveedor.
- Alguna política del plan de atención médica administrada de MO HealthNet con la que no está de acuerdo.

¿Qué es una apelación?

Una "apelación" es una manera de solicitar una revisión cuando HealthCare USA:

Toma medidas para:

- Denegar o dar una aprobación limitada de un servicio solicitado.
- Rechazar, reducir, suspender o dejar de cubrir un servicio que usted ya recibe.
- Negar el pago de un servicio.

O deja de:

- Actuar dentro de los plazos requeridos para recibir un servicio;
- Tomar una decisión relacionada con una queja dentro de los treinta (30) días de recibir el pedido;

HealthCare USA debe darle una notificación de resolución por escrito ante alguna de estas situaciones. En la notificación de resolución, le indicaremos qué hicimos y por qué, y le informaremos que tiene derecho a presentar una apelación o a pedir una audiencia estatal imparcial.

Cómo presentar una queja, una apelación o pedir una audiencia estatal imparcial

1. QUEJA: puede presentar una queja por teléfono, personalmente o por escrito. Llame a HealthCare USA al 1-800-566-6444 para presentar una queja.

- HealthCare USA le escribirá dentro de los diez (10) días y le informará que hemos recibido su queja.
- HealthCare USA debe darle una notificación por escrito de la decisión dentro de los treinta (30) días.

2. APELACIÓN: puede presentar una apelación oral o escrita a HealthCare USA. A menos que necesite una evaluación inmediata, debe completar una solicitud por escrito, incluso si la presentó en forma oral.

- Debe presentar una apelación dentro de los noventa (90) días a partir de la fecha de su notificación de resolución.
- Si quiere obtener ayuda para realizar una apelación, llame a HealthCare USA al 1-800-566-6444.
- Envíe su apelación por escrito a: Appeals and Grievances Department, Compliance Analyst, HealthCare USA, 10 S. Broadway,

- HealthCare USA debe darle un aviso por escrito de una decisión dentro de los treinta (30) días, a menos que sea una evaluación inmediata. Una apelación inmediata se evalúa en tres (3) días hábiles o antes.

3. AUDIENCIA ESTATAL IMPARCIAL:

Usted tiene derecho a pedir una audiencia estatal imparcial cuando su plan de atención médica administrada de MO HealthNet toma una medida o cuando su apelación no se decide a su favor. Puede pedir una audiencia estatal imparcial en forma oral o escrita. A menos que necesite una evaluación inmediata, debe completar una solicitud por escrito, incluso si la presentó en forma oral.

- Debe pedir una audiencia estatal imparcial dentro de los noventa (90) días, a partir de la fecha de la notificación de resolución por escrito del plan de atención médica administrada de MO HealthNet o de la carta de la decisión de la apelación.
- Si necesita ayuda para pedir una audiencia estatal imparcial, llame a la División de MO HealthNet al 1-800-392-2161.
- Si usted no habla o entiende inglés, llame al 1-800-392-2161 para obtener ayuda de alguien que habla su idioma.
- Puede enviar una solicitud por escrito a Participant Services Unit, MO HealthNet Division, P.O. Box 6500, Jefferson City, MO 65102-6500.

2.15.2e. The health plan shall also distribute the information on the grievance system to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim whichever is earlier. This information may be distributed to providers via the member flyer, a flyer designed for providers, or the grievance system policies and procedures.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (e).

All HealthCare USA network providers, subcontractors and affiliates receive the Provider Manual at contract orientation. This booklet includes HealthCare USA's process for member grievances and appeals. The grievance and appeal process is given to non-participating providers within 10 calendar days of prior approval for a service, or the date of receipts of a claim,



whichever is earlier. The grievance and appeal process is included on the remittance advice of the provider's claim, and a grievance flyer is also available to all providers.

For specific information, see:

- *HealthCare USA Provider Manual*, pp. 85-88

The following policy outline our procedure, and are available upon request:

- HealthCare USA policy *C6 Provider Complaint and Appeal Process*

2.15.2f. As part of the grievance system, the health plan shall ensure that health plan executives with the authority to require corrective action are involved in the grievance and appeal processes.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (f).

HealthCare USA's Quality Management Committee receives appeals and grievance data quarterly. These meetings include not only HealthCare USA's executive management, but also external physicians from across the State of Missouri. Appeal and grievance trends and recommendations for corrective actions are discussed and approved for implementation at these meetings. Additional Appeal and Grievance data are presented in HealthCare USA's Staff Management Meeting that is attended by the CEO, CFO, CMO, vice presidents, and directors.

Further, a Grievance and Appeal Work Group meets to review data for patterns in appeals, complaints, and grievances. This group is a cross-functional team with the authority to make recommendations for corrective action. Its goal is to reduce—if not eliminate—appeals, complaints and grievances.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C3 Member Grievance System Process—Grievances*

2.15.2g. The health plan shall thoroughly investigate each grievance and appeal using applicable statutory, regulatory, and contractual provisions, and the health plan's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (g).

HealthCare USA takes into consideration all information provided to us by the member, the member's representative or the provider.

Grievances and appeals are reviewed by the appropriate professionals using applicable statutory, regulatory, and contractual provisions, as well as HealthCare USA's written policies and procedures. Information from grievances and appeals is documented and data is collected from members, providers, facilities, subcontractor and affiliates.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy *C1 Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*



- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.2h. The health plan shall probe inquiries so as to validate the possibility of any inquiry actually being a grievance or appeal. The health plan shall identify any inquiry pattern.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (h).

HealthCare USA verifies that an inquiry is neither a grievance nor an appeal.

Our Member Service staff is trained to ask members if they wish to file a grievance or appeal regarding the subject of their phone call. All inquiries are tracked and reports are produced to identify trends. HealthCare USA investigates patterns to determine if internal processes need to be changed or if corrective action is warranted.

For specific information, see:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

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- 2.15.2i. The health plan's grievance system shall not be a substitute for the state fair hearing process. The state agency shall maintain an independent state fair hearing process as required by Federal law and regulation, as amended. The state fair hearing process shall provide members with an opportunity for a state fair hearing before an impartial hearing officer. The parties to the state fair hearing include the health plan, as well as the member, and his or her representative or the representative of a deceased member's estate. The health plan shall comply with decisions reached as a result of the state fair hearing process. Health plan members shall have the right to request information regarding:
- 1) The right to request a state fair hearing;
 - 2) The procedures for exercising the rights to appeal or request a state fair hearing;
 - 3) Representing themselves or use legal counsel, a relative, a friend, or other spokesperson;
 - 4) The specific regulations that support or the change in Federal or State law that requires, the action;
 - 5) The individual's right to request a state fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted; and
 - 6) A state fair hearing within ninety (90) calendar days from the health plan's notice of action.
-

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (i)1-6.

We assist members with the state fair hearing process by providing information collected during the member's appeal to the state. Any additional information that is requested is also



provided to assist the member's state fair hearing. HealthCare USA provides information to the State within the timelines identified by the State.

HealthCare USA staff participates in the hearing proceedings when requested. As required, HealthCare USA makes available the Medical Director for physical, mental health, and dental hearings.

For specific information refer to:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.2j. The State must reach its decisions within the specified timeframes:

- 1) Standard resolution: within ninety (90) calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a state fair hearing) or the date the member filed for direct access to a state fair hearing.
- 2) Expedited resolution (if the appeal was heard first through the health plan appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that:
 - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or
 - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
3. Expedited resolution (if the appeal was made directly to the state fair hearing process without accessing the health plan appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.2 (j)1-3.

We assist members with the state fair hearing process by providing information collected during the member's appeal to the state. Any additional information that is requested is also provided to assist the member's state fair hearing. HealthCare USA provides information to the State within the timelines identified by the State.

HealthCare USA staff participates in the hearing proceedings when requested. As required, HealthCare USA makes available the Medical Director for physical, mental health, and dental hearings.



For specific information refer to:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.3 Record Keeping and Reporting Requirements:

- a. The health plan shall log and track all inquiries, grievances, and appeals.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.3(a).

HealthCare USA logs and tracks all inquiries, grievances and appeals. All grievances and appeals are reported quarterly to the state.

We enter all grievances and appeals into our tracking system, noting whether the inquiry was received by phone, in person, or in the mail (region is also identified, for tracking and trending). As grievances and appeals are entered into our tracking system, they are assigned to a compliance analyst for investigation and resolution and our tracking system reports on appeals and grievances assigned to each compliance analyst. HealthCare USA then tracks the timeframe that a compliance analyst has to complete the grievance or appeal.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

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- 2.15.3b. The health plan shall maintain records of grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of grievance, date of decision, and the disposition. If the health plan does not have a separate log for MO HealthNet Managed Care members, the log shall distinguish MO HealthNet Managed Care members from other health plan members.
-

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.3 (b).

HealthCare USA maintains a record of all verbal and written grievances. These records are maintained in our tracking system and include:

- Name of grievant



- Region of the state
- Date the grievance was received
- Documentation of the substance of the grievance
- Dated synopsis or the information gathered in the course of the investigation including any clinical information and its source
- Date of resolution of the grievance
- Disposition of the grievance
- Copy of the resolution letter and the date it was sent to the member or the member's representative regarding the disposition of the grievance and any rights to appeal

HealthCare USA has the ability to distinguish MO HealthNet Managed Care member from other health plan members, if applicable.

2.15.3c. The health plan shall maintain records of appeals, whether received verbally or in writing, that include a short, dated summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution. If the health plan does not have a separate log for MO HealthNet Managed Care members, the log shall distinguish MO HealthNet Managed Care members from other health plan members.

Healthcare USA understands and shall comply with the requirements set forth in Section 2.15.3 (c).

HealthCare USA maintains a record of all appeals whether received verbally or in writing. These records are maintained in our online tracking system and include:

- Name of appellant
- Region of the State of Missouri
- Date the appeal was received
- Documentation of the substance of the appeal
- Dated synopsis of the information gathered in the course of the investigation, including any clinical information and its source
- Date of the resolution of the appeal
- Disposition of the appeal
- Copy of the resolution letter sent to the member or the member's representative with any further level of appeal, if applicable

HealthCare USA can distinguish MO HealthNet Managed Care members from other health plan members, if applicable.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy *C1 Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*



- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.3d. The health plan shall report grievances and appeals to the state agency in the format and frequency specified by the state agency. The state agency shall provide the health plan with no less than ninety (90) days notice of any change in the format or frequency requested.

HealthCare USA understands and shall comply with the requirement set forth in Section 2.15.3(d)

All grievances and appeals are reported to the state in the format and frequency specified by the state.

For specific information, see:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*
- HealthCare USA policy C6 *Provider Complaint and Appeal Process*

2.15.3e. The state agency may publicly disclose summary information regarding the nature of grievances and appeals and related dispositions or resolutions in consumer information materials.

HealthCare USA understands and shall comply with the requirement set forth in Section 2.15.3(e).



2.15.4 Notice of Action Requirements:

- a. The health plan's notice must be in writing and must meet the language and content requirements specified herein to ensure ease of understanding.
- b. The health plan's notice must explain the following:
 - 1) The action the health plan has taken or intends to take;
 - 2) The reasons for the action;
 - 3) The member's or the provider's right to file an appeal;
 - 4) The member's right to request a state fair hearing;
 - 5) The procedures for exercising the rights to appeal or request a state fair hearing;
 - 6) The member's right to represent himself or use legal counsel, a relative, a friend, or other spokesperson;
 - 7) The specific regulations that support or the change in Federal or State law that requires the action;
 - 8) The member's right to request a state agency hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted;
 - 9) The circumstances under which expedited resolution is available and how to request it; and
 - 10) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.
- c. The health plan shall mail the notice to the member within the following timeframes:
 - 1) For termination, suspension, or reduction of previously authorized covered services, at least ten (10) calendar days before the date of action. The health plan may mail a notice not later than the date of action under the following circumstances:
 - The health plan has factual information confirming the death of the member;
 - The health plan receives a clear, written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information;
 - The member's whereabouts are unknown and the post office returns health plan mail directed to the member indicating no forwarding address (refer to 42 CFR 431.231 (d) for procedures if the member's whereabouts become known);
 - The member's physician prescribes a change in the level of medical care;
 - The health plan may shorten the period of advance notice to five (5) calendar days before date of action if the health plan has facts indicating that action should be taken because of probable fraud by the member and the facts have been verified, if possible, through secondary sources;
 - The member's admission to an institution where he is ineligible for further services; and
 - The member has been accepted for MO HealthNet services by another local jurisdiction.
 - 2) For denial of payment decisions that result in member liability, at the time of any action affecting the claim.
 - 3) For service authorization decisions that deny or limit services, within the timeframes required by the service accessibility standards for prior authorization specified herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.4.

HealthCare USA's notice of action letter continues to meet the language and content requirements as specified by the State and NCQA. Our notice of action letters include:

- The action that HealthCare USA plans to take
- The reason and rationale for the action



- The member/provider’s right to appeal
- The member’s right to request a state fair hearing and the procedures to do so
- A statement indicating that the member may self-represent or use legal counsel, a relative, a friend, or a spokesperson
- Specific regulations that support the action, or the specific change in federal or state law that requires the action
- The member’s right to request a state fair hearing or, if the action is based on change in law, the circumstance under which a hearing will be granted
- The member’s right to have benefits continue, pending resolution of the appeal, how the member can request that benefits be continued, and the circumstances under which the member may request to pay the costs of these services

HealthCare USA also meets all timeframes set forth by the State and NCQA regarding the mailing of notice of action letters:

- At least 10 calendar days before the date of action for termination, suspension, or reduction of previously authorized covered services
- At the time of any action affecting the claim for denial of payment decisions that may result in member liability
- Within the timeframes required by the service accessibility standards for prior authorization.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*
- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.5 Grievance Process:

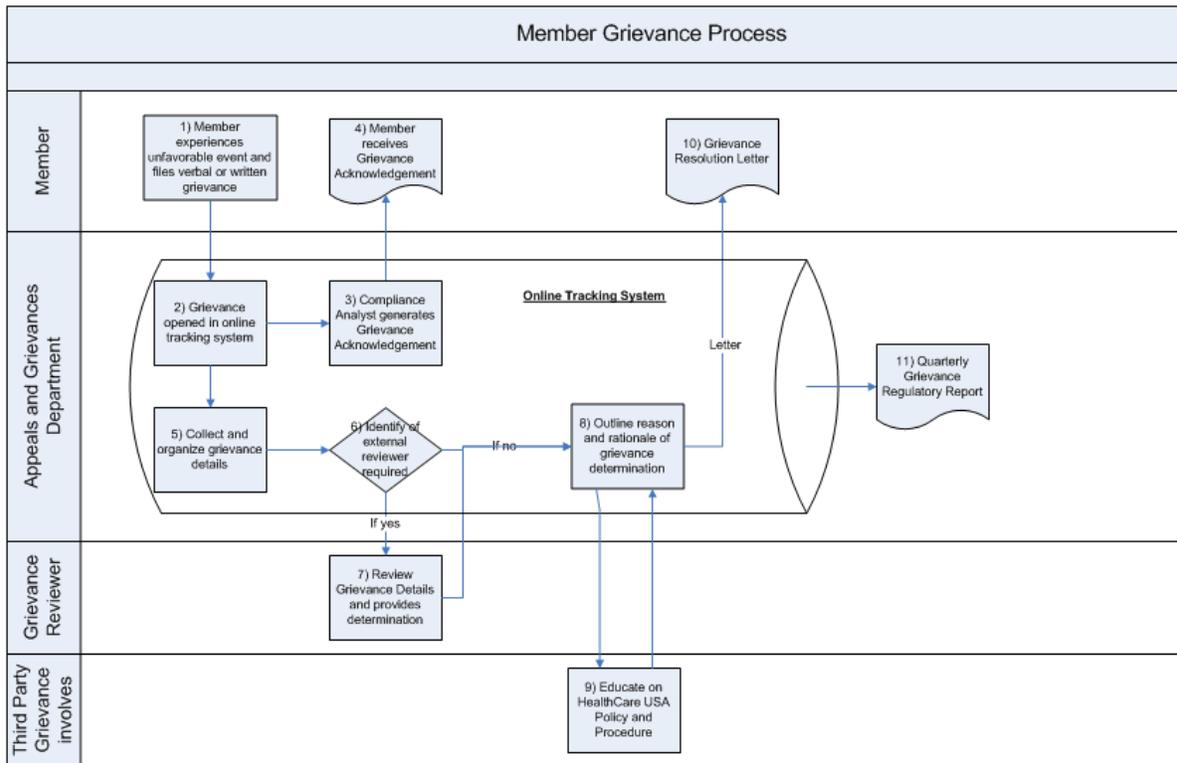
- a. A member may file a grievance either orally or in writing. A member’s authorized representative including the member’s provider may file a grievance on behalf of the member.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.5(a).

HealthCare USA accepts grievances filed verbally or in writing. A member may file a grievance using his/her provider or an authorized representative. If a member’s authorized representative files the grievance, we require an Authorization for Disclosure of Personal Health Information to be completed by the member for HIPAA compliance.



Figure 2- 21: HealthCare USA Member Grievance Process



The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.5b. The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.5(b).

HealthCare USA includes the direct phone numbers of the compliance analyst in the grievance acknowledgement letter. The compliance analyst provides the member with any reasonable assistance that includes but is not limited to, providing an interpreter or giving the toll-free numbers that have adequate TTY/TTD and interpreter capability.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C3 *Member Grievance System Process—Grievances*



2.15.5c. The health plan shall acknowledge receipt of each grievance in writing within ten (10) business days after receiving a grievance.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.5(c).

HealthCare USA acknowledges receipt of grievances within 10 business days after receiving the grievance. These letters are sent by the compliance analyst to the member or member's authorized representative.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C3 Member Grievance System Process—Grievances*
-

2.15.5d. The health plan shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease:

1. A grievance regarding denial of expedited resolution of an appeal.
 2. A grievance that involves clinical issues.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.5(d).

Compliance analysts review grievances and refer them to the appropriate department for action, ensuring that individuals who were not involved in any previous level of review are not included in decision-making.

For quality of care issues, the grievance is referred to our Quality Improvement Department to research the member's grievance and request medical records. In cases of a clinical or a grievance regarding the denial of an expedited resolution of an appeal, an appropriate healthcare professional is contacted to review the grievance.

2.15.5e. The health plan shall dispose of each grievance and provide written notice of the disposition of the grievance, as expeditiously as the member's health condition requires but shall not exceed thirty (30) calendar days of the filing date.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.5(e).

HealthCare USA responds to grievances as expeditiously as the member's health condition requires, not exceeding 30 calendar days from the date the grievance was filed.

On average, HealthCare USA resolved grievances in 6.6 days in 2009, 2010, and 2011 combined (Source: HealthCare USA's Navigator reporting).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C3 Member Grievance System Process—Grievances*
-



2.15.5f. The health plan may extend the timeframe for disposition of a grievance for up to fourteen (14) calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest. If the health plan extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.5(f).

HealthCare USA allows an up to 14 calendar day extension of a grievance if requested by the member. HealthCare USA requests an extension when it is in the best interest of the member. Notification of the grievance extension is sent to the member, which includes the reason HealthCare USA is requesting a delay.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C3 *Member Grievance System Process—Grievances*

2.15.6 Appeal Process:

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6. As detailed here, our appeal process is fully compliant.

HealthCare USA Member Appeal Process

1. Member requests/receives medical treatment from a HealthCare USA provider
2. HealthCare USA receives the request for medical treatment. The medical treatment is approved or denied
3. HealthCare USA produces a Notice of Action (NOA) letter. The NOA is sent to member.
4. Member reviews NOA
5. Member or authorized representative of member appeals denial due to disagreement with HealthCare USA action (verbally, written, or in person)
6. Member or authorized representative of member documents reason of appeal and sends to HealthCare USA
7. HealthCare USA receives appeal
8. HealthCare USA compliance analyst documents appeal details in online tracking system
9. Compliance analyst creates acknowledgement letter and mails to member. Letter details pertinent details such as:
 - o Received Date
 - o Confirms medical service being appealed
 - o Expected member appeal hearing date
 - o Name of HealthCare USA compliance analyst working the case

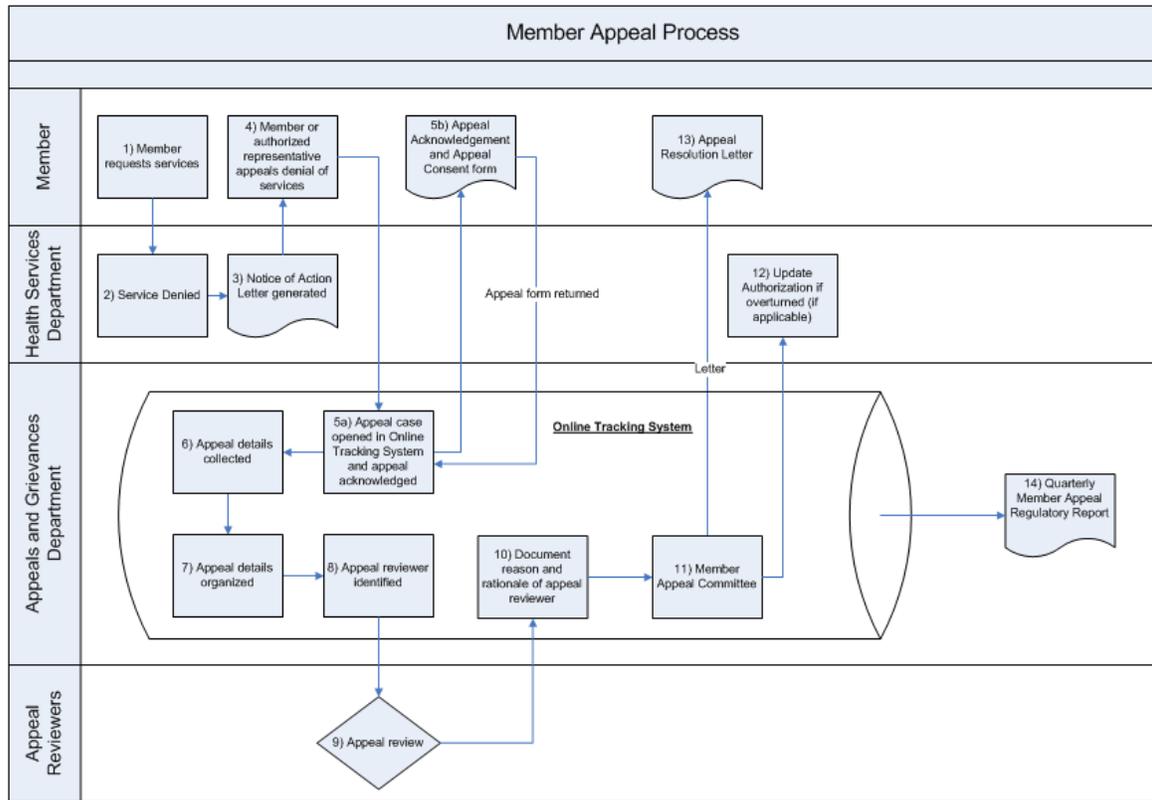


- HealthCare USA appeal number
- Written appeal consent form to be returned (if filed verbally)
- 10. HealthCare USA collects details of the appeal
- 11. Compliance analyst reviews the member appeal
- 12. Compliance analyst determines the appropriate HealthCare USA criteria the appeal involves
- 13. Compliance analyst gathers the appropriate HealthCare USA criteria
- 14. HealthCare USA organizes the collected appeal information for review
- 15. HealthCare USA compliance analyst identifies appropriate appeal reviewer and sends the organized appeal details to reviewer
- 16. HealthCare USA sends member appeals to 2 medical professional consultants with the same or similar specialty and are board certified in the appeal specialty (if applicable)
- 17. Appeal reviewer receives appeal details, reviews the HealthCare USA criteria involving the appeal, and makes determination. Reason and rationale of the appeal determination is sent the compliance analyst
- 18. Compliance analyst documents reason and the rationale of appeal review in our online tracking system
- 19. Compliance analyst prepares appeal details, member statement, and appeal reviews for member the appeal hearing (occurs weekly)
- 20. Member appeal is presented
- 21. If member attends hearing (phone/person), member provides statement
- 21. Member appeal committee takes all of member appeal information into consideration and upholds or denies the appeal. The Appeal Committee cannot deny any services that were approved by the appeal reviewer
- 22. Compliance analyst creates appeal resolution letter. The letter:
 - Identifies HealthCare USA determination (Uphold or Overturn)
 - Includes reason and rationale of determination
 - Cites HealthCare USA criteria used in determination
 - Outlines credentials of appeal reviewers
 - Identifies member has access to their appeal file
 - Informs member of state fair hearing process (if denied)
- 23. Compliance analyst has authorization updated for medical services if the appeal is overturned. Once the authorization is updated, the compliance analyst closes the appeal in the online tracking system
- 24. Compliance analyst sends the appeal resolution letter to the member
- 25. HealthCare USA sends MO HealthNet member appeal details in the quarterly regulatory report



Figure 2- 22 illustrates the HealthCare USA Member Appeal Process.

Figure 2- 22: HealthCare USA Member Appeal Process



The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C2 *Member Grievance System Process—Appeals*

2.15.6a. A member may file an appeal and may request a state fair hearing within ninety (90) calendar days from the date on the health plan’s notice of action. A provider, acting on behalf of the member and with the member’s written consent, may file an appeal.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(a).

HealthCare USA allows 90 days for a member to file an appeal from the date on the notice of action letter. A member’s provider or an authorized representative may file an appeal on the member’s behalf, with the appropriate member’s written consent. The member may file for a state fair hearing at the same time he/she files for an appeal with HealthCare USA.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C2 *Member Grievance System Process—Appeals*



2.15.6b. The member or provider may file an appeal either orally or in writing. Unless he or she requests expedited resolution, the member or provider must follow an oral filing with a written, signed appeal.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(b).

Members may file an appeal verbally or in writing.

For verbal appeals, the member is required to acknowledge the appeal in writing. A compliance analyst sends an appeal form letter to the member that summarizes HealthCare USA's understanding of the appeal. This form also allows the member to document their statement and identify if they would like to attend the member appeal hearing in person or by phone. The member returns the signed form to HealthCare USA in the self-addressed stamped envelope provided.

If the member files an expedited appeal, written acknowledgement of the appeal is not required. For specific information, see:

- *HealthCare USA Member Manual*, pp. 49-55

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C2 Member Grievance System Process—Appeals*
-

2.15.6c. The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(c).

Each compliance analyst includes his or her direct phone number in all correspondence to the member. The compliance analyst contacts the member as often as necessary between when the appeal is filed until the resolution. If interpreter services or toll-free numbers with adequate TTY/TTD are needed, the compliance analyst assists.

For specific information, see:

- *HealthCare USA Member Manual*, pp. 49-55

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C2 Member Grievance System Process—Appeals*
-

2.15.6d. Appeals shall be filed directly with the health plan's governing body, or its delegated representatives. The governing body may delegate this authority to an appeal committee, but the delegation must be in writing.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(d).



HealthCare USA's Board of Managers delegates authority in writing for appeals to HealthCare USA's Grievance and Appeal Department.

compliance analysts prepare all documents for the Appeal Committee to review. Pertinent information includes but is not limited to:

- Referral system information
- Member statement / appeal form
- Member service system documentation
- Medical records (including letters from physicians or other healthcare providers)
- Medical Criteria
- Applicable claims data

For specific information, see:

- *HealthCare USA Member Manual*, pp. 49-55

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C2 Member Grievance System Process—Appeals*

2.15.6e. The health plan shall acknowledge receipt of each appeal in writing within ten (10) business days after receiving an appeal.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(e).

HealthCare USA acknowledges the receipt of a written or verbal appeal in writing within 10 business days. The acknowledgement letter includes the direct phone number of the compliance analyst assigned to the member appeal. If the member needs assistance, the compliance analyst is available to address any questions.

For specific information, see:

- *HealthCare USA Member Manual*, pp. 49-55

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C2 Member Grievance System Process—Appeals*

2.15.6f. The health plan shall ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease:

- 1) An appeal of a denial that is based on lack of medical necessity.
 - 2) An appeal that involves clinical issues.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(f).



HealthCare USA sends the entire member appeal record to two same or similar medical specialists who:

- Have the appropriate clinical expertise in treating the member’s condition or disease (same or similar)
- Were not involved in the initial action
- Are not the subordinate of or an individual that made the initial action decision
- Hold an active, unrestricted license to practice medicine or a health profession and are board certified, if applicable

The compliance analyst reviews system notes to identify who made the initial decision and records the original reviewer in our online tracking system. When the appeal is ready for review, the compliance analyst sends the complete appeal record to the appropriate healthcare professional, based on specialty, licensure, board-certification (if applicable) and lack of involvement in any review of the case or subordinate of any review on the case.

For specific information, see:

- *HealthCare USA Member Manual*, pp. 49-55

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C2 Member Grievance System Process—Appeals*

2.15.6g. The appeals process must provide that oral inquiries seeking to appeal are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(g).

Inquiries are reviewed to determine if they are appeals. While on the phone with the member service representative, the member is asked if he/she was to file an appeal regarding his/her inquiry. If the member files an appeal at that time, it is logged in our online tracking system as an appeal and forward to the Appeal and Grievance Department. The day HealthCare USA receives the verbal appeal is considered the start date of the appeal. This is also the receipt date recorded in our online tracking system.

The appeal is acknowledged in writing within ten (10) business days of receipt by the compliance analyst. The member is sent an appeal form to be returned as written confirmation of the appeal. HealthCare USA also accepts any signed letter from the member as written confirmation of the appeal in lieu of the appeal form.

If the member requests an expedited appeal, the written confirmation from the member is not required.

For specific information, see:

- *HealthCare USA Member Manual*, pp. 49-55

The following policy outlines our procedure, and is available upon request:



- HealthCare USA policy C2 *Member Grievance System Process—Appeals*

2.15.6h. The appeals process must provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The health plan shall inform the member of the limited time available for this in the case of expedited resolution.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(h).

HealthCare USA's appeal committee meets weekly to allow the member a reasonable opportunity to present evidence. The member is invited to participate during the appeal hearing and can attend the hearing in person or by telephone. This way, the member can present his/her case to the committee in his/her own words and the committee can ask the member questions directly and clarify any evidence presented.

During the investigation phase of the appeal, the compliance analyst contacts the member to determine if the member has information to present to the committee. If the member suggests that medical records from a specific provider would be valuable for the case, the compliance analyst assists in obtaining those records.

At any time during the appeal process, the member and the member's representative may review the appeal file.

If the member is not able to attend the appeal hearing but has written evidence for the committee to consider, the appeal committee reviews this evidence.

If the appeal is expedited, resolution must be within 72 hours. The compliance analyst advises the member of the short timeframe to collect evidence and assists the member in obtaining the evidence.

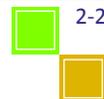
2.15.6i. The appeals process must provide the member and his or her representative with an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(i).

HealthCare USA provides the member, or the member's authorized representative, with the opportunity to review all information in the member's case file. The appeal information is available before and during the appeal process. This information includes medical records, clinical criteria, and any other records or documents to be reviewed during the appeal process.

Upon request, appeal documents can be sent to the member by certified mail, by fax to a designated fax number, or by secure email. The member may review the documents prior to the Appeal Committee meeting at HealthCare USA, and the member is allowed access in a private area to review the appeal documentation, with a compliance analyst available to assist the member.

The following policy outlines our procedure, and is available upon request:





- HealthCare USA policy *C2 Member Grievance System Process—Appeals*

2.15.6j. The appeals process must include as parties to the appeal the member and his or her representative or the legal representative of a deceased member's estate.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(j).

HealthCare USA includes as parties to the appeal the member and his or her representative or the legal representative of a deceased member's estate, if applicable to the member appeal.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C2 Member Grievance System Process—Appeals*

2.15.6k. The health plan shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed forty-five (45) calendar days from the date the health plan receives the appeal. For expedited resolution of an appeal and notice to affected parties, the health plan has no longer than three (3) working days after the health plan receives the appeal. For notice of an expedited resolution, the health plan shall also make reasonable efforts to provide oral notice.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(k).

HealthCare USA resolves appeals as expeditiously as the member's health condition requires, and provides the member with written notification of the resolution, not to exceed 30 calendar days from the date the appeal was received (as required by NCQA section UM9, Element B Factor 1).

Appeals are tracked for timeliness and by region in our online tracking system so the compliance analyst can maintain the appeal timelines while investigating the case. Reports are available in the tracking system so the regulatory compliance manager can view the timeliness of the appeals at any time.

Resolution of an expedited appeal is given verbally to the affected parties within 72 hours of the request. The resolution is confirmed in writing and sent by certified mail within 3 calendar days of the request.

For specific information, refer to:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy *C1 Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy *C2 Member Grievance System Process—Appeals*



2.15.6l. The health plan may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest. If the health plan extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(l).

A member can request an extension to a standard or expedited appeal. If a delay is in the member's interest, HealthCare USA can request an extension. We will acknowledge the extension with written notification that explains the reason of the delay.

For specific information, refer to:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
 - HealthCare USA policy C2 *Member Grievance System Process—Appeals*
-

2.15.6m. The written notice of the appeal resolution must include the following:

1. The results of the resolution process and the date it was completed; and
2. For appeals not resolved wholly in the favor of the members, the right to request a state fair hearing and how to do so; the right to request a continuation of benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the health plan's action.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(m).

HealthCare USA includes the following in our appeal resolution letter:

- Result of the appeal process: upheld or overturned
- Date the appeal was completed
- Reason and rationale of the decision

For appeals not resolved wholly in favor of the member, the appeal resolution letter also contains:

- Specific reason for the appeal decision
 - Reference to the benefit provision, guideline, protocol or other criteria that the decision was based on
 - Notification to the member that, upon request, a copy of the benefit provision, guideline, protocol or other criteria will be sent
-





- Notification that the member is entitled to receive, upon request, access to and copies of all documents relevant to the appeal
- The title, qualifications, and specialty of each reviewer that participated in the appeal review
- The member's right to a state fair hearing and the instructions on how the member may file a state fair hearing
- If the member chooses to continue benefits while the appeal is being heard, the member is advised that these benefits will continue during the state fair hearing process. However, if the State makes the same decision as HealthCare USA, the member may be responsible for the cost of those benefits

For specific information, refer to:

- *HealthCare USA Member Manual*, pp. 49-55

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy C2 *Member Grievance System Process—Appeals*

2.15.6n. The health plan shall establish and maintain an expedited review process for appeals when the health plan determines (for a request from the member) or the provider indicates (in making the request on the member's behalf) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The health plan shall ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.

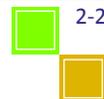
HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(n).

HealthCare USA recognizes that some appeals require urgency based on the member's health, and has established an expedited appeal process as required. An expedited review is resolved within 72 hours whether received verbally or in writing (whichever is earlier). If received verbally, written confirmation is not required.

If the Medical Director determines that the appeal should be expedited, the compliance analyst advises the member within 24 hours of the limited time available for the expedited appeal. The compliance analyst also investigates the case and works with the appropriate medical personnel and HealthCare USA staff to obtain the necessary information to prepare the expedited review.

The Medical Director or the health care professional/physician reviewer is required to impartially consider the member's appeal based on the member's benefits. All comments, documents, records, or any other information related to the appeal submitted by the member and information contained in the appeal file, including any findings from consultant's reports are reviewed as part of the appeal.

The compliance analyst notifies the member, or the member's authorized representative, by telephone of the expedited appeal decision no later than 72 hours after receipt of the expedited





appeal request. Written confirmation of the resolution is sent by mail within three (3) calendar days.

HealthCare USA's written confirmation letter advises members of:

- The resolution of his/her appeal
- The reason the decision was made
- The member's right to request the clinical information and/or guidelines, protocols or other criteria used to make the decision
- The title and specialty of the medical reviewer
- The member's right to a state fair hearing if the decision was adverse to the member

The letter contains instructions on how the member may file for a state fair hearing. The member is also advised that benefits will continue while waiting for a state fair hearing. However, if the state fair hearing upholds the same decision as HealthCare USA, the member may be responsible for the cost of those benefits.

HealthCare USA may extend the timeframe for an expedited appeal up to 14 days if the member requests an extension or if HealthCare USA demonstrates that there is a need for additional information and the delay is in the member's interest. If HealthCare USA or the member extends the timeframe, we advise the member in writing of the reason for the delay.

HealthCare USA ensures that punitive action is neither taken against a provider who requests an expedited resolution nor supports a member's appeal.

For specific information, refer to:

- *HealthCare USA Member Manual*, pp. 49-55

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C1 *Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*

2.15.6o. If the health plan denies a member's request for expedited resolution, the health plan shall transfer the appeal to the timeframe for standard resolution specified herein and shall make reasonable efforts to give the member prompt oral notice of the denial, and follow-up within two (2) calendar days with a written notice.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(o).

All expedited appeal requests are reviewed by a HealthCare USA Medical Director to determine if the appeal qualifies for an expedited review. If he/she determines the appeal does not qualify for an expedited review, the case is resolved using the standard appeal timeframes. The compliance analyst attempts to notify the member verbally within 24 hours and notifies the member in writing within two (2) calendar days. The member is advised that the appeal is being treated as a standard appeal.



The member may file a grievance regarding HealthCare USA's denial to hear the appeal as expedited.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C3 Member Grievance System Process—Grievances*

2.15.6p. Continuation of benefits while the health plan appeal and state fair hearing are pending.

1. As used in this section, "timely" filing means filing on or before the later of the following:

- Within ten (10) calendar days of the health plan mailing the notice of action; or
- The intended effective date of the health plan's proposed action.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(p)1.

If the member requests that benefits be continued during the appeal or state fair hearing process, HealthCare USA complies. The compliance analyst is available to answer any questions pertaining to the continuation of benefits.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy *C1 Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy *C2 Member Grievance System Process—Appeals*

2.15.6p.2. The health plan shall continue the member's benefits if the member or the provider files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(p)2.

If the member requests the benefits be continued during the appeal or state fair hearing process, HealthCare USA complies. The compliance analyst is available to answer any questions pertaining to the continuation of benefits.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C1 Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*



HealthCare USA policy *C2 Member Grievance System Process—Appeals* 2.15.6p 3. If, at the member's request, the health plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The member withdraws the appeal;
 - Ten (10) calendar days pass after the health plan mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) calendar day timeframe, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached;
 - A state fair hearing officer issues a hearing decision adverse to the member; or
 - The time period or service limits of a previously authorized service has been met.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(p)3.

If the member requests the benefits be continued during the appeal or state fair hearing process, HealthCare USA complies. The compliance analyst is available to answer any questions pertaining to the continuation of benefits.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy *C1 Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
 - HealthCare USA policy *C2 Member Grievance System Process—Appeals*
-

2.15.6p 4. If the final resolution of the appeal is adverse to the member, that is, upholds the health plan's action, the health plan may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(p)4.

If the final resolution of the appeal is the same as HealthCare USA's, the member may be responsible for the cost of those benefits.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy *C1 Member Grievance System Process—Expedited Appeals from Members or their Representatives Appeals*
- HealthCare USA policy *C3 Member Grievance System Process—Grievances*



2.15.6q. If the health plan 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 health plan shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(q).

If the health plan or state fair hearing decision is reversed, HealthCare USA authorizes or provides the services in a prompt manner and as expeditiously as the member's condition requires.

2.15.6r. If the health plan or the state fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan shall pay for those services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.15.6(r).

If the health plan or state fair hearing decision is reversed and the member received the services during the appeal process, HealthCare USA will pay for those services.

2.16 Provider Services [4.4.13, 4.5.2.c3]

The health plan shall provide all provider services as described herein. The health plan shall have and implement provider services policies and procedures that address all provider services activities.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.

2.16.1 Provider Services Staff:

The health plan shall provide adequately trained provider services staff to operate at least nine (9) consecutive hours during the hours of 7:00 a.m. through 7:00 p.m. (e.g., 8:00 a.m. through 5:00 p.m.), Monday through Friday. The health plan may observe State designated holidays or the holidays designated in the health plan's awarded proposal for its operation of provider services. If the health plan observes holidays different than the State's, the health plan shall obtain the prior written approval of the state agency. The health plan's provider services staff shall be responsible for the following:

4.4.13 Member Services and Provider Services

The offeror shall describe the hours of operation, holiday schedule, member and provider communication and education plans, and staff training plans for member services and provider services. (2.14 and 2.16)

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1 and 4.4.13.



The following response for Section 4.4.13 focuses on Section 2.16.1 Provider Services. For Member Services, see Section 2.14.1.

Operation Hours

Provider Relations Representatives and Provider Service Specialists are available Monday through Friday, 8:00 a.m.–5:00 p.m. (CT), except for state-designated holidays, including observed holidays as indicated by the state.

During non-business hours, the Provider Relations toll-free lines have a voicemail option available for providers to leave messages with any inquiries. All callers who leave messages receive a return call by the end of the next business day by a dedicated Provider Relations Representative.

Provider Service Specialists are available Monday through Friday, 8:00 a.m.–5:00 p.m. (CT), except on our designated holidays:

- Martin Luther King Day
- Memorial Day
- Independence Day (Observed day)
- Labor Day
- Thanksgiving
- Day after Thanksgiving
- Christmas (Observed day)
- New Years Day (Observed day)

The Provider Services team also observes the following state-designated holidays for staff training and development:

- Lincoln Day
- Truman Day
- Columbus Day

Comprehensive 18-Month Training Program

Provider Service Specialists participate in a comprehensive training curriculum conducted over an 18-month period. The first eight weeks incorporates classroom-based training facilitated by three dedicated trainers that includes:

- **New Hire Orientation**
E-mail usage, internet usage, attendance, office tour and code of conduct. Each employee is provided with all required documentation, policies, procedures, HealthCare USA plan benefits, Provider Manual and directories.
- **HIPAA Regulations**



Standards to protect the privacy and confidentiality of an individual's Protected Health Information and anonymous reporting of violations. All employees are required to take yearly assessments on HIPAA guidelines.

- **Fraud and Abuse**

Identify intentional deception, concealment or misrepresentation that could result in unauthorized benefit to an individual or entity. Identify how to report and handle suspected fraud and abuse. All employees are required to take annual assessments on fraud and abuse guidelines.

- **Member Rights and Responsibilities**

Education for Provider service specialists on benefits, various health initiatives, Doc Bear programs and state guidelines and regulations and educating members on their rights and responsibilities, including but not limited to, the right to be treated with respect, the right to receive information on available treatment options and alternatives, the right to participate in decisions, the right to receive a copy of their medical records and the right to participate in decisions regarding their health care.

- **Advance Directives**

Ensure providers are informed of member's rights to refuse any medical treatment, including life-prolonging procedures in accordance with the Patient Self Determination Act of 1990.

- **System Training**

Access and carry out all tasks and features of all navigational and functional key systems on the Medicaid Specific Platform. Learn to navigate through all HealthCare USA systems, including Navigator, IDX (claim system), provider search and HealthCare USA's internet sites.

- **Primary Care Provider Changes**

Process for allowing new and/or established members to select a primary care provider; assign a primary care provider to new members that have not selected a provider, assist in the selection and transition of members whose primary care provider is no longer participating with HealthCare USA and review the process for members to request a specialist as their primary care provider.

- **Primary Care Provider Addresses**

Listing of addresses for all participating or non-participating primary care providers with directions, maps and mileage.

- **Provider Look Up**

Online provider search that selects providers by name, zip code, county, specialty and gender. Updates are made available every 48 hours via the internet (including supplying directions to all locations).

- **Benefits Training**

Review of documents and interpretation of benefits.

- **Grievance, Complaints and Appeals**



Identification, documentation, investigation, resolution and closure of all grievances, complaints and appeals for members and providers by representatives.

- **Member Look Up**

Complete member information such as claims, referrals, invoices, other insurance coverage information, eligibility, benefit plan usage, plan information and ID card history.

- **Coding**

Basic comprehension on Current Procedural Terminology (CPT), International Classification of Diseases, 9th Revision (ICD9), Health Care Common Procedure Coding System (HCPCS), Revenue and Disease Related Group (DRG) codes and terms for identifying medical services for providers and facilities.

- **Telephone Etiquette**

Ensure consistent, high-quality service to our members and have a major impact on the accuracy and effectiveness of our customer interactions.

- **Online Documentation**

Intranet Web-based central repository of company-wide information—from Legislative to HealthCare USA-specific policies and procedures.

- **HealthCare USA Policies and Procedures**

Education for Provider Service Specialists on benefits, various health initiatives, Doc Bear programs and state guidelines and regulations.

- **Soft Skills Training**

Customer service skills through courses entitled Foundation of Service, Customer Care, Attitude Adjusting, Diffusing Anger, Empathetic Listening and Exceeding Expectations. Annual training is provided to all member and provider service specialists.

- **Cultural Competency**

Describes our requirement to provide care to members with diverse values, beliefs, and behaviors, including tailoring delivery to meet members' social, cultural and linguistic needs.

- **Early, Periodic Screening, Diagnosis & Treatment Services (EPSDT)**

Review of the EPSDT services and benefits available to members under 21 years old.

- **Contract Overview**

Review of HealthCare USA provider contracts for interpretation.

Throughout the course and again upon completion of the program, each new Provider Service Specialist completes detailed assessments and simulated calls to ensure they are retaining information and fulfilling established job requirements. New hires who fail to meet required benchmarks or demonstrate their ability to perform job functions within HealthCare USA's stringent quality requirements are evaluated for additional training needs or terminated if outcomes continue to be below acceptable performance norms.



To augment the initial classroom-based training, the Providing Employees with Education and Resources (PEER) program is an in-house program developed specifically for our Customer Service Operation (CSO). PEER uses experienced customer service representatives to support and guide new hires as they begin their employment. Following the formal training, PEERs are seated near the new hire and are required to follow a pre-determined checklist of tasks and assignments to ensure continuous learning and coaching outside of the classroom environment. Supervisors meet with new staff daily throughout their classroom training and follow a weekly curriculum to assess basic understanding of materials, review training objectives and address additional training opportunities.

Ongoing Training

Training does not stop with initial training. Our approach reflects our effort for continuous improvement and to deliver optimal service to our members. Upon hire, we add new employees into SABA, our learning management system. SABA is an advanced online tool that supports growth and development by linking employees to all types of learning activities, including instructor-led classes, online training, webinars and local career center resources. SABA also maintains records of all completed learning activities, assessments, events and other curriculum.

Ongoing training ensures continued success of our programs and performance. Training targets both new and modified policies and procedures and areas that we identify as warranting additional training. All Service Specialists must attend at least two service development training courses a year. Specific courses enhance the staff's knowledgebase and service ability. The following courses are part of a formal training curriculum, conducted over an 18 month period:

- **Claims Interpretation**
Understanding claims, including code types, dictionaries, terminology, workflows, coordination of benefits (COB), adjustment procedures and provider alerts.
- **Correct Coding System Edits Interpretation**
Correct coding initiatives, and how to interpret affected claims with system coding edits.
- **Service Recovery**
Soft skills including how to identify and meet caller expectations and turnaround.
- **Benefit Interpretation**
Refresher course designed to improve interpretation of plan-specific benefits.
- **COB Claims Interpretation**
Identification and validation of COB information as well as a refresher on interpreting claims payments when other insurance is involved.
- **IN TOUCH**
The knowledge and skills necessary to deliver exceptional service to all customers, focusing on internal customer service.



essentials

The Provider Services team also has access to essentials, a company intranet site with subject matter reference tools and education aids to assist with ongoing training.



What is essentials?

essentials is an intranet web-based central repository of HealthCare USA information – from Legislative to plan-specific policy and procedures.

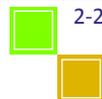
essentials allows users to move beyond the borders previously established by paper, into an electronic environment where all of the tools needed are at their fingertips.

Plan-specific details included in essentials are:

- Customer Service Handbook, including an alphabetized list of policies and procedures
- Member Handbook
- Provider Directory
- Inquiry, complaints and appeals processes
- Legal calls, correspondence and subpoenas policy
- Important contact names and numbers, including workflows
- Maps—state and service area
- Telephone scripts—inbound and outbound
- Claims processing manuals and information
- Check run calendars
- Online forms
- Eligibility information
- Provider alerts
- Breaking HealthCare USA news

Other essentials features beneficial to Provider Service Specialists include:

- Google search function
- Reference tools, including code manuals and online reference books
- COB information
- Terminology
- Julian date calendar
- Electronic submission guidelines





All content is controlled through a content management system. Only those designated by management may update essentials policies. Provider Service Specialists have online access to bank draft images, online images of remittance advices and provider contract summaries.

Quality and Accuracy

Reinforcing our commitment to providing quality service and increasing member loyalty, HealthCare USA maintains a formal call quality program for all staff. Internal Quality Auditors (QA), along with our service supervisors, monitor quality and attend monthly calibration sessions to “audit the auditor” and ensure accuracy and consistency. Monitoring is based on our “Come On In!” call quality program, where audits address the specialist’s ability to follow appropriate processes, communicate effectively and provide a solution.

Verint® Quality Management System

The Verint® Witness Actionable Solutions™ quality management system is a state-of-the-art system, which enables efficient monitoring by capturing and analyzing customer interactions, maximizing workforce performance and optimizing CSO processes. The system records 100 percent of voice interaction between the Provider Service Specialist and the caller, along with a 30 percent capture of the corresponding computer desktop activity. The system then synchronizes voice and data capture during replay, thus allowing our leadership to observe and analyze complete customer interactions as they actually occurred. The Verint system stores corresponding audit and screens for 365 days and all audio is stored for four years.

Quality Foundation, Quality Goals

Our goal is to monitor at least 1% of all calls answered— approximately two to three calls per Provider Service Specialist per week. We adjust the frequency of monitoring as necessary, based on call volume fluctuations and individual audit results.

To establish a quality foundation, our new hires meet on weekly with our quality staff to listen to calls, review program guidelines and receive coaching. This takes place for at least one month or until quality scores are favorable. Following these quality sessions, Provider Service Specialists meet with QAs on a monthly basis to review scores and receive coaching. QAs are responsible for providing immediate feedback, fostering self-correcting techniques and promoting continuous improvement opportunities.

Monitoring for Adherence to Performance Standards

HealthCare USA is committed to ensuring our staff has the training, tools and systems to deliver first-class service to our members.

To ensure an optimal level of performance, HealthCare USA has developed and implemented stringent standards and metrics. These standards reflect leading industry standards as well as contract-mandated measures of performance. Our service leadership monitors productivity and availability reports to ensure contract obligations are met or exceeded.

Performance is monitored using Symposium’s™ Real-time Statistical Display feature. This system allows our leadership, as well as staff, to view real-time and historical call center



performance and resource usage through a desktop Web browser. Throughout the day, we review and analyze performance to identify service gaps, and management can configure call routing to ensure calls are answered in order of their priority. For example, a caller who indicates that he or she has a crisis is routed with highest priority to a trained representative with a skill set to address their needs.

Business Continuity Plan for Uninterrupted Transition of Call Response

In the event of a service disruption, HealthCare USA is integrated into the company-wide business continuity plan. Member services have an uninterrupted transition of call response.

2.16.1a. Establishing a mechanism by which providers may determine in a timely manner whether a member is covered by the health plan and the member's primary care provider assignment;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1(a).

In recognition of our providers' need to gain administrative efficiencies using electronic solutions, HealthCare USA provides a robust, real-time, secure, web-based provider portal (www.directprovider.com), available at no cost to providers to verify:

- Member eligibility
- PCP name and history
- COB primary carrier information
- Authorization status
- Claims status
- Claims adjustment
- Secure messaging with provider customer service
- HEDIS reports

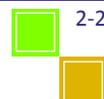
For those providers without internet access, we also have a telephone-based Interactive Voice Response (IVR) system that provides automated eligibility, claim and authorization confirmation 24 hours a day, 7 days a week.

2.16.1b. Educating providers on the above mechanism's use;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1(b).

Our provider orientation includes review of processes providers should use to determine in a timely manner whether a member is covered by the health plan, including:

- DirectProvider.com
- Telephone inquiry





- IVR system

2.16.1c. Educating and assisting providers with the health plan service accessibility standards including but not limited to prior authorization, denial, and referral procedures;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1(c).

Our provider orientation includes:

- Review of the *HealthCare USA Provider Manual*, regarding the authorization and referral process, and the appeal and complaint procedures
- Requirements of the State contract a it regards member accessibility standards transfer and disenrollment procedures, etc.)
- Assisting providers with our prior authorization, denial, and referral procedures

Our telephone Interactive Voice Response (IVR) system provides automated claim and authorization confirmation 24 hours a day, 7 days a week.

2.16.1d. Educating and assisting providers with claims submission and payment procedures;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1(d).

Our provider orientation includes:

- Review of the *HealthCare USA Provider Manual*, regarding claims submission
- Assisting providers with claims payment procedures

2.16.1e. Educating providers about conditions under which members may directly access services including, but not limited to, behavioral health and substance abuse, family planning, and public health services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1(e).

Our provider orientation includes:

- Review of the requirements of the state contract regarding member eligibility, benefit plan, service and member accessibility standards, marketing guidelines, transfer and disenrollment procedures, behavioral health and substance abuse, family planning, and public health services



2.16.1f. Educating providers about how a member can access emergency care and after-hour services;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1(f).

Our provider orientation includes:

- Review of the *HealthCare USA Provider Manual* regarding emergency care procedures and after-hours access standards

2.16.1g. Handling provider inquiries and complaints; and

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1(g).

Our provider orientation includes:

- Review of the *HealthCare USA Provider Manual*, regarding the authorization and referral process, and the appeal and complaint procedures

Also, our provider relations representatives routinely meet with providers and supply information about HealthCare USA policies and procedures and collaborate with provider offices to resolve issues.

2.16.1h. Serving as a liaison between the health plan and the in-network providers and communicate at least quarterly with the in-network providers, including oversight of provider education, in service training, and orientation. Newsletter, web sites, and other media may be used to meet this requirement.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.1(h).

Our provider relations team has 10 on-the-ground provider relations representatives, each with an average of 10 years work experience in provider relations. They are responsible for field service and ongoing provider education and training.

Representatives routinely meet with providers, conduct orientations, provide information about HealthCare USA policies and procedures and collaborate with provider offices to resolve issues.

HealthCare USA provider relations representatives are required to make a minimum number of provider visits with PCP, Ob/Gyn, high-volume specialty, hospital and ancillary providers, and provide ongoing support and education in accordance with the service standards listed below.

Provider visits are scheduled for the purpose of provider orientation, education, issue resolution, routine service calls, site visits, recruitment, and investigation of quality of care or service issues. In addition, provider relations hosts annual provider seminars in all three regions to provide training and information in group settings on new policies, quality initiatives and member programs.



Providers with low volume are provided telephonic support, and visits are scheduled as needed to resolve issues or distribute information regarding new initiatives.

Provider Type	Visit Standard (Minimum)
High Volume PCP, Ob/Gyn, Hospital providers	Three visits per year
High Volume specialty care	Semi-Annually
High Volume Ancillary providers	Annually
All other providers	Telephonic Visits as needed

2.16.2 Provider Telephone Lines/Call Center:

a. The health plan shall maintain a toll-free provider services line to respond to provider questions, comments, and inquiries. During non-business hours when the provider services line is not staffed, the health plan shall have an automated system or answering service. The automated system or answering service shall provide callers with: operating instructions on what to do if seeking a prior authorization and instructions on how to leave a message and when the message will be returned. The health plan shall ensure that the voice mailbox has adequate capacity to receive all messages and that provider services staff return all calls by close of business the following business day.

4.5.2.c Provider Services- The offeror shall:

3. Describe the activities proposed to monitor and track compliance with provider toll-free telephone line performance standards as described herein. (2.16.2)

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.2(a) and 4.5.2(c)3.

HealthCare USA consistently exceeds all call center standards using the same software and approach – including cross-training with other departments to handle spikes and peak workload times — as proposed here today.

This answer applies to all regions.

HealthCare USA provides a toll-free number for providers to access our Provider Services Department.

- Provider Service Specialists are available Monday – Friday, 8:00 a.m. – 5:00 p.m. (CT), except for company and State-designated holidays.
- During non-business hours the Provider Relations toll-free line also has a voicemail option available for providers to leave messages with any inquiries. All callers who leave messages receive a return call by the end of the next business day.

HealthCare USA monitors performance metrics for provider inquiries on a daily, weekly, and monthly basis to ensure we are adhering not only to the performance measures set by the State, but our own internal goals. Performance tracking metrics are in place for all provider service



telephone lines. Utilizing our existing call tracking system, Symposium, HealthCare USA captures and reports call servicing metrics, including the MO HealthNet program requirements of average speed to answer, abandonment rate, average hold times and call blockage rate. Figure 2- 23 illustrates how we measure up.

Figure 2- 23: HealthCare USA Exceeds MO HealthNet Requirements

Performance Measure	MO HealthNet Performance Standard	HealthCare USA 2011 Results
% Calls Answered in 30 Seconds	90%	91%
Abandonment Rate	<5%	1.0%
Average Hold Time	<120 seconds	9 seconds
Blocked Call Rate	0%	0%

HealthCare USA has demonstrated the ability to exceed performance requirements for the MO HealthNet program.

Monitoring

The HealthCare USA dedicated Provider Services Supervisors monitor the performance results to ensure all standards are in line with program requirements. The supervisor and/or team lead, is able to allocate resources depending on call volumes, service levels and/or hold times. Symposium provides extensive details for all call activity, call queues, talk times and metrics for performance service levels. Symposium reports are also employed to scrutinize average talk time, schedule availability, average hold time and after call work. The findings are used as both educational and to assess call types received throughout the day. The management team reviews the reports generated from Symposium, as shown in Figure 2- 24 to analyze staffing, call activity and identify opportunities for resource balancing.



Figure 2- 24: Symposium Call Monitoring Screen

Newark: Delaware - Windows Internet Explorer

Newark Standard Agent Display (Newark)*

Filter	Agt ID	Agt Last Name	Agt First Name	Time In State	In Calls Status	NR Reason	Ans SklSet	P
HCUSA	8068	Lloyd	Barbara	00:11	Idle			
HCUSA	6320	Mundy	Bonnie	00:27	Idle			
HCUSA	6324	Goff	Ashley	00:36	On Hold		HCUSA_Provic	
HCUSA	6401	Allen	Melissa	00:44	Idle			
HCUSA	2214	Campbell	Teresa	00:54	Active		HCUSA_MemE	
HCUSA	4357	Shivery	Claudia	01:15	Idle			
HCUSA	6459	Tomczyk	Theresa	01:36	Idle			
HCUSA	4805	Petrucci	Karen	01:50	Active		HCUSA_MemE	1
HCUSA	3747	Tate	Rita	01:55	Idle			

Newark Standard Application Display*

Filter	Application	Avg Ans Dly	Srv Lvl %	Offer	Ans	Calls Wait	Max Wait Time	% Calls_Abandoned	Ab
+ BCP		0	100	0	0	0	00:00	0	
- HCUSA		2	100	72	66	0	00:00	0	
	HealthCareUSA_Member	2	100	53	48	0	00:00	0	
	HealthCareUSA_Provider	2	100	17	16	0	00:00	0	
	HealthCareUSA_Spanish	2	100	2	2	0	00:00	0	
+ Medicaid		4.35	96.6	560	530	0	00:00	0	

Interval-to-Data refreshing every 2 seconds

Symposium provides HealthCare USA with an immediate view of all activity in the call center to balance staff and ensure service levels are maintained for all callers.

Daily team collaboration meetings are held to ensure appropriate staffing to support daily business needs. Supervisors also align their team to ensure the appropriate number of staff is available to adhere to current call volumes to attain performance measures. Additionally, breaks, lunches, vacations and absenteeism are taken into consideration for balance resourcing. HealthCare USA also relies on historical data to gauge call volumes based on weekly, monthly and yearly results. Depending on the analysis, additional resources will be proactively added to support the customer service team.

All call center staff are capable of being monitored during a phone call. This allows supervisors to simultaneously review call content with the identical view on the staff person’s screen. This permits quality monitoring of what was said during the call, along with the information accessed in the system during the call and the documentation entered about the call, for a complete view of the provider’s call experience. Through use of this system, call center supervisors identify opportunities for staff to improve their technique and provide recognition of well-handled calls.



Tracking

The HealthCare USA call tracking system, Symposium, is configured to ensure optimum performance and uptime of all telephony systems and services needed to support the MO HealthNet call center. Symposium provides real-time tracking and historical reporting for the call center, including the program metrics for ASA, abandonment, holds time and blocked calls.

HealthCare USA also monitors phone statistics of our program subcontractors and affiliates through formal monthly reviews to ensure compliance standards are being met. If subcontractors and affiliates are not meeting the required compliance standards, HealthCare USA implements a Corrective Action Plan (CAP) and requires vendors to actively submit reports more frequently until program statistics can meet the MO HealthNet standards.

Provider Services Call Support

In addition to 29 dedicated provider service specialists, 23 existing HealthCare USA claims representatives are cross-trained to support provider services calls. As HealthCare USA recognizes the need to provide exceptional service during peak call volume periods, the claims representatives are logged into the phone system to support provider inquiries. Along with the cross trained claims representatives, supervisors and managers are trained to handle all types of call inquiries to guarantee HealthCare USA is adhering to the program goals.

Provider calls received after business hours direct the caller with the capability to speak with a representative immediately and instruct on how to leave a message for Provider Services. Callers are able to immediately talk with provider relations staff to obtain prior authorization and verify member enrollment. Voicemail messages are not taken for these services. For other provider related calls, they are advised that messages will be returned by the close of business the following business day. The Symposium system provides adequate voicemail storage capability to accommodate the volume of after-hours messages received.

2.16.2b. The health plan shall operate a twenty-four (24) hours, seven (7) days per week toll free line to provide prior authorizations and confirmations of member enrollment. Recorded messages are not acceptable for this hotline. The number for this line can be the same as the number for the provider services line, provided there are clear prompts to ensure providers are able to access the appropriate provider services or prior authorization staff.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.2(b).

Providers have 24 hour access to information about member benefits, claims, and authorization status through our website (www.directprovider.com). The website provides secured messaging options where providers can email questions to our CSO. All emails received are recorded in the call documentation system, Navigator, and responded to within 48 hours of receipt.



2.16.2c. All toll free telephone lines and call centers shall meet, at a minimum, the following call center standards:

1. Ninety (90) percent of calls are answered within thirty (30) seconds;
2. The call abandonment rate is five (5) percent or less;
3. The average hold time is two (2) minutes or less; and
4. The blocked call rate does not exceed one (1) percent.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.2(c).

HealthCare USA monitors performance metrics on a daily, weekly, and monthly basis to ensure we are adhering not only to the performance measures set by the State, but also our own internal measures. Performance metrics are in place for all telephone lines. Utilizing our existing call tracking system, Symposium, management has the capability to report the call servicing metrics identified below:

- Average speed to answer
- Abandonment rate
- Service level (percent of calls answered within 30 seconds)
- Calls offered/calls answered by skill-set (member/provider/foreign)
- Average hold times
- Call blockage rate

The management team reviews reports generated from Symposium to analyze trends and identify opportunities for resource balancing. Daily team collaboration meetings are held to ensure appropriate staffing to support daily business needs. All key service indicators are monitored to ensure operational targets are met and/or exceeded on a daily basis. Additionally, HealthCare USA does not block calls.

To demonstrate our ability to meet and exceed service standards, presented below is our 2010/2011 YTD* Customer Service Performance Summary.

2010/2011 YTD Customer Service Performance Summary

Performance Measure	HealthCare USA Goal	MO HealthNet Requirement	HealthCare USA Result
% of Calls Answered in 30 seconds	100%	90%	90.5%
Abandonment Rate	< 3%	< 5%	1%
Average Hold Time	< 30 seconds	< 2 minutes	9 seconds
Blocked Call Rate	0%	1%	0%
Average First Call Resolution	90%	N/A	94.3%

* 2010/2011 YTD RESULTS MEASURE PERFORMANCE FROM JULY 2010 THROUGH JUNE 2011.



These metrics continue to be reviewed and monitored on a weekly basis by the HealthCare USA management team to ensure State obligations are met or exceeded.

2.16.3 Website for Providers: The health plan shall have a provider portal on its website that is accessible to providers. The portal shall include all pertinent information including, but not limited to, the provider manual, update newsletters and information, information on obtaining prior authorizations, and information about how to contact the health plan. The health plan shall have policies and procedures in place to ensure the website is updated regularly and contains accurate information.

Provider Portal

The Healthcare USA provider portal, www.directprovider.com, offers providers our comprehensive, real-time, direct, secure provider portal. Providers are able to access this portal directly or through a link at www.hcusa.org. This provider-friendly portal is compliant with MO HealthNet requirements and includes:

- Current Provider Manual
- Newsletters (going back at least two years)
- Authorization Directory and Information on how to obtain prior authorizations
- How to contact the health plan

In addition, the site contains real-time information on:

- Member eligibility
- PCP name and history
- COB primary carrier information
- Authorization status
- Viewable and printable ID cards
- Claims status
- Claims adjustment
- Secure messaging with provider customer service
- Searchable and downloadable Remittance Advices
- Resource Library - Forms and manuals coverage polices, prior authorization lists and criteria, technology assessments and many other clinical reference materials.
- HEDIS reports—Gaps in Care reports (for PCPs) - Providers can view/generate reports for an individual member or every member on their panel, and can toggle between all HEDIS measures for their members, both compliant or non-compliant. Providers identifying medical record documentation of HEDIS data noted as non-compliant, can upload their

“Claims processing is very crucial to our small clinic to keep cash flow stable. The turnaround time on claims is very reasonable, and with the ease of www.directprovider.com, I can track our deposits and print remittance advices and also check the status of claims and see if a member is still current.”

-Kim Thompson, Family Practice



documentation to our Quality Improvement Department for consideration to meet the measure and update our health plan records.

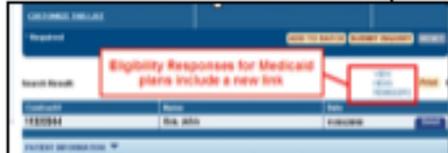
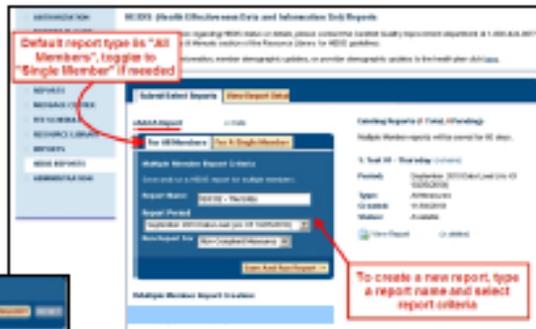


HEDIS measurements and reporting is now available for select Coventry Medicaid plans via Directprovider.com!

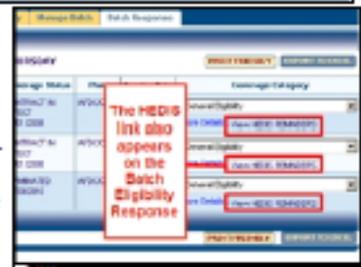
Effective Monday, 12/20/2010, Coventry Health Care has implemented access for HEDIS reports and data collection via directprovider.com (DP.com) for the following Medicaid plans: Carelink Medicaid (WV), CareNet (VA), Diamond Plan (MD), HealthCare USA (MO), OmniCare (MI Medicaid), Vista Medicaid (FL). HEDIS (Health Effectiveness Data and Information Set) Data rates are statistical representations of a provider's and/or member's compliance or non-compliance with certain prescribed care measures.

Navigation

- Users will be able to access it through the eligibility function or by clicking "HEDIS REPORTS" in the left navigation.
- A link also exists in the Eligibility Response screen which opens a new window to display HEDIS information for that specific member.

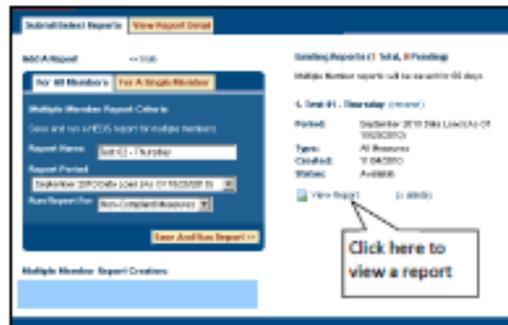


- It will also be available in the batch eligibility response screen.
- Both existing and new DP.com users will receive access to the HEDIS Reports link.



Reports/Messaging

- Providers can view/generate reports for an individual member or every member associated with them.
- Users will be able to toggle between all measures, both compliant or non-compliant.
- They will also be able to show or hide any specific measure categories.





Reports/Messaging (cont.)

- Via Message Center (secure messaging) in DP.com, a provider can submit HEDIS care information data to Coventry.

A hyperlink allows users to send a secure message where they can update any HEDIS measure that are inaccurate

User can toggle between HEDIS measures

User can forward to 602-696-0246

Clicking "Here" to submit HEDIS information takes user to Secure Messaging

Downloading/Export Capability

- Exporting Eligibility Responses will now include HEDIS data.

Member Name	444 000		
Member ID#	888888		
Member ID	7000000		
Health Plan	Coventry 60 ASAR STREET ANN ARBOR, MI 48106-0000 UNITED STATES		
Home Phone	733-767-788		
Genetic Plan	APOCCHA		
This member has been annually enrolled with no more than one gap in enrollment, not exceeding 45 days during the year.			
Measure	Sub-Measure	Description	Completed?
Children and Adolescents Access to Primary Care Practitioners 2009	Members 20-Months to 6 Years of Age	Members 12 months - 25 years who had a visit with a PCP during the measured year. (3 separate percentages reported)	Yes
Data Last Updated On: 11/04/2010			
For more information regarding HEDIS status or details, please contact Coventry's Quality Improvement Department at 1-800-424-0277 or visit the Policies & Manuals section of the Resource Library for HEDIS guidelines.			

Exporting the Eligibility Response includes HEDIS data

Higher HEDIS compliance rates are better for everyone: Coventry, its Providers and, most of all, the Patients!

PLEASE NOTE:

- HEDIS measurements are NOT currently available for CoventryCares (PA Medicaid) or Coventry Nebraska - Medicaid. HEDIS data for both Medicaid plans will be available at a later date—during 2011— after 1 year's worth of claims data has been captured/aggregated to allow for proper measurements and reporting of the applicable services.

For more information, please contact your Coventry Medicaid plan Provider Relations Representative.



2.16.4 Provider Manual: The health plan shall develop, distribute, and maintain a provider manual.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.4.

We provide our participating physicians and other providers with the *HealthCare USA Provider Manual*, which contains information on

- Member benefits
- Prior authorization procedures
- Claim submission
- Provider portal website
- Fraud and abuse
- Quality management

and other topics vital to successful business relationships with HealthCare USA.

2.16.4a. The health plan shall obtain and document the approval of the provider manual by the health plan's Health Plan Administrator and Medical Director and shall review the provider manual at least annually and maintain documentation verifying such.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.4(a).

Our Provider Manual is updated annually and reviewed and approved by our Health Plan Administrator and Medical Director (evidenced by their signatures on page 2 of the manual) before it is published and distributed to all participating provider offices.

2.16.4b. The health plan shall issue a copy of the provider manual to providers at the time of inclusion in the provider network, and shall educate the provider as to its full content and usage.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.4(b).

The Provider Manual is distributed to newly participating providers and reviewed with them within 30 days of their effective participation date in HealthCare USA's provider network. Provider Relations Field Representatives review important information in the Provider Manual during provider visits, initial orientation sessions and subsequent field service calls. The Provider Services staff also educates new office staff in existing provider offices when needed.

Feedback received from our provider network has indicated a preference for online and CD versions of the Provider Manual versus receiving a paper copy. Consequently, combined with our effort to go "green", we have distributed the Provider Manual in CD format instead of a paper copy to our provider network for the past three years. HealthCare USA stills prints a limited supply of paper copies for any providers unable to use the CD version. A copy is also



posted to the HealthCare USA website (www.hcusa.org) and the Provider Portal (www.directprovider.com), to ensure its availability to all providers and non-participating providers administering services to HealthCare USA members. When our Medical Management team approves services from out-of-network providers, formal letters of agreement are sent to the out-of-network provider, directing them to our website if they have any questions or need to review the Provider Manual.

Off-cycle updates to the Provider Manual are published in the Provider Newsletter, which is faxed to all network providers and also posted to both the Provider Portal (www.directprovider.com) and public Web site (www.hcusa.org). It is also emailed to key provider group administrative personnel and billing companies and mailed via MBE/WBE vendor to any providers without a fax machine or who prefer print copy communication materials. These changes are also reviewed with providers during provider visits and field service calls.





2.16.4c. At a minimum, the provider manual shall contain sections regarding:

1. Specific covered health services for which the provider shall be responsible, including any limitations or conditions on services;

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2. The requirement that the provider implement a policy of, before providing non-emergency services to an adult MO HealthNet Managed Care member, requesting and inspecting the adult member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card. If the adult member doesn't produce their health plan membership card, and the provider verifies eligibility and health plan enrollment, the provider may provide service if they have notified the health plan that the member has no health plan identification card. The provider must document this verification in the member's medical record;
3. Claims submission instructions and the procedure for review of denied claims;
4. Prior authorization procedures, and referral procedures including exceptions, second, or third opinions;
5. Primary care provider responsibilities;
6. Specialist/ancillary provider responsibilities;
7. Provider complaint and appeal processes including any State-determined provider appeal rights to challenge the failure of the health plan to cover a service;
8. Information on the member grievance system including:

- The member's right to file grievances and appeals and their requirements and timeframes for filing;
- The availability of assistance in filing;
- The toll-free numbers to file oral grievances and appeals;
- The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the health plan's action is upheld in a hearing, the member may be liable for the cost of any continued benefits; and

- The member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing.
- A member may request a State fair hearing within ninety (90) calendar days from the health plan's notice of action.

- The State shall reach its decisions within the specified timeframes:
- Standard resolution: within ninety (90) calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
- Expedited resolution (if the appeal was heard first through the health plan appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that:
 - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes; or
 - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.



- Expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the health plan appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

- 9. Procedure for obtaining member eligibility status;
- 10. Appointment/Service Accessibility Standards;
- 11. Multilingual and TDD availability;
- 12. Quality Assessment and Improvement activities and requirements;
- 13. Provider Credentialing requirements and standards;
- 14. Management and retention of medical records requirements;
- 15. Confidentiality requirements;
- 16. Advance directives requirements; and
- 17. Fraud and abuse guidelines, including the MFCU fraud and abuse hotline number.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.4(c).

Since 2.16.4(c)2 is a new requirement, it will be added to our provider manual by March 1, 2012.

The Provider Manual includes information on this sections requirements listed in order below:

- Specific covered health services for which the provider is responsible
- Covered member benefits
- Routine Vision Services
- Claims submission instructions and the procedure for review of denied claims
- Encounter Reporting/Data/Claim Submission
- Prior authorization and referral guidelines
- Second and third opinions
- PCP responsibilities
- Specialist/ancillary care provider responsibilities
- Provider complaint, grievance and appeal processes, including members rights and information on State Fair Hearing process
- Member grievance system and process
- Member Rights and Responsibilities
- Member eligibility status procedure
- Appointment/access standards
- Multilingual and TDD availability
- Quality assessment and improvement activities
- HEDIS



- Provider credentialing process and application requirements
- Management and retention of medical records
- Confidentiality
- Advance directives
- Fraud and abuse guidelines, including MFCU fraud and abuse hotline
- HIPAA

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2.16.5 Provider Disclosures: The health plan shall request from the provider, in order to supply the state agency, the following information for each provider performing services for the health plan, using the template provided in Attachment 6b that includes the: address, Social Security Number, Employer Identification Number, date of birth, provider type, Missouri license number or appropriate State license number, NPI (if available), and OIG exclusion status, exclusion type (if applicable), date of exclusion (if applicable), and date exclusion ends (if applicable). The Social Security Number is due upon contract award. The health plan shall collect the information from the provider:

AMENDMENT 2 ADDED ITEMS a. THROUGH d.

- a. At the stage of provider credentialing and re-credentialing;
- b. Upon execution of the provider agreement;
- c. Within thirty-five (35) days of any change in ownership of the provider; and
- d. At any time upon the request of the state agency for any or all of the information described in this section.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.5(a-d).



- 2.16.6 Materials and Information for Out-of-Network Providers: The health plan shall specify in writing the following to out-of-network providers at the time a service is approved to be performed by the out-of-network provider:
- a. Claims submission instructions and the procedure for review of denied claims;
 - b. Prior authorization procedures and referral procedures including exceptions, second, or third opinions;
 - c. Provider complaint and appeal procedures including any State-determined provider appeal rights to challenge the failure of the health plan to cover a service.
 - d. The following information about the member grievance system:
 1. The member's right to file grievances and appeals and their requirements and timeframes for filing;
 2. The availability of assistance in filing;
 3. The toll-free numbers to file oral grievances and appeals;
 4. The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the health plan's action is upheld in a hearing, the member may be liable for the cost of any continued benefits; and
 5. The member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing:
 - A member may request a State fair hearing within 90 calendar days from the health plan's notice of action.
 - The State shall reach its decisions within the specified timeframes:
 - Standard resolution: within 90 calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
 - Expedited resolution (if the appeal was heard first through the health plan appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that:
 - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or
 - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
 - Expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the health plan appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.
- e. Procedure for obtaining member eligibility status;
- f. Multilingual and TDD availability; and
- g. Confidentiality requirements.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.16.6(a-g).



As indicated and annotated in Section 2.16.4, the *HealthCare USA Provider Manual* contains all of the required information identified in Section 2.16.6(a-g) and is available for viewing and printing on our website for in and out-of-network providers; paper and digital media copies are also available when requested.

When our Medical Management team approves services from an out-of-network provider, we send formal letters of agreement to the out-of-network provider to ensure compliance with all requirements in Section 2.16.6. The letters of agreement include our website address, www.hcusa.org, and the toll-free telephone number for HealthCare USA's Customer Service Organization. When appropriate, these out-of-network providers are also identified for recruitment into HealthCare USA's participating provider network.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA Policy HS-44 *Out-of-Network Provider Authorization and Negotiation Policy*

2.17 Provider Complaints and Appeals

The health plan shall establish a provider complaint and appeal process that provides for the timely and effective resolution of any disputes between the health plan and providers. This system is specific to providers and does not replace the member grievance system which allows a provider to submit a grievance or an appeal on behalf of a member. When a provider submits a grievance or appeal on behalf of a member, the requirements of the member grievance system shall apply.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.

HealthCare USA partners with our providers and values the feedback we receive from the provider community. HealthCare USA has an established provider complaint and appeal process to assist providers, serving as an avenue for them to submit their complaints and appeals.

HealthCare USA responds to the providers in an effective and timely manner.

The provider complaint and appeal process is specific to the providers. It does not replace the member grievance system. Providers may file a grievance or an appeal on behalf of the member. When this occurs, the grievance and/or appeal is handled according to the requirements of the member grievance system.

For further information, see:

- *HealthCare USA Provider Manual*, p. 85-87

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C6 *Provider Complaint and Appeal Process*



2.17.1 Definitions: For purposes of this document, the following definitions shall apply:

Complaint - A verbal or written expression by a provider which indicates dissatisfaction or dispute with health plan policy, procedure, claims, or any aspect of health plan functions. All complaints must be logged and tracked whether received by telephone, in person, or in writing.

Provider Appeal - The mechanism which allows the right to appeal actions of the health plan to a provider who:

- a. Has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or
- b. Is aggrieved by any rule or policy or procedure or decision by the health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.1(a-b).

HealthCare USA includes the definition for a complaint and provider appeal as part of our policies and procedures for the provider-specific complaint and appeals system.

For further information see:

- *HealthCare USA Provider Manual*, p. 85-87

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C6 Provider Complaint and Appeal Process*

2.17.2 Policies and Procedures:

- a. The health plan shall have and implement written policies and procedures which detail the operation of the provider complaint and appeal process. The policies and procedures shall be approved by the health plan governing body and be the direct responsibility of the governing body. The health plan shall submit the policies and procedures to the state agency for prior approval.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(a).

- HealthCare USA identifies a complaint as a verbal or written expression by a provider which indicates dissatisfaction or dispute with health plan policy, procedure, claims or any aspect of health plan function.
- HealthCare USA identifies a provider appeal as a verbal or written expression by a provider which indicates dissatisfaction with a health plan final decision. A health plan final decision is identified as any denial of a medical decision where a Notice of Action was sent notifying the provider of the denial.

The Policy and Procedure Workgroup at HealthCare USA reviews and approves provider-specific complaints and appeals system policies and procedures. Once approved, the policies and procedures are submitted to the Quality Management Committee for approval. The Quality Management Committee is given the authority to approve and be responsible for the provider-specific complaints and appeals system by HealthCare USA's Board of Managers. Current Provider Appeal and Complaint policies are approved by the State Agency and will continue to be sent for approval.



For further information, see:

- *HealthCare USA Provider Manual*, p. 85-87

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C6 Provider Complaint and Appeal Process*

2.17.2b. The policies and procedures shall include, at a minimum:

1. A description of how providers file a complaint or provider appeal, including whether it must be in writing;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(b)1.

HealthCare USA's policies and procedures include a description of how providers are to file a complaint or appeal. Complaints and appeals can be made in person, by telephone or in writing. All complaints and appeals are logged into our online tracking system.

For further information, see:

- *HealthCare USA Provider Manual*, p. 85-87

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C6 Provider Complaint and Appeal Process*

2.17.2b2 Information on the amount of time a provider has to file and the resolution timeframe;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(b)2.

HealthCare USA's policies and procedures include the timelines that will be followed for provider complaints and appeals.

Timeframes to file a complaint/appeal are as follows

- Complaint must be filed in 365 days from the start of the dissatisfaction or dispute
- Provider Appeal must be filed in 180 days of the notice of action letter denying services

Resolutions timeframes are as follows

- Pre-service appeals will be 30 calendar days.
- Post-service appeals will be 60 calendar days
- Complaints will be 60 calendar days
- Expedited appeals will be 72 hours.

For further information, see:

- *HealthCare USA Provider Manual*, p. 85-87

The following policy outlines our procedure, and is available upon request:



- HealthCare USA policy C6 *Provider Complaint and Appeal Process*

2.17.2b3. A process for thoroughly investigating each complaint and appeal using applicable statutory, regulatory, and contractual provisions, and for collecting pertinent facts from all parties during the investigation.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(b)3.

We also have a process for thoroughly investigating each complaint and appeal using applicable statutory, regulatory, and contractual provisions, and for collecting pertinent facts from all parties during the investigation.

HealthCare USA's policies and procedures identify the process for reviewing appeals and complaints. Please find the below summary of the existing process for each scenario.

Provider Appeals

An appeal is the mechanism that allows the provider the right to have actions taken by the health plan review when the provider (a) has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness; or (b) is aggrieved by any rule or policy or procedure or decision by the health plan. HealthCare USA has a process for both administrative and medical appeal.

The turnaround time for an appeal is dictated by the type of the appeal. Each appeal is identified as either pre-service or post-service. Pre-service appeals are completed within 30 calendar days while post-service appeals are completed within 60 days. If the provider has asked for an expedited appeal, the appeal is referred to a medical director for review to determine if the appeal meets criteria for an expedited review. Expedited appeals are resolved within 72 hours. In addition, a compliance analyst reviews the appeal to determine if the appeal is administrative or clinical

Provider Appeals Administrative

Once the appeal is identified as an administrative appeal, compliance analysts will review the substance of the appeal in addition to the claim details to identify what the provider is appealing. Upon review of the claim and the reason for the appeal, the compliance analyst identifies the specific guideline (Examples: policy/procedure, claim edit, or contract) used in the original determination. The compliance analyst will review the applied guideline and determine if the appropriate decision is made. The compliance analyst will notify the requestor in writing of the following administrative appeal resolution details:

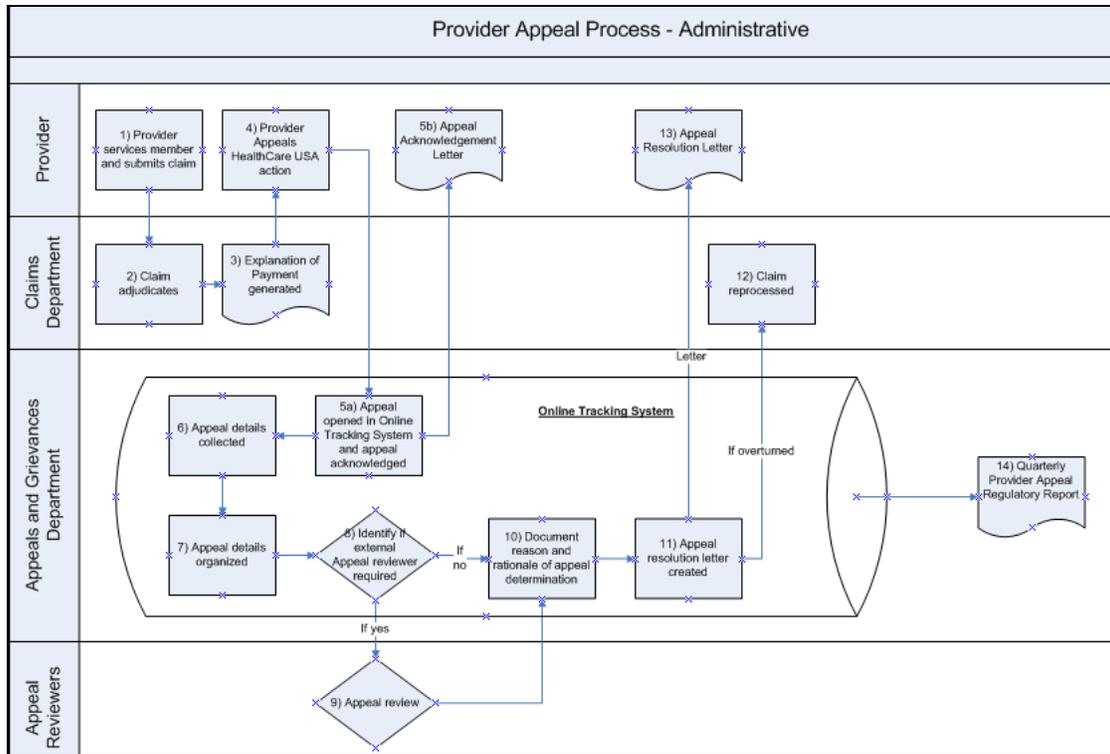
- The appeal determination (uphold or overturn)
- The reason and rationale of the determination
- The qualifications of who made the determination
- The name of the Compliance Analyst





- The contact information should there are any questions

Figure 2- 25: Provider Appeal Process, Administrative



Provider Appeals—Medical:

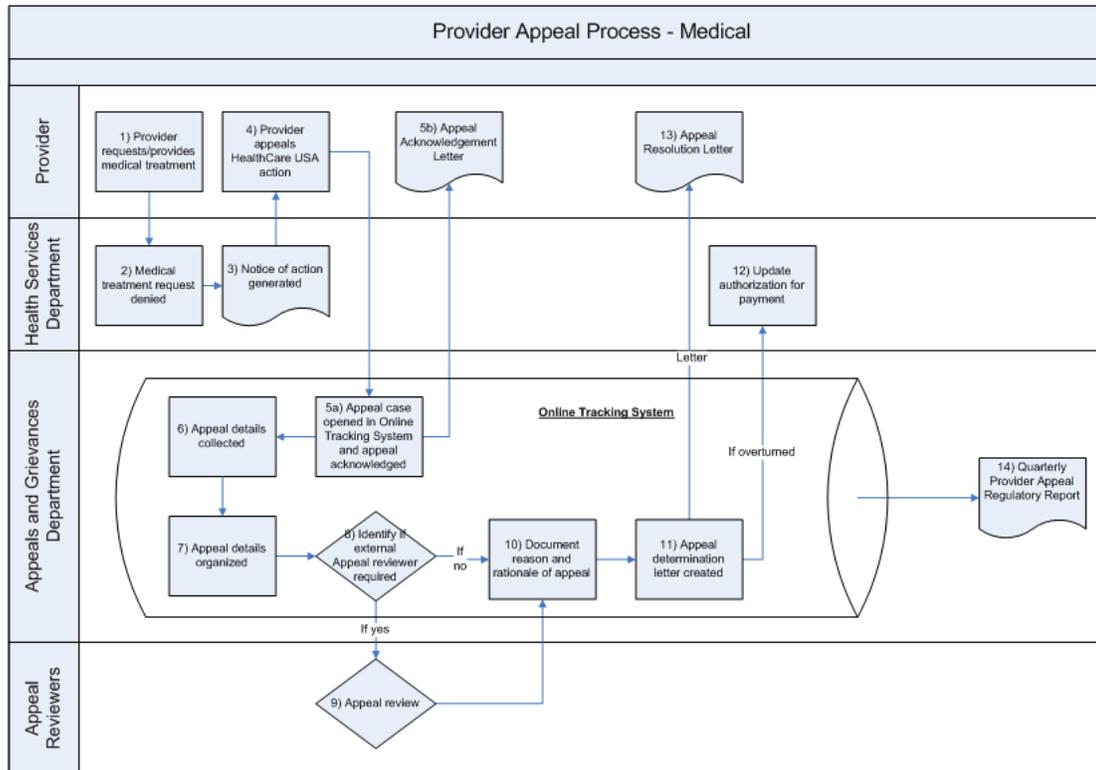
Once the appeal is identified as a clinical appeal, the compliance analyst assigns it to a medical review nurse. The medical review nurse reviews the substance of the appeal in addition to the authorization details, medical records and/or claim to identify what the provider is appealing. Upon review of these details, the medical review nurse identifies the specific guideline (criteria, policy/procedure, contracts, for example) using the original auth/claim determination. The medical review nurse identifies the original reviewer on the case and sends all of the provided documents, system notes, and criteria to an appropriate medical professional. The clinical appeal reviewer is not the same as the original reviewer nor a subordinate of the original reviewer. Once the appeal reviewer makes their determination, the appeal is resolved. The medical review nurse notifies the requestor, in writing, of the following clinical appeal resolution details:

- The appeal determination
- The reason and rational of the determination
- The criteria used to make the determination
- The degree and specialty of the reviewers



- The name of the medical review nurse
- The contact information should there be any questions

Figure 2- 26: Provider Appeal Process, Medical



Provider Complaints

A complaint is identified as a verbal or written expression that indicates dissatisfaction or dispute with policies, procedures, claims, denials, or any aspect of health plan functions.

When a complaint is identified, the compliance analyst seeks assistance from the appropriate department in resolving the complaint. If the provider requests participation in the decision process, HealthCare USA accommodates this request.

For example: if a provider files a complaint stating that a specific procedure code is not being paid according to their contract, the compliance analyst would review the provider’s contract to determine what it states regarding the provider’s reimbursement then compares the examples of what the provider was paid. If the payment was correct, the compliance analyst advises the provider and requests that provider relations advise the provider of the payment provisions of the contract. If the payment is not correct, the compliance analyst makes sure the provider is paid correctly and notifies the contracting team of the issue to assure system correction. In the effort of process improvement, the compliance analyst researches the root cause of the complaint in order to assure that there is not a global issue.



The compliance analyst notifies the requestor in writing of these provider complaint resolution details:

- The complaint determination
- The reason and rationale of the determination
- The guideline used to make the determination
- The qualifications of the complaint reviewer
- The name of the compliance analyst
- Contact information, should there be any questions

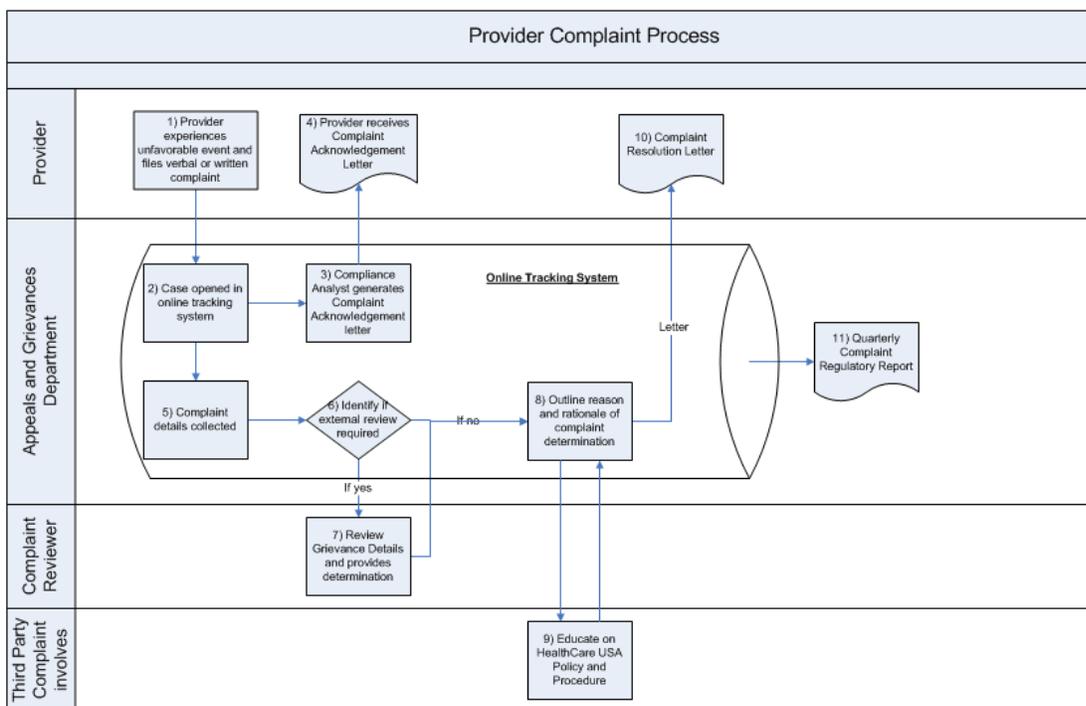
For further information, see:

- *HealthCare USA Provider Manual*, p. 85-87

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C6 *Provider Complaint and Appeal Process*

Figure 2- 27: Provider Complaint Process



2.17.2b4. A description of the methods used to ensure that health plan executives with the authority to require corrective action are involved in the complaint and appeal process;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(b)4.



Medical-related overturns are reviewed by the medical director. The medical director reviews specific cases and reports that break down specifics such as:

- Type of Appeal/Complaint
- Regional trends of Appeal Type/Complaint
- Top Providers with Appeals/Complaints
- Turn around times
- Overturn percentages.

HealthCare USA also has a Complaint, Grievance, and Appeal Committee that meets monthly to review patterns in grievances and appeals. The work group is comprised of management level staff from multiple functional areas. They identify patterns in grievances and appeals, and from this identification, corrective actions such as training or functional changes are made.

Quarterly, the Appeal and Grievance Department presents member appeal, provider appeal, member grievance, and provider complaint data to the Quality Management Committee. This information focuses on details and trends in these categories.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C6 *Provider Complaint and Appeal Process*

2.17.2b5. A process for giving providers (or their representatives) the opportunity to present their cases in person to the health plan's appellate body; and

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(b)5.

Upon request, a provider or the provider's representative can present their case to the hearing body of their complaint or appeal.

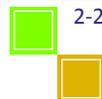
The hearing body is made up of HealthCare USA management staff involved with the complaint/appeal in question. For example, if the complaint or appeal regards a provider's contract, representatives from contracting and provider relations hear the provider's complaint or appeal. If the complaint or appeal is clinical in nature, a medical direction and the health services department hear the provider's complaint or appeal.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C6 *Provider Complaint and Appeal Process*

2.17.2b6. Identification of specific individuals who have authority to administer the provider complaint and appeal process.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(b)6.





HealthCare USA's policies and procedures identify the compliance analyst (administrative) with the Grievance and Appeal Department who is responsible for the acknowledgement, investigation and resolution of the complaints and appeals for administrative appeals.

For medical appeals, the compliance analyst investigates the appeal, making sure that all medical documentation necessary to make a decision is available. This information is forwarded to a health care professional of same or similar specialty as the provider requesting the appeal. The compliance analyst verifies that neither the original decision maker is involved in any decision on the appeal nor a subordinate of the original decision maker be involved in any decision on the appeal. If the provider has requested participation in the decision process, the compliance analyst arranges for a hearing to include a health care professional of the same or similar specialty as the provider requesting the appeal. HealthCare USA's medical director also attends the hearing. If the medical director was involved with any earlier review on this case or is the subordinate to the original reviewer, then the Medical director can provide the reasons for the original denial but has no vote on the decision.

Once the resolution of the complaint and/or appeal is made, the compliance analyst ensures the resolution letter is sent to the provider or provider representative making the complaint or appeal.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C6 Provider Complaint and Appeal Process*

2.17.2c. The health plan shall distribute an information packet to providers containing the complaint and appeal policies and procedures; specific instructions regarding how to contact the health plan's provider services staff; and contact information for the person from the health plan who receives and processes complaints and provider appeals. The health plan shall distribute the policies and procedures to in-network providers at the time of subcontract and to out-of-network providers with the remittance advice of the processed claim.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(c).

HealthCare USA has a provider information packet. This packet contains:

- Complaint policy and procedure
- Appeal policy and procedure
- Instructions on how to contact Provider Relations
- Contact information on the person who receives and processes provider complaints and appeals

The provider information packets are distributed to the contracted providers at the time of their initial orientation. Out-of-network providers receive necessary complaint and appeal instructions along with their remittance advice of the processed claim.

For further information, see:

- *HealthCare USA Provider Manual*, p. 85-87



2.17.2d. The health plan shall include a description of the provider complaint and appeal process in the provider manual.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.2(d).

HealthCare USA provides a description of the provider complaint and appeal process in the Provider Manual. Information provided includes:

- Definition of a provider complaint
- Definition of a provider appeal
- Definition of expedited appeals
- Timeframes for the resolution
- Timeframes for filing a complaint and appeal
- Fax number for submitting complaints and appeals
- Mailing address for complaints and appeals
- Phone number for expedited appeal requests

For further information, see:

- *HealthCare USA Provider Manual*, p. 85-87

2.17.3 Records/Reporting

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.3.

The health plan shall maintain records of complaints that include:

- Short, dated summaries of each of the questions or problems
- Name of the complainant
- Date of complaint
- Response to the complaint
- Complaint resolution

2.17.3a. If the health plan does not have a separate log for in-network providers, the log shall distinguish in-network providers from other health plan providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.3(a).

HealthCare USA logs all complaints in Navigator, our online tracking system. The documentation in this system includes:

- Name of complainant





- Date the complaint was received either by mail or phone.
- Region of the complaint
- Short summary of the complaint
- Dated summary of the investigation, questions, problems and names of persons interviewed
- The resolution of the complaint
- Copy of the resolution letter

HealthCare USA has the capability to distinguish between in-network providers and out-of-network providers.

Quarterly, HealthCare USA provides the State complaint details in the state-requested format.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C6 Provider Complaint and Appeal Process*

2.17.3b. The health plan shall maintain provider appeal records that include a copy of the original provider appeal, the response, and the resolution. This system shall distinguish in-network providers from other health plan providers and identify the appellant and the date of filing.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.3(b).

HealthCare USA logs all appeals in Navigator, our online tracking system. Navigator documents the:

- Original provider appeal
- Response
- Resolution
- Network providers
- Appellant
- Date of filing

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy *C6 Provider Complaint and Appeal Process*

2.17.3c. The health plan shall report provider complaints and appeals to the state agency in the format requested by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.17.3(c).



HealthCare USA maintains documents of all provider complaints and provider appeals in our online tracking system. Reports are sent to the State in the format and as frequently as requested by the state. Currently, these are provided to the State quarterly.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy C6 *Provider Complaint and Appeal Process*

2.18 Quality Assessment and Improvement [4.5.3.a]

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.

2.18.1 The state agency's quality assessment and improvement program shall consist of internal monitoring by the health plan, oversight by Federal and State governments, and evaluations by an independent, external review organization. The state agency regulates the quality assessment and improvement functions of the health plan. The quality assessment and improvement program will be annually evaluated for effectiveness. This process includes obtaining input from stakeholders, the State Quality Assessment & Improvement Advisory Group, Consumer Advisory Committee, and approval from CMS prior to implementation. In the instance there is significant change in outcome or indicator status that is not self-limiting and impacts on more than one area of the populations' health status, modifications will be made to the reporting process. These modifications may include changes to the monthly, quarterly, and annual MO HealthNet Managed Care health plan reports, on-site review topics, and MO HealthNet Managed Care performance measures. The health plan shall attend and participate in the state agency's Quality Assessment & Improvement Advisory Group meetings. The health plan shall adhere to the requirements contained within the State of Missouri Quality Improvement Strategy located in Attachment 16.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.1.

To support the States Quality Assessment and Improvement Program, we conduct ongoing monitoring of our internal quality program that includes:

- Completion of an annual evaluation
- Cooperation and collaboration with the State's external quality review organization,
- Participation in the State Quality Assessment & Improvement Advisory Group and its subcommittees.
- Participation in the State's Behavioral Health Task Force

HealthCare USA has been open to reporting changes and other modifications from the State and will continue to cooperate with such modifications in the future.

We will also continue to participate in the Advisory Group and its subcommittees. We will continue to adhere to the requirements contained within the State of Missouri Quality Improvement Strategy.

2.18.2 The health plan shall comply with all the state agency's quality assessment and improvement programs as described herein. The health plan shall participate in the State's efforts to promote



the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The health plan shall be held accountable for the ongoing monitoring, evaluation, and actions as necessary to improve the health of its members and the care delivery systems for those members. The health plan shall be held accountable for the quality of care delivered by providers. The health plan shall have a quality assessment and improvement program which integrates an internal quality assessment process that conforms to Quality Improvement System for Managed Care (QISMC) and additional current standards and guidelines prescribed by CMS. The health plan shall have a quality assessment and improvement program composed of:

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.2.

We participate in the state's efforts to promote the culturally competent delivery of services to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds by:

- Employing Spanish-speaking customer service staff
- Providing interpretation services through Language Line
- Providing face-to-face interpretation services throughout all three regions through agencies including
 - Language Access Metro Project (LAMP)
 - Jewish Vocational Services
 - International Institute
 - A-Z Translating Services
 - AAA Translation
- Providing interpretation services for hearing impaired members through:
 - Deaf Inter-Link
 - Deaf Expression, Inc.
 - DEAF Way
- Employing bilingual staff on our 24-hour nurse lines, supported by a third-party interpretation service vendor as needed
- Adding a language block to all member literature in accordance with the Oct. 1, 2009 contract with the state of Missouri
- Offering our member handbook in Braille and audio to our speech, hearing and visually-impaired members upon request.

2.18.2.a An internal system of monitoring, analysis, evaluation, and improvement of the delivery of care that includes care provided by all providers;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.2(a).



We have in place a Quality Management Committee that meets monthly to monitor evaluate the care delivery that includes:

- Utilization management process
- Provider profiling
- Investigation of quality of care issues
- Investigation of fraud and abuse
- Credentialing and re-credentialing
- Medical record reviews
- Appeals and grievances

2.18.2.b Designated staff with expertise in quality assessment, utilization management, and continuous quality improvement;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.2(b).

The HealthCare USA Quality and Health Services departments have designated staff that include:

- Missouri-licensed medical professionals
- Certified Case Managers
- Missouri-licensed Social Workers
- Master's prepared staff with years of health plan experience

2.18.2.c Written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically analyzed and evaluated for impact and effectiveness;

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.2(c).

Our process for written policies and procedures:

- HealthCare USA's Regulatory Compliance Department acts as custodian of all policies and procedures(P&P) for all departments
- P&P are accessible to all HealthCare USA employees in the shared drive in the P&P Template folder
- Each department maintains their policies in Shared Drive
- A standard template is stored in Shared Drive in P&P the Template folder
- At least annually, the HealthCare USA P&P Work group reviews and approves all policies
 - Policies can be rejected via our established policy rejection process





- The Regulatory Compliance Department receives and retains signed and approved policies HealthCare USA Policy RC-11 *Policy Updating Process* shows the Policy and Procedure Approval Process in graphic format.

2.18.2.d Results, conclusions, team recommendations, and implemented system changes which are reported to the health plan’s governing body at least quarterly; and

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.2(d).

Monthly, results, the Quality Management Committee receives conclusions, team recommendations, and reports.

2.18.2.e Reports that are evaluated, recommendations that are implemented when indicated, and feedback provided to providers and members.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.2(e).

Feedback from the committee is acted upon and reported back to the committee and to providers and members as applicable.

Submitters receive feedback from the committee and act on it, reporting back to applicable providers and members.

2.18.3 The health plan shall meet program standards for monitoring and evaluation of systems to meet Federal and State regulations. The health plan shall implement a Quality Improvement strategy that includes components to monitor, evaluate, and implement the contract standards and processes to improve:

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3. The HealthCare Quality Improvement Strategy includes components to monitor, evaluate, and implement contract standards and processes to improve each of the following:

2.18.3.a. Quality management

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(a).

We manage quality in a variety of ways, including:

Monitoring

- Monitoring and tracking HEDIS rates throughout the year
- Monitoring member and provider appeals and grievances



- Holding monthly Quality Management Committee (QMC) meetings of participating providers
- Establish policies and procedures to achieve and maintain compliance with
 - Internal and external standards
 - Regulatory and accrediting body requirements
 - All applicable federal and state laws/regulation

Evaluating

- Enhancing member satisfaction by administering an annual CAHPS survey for each region, with results reported to the DHSS, members, providers, and the Quality Management Committee
- Enhancing provider satisfaction by administering an annual survey with results reported to providers and the Quality Management Committee
- Evaluating annually the program results provided to MO HealthNet for the fiscal year in accordance with the contract requirements
- Evaluating annually the program results presented to the QMC and the Board of Managers for the calendar year ,in accordance with NCQA requirements
- Annually presenting a QI Program Description /Strategy and Workplan to the QMC and the Board of Managers
- Review of translation line utilization to identify specific cultural/linguistic needs

Implementing

- Compliance with NCQA standards and maintaining our Commendable Accreditation status
- Compliance with state requirements
- Performing barrier analysis and implementing interventions
- Annually presenting a QI Program Description /Strategy and Workplan to the QMC and the Board of Managers

2.18.3.b. Utilization management

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(b).

We manage utilization through:



Monitoring

- Monitoring specific areas of health care management (i.e., HEDIS® measures, areas of high volume, high risk, high cost, and high resource utilization)
- Daily collaboration between the Concurrent Review Nurse and the Medical Director or designee to discuss determinations
- Holding weekly Grand Rounds meetings to discuss problem cases; present at these meetings are the concurrent nurses, complex case managers, disease managers, social worker, behavioral health liaison and Medical Directors

Evaluating

- Study member satisfaction results by administering case and disease management satisfaction surveys to members, with results reported to the Quality Management Committee
- Evaluating at least annually the consistency with which the health care professionals (physicians and non-physicians) gather relevant clinical information and apply the criteria and guidelines in making medical appropriateness determinations
- Evaluating Health Services staff consistency and accuracy in implementing criteria in the authorization process using a standard, McKesson-developed, inter-rater reliability (IRR) examination

Implementing

- Compliance with NCQA Standards to maintain our Commendable Accreditation status
- Compliance with State requirements
- Promoting efficient provision of services in a setting appropriate to the needs of the subscribers.
- Applying appropriate industry standards and plan-approved utilization management criteria during the Care Management process
- Integrating utilization management activities and performance measures into the Quality Improvement Program; to coordinate opportunities for improvement at all levels of the organization; develop and implement action plans and evaluate the effectiveness of the interventions
- Designing systems that address priority issues in an ongoing, efficient and effective manner
- Establishing policies and procedures to achieve and maintain compliance with internal and external standards, regulatory- and accrediting-body requirements, and all applicable federal and state laws and regulations



2.18.3.c. Records management

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(c).

The *HealthCare USA Provider Manual*, p. 63, Section X, item F informs physicians they must comply with Missouri law (RSMO Section 334.097), which states that each physician shall maintain an adequate and complete medical record for each member

We monitor provider records management through:

Monitoring

- Medical record reviews completed during the HEDIS hybrid review process
- Utilization management record review
- Quality of care investigations
- Routine medical record reviews
- Reviews done during the appeals and grievance process

We ensure that all records received by the health plan are managed in accordance with HIPAA requirements through:

Evaluating

- Onsite audits
- Credentialing
- NCQA audit

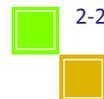
Implementing

- Confidential storage
- Requesting minimum necessary information
- Following all other HIPAA requirements regarding PHI

2.18.3.d. Information management

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(d).

HealthCare USA's parent organization, Coventry Health Care, Inc., supports comprehensive information systems that include:





Monitoring

- NavCare online case management that supports member assessments, care plans, follow-up triggers, case notes, summaries, referrals to behavioral health, etc.
- Pop-up reminders regarding gaps in care so Member Services representatives and case managers can educate and remind members when speaking with them
- Monthly reports providing ongoing HEDIS information to facilitate member outreach and ongoing monitoring
- Provider profiling software
- Predictive modeling software

Evaluating

- Monthly reports providing ongoing HEDIS information to facilitate member outreach and ongoing monitoring
- Provider profiling software
- Predictive modeling software

Implementing

- Claims processing system
- InterQual® criteria online support for prior authorization and concurrent review
- NavCare online case management that supports member assessments, care plans, follow-up triggers, case notes, summaries, referrals to behavioral health, etc.
- NCQA-certified software to manage the annual HEDIS process, including the CAHPS survey
- A 24/7 Help Desk is available to support staff 365 days of the year.
- A business continuity and disaster recovery plan is maintained

2.18.3.e. Care management

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(e).

The scope of duties within the Health Services Department includes services authorization, discharge planning and case (i.e., care) management, provided in both institutional and non-institutional settings as follows:





Monitoring

- Complex case managers and disease managers attend Grand Round meetings with the Health Services staff and Medical Directors. Cases are reviewed and discussed.
- The NavCare case management system supports case management so all clinical staff can review notes to coordinate and monitor patient care.
- Caseloads for each case manager is monitored on an ongoing basis by management.
- Member and provider grievances are monitored for any issues with case or disease management.

Evaluation

- Monthly audits of case management notes are done for compliance with the state contract and to assure they are meeting NCQA standards.
- Member and provider satisfaction surveys are evaluated for case management.
- Case management evaluation data is included in the QM annual evaluation provided to MO HealthNet as well as the annual UM program evaluation that is presented to the Quality Management Committee and the HealthCare USA Board of Managers.

Implementing

- Provision of proactive Case Management and Disease Management Programs
- Case management , which includes
 - Case review
 - Proactive discharge planning
 - Identification and management of members with chronic conditions
 - Enrollment into Complex Case Management or Disease Management (if appropriate)

Behavioral health and substance abuse case management is administered by HealthCare USA's sister organization, MHNet, a managed behavioral health organization (MBHO) accredited by the National Committee for Quality Assurance (NCQA)

HealthCare USA has two MHNet behavioral health liaisons on-site to assist in coordinating care and referral into the case management process. HealthCare USA Health Services Policy - HS-65 describes the coordination of services with mental/behavioral health

Complex case managers and disease managers attend Grand Round meetings with the Health Services staff and Medical Directors.

The NavCare case management system supports case management so all clinical staff can review notes and coordinate patient care



2.18.3.f. Member services

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(f).

Monitoring

- We monitor telephone statistics and report them to management and the Quality Management Committee
- Annually, member satisfaction surveys (CAHPS)[™] are conducted for each region and results are reported to Executive staff, members, providers, DHSS, the Quality Management Committee. Our annual program evaluation is also provided to MO HealthNet, and the Board of Managers
- Member Advisory Councils meeting are conducted by Community Development per region.

Evaluating

- We monitor telephone statistics and report them to management and the Quality Management Committee
- Annually, member satisfaction surveys (CAHPS)[™] are conducted for each region and results are reported to Executive staff, members, providers, DHSS, the Quality Management Committee. Our annual program evaluation is also provided to MO HealthNet, and the Board of Managers
- Member Advisory Councils meeting are conducted by Community Development per region.

Implementing

- HealthCare USA maintains a toll-free member services telephone number to respond to member questions, comments, and inquiries.
- Our staff is trained on a wide of range of common member service topics, so our representatives can directly assist members with the majority of their questions without transferring calls to another area.
- When assistance is needed or a transfer is required, our member services representatives perform a “warm transfer” where the additional department or functional area is conference into the phone conversation but the Member Services Specialist stays on line until all of the member’s questions are answered. This way, a member with multiple questions can make just one call to HealthCare USA for all their questions.

2.18.3.g. Provider services

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(g).



Monitoring & Evaluating

To improve provider relations, we monitor and evaluate to ensure contract implementation standards by employing:

- **Practice Manager Advisory Committee**—meets three times a year to ensure we are regularly communicating with providers, which allows for feedback on HealthCare USA's policies and procedures
- **Physician Advisory Committee**— this meeting facilitates feedback and communication with the practicing providers, ranging from administration topics to clinical discussions
- **Annual Provider Seminars**—held in all three regions for provider education and outreach
- **Post Seminar satisfaction surveys**—conducted, analyzed and presented to the Quality Management Committee
- **Provider Satisfaction surveys**—conducted annually regarding customer service and provider satisfaction with the UM process. Results are communicated to providers in the Provider Newsletter

Implementing

- HealthCare USA maintains a strong commitment to meeting the needs of our providers. We assign a provider relations representative to all participating providers so each practice becomes familiar with and forms a solid working relationship its representative.
- The Provider Relations Department is responsible for field service and ongoing education and training of HealthCare USA's provider community. Upon credentialing approval by HealthCare USA, a welcome letter is sent to the practitioner. Within 30 days of the provider's effective date, a PR representative contacts the provider's office to schedule an orientation.
- **Refresher orientations**—conducted by PR representatives when requested by provider's office, e.g. they have new office staff
- HealthCare USA monitors provider appeals and grievances for trends, and problem areas.

2.18.3.h. Organizational structure

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(h).

The HealthCare USA Board of Managers has the ultimate authority for the Utilization Management and Quality Management Programs. The board formally delegated the planning, implementation, coordination and oversight of the Health Service and Quality Management program to the Quality Management Committee (QMC).



Monitoring

- The board receives regular reports from the QMC and is responsible for reviewing and approving the annual Quality and Utilization Management Program documents
- The **Plan Administrator** has the overall responsibility to ensure that HealthCare USA delivers high-quality health care and services to its members. The Chief Executive Officer reports to the Coventry CEO of State Health Care Services and oversees management of operations, Health Services, Finance, Network Development, and Quality Improvement.
- The **Chief Financial Officer (CFO)** has the responsibility of formulating financial policy and plans.
- The **Chief Medical Officer (CMO)** is a Missouri licensed physician responsible for the Quality and Utilization Management Programs. The CMO reports to the CEO. The CMO provides clinical direction and support to the Health Services Department and peer review of referred cases for medical appropriateness determinations and quality of care issues.
- The **Associate Medical Director** is a Missouri-licensed physician and reports to the CMO. The Associate Medical Director assists the CMO in implementing the Quality and Utilization Management Programs.
- The **Vice President (VP) of Health Services** is a Missouri-licensed registered nurse who is responsible for the strategic direction, management, and oversight of the operations of the Health Services Department. The Vice President of Health Services reports to the CMO.
- The **Director of Quality Improvement (QI)**, a registered nurse, reports to the CMO and is responsible for the strategic direction, management, and oversight of the operations of the QI department. This individual is accountable for monitoring and evaluating quality of care issues, developing and implementing quality improvement activities and performance improvement projects (PIPs), and monitoring health plan quality indicators including member/provider complaints/appeals.

Evaluating & Implementing

- The **Director of Quality Improvement (QI)**, a registered nurse, reports to the CMO and is responsible for the strategic direction, management, and oversight of the operations of the QI department. This individual is accountable for monitoring and evaluating quality of care issues, developing and implementing quality improvement activities and performance improvement projects (PIPs), and monitoring health plan quality indicators including member/provider complaints/appeals.

2.18.3.i. Credentialing

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(i).



Monitoring

- We re-credential participating providers at least every 36 months. Our selection standards include primary source verification and ongoing monitoring for quality of care and service issues that are monitored and tracked and trended by the Quality department in collaboration with Provider Relations.

Evaluating

- HealthCare USA follows NCQA credentialing and re-credentialing standards

Implementing

- HealthCare USA follows NCQA credentialing and re-credentialing standards.
- We re-credential participating providers at least every 36 months. Our selection standards include primary source verification and ongoing monitoring for quality of care and service issues that are monitored and tracked and trended by the Quality department in collaboration with Provider Relations.

2.18.3.j. Network performance

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(j).

HealthCare USA monitors and evaluates network performance by the following: provider selection standards:

Monitoring

- Practice locations meet our needs as determined by Provider Relations department
- The provider's practice location is within the MO HealthNet or contiguous to the state-mandated service area
- Financial and quality measures
- Geo Access

Evaluating

- Need is determined by the network adequacy reviews and network accessibility studies completed by Provider Relations
- The provider's practice location is within the MO HealthNet or contiguous to the state-mandated service area
- Financial and quality measures
- Geo Access



Implementing

- Provider is primarily engaged in providing services of the type covered under the benefit contracts
- Provider holds a current Missouri license
- Provider maintains hospital privileges at a HealthCare USA participating hospital
- Action against provider who did not meet standards

2.18.3.k. Fraud and abuse detection and prevention

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(k).

We have several methods to detect fraud and abuse, including:

Monitoring

- Provider Relations representatives who are trained to recognize and report issues
- Confidential hotline to report any concerns and/or potential detections (See *HealthCare USA Provider Manual Section XIII*, Item E, p 89 instructs providers how to report fraud, waste or abuse)
- Special Investigation Unit (SIU) with specially trained staff reviews potential cases with the assistance of an on-line system.

Implementing

- Mandatory annual training of all employees on compliance and ethics
- Special Investigation Unit (SIU) with specially trained staff reviews potential cases with the assistance of an on-line system.

Evaluating

- Compliance Committee that reviews reports, trends and service measures that implicate fraud or abuse
- Special Investigation Unit (SIU) with specially trained staff reviews potential cases with the assistance of an on-line system.

2.18.3.l. Access and availability

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(l).

The Provider Relations department monitors access and availability through:



Monitoring

- Geo Access programs
- Monitoring open and closed panels
- Member complaints
- Appointment availability
- After-hours access monitoring
- PCP capacity

Evaluating

- Geo Access programs
- Member complaints
- Appointment availability
- PCP capacity

Implementing

- Geo Access programs
- PCP capacity
- Annual filing for Network Access to the Department of Insurance

For additional details, see our responses to Section 2.5.4 and Section 4.5.4a1.

2.18.3.m. Data collection, analysis, and reporting

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.3(m).

Monitoring, Evaluating and Implementing

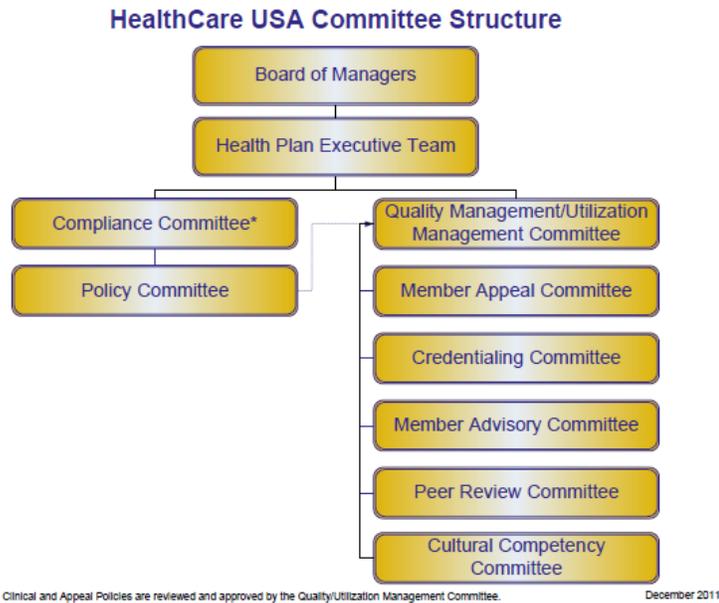
HealthCare USA performs extensive data collection, analysis and reporting through all of the mechanisms outlined in 2.18.3(a)l.

2.18.4 Internal Staff: The health plan shall designate a Quality Assessment and Improvement and Utilization Management Coordinator. Specifically, the Quality Assessment and Improvement and Utilization Management Coordinator must:

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.4.



The Quality Assessment and Improvement, Laurel Ruzas and the Utilization Management Coordinator, Lisa Fillback are Missouri licensed registered nurse and certified case managers. The figure below



2.18.4a. Be responsible for assisting the governing body and their designee in the process of continually developing, implementing, evaluating, and improving the written quality assessment and improvement program. The continuous improvement process shall include care delivery objectives, specific activities implemented from issues identified as a result of the on-going monitoring process, systems methodologies for continuous tracking of care delivery, and provider review. The process must include a focus on health outcomes and action plans for improvement of those outcomes.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.4(a).

The Quality Assessment Coordinator and Utilization Management Coordinator are responsible for the continuous process of developing, implementing, evaluating and improving the written quality assessment and improvement program that is completed annually. A Fiscal Year Annual Evaluation is provided to MO HealthNet in accordance with the contract and a calendar year report is developed for NCQA compliance. The annual evaluation is presented to the QMC and to the Board of Mangers. The process includes a focus on health outcomes and action plans for improvement. This is achieved through monitoring of Performance Improvement projects, Focus Studies, departmental reports, service monitors, appeals and grievances, peer to peer reviews, HEDIS, CAHPS surveys, delegation oversight, collaboration with Provider Relations, Member Services, Compliance and Community Development.

2.18.4b. Be responsible for the health plan's utilization management and quality assessment committee, assist the governing board in directing the development and implementation of the



health plan's internal quality assessment and improvement program, and monitor the quality of care that members receive.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.4(b).

The Quality Assessment Coordinator and Utilization Management Coordinator are responsible for the HealthCare USA Quality and Utilization Management Committee that meets monthly. Reports are prepared and presented for feedback from the participating physicians on the Committee.

2.18.4c. Review all potential quality of care problems, both physical and behavioral health, and oversee development and implementation of continuous assessment and improvement of the quality of care provided to members.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.4(c).

The Quality Improvement department is responsible for reviewing all quality of care problems including regarding physical health. MHNet the behavioral health organization oversees behavioral health quality of care problems and reports to the HealthCare USA QMC quarterly as well as during delegation oversight meetings. The MHNet Medical Director is a member of the HealthCare USA QMC.

2.18.4d. Ensure that health education resources are available for the provision of proper medical care to members.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.4(d).

Both the Quality Assessment Coordinator and Utilization Management Coordinator ensure that health education resources are available for the provision of proper medical care to members. This is achieved by member education materials, case management, disease management, member newsletters, member website materials, submission of member materials to MO HealthNet for approval, etc. All member material are written at the required 6th grade reading level.



- 2.18.4e. Utilize staff in an effective and efficient manner to monitor and assess care delivery.
- f. Specify clinical or health services areas to be monitored.
 - g. Specify the use of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by the state agency as well as for areas the health plan selects.
 - h. Ensure that all denied services are reviewed by a physician, physician assistant, or advanced nurse practitioner. The reason for the denial must be documented and logged. Any alternative services authorized must be documented. All denials must identify appeal rights of the member.
 - i. Monitor and report the following through the health plan's internal quality assessment and improvement process:
 - 1. The management of the health plan's EPSDT program;
 - 2. The health plan's referral process for specialty and out-of-network services;
 - 3. The health plan's credentialing and recredentialing activities;
 - 4. The health plan's process for prior authorizing and denying services;
 - 5. The health plan's process for ensuring the confidentiality of medical records and member information;
 - 6. The health plan's process for ensuring the confidentiality of the appointments, treatments, and required state agency reporting of adolescent STDs;
 - 7. Monitor providers for compliance that reports of disease and conditions are made to the State Department of Health and Senior Services in accordance with all applicable State statutes, rules, guidelines, and policies and with all metropolitan ordinances and policies;
 - 8. Monitor providers for compliance that control measures for tuberculosis, STDs, and communicable diseases are carried out in accordance with applicable laws and guidelines; and
 - 9. The toll-free nurse hotline activities.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.4(e-i).

- 2.18.5 Practice Guidelines:
- a. The health plan shall adopt practice guidelines that meet the following requirements:
 - 1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - 2. Consider the needs of the members;
 - 3. Are adopted in consultation with contracting health care professionals;
 - 4. Are reviewed and updated periodically as appropriate; and
 - 5. Are disseminated to all affected providers, and upon request, to members and potential members.
 - b. The health plan shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.5.

a) HealthCare USA adopts and disseminates clinical practice guidelines (CPG's) and/or standards of care that meet NCQA Standards and that meet the following requirements:

- 1) All clinical practice guidelines are based on either nationally recognized criteria or are developed in conjunction with board – certified practitioners from appropriate specialties.



- 2) HealthCare USA utilizes various data sources to determine relevance to the current member needs. Data sources may include, but are not limited to, claims, encounters, healthcare delivery costs, and frequency of admissions or frequency of Emergency Department encounters.
- 3) When CPG's are developed and additional physician input is needed, draft guidelines are sent to an appropriate HealthCare USA specialist for their review and recommendations. The guidelines will be shared with the Quality Management Committee (QMC) for final approval.
- 4) Each guideline is reviewed and updated as national guidelines change, but no less than every two years by the QMC to ensure that the information contained within the guideline remains consistent with medical advancements in technology and standards of care.
- 5) The new and revised CPG's are to be distributed to network practitioners through the Provider Newsletter, the web-site, and the Provider Manual. Providers can call HealthCare USA Provider Relations at 1-800-213-7792 to request a hard copy of the Clinical Practice Guidelines.

b) On an annual basis, performance will be measured against two aspects of care for four (4) of the clinical practice guidelines, two of which relate to behavioral health, to determine the extent to which practitioners follow the clinical practice guidelines. This will be accomplished through the review of Healthcare Effectiveness Data and Information Set (HEDIS) Effectiveness of Care outcomes if applicable and other data as needed.

HealthCare USA UM decisions are consistent with approved clinical practice guidelines.

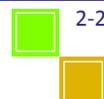
2.18.6 Reporting: In addition to internal monitoring of quality of care, the health plan shall submit reports to the state agency regarding the results of their internal monitoring, evaluation, and action plan implementation. The reports shall include targeted health indicators monitored by the state agency and specific quality data periodically requested by the Federal government. The reports may be required on a monthly, quarterly, or annual basis or as specified by the state agency. (Refer to Attachments 6, 6a, 6b and 6c for the current report formats.) The report format shall be periodically reviewed and updated by the state agency. The state agency shall provide the health plan with no less than ninety (90) calendar days notice of any changes in the format requested. The health plan shall comply with all subsequent changes specified by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.6.

2.18.7 Monitoring: The health plan shall provide access to documentation, medical records, premises, and staff as deemed necessary by the state agency. The health plan shall provide the state agency's independent external evaluators access to documentation, medical records, premises, and staff as deemed necessary by the state agency for the independent external review.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.7.

2.18.8 Internal Procedures: The health plan shall have an internal written quality assessment and improvement program. The health plan shall include monitoring, assessment, evaluation, and improvement of the quality of care for all clinical and health service delivery areas. Emphasis





- should be placed on, but need not be limited to, clinical areas relating to maternity, pediatric and adolescent development, HCY/EPSTD, family planning, and well woman care, as well as on key access or other priority issues for members such as reducing the incidence of STDs, acquired immune deficiency syndrome, and smoking related illnesses. The health plan shall have implemented mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. The health plan's quality review mechanisms shall address members with special needs as well as COA 1, COA 4, and COA 5 members in the written monitoring, assessment, evaluation, and improvement plan.
- a. Internal policies and procedures shall:
 1. Ensure that the utilization management and quality assessment committees have established operating parameters. The committees shall meet at least quarterly, on a regular schedule. Committee members must be clearly identified and representative of the health plan's providers. The committee shall be accountable to the Medical Director and governing body. The committees must maintain appropriate documentation of the committees' activities, findings, recommendations, actions, and follow-up.
 2. Provide for regular utilization management and quality assessment reporting to the health plan management and health plan providers, including profiling of provider utilization patterns.
 3. Be developed and implemented by professionals with adequate and appropriate experience in quality assessment and improvement: quality assessment, utilization management, and continuous improvement processes.
 4. Provide for systematic data collection, analysis, and evaluation of performance and member results.
 5. Provide for interpretation of this data to practitioners.
 6. Provide timelines for correction, and assign a specific staff person to be responsible for ensuring compliance and follow-up.
 7. Clearly define the roles, functions, and responsibilities of the quality assessment committee and the Medical Director.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(a).

HealthCare USA has an internally developed and written quality assessment and improvement program. The program strategy/description includes information on monitoring, assessment, evaluation and improvement of the quality of care for all clinical and health service delivery. Emphasis is placed on the clinical areas that relate to our membership. This includes but is not limited to maternity, pediatric & adolescent development, HCY/EPSTD, family planning, and well woman care and other important health issues such as cancer screenings. Furthermore, HealthCare USA has programs that assess the quality and appropriateness of care for members with special health care needs.

a) Internal policies and procedures are in place to assure the following:

- 1) The Quality Management Committee operates under a charter that provides for: monthly meetings, the members are participating providers with specialties that are related to HealthCare USA member's medical care/needs. The QMC is chaired by a HealthCare USA Medical Director and minutes are retained that document all actions of the committee.
- 2) HealthCare USA provides reporting to management and providers in a variety of ways including service reports, utilization management statistics, quality improvement projects, HEDIS results, CAHPS survey outcomes, tracking and trending of appeals &



grievances data. Furthermore, HealthCare USA has the following provider profiling capabilities:

- PQM
 - HEDIS compliance by provider – 2 versions PCP and OB/GYN
 - Have option to set minimum level of patients to ensure statistical validity
 - Annually & Monthly – available upon request
- QSI – rate grouper
 - Allows us to see high volume PCPs with some options to roll up to practice level – HEDIS compliance is the driver for the report
- Provider reports in Webi part of the Navigator software system
 - Current reports we are capable of running:
 - HEDIS non compliant members by Provider
 - HealthCare USA Medical Home providers and member HEDIS compliance
 - HEDIS outreach to members activity report by Provider
 - HEDIS provider Rate report by Period
- Provider self pull reports on DP.com
 - HEDIS compliance can be pulled when checking member eligibility
- Reports related to ED usage
 - Have the capability to report on providers with a high volume of members who are repeat ED users
- CMT tool (Coventry Care Management Tool)– developed for high volume providers such as medical home and HPN has prospective modeling options
- EPSDT Cognos Cube
 - Reports by provider of all noncompliant members
 - Summary report by provider

3) HealthCare USA staff are Missouri licensed health care professionals or Master's prepared professionals who have years of experience in quality assessment and utilization management.

4) HealthCare USA has internal policies and procedures that are supported by sophisticated information management systems that provide for systematic data collection, analysis, and evaluation of performance and member results. This is well demonstrated by the annual HEDIS results, CAHPS surveys, utilization management reports and other reports that have been described throughout Quality Assessment and Improvement section.



5) HealthCare USA provides for interpretation of data to practitioners through the provider portal DP.com. In addition to DP.com, HealthCare USA can provide ad hoc reports to providers as applicable.

6) The HealthCare USA quality improvement process, delegation oversight and compliance standards provide for timelines for correction, and assign specific staff person(s) to be responsible for ensuring compliance and follow-up. The Compliance Committee and the Quality Management Committee monitor any corrective actions that are required.

7) The Quality Management Committee charter clearly defines the role and responsibilities of the quality committee and the Medical Director.

2.18.8b. Utilization Management: The health plan shall have and implement written utilization management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims that comply with Federal and State laws and regulations, as amended. The utilization management policies and procedures must be clearly specified in provider contracts or provider manuals and consistently applied in accordance with the established utilization management guidelines. As part of the health plan's utilization management function, the health plan shall also have processes to identify both over and under utilization problems for inpatient and outpatient services, undertake corrective action, and follow-up. This review must consider the expected utilization of services regarding the characteristics and health care needs of the member population. In addition, the health plan shall use an emergency room log, or equivalent method, to track emergency room services (e.g. daily emergency room report from targeted high volume facilities). Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(b).

HealthCare USA's *Utilization Management Program Description* documents our medical management procedures that include, but are not limited to:

- Denial of services
- Prior approval
- Hospital discharge planning
- Physician profiling
- Concurrent, prospective and retrospective review of claims
- Over and under utilization of inpatient and outpatient services
- Emergency Department logs when provided by hospitals

Our utilization management guidelines are communicated to providers via the *HealthCare USA Provider Manual*, pp. 41-43, as well as in provider contract verbiage. HealthCare USA does not incentivize providers or staff to deny, limit or discontinue medically necessary services to any member.





AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2.18.8c. Provider Credentialing: The health plan shall have written credentialing and re-credentialing policies and procedures 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. The health plan shall have written policies and procedures 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 health plan's medical management standards. The policies and procedures shall include the timeframe in which the credentialing and re-credentialing must take place. The credentialing and re-credentialing process shall not take longer than one hundred eighty (180) days. The health plan shall use the Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180, as amended. The Social Security Number is due upon contract award. The health plan shall follow the requirements outlined in the policy statements found in Attachment 3. HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(c).

We follow NCQA Credentialing standards and have all necessary elements related to the requirements set by NCQA reflected in our Policies and Procedures. HealthCare USA requires all providers to use the CAQH form pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180 as amended. We have established credentialing and re-credentialing Policies and Procedures that are approved by MO HealthNet.

The following policies outlines our procedure, and are available upon request:

- HealthCare USA Policy CRED-9 *Provider Credentialing*
- HealthCare USA Policy CRED-10 *Provider Recredentialing*.

2.18.8c1. As part of recredentialing, the health plan shall audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(c)1.

The HealthCare USA Quality Improvement department conducts medical record documentation audits of network providers that include a review of documentation regarding discussion of advance directives for adult members as stated in HealthCare USA QI-14 *Monitoring of Medical Records*.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- 2.18.8c2. As part of credentialing and re-credentialing, the health plan shall collect from providers directly contracted with the health plan, full and complete information, as described herein, regarding ownership, 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 health plan shall collect and provide this information to the state agency using the template provided in Attachment 3:
1. As part of recredentialing, the health plan shall audit records of primary care providers, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2. As part of credentialing and re-credentialing, the health plan shall collect from providers directly contracted with the health plan, full and complete information, as described herein, regarding ownership, 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 health plan shall collect and provide this information to the state agency using the template provided in Attachment 6b:
 - At the stage of provider credentialing and re-credentialing;
 - Upon execution of the provider agreement;
 - Within thirty-five (35) days of any change in ownership of the provider; and
 - At any time upon the request of the state agency for any or all of the information described in this section.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(c)2.

All HealthCare USA subcontractors, affiliates and providers are required by contract to follow all MO HealthNet requirements and collect ownership information and confirm the debarment status of all of their providers as part of their credentialing and re-credentialing process. In addition, we conduct ongoing monitoring and report this information through the annual subcontractor/affiliate oversight and audit process. If an action is identified during ongoing monitoring, it is sent the health plan by the Credentialing Verification Center for review by the Credentialing Committee.

- 2.18.8c3. The health plan shall promptly forward such disclosures to the state agency, in accordance with prescribed timeframes. Per the subcontracting requirements specified herein, the health plan shall include provisions in its subcontracts for health care services notifying the provider or benefit management organization to provide the disclosures to the health plan. The state agency will, in accordance with 42 CFR 455.106(b), notify the HHS Office of the Inspector General (HHS-OIG) within twenty (20) working days from the date it receives the information, of any disclosures made by providers under 42 CFR 455.106 (relating to criminal convictions of the



provider, or of a person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider).

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(c)3.

As part of their credentialing and re-credentialing process, our subcontractors and affiliates are required to follow all MO HealthNet requirements. They collect ownership information and confirm the debarment status of all of their providers, conduct ongoing monitoring and report this information through the subcontractor/affiliate oversight process.

All HealthCare USA subcontractors and affiliates are compliant with this requirement.

2.18.8c4. The health plan shall promptly notify the state agency of any denial of provider credentialing or re-credentialing. This requirement is in addition to the requirement herein for the health plan to report provider terminations as part of its quarterly fraud and abuse report. The state agency shall, pursuant to 42 CFR 1002.3(b), promptly notify HHS-OIG of the denial of credentialing or re-credentialing where that denial is based on a determination that the provider has been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program; has failed to renew its license or certification registration, or has a revoked professional license or certification; has been terminated by the state agency; or has been excluded by OIG under 42 CFR 1001.1001 or 1001.1051. In making such disclosures, the health plan shall use the template provided in Attachment 6b.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(c)4.

The HealthCare USA Credentialing Verification Center (CVC) continuously monitors all provider files for federal sanctions (Detailed in the HealthCare USA Policy and Procedure *CRED-Sanction Report Monitoring* and in Section 2 of the *Credentialing Verification Center (CVC) Policy Manual*). By reviewing sanction reports, we determine if a practitioner's license has been revoked, suspended or disciplined. We review sanction reports at initial credentialing and every three years thereafter at re-credentialing.

In addition, monthly reports determine if new activity exists. Sanction report activities are conducted as follows:

- The Credentials Verification Center (CVC) queries the National Practitioner Data Bank (NPDB)—which includes any Medicare and Medicaid sanctions—at the time of initial credentialing and as part of the re-credentialing process. The online query process initiates upon receipt of a completed practitioner application (initial or re-credentialing).
- The CVC performs ongoing monitoring of state and federal sanctions on licensure during the period between initial credentialing and re-credentialing for all practitioners, including practitioners who are considered delegated for credentialing.
- The CVC monitors federal sanctions monthly, as published by the U.S. Government Department of Health and Human Services Office of the Inspector General (OIG) database, Office of Personnel Management (OPM) database and the General Services Administration Excluded Party List (EPLS) as available and will reconcile new exclusions and/or sanctions with HealthCare USA's population of participating network practitioners. If the CVC



discovers either a new licensing sanction or an OIG sanction for a HealthCare USA practitioner, the information is brought to the CVC director. After the CVC Director review, sanction reports are sent to the Provider Relations Supervisor to review with the Medical Director to determine required action, including but not limited to immediate termination. Such disclosures are addressed at HealthCare USA credentialing meetings and determinations made at those meeting are reported to the state.

Monthly, as part of the required reporting under Requirement 2.32.3(a)3, HealthCare USA notifies the state agency of any providers denied for credentialing or re-credentialing, along with an explanation for the basis for this action.

2.18.8c5. As part of credentialing and re-credentialing, the health plan 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) and the Excluded Parties List System (EPLS) located online at <https://www.epls.gov>. The screening shall also consist of consulting the following additional databases, consistent with State and Federal requirements: the National Plan and Provider Enumeration System (NPPES), located online at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, the Missouri Professional Registration Boards website, and any such other State or Federal required databases. The health plan may choose to use the template provided in Attachment 6b to memorialize these screenings. The health plan shall deny credentialing or re-credentialing to any subcontractor that falls within this section. In addition, the health plan shall terminate the provider contract of any subcontractor for which a check reveals that the subcontractor falls within this section.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(c)5.

As stated in Section 2 of the HealthCare USA *Credentialing Verification Center (CVC) Policy Manual*, the CVC monitors monthly the federal sanctions published by the U.S. Government Department of Health and Human Services Office of the Inspector General (OIG) database, Office of Personnel Management (OPM) database and the General Services Administration Excluded Party List (EPLS) and reconciles new exclusions and sanctions with HealthCare USA's population of participating network practitioners.

For all practitioners, the CVC monitors state and federal sanctions on licensure during the period between initial credentialing and re-credentialing, including practitioners who are delegated for credentialing. If either a new licensing sanction or an OIG sanction is discovered for a HealthCare USA practitioner, the CVC director is notified. After review by the CVC Director, sanction reports are sent to the HealthCare USA Provider Relations Supervisor to review with the Medical Director to determine required action, including but not limited to immediate termination. Such disclosures are addressed at a HealthCare USA credentialing meeting and reported to the state.

2.18.8d. Performance Improvement Projects: The health plan shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and



intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. As requested, the health plan shall report the status and results of one clinical and one non-clinical performance improvement project to the state agency which must include State and/or health plan designated performance improvement projects. This includes the statewide performance improvement project, Improving Oral Health. The performance improvement projects shall involve the following:

1. Measurement of performance using objective quality indicators;
2. Implementation of system interventions to achieve improvement in quality;
3. Evaluation of the effectiveness of the interventions;
4. Planning and initiation of activities for increasing or sustaining improvement;
5. Completion of the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year; and
6. Performance measures and topics for performance improvement projects specified by the state agency in consultation with other stakeholders.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(d).

HealthCare USA has regularly reported performance improvement projects to the State. On March 1, of this year, HealthCare USA submitted statewide improvement project, Improving Oral Health as its non clinical and Decreasing Non-Emergent/Avoidable Emergency Department utilization performance improvement project as its clinical project.

All of HealthCare USA 's performance improvement projects (PIPs) involve a quality indicator that is objective and measurable such as HEDIS. All planned interventions in PIPs have the goal of improving the quality HealthCare USA provides to its members. These interventions will be tied to an indicator that is measurable either qualitatively or quantitatively. As interventions or activities are evaluated, the criteria will include the level of improvement that was increased and the sustainability of that level. Annually each PIP is evaluated to determine whether it is appropriate to close the PIP, if more time is needed for an intervention, or if a new intervention is needed. HealthCare USA participates in the QA&I and other groups where it may share success stories it has achieved in its PIPs. HealthCare USA will complete performance projects specified by the state agency.



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- 2.18.8e. Member Incentives: The health plan may offer member incentives with a value of \$30.00 or less per eligible member, per month. All member incentives must be prior approved by the state agency. The state agency approval process includes an evaluation of the health plan's member incentive using a state agency designated evaluation period.
1. The purpose of the health plan's member incentives:
 - Must be directly related to a health plan quality initiative;
 - Must be measurable via the quality activity;
 - Cannot have any relationship to the health plan's marketing activities; and
 - Cannot be convertible to cash or redemption in any way for alcohol, tobacco products, firearms, or ammunition.
 2. The health plan shall monitor their member incentives program to ensure that the program has met the health plan's quality initiative and to evaluate on an ongoing basis the effectiveness of the member incentive program.
 3. The health plan shall report the status and results of member incentives to the state agency as requested.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.8(e).

HealthCare USA associates all of its member incentive programs with focus studies to allow for evaluation of the incentive program. All of HealthCare USA's member incentive programs are directly related to a health plan quality initiative which is measurable. Healthcare USA does not relate any of its member incentive programs to its marketing programs. Healthcare USA uses a rewards card for its member incentive programs that can not be converted to cash or redeemed for: alcohol, tobacco products, firearms or ammunition.

HealthCare USA maintains databases specifically for its member incentive programs. From these databases, HealthCare USA is able to monitor the effectiveness of the program and to correlate the incentive program to its related quality initiative. HealthCare USA reports through the focus study process the results of its member incentive programs to the state agency.



2.18.9 Accreditation:

- a. The health plan shall obtain health plan accreditation, at a level of “accredited” or better, for the MO HealthNet product from NCQA within twenty-four (24) months of the first day of the effective date of the contract. The health plan shall maintain such accreditation thereafter and throughout the duration of the contract.
- b. Health plans new to MO HealthNet Managed Care shall obtain accreditation, at a level of “accredited” or better, for the MO HealthNet product from NCQA within eighteen (18) months of the first day of the effective date of the contract, but no later than thirty (30) months following the effective date of the contract. The health plan shall file its application within ninety (90) days of the effective date of the contract. Failure to obtain accreditation at a level of “accredited” or better within this timeframe and failure to maintain accreditation thereafter shall be considered a breach of the contract and shall result in termination of the contract in accordance with the terms set forth herein. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the final NCQA report and may result in termination of the contract in accordance with the terms and conditions set forth herein.
- c. In order to ensure that the health plan is making forward progress, the health plan shall provide to the state agency the following information at the following times:
 - 1. Status update to include, at a minimum, the proof of application and all supporting documents six (6) months after the first day of the effective date of the contract;
 - 2. Status update to include, at a minimum, the projected date for the on-site reviews twelve (12) months after the first day of the effective date of the contract.
- d. If the health plan fails to meet the applicable requirements stated above, the health plan shall be considered to be in breach of the terms of the contract and may be subject to remedies for violation, breach, or non-compliance of contract requirements as described herein.

4.5.3a. The offeror shall indicate if the offeror is NCQA-accredited. If so, list the states in which the offeror is NCQA-accredited, indicate the accreditation status by product line and include a copy of the applicable NCQA report cards for the offeror. The offeror shall include the offeror’s parent organization, affiliates, and subsidiaries. (2.18.9)

HealthCare USA understands and shall comply with the requirements set forth in Section 2.18.9 and 4.5.3(a).

HealthCare USA has complied with Section 2.18.9 by achieving a Commendable NCQA accreditation effective August 3, 2011 through August 3, 2014. NCQA accreditation of our parent organization’s affiliates and subsidiaries are included in Figure 2- 28.

Figure 2- 28: Coventry NCQA Accreditation

CHC Health Plans			
Health Plan	Accreditation	Line of Business	Level
Carelink	NCQA Health Plan	Commercial - HMO	Commendable 9/28/10-11/4/2013
Health America/Health Assurance (HAPA)	NCQA Health Plan	Commercial - HMO/POS	Excellent 3/06/09-3/06/12
Health America/Health	NCQA Health Plan	Medicare - HMO	Excellent 3/06/09-3/06/12



CHC Health Plans			
Health Plan	Accreditation	Line of Business	Level
Assurance (HAPA)			
HAPA	In process – NCQA Health Plan	Medicaid - HMO	TBD
HealthCare USA	NCQA Health Plan	Medicaid - HMO	Commendable 8/3/11-8/3/14
OmniCare	NCQA Health Plan	Medicaid - HMO	Excellent 9/22/09-9/22/12
PersonalCare	NCQA Health Plan	Commercial - HMO/POS/PPO	Excellent for HMO/POS & Commendable for PPO 6/28/2010-6/28/2013
Southern Health	NCQA Health Plan	Commercial - HMO/POS	Excellent for Commercial 5/08/09-5/08/12
CareNet	NCQA Health Plan	Medicaid - HMO	Commendable for Medicaid 5/08/09-5/08/12
Other Coventry Health Care, Inc. Subsidiaries			
Entity	Accreditation	Line of Business	Level
MHNet	NCQA MBHO	Commercial, Medicare & Medicaid	NCQA: Full Accreditation 09/01/12

HealthCare USA has been NCQA-accredited since August 2011. We received a “Commendable” status. A copy of our report card appears at the end of this response.

Additionally, HealthCare USA plans to obtain the NCQA Multicultural Health Care *Distinction* designation in support of our commitment to addressing diverse cultural needs and reducing racial disparity in health care. The Multicultural Health Care Distinction evaluates organizations through use of an evidence-based set of requirements. Organizations who obtain this distinction are equipped to fulfill federal and state mandates. We will submit an application in Year One of the contract and obtain the Distinction in Year Two.

HealthCare USA’s commitment to quality is emblematic of our parent company. Coventry is committed to quality in all facets of operations: Figure 2- 28 provides our NCQA accredited



plans for Coventry plans nationwide. All the plans listed in this table are health plans, with the exception of MHNet, our behavioral health affiliate. NCQA Report Cards for all of these plans are in Attachment 23.

2.19 Community Health Initiatives

- 2.19.1 The health plan shall participate in community health improvement initiatives along with local public health agencies that align with the Maternal Child Health Program (MCH), Department of Health and Senior Services (DHSS) strategic priorities. DHSS will provide their strategic priorities and a list of corresponding best practices for MCH health improvement initiatives to the health plans. DHSS, MCH/Center for Local Public Health Services shall provide technical assistance to link the health plan to health improvement initiatives being conducted at a local level. The health plan shall participate in health improvement initiatives by, at a minimum:
- a. Becoming a member of a regional and/or community-wide MCH planning coalition. Community means a geographic entity (usually a county(ies) with broad based representation from local public health agencies, community providers, businesses, local organizations, schools, etc. DHSS will provide information to the health plans about DHSS/MCH strategic priorities. The health plan shall not be required to be the lead agency in establishing a coalition.

HealthCare USA understands and shall comply with the requirements of Section 2.19.1(a).

HealthCare USA’s team represents an array of both regional and community wide planning coalitions in all regions; including Maternal Child Health Coalition (MCH), Head Start Health and Wellness Advisory Boards, CHART task force memberships and local health care efforts. HealthCare USA’s Quality Department and Community Development Team serve and assist on the following coalitions in the following the western region:

WESTERN REGION

- Mother and Child Health Coalition Board Member (Community Development and Nurses)
- The Black Health Care Coalition
- Sponsorship of Black Health Care Coalition Annual Asthma Education Workshop for local school nurses
- Community Health and Resource Team(CHART)- (Henry, Clay, St Clair and Vernon counties)
- Operation Breakthrough Wellness Committee

Building a Healthier Heartland (BHH) is a coalition building initiative that will promote policy, systems and environmental changes to address obesity using sustainable, innovative, and replicable evidence-based efforts. The goal of the initiative is to capitalize on local efforts already underway, and build capacity for additional collaborative efforts within the region.

The Community Development Team in the western region is also actively involved and participates in other health care and wellness initiatives:

- KC Health Dept – Health Commission



- YMCA Headstart Healthy University/ Parent University
- Mid-America Regional Council Health Services Advisory Committee
- Truman Medical Center/ KC Public Library Bluford Branch (31st & Prospect) Neighborhood Health Wellness Education Initiative
- KC Health Dept – Minority Health/ Health Equity Committee
- KC Free Health Clinic Stakeholder All Stars Program
- CHART (Community Health and Resource Team) in Cass, Cedar, Henry, St Clair, Ray and Vernon counties).

CENTRAL REGION

WECAN Coalition-(Ways to Enhance Children’s Activity and Nutrition Program) Cole County- Collaborative effort with schools, health dept., YMCA, MU Extension Service and WIC dietician. This collaborative effort focused on physical activity, mental awareness and nutritional counseling for elementary students attending East School (K-5). **(Childhood Obesity)**

- **Community Health Ministry Team-Audrain County**

HealthCare USA joined the Community Health Ministry Team in helping them access care and resources for their local community. HealthCare US sponsored an after school fitness program in combating obesity and mental wellness. We also partnered to bring the first ever Doc Bear Back to School Health Fair to Audrain County where hundreds of children received health screenings, school supplies, hair cuts, dental kits and a nutritious meal. (physical fitness, nutrition, mental wellness)

- **Eat Smart-Move More Health Coalition- Boone County (childhood obesity)**

In partnering with the health department, hospitals, PedNet, social service agencies, businesses and faith based organizations, HealthCare USA serves and supports this coalition in educating families about healthy choices and the barriers that lend in the creation of unhealthy choices in the community.

The Central region also serves on several other coalitions who are aligned in providing health services to the people we serve:

- Marion County CHART Teen Task Force, CHART Wellness, CHART Partnerships’
- Callaway County Dental Coalition
- Bright Futures in Phelps and Randolph- (Faith) national organization
- HealthCare USA and the Bright Futures partners with local community influencers to help connect health care services to the families who need them.
- MVCCA Head Start Health Advisory Council
- Missouri Coalition for Oral Health
- United Way Early Childhood Advisory Board



EASTERN REGION

- 27th Ward Infant Mortality Coalition
- Family Mental Health Collaborative
- Franklin County Service Providers
- Grace Hill MORE Board
- Lincoln County Healthy Communities
- Minority Health Alliance-Eastern Region
- Refugee and Immigrant Consortium
- Jefferson Count Head Start Health Advisory Committee
- Franklin County Head Start Health Advisory Council
- Youth in Need Health Advisory Council
- EMAA Head Start Health Advisory Council

HealthCare USA plays an engaging and active role in the following local and community coalitions:

- St. Louis Lead Prevention Coalition
- Urban League of Metropolitan St Louis
- Wellston School District Health Advisory Council
- St. Louis Regional Health Commission
- Washington County Health Coalition
- Asthma and Allergy Foundation

2.19.1.b. Being actively involved in the development and implementation of the community agency in establishing a coalition

HealthCare USA understands and shall comply with the requirements set forth in Section 2.19.1(b).

WESTERN REGION

- **Belton Dental Coalition Group:**
Working with the local community in building a coalition to help increase access to dental services and help community members in finding a dental home.

- **Dept. of Health and Human Services**

HealthCare USA served on the planning committee for the Annual Teen and Youth Health Summit in the Kansas City area.

- **Operation BreakThrough**



HealthCare USA is an active contributor to the over all program and played an integral role in the development of their Health and Wellness committee to better serve their teen moms and children.

CENTRAL REGION

- **Mental Health Coalition in Marion County:**

HealthCare USA is leading the way to help others access mental health services and learn the importance of their follow up visits. The first mental health effort was held in Marion County with HealthCare USA sponsoring this event and MHNet reference point for local services.

- **Central Missouri Pregnancy Resource Center:**

The Community Development Team contributed to a local effort in establishing a pregnancy resource center for teen parents in Cole County due to lack of care and intervention for expectant teens.

- **Monroe County Human Services Council**

HealthCare USA Community Development Team in the Central region is involved in the development and creation of a group who will focus on health, wellness, dental and mental awareness programs.

- **Determination, Initiative, Growth and Success, Inc (DIGS Program)**

Saline county will be creating an avenue for the teen homeless population to access health care within their community and HealthCare USA Community Development Team will contribute to the success of this program by serving as a board member and helping to make connections within the community.

- **Doc Bear Dental Days- Marion County**

HealthCare USA identifies needs with our communities and strives to fill the gaps in care. In partnering with the FQHC dental clinic, HealthCare USA helped our members access and receive dental services.

EASTERN REGION

- **Jefferson County Dental Coalition**

HealthCare USA plays an active role in the development and implementation of the program and it's goals in enhancing access to much needed dental health services at the county level.

2.19.1c. Providing feedback on the community strategic plan and it's effectiveness.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.19.1(c).



HealthCare USA is consistently observing the effectiveness of the Department of Health and Senior Services (DHSS) health care initiatives in both the rural and urban counties. We provide feedback as requested by the DHSS through surveys, informal interaction and meetings.

2.20 State and Federal Reviews

- 2.20.1 General: The health plan shall make available to the state agency or its outside reviewers, on an annual basis and on an as needed basis, medical and other records for review of quality of care, access, financial, and other issues and shall cooperate fully in any associated reviews or investigations. The state agency's quality assessment and improvement review may include but is not limited to:
- a. On-site visits and inspections of facilities;
 - b. Staff and member interviews;
 - c. Review of utilization, denial of services, and other areas that will indicate quality of care delivered to members;
 - d. Medical records reviews;
 - e. Financial records reviews;
 - f. Review of all quality assessment procedures, reports, committee activities and recommendations, and corrective actions;
 - g. Review of staff and provider qualifications;
 - h. Review of the complaint, grievance, and appeal process and resolutions;
 - i. Review of requests for transfers between primary care providers within each health plan;
 - j. Review of fraud and abuse detection, prevention, and review process, procedures, cases, and reports; and
 - k. Evaluation and analysis of coordination and continuity of care.

HealthCare USA understands and shall comply with the requirements set for in Section 2.20.1.

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- 2.20.2 Service Validation: The health plan shall make available full detailed claims data to the Department of Social Services and the state agency's designated Recovery Audit Contractor(s) for the purpose of validation of services rendered and determination of proper payments.

HealthCare USA understands and shall comply with the requirements set for in Section 2.20.2.

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- 2.20.3 External Reviews: The state agency contracts with independent external evaluators to examine the quality of care provided by the health plans. CMS designates an outside review agency to conduct an evaluation of the program and its progress toward achieving program goals. The health plan shall make available to CMS's outside review agency and the state agency's external evaluator medical and other records for review as requested. The health plan shall provide information for External Quality Reviews in the format specified by the state agency.

HealthCare USA understands and shall comply with the requirements set for in Section 2.20.3.



2.21 Financial Reporting

- 2.21.1 Financial Data Reporting: The health plan shall submit unaudited, semi-annual reports and an audited, annual report for their MO HealthNet Managed Care book of business to the state agency's contracted actuary. The health plan shall submit the semi-annual and annual reports in the format and in accordance with the audit guidelines specified by the state agency. The current report format and audit guidelines can be found in Attachment 10. Changes to the report format must be approved by the state agency prior to submission.
- a. The unaudited, semi-annual and audited, annual reports must be certified by one of the following:
 1. The health plan's Chief Executive Officer;
 2. The health plan's Chief Financial Officer; or
 3. An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
 - b. The certification must attest, based on best knowledge, information, and belief, as follows:
 1. To the accuracy, completeness, and truthfulness of the data; and
 2. To the accuracy, completeness, and truthfulness of the semi-annual and annual reports.
 - c. The health plan shall submit the certification concurrently with the semi-annual and annual reports.

HealthCare USA understands and shall comply with the requirements of Section 2.21.1.

HealthCare USA's finance department will continue to submit timely and accurate unaudited semi-annual reports and audited annual reports to the state agency's contracted actuary. As in the past, HealthCare USA will submit the semi annual reports in compliance with the guidelines for Attachment 10. HealthCare USA prepares our annual audited statutory-based financial statements to conform to the accounting practices prescribed or permitted by the State of Missouri Department of Insurance (DOI). HealthCare USA understands that any changes to the report must be approved by the state agency prior to submission.

HealthCare USA will continue to submit certification as to the completeness, accuracy and truthfulness of the data in the semi-annual and annual reports. The Chief Executive Officer, Chief Financial Officer or an appropriate designee will attest to the certification.

HealthCare USA will continue to partner with the appropriate State of Missouri departments to provide the financial reports and analysis needed to ensure timely and quality information is available.

For further details on Section 2.21.1, see Section 4.4.5.



- 2.21.2 Physician Incentive Plan Reports: On an annual basis and in compliance with the Federal regulation, the health plan shall disclose PIPs to CMS and the state agency. The information to be disclosed shall include the following:
- a. Effective date of the PIP;
 - b. The type of incentive arrangement;
 - c. The amount and type of stop-loss protection;
 - d. The patient panel size;
 - e. If pooled, a description of the method;
 - f. The computations of significant financial risk;
 - g. Whether the health plan does not have a PIP; and
 - h. Name, address, telephone number, and other contact information for a person from the health plan who may be contacted with questions regarding the PIP.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.21.2 (a-h).

- 2.21.3 Third Party Savings Report: The health plan shall provide quarterly reports to the state agency detailing third party savings in a format prescribed by the state agency (see Attachment 6b). The state agency shall provide the health plan with no less than ninety (90) calendar days notice of any change in the format requested. These reports are due on the thirtieth (30) day following the close of the quarter. The health plan shall maintain records in such a manner as to ensure that all money collected from third party resources may be identified on behalf of members. The health plan shall make these records available for audit and review and certify that all third party collections are identified and used as a source of revenue.
- a. The quarterly reports must be certified by one of the following:
 1. The health plan's Chief Executive Officer;
 2. The health plan's Chief Financial Officer; or
 3. An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
 - b. The certification must attest, based on best knowledge, information, and belief, as follows:
 1. To the accuracy, completeness, and truthfulness of the data; and
 2. To the accuracy, completeness, and truthfulness of the quarterly reports.
 - c. The health plan shall submit the certification concurrently with the quarterly reports.

HealthCare USA understands and shall comply with the requirements of Section 2.21.3(a-c).

HealthCare USA will continue to provide quarterly reports to the state agency detailing third party savings in the format prescribed by Attachment 6b. In addition HealthCare USA shall continue to include a certification as to the completeness, accuracy and truthfulness of the third party savings. The Chief Executive Officer, Chief Financial Officer or an appropriate designee will attest to the certification.

For further details on Section 2.21.3, see Section 4.4.5.



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- 2.21.4 Third Party Liability Collections Categories: The health plan shall report the categories of all third party liability collections to the state agency and shall include a complete disclosure demonstrating its efforts to obtain payment from liable third parties and the amounts and nature of all third party payments recovered for members.
- a. This includes, but not limited to, payments for services and conditions which are:
 - 1. Employment related injuries or illnesses;
 - 2. Related to motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists; and
 - 3. Contained in diagnosis codes 800 through 999 (ICD 9-M), with the exception of Code 994.6.
 - b. The reports shall be certified by one of the following:
 - 1. The health plan's Chief Executive Officer;
 - 2. The health plan's Chief Financial Officer; or
 - 3. An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
 - c. The certification must attest, based on best knowledge, information, and belief, as follows:
 - 1. To the accuracy, completeness, and truthfulness of the data; and
 - 2. To the accuracy, completeness, and truthfulness of the reports.
 - d. The health plan shall submit the certification concurrently with the reports.
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HealthCare USA understands and shall comply with the requirements of Section 2.21.4.

HealthCare USA will continue to report the categories of all TPL collections to the state agency. TPL collections reports include a complete disclosure demonstrating efforts to obtain payment from liable parties and the amounts and nature off all TPL payments removed for members. In addition, HealthCare USA shall continue to include a certification as to the completeness, accuracy and truthfulness of the TPL report. The Chief Executive Officer, Chief Financial Officer or an appropriate designee will attest to the certification. HealthCare USA will continually strive to identify opportunities to enhance our TPL processes.

For further details on Section 2.21.4, see Section 4.4.5.

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- 2.21.5 Ownership and Financial Disclosure: The health plan shall update ownership and financial disclosure information on an annual basis. The information shall be submitted to the state agency within thirty-five (35) days of a written request. This report shall include full and complete information regarding ownership, financial transactions, and persons as described herein. The current report formats can be found in Attachment 6b.
- a. The health plan shall keep copies of all of these requests and responses to them, make them available upon request, and advise the state agency when there is no response to a request.
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HealthCare USA understands and shall comply with the requirements of Section 2.21.5

HealthCare USA agree to submit timely reports of the annual changes to the Officers and Directors in conformance with Attachment 6b.

For further details on Section 2.21.5, see Section 4.4.5.

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- 2.21.6 Financial Transparency and Analysis: Upon request from the state agency, the health plan shall submit provider (for all types, e.g. physicians, clinics, hospitals, etc.) specific payment data in the



format and for the time-period specified by the state agency. The health plan shall indicate the extent to which such information shall be held confidential under RSMo 610.21.

HealthCare USA understands and shall comply with the requirements of Section 2.21.6.

Upon request from the state agency, HealthCare USA shall submit provider-specific payment data in the format and for the time-period specified by the state agency. We understand that the state agency shall hold such provider-specific payment data confidential as a Trade Secret pursuant to § 417.450 et seq. RSMo. As such, provider-specific payment data should be deemed a "closed record" under § 610.021(14) RSMo. HealthCare USA's payment terms to our contracted providers are confidential pursuant to the terms of such contracts. The payment terms would not be known to persons or entities other than the provider and HealthCare USA. HealthCare USA maintains this information on a highly confidential basis because it is competitive information and its disclosure would:

- a) impact HealthCare USA's ability to effectively negotiate payment terms with providers
- b) serve as an advantage to HealthCare USA's competitors seeking to obtain contracts with potentially the same providers.

For further details on Section 2.21.6, see Section 4.4.5.

2.22 Operational Data Reporting

2.22.1 The health plan shall provide the state agency with information concerning uniform utilization, quality assessment and improvement, member satisfaction, complaint, grievance, and appeal, fraud and abuse detection, and behavioral health data on a regular basis. On a periodic basis, the health plan shall make available clinical outcome data in areas of concern to the state agency, to include, but not be limited to behavioral health data. The health plan shall cooperate with the state agency in carrying out data validation steps. The state agency will provide report formats and variable definitions for the health plan to use in reporting operational data. Data elements and reporting requirements are outlined in herein. Final formats will be made available as finalized; some of the report formats are available in Attachment 6 and Attachment 7.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.1.

2.22.2 Presentation of Findings: The health plan shall obtain the state agency's approval prior to publishing or making formal public presentations of statistical or analytical material based on the health plan's membership.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.2.



2.22.3 Provider Network Reports:

- a. The annual access plan as required by the Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP). Information on these reports is available at <http://insurance.mo.gov/industry/filings/mc/accessMain.php>. In the event the health plan attains accreditation, the health plan shall continue to submit network files and the access plan as outlined in DIFP regulations.
- b. In addition, the health plan shall update the provider network file at the time of any change and as required in the Health Plan Record Layout Manual available at http://manuals.momed.com/edb_pdf/Health%20Plan%20Record%20Layout%20Manual.pdf.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.23.3 (a-b).

HealthCare USA submits an annual network access filing to DIFP as required by Missouri statutes. HealthCare USA achieved NCQA accreditation in 2011 and will continue to submit network files and the access plan.

HealthCare USA also submits network information updates to the State on an as needed basis, when changes occur, according to specifications provided in the Health Plan Record Layout Manual.

2.22.4 FQHC/RHC Reporting:

- a. The health plan shall submit Schedule M-1 included with Attachment 7 documenting the accepted charges, denied charges, and payments for each contracted RHC/FQHC. The health plan shall submit Schedule M-1 thirty (30) calendar days after the month end for services provided by the contracted FQHC/RHC. Attachment 7 also provides the instructions for completing Schedule M-1.
- b. The health plan shall submit Schedule M-2 included with Attachment 7 documenting the accepted charges, denied charges, and payments for each contracted RHC/FQHC for the FQHC's/RHC's entire fiscal year. The health plan shall submit Schedule M-2 within fourteen (14) business days of request by the state agency for MO HealthNet Managed Care services provided by contracted FQHC/RHC during the reporting period requested. Attachment 7 also provides the instructions for completing Schedule M-2.
- c. The health plan shall submit a list of the health plan's in-network FQHCs, RHCs, and CMHCs to the state agency annually at the start of each contract period. The report format is available in Exhibit A.
- d. The paid claim data reported on Schedule M-1 and Schedule M-2 for the health plan's contracted FQHCs and RHCs shall be accumulated by the group National Provider Identifier (NPI) number of each contracted FQHC/RHC.
- e. If the health plan chooses to subcontract certain services, the health plan shall require its subcontractors to submit and prepare Schedule M-1 and Schedule M-2 for FQHCs and RHCs that are contracted with the health plan. The requirements and deadlines for Schedule M-1 and Schedule M-2 shall apply to both health plans and subcontractors. The health plan shall pass on to its subcontractors the forms and instructions included in Attachment 7 and shall assist its subcontractors, if necessary, with the preparation and submission of Schedule M-1 and Schedule M-2.
- f. The Schedule M-1 and Schedule M-2 submitted by the health plan or subcontractor shall include only FQHC or RHC claim data. If a contracted health care provider converts to FQHC or RHC status during the reporting period of Schedule M-1 and Schedule M-2, the health plan or subcontractor shall report only FQHC/RHC claim data for dates of service beginning with the contracted provider's effective date as an FQHC or RHC. If a contracted health care provider



terminates its FQHC or RHC status during the reporting period of Schedule M-1 and Schedule M-2, the health plan or subcontractor shall not include claim data for the contracted provider for dates of service after the termination of FQHC or RHC status.

HealthCare USA understands and shall comply with the requirements set forth in 2.22.4(a-f).

2.22.5 Fraud and Abuse Activities Reports: The health plan shall provide a quarterly report of fraud and abuse activities to the state agency. The report must be submitted in accordance with state agency guidelines contained within the fraud and abuse policy statement and herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.5.

2.22.6 Timeliness of Claim Adjudication Report: On a quarterly basis, the health plan shall submit to the state agency a "Timeliness of Claims Adjudication Report" in accordance with the quarterly reporting schedule outlined in Attachment 6a in a format specified by the state agency. Following the effective date of the contract, the state agency shall provide the reporting format to the health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.6.

HealthCare USA tracks Timeliness of Claims Adjudication on a monthly and quarterly basis. This information is retained at HealthCare USA and is provided to the State agency.

Our timeliness reports track both participating and non-participating provider data. This following data is obtained:

- Total number of claims
- Total number of claims processed within 15 days
- Total percentage of claims processed within 15 days
- Total number of claims processed within 30 days
- Total percentage of claims processed within 30 days

2.22.7 Quarterly Complaint, Grievance, and Appeal Report: On a quarterly basis, the health plan shall submit to the state agency a Quarterly Complaint, Grievance, and Appeal Report, for both member and provider complaints, grievances, and appeals. The health plan shall use the access database format as required by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.7.



2.22.8 Monthly Special Needs: The health plan shall submit a monthly special needs report in a format specified by the state agency (see Attachment 6b). Monthly reports will be due the last working day of each month.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.8.

HealthCare USA's special needs coordinator receives a monthly listing of special needs members from the State. Each of the names on the list is checked to see if they are currently enrolled in case management. HealthCare USA's special needs coordinators and complex case managers evaluate the remaining members on the list for potential case management services. A report of the members who are currently enrolled in case management is sent back to the State the last working day of the month.

2.22.9 Monthly Lead Poisoning Prevention: The health plan shall submit a monthly lead poisoning prevention report in a format specified by the state agency (see Attachment 6b).

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.9.

HealthCare USA receives a monthly report from the State which contains all lead levels of HealthCare USA children that have been reported to the State that month, as well as demographic and provider information for those specific members. All the lead levels are processed according to policy and enrolled/offered case management, if appropriate. Our lead case manager reports back to the State any interventions taken with those members, as well as demographic information and interventions on any members that the lead case manager has worked with during the month.

2.22.10 Disease Management Update Report: The health plan shall provide the stage agency with a quarterly report that includes the total number of members enrolled and disenrolled during the quarter. The report shall be submitted in a format prescribed by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.10.

2.22.11 Annual Verification of Review of Education and Marketing Materials: The health plan shall provide the state agency with copies of materials and documentation verifying the health plan reviewed its education and marketing materials and acted upon any required changes.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.11.

2.22.12 Call Center Report: The health plan shall submit quarterly reports on the activities of all call center/hotlines required herein. Following the effective date of the contract, the state agency



shall provide the reporting format to the health plan. This report shall include, at a minimum, the following information:

- a. Number of calls (actual number and number reported per 1,000 members);
 - b. Call abandonment rate;
 - c. Average hold time;
 - d. Longest wait in queue;
 - e. Average talk time;
 - f. Type of call (i.e. benefit question, enrollment issues, inquiry, grievance, etc.);
 - g. Average speed of answering; and
 - h. Blocked call rate.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.12.12(a-h).



2.22.13 Quality Assessment and Improvement Evaluation and Reports:

- a. Periodic Reports of Quality and Utilization: The health plan shall provide periodic reports regarding case management, quality initiatives, and other quality analysis reports per request of the state agency. In addition, the health plan shall provide all reports detailed herein.
- b. HEDIS Measures: The health plan shall submit the HEDIS measures as required by the state agency and described in Attachment 6a, Exhibit 2.
- c. Annual Quality Assessment and Improvement (QA & I) Evaluation and Report. The health plan shall submit an annual quality assessment improvement evaluation and report in the format provided in Attachment 6a, Exhibit 3. The report shall contain information concerning the effectiveness and impact of the health plan’s quality assessment and improvement strategy. The report must provide information that indicates that data is collected, analyzed, and reported, and health operations are in compliance with State, Federal, and MO HealthNet Managed Care contractual requirements. The report must incorporate multiple year outcomes and trends. The report must show that the health plan’s QA & I program is ongoing, continuous, and based upon evaluation of past outcomes. The state agency shall periodically review and update the format. The health plan shall provide this report in the most up-to-date format and shall comply with all changes as specified by the state agency. The state agency shall provide the health plan with no less than ninety (90) calendar days notice of any change in the format requested. The evaluation will, at a minimum, contain information from subcontractors and internal processes including:
 - 1. An analysis and evaluation of member grievances and appeals and provider complaints and appeals.
 - 2. An analysis and evaluation of how the health plan incorporates race, ethnicity, and primary language into its quality strategy. The Department of Social Services asks each potential enrollee their race, ethnicity, and primary language at the time of application in accordance with MO HealthNet eligibility rules. The Department of Social Services uses the federally recognized categories for race, ethnicity, and language. The state agency shall electronically provide race, ethnicity, and language to the health plan upon member enrollment.
 - 3. An analysis and evaluation of utilization and clinical performance data that supports use of evidenced based practice.
 - 4. An analysis and evaluation of 24 hour access/after hours availability, appointment availability, and open/closed panels.
 - 5. An analysis and evaluation of the health plan’s provider network including provider/participant ratios.
 - 6. An analysis and evaluation of all MO HealthNet Managed Care quality indicators: Trends in Missouri Medicaid Quality Indicators provided by the Department of Health and Senior Services (Attachment 6a Exhibit 4); HEDIS Indicators by MO HealthNet Managed Care Health Plans Within Regions, Live Births provided by the Department of Health and Senior Services (Attachment 6a Exhibit 5); and MO HealthNet Managed Care HEDIS Measures (Attachment 6a Exhibit 2).
 - 7. An analysis and evaluation of quality issues and actions identified through the quality strategy and how these efforts were used to improve systems of care and health outcomes.
 - 8. An analysis and evaluation of action items documented in the meeting minutes of the health plan’s quality and compliance committee(s).
 - 9. Trends identified for focused study; results of focused studies; corrective action taken; and evaluation of the effectiveness of the actions and outcomes.
 - 10. An analysis and evaluation of Performance Improvement Projects that addresses clinical and non-clinical performance improvement projects and the requirement for on-going interventions and improvement.
 - 11. An analysis and evaluation of subcontractor relationships that addresses integration with the health plan’s QA&I program. This analysis and evaluation is not a replication of the Subcontractor Oversight Annual Evaluation report.
 - 12. An analysis and evaluation of the health plan’s fraud and abuse program.
 - 13. An analysis and evaluation of case management activities.



14. An analysis and evaluation of the disease management programs to include the following information for each disease management program:

A narrative description of the eligibility criteria and the method used to identify and enroll eligible members;

The active participation rate as defined by NCQA (the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility);

The total number of active members having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the disease management programs; and

Information on the programs' activities, benchmarks, and goals; the number of disease management cases closed due to non-compliance with treatment plans; and a description of activities aimed at engaging members and reducing non-compliance rates.

15. An analysis and evaluation of the health plan's claims processing and Management Information System.

16. An analysis and evaluation of the multilingual services provided, to include, at a minimum:

A count by language of how many members declared a language other than English as their primary language;

A summary by language of translation services provided to members (oral and in-person);

A count of members identified as needing communication accommodations due to visual or hearing impairments or a physical disability;

A summary of services provided to members with visual or hearing impairments or members who are physically disabled (Braille, large print, cassette, sign interpreters, etc.);

An inventory by language of member material translated;

An inventory of member materials available in alternative formats; and

A summarization of grievances regarding multilingual issues and dispositions.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.13.

The Quality Improvement department, with input from other departments within the health plan (as applicable), prepares an Annual Evaluation that contains all the required components and data. These have been submitted in a timely manner in the required format and the content follows the outline and data requirements as outlined by MO HealthNet.

2.22.14 Suspected Fraud or Abuse Reports: The health plan shall provide quarterly reports of suspected fraud or abuse cases to the state agency using the format required by the state agency and in keeping with the requirements described herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.14.

2.22.15 Annual Subcontractor Oversight Reports: The health plan shall submit an annual subcontractor oversight report that reflects the health plan's monitoring activities in the previous year for each health care service subcontractor and any corrective actions implemented as a result of its monitoring activities. The annual subcontractor oversight reports shall be submitted in the format specified by the state agency (see Attachment 6a Exhibit 6). The report shall contain information concerning the effectiveness and impact of the health plan's quality assessment and improvement strategy. The report must provide information that indicates that data is collected, analyzed, and reported, and health operations are in compliance with State, Federal, and MO HealthNet Managed Care contractual requirements. The report must incorporate multiple year



outcomes and trends. The report must show that the health plan's QA & I program is ongoing, continuous, and based upon evaluation of past outcomes.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.15.

2.22.16 Member Satisfaction Data/Report: The health plan shall submit member satisfaction data to the Department of Health and Senior Services in accordance with 19 CSR 10-5.010, as amended. The health plan shall use the survey instrument specified by the Department of Health and Senior Services and shall fund the cost of the survey.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.16.

2.22.17 Behavioral Health Data: The health plan shall submit reports of behavioral health data using the format and within the timeframe required by the state agency. The 2010 report formats are available in Attachment 6a, Exhibit 7. Attachment 6c identifies the reporting contact. The required template format and/or technical specifications are subject to change. The state agency will provide the required template format prior to each reporting period. The health plan shall ensure use of the correct technical specifications and template for each reporting period.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.22.17.

2.23 Third Party Liability

Third Party Liability is defined as any individual, entity, or program that is or may be liable to pay all or part of the health care expenses of a Medicaid beneficiary. Under Section 1902(a) (25) of the Act, the State is required to take all reasonable measures to identify legally liable third parties and treat third party liability as a resource of the Medicaid beneficiary.

- 2.23.1 Coordination of Benefits: By law, MO HealthNet is the payer of last resort. Therefore, the health plan shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery (i.e., "pay and chase "). The health plan shall act as an agent of the state agency for the purpose of coordination of benefits.
 - a. If the health plan has established the probable existence of liability of a third party health insurance carrier at the time a claim is filed, the health plan shall reject the claim and return it to the provider for a determination of the amount of liability except in certain defined situations referenced below. This rejection is called *cost avoidance*. If a service is medically necessary, the health plan shall ensure that its cost avoidance efforts do not prevent a member from receiving such service and that the member is not required to pay any cost-sharing for use of the other insurer's providers.
 - b. The establishment of liability takes place when the health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability. If the probable existence of a liable third party cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule. When the amount of liability is determined, the health plan shall pay the claim to the extent that payment allowed under the



health plan's payment schedule exceeds the amount of the third party health insurance carrier's payment.

1. If a third party health insurance carrier (other than Medicare) requires the member to pay any cost-sharing (such as copayment, coinsurance, or deductible), the health plan is responsible only for the difference between the Medicaid allowable amount and the payment received from the third party health insurance carrier. If the health plan's subcontractor has negotiated a rate less than the Medicaid allowable amount with the third party carrier, the health plan has the option of paying the member's remaining cost-sharing amount if the health plan has included that provision in the contract with their subcontractor. At no time is the member responsible for any cost-sharing amounts.
2. The health plan's responsibility under subparagraph (1) applies even if services were provided by an out-of-network provider. The health plan may require prior authorization of out-of-network services. The out-of-network provider must agree in writing to accept the amount of the health plan's payment as payment in full prior to the service being provided. If the out-of-network provider does not agree to accept the health plan's payment as payment in full, the health plan shall inform the member verbally and in writing that, due to lack of such agreement, the member will be liable for cost sharing or balance billing amounts to the out-of-network provider, but the member may instead seek services without charge from an in-network provider.
3. For additional clarity on establishment of the health plan's liability, the following examples are provided:
 - A provider submits a charge for \$100 to the health plan for which the Medicaid allowable is \$80. The provider received \$75 from the third party insurance carrier. There is no agreement between the provider and third party insurance carrier that the amount paid by the carrier is payment in full. The provider normally bills all patients with this carrier the remaining balance of \$25. The provider would submit a claim to the health plan indicating the remaining balance of \$25 is owed after receiving \$75 from the third party carrier. The amount the health plan pays the provider is the difference between the Medicaid allowable (\$80) and the carrier's payment (\$75) or \$5.
 - A provider has a charge of \$100.00 for a service for which the Medicaid allowable amount is \$80. The provider has agreed to accept the third party carrier's payment as payment in full with the exception of any cost-sharing. The carrier has an allowable of \$50 with the remaining \$25 to be a contractual write-off. The member's cost-sharing amount is \$25.00. The provider normally bills all patients with this carrier only the cost-sharing amount (\$25). The provider receives \$50 from the third party carrier and submits a claim to the health plan in the amount of \$50. The health plan may pay the difference (\$30) between the Medicaid allowable amount (\$80) and the third party carrier's payment (\$50) or the health plan may choose to pay only the member's cost-sharing amount (\$25), if the health plan has included that provision in the contract with their subcontractor.
 - An out-of-network provider has a charge of \$100 for a service for which the Medicaid allowable amount is \$80 and the payment from the third party carrier is \$50. The out-of-network provider does not agree in writing to accept the difference (\$30) between the Medicaid allowable amount (\$80) and the third party carrier's payment (\$50) as payment in full prior to the service being provided. The health plan shall inform the member, verbally and in writing, that due to lack of such agreement, the member will be liable for the difference (\$50) between the provider's charge (\$100) and the payment from the third party carrier (\$50). If the member chooses to receive the service from the out-of-network provider, the member is responsible for the difference (\$50) between the provider's charge (\$100) and the payment from the third party carrier (\$50). The member may instead seek services without charge from an in-network provider. The health plan pays nothing to the out-of-network provider.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- c. Services referenced in Section 2.6.15 are not the responsibility of MO HealthNet or the health plan if there is a third party payer. The requirement of cost avoidance applies to all covered services except claims for labor and delivery and postpartum care (costs associated with the inpatient hospital stay for labor and delivery and postpartum care must be cost avoided); prenatal care for pregnant women; or if the claim is for a service that is provided to a member on whose behalf child support enforcement is being carried out by the Missouri Department of Social Services, Family Support Division. For these services (other than those referenced in Section 2.6.15), the health plan shall provide such service and then recover payment from the third party health insurance carrier ("pay and chase").
- d. The health plan may retain up to 100 percent (100%) of its third party collections if all of the following conditions exist:
 - 1. Total collections received do not exceed the total amount of the health plan's financial liability for the member;
 - 2. There are no payments made by the state agency related to fee-for-service; and
 - 3. Such recovery is not prohibited by Federal or State law.
- e. The state agency shall provide the health plan with a daily file of third party health insurance carrier information (other than Medicare) for the purpose of updating the health plan's files. The state agency shall continue to perform verification of the health insurance information. The state agency does not warrant that the information is complete or accurate. The file is to be considered a "lead" file to assist the health plan in identifying legally liable third parties. The health plan shall timely notify the state agency of any known changes, additions, or deletions of coverage in a format prescribed by the state agency.
- f. The state agency shall annually perform a data match with the United States Department of Defense to identify members covered by TRICARE. The state agency shall provide the health plan with the results of the data match annually and in a format specified by the state agency. The health plan shall perform post-payment recovery and cost avoidance activities as appropriate based on the information supplied by the data match.

HealthCare USA understands and shall comply with the requirements set forth in Sections 2.23.1(a-f).

At no time will our recoveries exceed the total amount of our liability for the member. We will recover only when there are no payments made by the state agency related to fee-for-service and only when recovery is not prohibited by Federal or State Law.

Monthly, the third-party carrier sends a complete list of all identified FSCs to the Finance department at the Health Plan. This file is forwarded monthly to the state agency in a format agreed upon by the state agency.

The recovery and cost avoidance of data matches made by the state will follow the same guidelines as recovery and cost avoidance of all primary insurance.



- 2.23.2 Casualty/Tort: The health plan shall act as an agent of the state agency for purposes of third party reimbursement pursuant to RSMo 208.215, as amended. In addition to coordination of benefits, the health plan shall pursue reimbursement in the following circumstances: Workers' Compensation, Tortfeasors, Motorist Insurance, and Liability/Casualty Insurance.
- a. The health plan shall take action to identify those paid claims for members that contain diagnosis codes 800 through 999 (ICD 9-CM), with the exception of 994.6, for the purpose of determining the legal liability of third parties so that the health plan may process claims under the third party liability payment procedures specified in 42 CFR 433.139 (b) through (f), as amended.
 - b. The state agency shall perform a data match with the Department of Labor, Division of Workers' Compensation to identify members that the Division of Workers' Compensation has a record of a work-related injury claim. The state agency shall provide the health plan with the results of the data match monthly and in a format specified by the state agency. The health plan shall perform post payment recovery and cost avoidance activities as appropriate based on the information supplied by the data match. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule.
 - c. The state agency shall perform a data match with the State Traffic Accident Reporting System (STARS) of the Missouri Highway Patrol to identify members that the STARS system has a record of a member involved in a motor vehicle accident. The state agency shall provide the health plan with the results of the match monthly and in a format specified by the state agency. The health plan shall perform further validation activities when using information supplied by the data match to ensure the member is in fact the person referenced in the match. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule.
 - d. The health plan shall perform all research, investigations, and payment of lien-related costs, including but not limited to, attorney fees and costs related to such cases.
 - e. If a member initiates a legal action as a result of an injury that occurred during the term of the contract, the health plan may file a lien for reimbursement for medical services provided to treat the injury that occurred during the term of the contract even after the contract has ended.
 - f. If the health plan initiates a lien during the term of the contract but the case remains unsettled at the end of the contract, the health plan may continue pursuit of the action for the medical services related to the injury that were provided during the term of the contract.
 - g. If the member enrolls with a new health plan while legal action is pending, each health plan may file separate liens to recover reimbursement for medical services related to the injury that were provided during the respective contract periods.

HealthCare USA understands and shall comply with the requirements of Section 2.23.2(a.-g).

The health plan has contracted with a third party vendor who specialized in Medicaid subrogation recovery to determine liability of third parties in cases including but not limited to:

- Workers Compensation
- Tortfeasors
- Motorist Insurance
- Liability/Casualty Insurance.

HealthCare USA's third-party vendor receives monthly data feeds of paid medical claims experience, as well as member and provider demographic information. HealthCare USA's third-



party vendor investigates diagnosis and trauma codes for potential subrogation cases by using proprietary software to perform automated analysis of:

- Claim data, based on review of all levels of ICD-9-CM diagnosis codes (not just the primary diagnosis code) and CPT codes within all episodes of care
- Cost of treatment
- Demographics and eligibility associated with an individual
- Any related claims matters

A subrogation recovery occurs when HealthCare USA's third-party vendor determines that another party was responsible for the insured's injuries and medical expenses and seeks reimbursement from the responsible party. The third party vendor sends correspondence to members to obtain clarification of the facts surrounding the medical expenses. If necessary, HealthCare USA's third-party vendor sends second, third, and fourth information requests at specifically-defined intervals. If the individual does not respond, HealthCare USA's third party vendor attempts telephone contact and may use various investigative tools, such as court docket searches, first-responding department, providers, other media sources and querying a national tort database (which provides filed third party liability claims information). After gathering all pertinent data, HealthCare USA's third-party vendor determines whether or not other insurer responsibility exists and any identified opportunities are pursued.

Additionally, the health plan provides leads from three sources to the third party vendor:

- State
- Member's Attorney General
- HealthCare USA Health Services department
- State Traffic Accident Reporting System (STARS)

Frequently, the health plan will receive notification from the state that an attorney has inquired about a member's insurance status. When the individual is a member of our plan, the state will forward a copy of the response to the attorney, to the health plan. That lead is then forwarded to the third party vendor by the liaison in the Finance department for investigation. When a member's attorney sends a letter to the health plan inquiring about payments made on behalf of his or her client, the inquiry is forwarded to the third party vendor for investigation, by the liaison in the Finance department. Finally, if a nurse in the pre-authorization department identifies a possible subrogation case, he or she will forward the information to the Finance department for communication to the third party vendor for investigation.

The third-party vendor determines if another party should be responsible for the member's injuries and seeks reimbursement from the responsible party as allowed by the applicable Medicaid agency contract and law. All cases are reviewed and handled by an attorney at the third party vendor to ensure compliance with all state and local laws, and to maximize our compliance. Refunds are sent directly to the third-party vendor who then submits a monthly report and refund, net of the contractual fee, to HealthCare USA. For reporting purposes, HealthCare USA processes the refunds through the claim system by attaching the corresponding claims that comprised the subrogation case. HealthCare USA's third-party vendor furnishes multiple monthly reports detailing subrogation activity, including:



- Cases open and under investigation
- Closed cases
- Member response reports
- Member complaint reports
- Major case reports
- Any additional state reporting requirements

2.24 Reinsurance

The state agency will not administer a reinsurance program funded from capitation payment withholdings.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.24. While HealthCare USA has sufficient available capital to meet all of the requirements for Missouri Medicaid coverage, reinsurance will be purchased for the Missouri Medicaid business.

2.25 Reserving

As part of its accounting and budgeting function, the health plan shall establish an actuarially sound process for estimating and tracking incurred but not reported costs. The health plan shall reserve funds by major categories of service (e.g., hospital inpatient; hospital outpatient) to cover both incurred but not reported, and reported but unpaid claims. As part of its reserving methodology, the health plan shall conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

HealthCare USA understands and shall comply with the requirements of Section 2.25

HealthCare USA has a sound actuarial reserving process for estimating and tracking health care costs that have been incurred but not recorded. The Chief Financial Officer has direct accountability for these processes and conducts monthly reviews of the incurred but not reported liability to assess the reserving methodology and makes adjustments as necessary. The HealthCare USA Chief Actuary reviews the monthly reserve methodology. In addition, a semi-annual review of the reserve methodology is performed by an outside auditor.



2.26 Claims Processing and Management Information Systems [4.4.12]

2.26.1 General Requirements: The health plan shall have a Claims Processing and Management Information System (MIS) capable of meeting the MO HealthNet managed care program requirements and maintaining satisfactory performance throughout the term of the contract. The health plan shall have the capability to transmit and receive data, support provider payments, and comply with data reporting requirements as specified herein. The health plan shall have the capability to process claims, retrieve and integrate enrollment data, assign primary care providers, maintain provider network data, and submit encounter data. The Claims Processing and MIS should be of sufficient capacity to expand as needed due to member enrollment or program changes.

4.4.12 Claims Payment Processes: The offeror shall submit the following information regarding the offeror's claims payment processes: (2.26)

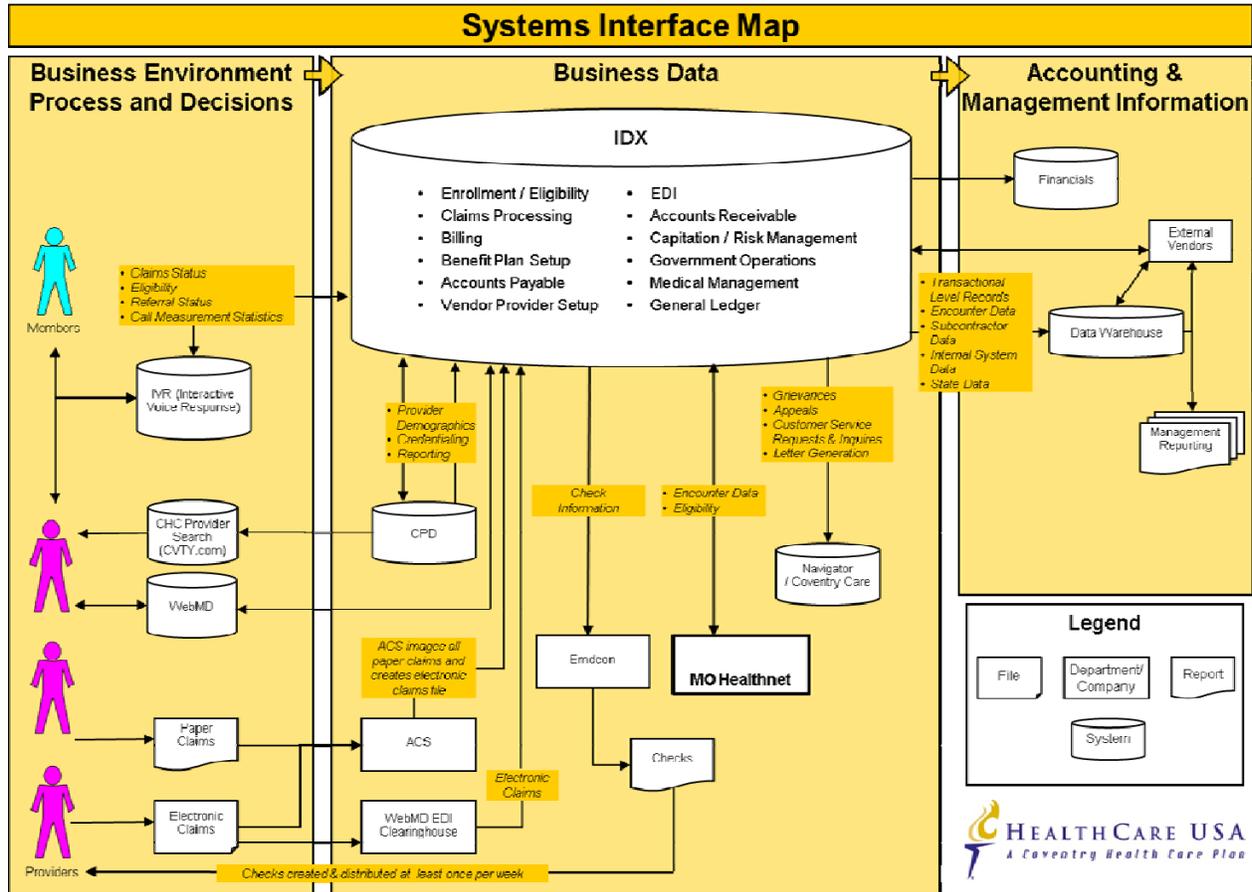
- c. A description of the offeror's claims processing and management information system functions, including, but not limited to information about the offeror's liability management practices regarding its "Incurred But Not Reported Claims" and "Received But Unadjudicated Claims".
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.1 and 4.4.12(c).

figure below illustrates the major system interfaces and information flows within HealthCare USA major IT functions.



Figure 2- 29: System Interface Map



The following systems description illustrates how HealthCare USA systems interface with other entities and how our various components support all major functional areas.

IDX—In-Plan Services, Maternity Care Payments, Provider Network, Service Access, Claims Payment and Processing (including Maternity) and Encounter Data Reporting

Our core system, IDX, serves as the backbone of managed care processing and uses powerful relational database technology. Navigator (our internal communication system), Navigator Care (Care Coordination Management System), Web portals, Coventry Provider Database (CPD), and the Coventry Data Warehouse (CDW) all reference this system for information such as eligibility, authorizations and claims.

IDX is a fully integrated, scalable application that encompasses all aspects of our business. This is our core transactional system that manages in-plan services, benefit usage tracking, enrollment and eligibility, provider contracts, fee schedules, provider network affiliations, claims payment and processing (including Maternity), encounter data reporting, premium billing and reconciliation.



IDX updates Navigator and Navigator Care eligibility data, authorization, and claims data each time a user requests a view of one of those items. Each IDX field is individually mapped to a corresponding field in Navigator. HealthCare USA is supported by the Coventry Health Care (our parent company), IT infrastructure, which is referenced throughout this section.

The IDX architecture is Client/Server based and highly scalable. The health plan servers are clustered and share redundant, network-attached storage devices. IDX uses high performance post-relational database technology that is suited to heavy transaction loads and high growth requirements. IDX has accommodated the continuous growth of all lines of business for over a decade and is ideally suited to accommodate our anticipated growth well into the future.

Navigator—Member Services, Complaint/Grievance/Fair Hearings, Service Access

HealthCare USA has designed and built its own custom system, (Navigator – a customer relationship management tool) which is used to document all contacts from customers and to track and manage all work related to those contacts. Navigator documents and tracks incoming and outgoing contacts. Any required follow-up or additional activity related to the contact is auto-generated to the appropriate area for fulfillment. The system monitors for evidence of completion of the activity.

Navigator maintains individual contact histories for all members, employer groups and providers, as well as external entities. Each and every customer contact coming into or out of each Coventry health plan, including correspondence and e-mail contacts, is maintained for a comprehensive contact history regarding the customer.

Navigator interacts with the Coventry source administrative and claim system, IDX, to provide real-time data regarding eligibility, contracted providers, authorizations and claims.

Navigator contains modules that apply specifically to appeals and clinical management. These modules are accessed through special user permissions to protect the data. Both have a selection of reports that provide information specific to the topic. The appeals module manages all aspects of an appeal from a member or provider from initiation to resolution, including timeliness of response. Data elements required for state-mandated reporting are provided for appeals.

Navigator Care – Coordination of Care, Quality Management/Utilization Management, Special Needs

Condition/disease management and complex case management are tracked in a dedicated module called Navigator Care. Navigator Care interfaces with IDX to locate candidates for these programs and solicit participation. Navigator Care monitors their ongoing participation and contact with health plan case managers. Programs supported include: 14 Disease Types (Asthma, Diabetes, etc.), Case Management and Condition Management, Member Reminders (Flu Shots, disease-specific, etc.) and Medicaid Wellness (EPSDT).

Navigator Care contains over 70 member assessment questions that are used as detailed analytic tools for monitoring member goals and self management. Case managers conduct goal planning with members to support member self-management. This information is available to providers via www.directprovider.com. A member's provider has the ability to update/comment on the member's progress and suggest alternative goals/objectives.



Coventry Provider Database (CPD) – Provider Network and Services

CPD maintains provider information for over 860,000 providers, of which over 17,000 are Medicaid providers, and captures key provider data (PIN, multiple office addresses, products, practices, etc.), ensuring data quality and preventing duplication. The CPD is the source of HealthCare USA's HEDIS[®] provider measurement data, which is audited according to NCQA HEDIS[®] Compliance Audit[™] specifications. This application is used to generate provider directories, both on paper and on the Web. Web directories are updated on a weekly basis, complete with languages spoken, directions to offices and whether new patients are being accepted.

CPD is the master system for provider credentialing and contracts. Once providers are entered in CPD, they may be entered for claims processing and payment in IDX. It is also the source system for www.directprovider.com, Coventry's provider Web portal (described below). In addition, customer service representatives are able to view CPD information through Navigator when providers call for support or information.

Directprovider.com – Provider Services

Directprovider.com is HealthCare USA's secure provider portal. This portal offers registered providers the ability to check a member's eligibility and benefits, inquire about claims, submit authorizations, view member ID cards and view remittance advices. This service is available at no cost. Directprovider.com is linked to the IDX system for the most recent data and status updates.

My Online Services (MOS) – Member Services

My Online Services is HealthCare USA's member portal. It is an easy-to-use member-friendly tool that allows members to access customer service. My Online Services offers the user the ability to view his/her personal and eligibility information; update his/her PCP; view and print his/her ID card; view benefits, claims and authorizations; search for a provider or specialist; access decision support tools such as hospital quality comparisons, respond to questions through a Health Risk Assessment (HRA) and enter personal health information through a Personal Health Record (PHR).

MOS draws its information in real time from the IDX system, so the user may see the most up-to-date data upon logging onto the portal. If a member requests to update his/her PCP or address information, the request is routed to Navigator for review and final update by a customer service representative. The request and follow-up are tracked within Navigator, and the actual change is recorded within IDX for full traceability.

Coventry Data Warehouse (CDW) – Reporting, Data Transmissions, Pharmacy

The CDW is an Oracle-based enterprise-wide data repository supporting decision making at the health plan and corporate levels we use to meet State and Federal reporting mandates. CDW derives its data from the transactional systems and integrates third party encounter data from a variety of areas, such as from a state's contracted pharmacy vendor. The CDW is refreshed on the last day of each month with a snapshot of application system data.



The warehouse supports reporting via multiple data sources. These data sources are accessed by management and staff to develop reports and further analyze data to monitor and constantly improve the delivery of services to our membership. Any external claims data such as Behavioral Health claims and additional third-party claims can be stored in CDW which allows a strengthened reporting relations between HealthCare USA and its subcontractors and affiliate.

These systems remain synchronized using interfaces, rather than manual data entry. This approach ensures that data integrity and consistency are maintained.

Figure 2- 30 below summarizes system interfaces and includes the trigger/type of interface and frequency

Figure 2- 30: Summary of System Interfaces

Interface	Source	Target	Frequency	Trigger	Direction	Type
Eligibility	IDX	Navigator	Real Time	Automated	One Way	P2P*
Eligibility	IDX	Navigator Care	Real Time	Automated	One Way	P2P
Eligibility	IDX	My Online Services	Real Time	Automated	One Way	P2P
Eligibility Inquiry & Response	IDX	Directprovider.com	Real Time	Automated	Bi-directional	Engine
Eligibility Inquiry & Response	IDX	Emdeon Office	Real Time	Automated	Bi-directional	Engine
Eligibility	IDX	CDW	Batch, monthly	Automated	One Way	P2P
Eligibility Updates	State	IDX	Batch, daily	Automated	One Way	Engine
Eligibility	IDX	State	Batch, daily	Automated	One Way	Engine
Authorizations	Navigator Care	IDX	Batch, daily	Automated	One Way	P2P
Authorizations Inquiry & Response	IDX	Emdeon	Batch, daily	Automated	One Way	Engine
Authorizations Inquiry, Update & Response	IDX	Directprovider.com	Real Time	Automated	Bi-directional	Engine
Authorizations Update	Directprovider.com	IDX	Real Time	Automated	One Way	Engine
Authorizations	IDX	My Online Services	Real Time	Automated	One Way	P2P
Authorizations	IDX	CDW	Batch, monthly	Automated	One Way	P2P
Reports	IDX	Directprovider.com	Batch, monthly	Automated	One Way	P2P
HRA Results	My Online Services	CDW	Batch, Daily	Automated	One Way	P2P
HRA Results	CDW	Navigator Care	Real Time	Automated	One Way	P2P
Claims Inquiry & Response	Emdeon Office	IDX	Real Time	Automated	Bi-directional	Engine
Claims Inquiry & Response	Directprovider.com	IDX	Real Time	Automated	Bi-directional	Engine
Claims	IDX	CDW	Batch, monthly	Automated	One Way	P2P



Interface	Source	Target	Frequency	Trigger	Direction	Type
Remittance Advice	IDX	Directprovider.com	Batch, twice weekly	Automated	One Way	Engine
Remittance Advice	IDX	Emdeon Office	Batch, twice weekly	Automated	One Way	Engine
Encounters	IDX	State	Batch, monthly	Automated	One Way	Engine
Claims View	IDX	My Online Services	Real Time	Automated	One Way	P2P
Provider ID File	CPD	State	Batch, weekly	Automated	One Way	P2P
Provider ID File	State	CPD	Batch, weekly	Automated	One Way	P2P
Enrollment Reconciliation	IDX	State	Batch, monthly	Automated	One Way	Engine
Premium Payment	State	FTP site	Batch, monthly	Automated	One Way	P2P
Lab	Lab vendor	CDW	Batch, monthly	Automated	One Way	P2P
Pharmacy	Pharmacy vendor	CDW	Batch, weekly	Automated	One Way	P2P
Behavioral Health	BH vendor	CDW	Batch, weekly	Automated	One Way	P2P

* P2P = POINT-TO-POINT





Figure 2- 31 illustrates HealthCare USA Network.

Figure 2- 31: Network Diagram

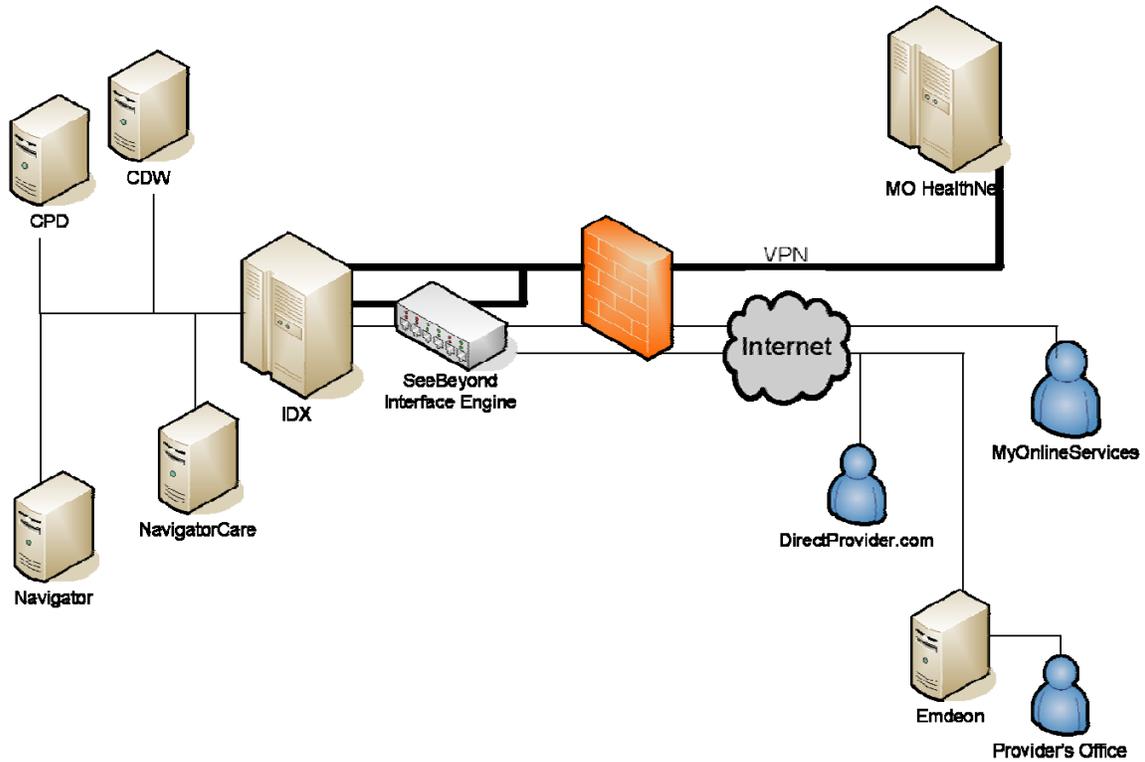
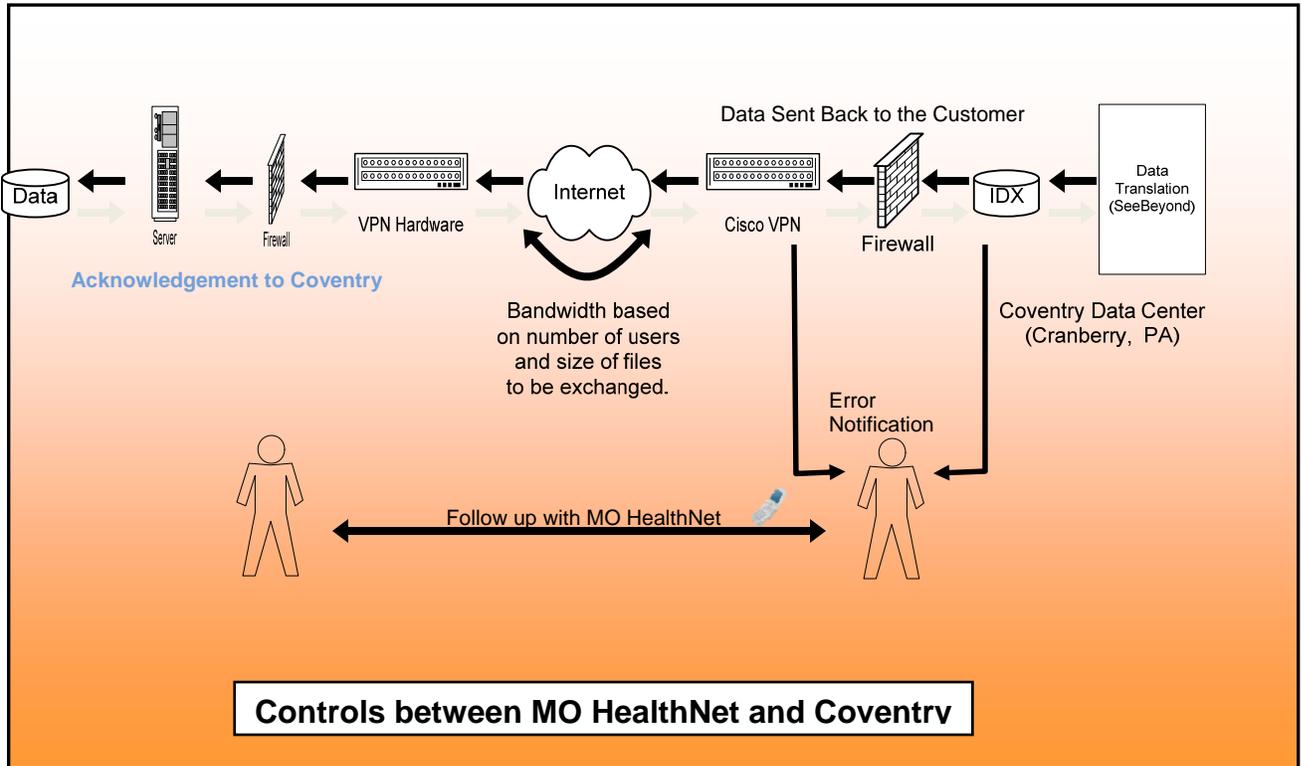




Figure XX illustrates HealthCare USA internal controls.

Figure 2- 32: Internal Controls Diagram



Provider Contract Installation:

In order to process medical claims appropriately, the IDX system uses provider contract data. Consequently, provider contract installation is an integral component of claims processing. Installation of provider contracts is described below.

A corporate department, Provider Systems Administration (PSA) performs this function. For purposes of this process, “contract” describes a unique reimbursement agreement with a facility, ancillary provider, individual practitioner, or a group practitioners that may follow the same contracted terms.

In some cases, individual practitioners or group practices can simply be linked to an existing rate structure in IDX for claims payment. In these instances, an EPIF (Electronic provider information form) could be presented to PSA through the CPD process (Coventry Provider Database), EPIFS are submitted by the Provider Relations Department to PSA. Linking a provider to a contract via an EPIF submission would indicate the contract set already exists in IDX, and therefore previously passed the required testing steps as outlined below in the Provider Contract Installation Process.

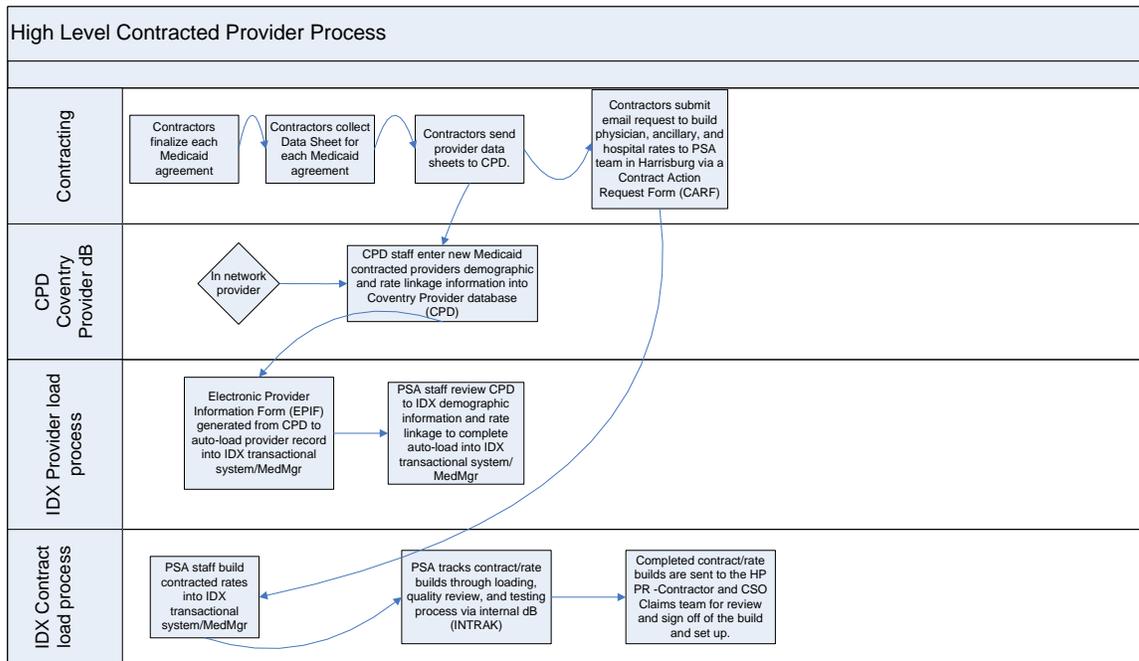


Provider Contract Installation Process:

HealthCare USA’s Provider Relations team negotiates each contract and obtains a signed contract with each provider or group. Provider Relations translates the contract terms onto a Contract Action Request Form (CARF) and forwards the appropriate CARF document and a copy of the contract rate sheets (from the original legal contract) to PSA.

Figure 2- 33 illustrates the provider contract maintenance process.

Figure 2- 33: Provider Contract Maintenance Process



Provider Network Data Maintenance

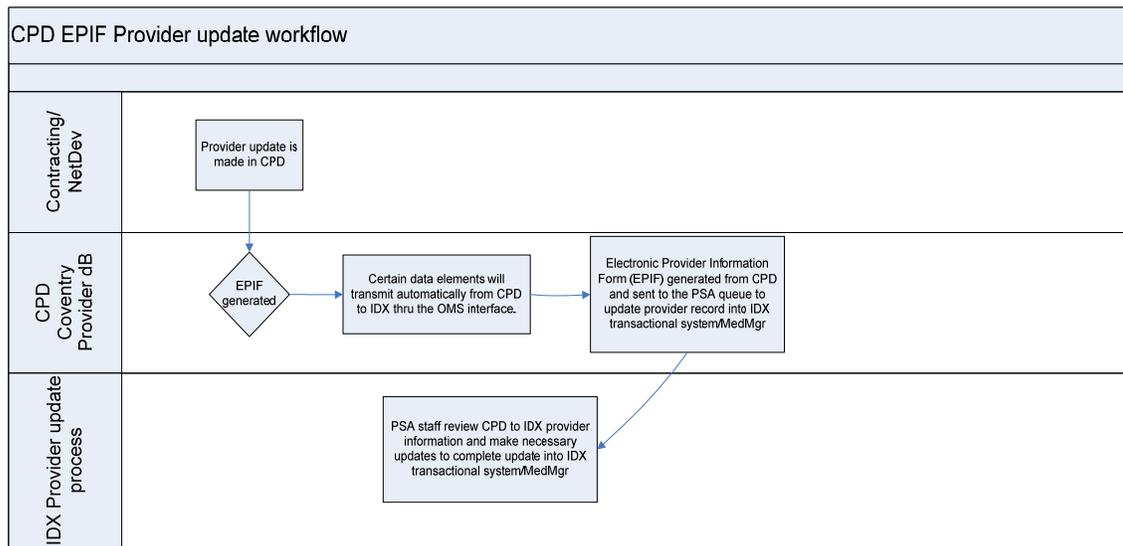
Coventry Provider Database(CPD) is the master system for provider credentialing and contracts. Once providers are entered in CPD, they may be entered for claims processing and payment in IDX. It is also the system of record for directprovider.com, HealthCare USA’s provider website.

IDX maintains provider contract terms within the system, including their network affiliation(s), payment terms, late claim penalties, etc. In fact, network usage is one of the many utilization reports available for MO HealthNet’s review.

Figure 2- 34 illustrates the Provider Network Data Maintenance Process.



Figure 2- 34: Provider Network Data Maintenance Process



Enrollment Process

HealthCare USA currently processes over one hundred (100) electronic enrollment files from a variety of sources. In each instance, HealthCare USA implements the data exchange format and transmission standards required. Consequently, electronic enrollment files are received and processed on a daily, weekly, and monthly basis, depending on the needs of the MCO.

All files are processed and loaded into the IDX system within 24 hours of receipt.*

* HealthCare USA has processes in place to compare the information stored in IDX system and the information in the reconciliation files received from MO HealthNet. If the variance level is greater than 1.5%, our enrollment department reports this immediately to the State to confirm the information sent on the file is accurate. The subsequent enrollment files including the file in question are held until the state has reviewed and/or approved the data in the files.

If any issues arise during the automated member loading process, an alert is sent to the IS Enrollment Support area as well as the enrollment department itself. The enrollment department is responsible for reviewing, researching and manually loading members in those instances where they could not be loaded electronically. In order to process enrollment data for MO HealthNet, we will duplicate its current HIPAA-compliant enrollment processes and incorporate any specific requirements.

HealthCare USA's electronic enrollment process utilizes intelligent member matching logic to detect and prevent the loading of duplicate members into the system. Members are matched on name (full or partial), Medicaid number, date of birth, gender, and social security number. Members matching less than four (4) criteria are routed to the enrollment department for exception processing. The enrollment department is also responsible for identifying suspect duplicate members. Every effort is made to ensure that duplicates are not loaded. However, if it should occur, there is a process in place to de-activate the duplicate record and link it to the active member record to ensure history is retained via the active member. The process is



performed by experienced staff utilizing tools developed specifically for this process and requires management oversight and approval.

HealthCare USA has established processes with MO HealthNet to support electronic enrollment and other data exchanges for MO HealthNet. MO HealthNet currently sends HealthCare USA four different electronic enrollment files. The first is a full weekly HIPPA 834 file for which HealthCare USA added termination by omission logic. The second is a daily HIPPA 834 file with future effective dates. The third and fourth are a proprietary health risk assessment file and a coordination of benefit file which is received on a daily basis. The proprietary files are electronically loaded. The enrollment department completes a standard state form on each newborn as well as a weekly summary report to the appropriate county office. In addition, our enrollment programs accept, process, and load day specific eligibility.

Liability Management Practices

The practices are monitored monthly by HealthCare USA and Coventry Health Care.

IBNR

HealthCare USA uses actuarially sound methodology for estimating claims liabilities. Each month, paid claims data is obtained to populate lag models. Separate models are produced for Hospital Inpatient, Hospital Outpatient, Physician and Dental incurred but not reported (IBNR) estimates. Completion factors are calculated based upon paid claims and trend data, and IBNR estimates are produced by each model.

The models are reviewed individually and in total through a monthly IBNR meeting attended by teams of our actuarial personnel, finance and executive teams. In addition, to a review of the models, factors such as claims inventory levels, pending claims, and other potential claim liabilities are discussed and analyzed to ensure their inclusion in the reserve setting process. The meeting also provides assurance that the objectives of HealthCare USA's SOX 404-compliant Claims Reserve policies and procedures have been met.

The actuarial and finance staffs make use of monthly checklists to ensure that consistent procedures are followed each month. Reserves are not considered final until completion of the IBNR meeting and approval by our management.

RBUCS

HealthCare USA reviews all pending claims on a weekly basis in order to monitor received but unadjudicated claims (RBUCS). All pending claims for HealthCare USA are loaded into secure and protected reporting databases maintained by the Claims and Service Reporting group. Only the Claims and Service Reporting Group can make any changes to the data or table structures in the databases. Additional users are only granted "Read Only" access. IT Security maintains access to these secure locations. In order to gain access to protected share drives, each user must have a director's approval. The pending claim databases are used only for reporting purposes and managing workload. All pending reports are refreshed daily and cumulatively.

Aging reports track each claim and the associated dollars of that claim. At least once a quarter, the total number of pending claims for each database is compared to that in the "Pend Queues" within IDX Managed Care Application (IDX MCA). Each database is reviewed for



reasonableness. This is an informal review that is performed online in IDX MCA by the Managers of Service Operations and is not typically documented unless issues are identified. All pending claims are held in “Pend Queues” within IDX MCA. The Claims and Service teams are responsible for working the Pend Queues daily. Each team works, as necessary, with other areas of the company to resolve the pend issue based on the reason for the pend. All teams work pending claims in a first-in/first-out order. HealthCare USA is responsible for working pending claims in conjunction with HealthCare USA’s associated State’s interest legislation. Claims will pend for many reasons, including filing issues, provider contract issues, member eligibility issues and other criteria set in accordance with HealthCare USA’s policy.

2.26.2 Resource Availability for Systems Changes: The health plan shall employ or have available, the resources necessary to make modifications to claims processing edits or expansion of MIS capabilities as a result of changes in MO HealthNet Managed Care policies and/or procedures. The state agency will make every effort to give the health plan sixty (60) calendar days notice of changes in the MO HealthNet Managed Care Program that may require the health plan to make system changes in order to comply.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.2.

Since 1995 HealthCare USA has successfully modified its claims processing edits and other MIS capabilities to meet changes in MO HealthNet Managed Care policies and procedures. For example, we successfully modified our claims processing edits and capabilities to meet processing and reporting requirements that became effective January 1, 2011 under Missouri Revised Statute 376.383 (2010 House Bill 1498), commonly known as the Missouri Prompt Pay Law.

HealthCare USA will continue to work closely with the State of Missouri to fully understand and incorporate modifications related to changes in the Missouri HealthNet program within a 60 day timeframe. Coventry’s skilled, in-house programming and development staff work with HealthCare USA leadership to tailor our systems to meet evolving needs. These changes include, but are not limited to changes in:

- Benefit plan design
- Reporting formats
- Claims processing





2.26.3 Electronic Claims Management (ECM) Functionality: The health plan shall have in place an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.). As part of this ECM function, the health plan shall also provide on-line and phone-based capabilities to obtain claims processing status information and shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

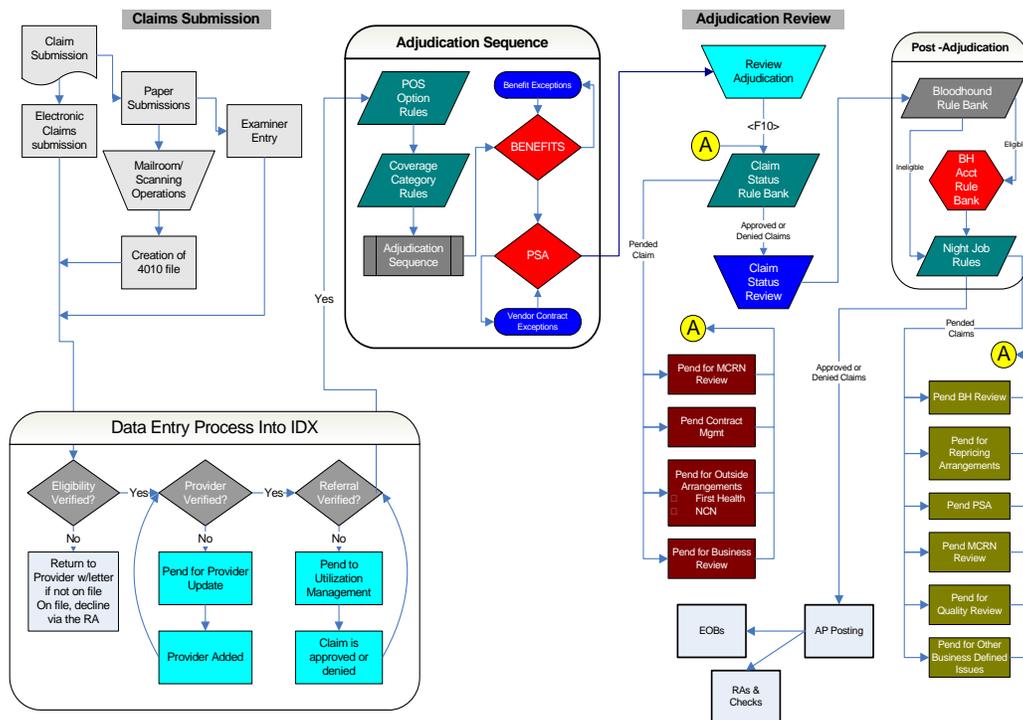
4.4.12 **Claims Payment Processes:** The offeror shall submit the following information regarding the offeror’s claims payment processes: (2.26)

- a. Information describing the offeror’s claim adjudication processes. The offeror shall provide a flow chart or written description that details the flow of claims from receipt until payment. Information shall be provided documenting the offeror’s audit trail of all claims that enter the system and any review processes that are in place.
- b. The offeror shall document the offeror’s past and current performance with regard to the timely payment to in-network and out-of-network providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.3 and 4.4.12(a-b).

Claims Processing System

Figure 2- 35: Claim Adjudication Flow





Monday through Saturday we receive electronic and paper claims in batches multiple times throughout the day. Batches are logged, loaded and processed in IDX in real time.

Paper claims received by our domestic subcontracted data vendor must be submitted into the claim system within 48 hours of the received date and marked with the actual received date, with no individual claim exceeding 72 hours. Once received and transferred to an electronic format (most by optical character recognition to expedite the process) claims are prepared and electronically submitted twice a day.

Claims submitted electronically pass directly through HealthCare USA's designated clearinghouse, Emdeon, or indirectly through use of the Provider's own clearinghouse where they are reviewed and edited. Electronic claims received through the clearinghouse transfer are entered into the system within 24 hours. All Electronic Data Interchange (EDI) claims that pass the review are forwarded to HealthCare USA along with statistical reports related to the claims submitted. Automated processes check the claim file for HIPAA compliance (ForeSight) then load claims that pass into the IDX system for processing. Any issues are reported to the clearinghouse for correction and resubmission according to service level agreements. The clearinghouse and EDI Team receive email notifications of all exception situations.

Once ForeSight validates the electronic claims transactions, the IDX system verifies the validity, integrity, and completeness of the data, including:

- Member matching and eligibility to confirm member eligibility on the dates of service; edits identify members who are retroactively enrolled beyond the start-up date of operations
- Provider matching logic to validate NPI against provider name and validate potential mismatches; HealthCare USA has formal procedures to educate providers with recurring billing errors to minimize issues
- Covered services review to confirm that billed services are covered by the member's benefit plan and determine if claims should pend for post-service review of medical necessity
- Valid service provider review to confirm a provider is contracted or has received authorization to provide out-of-network services (for example, family planning)
- Prior authorization review to match claim with approved authorization; HealthCare USA maintains service authorization requirements on IDX by procedure or procedure code range, and accommodates variations within benefit plan and by provider.
- Quantity of service review to confirm if quantity exceeds the authorized limit or benefit limit
- Third party liability review to check for other insurance, if other insurance was billed, if service is pay-and-chase, and if an EOB from the other insurer was submitted with the claim
- Duplicate review to confirm whether the claim was previously submitted and paid
- Possible duplicate—suspends claims with potential duplication of billed services for manual review
- Contract terms review to apply fee schedules/reimbursement methods from the provider's contract.



If the claim is approved or denied, it then goes through a series of rules that seek additional opportunities to pend the claim for review by a claims examiner.

HealthCare USA, working with a team of technical experts, applies a meticulous system process to scrub each claim prior to release. Rules used include.

- Real Time Edits to apply MCO benefits, provider contracts and referral requirements to the claim. The edits applied will assign payment or denial to each claim line.
- Duplicate Table to identify exact and possible duplicate claim and claim line submissions by reviewing the member's claim history. The Duplicate Table will assign each claim or claim line a hard duplicate denial, a possible duplicate pend status, or allow the claim to pass as an original submission.
- Rule Banks to assist in determining the claim's data element meets the conditions specified in one of the rules, the action specified by the rule is carried out by the system. The action specified by the rule are the resulting claim status to be assigned to the claim.
- Night Jobs to change the final status of an approved or denied claim to a pend or suspend status. Night Job rules examines line by line the individual items and sub-procedures that were involved in performing an overall procedure.
- Bloodhound Technologies Interface (BHI); a claim editing vendor that supplies edit recommendations to HealthCare USA claims in a real-time fashion. Claim line combinations and the member's claim history are considered. BHI may assign a claim line denial or assign a pend status for further coding review.

Claims that are validated to be approved or denied are batched to be run through the Accounts Payable process.

If the above rules do not lead to further investigation, the claim is considered adjudicated and sent to the IDX Accounts Payable (IDX "AP") module. All claims requiring further investigation are sent to the appropriate team for review and manual adjudication by an examiner. After appropriate steps are taken and the claim is approved or denied by the examiner, the claim re-enters the Night Job process to check if another rule applies. If another rule is applied, the claim again pends for examiner review. This process continues until the claim is no longer affected by Night Job rules. On average, HealthCare USA processes 94.1% of claims within 15 days from the date of receipt, with a financial accuracy of 99.7% and less than 5% adjustment rate due to retroactive processing. Once this process is complete, the claim is either denied or sent to IDX AP to prepare the payment, the remittance advice, and explanation of benefits to be sent to the provider and/or member

IDX contains multiple system edits to ensure that critical fields are valid. IDX then performs the actual claim payment calculation based on these valid fields. Critical system edits to determine the appropriate calculation of claims are tested and documented as part of this process.

Claims Screening

HealthCare USA also uses industry-standard, integrated claims auditing tools to capture provider submission errors and verify the clinical accuracy of professional claims.



The IDX system flags certain claims (non-inpatient claims) to go through an adjudication process using BHI software. BHI is a claim editing vendor that supplies edit recommendations on HealthCare USA claims in real-time. This software audit corrects coding combinations. With the advent of fee schedules, procedure codes determine provider reimbursement, and clinical accuracy is essential. BHI evaluates the non-inpatient claims against a set of rules to determine any submission errors by the provider. The edits are then applied to the claims in IDX to expedite and ensure claim payment accuracy. Intentional or not, many providers inappropriately increase their reimbursement by submitting claims with incorrect procedure codes. Many of these inaccuracies result from coding practices such as unbundled procedures, separate billing for incidental and mutually-exclusive procedures, and the incorrect use of coding rules. HealthCare USA uses this as an additional measure to support fraud and abuse prevention and investigation.

BHI helps expedite prompt payment to providers by reducing the number of claims pended or denied. BHI examines the coding relationship between the codes submitted to ensure procedural coding rules are correctly applied. If a claim is not in accordance with any of its criteria, the claim is pended for review and forwarded to the appropriate department for resolution.

Once a claim has gone through the BHI software, iHealth software reviews the claim for correct coding based on the Correct Coding Initiative (CCI), which follows Medicare and Medicaid coding guidelines.

The iHealth program aligns HealthCare USA's payment policies and claims adjudication system with nationally-accepted coding standards and guidelines of the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). It enhances the efficiency of HealthCare USA's clinical coding and medical payment policy application for professional and institutional claims. This implements an additional code review step through an interface with the code auditing vendor iHealth Technologies. iHealth Technologies' software application ensures accurate professional claims payment, and applies customized medical payment policies.

On a daily basis selected claims will be extracted and forwarded to iHealth in files for possible edit review and history. The daily claims file(s) are returned within 24 hours with the recommended edits from iHealth. Applicable edits are applied and claims are finalized.

Pended Claims

All pended claims are held in "Pend Queues" within IDX MCA. The Claims and Service teams are responsible for working the Pend Queues daily. Each team works with other areas of the company to resolve the pend issue based on the reason for the pend. All teams work pended claims in a first-in/first-out order. HealthCare USA is responsible for working pended claims in conjunction with HealthCare USA's associated State's interest legislation. Claims pend for many reasons, including filing issues, provider contract issues, member eligibility issues and other criteria (such as high-dollar claims) set in accordance with HealthCare USA's policy.



Duplicate Claim Logic

By using duplicate claims logic, claims are reviewed line by line to determine if any duplicates exist and predetermined weights are consulted to determine the claim status. For the entire claim to be denied as a duplicate, all claim lines must be duplicated; otherwise the claim is partially approved. This determination is reached based on:

- Line Procedure Code
- Vendor TIN/NPI
- Date of service
- Provider Specialty
- Modifiers (1st, 2nd, 3rd and 4th)
- Denied Duplicate Claim vs. Pend Possible Duplicate

Also, the claims duplicate logic allows claims to be processed in certain circumstances based upon the modifiers associated with the claim. The modifier priority code is also a component of the duplicate logic. By including a priority code in the duplicate logic check, claim lines with a soft pend duplicate score and modifiers having the same priority code continue to process without being pended as a duplicate.

High-Dollar Claim Review

All claims that generate a payment over certain thresholds are pended by IDX and placed into a high-dollar queue.

The monetary thresholds currently used by the company are \$3,000 and \$50,000. These thresholds are applied to the approved payment amount instead of the billed amount to ensure timely and accurate payments to our Providers. Once the claim is pended, the claim is reviewed by a minimum of two claim examiners for claims ranging from \$3,000 to \$50,000.

In addition, HealthCare USA has implemented a quality audit process for claims with approved dollars between \$1,000 and \$3,000. The claim pends to a specific status for review of process and payment. If the claim is determined to be correct after the audit, the examiner will release the claim for payment.

For review of claims approved between \$3,000 to \$40,000, two claim examiners review the claim for processing and payment accuracy. Claims with an approved amount between \$40,000-\$49,999 will also require Health Plan approval.

Claims in excess of \$50,000 are sent to the Corporate Medical Management Department for additional review. The process involves review of the itemized billing statement to ensure accuracy of billed charges. Additional considerations during review of the itemized bill include review for:

- Billing errors and/or, clinically suspicious billing
- Dug charges
- Duplicate charges/services



All claims that reach the high dollar audit review threshold are imported into a database for review by a High Dollar Review nurse. Once the High Dollar Review is completed the initial review of applicable claims that meet HealthCare USA suggested thresholds, claim information is entered into the High Dollar database, including the comment section of the claim in IDX. Approval can be made by the High Dollar team on behalf of the HealthCare USA based on predetermined thresholds. If the claim is above HealthCare USA threshold; the approval must come from HealthCare USA prior to being sent to the CSO for release. Once HealthCare USA approves it via e-mail, the CSO releases the claim for payment. The release authority for claims is:

- Claims paying greater than \$25,000.00 require the release authority of a Senior Claim Specialist or Senior Integrated Claim Specialist
- Claims paying greater than \$50,000.00 require the approval of a nurse and HealthCare USA
- Claims paying greater than \$75,000.00 require the release authority of a Supervisor
- Claims paying greater than \$150,000.00 require the release authority of a Business Manager
- Claims paying greater than \$350,000.00 require the release authority of a Director
- Claims paying greater than \$500,000.00 require the release authority of a Vice President
- Claims paying greater than \$750,000.00 require the release authority of a Senior Vice President.

Quality Audits

The Claims Quality Improvement Department performs three types of audits:

- Employee Audits (EAS)
- Auto Adjudication Audit
- Focused Audits (by claim type, provider or group)

Employee Audit System (EAS)

Twice a month these audits are conducted on claims that are processed by our employees. The month is divided into two periods: the 1st thru the 15th and the 16th through the end of the month. The number of claims pulled for each processor is based on the production of the processor. Supervisors, managers and directors can request an additional 25 claims be pulled on a processor based on performance. However, the general sample size is as follows:

Figure 2- 36: Processor Production vs. Sample Size

Processor Production	Sample Size
40-499	5
500 – 999	10
> 1000	15

The auditing staff has ten business days to complete the audits.



The data source used to generate the audit is updated weekly. Because of this schedule, there are some periods though out the year that require a 15 day auditing period.

The pre-appeal results are reviewed by all Coventry Senior Management and discussed with staff following the close of the auditing period. The release of this report opens the appeal period for the business. We have three levels of appeal. Appeals are due from the business based on the following timeline: First Level, Second Level and Third Level Appeal.

Auto Adjudication Audit

The Auto Adjudication Audit is conducted monthly on claims that are processed by the IDX system or the First Claim system without any manual intervention. The claims are audited by the auditing staff during a 2 – 5 day period. This audit is performed simultaneously with the EAS audits and is scheduled for the beginning or ending of the current EAS auditing period.

The sample size for this audit is 42 claims per plan. At the end of the quarter, the results are combined to provided a quarterly result based on a 126 claim sample.

The appeal report is released to the Senior Management Team for review.

Focused Audits

Focused Audits are performed on an as needed basis for a particular claim type, provider or employer group. Focused audits on a particular employer group are scheduled monthly in compliance with performance guarantees in place in the employer group contract. Audits based on claim types and provider are typically requested by the health plan, or based on a previous audit result.

The timelines for appeal on these types of audits are set by the auditor in charge of performing the review. There are no formalized appeal levels, but typically appeals can be forward to the initial auditor for review and upon request, are reviewed by the Business Manager of Claims Quality Improvement and shared with the claims and service team and upon request, with the Health Plan or Account Manager

HealthCare USA’s quality results for 2009-2011 are listed below.

Figure 2- 37: HealthCare USA’s quality results for 2009-2011

Metric	2009	2010	2011
Financial Accuracy	99.9%	99.8%	99.6%
(\$ error total/total correct \$)			
Payment Accuracy	99.8%	99.5%	99.5%
(# payment errors/total # audited)			
Overall Accuracy	99%	98.7%	98.5%
(# total errors/total # audited)			

*TOTALS FOR 2011 ARE THROUGH THE 3RD QUARTER



Timely Payment Process

Timely claims processing of the highest quality is a commitment HealthCare USA makes to our providers and members.

In our 2010 Provider Satisfaction Survey, 90% of HealthCare USA’s providers stated they were satisfied with our claims processing timeliness while 22% felt our timeliness was extraordinary. HealthCare USA has educated and encouraged utilization of electronic claims submission, electronic remittance advices and electronic funds transfer to improve turnaround times of processing and subsequent payments. In 2010, more than 87 percent of Medicaid claims were received electronically with an increase to over 88% in 2011 and all of HealthCare USA’s remits were sent electronically.

The IDX MCA) module is used to adjudicate claims with speed and accuracy. In 2010, HealthCare USA’s claims department achieved processing of 94.1percent of all claims within 15 days from date of receipt with a financial accuracy of 99.8 percent and less than five percent adjustment rate due to retroactive processing.

The ability to maintain consistent inventory levels displays our organization’s ability to provide outstanding and consistent results. HealthCare USA strives to exceed claims timeliness standards. HealthCare USA averaged less than a two day turnaround time from date of receipt of a claim to date of adjudication YTD in 2010. Such quick turnaround time is due to our commitment to auto adjudication, system rules that review and process claims without manual intervention.

While results shown in the Figure below are aggregated from year to year, each metric is monitored daily and reported throughout our organization. We are confident that we will continue to perform at these levels when awarded the contract with the State of Missouri.

Figure 2- 38: HealthCare USA Claims Timeliness Results 2010 and 2011

HealthCare USA 2010 Results					
Participating Providers					
Year	Total Claims	Within15	%Within15	Within30	%Within30
2010	1,954,150	1,830,846	93.69%	1,947,236	99.65%
HealthCare USA 2010 Results					
Non-Participating Providers					
Year	Total Claims	Within15	%Within15	Within30	%Within30
2010	177,589	168,211	94.72%	177,087	99.72%



HealthCare USA 2011 Results					
Participating Providers					
YTD	Total Claims	Within15	%Within15	Within30	%Within30
2011	1,407,603	1,336,485	94.95%	1,398,351	99.34%
HealthCare USA 2011 Results					
Non-Participating Providers					
YTD	Total Claims	Within15	%Within15	Within30	%Within30
2011	126,661	120,509	95.14%	125,915	99.41%

*2011 RESULTS ARE THROUGH THE 3RD QUARTER.

HealthCare USA is committed to providing timely notifications to providers of claims disposition and encourages providers to utilize electronic remittance advice (ERA) and electronic funds transfer (EFT) transactions.

Accuracy of Payment

In addition to exceeding timeliness standards, HealthCare USA prides itself on the ability to maintain claim payment accuracy that meets or exceeds industry standards. Regularly scheduled audits of our employee and system performance confirm payment accuracy results. Results are reviewed and appropriate corrective actions are taken in an effort to prevent future errors from occurring. Our team of dedicated Medicaid claims processing experts, combined with our advanced technology systems, has enabled us to deliver claim accuracy results 99% or greater consistently as illustrated in Figure 2- 39



Figure 2- 39: USA Claim Accuracy Results 2010 and 2011

Metric	2009	2010	2011	Coventry Goal
Financial Accuracy	99.9%	99.8%	99.6%	>99%
(\$ error total/total correct \$)				
Payment Accuracy	99.8%	99.5%	99.5%	>98%
(# payment errors/total # audited)				
Overall Accuracy	99%	98.7%	98.5%	>95%
(# total errors/total # audited)				

In summary, HealthCare USA believes our world-class claims system and processes speak volumes about the way we do business—not only our philosophy, but the way it is carried out each day. These results demonstrate the level of service achieved by HealthCare USA. HealthCare USA is committed to continuing the same world-class service to Missouri as has been demonstrated in the past.

2.26.4 Adherence to Key Claims Management Standards: The health plan shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, and RSMo 376.383 and 376.384.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.4

HIPAA Compliance

Coventry Health Care Inc. and all of its subsidiaries ("Coventry") are in compliance with all three sections of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Privacy, Electronic Transactions Standards, and Security.

HIPAA Privacy

Coventry Health Care, Inc. is in compliance with the Privacy regulations that were effective on April 14, 2003. Coventry Health Care, Inc. is dedicated to ensuring that our privacy practices regarding individually identifiable health information comply with all federal and state laws and regulations, including but not limited to, the HIPAA Privacy Rule. Coventry has established a corporate Privacy Office, which has overall responsibility for developing policies and procedures to safeguard Protected Health Information against uses and disclosures that are inconsistent with applicable law. Our Privacy Office is responsible for making certain that



training and education for our personnel regarding privacy policies and procedures is available, and for overseeing the implementation and enforcement of these policies and procedures.

Coventry has developed and maintains policies and procedures that assure the proper handling, use, and disclosure of its Members' PHI while administering its Members' health care benefits and providing an appropriate level of customer service. Coventry reviews policies and procedures to ensure they are current and complete at intervals no greater than two years. It is Coventry's policy to only use and disclose PHI in accordance with applicable law.

Coventry Health Care, Inc. recognizes each Member's right to privacy and treats their health information with the strictest confidence. Health Information is only to be shared with others when it is appropriate for ensuring delivery of health care services, administration of health care benefits, or health care payments, or as otherwise required by law.

Coventry Health Care, Inc. has implemented a Privacy Compliance Program for maintaining privacy and confidentiality of our Member's Protected Health Information. This program, under the oversight of the Privacy Office and Chief Privacy Officer, includes an educational program, audit process, and ongoing policy and procedure review.

HIPAA Transactions and Code Set

Coventry Health Care, Inc. is in compliance with the Transaction and Code Set regulations that were effective on October 16, 2003. Coventry accepts claims with the National Provider Identifier (NPI), and is also currently accepting ASC X12 5010 version electronic transactions in advance of the mandated 1/1/2012 date.

Coventry monitors claims and other inbound transactions through compliance checking software used internally and by our designated clearinghouses.

Additionally, Coventry staff continues to monitor both CMS and the industry for any HIPAA Transaction or Code Set developments. Recent developments being monitored are the ASC X12 version 6020 and ICD-10-CM/PCS.

HIPAA Security

Coventry Health Care, Inc. is in compliance with the HIPAA Security regulations that were effective on April 21, 2005. Security Standards were adopted to ensure that the integrity and confidentiality of electronic records and transmission are protected. A policy and procedure gap analysis was completed which included revisions and new policy development. A detailed 'Access Controls Review' of major systems was completed. A risk management process has been implemented along with a secure messaging system to encrypt email traffic for PHI or other confidential information across the Internet.

The HIPAA Security Team has developed a formalized security incident policy and procedure, as well as developed security and awareness training for all employees. Common facility access controls and security management procedures are in place. Existing business associates agreements have been updated with the appropriate security language.



In addition, the HIPAA Security Team continues with remediation efforts to support overall security best practices.

HITECH

The Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act (ARRA), makes significant changes to the Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated under HIPAA. These changes include:

- Breach notification requirements
- Changes to the minimum necessary requirements
- Modifications to the Business Associate requirements and
- New requirements related to accounting for disclosures, including those disclosures that fall under Treatment, Payment and Health Care Operations (TPO).

Many of these statutory changes will be subject to new regulations which have yet to be issued. In the meantime, Coventry has made changes to its policies and procedures to address those changes under HITECH which are effective and for which regulations have been issued (e.g., the breach notification requirements). Upon the issuance of future implementing regulations, scheduled throughout the coming months, Coventry will make appropriate modifications as necessary to comply with any new privacy and security requirements. In the meantime, given the nature of these anticipated changes, Coventry has established a working group to identify enterprise standards and resource requirements, and to coordinate preparation for final implementation.

Please be assured that Coventry Health Care, Inc. takes privacy and security compliance seriously and we are taking appropriate actions to ensure these additional provisions are addressed accordingly.

Electronic Claims Submission Process

Electronic claims are submitted through an electronic data interchange (EDI) utilizing the format mandated by the HIPAA transaction regulation, to an electronic mailbox that is established specifically for HealthCare USA. HealthCare USA has Emdeon as the primary third-party vendor that EDI claims may be submitted to by our providers.

Providers may submit their EDI claims either directly to Emdeon or they may submit them indirectly by using their own claim clearinghouse, such as Gateway Relay Health, SSI etc. Emdeon performs edits specific to the clearinghouse and some limited HealthCare USA-defined edits. Emdeon keeps track of all claims submitted to them by assigning a specific reference number to each submission.

In addition to the EDI claim submitters mentioned above, Coventry also receives EDI files from our third-party keying vendor, Affiliated Computer Services, Inc. (ACS). ACS is the third-party keying vendor HealthCare USA uses to key in the paper claims. These files follow the same steps as the true EDI claims described above.



Before EDI claims are loaded into IDX, the electronic claim files are processed through the SeeBeyond and Foresight systems. These systems perform file validation and generate acknowledgements as outlined below:

- Trading partner validation—validates that the trading partner has permission to submit the transaction.
- HIPAA validation as necessary (via Foresight InStream product).
- Translation and mapping — SeeBeyond translates files into formats acceptable for uploading into the claims adjudication system.
- Generation of HIPAA 997 functional acknowledgements.

EDI claims are then loaded into HealthCare USA's claims processing system through a batch upload program. Our Enterprise Business Integration department oversees an automated process for logging, loading and processing the daily EDI files from all trading partners as well as sending acknowledgment reports back to the trading partners. The Emdeon EDI claim files go through validation edit checks and any noncompliant claims are automatically sent back to Emdeon.

Validation is performed by the SeeBeyond system. This process validates the claim submission files and sends alert e-mails to trading partners and the Enterprise Business Integration department.

The Front End Operations staff in Customer Service Operations reconciles each day the file counts from all trading partners against claims accepted and filed into HealthCare USA's claims processing system. All discrepancies are researched and validated.



2.26.5 Encounter Data:

- a. As part of the 1996 HIPAA Title II Act-Administrative Simplification Standards 2009 Modifications, all HIPAA-covered entities are required to implement the Version 5010 transaction set. The transaction standards rule 45 CFR Part 162 [CMS-0009-F] published on January 16, 2009 mandates the use of new versions of electronic transaction standards effective January 1, 2012 including the conversion of the Accredited Standards Committee X12 (X12) to version 5010 for health care. The State of Missouri will enforce the health plan's compliance of all electronic exchanges of encounter or other data in the message formats detailed below:

Claim Transactions:

- 837P – Professional
- 837I – Institutional
- 837D – Dental

Remittance Advice

- 835

Eligibility Inquiry and Response

- 270/271

Claim Status Inquiry and Response

- 276/277

Group Premium Payment for Insurance Products

- 820

Benefit Enrollment and Maintenance - Change Transactions (Enrollments, Disenrollments and ME Code Changes): The health plan shall accept and process this daily file in accordance with the specifications laid out in the Health Plan Record Layout Manual.

- 834

New ASC X12 standard acknowledgement (999), in circumstances, may replace the current ASC X12 standard acknowledgement (997).

Compliance standards shall be enforced in accordance with the state agency's Companion Guides for each transaction. Companion Guides are available via the Internet at the state agency's website: <http://www.dss.mo.gov/mhd/providers/index.htm> (Look under HIPAA - EDI Companion Guide).



HealthCare USA understands and shall comply with the requirements of Section 2.26.5 a

837 – Claims Transactions

HealthCare USA, through its parent company Coventry, is successfully providing encounter data in the 837 format to the States of Missouri.

835 - Remittance Advice

The State currently provides a proprietary, HealthCare USA is performing testing of the 5010 process with the State, which will enable HealthCare USA to receive the 835.

270/ 270 - Eligibility Inquiry and Response

HealthCare USA, through its parent company Coventry, is successfully providing eligibility inquiries and responses in the 270/271 format in accordance with the state agency's Companion Guides and CMS.

276/277- Claim Status Inquiry and Response

File currently not received by HealthCare USA, We are performing testing of the 5010 process with the State, which will enable HealthCare USA to receive the 276/277.

820 - Group Premium Payment for Insurance Products

The State currently provides a proprietary, HealthCare USA is performing testing of the 5010 process with the State, which will enable HealthCare USA to receive the 820.

834- Benefit Enrollment and Maintenance

HealthCare USA accepts and process these daily file in accordance with the specifications laid out in the Health Plan Record Layout Manual.

ASC X12 standard acknowledgement

HealthCare USA accepting ASC X12 5010 version electronic transactions in advance of the mandated 1/1/2012 date. Additionally HealthCare USA staff continue to monitor both CMS and the industry for any HIPAA Transaction or Code Set developments. Recent developments being monitored are the ASC X12 version 6020 and ICD-10-CM/PCS

HealthCare USA's core system, IDX, has a fully-integrated, scalable application that encompasses all aspects of Coventry's Medicaid as well as other lines of business, IDX includes data for enrollment, provider referrals, claims processing, premium billing, capitation/risk management, accounts receivable and accounts payable.

We remain current with HIPAA mandates and Missouri specific requirements for our Medicaid customers. In addition we make necessary system modifications to correct processing errors and stay compliant with HIPAA and MO HealthNet standards. HealthCare USA's systems incorporates Federal and Statutory changes for edits and encounter processing requirements. All system changes follow our IT change management policy to maintain system stability and preserve the integrity of our data.

All Subcontracts with or other vendors of service have provisions requiring that Encounter Records are reported/submitted in an accurate and timely fashion.



2.26.5b. The health plan shall transmit at least one encounter data file per month and in accordance with the *Layouts Sent by the Health Plan to Wipro Infocrossing* section of the Health Plan Record Layout Manual, as amended or any applicable CMS requirements related to the appropriate versions of the Implementation Guide or Missouri's Companion Guide. The performing provider's national provider identifier (NPI) is required on all encounter submissions.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5(b).

HealthCare USA currently files at least one encounter data file per month, including the provider's NPI, in accordance with the *Layouts Sent by the Health Plan to Wipro Infocrossing* section of the Health Plan Record Layout Manual, as amended or any applicable CMS requirements related to the appropriate versions of the Implementation Guide or Missouri's Companion Guide.

2.26.5c. The health plan shall maintain at least a ninety-five percent (95%) submission rate of all encounters with an overall encounter acceptance rate of ninety-five percent (95%) as measured by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5(c).

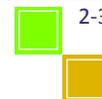
HealthCare USA's surpasses the 95% submission rate of all encounters, with an overall average acceptance rating of 98%.

2.26.5d. The health plan shall submit encounter data for all services provided including those services that are reimbursed by the health plan through a capitated arrangement or other subcontracted arrangement.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5(d).

HealthCare USA has a comprehensive and aggressive program to manage subcontractors and affiliates and guarantee performance to Medicaid agencies. This program includes contractual language to obligate subcontractors and affiliates to contract requirements, performance standards, guarantees, reporting requirements, subcontractor/affiliate audit support requirements and defined interface and management responsibilities. Before entering into an agreement with a subcontractor or affiliate, HealthCare USA verifies that all subcontractors or affiliates have information systems capabilities and processes, as applicable to their contract functions that are equivalent to those of the Medicaid agency and HealthCare USA.

HealthCare USA analyzes and responds to any encounter rejected by the State for medical claims. An encounter team comprised of claims processors, information systems analysts and certified professional coders reviews all claims-associated acceptance/rejection rates to ensure accuracy and increase acceptance rates.





2.26.5e. Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the health plan's applicable reimbursement methodology for that service.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5(e).

A HealthCare USA team with specialized knowledge of the HIPAA 837 encounter transaction will be assigned to the task of modifying the current encounter data generation process to include any new MO HealthNet specific requirements. This includes the definition and treatment of fields that are standard in encounter data submissions that follow Federal and/or MO HealthNet payment rule standards. In addition, the encounter data records submitted will comply with MO HealthNet's requirement that payment for discrete services submitted with a single claim can be ascertained.

2.26.5f. Encounters must be submitted within 30 days of the day the health plan pays the claim and must be received no later than two (2) years from the first date of service.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5(f).

HealthCare USA provider contracts have provisions for the submission of claims data within federal and state mandated timeframes. In addition, HealthCare USA has instituted and enforced policies which specifically define requirements for data quality and timeliness as well as specific sanctions if requirements are not met.

As a rule, batch jobs are created by our information technology department in order to create state Medicaid encounter files. They are designed with the flexibility to enter a date range, which ensures submission that meets individual state timeline requirements and needs.

2.26.5g. The encounter data must be certified by one of the following:

1. The health plan's Chief Executive Officer;
 2. The health plan's Chief Financial Officer; or
 3. An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5g.

2.26.5h. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness, and truthfulness of the encounter data.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5h.



2.26.5i. The health plan shall submit the certification concurrently with the encounter data.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5i.

2.26.5j. The health plan shall provide encounter data for the External Quality Reviews in the format specified by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5(j).

Internal Audit Coordinators from the Quality Improvement and Reporting Audit Departments perform random claim and auto-adjudication audits every two weeks and six weeks respectively, to monitor accuracy of claim payments. Claim audit addresses initial keying, system set up, and all source documentation including: provider contracts, employer benefit plans, claim images, and re-pricing contracts. Areas of focus include verifying payment amount, manual edits, disposition codes, fee-for-service versus capitation, timely filings, duplicate claims, and Claim Check edits. Audit reports are distributed throughout the organization upon audit completion. This internal audit process allows for ease in providing information to external auditors as well, such as for a HealthCare USA initiated audit.

2.26.5k. Effective July 1, 2012, the health plan shall submit the national provider identifier with the provider taxonomy code in the provider demographics file.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5(k).

HealthCare USA is in the last phase of testing for adding the taxonomy code to the provider demographics file and will implement in the first quarter of 2012.

2.26.5 j The health plan shall provide encounter data for the External Quality Reviews in the format specified by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5(j).

Internal Audit Coordinators from the Quality Improvement and Reporting Audit Departments perform random claim and auto-adjudication audits every two weeks and six weeks respectively, to monitor accuracy of claim payments. Claim audit addresses initial keying, system set up, and all source documentation including: provider contracts, employer benefit plans, claim images, and re-pricing contracts. Areas of focus include verifying payment amount, manual edits, disposition codes, fee-for-service versus capitation, timely filings, duplicate claims, and Claim Check edits. Audit reports are distributed throughout the organization upon audit completion. This internal audit process allows for ease in providing information to external auditors as well, such as for a HealthCare USA initiated audit.





2.26.5l. Effective July 1, 2012, the health plan shall submit the national provider identifier (NPI) taken from the claim for payment for services with the encounter data in the performing and rendering physician fields. Effective January 1, 2013 or later as directed by the state agency, the health plan shall submit the national provider identifier taken from the claim for payment for services with the encounter data in all provider fields.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5l.

Healthcare USA has commenced a project using a cross functional team in order to comply with the requirements set forth in Section 2.26.5 (l) & (m).

2.26.5m. Effective July 1, 2012, provider taxonomy codes related to the reported NPIs shall be required in the encounter data except where a taxonomy field for a reported NPI is not available in the transaction format.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.5lm

Healthcare USA has commenced a project using a cross functional team in order to comply with the requirements set for in Section 2.26.5 (l) & (m).

2.26.6 International Classification of Diseases (ICD-10): As part of the 1996 HIPAA Title II Act – Administrative Simplification Standards 2009 Modifications, all HIPAA-covered entities are required to implement the standard medical data code sets for coding diagnoses and inpatient hospital procedures by concurrently adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. The medical data code set standards rule 45 CFR Part 162 [CMS-0013-F] published on January 16, 2009 mandates the use of the ICD-10-CM and ICD-10-PCS medical data code sets effective October 1, 2013. These new codes replace the current International Classification, 9th Revision, Clinical Modification, Volumes 1 and 2 and the International Classification, 9th Revision, Clinical Modification, Volume 3 for diagnosis and procedure codes respectively. The State of Missouri will enforce compliance by the health plans for all electronic exchanges of encounter or other data effective October 1, 2013.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.6

Coventry is on track to support the conversion from ICD9 usage to the federally mandated ICD-10 transactions by 10/1/2013. We have been actively preparing for this change since 2009. Our planning and analysis phases were completed in 2010. Coventry has completed our internal inventory and analysis of all Business Processes and Applications requirements. Initial design and construction of systems to support the implementation of ICD 10 diagnosis and procedure codes have been the priority for 2011. Our implementation strategy will be to deploy the required changes in seven (7) phases throughout 2013 to mitigate risk. This project will continue to be monitored by Coventry’s executive leadership.

Timeline of the 7 phases of deployment



#	Work Package	Phase Level	Design Start Date	Deployment End Date	1Q10	2Q10	3Q10	4Q10	1Q11	2Q11	3Q11	4Q11	1Q12	2Q12	3Q12	4Q12	1Q13	2Q13	3Q13	4Q13				
1	5010 implementation with diagnosis and procedure expansion and increased occurrences for code storage	Phase I	1/1/2010	3/31/2012	Coventry Time-Line								Workers Comp											
2	Dictionary or table format changes to support new ICD10 procedure and diagnosis codes	Phase I	10/1/2010	3/31/2012				Coventry Time-Line																
3	CDW, WCDW, ODIS and other database format changes to support new ICD10 procedure and diagnosis codes	Phase I	10/1/2010	3/31/2012				Coventry Time-Line																
4	Development of inbound testing tools through EDI, FEO or FEP processes to convert ICD9 to ICD10 codes	Phase I	1/1/2011	3/31/2012					Coventry Time-Line				WE DI Internal Testing Time-Line											
5	Add new ICD10 diagnosis and procedure codes to legacy systems dictionaries or tables CDW, WCDW, ODIS and other databases	Phase II	10/1/2011	6/30/2012							Coventry Time-Line													
6	Development of trading partner or focused provider testing tools using ICD10 submitted codes	Phase III	10/1/2011	9/30/2012							Coventry Time-Line				WE DI Partner Testing									
7	Update core adjudication or tables with new ICD10 codes	Phase III	10/1/2011	9/30/2012							Coventry Time-Line													
8	Update core interfaces to support new ICD10 codes	Phase IV	10/1/2011	12/30/2012							Coventry Time-Line													
9	Update extracts to support new ICD10 codes	Phase V	4/1/2012	3/30/2013									Coventry Time-Line											
10	Update reports to support ICD10 codes	Phase VI	7/1/2012	6/30/2013											Coventry Time-Line									
11	Updates to essentials, other documentation or business processes to support new ICD10 codes	Phase VII	7/1/2012	9/30/2013											Coventry Time-Line									

Compliance Date Starts 10/01/2013

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Coventry Health Care, Inc has been engaged and dedicated to their budgeted ICD10 project since 2009. With the project, we:

- are supporting the compliance driven move to ICD10 diagnosis and procedure codes.
- have completed our over internal inventory and gap analysis of all Business Processes and Application requirements.
- have completed overall planning and development.
- are addressing the required changes in a go-forward strategy of 7 phases through 2013 to mitigate risk.
- are defining our approach for internal neutrality testing using remediated data.
- have defined our requirements for internal testing
- are defining out requirements and option for external testing.
- are developing our parameters for measuring neutrality.
- have established regular communications and training, as appropriate.

Coventry is on target and committed to being fully compliant with the ICD-10 requirements by October 1, 2013.

2.26.7 Other Electronic Data Exchange:

- a. **Provider Demographic File:** The health plan shall transmit primary care provider assignments and changes or additions, as well as update all deletions by including the stop date to the provider demographic file. In accordance with the [Health Plan Record Layout Manual](#), the health plan shall submit all required fields including the national provider identifier (NPI) and taxonomy if available.
 - b. **PCP Assignment File.**
 - c. **HBM Baseline Health Data File.**
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.26.7 HealthCare USA has defined processes for the data exchanges and will update the files and processes to meet the requirements stated in this section.

The provider demographic file is currently transmitted weekly. It includes the provider identifier (NPI) and the end date for primary care provider records being termed. Upon receipt of the new format from MO HealthNet, the file layout will be updated to include provider taxonomy. The PCP assignment file lists:

- All members
- Members' assigned PCP number
- PCP start date

Updates to the PCP assignments are captured in the file and submitted weekly.

HealthCare USA receives and processes the HBM Baseline Health Data file appropriately.





2.26.8 Information Systems Availability: The health plan shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to ECM and self-service customer service functions are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the state agency and the health plan. The health plan shall ensure that, at a minimum, all other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m. Unavailability caused by events outside of a health plan's span of control is outside of the scope of this requirement. In the event of a declared major failure or disaster, the health plan's core eligibility/enrollment and claims processing systems shall be back online within seventy-two (72) hours of the failure's or disaster's occurrence.

HealthCare USA understands and shall comply with the requirements set forth in section 2.26.8 Coventry IT ensures that its systems are up and running twenty-four 24 hours a day, seven days a week. This includes the critical functions such as Confirmation of MCO Enrollment (CME), Electronic Claims Management (ECM), and tools needed for our customer service organization. Exceptions apply to periods of scheduled system downtime. Coventry has established a standard of 99% system availability for its core information systems, which is consistently exceeded for all of our major systems.

Our dedicated staff is committed to ensuring minimal system disruptions for our customers. Coventry policies restrict all non-emergency system changes to weekend hours only. This includes routine system maintenance, repair or upgrades. IT Change Management meetings are held on a weekly basis to review scheduled infrastructure and application changes. All changes must be scheduled in advance and approved by the Change Management Committee to minimize impact on critical business operations. Once approved, the list of scheduled changes is broadcast to our user community via e-mail.

Systems availability is measured from 6:00 a.m. until 7:00 p.m. Central Time Monday through Friday and 7:00 a.m. until 12:00 p.m. Central Time on Saturdays. Any incident that halts system operation or renders the system unusable to the end user is considered an outage. Real-time performance is measured via a standard transaction that runs around the clock. Whenever the response time of this transaction exceeds the thresholds, a ticket is generated and system engineers pursue the issue until resolution. The Operations area is fully staffed twenty-four 24 hours a day, seven days a week and employs automated job scheduling that continuously checks for abnormal events in production job processes, sends an immediate alert to operators and opens a ticket to the problem management system.

Coventry understands the importance of timely communication of system outages or delays in providing services and information to our customers. When outages occur, we notify all affected parties via e-mail or telephone. In addition, customer communications are not limited to outages or delays—Coventry communicates major changes, upgrades and conversions of core transactional systems to our designated state liaisons in accordance with state timeframes. Previously, we have followed this process with major system changes affecting our customers. For example, in 2004, Coventry launched a privacy initiative to discontinue the use of a member social security number as an identifier and replace it with a unique, system-generated member identification number. Providers, members, employer groups, and brokers were well-prepared with advance notice of the change through e-mail, print ads, and flyers that accompanied new



ID cards, commission checks, provider remits and monthly statements. Notices were also posted on the HealthCare USA web site. Our third party vendors were notified and actively participated in the implementation throughout the project life cycle.

Failure or Disaster Recovery

Weekly and monthly full backups of all production systems in the Coventry Data Center, located in Cranberry Township, Pennsylvania, are archived at an environmentally controlled off-site storage facility. In the event of an emergency, backup media can be retrieved within 2 hours.

Coventry actively engages in comprehensive, ongoing Business Continuity-Disaster Recovery (BC-DR) planning and testing supported by a dedicated, full-time BC-DR team. Disaster recovery exercises are conducted annually at the IBM Recovery Center in Sterling Forest, NY.

Through efficient execution of a comprehensive BC-DR plan, Coventry was well-prepared to pull together its national resources in order to serve the health and well-being of our members and employees in the Gulf coast region.

Disaster Phases and Scenarios

Coventry's Business Recovery plan is designed to address three phases to any disaster:

- Immediate disaster and process recovery
- Operation on an interim basis at an alternate site
- Return to normal operations at the original or a newly chosen site

Each phase considers numerous scenarios including hardware and software destruction, system availability, and varying levels of system interruption. These levels address network, hardware, software and operational errors that may affect data integrity in either live or archival systems. Coventry's Disaster Recovery plan is supported by an infrastructure designed to provide access to any system application from any business site, including re-routing phone support. The plan specifies projected recovery times and data loss for our mission-critical systems, with detailed protocols in place to ensure recovery of these systems within 72 hours of a major failure or disaster.



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- 2.26.9 In accordance with Executive Order 07-12, signed by the Governor of the State of Missouri on March 2, 2007, the health plan shall:
- a. Support interoperable health information systems and products so long as the maintenance or exchange of health information includes provisions to protect member privacy as required by law;
 - b. Support the development and implementation of objective quality standards for services supplied by health care providers in that program, ultimately making provider performance on these standards available to consumers of the program's services;
 - c. Support making information available regarding the prices for procedures or services under the program; and
 - d. Make every effort to deliver high-quality and cost-effective health care that may include consumer-directed health care plans and reimbursement methods that reward providers for results.
-

HealthCare USA understands and shall comply with the requirements set forth in section 2.26.9.

2.27 Business Continuity and Disaster Recovery Planning

- 2.27.1 The health plan shall develop, and be continually ready to implement and monitor, a business continuity and disaster recovery (BC-DR) plan. The health plan's BC-DR plan shall address: 1) the processes and strategies the health plan shall implement to ensure member access to information and services in the event of an emergency (including, but not limited to natural events, inclement weather, and declared emergencies), systems failures and systems disruptions; and 2) the processes and strategies the health plan shall implement to resume business following an emergency (including, but not limited to natural events, inclement weather, and declared emergencies), systems failures and systems disruptions.
- 2.27.2 The BC-DR plan shall, at a minimum:
- a. Specify the staff responsible for oversight and administration of the plan;
 - b. Specify the applicable situations and emergencies and the extent to which strategies vary for each;
 - c. Indicate the order in which essential parties are notified of the situation and/or emergency and timeframes for notification;
 - d. Describe how members and providers will be notified and how they will access information and services; and
 - e. Describe the process for updating the plan and timeframes.
-

HealthCare USA understands and shall comply with the requirements set forth in section 2.27.1-2.

We have crisis management plan in place for all HealthCare USA locations providing services to the members and providers.

All crisis management, business continuity and disaster recover documents are considered proprietary and confidential and are available upon request.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2.27.3 The health plan shall periodically, but no less than annually, perform comprehensive tests of its BC-DR plan and update as necessary. Upon contract award, the health plan shall make available to the state agency its BC-DR plan and any necessary testing results.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.27.3.

2.28 Records Retention

2.28.1 The health plan shall maintain books and records relating to MO HealthNet Managed Care services and expenditures, including reports to the state agency and source information used in preparation of these reports. The books and records shall include, but are not limited to, financial statements, records relating to quality of care, medical records, and prescription files.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.1.

2.28.2 The health plan shall comply with all standards for record keeping specified by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.2.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy RC-25 *Record Retention*

2.28.3 The health plan shall maintain and retain all financial and programmatic records, supporting documents, statistical records, and other records of members for five (5) years. If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the five (5) year period, the health plan shall retain the records until completion of the action and resolution of all issues which arise from it or until the end of the regular five (5) year period, whichever is later.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.3.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy RC-25 *Record Retention*

2.28.4 The health plan shall retain the source records for the health plan's data reports for a minimum of five (5) years and shall have written policies and procedures for storing this information.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.4.



The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy RC-25 *Record Retention*

2.28.5 Medical Records: The health plan shall have and implement written policies and procedures for the maintenance of medical records so that the records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Complete medical records shall include but are not limited to medical charts, health status screens, prescription files, hospital records, physician specialists, consultant, and other health care professionals' findings, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided. The health plan shall make such medical records available to duly authorized representatives of the state agency and the United States Department of Health and Human Services to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed. The health plan shall have procedures to provide for prompt transfer of member records upon request to other in-network or out-of-network providers for the medical management of the member.

- a. In accordance with Senate Bill No. 1024, enacted by the General Assembly of the State of Missouri, Section A., Chapter 334, RSMo, amended to be known as Section 334.097, physicians shall maintain an adequate and complete medical record for each member and may maintain electronic records provided the record keeping format is capable of being printed for review. An adequate and complete medical record shall include documentation of the following information:
1. Identification of the member, including name, birth date, address and telephone number;
 2. The date(s) the member was seen;
 3. The current status of the member, including the reason for the visit;
 4. Observation of pertinent physical findings;
 5. Assessment and clinical impression of diagnosis;
 6. Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the medical record the medication and dosage of any medication prescribed, dispensed, or administered; and
 7. Any informed consent for office procedures.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(a).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*

2.28.5b. Medical records remaining under the care, custody, and control of the physician shall be maintained by the physician, or the physician's designee, for a minimum of seven (7) years from the date of when the last professional service was provided.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(b).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*



2.28.5c. Any correction, addition, or change in any medical record made more than forty-eight (48) hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(c).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*
-

2.28.5d. A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(d).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*
-

2.28.5e. The member's medical record is the property of the provider who generates the record. Upon the written request of a member, guardian, or legally authorized representative of a member, the health plan shall furnish a copy of the medical records of the member's health history and treatment rendered. Such medical records shall be furnished within a reasonable time of the receipt of the written request. Each member is entitled to one (1) free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(e).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*



2.28.5f. The health plan shall provide the state agency with access to all members' medical records, whether electronic or paper, within thirty (30) calendar days of receipt of written request at no charge. The health plan shall provide the state agency with access to a single or small volume of medical records within five (5) calendar days of receipt of written request at no charge. The health plan shall provide the state agency with immediate access for on-site review of medical records. For on-site review of medical records, the state agency may provide the health plan with an advance notice of a partial list of medical records. The health plan shall fax or send by overnight mail to the state agency all medical records involving an emergency or urgent care issue when requested by the state agency at no charge. Access to record requirements applies to the health plan and all providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(f).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*

2.28.5g. The health plan shall have written standards for documentation on the medical record for legibility, accuracy, and plan of care.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(g).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*

2.28.5h. The health plan shall require its providers to maintain medical records in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

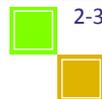
HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(h).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*

2.28.5i. When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(i).





The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*

2.28.5j. The state agency is not required to obtain written approval from a member before requesting the member's record from the provider.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(j).

2.28.5k.If the state agency requests, the health plan shall gather all medical records from their providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.28.5(k).

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy QI-1 *Provider on-going monitoring*

2.29 Risk Adjusted Rates

Rate Adjustments for Performance Based on HCY/EPSTDT Participant Ratio and Remedies for Violation, Breach, or Non-Compliance of Contract Requirements:

2.29.1 Risk Adjusted Rates: The state agency intends to risk adjust Base Capitation Rates beginning January 1, 2013 to reflect the different health status (acuity) of the members enrolled in the health plan. The state agency shall use a statistical methodology to calculate health-based risk factors developed using a generally accepted grouper model. The specific methodology used in the applicable contract period shall be provided in the Data Book, Attachment 9. Such risk adjustment shall be based on an aggregation of the individual risk scores of the members enrolled in the health plan. The state agency intends to update the risk adjustment results that are applied to the Base Capitation Rates at least semi-annually. Notwithstanding any provision of the contract to the contrary, the health plan shall accept the resulting final risk adjusted rates for each risk adjustment period to occur at least semi-annually including any retroactive adjustments as the state agency deems necessary without further contract negotiations or contract amendments.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.1.

Risk-adjusted rates allow MO HealthNet to pay higher rates to plans that serve members who are sicker and have greater health care needs than plans that serve healthier beneficiaries. The advantage of risk-adjusted rates is that they better match capitated plan payments to the health status and costs of the health plan member.

HealthCare USA supports this effort and looks forward to working with the State to assist in the process of developing effective and transparent process.

2.29.2 Rate Adjustments for Performance Based on HCY/EPSTDT Participant Ratio: In accordance with CMS guidelines, the state agency requires eighty percent (80%) of eligible members to have



HCY/EPSTDT well child visits, and accordingly, has included an eighty percent (80%) participant ratio in the rates paid to the health plan. In accordance with CMS 416 reporting methodology, the state agency shall measure the health plan's performance regarding the percentage of eligible members having HCY/EPSTDT well child visits (participant ratio). The state agency applies State specific criteria to the CMS methodology to reflect the MO HealthNet Managed Care Program. The State specific criteria reflects performance by Category of Aid and rate cell, the measurement schedule in Attachment 11, and recognition of a month to be greater than twenty-seven (27) days. The participant ratio is defined as the number of total eligible members receiving at least one initial or periodic well child visit divided by the number of total eligibles who should receive at least one initial or periodic well child visit. The current HCY/EPSTDT Measurement Schedule is reflected in Attachment 11. 2.29.2. The state agency reserves the right to amend the HCY/EPSTDT Measurement Schedule and shall give the health plan prior written notice of such amendment.

- a. In the event that the HCY/EPSTDT participant ratio is not equal to eighty percent (80%) of eligible members having an HCY/EPSTDT well child visit as calculated using the HCFA 416 reporting methodology, the state agency shall with five (5) calendar days prior notice make a pro rata adjustment to the monthly capitation payment to the health plan for each percentage point above or below eighty percent (80%), but not to exceed one hundred percent (100%). This pro rata adjustment shall be based on the portion of the monthly capitation payment related to HCY/EPSTDT well child visits and shall be applied to each rate cell in which well child visits are required. Refer to Attachment 13. The state agency shall continue making such adjusted monthly capitation payments until the next scheduled measurement.
- b. If the health plan is new to a MO HealthNet Managed Care region, the health plan shall agree that its capitation rate shall reflect the average participant ratio of the MO HealthNet Managed Care health plans that are not new to the region by rate cell and category of assistance for the applicable measurement period reflected in Attachment 11. Beginning July 2014, the new health plan shall agree that their future capitation rates shall be adjusted by the health plan's actual 12-month HCY/EPSTDT participant ratio.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.2.



2.29.3 Liquidated Damages: The health plan shall agree and understand that the provision of the managed care medical service delivery system in accordance with the requirements stated herein is considered critical to the efficient operations of the State of Missouri/ However, since the amount of actual damages would be difficult to establish in the event the contractor fails to comply with the requirements, the contractor shall agree and understand that the amount identified below as liquidated damages shall be reasonable and fair under the circumstances.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- a. Reports and Deliverables: For each working day that a report or deliverable is late, incorrect, or deficient, the health plan shall be liable to the state agency for liquidated damages in the amount of one hundred dollars (\$100) per day, per report or deliverable, unless otherwise specified in this section. When the due date falls on a Saturday or Sunday, the report is due on the last working day of the month. The mode of delivery shall include a return receipt. The health plan shall maintain this receipt in their files for audit purposes.
- b. Program Requirements: Liquidated damages for failure to perform specific program responsibilities as described herein are shown in the chart below.

PROGRAM RESPONSIBILITY	DAMAGE FOR BREACH
Failure to meet claims processing timeframes and other requirements herein	\$10,000 per month, for each month that the state agency determines that the health plan is not in compliance with the requirements
Failure to submit quality assessment and improvement reports as required herein	\$250 per day for every calendar day reports are late
Failure to maintain NCQA accreditation	\$500 per day for every calendar day in which the health plan provides services after the expiration of NCQA accreditation
Failure to obtain approval of member materials as required herein	\$500 per day for each calendar day that the state agency determines the health plan has provided member material that has not been approved by the state agency
Failure to comply with timeframes for providing member handbooks, identification cards, and provider directories	\$500 for each occurrence



PROGRAM RESPONSIBILITY	DAMAGE FOR BREACH
Failure to comply with fraud and abuse provisions herein (including health plan activities to monitor and combat both provider and member fraud and abuse)	\$500 per calendar day for each day that the health plan does not comply with fraud and abuse provisions
Failure to require and ensure compliance with ownership and disclosure requirements herein	\$5000 per provider attestation, subcontracted benefit management organization attestation, or health plan attestation that is not provided timely or does not contain complete and satisfactory information as required in 42 CFR Part 455
Failure to maintain a complaint and appeal system as required herein	\$500 per calendar day
Failure to maintain required insurance as required herein or to notify the state agency of the cancellation of liability insurance	\$500 per calendar day
Imposition of utilization controls or other quantitative coverage limits that arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition as prohibited herein	\$500 per occurrence
Failure to process credentialing applications or to maintain provider agreements as required herein	\$5000 per credentialing application or provider agreement found to be handled in breach of the contract
Failure to comply with staffing requirements described herein	\$250 per calendar day for each day that staffing requirements are not met
Failure to comply with requirements concerning work authorization of health plan employees (including attestation)	\$500 per calendar day for each day that work authorization requirements are not met



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- c. In addition to the liquidated damages described above, the state agency reserves the right to assess a general liquidated damage of five hundred dollars (\$500) per occurrence with any notice of deficiency.
 - d. The contractor shall understand that the liquidated damages described herein shall not be construed as a penalty.
 - e. The contractor shall agree and understand that all assessments of liquidated damages shall be within the discretion of the State of Missouri and shall be in addition to, not in lieu of, the rights of the State of Missouri to pursue other appropriate remedies.
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HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.3(a-e).

2.29.4 Notwithstanding the state agency's imposition on the health plan of any remedy or sanction, including liquidated damages, the health plan shall continue to perform all services under the contract except as specifically provided herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.4.



2.29.5 Remedies for Failure to Provide Covered Services or to Perform Administrative Services:

- a. In the event the state agency determines the health plan failed substantially to provide one or more medically necessary covered services as required herein, the state agency shall direct the health plan to provide such service. If the health plan continues to refuse to provide the covered service(s), the state agency shall authorize the members to obtain the covered service from another source and shall notify the health plan in writing that the health plan shall be charged (at the state agency's discretion) either the actual amount of the cost of such service or \$500 per occurrence. In such event, the charges to the health plan shall be obtained by the state agency in the form of deductions of that amount from the next monthly capitation payment made to the health plan. With such deductions, the state agency shall provide a list of the members with respect to whom payments were deducted, the nature of the service(s) that the health plan failed to provide, and payments the state agency made or will make to provide the medically necessary covered services. Use of the remedy under this section shall not foreclose the state agency from imposing any other applicable remedy listed herein. The failure to provide a covered service timely (i.e., in accordance with the timeframes specified herein, or when not specified herein, with reasonable promptness) shall be considered a violation resulting in either the actual amount of the cost of the service or \$500 per occurrence.
- b. In the event of any failure by the health plan to provide any services under the contract (including both covered services and administrative services), the state agency may, in addition to any other applicable remedies listed herein, require the health plan to submit and follow a corrective action plan, in order to ensure that the health plan corrects the error or resumes providing the service. If the state agency chooses to impose this remedy, the state agency shall issue to the health plan a notice of deficiency identifying the health plan's failure, and setting forth required timeframes in which the health plan shall resolve each violation. Within five (5) working days of receipt of the notice of deficiency, the health plan shall submit to the state agency a corrective action plan. For purposes of this section, "administrative services" are defined as any contract requirements other than the actual provision of covered services.
 1. If the corrective action plan submitted by the health plan is acceptable to the state agency, no remedial action under this subsection shall be taken by the state agency, provided that the health plan implements the corrective action as approved by the state agency.
 2. If the health plan fails to submit a corrective action plan within the five (5) working days of receipt of the notice of deficiency, fails to submit a revised correction plan in the timeframe specified by the state agency, or fails to implement the accepted corrective action plan within the timeframe required by the state agency, the state agency shall withhold payment from the next capitation payment due the health plan as stated below:
 - The amount withheld shall be no less than \$500 per calendar day, and may be higher, in the State's discretion, save that for any month the total amount withheld shall not exceed three percent (3%) of the total amount of the monthly capitation payment due the health plan.
 - For violations lasting for more than one month, the state agency shall continue to withhold up to three percent (3%) from subsequent monthly capitation payments until successful correction of the services failure by the health plan.
 - After successful correction of the services failure, the state agency may, in its discretion, pay the health plan the total amount of all payments withheld under this subsection.
 - The state agency may monitor the effectiveness of the health plan's implementation of a corrective action plan by, among other measures, requiring reporting by the health plan and making site visits to the health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.5.



- 2.29.6 Remedies for Failure to Comply with Marketing Requirements: In the event the state agency determines that the health plan has failed to comply with any of the marketing requirements of the contract, one or more of the remedial actions listed below (in addition to any other applicable remedies described herein) shall apply. The state agency shall notify the health plan in writing of the determination of the non-compliance, of the action(s) that must be taken, and of any other conditions related thereto such as the length of time the remedial actions shall continue and of the corrective actions that the health plan shall perform.
- a. The state agency shall require the health plan to recall the previously authorized marketing materials.
 - b. The state agency shall suspend enrollment of new members to the health plan.
 - c. The state agency shall deduct the amount of capitation payment for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the health plan and shall continue to deduct such payment until correction of the failure.
 - d. The state agency shall require the health plan to contact each member who enrolled during the period while the health plan was out of compliance, in order to explain the nature of the non-compliance and inform the member of his or her right to transfer to another health plan.
 - e. The state agency shall prohibit future marketing activities by the health plan for an amount of time specified by the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.6(a-e).

- 2.29.7 Basis for Imposing Intermediate Sanctions: In addition to the above, the state agency may impose intermediate sanctions when a health plan acts or fails to act as specified below. Before imposing intermediate sanctions, the state agency shall give the health plan timely written notice that identifies the violation and explains the basis and nature of the sanction. A health plan is subject to intermediate sanctions if it:
- a. Fails substantially to provide medically necessary services that the health plan is required to provide, under law or under the contract, to a member covered under the contract.
 - b. Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the MO HealthNet program.
 - c. Acts to discriminate among members on the basis of their health status or need for health care services.
 - d. Misrepresents or falsifies information that it furnishes to CMS or to the state agency.
 - e. Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.
 - f. Fails to comply with the requirements for PIPs, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
 - g. Distributes directly or indirectly through any agent or independent subcontractor, marketing materials that have not been approved by the state agency or that contain false or materially misleading information.
 - h. Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.7(a-h).



- 2.29.8 Types of Intermediate Sanctions: The types of intermediate sanctions that the state agency may impose upon the health plan include:
- a. Civil monetary penalties in the following specified amounts:
 1. A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members, or health care providers; failure to comply with PIP requirements; or marketing violations.
 2. A maximum of \$100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or the state agency.
 3. A maximum of \$15,000 for each member the state agency determines was discriminated against based on the member's health status or need for services (subject to the \$100,000 limit above).
 4. A maximum of \$25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the MO HealthNet program. The state agency shall return the amount of overcharge to the affected member(s).
 - b. Appointment of temporary management for a health plan as provided herein and in 42 CFR 438.706.
 - c. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
 - d. Suspension of all new enrollments, including default enrollment, after the effective date of the sanction.
 - e. Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the state agency is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
 - f. Additional sanctions as set forth herein or in State law or State regulation.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.8.

- 2.29.9 Special Rules for Temporary Management: The state agency shall impose the sanction of temporary management on the health plan in the following circumstances.
- a. Temporary management may be imposed by the state agency only if it finds that:
 1. There is continued egregious behavior by the health plan, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act;
 2. There is substantial risk to members' health; or
 3. The sanction is necessary to ensure the health of the health plan's members while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the health plan.
 - b. The state agency shall impose temporary management if it finds that the health plan has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Act. The state agency shall also grant members the right to terminate enrollment without cause and shall notify the affected members of their right to terminate enrollment.
 - c. The state agency's election to appoint temporary management shall not act as an implied waiver of the State's right to terminate the contract, suspend enrollment, or to pursue any other remedy available to the state agency under the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.9(a-c).



2.29.10 Legal Actions and Attorney Fees: In addition to the above described rate adjustments and remedies, if the state agency determines that the health plan is not taking proper action to correct the identified failures, the state agency shall have the right to implement any other legal processes deemed necessary including, but not limited to, cancellation of the contract, recovery of damages, and suspension of new enrollments in the health plan. In the event the state agency should prevail in any legal action arising out of the performance or non-performance of the contract, the health plan shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.10.

2.29.11 Federal Sanctions: Section 1903(m)(5) of the Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a health plan for members who enroll after the date on which the health plan has been found to have committed one or more of the violations identified below ("new members"). In addition to any sanctions and actions specified above, the state agency shall deny payments under the contract with respect to new members when, and for so long as, payment for the new members is denied by the Secretary of Health and Human Services under the authority of Section 1903(m)(5) of the Act or 42 CFR 438.730.

- a. Substantial failure to provide a member with medically necessary items or services that the health plan is required to provide, under law or under the contract, when the failure has adversely affected (or has a substantial likelihood of adversely affecting) the member,
- b. Discrimination among individuals in violation of Section 1903(m)(2)(A)(v) of the Act, including expulsion or refusal to re-enroll an individual or engage in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as otherwise permitted by statute) by eligible individuals with the health plan whose medical condition or history indicates a need for substantial future medical services,
- c. Misrepresentation or falsification of certain information furnished to the Secretary of Health and Human Services, the state agency, an individual, or to any other managed care entity, or
- d. Failure to comply with the requirements for PIPs as specified herein and as set forth (for Medicare) in Section 1876(i)(8) of the Act.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.11(a-d).



2.29.12 Termination of a Health Plan Contract:

- a. Nothing in this section shall limit the State's right to terminate the contract or to pursue any other legal or equitable remedies. Pursuant to 42 CFR 438.708, the State may terminate the contract as a sanction and enroll the health plan's members in other health plans or provide their benefits through other options included in the State plan if the state agency, at its sole discretion, determines that the health plan has failed to:
 - 1. Carry out the substantive terms of the contract; or
 - 2. Meet applicable requirements in sections 1932 and 1903(m) of the Act.
- b. After the State notifies the health plan that it intends to terminate the contract, the state agency may do the following:
 - 1. Give the health plan's members written notice of the State's intent to terminate the contract; or
 - 2. Allow members to disenroll immediately without cause.
- c. Before terminating a health plan's contract under 42 CFR 438.708, the state agency shall provide the health plan a pre-termination hearing. The state agency shall:
 - 1. Give the health plan written notice of its intent to terminate, the reason for termination, and the time and place of the pre-termination hearing;
 - 2. Give the health plan (after the pre-termination hearing) written notice of the decision affirming or reversing the proposed termination of the contract, and for an affirming decision, the effective date of termination; and
 - 3. For an affirming decision, give members of the health plan notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.29.12(a-c).

2.30 Access to Premises

During normal business hours (defined as 8:00 a.m. through 5:00 p.m., Monday through Friday, except State designated holidays), the health plan shall allow duly authorized agents or representatives of the Federal or State government access to the health plan's premises or the health plan's subcontractor's premises to inspect, audit, monitor, or otherwise evaluate the performance of the health plan or its subcontractors.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.30.

2.31 Advance Directives

2.31.1 The health plan shall have and implement written policies and procedures related to advance directives. At the time of enrollment, the health plan shall provide written information to all adult members regarding the member's rights under the Missouri law to make decisions concerning medical care.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.31.1.

HealthCare USA Policy QI-10 *Advance Directives* addresses all required aspects of advance directives. At the time of enrollment, the member receives a new member packet that contains a welcome letter and a Member Handbook. Both documents provide written information for adult



members regarding their rights under Missouri law to make decisions concerning medical care. (*Healthcare USA Member Handbook*, p. 67). Further, the HealthCare USA Member Website section *Understanding Your Rights* contains information on Advance Directives.

We also have a MO HealthNet-approved Advance Directive brochure available to members (see below).



2.31.2 The health plan shall provide education to the health plan's personnel and members on issues concerning advance directives.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.31.2. New staff members are educated on advance directives during orientation and through employee newsletters. Members are educated through the New Member Welcome Packet, the Member Handbook and the Member Website.

2.31.3 The above provisions shall not be construed to prohibit the application of any Missouri law which allows for an objection on the basis of conscience for any provider or agent of such provider.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.31.3.



2.32 Fraud and Abuse

2.32.1 Definitions:

- a. The following definitions are taken from “Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care”, A Product of the National Medicaid Fraud and Abuse Initiative, Health Care Financing Administration National Initiative, October 2000:
 1. Medicaid Managed Care Fraud: Any type of intentional deception or misrepresentation made by an entity or person in a capitated Managed Care Organization (MCO), Primary Care Case Management (PCCM) program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.
 2. Medicaid Managed Care Abuse: Practices in a capitated MCO, PCCM program, or other managed care setting that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations for health care. The abuse can be committed by an MCO, contractor, subcontractor, provider, State employee, Medicaid beneficiary, or Medicaid managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary cost to the Medicaid program or MCO, contractor, subcontractor, or provider. It should be noted that Medicaid funds paid to an MCO, then passing to subcontractors, are still Medicaid funds from a fraud and abuse perspective.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.32.1.

For specifics, refer to:

- *HealthCare USA Provider Manual*, p. 89.
- *HealthCare USA Member Manual*, pp. 48-49.

The following policies outline our procedure, and are available upon request:

- HealthCare USA policy RC-26 *Fraud, Waste & Abuse Coordination*
- HealthCare USA policy RC-10 *Subcontractors—Fraud and Abuse*



2.32.2 Fraud and Abuse and Program Integrity Policies:

- a. The health plan shall implement internal controls, policies, and procedures designed to prevent, detect, review, report to the state agency, and assist in the prosecution of fraud and abuse activities by providers, subcontractors, and members. The policies and procedures shall articulate the health plan's commitment to comply with all applicable Federal and State standards. In order to implement the above, the health plan shall submit a written fraud and abuse plan to the state agency for approval prior to implementation. Any changes to the approved fraud and abuse plan must have state agency approval prior to implementation.
- b. The health plan's fraud and abuse plan must include, but is not limited to, the following components:
 1. Provision stating that if a network provider submits fraudulent billings to the MO HealthNet Managed Care health plan, any recoveries associated with the fraudulent billing will be recovered by the State and not the health plan if the health plan previously reported those costs in a cost report used to establish rates. If, however, the fraudulent billing and recovery is done in a period where cost reports have not been submitted by the MO HealthNet Managed Care health plan for that service period, then the recovery shall go to the health plan and the health plan shall not report any of the medical costs associated with the fraudulent billings in the cost report.
 2. The designation of a compliance officer and a compliance committee that are responsible for the health plan's fraud and abuse program and activities. The compliance officer is supervised by and reports to the Chief Executive Officer (CEO), Health Plan Administrator, or the governing body;
 3. Provision for a data system, resources and staff to perform the fraud, abuse, and other compliance responsibilities;
 4. Procedures for internal prevention, detection, reporting, review, and corrective action;
 5. Procedures for prompt response to detected offenses;
 6. Procedures for reporting to the state agency, including the requirement of a quarterly fraud and abuse report and the use of State approved forms;
 7. Written standards for organizational conduct;
 8. A compliance committee that periodically meets and documents review of compliance issues. These issues include fraud, abuse, and regulatory and contractual compliance.
 9. Effective training and education for the compliance officer and the organization's employees, management, board members, and subcontractors;
 10. Inclusion of information about fraud and abuse identification and reporting in provider and member materials; and
 11. Enforcement of standards through well-publicized disciplinary guidelines.
- c. The health plan's activities to combat fraud and abuse shall include, but not be limited to the following:
 1. Conducting regular reviews and audits of operations, and provider and member conduct to guard against fraud and abuse;
 2. Assessing and strengthening internal controls to ensure claims are submitted and payments are made properly, and that only MO HealthNet Managed Care members are served under the contract;
 3. Requesting documentation from adult MO HealthNet members, such as MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility), as well as the health plan membership card prior to accessing non-emergency services;
 4. Educating employees, network providers, and beneficiaries about fraud and abuse and how to report it;
 5. Use of effective organizational resources to respond to complaints of fraud and abuse;
 6. Establishing procedures to process fraud and abuse complaints;
 7. Establishing procedures for reporting information to the state agency; and
 8. Developing procedures to monitor utilization/service patterns of providers, subcontractors, and beneficiaries.



- d. The health plan shall initiate an immediate investigation to gather facts regarding any suspected fraud or abuse by providers or members. The health plan shall notify the state agency of all suspected fraud or abuse, as provided herein, in keeping with Federal requirements at 42 CFR 455.13. In addition, the health plan shall provide reports of its investigative, corrective, and legal activities to the state agency in accordance with contractual and regulatory requirements.
- e. The health plan and its subcontractors shall cooperate fully in any State or Federal reviews or investigations, including the preliminary and full investigations referenced in 42 CFR Part 455, Subpart A (Medicaid Agency Fraud Detection and Investigation Program), and in any subsequent legal action.
- f. The health plan shall implement corrective actions in instances of fraud and abuse detected by the state agency, or other authorized agencies or entities. The health plan shall suspend payment to any provider, pending any State or Federal review or investigation of suspected fraud or abuse, if so instructed by the state agency.
- g. Failure on the part of the health plan to adhere to all Federal and State fraud and abuse requirements and standards may subject the health plan to sanctions as described herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.32.2(a-g).

HealthCare USA has internal controls, policies and procedures in place that are designed to prevent, detect, review report to the State agency, and assist in the prosecution of fraud and abuse activities by providers, subcontractors, affiliates, and members.

HealthCare USA adheres to a fraud and abuse plan, which has been approved by the State. Within the plan, there are several policies and procedures which articulate the commitment to comply with the standards set federally and by the State. Any changes that are made to the plan are sent to the State for approval prior to implementing these changes.

HealthCare USA has a Compliance Committee that addresses the fraud and abuse program and activities. The Committee meets periodically to review fraud and abuse issues. Monthly fraud and abuse meetings are held to discuss open cases regarding members, providers, subcontractors or affiliates in detail. The results are reported, documented and made accessible for future references. Annually, the fraud and abuse program is presented to the Quality Management Committee (QMC). The Compliance Committee also evaluates the overall internal fraud and abuse program in order to assess the outcomes of the plan and improve prevention and detection methods. The Compliance Officer, HealthCare USA's Director of Government Relations and Regulatory Affairs, reports directly to the Chief Executive Officer (CEO).

HealthCare USA has several approaches to internally controlling fraudulent or abusive behaviors among our providers, members and employees.

PREVENTION

- Training employees on prevention, detection and reporting activities.
- Educating employees, providers and members with clear documentation.
- Maintaining lists of suspected members and providers to monitor their activities and services.



DETECTION

- Receiving “red flag” lists and reviewing the individual’s actions. These lists include but are not limited to PCP change requests and high Emergency Department utilization.
- Regularly auditing and reviewing providers, subcontractors, affiliates, members and employees.
- Referring any unmet medical needs that are identified to a complex case manager for evaluation.
- Monitoring of member grievances and appeals and provider complain, grievances and appeals.

REPORTING

- Maintaining a hotline for employees to report any suspected issues.
- Providing means of reporting to members and providers.
- Regularly holding meetings to discuss possible fraud and abuse cases.
- Updating data systems, as well as “red flag” lists to facilitate the detection process.
- Submitting reports to the State, which contain demographics and activity descriptions and quarterly reports, which contain the resolution and corrective action taken.

REVIEW

- Developing new cases and starting the investigation process.
- Contacting providers, members, or other individuals involved in the case.
- Inspecting the suspected individual’s previous activities or audits.
- Discussing the options for corrective action in committee meetings.

CORRECTIVE ACTION

- Sending notification letters, including the general member notification letter and the transportation notification letter, which provide the necessary education to members, provider, and/or employees.
- Placing suspected individuals in the “red flag” lists.
- Utilizing case management and the lock-in program when necessary.
- Allocating necessary disciplinary actions including warning, suspension, termination or legal action.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy RC-26 *Fraud, Waste & Abuse Coordination*
- HealthCare USA policy RC-10 *Subcontractors—Fraud and Abuse*



2.32.3 Fraud and Abuse Reporting:

- a. Quarterly Reporting: On a quarterly basis, the health plan shall report to the state agency all instances of suspected provider fraud, abuse or waste, or member abuse of services covered under the contract, using a format and data elements prescribed by the state agency. The health plan shall follow the requirements outlined in the policy statements found in Attachment 3.
 1. At a minimum, the health plan shall include the following in each report, with respect to individual investigations of provider fraud, abuse, or waste:
 - Member name and ID number;
 - Provider name and NPI;
 - Source of complaint;
 - Type of provider;
 - Nature of complaint, including alleged persons or entities involved, category of services, factual explanation of the allegation, and dates of the conduct;
 - All communication between the health plan and the provider about the complaint;
 - Date of the complaint;
 - Approximate dollars involved or amount paid to the provider during the past three years, whichever is greater;
 - Disciplinary measures imposed, if any;
 - Contact information for health plan personnel with relevant knowledge of the matter; and
 - Legal and administrative disposition of the case.
 2. The health plan shall include in the report the following information concerning suspected fraud by members or other persons seeking services:
 - Member name and ID number, if applicable;
 - Name of provider who is the source of the information, if applicable;
 - Alleged persons or entities involved, factual allegations, and dates of the conduct; and
 - Contact information for health plan personnel with relevant knowledge of the matter.
 3. The health plan shall include in the list a report of all provider terminations, or denials of credentialing or re-credentialing, that occurred during the report period. The report shall clearly indicate the basis for the health plan's action.
 4. The health plan shall also include in the report a summary (not specific to an individual case) of investigative activities, corrective actions, prevention efforts, and results relating to provider or member fraud and abuse.
- b. Other Fraud and Abuse Reporting:
 1. The health plan shall report to the state agency, within one (1) business day of receiving such information, any information concerning member fraud or abuse. This includes information that the health plan receives concerning an adult member or other person who is suspected of fraudulently transferring his or her MO HealthNet identification card or health plan membership card to another person, or of fraudulently using another person's card in order to access health services.
 2. Within one (1) business day of initiating an investigation, the health plan shall report to the state agency on the suspected case(s) of provider fraud and abuse. In addition, the health plan shall provide reports to the state agency on the outcomes of its investigations. This requirement does not supplant the requirement, contained herein, that the health plans submit to the state agency a quarterly fraud and abuse report.



- c. The state agency shall refer to the MFCU the information reported by health plans under this subsection, if the reports of suspected fraud or abuse are substantiated by the state agency's preliminary investigation (see 42 CFR Part 455, Subpart A).

HealthCare USA understands and shall comply with the requirements set forth in Section 2.32.3.

2.32.4 Identification of Debarred Individuals or Excluded Providers in Health Plans:

- a. The health plan shall exclude providers from the health plan network that have been identified as having Office of Inspector General (OIG) sanctions, having failed to renew license or certification registration, having a revoked professional license or certification, or have been terminated by the state agency.
- b. The health plan shall not contract with, or otherwise pay for any items or services furnished, directed or prescribed by a provider that has been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either 1128 or section 1128A of the Social Security Act, except as permitted under 42 CFR 1001.1801 and 1001.1901.
- c. The health plan can access debarred and OIG (<http://oig.hhs.gov>) sanction information on the Internet. The health plan shall also access information from the Professional Registration Boards Internet site (<http://pr.mo.gov>) to identify State initiated terminations.
- d. The state agency or its authorized agent shall conduct a periodic review to determine if appropriate exclusions and corrective action have occurred. The health plan shall promptly notify the state agency, using the template provided in Attachment 6b, when it learns that a provider in its network has been debarred. The state agency shall report such information to the Secretary of Health and Human Services, as required by 42 CFR 438.610(c).
- e. The health plan shall on a monthly basis submit a letter to the state agency to confirm that the health plan is compliant with the contractual requirement to review provider exclusions.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.32.4(a-e).

For further details on Section 2.32.4, see Sections 4.4.4 and 4.4.7.

2.32.5 Disclosure of Ownership and Control Information, Criminal Convictions, and Significant Business Transactions: Within thirty-five (35) days of a written request from the state agency, the health plan shall disclose to the state agency 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 1001.1001-1051. This disclosure shall be made in accordance with the requirements herein.

- a. The current report format may be found in Attachment 6b.
 1. Information on Ownership and Control:

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- The name and address of any person (individual or corporation) with an ownership or control interest in the health plan, or in any provider or subcontractor in which the health plan has an ownership of



five percent (5%) or more; the date of birth and Social Security Number (in the case of an individual); and the tax identification number (in the case of a corporation). The Social Security Number is due upon contract award.

- Whether the person(s) (individual or corporation) named is related as a spouse, parent, child, or sibling to another named person.
- The name of any other disclosing entity (as defined in 42 CFR 455.101) in which an owner of the health plan has an ownership or control interest.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- The name of any other disclosing entity (as defined in 42 CFR 455.101) in which an owner of the health plan has an ownership or control interest.
2. Criminal Convictions: The identity of any person who has an ownership or control interest in the health plan, or is an agent or managing employee of the health plan and who has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.
 3. Disclosure from officials in legislative and executive branches of government as to possible conflicts of interest.
 4. Significant Business Transactions:
 - If the contract is renewed or extended, the health plan shall disclose information on business transactions which occurred during the prior contract period. If the contract is an initial contract with the state agency, but the health plan has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed. The health plan shall provide this information on the date contracts are renewed and in an electronic format specified by the state agency. The business transactions which shall be reported are not limited to transactions related to serving the MO HealthNet Managed Care Program enrollment. All of the health plan’s business transactions shall be reported.
 - The ownership of any provider or subcontractor with whom the health plan has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the disclosure.
 - Any significant business transactions (defined in 42 CFR 455.101 as those that, during any one fiscal year, exceed the lesser of \$25,000 and five percent (5%) of the health plan’s total operating expenses) between the health plan and any wholly owned supplier, or between the health plan and any provider or other subcontractor, during the five (5) year period ending on the date of the disclosure.
 5. If the health plan is not a federally qualified HMO, the disclosure of certain transactions with parties in interest to the state agency. Transactions shall be reported according to the following guidelines:
 - The health plan shall disclose the following transactions:
 - Any sale, exchange, or lease of any property between the health plan and a party in interest;
 - Any lending of money or other extension of credit between the health plan and a party in interest;



- Any furnishing for consideration of goods, services (including management services), or facilities between the health plan and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.
 - The information which shall be disclosed in the transactions includes:
 - The name of the party in interest for each transaction;
 - A description of each transaction and the quantity or units involved;
 - The accrued dollar value of each transaction during the fiscal year; and
 - Justification of the reasonableness of each transaction.
 - b. The health plan shall collect from subcontracted benefit management organizations and their contracted providers, and from all other providers directly contracted with the health plan, the same disclosures as are listed in subsections (a)(1)-(4) above (with each instance, the term “health plan” being deemed to apply to the reporting subcontracted organization or provider), according to the timeframes described herein. The health plan shall promptly forward such disclosures to the state agency and shall also forward to the state agency information concerning failure of a provider to make timely or accurate disclosures.
 - c. If the health plan fails to comply with the disclosure requirements in this subsection, the health plan shall be subject to the Federal sanction of denial of Federal financial participation, pursuant to 42 CFR 455.104(e). The state agency shall withhold all payments to the health plan, of which the Federal share has been withheld pursuant to 42 CFR 455.104(e).
 - d. Definitions:
 1. In general, the definitions listed in 42 CFR 455.101 shall govern disclosures under this subsection.
 2. A “managing employee” is defined in 42 CFR 455.101 as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
 3. A “person with an ownership or control interest” shall mean a person or corporation that (1) has an ownership interest totaling five percent (5%) or more of the health plan; (2) has an indirect ownership interest equal to five percent (5%) or more of the health plan; (3) has a combination of direct and indirect ownership interests equal to five percent (5%) or more in the health plan; (4) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the health plan or by its property or assets, if that interest is equal to or exceeds five percent (5%) of the total property and assets of the health plan; (5) is an officer or director of the health plan (if it is organized as a corporation); or (6) is a partner in the health plan (if it is organized as a partnership).
 - The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the health plan’s assets used to secure the obligation (e.g., if a person owns 10 percent (10%) of a note secured by 60 percent (60%) of the health plan’s assets, the person owns six percent (6%) of the health plan).
 - The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization (e.g., if a person owns ten percent (10%) of the stock in a corporation which owns 80 percent (80%) of the stock of the health plan, the person owns eight percent (8%) of the health plan).
4. A party in interest is:



- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
- Any organization in which a person described in the subsection above is director, officer, or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
- Any person directly or indirectly controlling, controlled by, or under common control with an HMO; or
- Any spouse, child, or parent of an individual described herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.32.5(a-d).

For further details on Section 2.32.5(a)1, see Section 4.4.3(a).

For further details on Section 2.32.5(a)2, see Section 4.4.3(b).

For further details on Section 2.32.5(a)3-4, see Section 4.4.3(c).

For further details on Section 2.32.5(a)5, see Section 4.4.2.

For further details on Section 2.32.5(d), see Section 4.4.3(d).

2.32.6 In accordance with 42 CFR 455.106(b), the state agency shall notify the HHS Office of the Inspector General (OIG) within twenty (20) working days of any disclosures made by the health plan under 42 CFR 455.106 (relating to criminal convictions of the provider, or of a person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider).

HealthCare USA understands and shall comply with the requirements set forth in Section 2.32.6.

2.32.7 The State shall terminate the contract with the health plan if it determines at any time that the health plan has been excluded by OIG under 42 CFR 1001.1001 (relating to OIG exclusion of entities owned or controlled by a sanctioned person) or 1001.1051 (relating to OIG exclusion of individuals with ownership or control interest in sanctioned entities); or that the health plan has, directly or indirectly, a substantial contractual relationship with an individual or entity that has been excluded by OIG under those regulations.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.32.7.

2.32.8 At a minimum, as part of the initial screen, the state agency shall screen the health plans, and their personnel, to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any other 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. In conducting this screening, the state agency will consult the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) on at least a monthly basis; and, consistent with State and Federal timeframes, the National Plan and Provider Enumeration System (NPPES), the Missouri Professional Registration Boards website, as well as any such other Federally required databases or databases as the state agency deems appropriate.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.32.8.

2.33 Other Administrative Requirements

2.33.1 Member Lock-In:

- a. The health plan shall conduct a member lock-in program in accordance with 13 CSR 70-4.070, as amended. At a minimum, the health plan shall evaluate utilization patterns of its members to identify members for lock-in, initiate and manage lock-in procedures and activities, and notify members of their rights to grieve the lock-in.
- b. The health plan shall submit its lock-in policies and procedures to the state agency for review and approval prior to implementing the program.
- c. The health plan is not responsible for the implementation of a lock-in program for pharmacy services; this is the responsibility of the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.33.1. The following policy outlines our procedure, and is available upon request:

- HealthCare USA's policy *RC-12 Member Lock-In*

2.33.2 Member Explanation of Benefits (EOB):

- a. The health plan shall provide an EOB to members upon request. In addition, on a quarterly basis, the health plan shall issue EOBs to members receiving services based on a statistically valid sample, with a level of confidence of 95%. The health plan shall ensure that the EOBs constitute a representative sample of service types and provider types.

HealthCare USA understands and shall comply with the requirements in Section 2.33.2a.

EOBs Upon Request

Upon request, HealthCare USA provides our members with an explanation of benefits (EOB). To request an EOB, members may call Member Services at 1-800-566-6444 and specify the date range for which they would like information.

Once the request is received, a Private Health Information (PHI) form is mailed to the member to obtain authorization for release of PHI. Upon return of the PHI form, Member Services requests the EOB and mails it to the member, along with an explanation of the member's appeal rights and responsibilities.



EOBs to Randomly-Selected Members with Claims

In addition to member-requested explanation of benefits, each quarter HealthCare USA extracts a statistically valid sample of claims that were paid for our members in that quarter with a 98% level of confidence.

For each randomly-selected claim, an explanation of benefits letter is sent to the member the claim was for. This letter includes the required fields of an EOB as outlined in Section 2.33.2b and is written in the sixth-grade reading level. We use this letter rather than a standardized EOB form because the format is easier for members to understand and because we are requesting members to call Member Services if they did not receive the care.

If Member Services receives a call indicating the member did not receive the service, we document the issue and research the claim. If HealthCare USA finds that the service was not furnished, the claim is recouped from the provider. Additionally, the provider may be referred to the HealthCare USA Special Investigations Unit (SIU), law enforcement agencies, and/or the State Medicaid agency.

2.33.2b. The EOB shall consist of:

1. A list of services provided and billed to the health plan;
 2. The name of the provider furnishing the service;
 3. The date on which the service was furnished; and
 4. Paid and unpaid claims. For any unpaid claims, the health plan shall provide the reason the claim was not paid.
-

HealthCare USA understands and shall comply with the requirements of Section 2.33.2b.

All EOBs sent to HealthCare USA members contain a list of services billed to HealthCare USA. EOBs sent to our members list the provider furnishing the services and the date the services were furnished. Both paid and unpaid claims are listed, and for unpaid claims, the reason why they were not paid is included.

2.33.2c. The health plan shall develop and implement a process to track and monitor all EOB requests.

- The process shall include, at a minimum:
1. The date of each EOB request;
 2. The name of the member requesting the EOB;
 3. The date the EOB is provided to the member;
 4. Any complaint received from members as a result of an EOB, including date of complaint and nature of complaint; and
 5. Resolution of the complaint, including date of resolution.
-

HealthCare USA understands and shall comply with the requirements of Section 2.33.2c.

All EOB requests are documented in Navigator, our premier integrated contact management application used for documenting all member, provider, and non-member inquiries, grievances and appeals. The Member Services staff documents all information regarding the dispute in Navigator, and forwards the issue to the appropriate department for further review.



EOB request information is tracked and monitored in Navigator including, but are not limited to;

- Date of the EOB request
- Name of the member requesting the EOB
- Date the EOB is provided to the member
- Any complaints related to the EOB request and the complaint resolution

HealthCare USA tracks complaints received from the members and resolves the complaints according to its established policies and procedures. All complaints are investigated and handled according to HealthCare USA's grievance policy. Additionally, Coventry identifies, reports, monitors, and when appropriate, refers for prosecution, situations in which suspected fraud or abuse occurs in accordance with applicable state and federal law guidelines.

2.33.2d. The health plan shall make copies of EOBs and monitoring results available to the state agency upon request.

HealthCare USA understands and shall comply with the requirements of Section 2.33.2d.

HealthCare USA shall make available all EOB results to the state agency upon request.

All EOB requests and supporting attachments are logged and stored in Navigator. Reports are available upon request on a daily, weekly, quarterly or yearly basis.

2.33.3 MO HealthNet Consumer Advocacy Project Meetings: The health plan shall meet with the MO HealthNet Consumer Advocacy Project three (3) times per year to discuss trends of program occurrences, both positive and negative, and to discuss the services provided by the health plan during the period. At least one of the meetings will be face-to-face with the MO HealthNet Consumer Advocacy Project.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.33.3.

HealthCare USA's Director of Government Relations regularly attends these meetings with support from our community development team. In addition, HealthCare USA meets quarterly with our own Member Advisory Committees (MAC) in each of the regions and brings feedback from our MAC meetings to the MO HealthNet Consumer Advocacy Project meetings.

HealthCare USA will continue attending the MO HealthNet Consumer Advocacy Project meetings in the future and will also continue meeting quarterly with our MAC members as we very much value the feedback of our membership.



2.34 Other State and Federal Legal Compliance Requirements

2.34.1 Unless otherwise specified herein, the health plan shall furnish all materials, labor, facilities, equipment, and supplies necessary to perform the service required herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.1. HealthCare USA currently furnishes all materials, labor, facilities, equipment, and supplies necessary to perform the services required under the contract, either directly or through the use of the subcontractors or affiliate. As explained in detail throughout this response, HealthCare USA's three offices in Missouri, one in each region, are equipped to continue to provide services to MO HealthNet enrollees and the state agency, as it has done for sixteen years. Transition from the existing contract that HealthCare USA holds with the MO HealthNet Division to the new contract beginning in July 2012 will be seamless as a result of HealthCare USA's deeply-rooted experience and familiarity with the program.

2.34.2 Within five (5) business days after issuance of the Notice of Award by the Division of Purchasing and Materials Management, the health plan shall submit a written identification and notification to the state agency of the name, title, address, and telephone number of one (1) individual within its organization as a duly authorized representative to whom all correspondence, official notices, and requests related to the health plan's performance under the contract shall be addressed. The health plan shall have the right to change or substitute the name of the individual described above as deemed necessary provided that the state agency is notified immediately.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.2.

2.34.3 The health plan shall understand and agree that the contract, in part, shall implement the MO HealthNet Managed Care Program. Therefore, the health plan shall conform to such requirements or regulations as the United States Department of Health and Human Services issues.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.3.

2.34.4 The health plan shall understand and agree that the MO HealthNet Managed Care Program is subject to modification by the Missouri General Assembly, the State of Missouri, and the United States Department of Health and Human Services. Any changes to the program shall be made via notification to the health plan. The state agency will ensure that any program changes resulting in changes to rate will be done in an actuarially sound manner.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.4.



2.34.5 If the state agency receives written notice from the United States Department of Health and Human Services that the health plan does not meet the definition of an HMO as set forth in the Medicaid State Plan and 42 CFR 434 or receives written notice from the Department of Insurance, Financial Institutions & Professional Registration that the health plan does not have a certificate of authority to establish or operate an HMO, the Division of Purchasing and Materials Management may cancel the contract with the health plan pursuant to contract cancellation provisions contained herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.5.

2.34.6 In the event that changes in Federal or State law require the Division of Purchasing and Materials Management to modify the contract, when deemed appropriate a written amendment will be issued to the health plan pursuant to provisions for contract amendment stated herein.

a. The terms of the contract and any amendment thereto must receive the approval of the United States Department of Health and Human Services. The United States Department of Health and Human Services failure to approve a provision of the contract shall render the provision null and void.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.6.

2.34.7 The health plan shall guarantee and certify that no State of Missouri legislator or State of Missouri employee holds a controlling interest in the health plan.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.7.

HealthCare USA is a fully-owned subsidiary of Coventry Health Care, Inc. There is no State of Missouri legislator or State of Missouri employee who holds a controlling interest in HealthCare USA.

2.34.8 The health plan shall guarantee and certify that no funds paid to the health plan by the state agency shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or state agency, a member of the United States Congress, or State Legislature. The health plan shall disclose if any funds other than those paid to the health plan by the state agency have been used or will be used to influence the persons or entities indicated above and will assist the state agency in making such disclosures to CMS.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.8.



2.34.9 The health plan shall understand and agree that the State of Missouri (its departments and employees) does not maintain commercial liability insurance.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.9.

2.34.10 Members are the intended beneficiaries of the contracts and as such are entitled to the remedies accorded to third party beneficiaries under the law.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.10.

2.34.11 The health plan is prohibited from using MO HealthNet Managed Care funds for services provided in the following circumstances:

- a. Items or services provided by any financial institution or entity located outside the United States;
- b. Non-emergency services provided by or under the direction of an excluded individual;
- c. Any funds not used under the Assisted Suicide Funding Restriction Act of 1997; and
- d. Any amount expended for roads, bridges, stadiums, or any other item.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.11 (a-d).

2.34.12 The Missouri Department of Insurance, Financial Institutions & Professional Registration regulates the health plans licensed in Missouri including their financial stability. Therefore, the health plan shall comply with all Department of Insurance, Financial Institutions & Professional Registration applicable standards.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.34.12.

2.35 Actions Upon Termination of Contract

2.35.1 Termination or cancellation of the contract does not eliminate the health plan's responsibility to the state agency for overpayments made to the health plan. If the contract is terminated or canceled, the health plan shall return to the state agency any payments advanced to the health plan for coverage of members for periods after the date of contract termination or cancellation. The health plan shall return such payments to the state agency within ninety (90) calendar days of contract termination/cancellation.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.35.1.



2.35.2 If the contract is terminated, the health plan shall promptly supply all information necessary for the reimbursement of any outstanding claims.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.35.2.

2.35.3 In the event the contract is canceled, the state agency shall notify all members of the date of cancellation and process by which the members will continue to receive contract services and the health plan shall be responsible for all expenses related to said notification under these circumstances. In the event the contract is terminated by mutual consent, the state agency shall notify all members of the date of termination and process by which the members will continue to receive contract services; and the state agency shall be responsible for all expenses relating to said notification.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.35.3.

2.36 Sexual Harassment Policy

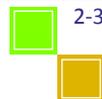
The health plan shall have a written policy regarding the illegality of sexual harassment. At a minimum, the policy shall include:

- a. The definition of sexual harassment under Federal and State law, as amended;
 - b. The health plan's internal complaint process including penalties;
 - c. The legal recourse, investigative, and complaint process available for members through the state agency and for employees through the Missouri Commission on Human Rights; and
 - d. Instructions on how to contact the state agency and the Missouri Commission on Human Rights.
-

HealthCare USA understands and shall comply with the requirements set forth in 2.36.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy HR-2 *Sexual Harassment*.





2.37 Invoicing and Payment Requirements

On a monthly basis, as near as practical to the fifth day of the calendar month following the month for which services have been performed and for which payment is being made, the state agency shall make payments to the health plan via electronic funds transfer in accordance with the following:

- 2.37.1 For each member enrolled on the first of the month, the state agency shall pay the health plan the firm, fixed per member, per month base capitation rate specified on the specific region's Pricing Page for the Category of Aid Rate Subgroup for the member. The per member, per month base capitation rate shall reflect any reduction or increase pursuant to the health plan's performance in screening 80 percent (80%) of eligible members as measured in accordance with the CMS 416 reporting methodology. Effective January 1, 2013, the per member, per month base capitation rate shall also reflect any upward or downward adjustment due to the health plan's budget neutral case mix factor as determined by the risk adjustment process.
- a. The state agency shall pro-rate the base capitation rate when the member's birth date necessitates a change to a different Category of Aid or Rate Subgroup in a given month.
 - b. For members enrolled at any time after the beginning of the month's payment cycle, the state agency shall pro-rate the base capitation rate for the first partial month.
 - c. For members whose enrollment lapses for any period of a month in which a capitation payment was made due to loss of eligibility, death, or other circumstance, the state agency shall adjust its next monthly capitation payment to recoup the portion of the capitation payment to which it is due a refund.
 - d. Any payment pro-rations shall be on a daily basis.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.37.1 (a–d).

HealthCare USA has created and maintains a detailed premium and membership reconciliation processes. Our team partners with MO HealthNet to ensure the premium and membership processes are accurate and reliable. HealthCare USA is prepared for this transition and anticipates an efficient and transparent process with the state.

- 2.37.2 In addition to the base capitation payment specified above, after receipt of encounter data from the health plan, the state agency shall make a one-time supplemental payment for the following events:
- a. Following deliveries, the state agency shall make a one-time delivery event payment to the health plan in the amount specified on the Pricing Pages for a member where a delivery has occurred. The one-time delivery event payment shall constitute the health plan's total reimbursement for all delivery-related services provided to the mother during her associated hospital admission. Multiple births shall constitute one (1) delivery. Monthly capitation payments will continue to be paid for pregnant women during their pregnancy.
 - b. Following a birth of a low birth weight newborn, the state agency shall make a neonatal intensive care unit (NICU) payment to the health plan in the amount specified on the Pricing Pages for a member where a very low birth rate newborn has been documented. The NICU payment shall constitute the health plan's total reimbursement for the additional risk associated with the low birth weight newborn during the first year of life not already reimbursed through the per member, per month capitation payment.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.37.2.



2.37.3 The health plan shall accept capitation payments as specified herein and shall have and implement written policies and procedures for receiving and processing the capitation payments.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.37.3.

2.37.4 The health plan shall agree and understand that the capitation and supplemental payments specified herein shall be the only payments made to the health plan for all services required herein and that no other payment or reimbursement for any reason whatsoever shall be made to the health plan. In exchange for the capitation and supplemental payments, the health plan shall be liable or “at risk” for the costs of all covered services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.37.4.

2.37.5 In the event that the Missouri General Assembly appropriates funds expressly for the services required herein, the State of Missouri shall amend the contract. In such event, the health plan shall pass fee increases to its providers commensurate with the Missouri General Assembly’s intent. It must clearly be the intent of the Missouri General Assembly that increases be added during an ongoing contract period for any such amendment to take place.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.37.5.



2.38 Business Associate Provisions

- 2.38.1 Health Insurance Portability and Accountability Act of 1996, as amended - The state agency and the health plan are both subject to and must comply with 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, and hereinafter, HIPAA) and all regulations promulgated pursuant to authority granted therein. The health plan constitutes a “Business Associate” of the state agency as such term is defined in the Code of Federal Regulations (CFR) at 45 CFR 160.103. Therefore, the term, “health plan” as used in this section shall mean “Business Associate.”
- a. The health plan shall agree and understand that for purposes of the Business Associate Provisions contained herein, terms used but not otherwise defined shall have the same meaning as those terms defined in 45 CFR parts 160 and 164 and 42 U.S.C. §§ 17921 *et. seq.* including, but not limited to the following:
 1. “Access”, “administrative safeguards”, “confidentiality”, “covered entity”, “data aggregation”, “designated record set”, “disclosure”, “hybrid entity”, “information system”, “physical safeguards”, “required by law”, “technical safeguards”, “use” and “workforce” shall have the same meanings as defined in 45 CFR 160.103, 164.103, 164.304, and 164.501 and HIPAA.
 2. “Breach” shall mean the unauthorized acquisition, access, use, or disclosure of Protected Health Information which compromises the security or privacy of such information, except as provided in 42 U.S.C. § 17921. This definition shall not apply to the term “breach of contract” as used within the contract.
 3. “Electronic Protected Health Information” shall mean information that comes within paragraphs (1)(i) or (1)(ii) of the definition of Protected Health Information as specified below.
 4. “Enforcement Rule” shall mean the HIPAA Administrative Simplification: Enforcement; Final Rule at 45 CFR parts 160 and 164.
 5. “Individual” shall have the same meaning as the term “individual” in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502 (g).
 6. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.
 7. “Protected Health Information” as defined in 45 CFR 160.103, shall mean individually identifiable health information:
 - (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; or (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
 - (2) Protected Health Information excludes individually identifiable health information in (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity (state agency) in its role as employer.
 8. “Security Incident” shall be defined as set forth in the “Obligations of the Health Plan” section of the Business Associate Provisions.
 9. “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 164, subpart C.
 10. “Unsecured Protected Health Information” shall mean Protected Health Information that is not secured through the use of a technology or methodology determined in accordance with 42 U.S.C. § 17932 or as otherwise specified by the secretary of Health and Human Services.
 - b. The health plan agrees and understands that wherever in this document the term Protected Health Information is used, it shall also be deemed to include Electronic Protected Health Information.
 - c. The health plan must appropriately safeguard Protected Health Information which the health plan receives from or creates or receives on behalf of the state agency. To provide reasonable assurance of appropriate safeguards, the health plan shall comply with the Business Associate Provisions stated herein.



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- d. The state agency and the health plan agree to amend the contract as is necessary for the parties to comply with the requirements of HIPAA and the Privacy Rule, Security Rule, Enforcement Rule, and other rules as later promulgated (hereinafter referenced as the regulations promulgated there under).
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.1(a-d).

For specifics, refer to:

- HealthCare USA *Provider Manual Section XIV: HIPAA*, pp. 90-92.

The following policy outlines our procedure, and is available upon request:

- HealthCare USA policy RC-13 *Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security*
 - HealthCare USA policy RC-20 *Health Insurance Portability and Accountability Act (HIPAA) Violations*.
-

2.38.2 Permitted uses and Disclosures of Protected Health Information:

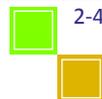
- a. The health plan may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the state agency as specified in the contract, provided that such use or disclosure would not violate HIPAA and the regulations promulgated thereunder.
 - b. The health plan 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 ten (10) calendar days after the health plan becomes aware of the disclosure of the Protected Health Information.
 - c. If required to properly perform the contract and subject to the terms of the contract, the health plan may use or disclose Protected Health Information if necessary for the proper management and administration of the health plan's business.
 - d. If the disclosure is required by law, the health plan may disclose Protected Health Information to carry out the legal responsibilities of the health plan.
 - e. The health plan 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).
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.2(a-e).

2.38.3 Obligations of the Health Plan:

- a. The health plan shall not use or disclose Protected Health Information other than as permitted or required by the contract or as otherwise required by law, and shall comply with the minimum necessary disclosure requirements set forth in 45 CFR § 164.502(b).
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.1(a).





2.38.3b The health plan shall use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by the contract. Such safeguards shall include, but not be limited to:

1. Workforce training on the appropriate uses and disclosures of Protected Health Information pursuant to the terms of the contract.
2. Policies and procedures implemented by the health plan to prevent inappropriate uses and disclosures of Protected Health Information by its workforce.
3. Encryption of any portable device used to access or maintain protected health information or use of equivalent safeguard.
4. Encryption of any transmission of electronic communication containing protected health information or use of equivalent safeguard.
5. Any other safeguards necessary to prevent the inappropriate use or disclosure of Protected Health Information.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.1(b).

HealthCare USA implements administrative, physical and technical safeguards for PHI that reasonably and appropriately protect the confidentiality, integrity and availability of PHI, including EPHI, that HealthCare USA creates, receives, maintains or transmits on behalf of the State agency, as outlined in HealthCare USA policy RC-13 *Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security*.

Such safeguards include:

- Providing training and education for our personnel on policies and procedures regarding the appropriate uses and disclosures of PHI and overseeing the implementation and enforcement of these policies and procedures.
- Assuring the proper handling, use and disclosure of members' PHI while administering their health care benefits and providing an appropriate level of customer service.
- Using encrypted portable devices when circumstances require the mobile transmission of PHI. Only select employees have the ability to store information on encrypted portable devices. System safeguards are in place to ensure that such storage only occurs with approved encrypted portable devices.
- Encrypting any transmission of electronic communication containing protected health information.
- Recognizing each member's right to privacy and treating their health information with the strictest confidence.
- Only sharing health information with others when it is appropriate for ensuring delivery of health care services, administration of health care benefits or health care payments, or as otherwise required by law.
- Sending all faxes and e-mails with a confidentiality notice that notifies the recipient that the information contained in the transmission is confidential, proprietary or privileged information and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act.



- Using a HIPAA-compliant e-mail system ensuring that if information containing PHI must be submitted to the recipient via e-mail, it can be transmitted through an encrypted secure appliance. Only the recipients intended to receive these e-mails will be notified to create an account and a password and will then be able to open the message.
- Possessing shredder bins in multiple locations throughout the office. All employees are mandated to shred all documentation containing any PHI once it is not needed to perform job functions.
- Locating all confidential data in secure locked file cabinets when it is not needed to conduct current business activities.
- Identifying, monitoring and restricting access by all guests or visitors.
- Conducting regular walk-throughs of the office premises at all three locations to assure PHI is in secure locked file cabinets when it is not needed to perform job functions.
- Guaranteeing management is responsible for authorizing all user access.
- Maintaining a managed care system of record, IDX, which is role-based and controlled through user profiles in Security Plus, a modular component of IDX. Password authentication is required and login/password security is monitored. Accounts are locked after three failed login attempts. Access is removed promptly upon employee termination and also after 90 days of account inactivity.
- Regularly backing up and securely storing all information system and electronic media.

2.38.3c. With respect to Electronic Protected Health Information, the health plan shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that health plan creates, receives, maintains or transmits on behalf of the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(c).

2.38.3d. The health plan shall require that any agent or subcontractor to whom the health plan provides any Protected Health Information received from, created by, or received by the health plan pursuant to the contract, also agrees to the same restrictions and conditions stated herein that apply to the health plan with respect to such information.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(d).

2.38.3e. By no later than ten (10) 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 health plan shall make the health plan's 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 health plan 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 Privacy Rule.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(e).

2.38.3f. The health plan shall document any disclosures and information related to such disclosures of Protected Health Information as would be required for the state agency to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 42 USCA §17932 and 45 CFR 164.528. By no later than five (5) 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 health plan shall provide an accounting of disclosures of Protected Health Information regarding an individual to the state agency. If requested by the state agency or the individual, the health plan shall provide an accounting of disclosures directly to the individual. The health plan shall maintain a record of any accounting made directly to an individual at the individual's request and shall provide such record to the state agency upon request.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(f).

2.38.3g. In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, the health plan shall, within five (5) calendar days following a state agency request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, provide the state agency access to the Protected Health Information in an individual's designated record set. However, if requested by the state agency, the health plan shall provide access to the Protected Health Information in a designated record set directly to the individual for whom such information relates.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(g).

2.38.3h. At the direction of the state agency, the health plan shall promptly make any amendment(s) to Protected Health Information in a Designated Record Set pursuant to 45 CFR 164.526.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(h).

2.38.3i. The health plan shall report to the state agency's Security Officer any security incident immediately upon becoming aware of such incident and shall take immediate action to stop the continuation of any such incident. For purposes of this paragraph, security incident shall mean the attempted or successful unauthorized access, use, modification or destruction of information or interference with systems operations in an information system. This does not include trivial incidents that occur on a daily basis, such as scans, "pings," or unsuccessful attempts that do not penetrate computer networks or servers or result in interference with system operations. By no



later than five (5) days after the health plan becomes aware of such incident, the health plan shall provide the state agency's Security Officer with a description of any remedial action taken to mitigate any harmful effect of such incident and a proposed written plan of action for approval that describes plans for preventing any such future security incidents.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(i).

2.38.3j. The health plan shall report to the state agency's Privacy Officer any unauthorized use or disclosure of Protected Health Information not permitted or required as stated herein immediately upon becoming aware of such use or disclosure and shall take immediate action to stop the unauthorized use or disclosure. By no later than five (5) calendar days after the health plan becomes aware of any such use or disclosure, the health plan shall provide the state agency's Privacy Officer with a written description of any remedial action taken to mitigate any harmful effect of such disclosure and a proposed written plan of action for approval that describes plans for preventing any such future unauthorized uses or disclosures.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(j).

2.38.3k. The health plan shall report to the state agency's Security Officer any breach immediately upon becoming aware of such incident and shall take immediate action to stop the continuation of any such incident. By no later than five (5) days after the health plan becomes aware of such incident, the health plan shall provide the state agency's Security Officer with a description of any remedial action taken to mitigate any harmful effect of such incident and a proposed written plan for approval that describes plans for preventing any such future incidents.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(k).

2.38.3l. The health plan's reports specified in the preceding paragraphs shall include the following information regarding the security incident, improper disclosure/use, or breach, (hereinafter "incident"):

1. The name, address, and telephone number of each individual whose information was involved if such information is maintained by the health plan;
2. The electronic address of any individual who has specified a preference of contact by electronic mail;
3. A brief description of what happened, including the date(s) of the incident and the date(s) of the discovery of the incident;
4. A description of the types of Protected Health Information involved in the incident (such as full name, Social Security Number, date of birth, home address, account number, or disability code) and whether the incident involved Unsecured Protected Health Information; and
5. The recommended steps individuals should take to protect themselves from potential harm resulting from the incident.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(l).



2.38.3m. Notwithstanding any provisions of the Terms and Conditions attached hereto, in order to meet the requirements under HIPAA and the regulations promulgated thereunder, the health plan shall keep and retain adequate, accurate, and complete records of the documentation required under these provisions for a minimum of six (6) years as specified in 45 CFR part 164.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(m).

2.38.3n. The health plan shall not directly or indirectly receive remuneration in exchange for any protected health information without a valid authorization.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(n).

2.38.3o. If the health plan becomes aware of a pattern of activity or practice of the state agency that constitutes a material breach of contract regarding the state agency's obligations under the Business Associate Provisions of the contract, the health plan shall notify the state agency's Security Officer of the activity or practice and work with the state agency to correct the breach of contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(o).

2.38.3p. The health plan 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 health plan or its employee(s), agent(s) or subcontractor(s). The health plan 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 health plan's negligent or wrongful actions or inactions or violations of this Agreement.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.3(p).



2.38.4 Obligations of the State Agency:

- a. The state agency shall notify the health plan of limitation(s) that may affect the health plan's use or disclosure of Protected Health Information, by providing the health plan with the state agency's notice of privacy practices in accordance with 45 CFR 164.520.
 - b. The state agency shall notify the health plan of any changes in, or revocation of, authorization by an Individual to use or disclose Protected Health Information.
 - c. The state agency shall notify the health plan of any restriction to the use or disclosure of Protected Health Information that the state agency has agreed to in accordance with 45 CFR 164.522.
 - d. The state agency shall not request the health plan to use or disclose Protected Health Information in any manner that would not be permissible under HIPAA and the regulations promulgated thereunder.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.4(a-d).

2.38.5 Expiration/Termination/Cancellation - Except as provided in the subparagraph below, upon the expiration, termination, or cancellation of the contract for any reason, the health plan shall, at the discretion of the state agency, either return to the state agency or destroy all Protected Health Information received by the health plan from the state agency, or created or received by the health plan on behalf of the state agency, and shall not retain any copies of such Protected Health Information. This provision shall also apply to Protected Health Information that is in the possession of subcontractor or agents of the health plan.

- a. In the event the state agency determines that returning or destroying the Protected Health Information is not feasible, the health plan shall extend the protections of the contract to the Protected Health Information for as long as the health plan maintains the Protected Health Information and shall limit the use and disclosure of the Protected Health Information to those purposes that made return or destruction of the information infeasible. If at any time it becomes feasible to return or destroy any such Protected Health Information maintained pursuant to this paragraph, the health plan must notify the state agency and obtain instructions from the state agency for either the return or destruction of the Protected Health Information.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.5.

2.38.6 Breach of Contract – In the event the health plan is in breach of contract with regard to the Business Associate Provisions included herein, the health plan shall agree and understand that in addition to the requirements of the contract related to cancellation of contract, if the state agency determines that cancellation of the contract is not feasible, the State of Missouri may elect not to cancel the contract, but the state agency shall report the breach of contract to the Secretary of the Department of Health and Human Services.

HealthCare USA understands and shall comply with the requirements set forth in Section 2.38.6.

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3. GENERAL CONTRACTUAL REQUIREMENTS



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3.1 Contract

A binding contract shall consist of: (1) the RFP, amendments thereto, and any Best and Final Offer (BAFO) request(s) with RFP changes/additions, (2) the health plan's proposal including any health plan BAFO response(s), (3) clarification of the proposal, if any, and (4) the Division of Purchasing and Materials Management's acceptance of the proposal by "notice of award". All Exhibits and Attachments included in the RFP shall be incorporated into the contract by reference.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.1.

3.1.1 A notice of award issued by the State of Missouri does not constitute an authorization for shipment of equipment or supplies or a directive to proceed with services. Before providing equipment, supplies and/or services for the State of Missouri, the health plan must receive a properly authorized purchase order or other form of authorization given to the health plan at the discretion of the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.1.1.

3.1.2 The contract expresses the complete agreement of the parties and performance shall be governed solely by the specifications and requirements contained therein.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.1.2.

3.1.3 Any change to the contract, whether by modification and/or supplementation, must be accomplished by a formal contract amendment signed and approved by and between the duly authorized representative of the health plan and the Division of Purchasing and Materials Management prior to the effective date of such modification. The health plan expressly and explicitly understands and agrees that no other method and/or no other document, including correspondence, acts, and oral communications by or from any person, shall be used or construed as an amendment or modification to the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.1.3.

3.2 Contract Period

The original contract period shall be as stated on page 1 of the Request for Proposal (RFP). The contract shall not bind, nor purport to bind, the state for any contractual commitment in excess of the original contract period. The Division of Purchasing and Materials Management shall have the right, at its sole option, to renew the contract for





two (2) additional one-year periods, or any portion thereof. In the event the Division of Purchasing and Materials Management exercises such right, all terms and conditions, requirements and specifications of the contract shall remain the same and apply during the renewal period, pursuant to the following:

HealthCare USA understands and shall comply with the requirements set forth in Section 3.2.

3.2.1 The state agency will include in each year's budget request to the Office of Administration, Division of Budget and Planning, a rate change based on the state agency's review of recent health plan financial experience and medical trends from other state Medicaid programs and national trend indices (CPI/DRI). The rate changes will be reflective of anticipated programmatic changes.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.2.1.

3.2.2 If the State of Missouri elects to renew the contract for the first renewal option, the health plan shall accept the amount appropriated by the Governor and the Missouri General Assembly.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.2.2.

3.2.3 If the State of Missouri elects to renew the contract for the second renewal option and if the health plan intends to renew the contract for the second renewal option, the State of Missouri and the health plan shall negotiate the firm, fixed rates applicable to the second renewal period. The State of Missouri shall commence such negotiation process approximately six months prior to the expiration of the first renewal period. Individual negotiations shall be conducted with each health plan in accordance with the negotiation provisions provided elsewhere herein.

- a. The health plan must submit information which establishes and supports the actuarial soundness of the proposed rates and a certification of said soundness from an Associate of the Society of Actuaries (ASA), a Fellow of Society of Actuaries (FSA), or a Member of the American Academy of Actuaries (MAAA).
- b. If the State of Missouri and the health plan are unable to agree upon the firm, fixed rates for the second renewal period, the pending contract renewal shall be canceled. In the event of such, the State of Missouri reserves its right to extend the contract at the current firm, fixed rates for no more than 180 days from the date such determination is made.
- c. If the health plan does not intend to renew the contract for the second renewal option and does not desire to enter into the negotiation process, the health plan shall provide written notification to the State of Missouri of such within at least 180 calendar days prior to the expiration of the contract period.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.2.3.



3.2.4 During the second and final renewal option, the State of Missouri may issue a public notice of the pending contract expiration and the upcoming opportunity to contract with the State of Missouri for MO HealthNet Managed Care services. If no health plans, other than the health plans the State of Missouri currently contracts with, indicate interest in contracting with the State of Missouri for such, the State of Missouri may elect to renew the contract with the health plan for the continuation of the MO HealthNet Managed Care services. In the event of such, the State of Missouri and the health plan shall negotiate the firm, fixed rates applicable to the renewal period. The State of Missouri shall have the option of issuing such notification on an annual basis.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.2.4.

3.3 Price

All prices shall be as indicated on the Pricing Page. The state shall not pay nor be liable for any other additional costs including but not limited to taxes, shipping charges, insurance, interest, penalties, termination payments, attorney fees, liquidated damages, etc.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.3.

3.4 Termination

The Division of Purchasing and Materials Management reserves the right to terminate the contract at any time, for the convenience of the State of Missouri, without penalty or recourse, by giving written notice to the health plan at least thirty (30) calendar days prior to the effective date of such termination. In the event of termination pursuant to this paragraph, all documents, data, reports, supplies, equipment, and accomplishments prepared, furnished or completed by the health plan pursuant to the terms of the contract shall, at the option of the Division of Purchasing and Materials Management, become the property of the State of Missouri. The health plan shall be entitled to receive compensation for services and/or supplies delivered to and accepted by the State of Missouri pursuant to the contract prior to the effective date of termination.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.4.

3.5 Force Majeure

The health plan shall not be liable for any excess costs for delayed delivery of goods or services to the State of Missouri, if the failure to perform the contract arises out of causes beyond the control of, and without the fault or negligence of the health plan. Such causes may include, however are not restricted to: acts of God, fires, floods, epidemics, quarantine restrictions, strikes, and freight embargoes. In all cases, the failure to perform



must be beyond the control of, and without the fault or negligence of, either the health plan or any subcontractor(s). The health plan shall take all possible steps to recover from any such occurrences.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.5.

3.6 Transition

Upon expiration, termination, or cancellation of the contract, the health plan shall assist the state agency to ensure an orderly and smooth transfer of responsibility and continuity of those services required under the terms of the contract to an organization designated by the state agency. If requested by the state agency, the health plan shall provide and/or perform any or all of the following responsibilities:

HealthCare USA understands and shall comply with the requirements set forth in Section 3.6

In such an event, we will provide the state with our implementation plan to transition members.

3.6.1 For a period not to exceed ninety (90) calendar days after the expiration, termination, or cancellation of the contract, the health plan shall continue providing any part or all of the services in accordance with the terms and conditions, requirements and specifications of the contract for a price not to exceed those prices set forth in the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.6.1.

3.6.2 In addition, for 365 calendar days after expiration, termination, or cancellation of the contract, the health plan shall provide those administrative functions that cannot be completed prior to the expiration, termination, or cancellation of the contract due to the nature of the function. Such administrative functions, shall include, but are not limited to, payment of claims for service dates prior to expiration, termination, or cancellation of the contract; operation of the member grievance system and provider complaints and appeals; operational data reporting, financial reporting, and communication links with the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.6.2.





3.6.3 The health plan shall deliver, FOB destination, all records, documentation, reports, data, recommendations, or printing elements, etc., which were required to be produced under the terms of the contract to the state agency and/or to the state agency's designee within thirty (30) days after receipt of the written request in a format and condition that are acceptable to the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.6.3.

3.6.4 The state agency, at its sole option, may discontinue enrolling new membership to the health plan, on a date specified by the state agency, prior to expiration, cancellation, or termination of the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.6.4.

3.7 Health Plan Liability

The health plan shall be responsible for any and all personal injury (including death) or property damage as a result of the health plan's negligence involving any equipment or service provided under the terms and conditions, requirements and specifications of the contract. In addition, the health plan assumes the obligation to save the State of Missouri, including its agencies, employees, and assignees, from every expense, liability, or payment arising out of such negligent act.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.7.

As in our present agreement with the state of Missouri, HealthCare USA shall continue to be responsible for any and all personal injury (including death) or property damage as a result of the health plan's negligence involving any equipment or service provided under the terms and conditions, requirements and specifications of the contract.

3.7.1 The health plan also agrees to hold the State of Missouri, including its agencies, employees, and assignees, harmless for any negligent act or omission committed by any subcontractor or other person employed by or under the supervision of the health plan under the terms of the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.7.1.





- 3.7.2 The health plan shall not be responsible for any injury or damage occurring as a result of any negligent act or omission committed by the State of Missouri, including its agencies, employees, and assignees.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.7.2.

- 3.7.3 Under no circumstances shall the health plan be liable for any of the following: (1) third party claims against the state for losses or damages (other than those listed above); or (2) economic consequential damages (including lost profits or savings) or incidental damages, even if the health plan is informed of their possibility.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.7.3.

3.8 Insurance

The health plan shall understand and agree that the State of Missouri cannot save and hold harmless and/or indemnify the health plan or employees against any liability incurred or arising as a result of any activity of the health plan or any activity of the health plan's employees related to the health plan's performance under the contract. Therefore, the health plan must have and maintain insurance adequate liability insurance in the form(s) and amount(s) sufficient to protect the State of Missouri, its agencies, its employees, its clients, and the general public against any loss, damage, and/or expense related to his/her performance under the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.8.

- 3.8.1 The insurance coverage shall include, but shall not necessarily be limited to, general liability, professional liability, etc. In addition, automobile liability coverage for the operation of any motor vehicle must be maintained if the terms of the contract require any form of transportation services.
- a. The limits of liability for all types of liability coverage shall not be less than \$2,000,000 per occurrence.
 - b. The insurance shall include an endorsement that adds the State of Missouri as an additional insured.
 - c. Self-insurance coverage or another alternate risk financing mechanism may be utilized provided that such coverage is verifiable and irrevocably reliable and the State of Missouri is protected as an additional insured.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.8.1



3.8.2 The health plan shall provide written evidence of the insurance to the state agency prior to performance under the contract. The evidence of insurance shall include, but shall not necessarily be limited to: effective dates of coverage, limits of liability, insurer's name, policy number, endorsement naming the State of Missouri as an additional insured/loss payee, endorsement by representatives of the insurance company, etc.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.8.2.

3.8.3 In the event any insurance coverage is canceled, the state agency must be notified immediately.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.8.3.

3.9 Subcontractors [4.4.10.a]

Any subcontracts for the products/services described herein must include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to by the health plan and the State of Missouri and to ensure that the State of Missouri is indemnified, saved, and held harmless from and against any and all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract in those matters described in the contract between the State of Missouri and the health plan.

4.4.10 Health Care Service Subcontractors

a. The offeror shall list each health care service subcontractor to whom the offeror proposes to delegate contract requirements. Examples include, but are not limited to, behavioral health services, vision, or dental. The offeror shall describe the services and activities that will be provided by such health service subcontractor. (3.9)

HealthCare USA understands and shall comply with the requirements set forth in Section 3.9 and 4.4.10(a).

HealthCare USA's agreements with our providers and subcontractors ensure that disputes remain between the provider/subcontractor and HealthCare USA. The contracts include the specific indemnification and hold harmless language, cited in our response to Section 3.9.1, to protect the State of Missouri, the Department of Social Services, and its officers, employees, and agents, and enrolled MO HealthNet members. Additional member protections are included in all provider contracts and subcontracts pursuant to applicable Missouri law and Section 2.14.9 of this RFP.

In addition, HealthCare USA's provider agreement templates and typical subcontracts include a dispute resolution provision that requires parties to make good-faith efforts to settle any disputes by negotiation within sixty (60) days of one party notifying the other party of the dispute. In the event resolution cannot be achieved through such negotiation, either party may pursue binding arbitration.



HealthCare USA has five subcontractors and one affiliate, MHNet, who acts as a subcontractor, the following describes their services and activities.

HealthCare USA Subcontractors and Affiliates	Services and Activities Provided
CareCore National	CareCore provides radiology benefit Management services for HealthCare USA.
DentaQuest, LLC.	DentaQuest provides dental services for all HealthCare USA members eligible for dental benefits.
March Vision Care Group, Inc.	March Vision provides vision services for all HealthCare USA members.
McKesson Health Solutions, LLC.	McKesson provides Nurse Hotline Services for HealthCare USA members.
MHNet Behavioral Health, Inc.	MHNet provides Mental Health and Substance Abuse Services for HealthCare USA members.
Medical Transportation Management, Inc. (MTM)	MTM provides non-emergent Transportation Services for all HealthCare USA members.

3.9.1 Health Plan Disputes With Other Providers

All disputes between the health plan and any subcontractors, shall be solely between such subcontractors and the health plan. The health plan shall indemnify, defend, save, and hold harmless the State of Missouri, the Department of Social Services and its officers, employees and agents, and enrolled MO HealthNet Managed Care members from any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of the contract because of any breach of the contract by the health plan, its subcontractors, agents, providers or employees, including but not limited to any negligent or wrongful acts, occurrence or omission of commission or negligence of the health plan, its subcontractors, agents, providers, or employees.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.9.1.

HealthCare USA’s agreements with our subcontractors ensure that disputes remain between the subcontractor and HealthCare USA. HealthCare USA includes in all subcontractor agreements a section entitled “Dispute Resolution” All subcontractor agreements have been submitted to and approved by MO HealthNet.



3.9.2 The health plan shall expressly understand and agree that the health plan shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.9.2.

3.9.3 The health plan shall agree and understand that utilization of a subcontractor to provide any of the products/services in the contract shall in no way relieve the health plan of the responsibility for providing the products/services as described and set forth herein.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.9.3.

3.9.4 The health plan must obtain the approval of the State of Missouri prior to establishing any new subcontracting arrangements and before changing any subcontractors. The approval shall not be arbitrarily withheld.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.9.4.

3.9.5 Pursuant to subsection 1 of section 285.530, RSMo, no contractor or subcontractor shall knowingly employ, hire for employment, or continue to employ an unauthorized alien to perform work within the state of Missouri. In accordance with sections 285.525 to 285.550, RSMo, a general contractor or subcontractor of any tier shall not be liable when such contractor or subcontractor contracts with its direct subcontractor who violates subsection 1 of section 285.530, RSMo, if the contract binding the contractor and subcontractor affirmatively states that:

- a. The direct subcontractor is not knowingly in violation of subsection 1 of section 285.530, RSMo, and shall not henceforth be in such violation.
- b. The contractor or subcontractor receives a sworn affidavit under the penalty of perjury attesting to the fact that the direct subcontractor's employees are lawfully present in the United States.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.9.5.

HealthCare USA includes in all provider/subcontractor agreements a section entitled "Employment of Unauthorized Aliens." All provider agreements have been submitted to and approved by MO HealthNet.

3.9.6 All subcontracts for health care services must be in writing and shall comply with all provisions of the contract and shall include at least the items listed below. In addition, all subcontractors shall comply with the applicable provisions of Federal and State laws and regulations, as amended, and policies. Before any delegation of any functions and



responsibilities to any subcontractor, the health plan shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. The health plan shall have policies and procedures to monitor the performance of health care service subcontractors to ensure that such subcontractors comply with the provisions of the contract. In addition, the health plan shall fully investigate and timely respond to issues involving subcontractors upon request of the state agency.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.9.6.

HealthCare USA has and shall obtain approval of the State of Missouri prior to establishing any new subcontracting arrangements or changing any subcontractor agreements.

We evaluate prospective subcontractors by performing pre-delegation audits before finalizing any new subcontractor agreements.

To ensure subcontractors comply with the required provisions, HealthCare USA has policies and procedures to monitor the subcontractor performance. We perform ongoing subcontractor oversight and monitoring by conducting quarterly oversight meetings and annual subcontractor evaluation.

The following policies outline our procedure and are available upon request:

- HealthCare USA policy RC-10 *Subcontractors Fraud & Abuse*
- HealthCare USA policy RC-4 *Oversight of Delegated Subcontractors*

If any issue arises with a subcontractor, HealthCare USA fully investigates the issue in a timely manner and responds to any requests from MO HealthNet.



- 3.9.6.a. A description of services to be provided or other activities performed. This description shall be in such form as to permit the state agency to ascertain definitively which contractual obligations have been subcontracted.
- b. The timeframes for paying in-network providers for covered services.
- c. Provision(s) for release to the health plan of any information necessary for the health plan to perform any of its obligations under the contract including but not limited to compliance with all reporting requirements (for example encounter data reporting requirements), timely payment requirements, and quality assessment requirements.
- d. The provision available to a health care provider to challenge or appeal the failure of the health plan to cover a service.
- e. Provision(s) that (1) the subcontractor's facilities and records shall be open to inspection by the health plan and appropriate Federal and state agencies, and (2) the medical records, or copies thereof, shall be provided to the health plan, upon request, for transfer to subsequent subcontractors for review by the state agency.
- f. Provisions that require each health care provider to maintain comprehensive medical records for a minimum of five years.
- g. A provision that when no member co-payment is required, the subcontractor shall look solely to the health plan for compensation for services provided to member.
- h. Provision(s) that prohibit any financial incentive arrangement to induce subcontractors to limit medically necessary services. A description of all financial incentive arrangements shall be included in the subcontract. In the event of a change to these financial incentive arrangements, the subcontractor shall immediately notify the health plan of such change so the health plan can meet its requirement to notify the state agency.
- i. Provisions that the health plan may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:
 - 1. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - 2. For any information the member needs in order to decide among all relevant treatment options.
 - 3. For the risks, benefits, and consequences of treatment or non-treatment.
 - 4. For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- j. Provisions that subcontractors shall not conduct or participate in health plan enrollment, disenrollment, transfer, or opt out activities. The subcontractors shall not influence a member's enrollment. Prohibited activities include:
 - 1. Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet Managed Care;
 - 2. Requiring or encouraging the member and/or guardian to use the opt out provision as an option in lieu of delivering health plan benefits;
 - 3. Mailing or faxing health plan enrollment forms;
 - 4. Aiding the member in filling out health plan enrollment forms;
 - 5. Photocopying blank health plan enrollment forms for potential members;
 - 6. Distributing blank health plan enrollment forms;
 - 7. Participating in three way calls to the MO HealthNet Managed Care enrollment helpline;
 - 8. Suggesting a member transfer to another health plan; or
 - 9. Other activities in which subcontractors are engaged in to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan.



- k. If a subcontract is with a federally qualified health center (FQHC) or rural health clinic (RHC) to provide services to members under a prepayment arrangement, a provision that the state agency shall reimburse the FQHC or RHC one hundred percent (100%) of its reasonable cost for covered services.
- l. All hospital subcontracts must require that the hospital subcontractor notify the health plan of births where the mother is a member. The subcontracts must specify which entity is responsible for notifying the Family Support Division of the birth.
- m. For contracted services, the subcontractor shall follow the claim processing requirements set forth by RSMo 376.383 and 376.384, as amended.
- n. Provisions in accordance with Federal and State laws and regulations, as amended, and policy regarding termination of the subcontract between the health plan and the subcontractor.
- o. Provisions that in the event of the subcontractor's insolvency or other cessation of operations, covered services to members shall continue through the period for which a capitation payment has been made to the health plan or until the member's discharge from an inpatient facility, whichever time is greater.
- p. The health plan and its subcontractors shall establish reasonable timely filing requirements for claims to be filed by a provider for reimbursement. The subcontractor shall inform its provider network of the timely filing requirements.
 - 1. In the case of capitated arrangements with providers, the subcontractor shall establish reasonable reporting of encounters to the health plan in sufficient detail to meet the health plan's encounter data reporting requirements.
 - 2. In the case of services provided by out-of-network providers, the health plan shall comply with State law regarding timely filing requirements.
- q. Provision for revoking the subcontract agreement or imposing other sanctions if the subcontractor's performance is inadequate.
- r. The health plan shall agree and understand that consumer protection shall be integral to the MO HealthNet Managed Care Program. All contracts between the health plan and providers shall ensure that the provider complies with the consumer protection provisions outlined in the marketing guidelines.
- s. Provision(s) that entitle each member to one free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.
- t. Provisions requiring the subcontractor to comply with all fraud and abuse provisions contained herein that are applicable to providers or other subcontractors.
- u. Provisions requiring the subcontractor to screen its employees and subcontractors to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (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 subcontract shall require that the subcontractor consult the following databases to conduct the screening on at least a monthly basis: the List of Excluded Individuals /Entities (LEIE) and the Excluded Parties List System (EPLS), located online at <https://www.epls.gov>. The subcontract shall require that the subcontractor consult the following databases, per State and Federal requirements: the National Plan and Provider Enumeration System (NPPES) located online at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, the Missouri Professional Registration Boards website, and any such other databases as the state agency may prescribe. The subcontract agreement shall require the health plan to promptly report relevant information disclosed as a resulting of the screening process. The subcontract agreement shall require the subcontractor not to employ or contract with an individual or entity identified by an initial screening; and to terminate any current employee or subcontractor identified by a routine monthly screening.



- v. Provisions requiring that subcontractors that are providers or benefit management organizations make disclosures to the health plan 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.
 - 1. For directly contracted providers, the subcontract shall require the disclosures to be provided:
At the stage of credentialing and re-credentialing,
Upon execution of the provider agreement,
Within thirty-five (35) calendar days of any change in ownership of the provider, and
At any time upon request by the state agency for any or all of the information described in herein.
 - 2. For benefit management organizations, the subcontract shall require:
That the benefit management organization provide the disclosures (concerning its own business) upon execution of its contract with the health plan, and within thirty-five (35) calendar days of any change in ownership of the organization;
That the benefit management organization collect the disclosure information from its subcontracted providers:
At the stage of credentialing and re-credentialing,
Upon execution of the provider agreement with the benefit management organization,
Within thirty-five (35) calendar days of any change in ownership of the provider, and
At any time upon request by the state agency for any or all of the information described herein.
That the benefit management organization shall promptly provide to the health plan the disclosures that it has collected from subcontracted providers.
- w. Provisions requiring that subcontracted providers observe the following requirements:
 - 1. Include the NPI of the ordering or referring physician or other professional with each claim for payment for services;
 - 2. Implement a policy of, before providing a Medicaid service to a MO HealthNet adult member, requesting and inspecting the member's MO HealthNet identification card (or other documentation provided by the state agency demonstrating MO HealthNet eligibility) and health plan membership card; and
 - 3. Report to the health plan any identified instance when the inspection discloses that the person seeking services is not a MO HealthNet Managed Care Program member.
- x. Provisions specifying that no services under the subcontract may be performed outside the United States.
- y. Provisions requiring that, at the time of execution of the subcontract and semi-annually thereafter, the health plan provide a written attestation that the subcontractor shall not knowingly utilize the services of an unauthorized alien to perform work under the subcontract, and shall not knowingly utilize the services of any subcontractor who will utilize the services of an unauthorized alien.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.9.6(a-y).





HealthCare USA's subcontractor agreements currently in place have been approved by the Missouri Department of Insurance and MO HealthNet and will be amended to include the new provisions required herein.

3.10 Assignment

HealthCare USA understands and shall comply with the requirements set forth in Section 3.10.

3.10.1 The health plan shall not transfer any interest in the contract, whether by assignment or otherwise, without the prior written consent of the Division of Purchasing and Materials Management.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.10.1.

3.10.2 The health plan shall agree and understand that, in the event the Division of Purchasing and Materials Management consents to a financial assignment of the contract in whole or in part to a third party, any payments made by the State of Missouri pursuant to the contract, including all of those payments assigned to the third party, shall be contingent upon the performance of the prime contractor in accordance with all terms and conditions, requirements and specifications of the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.10.2.

3.11 Substitution of Personnel

The health plan agrees and understands that the State of Missouri's agreement to the contract is predicated in part on the utilization of the specific key individual(s) and/or personnel qualifications identified in the proposal. Therefore, the health plan agrees and understands that any substitution of the specific key individual(s) and/or personnel qualifications identified in the proposal must be with individual(s) of equal or better qualifications than originally proposed.

HealthCare USA understands and shall comply with the requirements of Section 3.11.

3.12 Authorized Personnel

HealthCare USA understands and shall comply with the requirements set forth in Section 3.12.



3.12.1 The contractor shall only employ personnel authorized to work in the United States in accordance with applicable federal and state laws. This includes but is not limited to the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) and INA Section 274A.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.12.1.

3.12.2 If the contractor is found to be in violation of this requirement or the applicable state, federal and local laws and regulations, and if the State of Missouri has reasonable cause to believe that the contractor has knowingly employed individuals who are not eligible to work in the United States, the state shall have the right to cancel the contract immediately without penalty or recourse and suspend or debar the contractor from doing business with the state. The state may also withhold up to twenty-five percent of the total amount due to the contractor.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.12.2.

3.12.3 The contractor shall agree to fully cooperate with any audit or investigation from federal, state, or local law enforcement agencies.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.12.3.

3.12.4 If the contractor meets the definition of a business entity as defined in section 285.525, RSMo, pertaining to section 285.530, RSMo, the contractor shall maintain enrollment and participation in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the contracted services included herein. If the contractor's business status changes during the life of the contract to become a business entity as defined in section 285.525, RSMo, pertaining to section 285.530, RSMo, then the contractor shall, prior to the performance of any services as a business entity under the contract:

- a. Enroll and participate in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services required herein; AND
- b. Provide to the Division of Purchasing and Materials Management the documentation required in the exhibit titled, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization affirming said company's/individual's enrollment and participation in the E-Verify federal work authorization program; AND
- c. Submit to the Division of Purchasing and Materials Management a completed, notarized Affidavit of Work Authorization provided in the exhibit titled, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.12.4.





3.12.5 In accordance with subsection 2 of section 285.530, RSMo, the contractor should renew their Affidavit of Work Authorization annually. A valid Affidavit of Work Authorization is necessary to award any new contracts.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.12.5.

AMENDMENT 2 DELETED THE FOLLOWING ITEM.

3.12.6 DELETED

3.13 Health Plan Status

The health plan represents himself or herself to be an independent contractor offering such services to the general public and shall not represent himself/herself or his/her employees to be an employee of the State of Missouri. Therefore, the health plan shall assume all legal and financial responsibility for taxes, FICA, employee fringe benefits, workers compensation, employee insurance, minimum wage requirements, overtime, etc., and agrees to indemnify, save, and hold the State of Missouri, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.13.

3.14 Coordination

The health plan shall fully coordinate all contract activities with those activities of the state agency. As the work of the health plan progresses, advice and information on matters covered by the contract shall be made available by the health plan to the state agency or the Division of Purchasing and Materials Management throughout the effective period of the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.14.

To facilitate regular communication concerning these matters, HealthCare USA proposes quarterly meetings with the state, using a set agenda for review and updates, throughout the effective period of the contract.



3.15 Property of State

All documents, data, reports, supplies, equipment, and accomplishments prepared, furnished, or completed by the health plan pursuant to the terms of the contract shall become the property of the State of Missouri. Upon expiration, termination, or cancellation of the contract, said items shall become the property of the State of Missouri.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.15.

3.16 Confidentiality

3.16.1 The health plan shall agree and understand that all discussions with the health plan and all information gained by the health plan as a result of the health plan'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.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.16.1.

3.16.2 If required by the state agency, the health plan and any required health plan personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request. Failure of the health plan and any required personnel to sign such documents shall be considered a breach of contract and subject to the cancellation provisions of this document.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.16.2.

3.16.3 The health plan shall provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.16.3.





3.16.4 The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.16.4.

3.16.5 In complying with the requirements of this section, the health plan and the state agency 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 alcohol and drug abuse patient records.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.16.5.

3.16.6 The health plan 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.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.16.6.

3.17 Performance Security Deposit

The health plan must furnish a performance security deposit in the form of an original bond issued by a surety company authorized to do business in the State of Missouri (no copy or facsimile is acceptable), check, cash, bank draft, or irrevocable letter of credit to the Office of Administration, Division of Purchasing and Materials Management within thirty (30) days after award of the contract and prior to performance of service under the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.17.

As we currently hold in our present agreement with the state of Missouri, HealthCare USA shall continue to furnish three performance security bonds—one for each region—with Liberty Mutual Insurance Company in favor of the State of Missouri.





3.17.1 The performance security deposit must be made payable to the State of Missouri in an amount equal to \$1,000,000. In the event the health plan is awarded a contract for more than one region, the health plan shall provide a separate performance security deposit in the amount of \$1,000,000.00 for each region.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.17.1

As for our present agreement with the state of Missouri, HealthCare USA shall continue to provide three performance security bonds—one for each region—with Liberty Mutual Insurance Company in favor of the State of Missouri in the sum of \$1,000,000.00 each in order to remain in compliance with this requirement.

3.17.2 The contract number and contract period must be specified on the performance security deposit.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.17.2.

3.17.3 In the event the Division of Purchasing and Materials Management exercises an option to renew the contract for an additional period, the health plan shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.17.3.

3.17.4 Additionally, during the 365 day transition period, the health plan shall maintain the validity and enforcement of the performance security deposit for performance of the administrative functions pursuant to the provisions of this paragraph, in an amount stipulated via written notification by the Division of Purchasing and Materials Management.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.17.4.

3.18 Participation by Other Organizations

The health plan must comply with any Organization for the Blind/Sheltered Workshop and/or Minority Business Enterprise/Women Business Enterprise (MBE/WBE) participation levels committed to in the health plan's awarded proposal.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.18.





3.18.1 The health plan shall prepare and submit to the Division of Purchasing and Materials Management a report detailing all payments made by the health plan to Organizations for the Blind/Sheltered Workshops and/or MBE/WBEs participating in the contract for the reporting period. The health plan must submit the report on a monthly basis, unless otherwise determined by the Division of Purchasing and Materials Management.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.18.1.

3.18.2 The Division of Purchasing and Materials Management will monitor the health plan's compliance in meeting the Organizations for the Blind/Sheltered Workshop participation levels committed to in the health plan's awarded proposal. The Division of Purchasing and Materials Management in conjunction with the Office of Equal Opportunity (OEO) will monitor the health plan's compliance in meeting the MBE/WBE participation levels committed to in the health plan's awarded proposal. If the health plan's payments to the participating entities are less than the amount committed, the state may cancel the contract and/or suspend or debar the health plan from participating in future state procurements, or retain payments to the health plan in an amount equal to the value of the participation commitment less actual payments made by the health plan to the participating entity. If the Division of Purchasing and Materials Management determines that the health plan becomes compliant with the commitment, any funds retained as stated above, will be released.

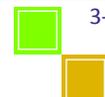
HealthCare USA understands and shall comply with the requirements set forth in Section 3.18.2.

3.18.3 If a participating entity fails to retain the required certification or is unable to satisfactorily perform, the health plan must obtain other certified MBE/WBEs or other organizations for the blind/sheltered workshops to fulfill the participation requirements committed to in the health plan's awarded proposal.

- a. The health plan must obtain the written approval of the Division of Purchasing and Materials Management for any new entities. This approval shall not be arbitrarily withheld.
- b. If the health plan cannot obtain a replacement entity, the health plan must submit documentation to the Division of Purchasing and Materials Management detailing all efforts made to secure a replacement. The Division of Purchasing and Materials Management shall have sole discretion in determining if the actions taken by the health plan constitute a good faith effort to secure the required participation and whether the contract will be amended to change the health plan's participation commitment.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.18.3.

3.18.4 Within thirty days of the end of the original contract period, the health plan must submit an affidavit to the Division of Purchasing and Materials Management. The affidavit must be signed by the director or manager of the participating Organizations for the Blind/Sheltered Workshop verifying provision of products and/or services and compliance





of all health plan payments made to the Organizations for the Blind/Sheltered Workshops. The health plan may use the affidavit available on the Division of Purchasing and Materials Management's website at <http://oa.mo.gov/purch/vendor.html> or another affidavit providing the same information.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.18.4.

3.19 Federal Funds Requirements

The health plan shall understand and agree that the contract may involve the use of federal funds. Therefore, for any federal funds used, the following paragraphs shall apply:

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.

- 3.19.1 In performing its responsibilities under the contract, the health plan shall fully comply with the following Office of Management and Budget (OMB) administrative requirements and cost principles, as applicable, including any subsequent amendments:
- a. Uniform Administrative Requirements - A-102 - State/Local Governments; 2 CFR 215 - Hospitals, Colleges and Universities, For-Profit Organizations (if specifically included in federal agency implementation), and Not-For-Profit Organizations (OMB Circular A-110).
 - b. Cost Principles - 2CFR 225 – State/Local Governments (OMB Circular A-87); A-122 - Not-For-Profit Organizations; A-21 - Colleges and Universities; 48 CFR 31.2 - For-Profit Organizations; 45 CFR 74 Appendix E – Hospitals.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.1.

- 3.19.2 Steven's Amendment – In accordance with the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, Public Law 101-166, Section 511, "Steven's Amendment", the health plan shall not issue any statements, press releases, and other documents describing projects or programs funded in whole or in part with Federal money unless the prior approval of the state agency is obtained and unless they clearly state the following as provided by the state agency:
- a. The percentage of the total costs of the program or project which will be financed with Federal money;
 - b. The dollar amount of Federal funds for the project or program; and
 - c. The percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.2.



3.19.3 The health plan shall comply with 31 U.S.C. 1352 relating to limitations on use of appropriated funds to influence certain federal contracting and financial transactions. No funds under the contract shall be used to pay the salary or expenses of the health plan, or agent acting for the health plan, to engage in any activity designed to influence legislation or appropriations pending before the United States Congress or Missouri General Assembly. The health plan shall comply with all requirements of 31 U.S.C. 1352 which is incorporated herein as if fully set forth. The health plan shall submit to the state agency, when applicable, Disclosure of Lobbying Activities reporting forms.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.3.

3.19.4 The health plan shall comply with the requirements of the Single Audit Act Amendments of 1996 (P.L. 104-156) and Circular A-133, including subsequent amendments or revisions, as applicable or 2 CFR 215.26 as it relates to for-profit hospitals and commercial organizations. A copy of any audit report shall be sent to the state agency each contract year if applicable. The health plan shall return to the state agency any funds disallowed in an audit of the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.4.

3.19.5 The health plan shall comply with the Pro-Children Act of 1994 (20 U.S.C. 6081), which prohibits smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.5.

3.19.6 The health plan shall comply with 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations, as applicable.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.6.

3.19.7 The health plan shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.).

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.7.



3.19.8 If the health plan is a sub-recipient as defined in OMB Circular A-133, Section 210, the health plan shall comply with all applicable implementing regulations, and all other laws, regulations and policies authorizing or governing the use of any federal funds paid to the health plan through the contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.19.8.

3.20 Terminology

All references to the term “contractor” as used in the Terms and Conditions attached hereto shall mean “health plan”.

HealthCare USA understands and shall comply with the requirements set forth in Section 3.20.



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4.4 PROPOSAL SUBMISSION INFORMATION REQUIRED



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4.4 Proposal Submission Required Information - The offeror shall submit the information listed below: To the extent possible, the specific paragraph number of the applicable section of the Performance Requirements is provided with the following items and is denoted in parenthesis. The State does not guarantee that all references have been provided or that the referenced paragraph number is correct.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.1 Addressing Performance Requirements

The offeror shall address each specific paragraph and subparagraph of the Performance Requirements, Section 2, and General Contractual Requirements, Section 3, by identifying the paragraph number then providing a description of how, when, by whom, with what, to what degree, why, where, etc., the requirement will be satisfied and otherwise detailing the offeror's understanding of the requirements and ability and methodology to successfully perform. Additionally, within the offeror's response to the Performance Requirements and General Contractual Requirements, the offeror should provide the information required/requested to be submitted with the offeror's proposal, as identified in Section 4, Proposal Submission Information. The offeror shall also identify each paragraph number within Section 4, Proposal Submission Information, and then provide the required/requested information. However, if the offeror has already provided the requested/required information within the offeror's response to the Performance Requirements or the General Contractual Requirements, the offeror should identify the location within the offeror's proposal where the requested/required information is located. The offeror should avoid providing duplication of information.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.1.

4.4.2 Business Transaction Disclosure

If the offeror is not a federally qualified HMO, the offeror shall disclose the following information on certain types of business transactions the offeror has with a "party in interest" as defined in the Public Health Services Act.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.2

HealthCare USA is not federally qualified and understands that certain types of business transactions with a "party in interest" must be disclosed.

4.4.2a. Any sale, exchange, or lease of any property between the offeror's organization and a "party in interest"

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.2(a).



There have been no sale, exchange, or property lease transactions between HealthCare USA and a “party in interest.”

4.4.2b. Any lending of money or other extension of credit between the offeror’s organization and a “party in interest”

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.2(b).

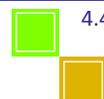
There have been no extensions of credit or lending of money between HealthCare USA and a “party in interest.”

4.4.2c. Any furnishing for consideration of goods, services (including management services), or facilities between the offeror’s organization and a “party in interest”. This does not include salaries paid to employees for services provided in the normal course of their employment.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.2(c).

HealthCare USA has five agreements in place with “parties in interest.” Under each agreement, services are provided to HealthCare USA. These agreements are as follows:

1. **Management Services Agreement:** This Agreement is between HealthCare USA and Coventry Health Care, Inc. regarding management services that Coventry Health Care, Inc. provides for HealthCare USA in exchange for a per member per month (PMPM) fee. The Agreement was filed with and approved by the Department of Insurance, Financial Institutions and Professional Registration (DIFP), and was effective January 1, 2003 and most recently amended as of March 1, 2010. For the ten months period ending October 30, 2011, under this agreement, HealthCare USA paid or accrued to Coventry Health Care, Inc., approximately \$10.1 million.
2. **Management Services Agreement:** This Agreement is between HealthCare USA and Coventry Management Services, Inc. Both HealthCare USA and Coventry Management Services, Inc. are subsidiaries of Coventry Health Care, Inc. Under this agreement, Coventry Management Services provides certain information system and service center services for HealthCare USA in exchange for a per member per month (PMPM) fee. The Agreement was filed with and approved by the DIFP, and was effective January 1, 2003 and most recently amended as of March 1, 2010. For the ten months period ending October 31, 2011, under this agreement, HealthCare USA paid or accrued to Coventry Management Services, Inc., \$20.6 million.
3. **Amended & Restated Tax Sharing Agreement:** This Agreement is between HealthCare USA and Coventry Health Care, Inc. Under the terms of the Agreement, HealthCare USA’s taxable income is included in the consolidated income tax return filed by Coventry Health Care, Inc. The Agreement was filed with and approved by the DIFP, and was





effective December 31, 2004. Through October 31, 2011, under this agreement, HealthCare USA allocated \$121,000 of income tax to Coventry Health Care, Inc.

4. **Guarantor Agreement:** This Agreement is between HealthCare USA and Coventry Health Care, Inc. Under the terms of the Agreement, HealthCare USA members are protected in the event of HealthCare USA’s insolvency. This Agreement was filed with and approved by the DIFP, and was effective January 1, 2001.
5. **Excess Risk Reinsurance Agreement:** This Agreement is between HealthCare USA and Coventry Health and Life Insurance Company. Both HealthCare USA and Coventry Health and Life Insurance Company are subsidiaries of Coventry Health Care, Inc. Under the terms of this Agreement, HealthCare USA pays Coventry Health and Life Insurance Company premiums for reinsurance coverage and Coventry Health and Life Insurance Company provides reinsurance to HealthCare USA. The Agreement was effective January 4, 2001, and most recently amended as of April 1, 2011.

4.4.2d. If the offeror has operated previously in the commercial or Medicare markets, the offeror shall disclose the information listed below regarding business transactions for the previous year. The offeror shall report all of the offeror’s business transactions, not just the transactions relating to serving the MO HealthNet enrollment:

1. The name of the “party in interest” for each business transaction;
2. A description of each business transaction and the quantity or units involved;
3. The accrued dollar value of each business transaction during the fiscal year; and
4. Justification of the reasonableness of each business transaction.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.2(d).

HealthCare USA has not previously operated in the commercial or Medicare markets. Therefore, no disclosures pursuant to Section 4.4.2(d) are necessary.

4.4.2e. For purposes of the above information, a “party in interest” shall be as defined herein

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.2(e).

4.4.3 Financial, Ownership and Transaction Reporting

The offeror shall disclose the following. The current report format may be found in Attachment 6b.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.3.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.3a. Information Relating to Ownership and Control:

1. The name and address of any person (individual or corporation) with an ownership or control interest in the offeror's organization, or in any provider or subcontractor in which the offeror has an ownership of five percent (5%) or more; the date of birth (in the case of an individual); and the tax identification number (in the case of a corporation).
2. Whether a person(s) (individual or corporation) named is related as a spouse, parent, child, or sibling to another named person.
3. The name of any other disclosing entity (as defined in 42 CFR 455.101) in which the owner of the offeror's organization has an ownership or control interest.
4. The name, address, and date of birth of any managing employee of the offeror's organization.

HealthCare USA understands and shall comply with the requirements of Section 4.4.3(a).

Healthcare USA of Missouri LLC is a wholly owned subsidiary of Coventry Health Care, Inc.

The TIN for Coventry Health Care, Inc. is 52-2073000 and the address is listed below. Refer to Attachment 5 in Volume 2 of our response for the Coventry Health Care, Inc. information also.

Coventry Health Care, Inc.
6705 Rockledge Drive, Suite 900
Bethesda, MD 20817

Refer to Figure 2.4 for a Coventry Organizational chart showing HealthCare USA as a subsidiary.

Refer to Attachment 5 in Volume 2 of our response for managing employees as they have a bearing on the operation/administration of Healthcare USA of Missouri LLC.

- 4.4.3b. Information on Criminal Convictions: The identity of any person who has an ownership or control interest in the offeror's organization, or is an agent or managing employee of the offeror's organization and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.3(b).

No Directors or Officers of Healthcare USA of Missouri LLC has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.

4.4.3c. Information on Significant Business Transactions:

1. The ownership of any provider or subcontractor with whom the offeror's organization has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the disclosure.
2. Any significant business transactions (defined in 42 CFR 455.101 as those that, during any one fiscal year, exceed the lesser of \$25,000 and five percent (5%) of the offeror's total operating



expenses) between the offeror and any wholly owned supplier, or between the offeror and any provider or other subcontractor, during the five (5) year period ending on the date of the disclosure.

3. If the offeror is new to the MO HealthNet Managed Care Program, but the offeror has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period shall be disclosed.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.3(c).

For further information, refer to Attachment 6 in Volume 2 of our response.

4.4.3d. Definitions:

1. In general, the definitions listed in 42 CFR 455.101 shall govern disclosures under this subsection.
 2. A “managing employee” is defined in 42 CFR 455.101 as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
 3. A “person with an ownership or control interest” shall mean a person or corporation that (1) has an ownership interest totaling five percent (5%) or more of the offeror’s organization; (2) has an indirect ownership interest equal to five percent (5%) or more of the offeror’s organization; (3) has a combination of direct and indirect ownership interests equal to five percent (5%) or more in the offeror’s organization; (4) owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the offeror’s organization or by its property or assets, if that interest is equal to or exceeds five percent (5%) of the total property and assets of the offeror’s organization; (5) is an officer or director of the offeror’s organization (if it is organized as a corporation); or (6) is a partner in the offeror’s organization (if it is organized as a partnership).
- The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the offeror’s assets used to secure the obligation (e.g., if a person owns 10 percent of a note secured by sixty percent (60%) of the offeror’s assets, the person owns six percent (6%) of the offeror).
 - The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization (e.g., if a person owns 10 percent (10%) of the stock in a corporation which owns 80 percent (80%) of the stock of the offeror’s organization, the person owns eight percent (8%) of the offeror’s organization).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.3(d).

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- 4.4.3e. Financial statements for all owners with five percent (5%) or more ownership interest shall be submitted.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.3(e).



Healthcare USA of Missouri LLC is a wholly owned subsidiary of Coventry Health Care, Inc. Financial statements start on page 3 of the most recent Coventry Health Care, Inc. Form 10Q Quarterly Report filed on November 4, 2011 for the period ending September 30, 2011. The Form 10Q is included as Attachment 11 in Volume 2 of our response.

4.4.4 **OIG Exclusion**

The offeror must provide certification that the offeror is not subject to exclusion by OIG pursuant to 42 CFR 1001.1001 (relating to OIG exclusion of entities owned or controlled by a sanctioned person) or 1001.1051 (relating to OIG exclusion of individuals with ownership or control interest in sanctioned entities).

AMENDMENT 2 ADDED THE FOLLOWING ITEM, INCLUDING SUB ITEMS 1) THROUGH 3).

- a. Certification must be provided in the form of a notarized attestation letter. An original signature by one of the following is required:
 - 1. The offeror's Chief Executive Officer;
 - 2. The offeror's Chief Financial Officer; or
 - 3. An individual who has delegated authority to sign for, and who reports directly to, the offeror's Chief Executive Officer or Chief Financial Officer.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.4(a).

For further information, refer to Attachment 7 in Volume 2 of our response.

- #### 4.4.5 The offeror shall provide the following financial information pertaining to the offeror's organization (the legal entity that is submitting the proposal and that will be the party responsible for any contract awarded):

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5.

- 4.4.5a. Audited financial statements and balance sheets for the previous three (3) years, or as many years up to three (3) years that the entity has been in operation. If the offeror has not been in operation for at least one year, the offeror shall submit unaudited financial statements and balance sheets. If the offeror is an existing HMO, a financial statement shall be submitted on the form as prescribed by the National Association of Insurance Companies (NAIC) and shall include an actuarial certification.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5 (a).

Year Ending December 31, 2010, 2009 & 2008 audited financial statements and actuarial certification are located in Volume 2 of our response, see Attachment 8.



4.4.5b. The following information (in table format) regarding the most recent audited financial statements:

1. Working capital;
2. Current ratio;
3. Quick ratio;
4. Net worth; and
5. Debt-to-worth ratio.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5 (b).

Figure 4.4- 1: Financial Information form Most Recent Audited Financial Statements

1) Working Capital	2) Current Ratio	3) Quick Ratio	4) Net Worth	5) Debt-to-worth ratio
\$7,855,146	1.13 to 1	1.13 to 1	82091307	0.74 to 1

4.4.5c. Financial plan for the offeror’s current fiscal year.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5 (c)

For further information, refer to Attachment 9 in Volume 2 of our response.

4.4.5d. Information about the offeror's financial forecasts for the original contract period and possible contract renewal periods. These forecasts shall include at least income statements and enrollment forecasts.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5(d).

For further information, refer to Attachment 10 in Volume 2 of our response.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.5e. A statement of whether there is any pending or recent (within the past five (5) years) litigation against the offeror. This shall include, but not be limited to, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. The offeror does not need to report workers' compensation cases. If there is pending or recent litigation against the offeror, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether pending or recent litigation will impair the offeror's performance in a contract. The offeror shall also include any Securities and Exchange Commission (SEC) filings discussing any pending or recent litigation. The offeror shall also address the parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5(e).

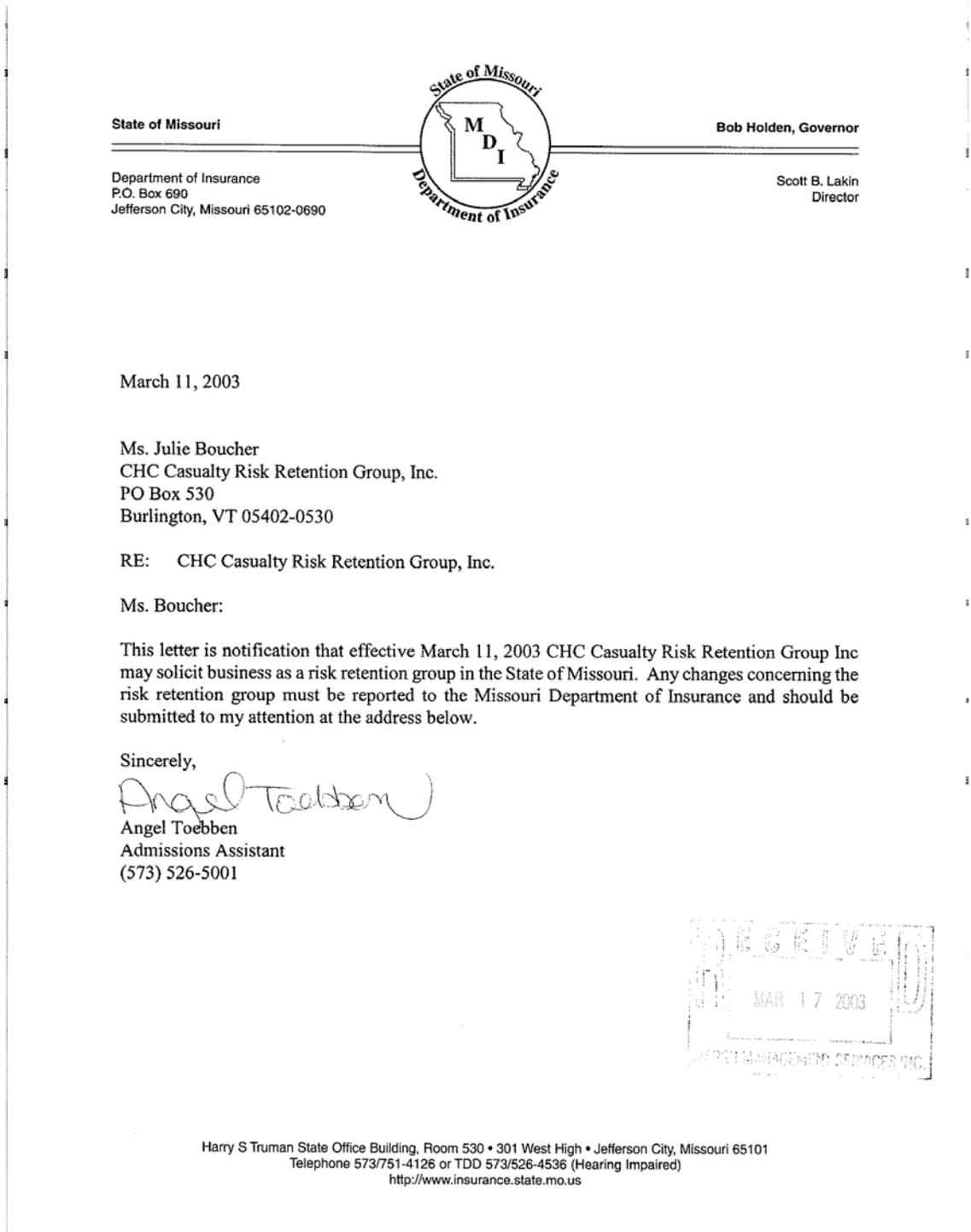
In the course of normal business operations, lawsuits are brought against Coventry Health Care, Inc. (Coventry) and/or its subsidiaries (parent organization and affiliates of the offeror, HealthCare USA of Missouri, LLC) from time to time. As may be appropriate, reserves are set aside for such lawsuits and insurance coverage may be provided through a Risk Retention Group, CHC Casualty Risk Retention Group, Inc. (the RRG). The RRG is an owner-controlled insurance company chartered and regulated by the laws of the state of Vermont, and also registered in the state of Missouri.

Recent SEC filings discussing recent or pending litigation is also included, starting on page 9 of the most recent Coventry Health Care, Inc. Form 10Q Quarterly Report filed on November 4, 2011 for the period ending September 30, 2011. The Form 10Q is included as Attachment 11 in Volume 2 of our response.

Attachment 12, in Volume 2 of our response, lists pending or recent litigation against Coventry and/or its subsidiaries (parent organization and affiliates of the offeror, HealthCare USA of Missouri, LLC) in the past five years. Amounts listed in the "Claim Amount" column represent the amount sought by the plaintiff in the litigation. In many instances, the plaintiff does not specify an amount sought; accordingly, that information may be blank. Actual settlement amounts, court awards and case outcomes may differ from these amounts, and in some instances no amounts were paid out or awarded. If additional information is required for any of the cases listed, HealthCare USA of Missouri, LLC will provide it upon request.



Figure 4.4- 2: Missouri Risk Retention Registration



Any questions regarding this information can be directed to Paul Weller, Chief Litigation Counsel, at (610) 729-7531.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.5f. A statement of whether, within the past five (5) years, the offeror or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, the offeror shall provide an explanation providing relevant details including the date in which the offeror emerged from bankruptcy or expects to emerge. If still in bankruptcy, the offeror shall provide a summary of the court-approved reorganization plan. The offeror shall also address the parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5(f).

In the past five (5) years, neither HealthCare USA of Missouri, nor its parent company, Coventry Health Care, Inc., nor any affiliates of HealthCare USA of Missouri has filed (or has had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.5g. As applicable, provide (in table format) the offeror's current ratings, as well as ratings for each of the past three (3) years, from three (3) of the following rating agencies:

1. AM Best Company (financial strengths ratings);

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

2. TheStreet.com, Inc. (safety ratings);

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

3. Standard & Poor's (long-term insurer financial strength); and

AMENDMENT 2 ADDED THE FOLLOWING ITEM.

4. Other rating agency.
The offeror shall also address the parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5(g).



HealthCare USA is a wholly owned subsidiary of Coventry Health Care, Inc. Ratings are not prepared for HealthCare USA, below are the ratings for Coventry Health Care, Inc.

	2009	2010	2011
AM Best Company	B+	B+	B++
Moody's	Ba1	Ba1	Baa3
Standard & Poors	BBB-	BBB-	BBB-

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.5h. Identify whether the offeror has had a contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/non-renewal and the parties involved, and provide the address and telephone number of the client. If the contract was terminated/non-renewed based on the offeror's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. The offeror's response shall address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5(h).

In the past five (5) years, certain of HealthCare USA of Missouri's affiliated companies have had contracts terminated or not renewed with Medicaid agencies or other state/federal health programs in the three (3) instances described in the chart below. In none of these instances, however, was the termination/non-renewal based upon Coventry Health Care, Inc.'s or its subsidiaries performance under the contracts. Therefore, there were no corrective actions taken to prevent future occurrence. Additionally, HealthCare USA's affiliate company, MHNet, which also services as its behavioral health subcontractor, had two contracts terminate with Medicaid managed care health plans due to inability to negotiate and agree upon acceptable rates. These contracts were with the Health Plan of Michigan in 2008 and Molina Healthcare of Missouri in 2010.



Figure 4.4- 3: Contract Termination/non-renewal In The Past Five Years

Contract Name	Termination or Non-renewal Information	Reason	Client Contact
WellPath of South Carolina, Inc. (CHCcares of South Carolina) contract with Department of Health and Human Services for Medicaid managed care program, South Carolina Healthy Connections Choices, for 16 counties primarily in Midlands region	Contract ended on August 31, 2009	The state was unwilling to change the rate structure, which the health plan thought was necessary in order for it to continue with the contract.	At the time it was Beverly Hamilton, Bureau Chief Division of Care Management and Medical Support Services South Carolina Department of Health and Human Services P. O. Box 8206 Columbia, SC 29202-8206 803-898-4614
Coventry Health Care of Iowa contract with Department of Human Services for Medicaid managed care program in three counties in Waterloo area	Contract ended on January 31, 2009	Capitation rates were not adjusted to account for actual medical loss ratio of the health plan, so the health plan exited the program.	At the time it was Dennis Janssen, Bureau Chief Managed Care and Clinical Services Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315 515-725-1136
HealthAssurance Pennsylvania Medicaid contract for Pennsylvania HealthChoices Behavioral Health for Dauphin, Perry, Cumberland, Lancaster, and Lebanon counties through arrangement with Capital Area Behavioral Health Collaborative (CABHC)	Contract ended on June 30, 2008	There was no longer the requirement or necessity for the Commonwealth of Pennsylvania to have a licensed risk-bearing entity manage the Behavioral Health benefits, so the Commonwealth decided to end the contract	Scott Suhring, President & CEO CABHC 2300 Vartan Way, Ste 206 Harrisburg, PA 17110 717-671-7190 Helen Shuman Pennsylvania Department of Public Welfare Staff Liaison 717-772-7226



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- 4.4.5i. As applicable, if, within the past five (5) years, a contracting party for any of the offeror’s contracts to provide physical or behavioral health services have found the offeror to be in breach of the contract:
1. Provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the offeror’s control.
 2. If a corrective action plan was imposed, describe the steps and timeframes in the corrective action plan and whether the corrective action plan was completed.
 3. If a sanction was imposed, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage).
 4. If the breach was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation.
The offeror’s response shall address the parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5(i).

For its contracts to provide physical or behavioral health services, neither HealthCare USA of Missouri, nor its parent company (Coventry Health Care, Inc.), nor its affiliates conducting Medicaid or other state or federal health business have been notified that they have been found in breach of the contract by the other contracting party.

4.4.5j. Names and addresses of independent auditors.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.3(j).

Ernst & Young LLP
621 East Pratt Street
Baltimore, MD 21202

4.4.5k. Documentation of insurance coverage such as a list of the insurers used (including contact person and address) and the type and amounts of each policy held.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.3(k).

For further information, refer to Attachment 13 in Volume 2 of our response.

4.4.5l. Proof of reinsurance.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.5(l).

For further information, refer to Attachment 14 in Volume 2 of our response.



4.4.6 Investigations

The offeror shall provide the following information pertaining to any recent or pending investigations:

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.6a. A statement of whether there have been any SEC investigations, civil or criminal, involving the offeror within the past five (5) years. If there have been any such investigations, provide an explanation with relevant details and outcome. Also provide a statement of whether there are any current or pending SEC investigations, civil or criminal, involving the offeror, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the offeror's performance in a contract. The offeror shall address the offeror's parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.6b. A statement of whether the offeror is currently the subject, or has recently (within the past five (5) years) been the subject, of a criminal or civil investigation by a state or Federal agency or state Medicaid agency other than SEC investigations. If the offeror is or has recently been the subject of such an investigation, the offeror shall provide an explanation with relevant details and the outcome. The offeror shall address the parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.6(a-b).

Neither HealthCare USA of Missouri, LLC nor its parent company, Coventry Health Care, Inc., nor its affiliate companies, have been the subject of any Securities Exchange Commission (SEC) investigations, civil or criminal, in the past five (5) years. Additionally, there are no current or pending SEC investigations, civil or criminal against HealthCare USA of Missouri, Coventry Health Care, Inc. or any other Coventry Health Care, Inc. subsidiaries.

In 2008 Coventry Health Care, Inc., the parent company of HealthCare USA of Missouri, LLC, received a subpoena from the U.S. Attorney for the District of Maryland, Northern Division, requesting information regarding the operational process for confirming Medicare eligibility for its Workers' Compensation set-aside product. The company is cooperating fully and is providing the requested information. The company cannot predict what, if any, actions may be taken by the U.S. Attorney. However, based on the information known to date, the company does not believe that the outcome of this investigation will have a material adverse effect on its financial position or results of operations.



4.4.7 Debarment Certification

- a. Debarment Certification – The offeror certifies by signing the signature page of this original document and any amendment signature page(s) that the offeror is not presently debarred, suspended, proposed for debarment, declared ineligible, voluntarily excluded from participation, or otherwise excluded from or ineligible for participation under federal assistance programs. The offeror shall complete and return the attached certification regarding debarment, etc., Exhibit F with the proposal. This document must be satisfactorily completed prior to award of the contract.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

- 4.4.7b. The offeror shall identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any Federal or state regulatory entity or state Medicaid agency against the offeror’s organization within the past five (5) years, which is not identified in subsection (a) above. In addition, identify and describe any letter of deficiency issued by, as well as any corrective actions requested or required by, any Federal or state regulatory entity or state Medicaid agency within the past five (5) years that relate to Medicaid or CHIP contracts. The offeror shall include the offeror’s parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business.
- c. The state agency shall report to the Secretary of Health and Human Services any information it receives concerning an offeror that has been debarred.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.7(a-c).

(a) By signing the signature page of this RFP, HealthCare USA certifies that HealthCare USA is not presently debarred, suspended, proposed for debarment, declared ineligible, voluntarily excluded from participation, or otherwise excluded from or ineligible for participation under federal assistance programs. For further information, refer to Exhibit F in Volume 2 of our response.

(b) The following is a list of regulatory actions and sanctions, both monetary and non-monetary, imposed by any federal or state regulatory entity or state Medicaid agency against HealthCare USA, its parent company (Coventry Health Care, Inc.), and any affiliate company of HealthCare USA (i.e. other subsidiaries of Coventry Health Care, Inc.) that conducts Medicaid or other state or federal health business within the last 5 years. Letters of deficiency issued by and corrective action plans required or requested by any Federal or state regulatory entity, or state Medicaid agency within the last 5 years that relate to Medicaid or CHIP contracts are also listed below.

Coventry Entity	Action	Description and Resolution
Coventry Health Care, Inc.	Voluntary Suspension of Marketing	Coventry initiated the voluntary suspension of marketing individual private fee for service (PFFS) plans for less than 2 months. As an aside, Coventry no longer operates the PFFS line of business (2007).
Coventry Health Care, Inc.	Fine	Coventry Health Care, Inc., on behalf of its subsidiaries that offered Medicare PFFS plans,



Coventry Entity	Action	Description and Resolution
		reached a settlement with CMS related to Coventry's alleged failure to oversee agents' marketing of PFFS products. Coventry paid a fine in the amount of \$190,000 to CMS (2008).
Coventry Health Care, Inc.	Fine	Certain Coventry subsidiaries were cited for having inaccurate information in their 2010 Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents (2010).
Coventry Health Care of Delaware, Inc.	Corrective Action Plan	EQRO Audit – findings of deficiency for Diamond Plan (2006-2010).
Coventry Health Care of Iowa, Inc.	Findings of Deficiency	Medicaid EQRO audit; finding of deficiency (2006).
GHP, Inc.	Refund	Office of Personnel Management required GHP to refund money related to its Federal Employees Health Benefit Plan business for the years 2000-2002; 2004, and 2005 (2007).
HealthAmerica Pennsylvania & HealthAssurance Pennsylvania	Letter of Deficiency and Plan of Corrective Action	Letter of deficiency for compliance with Executive Management Requirements (staffing) of the Pennsylvania HealthChoices contract (2010)
HealthCare USA of Missouri, LLC	Corrective Action Plan	As a result of the Medicaid agency's audit of HealthCare USA's behavioral health affiliate, HealthCare USA entered into a Corrective Action Plan to address various deficiencies (2009).
OmniCare Health Plan, Inc.	Corrective Action Plan	CAP to address improvements in its HEDIS Access to Care and CAHPS Getting Care Quickly scores (2007).
OmniCare Health Plan, Inc.	Corrective Action Plan	CAP as a result of Site Visit to address incomplete gathering of ownership and controlling interest information for providers (2010).
Vista Healthplan and Vista Healthplan of South Florida	Corrective Actions Plan	Medicaid fraud prevention program review; CAP audited and accepted (2007/2008).
Vista Healthplan and Vista Healthplan of South Florida	Corrective Action Plan (submitted and accepted; no further action required)	Medicaid review related to conduct of marketing agents; required additional training specific to presentations made to prospective members (2006).
Vista Healthplan	Fine	Fine for alleged marketing violations to Medicaid members (2006).
Vista Healthplan and Vista Healthplan of South Florida and Summit Health Plan	Corrective Action Plan for period of 6 months	Medicare Comprehensive review; areas impacted included appeals, credentialing, provider contracts, and the availability of member materials in Spanish (2007).
Vista Healthplan	Corrective Action	Medicaid Comprehensive review; areas impacted



Coventry Entity	Action	Description and Resolution
and Vista Healthplan of South Florida	Plan (submitted and accepted; no further action required)	include quality management, credentialing, and fraud prevention (2007).
Vista Healthplan and Vista Healthplan of South Florida	Corrective Action Plan (submitted 2/15/08)	Medicaid EPSDT/Childhood Check-Up Reports audit; federal participation ratio of 80% was not met (2007).
Vista Healthplan	Corrective Action Plan (submitted and accepted; no further action required)	Nursing Home Diversion/Long Term Care Contract Comprehensive Review; areas impacted included case management files, quality assurance studies, and submission of encounter data (2007).
Vista Healthplan and Vista Healthplan of South Florida	Corrective Action Plan	Comprehensive review required the revision of certain Medicaid policies and procedures, credentialing and Practitioner Office Site tool. CAP accepted, no further action taken (2008).
Vista Healthplan and Vista Healthplan of South Florida	Fine	Untimely submission of disease management program descriptions and policies for Medicaid plan (2008).
Vista Healthplan of South Florida & Vista Healthplan; Summit Health Plan	Corrective Action Plan	Financial examination of Medicare bids for 2006. CAP issued for various reasons; accepted and no further action required (2009).
Coventry Health Care, Coventry Health Plan, Coventry Summit Health Plan*	Corrective Action Plan	Medicare Part D. Various components found to be deficiency such as grievances, appeals, enrollment, compliance plan, etc. CAP accepted, no further action taken. Notice of follow up review received in May 2011 (2010).
Coventry Health Care and Coventry Health Plan*	Corrective Action Plan	Comprehensive review required the revision of certain Medicaid policies and procedures for case management, care coordination, utilization management, quality improvement, grievances and appeals, and administration/management. CAP was accepted, no further action taken (2011).
Coventry Health Care and Coventry Health Plan*	Settlement/Contractual Assessment	Settlement with Florida Agency for Health Care Administration regarding overpayment of Medicaid claims related to unborn activation process for the period of 7/1/04 – 12/31/07 (2011).
Coventry Summit Health Plan*	Consent Order	Financial examination of Medicare bids for 2008. CAP issued because the health plan was not able to produce copies of prescriptions issued by treating providers. CAP accepted, no further action taken (2011).
Coventry Health Care and Coventry	Fines	The Florida Agency for Health Care Administration has the contractual authority to assess fines of \$200 per



Coventry Entity	Action	Description and Resolution
Health Plan*		day for each instance in which reports required by the Medicaid program are submitted late. There have been instances during this period in which reports were submitted late because of various reasons, i.e. system conversion, staff turnover, etc. The fines have been minimal and have not exceeded \$2,000 per occurrence, per legal entity (2006-present).
Coventry Health Care of Florida; Coventry Health Plan of Florida; Coventry Summit Health Plan	Notice of Non-Compliance (Medicare)	Medicare marketing ads were run in local newspapers in which the disclaimer was printed in grey ink instead of black ink. The grey ink printed lighter than the rest of the content in the ad which CMS deemed to be a violation of Medicare Marketing guidelines.

*In 2010 the FL plans experienced a name change for the organizations. Vista Healthplan is n/k/a Coventry Health Care of Florida, Inc.; Vista Healthplan of South Florida is n/k/a Coventry Health Plan of Florida, Inc.; and Summit Health Plan is n/k/a Coventry Summit Health Plan, Inc.

AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.8 Certificate of Authority [2.1.4]

The offeror shall submit proof that the offeror has a Certificate of Authority from the Missouri Department of Insurance, Financial Institutions & Professional Registration to operate a HMO in each county specified herein. (2.1.4 a)

- a. If the offeror does not currently have a certificate for a certain county, the offeror shall provide documentation that the offeror has or will submit an application to the Department of Insurance, Financial Institutions & Professional Registration for such certification.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.8(a).

For further information, refer to Attachment 15 in Volume 2 of our response.

For further details on Section 4.4.8, see Section 2.1.4.



4.4.9 Physician Incentive Plans [2.6.13]

The offeror shall provide a minimum of the following information regarding each of the offeror's PIPs and each of the proposed subcontractor's PIPs with their downstream providers (provider of the subcontractor), if the PIPs place the providers at significant financial risk. (2.6.13)

- a. Effective date of the PIP;
 - b. The type of incentive arrangement;
 - c. The amount and type of stop-loss protection;
 - d. The patient panel size;
 - e. If the patient panel is pooled, provide a description of the method;
 - f. The computations of significant financial risk; and
 - g. The name, address, telephone number, and other contact information for a person from the offeror's organization who may be contacted with questions regarding the PIP.
- If the offeror has no PIPs with the health care service providers, the offeror shall confirm in the proposal that no such arrangements exist. If the offeror's subcontractors do not have any PIPs with their downstream providers, the offeror shall confirm in the proposal that no such arrangements exist and maintain documentation that demonstrates that no such arrangements exist.
-

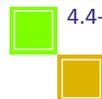
HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.9. For further details on Section 4.4.9, see Section 2.6.13.

4.4.10 Health Care Service Subcontractors [3.9]

- a. The offeror shall list each health care service subcontractor to whom the offeror proposes to delegate contract requirements. Examples include, but are not limited to, behavioral health services, vision, or dental. The offeror shall describe the services and activities that will be provided by such health service subcontractor. (3.9)
-

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.10(a).

For further details on Section 4.4.10(a), see Section 3.9.





- b. Provide the names and mailing addresses of the health care service subcontractors and a description of the scope and portions of the work the health care service subcontractors will perform.
- c. Describe how the offeror intends to monitor and evaluate the health care service subcontractors' performance.
- d. Specify whether the health care service subcontractors are currently providing services for the offeror in other states and where the subcontractors are located.
- e. Identify and describe any debarment or suspension, regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any Federal or state regulatory entity or state Medicaid agency against the subcontractor within the past five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any Federal or state regulatory entity or state Medicaid agency within the past five (5) years that relate to subcontractor Medicaid or CHIP contracts. The offeror shall address the subcontractors' parent organization, affiliates, and subsidiaries.
- f. Specify whether there is any pending or recent (within the past five (5) years) litigation against a health care service subcontractor. This shall include, but not be limited to, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. The offeror does not need to report workers' compensation cases. If there is pending or recent litigation against a health care service subcontractor, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Also the offeror shall include any SEC filings discussing any pending or recent health care service subcontractor litigation. The offeror shall address the subcontractors' parent organization, affiliates, and subsidiaries.
- g. Indicate if, within the past five (5) years, a health care service subcontractor or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, the offeror shall provide an explanation providing relevant details including the date in which the health care service subcontractor emerged from bankruptcy or expects to emerge. If still in bankruptcy, the offeror shall provide a summary of the health care service subcontractor's court-approved reorganization plan. The offeror shall address the health care service subcontractors' parent organization, affiliates, and subsidiaries.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.10(b-g).

HealthCare USA has five subcontractors and one affiliate, MHNET, who acts as a subcontractor.

MHNet Specialty Services, LLC (MHNet)

MHNet Contract Section	MHNET Response
4.4.10.b Names, Mailing Addresses and Description of Scope.	MHNet Behavioral Health, Inc. 550 Maryville Centre Drive Suite 300 St. Louis, MO 63141 Scope and portions of the health care service the MHNet performs: <ul style="list-style-type: none"> • Member services. • Network management.



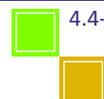
MHNet Contract Section	MHNET Response
	<ul style="list-style-type: none"> • Utilization management. • Care management. • Quality improvement • Claims adjudication • Credentialing and recredentialing • Contracting • Provider Services
<p>4.4.10.c Monitoring and Evaluation</p>	<p>Oversight Meetings - HealthCare USA will continue to conduct oversight meetings with MHNet no less than quarterly. These meetings allow HealthCare USA to monitor and address a range of topics such as:</p> <ul style="list-style-type: none"> • Coordination of care and collaborative activities • Service enhancements • Process improvements • Problem identification • Opportunities for improvement <p>Agendas are set, actions assigned and minutes taken with follow-up items reviewed at subsequent meetings. Representatives from the following HealthCare USA departments participate in the oversight meetings: Health Services, Network Development, Provider Relations, Finance, Appeals and Grievances, Regulatory Compliance, Quality Improvement, and Service Operations. The results of these meetings are reported to the Quality Management Committee (QMC).</p> <p>If issues are identified that need special attention, additional meetings directed at the specific issues will be held until the issues are resolved. If the issue is not resolved, a correction active plan will be imposed.</p> <p>Review of Operations Reports - HealthCare USA reviews MHNet's monthly and quarterly operations reports. Any noted operational concern is addressed with MHNet.</p> <p>Annual Audits - Coventry Health Care, Inc. (Coventry) conducts an annual audit of MHNet that evaluates MHNet's capacity to perform delegated functions to HealthCare USA and other Coventry Health Plans. In addition, HealthCare USA performs an annual claims audit to assure claims are paid according to the contracts.</p>
<p>4.4.10.d Services in Other States</p>	<p>MHNet provides services for HealthCare USA in Missouri. MHNet provides services for other Coventry Health Plans in Arkansas, Delaware, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Nebraska, Nevada, Ohio, Pennsylvania, South Dakota, Tennessee, Texas,</p>



MHNet Contract Section	MHNET Response
	Utah, and Virginia, West Virginia, Wyoming.
4.4.10.e Debarment, Suspension, Regulatory Action or Sanction	Fine: \$22,000 resulting from Maryland Insurance Administration Market Conduct Examination (2011). Consent Order & Fine: Consent Order with the Florida Office of Insurance Regulation for conducting business without a proper license; fine in the amount of \$35,000 plus \$5,000 in costs (2009).
4.4.10.f Pending or Recent Litigation	MHNet currently has two lawsuits pending. The first is a member benefit dispute involving a \$25,000 claim, and the other is an employment dispute. In addition, in the past five (5) years, there has been only one other lawsuit brought against MHNet. It involved a member benefit dispute and was settled between the parties.
4.4.10.g Bankruptcy	MHNet has not filed bankruptcy or insolvency in the last five (5) years.

DentaQuest , LLC (DentaQuest)

DentaQuest Contract Section	DentaQuest Response
4.4.10.b Names, Mailing Addresses and Description of Scope	DentaQuest, LLC. 12121 Corporate Parkway Mequon, WI 53092 The scope and portion of the health care service that DentaQuest performs: <ul style="list-style-type: none"> • Provider services • Network management • Utilization management • Claims adjudication • Quality improvement • Credentialing and Recredentialing • Contracting
4.4.10.c Monitoring and Evaluation	Oversight Meetings - HealthCare USA will continue to conduct oversight meetings with DentaQuest no less than quarterly. These meetings will allow HealthCare USA to monitor and address a range of topics such as: <ul style="list-style-type: none"> • Coordination of care and collaborative activities • Service enhancements • Process improvements





DentaQuest Contract Section	DentaQuest Response
	<ul style="list-style-type: none"> • Problem identification • Opportunities for improvement <p>Agendas are set, actions assigned and minutes taken with follow-up items reviewed at subsequent meetings. Representatives from the following HealthCare USA departments participate in the oversight meetings: Health Services, Network Development, Provider Relations, Finance, Appeals and Grievances, Regulatory Compliance, Quality Improvement, and Service Operations. The results of these meetings are reported to the Quality Management Committee (QMC)</p> <p>If issues are identified that need special attention, additional meetings directed at the specific issues will be held until the issues are resolved. If the issue is not resolved, a correction active plan will be imposed.</p> <p>Review of Operations Reports - HealthCare USA will review DentaQuest’s monthly and quarterly operations reports. Any noted operational concern is addressed with DentaQuest.</p> <p>Annual Audits - HealthCare USA conducts annual audits of DentaQuest that evaluate DentaQuest’s capacity to perform delegated functions to HealthCare USA. These audits include:</p> <ul style="list-style-type: none"> • Regulatory Compliance • Provider Credentialing and Recredentialing • Claims
4.4.10.d Services in Other States	DentaQuest provides services for HealthCare USA in Missouri. DentaQuest provides services for other Coventry Health Plans in Maryland and Pennsylvania.
4.4.10.e Debarment, Suspension, Regulatory Action or Sanction	DentaQuest has never been debarred, suspended, or sanctioned by any Federal, State, or Medicaid agency. Additionally, DentaQuest has not been issued a letter of deficiency or any corrective action from Federal, State, or Medicaid agencies within the past five (5) years.
4.4.10.f Pending or Recent Litigation	There have been a small number of actions brought against DentaQuest in the last five (5) years. None of this litigation has involved allegations that DentaQuest has failed to provide timely, adequate or quality health care services to program providers.
4.4.10.g Bankruptcy	DentaQuest has not filed bankruptcy or insolvency in the last five (5) years.



McKesson Health Solutions, LLC (McKesson)

McKesson Contract Section	McKesson Response
4.4.10.b Names, Mailing Addresses and Description of Scope	<p>McKesson Health Solutions, LLC. 329 Interlocken Pkwy Broomfield, CO 80021</p> <p>Scope and portions of the health care service that McKesson performs:</p> <ul style="list-style-type: none"> • 24/7 nurse advice (triage) line.
4.4.10.c Monitoring and Evaluation	<p>Oversight Meetings - HealthCare USA participates in joint oversight of McKesson with Coventry Health Care, Inc. (Coventry), our parent company. Periodic meetings are held to discuss problem identification and opportunities for improvement.</p> <p>Review of Operations Reports - HealthCare USA reviews McKesson's operations reports. Any noted operational concern is addressed with McKesson.</p> <p>Annual Audits - Coventry Health Care, Inc. (Coventry) conducts an annual audit of McKesson that evaluates McKesson's capacity to perform delegated functions to HealthCare USA and other Coventry Health Plans.</p>
4.4.10.d Services in Other States	<p>McKesson provides services for HealthCare USA in Missouri. McKesson provides services for other Coventry Health Plans in Kentucky, Louisiana, Nebraska and Pennsylvania.</p>
4.4.10.e Debarment, Suspension, Regulatory Action or Sanction	<p>To the best of their knowledge, in the last five (5) years, McKesson's nurse advice line service has not had any debarments or suspensions, regulatory actions or sanctions imposed by Federal state regulatory entities or state Medicaid agencies or had any letters of deficiency or corrective actions requested relating to any Medicaid or CHIP contracts.</p>
4.4.10.f Pending or Recent Litigation	<p>To the best of their knowledge, McKesson's nurse advice line services has not had any pending litigation in the last five (5) years.</p>
4.4.10.g Bankruptcy	<p>To the best of their knowledge, McKesson's nurse advice line services has not filed bankruptcy or insolvency proceedings in the last five (5) years.</p>



March Vision Care Group, Inc. (March Vision)

March Vision Contract Section	March Vision Response
<p>4.4.10.b Names, Mailing Addresses and Description of Scope.</p>	<p>March Vision Care Group, Inc. 6701 Centre West Suite 790 Los Angeles, CA 90045</p> <p>Scope and portions of the health care service that March Vision performs:</p> <ul style="list-style-type: none"> • Provider (vision) services • Utilization Management • Provider credentialing and recredentialing • Provider complaints • Claims adjudication • Vision service reimbursement • Quality Improvement
<p>4.4.10.c Monitoring and Evaluation</p>	<p>Oversight Meetings - HealthCare USA will continue to conduct oversight meetings with March Vision no less than quarterly. These meetings will allow HealthCare USA to monitor and address a range of topics such as:</p> <ul style="list-style-type: none"> • Coordination of care and collaborative activities • Service enhancements • Process improvements • Problem identification • Opportunities for improvement <p>Agendas are set, actions assigned and minutes taken with follow-up items reviewed at subsequent meetings. Representatives from the following HealthCare USA departments participate in the oversight meetings: Health Services, Network Development, Provider Relations, Finance, Appeals and Grievances, Regulatory Compliance, Quality Improvement, and Service Operations. The results of these meetings are reported to the Quality Management Committee (QMC).</p> <p>If issues are identified that need special attention, additional meetings directed at the specific issues will be held until the issues are resolved.</p> <p>Review of Operations Reports - HealthCare USA reviews March Vision's monthly and quarterly operations reports. Any noted operational concern is addressed with March Vision.</p> <p>Annual Audits - HealthCare USA conducts annual audits of March Vision that evaluate March Vision's capacity to perform delegated functions to HealthCare USA. These audits include:</p>



March Vision Contract Section	March Vision Response
	<ul style="list-style-type: none"> • Regulatory Compliance • Provider Credentialing and Recredentialing • Claims
4.4.10.d Services in Other States	March Vision provides services for HealthCare USA in Missouri. March Vision does not provide services for any other Coventry health plan.
4.4.10.e Debarment, Suspension, Regulatory Action or Sanction	March Vision has never been debarred, suspended, or sanctioned by any Federal, State, or Medicaid agency. Additionally, March Vision has not been issued a letter of deficiency or any corrective action from Federal, State, or Medicaid agencies within the past five (5) years.
4.4.10.f Pending or Recent Litigation	March Vision has not received any letters of deficiency or any corrective actions requested or required by any Federal or state regulatory entity or state Medicaid agency within the past five (5) years that relate to subcontractor Medicaid or CHIP contracts. However, March paid \$3,750 to a health plan customer serving public sector membership on July 25, 2007. This amount was paid at the request of such customer as reimbursement for a fine imposed by the Ohio Department of Jobs and Family Services ("ODJFS) in connection with having one vision care provider less than required by ODJFS in 1 out of 34 counties. The deficiency was promptly remedied.
4.4.10.g Bankruptcy	March Vision has not filed bankruptcy or insolvency in the last five (5) years.

Medical Transportation Management, Inc. (MTM)

MTM Contract Section	MTM Response
4.4.10.b Names, Mailing Addresses and Description of Scope	Medical Transportation Management, Inc. (MTM) 16 Hawk Ridge Drive Lake St. Louis, MO 63367 Scope and portions of the health care service MTM performs: <ul style="list-style-type: none"> • Member services • Network management • Claims adjudication • Quality Improvement
4.4.10.c Monitoring and	Oversight Meetings - HealthCare USA will continue to conduct



MTM Contract Section	MTM Response
Evaluation	<p>oversight meetings with MTM no less than quarterly. These meetings allow HealthCare USA to monitor and address a range of topics such as:</p> <ul style="list-style-type: none"> • Coordination of care and collaborative activities. • Service enhancements. • Process improvements. • Problem identification. • Opportunities for improvement. <p>Agendas are set, actions assigned and minutes taken with follow-up items reviewed at subsequent meetings. Representatives from the following HealthCare USA departments participate in the oversight meetings: Health Services, Network Development, Provider Relations, Finance, Appeals and Grievances, Regulatory Compliance, Quality Improvement, and Service Operations. The results of these meetings are reported to the Quality Management Committee (QMC).</p> <p>If issues are identified that need special attention, additional meetings directed at the specific issues will be held until the issues are resolved. If the issue is not resolved, a correction active plan will be imposed.</p> <p>Review of Operations Reports - HealthCare USA reviews MTM's monthly and quarterly operations reports. Any noted operational concern is addressed with MTM.</p> <p>Annual Audits - HealthCare USA conducts an annual audit of MTM that evaluates MTM's capacity to perform delegated functions to HealthCare USA.</p>
4.4.10.d Services in Other States	MTM provides services for HealthCare USA in Missouri. MTM provides services for other Coventry Health Plans in Michigan and Nebraska.
4.4.10.e Debarment, Suspension, Regulatory Action or Sanction	Neither MTM nor its affiliates have ever been debarred, suspended, or sanctioned by any Federal, State, or Medicaid agency. Additionally, MTM has not been issued a letter of deficiency or any corrective action from Federal, State, or Medicaid agencies within the past five (5) years.
4.4.10.f Pending or Recent Litigation	MTM is occasionally subject to claims regarding accident damage and workers compensation. All of these matters are of a size and scope that do not impact MTM's services as they work diligently to resolve all legal matters quickly and in a fair manner, ensuring their clients are never subject to any consequences stemming from legal action. MTM has, at all times, sufficient liability insurance to cover vehicle accident and workers compensation claims.



MTM Contract Section	MTM Response
	<p>MTM is also, from time to time, involved in litigation with transportation providers. As an example, such litigation might pertain to providers not meeting MTM's contract requirements, including not providing trip verification, failure to provide member signatures, or not paying liquidated damages for noncompliance.</p> <p>The financial stability of MTM, as well as their ability to perform contractual obligations, is not threatened by current litigation should an adverse judgment be entered against MTM. The providing by MTM, and the subsequent reviewing, of all litigation details for a company such as MTM with a national scope and numerous large contracts is impractical since much of this information is subject to attorney-client privilege and privacy/confidentiality considerations. Should information on any specific litigation or claim be required, MTM will supply that information which can be released with jeopardizing attorney-client privilege or privacy/confidentiality considerations incident to litigation.</p> <p>Additionally, MTM has never been subject to any SEC filings.</p>
4.4.10.g Bankruptcy	<p>MTM has not filed any bankruptcy or insolvency proceedings in the last five (5) years, nor have they ever in their 16 years of business.</p>

CareCore National (CareCore)

CareCore Contract Section	CareCore Response
4.4.10.b Names, Mailing Addresses and Description of Scope	<p>CareCore National 400 Buckwalter Place Blvd Bluffton, South Carolina 29910</p> <p>Scope and portions of the health care service that CareCore performs:</p> <ul style="list-style-type: none"> • Maintaining a pre-certification program for the advanced technology outpatient diagnostic imaging services. <p>Maintaining clinical review criteria required to evaluate medical necessity and the information resources and processes used to apply the criteria.</p>
4.4.10.c Monitoring and Evaluation	<p>Oversight Meetings - HealthCare USA will continue to conduct oversight meetings with CareCore no less than quarterly. These meetings allow HealthCare USA to monitor and address a range of topics such as:</p> <ul style="list-style-type: none"> • Coordination of care and collaborative activities • Service enhancements



CareCore Contract Section	CareCore Response
	<ul style="list-style-type: none"> • Process improvements • Problem identification • Opportunities for improvement. <p>Agendas are set, actions assigned and minutes taken with follow-up items reviewed at subsequent meetings. Representatives from the following HealthCare USA departments participate in the oversight meetings: Health Services, Network Development, Provider Relations, Finance, Appeals and Grievances, Regulatory Compliance, Quality Improvement, and Service Operations. The results of these meetings are reported to the Quality Management Committee (QMC).</p> <p>If issues are identified that need special attention, additional meetings directed at the specific issues will be held until the issues are resolved. If the issue is not resolved, a correction active plan will be imposed.</p> <p>Review of Operations Reports --HealthCare USA reviews CareCore's monthly and quarterly operations reports. Any noted operational concern is addressed with CareCore.</p>
4.4.10.d Services in Other States	CareCore provides services for HealthCare USA in Missouri. CareCore provides services for another Coventry Health Plan in Michigan.
4.4.10.e Debarment, Suspension, Regulatory Action or Sanction	<p>CareCore had a Market Conduct Survey by the Connecticut Department of Insurance that evaluated the 2007 UM program for Connecticut (CT) enrollees. CareCore was found to have one non-certification and one expedited appeal review not completed within the required timeframes. Utilization data provider to the CT DOI was not consistent with what CT considers statistically accurate. CareCore was fined \$2,000.</p> <p>During a Market Conduct Survey for the CT DOI of CareCore 2001 – 2002 UM Program, CareCore was found to not comply in all instances to issue a non-certification determination notice within 2 business days of the receipt of necessary information or providing accurate statistical information to the CT DOI. CareCore was fined \$2,000. There are no other adverse actions to report.</p>
4.4.10.f Pending or Recent Litigation	The assumptions made in responding to 4.4.10.f of the RFP were that "any ... litigation ... not ... limited to, litigation involving failure to provide timely, adequate or quality physical or behavioral health services" be included on this litigation list. As such, no arbitrations were included. However, actions were included despite not being related to the services provided by CareCore National (e.g. breach of vendor contract actions, employment actions). Further, because the question of whether



CareCore Contract Section	CareCore Response
	insurance would apply to an adverse judgment cannot be known with certainty prior to receiving an adverse judgment, if any, the response regarding insurance applicability was answered with regard to applicability to defense of the action instead. The question of reserves set aside for adverse judgments was assumed to be applicable only where such a reserve would be required by applicable law. Last, since the list is to include "any pending or recent (within the past five (5) years) litigation," several litigations exist on the list that are no longer pending, but were active at any time within the last five years. Please see below.
4.4.10.g Bankruptcy	CareCore has not filed bankruptcy or insolvency in the last five (5) years.

4.4.10.f Pending or Recent Litigation (continued) - CareCore National, Inc Litigation

Medical Diagnostic Imaging, et al. v. CCN, et al.

COURT: United States District Court for the Southern District of New York

TYPE: Action alleging inappropriate exclusion from provider networks

DATE OF FILING: September 27, 2006

CURRENT STATUS: Trial is slated for February 2012

DAMAGES CLAIMED: \$15,609,682 before trebling. Insurance would be anticipated to apply to defense of the action.

Moorecomm v. Citadel, et al.

COURT: Mecklenburg County Superior Court, North Carolina

TYPE: Action for breach of contract

DATE OF FILING: April 10, 2009

CURRENT STATUS: Settled out of court and contract continued

Steven Cohn, M.D. and Michael K. Dovernarsky, M.D. v. Horizon Blue Cross Blue Shield of N.J., et al.

DATE OF FILING: December 15, 2009

TYPE: Antitrust and other claims alleging that Horizon Blue Cross Blue Shield of New Jersey and CareCore are improperly refusing to cover and pay for certain services rendered by plaintiff doctors.



CURRENT STATUS: On July 25, 2011, all claims related to CareCore National were dismissed with prejudice from the litigation. Plaintiffs have a right of appeal of that decision, which expires at the termination of the litigation. However, no appeal is currently anticipated.

DAMAGES CLAIMED: Compensatory and punitive damages, costs of suit and reasonable attorneys' fees.

Hamilton, et. al v. CareCore National, LLC

COURT: United States District Court for the Southern District of Georgia

DATE OF FILING: Filed in Georgia state court on May 14, 2009, then removed to federal court on June 17, 2009.

TYPE: FLSA claim alleging underpayment of overtime.

CURRENT STATUS: CareCore's Summary Judgment motion was partially granted on March 30, 2011, with most of Plaintiffs' claims terminated. The only claims remaining are overtime claims for 2 of the plaintiffs, based on whether time available should count as work time.

DAMAGES CLAIMED: Non-specified claim. Insurance is not anticipated to apply to defense of the action.

Maurice Lewis v. CareCore National, LLC

COURT: United States District Court for the District of Colorado

DATE OF FILING: January 26, 2011

TYPE: wrongful termination and discrimination

CURRENT STATUS: Summary Judgment motions are due in late November.

DAMAGES CLAIMED: Monetary and punitive damages. Insurance would be anticipated to apply to defense of the action.

New Jersey Podiatric Medical Society, Inc. v. Horizon Blue Cross/Blue Shield of N.J., et al.

DATE OF FILING: December 3, 2009

CURRENT STATUS: On March 24, 2010, Plaintiffs released defendants, including CareCore, from all claims.

Bobby Ray Odom, et al. v. Blue Cross Blue Shield of Alabama, et al.

COURT: Circuit Court of Covington County, Alabama

TYPE: Action for breach of benefits contract

CURRENT STATUS: Dismissed without prejudice on April 3, 2008.

Komarow v. CareCore National, LLC, et al.

DATE OF FILING: July 26, 2007

COURT: Supreme Court of the State of New York, Dutchess County



TYPE: Shareholder equity dispute
CURRENT STATUS: Settled outside of court.

Omega Diagnostic Imaging, P.C. v. CareCore National, LLC, et al.

DATE OF FILING: March 13, 2009
COURT: United States District Court for the Southern District of New York
TYPE: Action alleging inappropriate exclusion from provider networks
CURRENT STATUS: Plaintiffs withdrew the case, without prejudice to refile.

Park West Radiology, P.C. et al. v. CCN, et al.

COURT: United States District Court for the Southern District of New York
TYPE: Action alleging inappropriate exclusion from provider networks
DATE OF FILING: December, 2006
CURRENT STATUS: This action settled during a December 2009 trial.

Allen Rothpearl, M.D., P.C., d/b/a Jericho Specialty Imaging v. CareCore National, et al.

COURT: United States District Court for the Eastern District of New York
DATE OF FILING: May 12, 2008; June 25, 2008-Amended Complaint
TYPE: Action alleging inappropriate exclusion from provider networks
CURRENT STATUS: Motions to dismiss and for summary judgment are pending, however the Court has set jury selection and trial dates for December 2011.
DAMAGES CLAIMED: \$4,300,000 before trebling. Insurance would be anticipated to apply to defense of the action.

Carl Rosenow v. CareCore National, LLC

COURT: United States District Court for the District of South Carolina, Beaufort Division
DATE OF FILING: June 21, 2010
TYPE: Action alleging employment discrimination.
CURRENT STATUS: Discovery has been extended into November 2011 to complete depositions.
DAMAGES CLAIMED: Lost wages and benefits, front pay if employment is inappropriate, liquidated damages against Defendant (for violation of ADEA), attorneys' fees and costs for violations of ADEA. Insurance may be anticipated to apply to defense of the action.

Staten Island Physician Practice v. CareCore National, LLC

COURT: Richmond County Supreme Court, New York
DATE OF FILING: October 25, 2010



TYPE: Action to force application of criteria for inclusion in one health plan network to be used for inclusion in other health plan networks.

CURRENT STATUS: Defendant's motion to dismiss the claim was granted in its entirety.

Stand-Up MRI of the Bronx, P.C., et al v. CareCore National, LLC, et al.

COURT: United States District Court for the Eastern District of New York

DATE OF FILING: July 22, 2008

TYPE: Action alleging inappropriate exclusion from provider networks

CURRENT STATUS: Trial of the matter has concluded with a jury verdict for Plaintiffs of approximately 11.7 million before trebling. CareCore National has filed a Notice of Motion to Appeal to the United States Court of Appeals for the Second Circuit.

DAMAGES CLAIMED: \$35.1 million (jury verdict includes trebling but not costs). Insurance would be anticipated to apply to defense of the action.

David Allen Tebbetts, et al. v. Blue Cross Blue Shield of Alabama, et al.

JURISDICTION: United States District Court for the Middle District of Alabama Northern Division

DATE OF FILING: September 10, 2007

TYPE: Action for failure to pay benefits and related claims.

CURRENT STATUS: Plaintiffs' claims were dismissed.

Thea Traynum, et al v. Regional Medical Imaging, P.C., et al

JURISDICTION: State of Michigan, Genesee County Circuit Court

DATE OF FILING: September 5, 2008

Claim and Damages: Medical Malpractice and monetary damages.

CURRENT STATUS: The case was settled out of court, and Plaintiffs signed releases of all claims. CareCore has no current or pending liability in this case.

Natasha Weil v. CareCore National, LLC

COURT: United States District Court for the District of Colorado

DATE OF FILING: April 7, 2010

TYPE: Action alleging wrongful termination

CURRENT STATUS: CareCore's Summary Judgment motion was granted in its entirety. Plaintiff has until July 14, 2011, to appeal that decision, although appeal is not expected based on the lengthy and thorough decision published by the Court.



AMENDMENT 2 REVISED THE FOLLOWING ITEM.

4.4.11 Personnel/Staffing

The offeror shall submit information related to the qualifications of the proposed personnel concerning their experience in serving the Medicaid population or other state/federal health business, including education, training, and previous work assignments. In particular, the offeror shall submit the following:

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.11.

- 4.4.11.a. The number of employees, client base, and location of offices. The offeror's response shall:
1. Include the activities and functions performed at each office location.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.11(a)1.

This answer applies to all regions.

HealthCare USA has been a managed care partner with MO HealthNet serving Missouri's TANF and CHIP populations since the initial contract in 1995. We have assembled a dynamic team of healthcare professionals each with an average of over 6 years of Missouri Medicaid experience and nearly 18 years in the healthcare industry. This team possesses an array of degrees/certifications as listed in Figure 4.4- 4: HealthCare USA Staff Education biographical summaries and resumes documenting the qualifications for the personnel in each required position is also included in Section 2.2.1.

Figure 4.4- 4: HealthCare USA Staff Education

Type of Certification/Degree	Number of Certifications/ Degrees
Juris Doctorate	2
Masters Degree	16
Bachelors Degree	41
Associates Degree	10
Medical Doctors (MD)	3
Registered Nurses (RN)	38
Licensed Practical Nurses (LPN)	2
Project Management Professional (PMP)	1
Certified Public Accountant (CPA)	3



Type of Certification/Degree	Number of Certifications/Degrees
Certified Professional HealthCare Quality (CPHQ)	2
Certified Professional Coder (CPC)	8
Academy for Healthcare Management (AHM)	1
Fellow Academy for Healthcare Management (FAHM)	1
Professional Academy for Healthcare Management (PAHM)	1
Medical Management Associate (MMA)	2
Doctor of Philosophy (PhD)	1
Licensed Professional Counselor (LPC)	1
Health Information Administrator (HIA)	1
Certified Case Managers (CCM)	8
Oncology Certified Nurse (OCN)	1
Certified Diabetes Educator (CDE)	1
Legal Nurse Consultant (LNC)	1

Local Presence

Recognizing the importance of a local presence to meet our member’s needs and support our extensive network of providers throughout Missouri, we shall continue to maintain 3 regional offices in addition to a new member service location in Springfield Missouri. HealthCare USA has offices in Kansas City, Jefferson City and St. Louis. Information regarding those offices, the client base served, employees and the activities and functions performed in each office are provided in Figure 4.4- 5: HealthCare USA Regional Office Information

Figure 4.4- 5: HealthCare USA Regional Office Information

	Western Region	Central Region	Eastern Region
Office Address	8320 Ward Parkway Kansas City, MO 64114	2420 Hyde Park Dr., Ste. B Jefferson City, MO 65109	10 S. Broadway Ste. 1200 St. Louis, MO 63102
Total Years Operating in Region	10	15	16
Total Years with office in	8	15	16



	Western Region	Central Region	Eastern Region
Region			
Total Number Employees	13	14	79
Client Base Served	Title XIX Federal Medicaid, Title XXI CHIP, and Children in the Care and Custody of the State and Receiving Adoption Subsidy Assistance	Title XIX Federal Medicaid, Title XXI CHIP, and Children in the Care and Custody of the State and Receiving Adoption Subsidy Assistance	Title XIX Federal Medicaid, Title XXI CHIP, and Children in the Care and Custody of the State and Receiving Adoption Subsidy Assistance
Number Members Served as of 10/31	31,072	33,899	124,919

Activities & Functions Performed			
Admin & Clerical Support		X	X
Appeals, Complaints & Grievances			X
Behavioral Health Case Management	Staff will be added to these locations by April 2012	Staff will be added to these locations by April 2012	X
Case Management	X	X	X
Community Development	X	X	X
Contracting	X		X
Compliance		X	X
Credentialing			X
Dental Consultant		X	
Disease Management	X	X	X
Finance		X	X



Activities & Functions Performed			
Government Relations		X	
Human Resources			X
Inpatient Certification	X	X	X
IT Support	X		X
Medical Directors			X
Network Operations (provider data management)			X
Prior Authorization			X
Provider Relations	X	X	X
Provider Services	X	X	X
Quality Improvement	X	X	X
Social Workers	X	X	X

4.4.11.a.2. Demonstrate a physical presence in Missouri. Additionally, the offeror shall demonstrate that the following personnel are located in and operate from Missouri: Health Plan Administrator, clerical and support staff, Medical Director, Chief Financial Officer, Quality Assessment and Improvement and Utilization Management Coordinator, Special Programs Coordinator, Case Management Supervisor, Behavioral Health Coordinator, Inpatient Certification Review Staff, Member Services Staff, Provider Services Staff, Compliance Officer and Complaint, Grievance, and Appeal Coordinator.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.11(a)2.

Figure 4.4- 6: HealthCare USA Physical Presence in Missouri by Office Location

	Western Region	Central Region	Eastern Region
Office Address	8320 Ward Parkway Kansas City, MO 64114	2420 Hyde Park Dr., Ste. B Jefferson City, MO 65109	10 S. Broadway Ste. 1200 St. Louis, MO 63102



	Western Region	Central Region	Eastern Region
Health Plan Administrator			X
Clerical and support staff	X	X	X
Medical Director			X
Chief Financial Officer			X
Quality Assessment and Improvement	X	X	X
Utilization Management Coordinator			X
Special Programs Coordinator			X
Case Management Supervisor			X
Behavioral Health Coordinator			X
Inpatient Certification Review Staff	X	X	X
Member Services Staff	The member function currently located in Newark, DE will be located in Springfield, MO by April, 2012		
Provider Services Staff	X	X	X
Compliance Officer		X	
Complaint, Grievance, and Appeal Coordinator			X



4.4.11.a.3. Address the parent organization, affiliates, and subsidiaries.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.11(a)3.

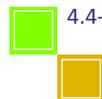
Parent Organizations, Affiliates and Subsidiaries

HealthCare USA is a wholly-owned subsidiary of Coventry Health Care, Inc.(Coventry). Coventry currently serves nearly 5 million members in all 50 states across a full range of products and services including group and individual health insurance, Medicare and Medicaid programs, and coverage for specialty services such as workers' compensation.

Coventry's Medicaid expertise helps communities around the nation support their local Medicaid recipients gain control over their health challenges. We cover 690,000 member lives in the following 9 states: Maryland, Florida, Kentucky, Michigan, Missouri, Nebraska, Pennsylvania, Virginia, and West Virginia.

Coventry's diverse Medicaid programs include experience with:

- Quality care management programs in:
 - Asthma
 - Maternity
 - HIV
 - High blood pressure
 - Early Periodic Screening, Diagnostic and Treatment
 - Immunizations
 - Woman Care
- Accredited by National Committee for Quality Assurance (NCQA) or URAC
- Temporary Assistance for Needy Families (TANF)
- Aged, Blind and Disabled (ABD)
- State Children's Health Insurance Program (CHIP)
- Old Age Assistance (OAA)
- Children in State Custody
- Pregnant Woman programs
- Woman, Infant and Children (WIC) Referrals
- Coordination with Maternal Support Services/Infant Support Services (MSS/ISS)
- Provider performance recognition programs





4.4.11b. Resumes, job descriptions, and full time equivalent status for the offeror's Missouri-based Health Plan Administrator, Medical Director, Quality Assessment and Improvement and Utilization Management Coordinator, Special Programs Coordinator, Behavioral Health Coordinator, and Chief Financial Officer.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.11(b).

The figure below cross references the RFP position titles to HealthCare USA's job description titles and notes the full-time equivalent status for each position.

Figure 4.4- 7: HealthCare USA Required Position Cross Reference

RFP Position Title	HealthCare USA Job Description Title	Employee Name	Full-Time Equivalent Status
Health Plan Administrator	Chief Executive Officer	Kim Covert	Full-Time FTE
Medical Director	Vice President Medical Affairs	William Rooney	Full-Time FTE
Quality Assessment & Improvement Coordinator	Director, Quality Improvement	Laurel Ruzas	Full-Time FTE
Utilization Management Coordinator	Vice President, Health Services	Lisa Fillback	Full-Time FTE
Special Programs Coordinator	Manager, Health Services	Tasha Smith	Full-Time FTE
Behavioral Health Coordinator	Regional Executive Director	Scott Frederick	Full-Time FTE
Chief Financial Officer	Chief Financial Officer	Patrick Brosnan	Full-Time FTE

For further information, refer to Attachment 17 in Volume 2 of our response.

4.4.11c. The offeror shall identify which, if any, of the key positions, including the administrative personnel identified herein, are not filled, provide a rationale for why the positions are not filled, and provide timeframes for filling positions prior to readiness review activities.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.11(c).

As an established MO HealthNet managed care partner since 1995, we have always recognized that having qualified, strategic personnel locally available to support our members and providers is imperative. HealthCare USA currently has all but one position filled related to new



contractual requirements set forth in this RFP. The position to be filled is the behavioral health case management supervisor. Additionally, the member services call center and the dental consultant will be relocated to the state of Missouri no later than April 1, 2012.

4.4.11d. Information for other personnel, including Dental Consultant, Complaint, Grievance, and Appeal Coordinator, MIS Director, and Compliance Officer.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.11(b).

The figure below cross references the RFP position titles to HealthCare USA’s job description titles and notes the full-time equivalent status for each position.

Figure 4.4- 8: HealthCare USA Required Position Cross Reference

RFP Position Title	HealthCare USA Job Description Title	Employee Name	Full-Time Equivalent Status
Dental Consultant	Vice President of Clinical Management for DentaQuest	James Thommes, DDS	Full-Time FTE
Complaint, Grievance and Appeal Coordinator	Manager, Regulatory Compliance	David Thielemier	Full-Time FTE
MIS Director	Director of Applications Development	Sherry Thornton	Full-Time FTE
Claims Administrator	Vice President of Medicaid Customer Service Operations	Joel Coppadge	Full-Time FTE
Compliance Officer	Director of Governmental Relations and Regulatory Compliance	Pam Victor	Full-Time FTE

For further information, refer to Attachment 18 in Volume 2 of our response.

4.4.11e. Information on staffing levels, job descriptions, and qualifications Prior Authorization Staff, Inpatient Certification Review Staff, Member Services Staff, and Provider Services Staff.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.11(e).



As shown in our organization chart (Figure 2.4), the following departments are currently staffed with FTE counts of:

- Prior Authorization -20
- Inpatient Certification Review – 16
- Member Services – 29

For further information, refer to Attachment 19 in Volume 2 of our response.

Type of Certification/Degree	Number of Certifications/Degrees
PROVIDER RELATIONS STAFF	
Masters Degree	1
Bachelors Degree	6
Certified Professional Coder (CPC)	3
Fellow Academy for Healthcare Management (FAHM)	1
HEALTH SERVICE STAFF	
Masters Degree	3
Bachelors Degree	16
Associates Degree	6
Medical Doctors (MD)	3
Registered Nurses (RN)	31
Certified Professional Coder (CPC)	2
Medical Management Associate (MMA)	2
Doctor of Philosophy (PhD)	1
Licensed Professional Counselor (LPC)	1
Certified Case Managers (CCM)	6
Certified Diabetes Educator (CDE)	1
PRE-AUTHORTION STAFF	
Masters Degree	4
Bachelors Degree	14
Associates Degree	4
Medical Doctors (MD)	1
Registered Nurses (RN)	13
Licensed Practical Nurses (LPN)	5
Certified Professional Coder (CPC)	1
Certified Case Managers (CCM)	8
Certified Professional Utilization Review (CPUR)	1
Public Health Nurse (PHN)	1
CSO - MEMBER SERVICE STAFF	
Bachelors Degree	5
Associates Degree	5
Managed Healthcare Professional (MHP)	1
(Professional, Health Insurance Advanced Studies(PHIAS)	1



4.4.12 Claims Payment Processes [2.26]

- 4.4.12 Claims Payment Processes: The offeror shall submit the following information regarding the offeror's claims payment processes: (2.26)
- a. Information describing the offeror's claim adjudication processes. The offeror shall provide a flow chart or written description that details the flow of claims from receipt until payment. Information shall be provided documenting the offeror's audit trail of all claims that enter the system and any review processes that are in place.
- 4.4.12b. The offeror shall document the offeror's past and current performance with regard to the timely payment to in-network and out-of-network providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.12(a).

For further details on Section 4.4.12(a-b), see Section 2.26.3.

-
- 4.4.12c. A description of the offeror's claims processing and management information system functions, including, but not limited to information about the offeror's liability management practices regarding its "Incurred But Not Reported Claims" and "Received But Unadjudicated Claims".

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.12(c).

For further information on Section 4.4.12(c), see Section 2.26.1.

4.4.13 Member Services and Provider Services [2.14; 2.16]

The offeror shall describe the hours of operation, holiday schedule, member and provider communication and education plans, and staff training plans for member services and provider services. (2.14 and 2.16)

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.13. For further details on Section 4.4.13, see Sections 2.14 and 2.16.

4.4.14 Member Grievance System [2.15]

The offeror shall describe the offeror's member grievance system being sure to address the grievance process, the appeal process, expedited resolution process, and process for ensuring that members receive proper notice of action. (2.15)

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.14. For further details on Section 4.4.14, see Section 2.15.



4.4.15 Release for Ethical Reasons [2.9]

The offeror shall state if reimbursement for, or provider coverage of, a counseling or referral service will be objected to based on moral or religious grounds. (2.9)

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.15. For further details on Section 4.4.15, see Section 2.9.

AMENDMENT 2 DELETED THE FOLLOWING ITEM.

4.4.16 DELETED

4.4.17 Implementation Plan

The offeror shall submit an implementation plan that identifies and elaborates on the critical actions the offeror will pursue to implement the programmatic responsibilities and performance requirements outlined herein. Submission of the implementation plan in no way affects the offeror's obligation to fulfill the readiness review requirements as described herein. The implementation plan shall include the following minimum elements:

- a. A list of the members of the implementation team, including each member's responsibilities and roles;

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(a).

The implementation for this contract will be led by HealthCare USA's VP Operations, Kathy Whaley. Kathy is certified through Project Management Institute as a Project Management Professional (PMP). She will have responsibility to lead a cross-functional team of HealthCare USA's experienced management staff, Coventry support staff and subcontractor personnel in executing the tasks outlined in Attachment 20 HealthCare USA RFP B3Z12055 Implementation Plan. Implementation team members and a summary statement regarding their role are included in Figure 4.4- 9. Detailed responsibilities for each team member are documented in the Implementation Plan.

Figure 4.4- 9: Implementation Team Roles

Implementation Team Member	Role
Whaley, Kathy	<u>Project Manager</u> - Responsible for tracking progress against project plan, leading implementation team meetings, monitoring critical path deliverables and working with senior leadership to quickly resolve unanticipated issues in a timely



Implementation Team Member	Role
	<p>manner.</p> <p>As VP Operations, also accountable for executing and coordinating tasks related to overall operations of the health plan or where tasks cross multiple areas.</p>
Covert, Kim	<p><u>Project Sponsor</u> – As Chief Executive Officer for HealthCare USA is ultimately responsible for project success.</p>
Rooney, William (MD)	<p>Accountable delivery of a medical management tasks associated with implementation including quality, physical/behavioral health integration, case management, disease management, health home coordination, transition of care, and other medical management activities designed to improve the health outcome of members.</p>
Profumo, Robert (MD)	<p>Accountable for delivery of health home coordination activities on the implementation plan.</p>
Fillback, Lisa	<p>Accountable for case management, disease management, transition of care and other medical management activities designed to improve the health outcome of members.</p>
Smith, Tasha	<p>Accountable for case management and disease management activities on the implementation plan.</p>
Frederick, Scott	<p>Responsible for ensuring the integration of physical/behavioral health activities and other behavioral health management activities designed to improve the health outcome of members and overseen by HealthCare USA’s Chief Medical Director (William Rooney) and our Compliance Department.</p>
Cox, Donnell	<p>Responsible to deliver dental-related activities on the implementation plan and overseen by HealthCare USA’s Compliance Department.</p>
Ruzas, Laurel	<p>Accountable for quality improvement program, performance improvement projects, focus studies, NCQA accreditation and certification activities on the implementation plan.</p>
Victor, Pamela	<p>Accountable for compliance and government relations activities on the implementation plan as well as responsible for some member communication and operations activities.</p>
Thielemier, David	<p>Responsible for compliance activities on the implementation plan including policies and procedures, state reporting,</p>



Implementation Team Member	Role
	contract compliance, subcontractor oversight, fraud waste and abuse program, and member and provider grievances, complaints and appeals.
Schrieber, Resmi	Accountable for provider servicing activities including provider communication strategies, access of care and availability of services activities, provider network servicing and physician recruitment and credentialing.
Zayas, Dawn	Accountable for member and provider telephonic call center support and provider claims processing activities on the implementation plan.
Thoenen, Peggy	Accountable for member communication strategies including community partners, member advisory committee, member newsletters, handbook, health fairs and HEDIS related wellness activities on the implementation plan.
Poisson, Gene	Accountable for implementation activities related hospital, large provider system and ancillary services contracting, including subcontractors as well as communication strategies related to these entities.
Goecke, Robyn	Responsible for providing legal expertise for implementation related activities.
Thornton, Sherry	Accountable for all Management Information Systems (MIS) activities on the implementation plan.
Leon, Angela	Accountable for enrollment, disenrollment and eligibility related activities on the implementation plan.
DeKemper, Stephanie	Responsible for providing CLAS standard expertise for implementation activities.
Brosnan, Patrick	Accountable for financial and encounter related activities on the implementation plan.
Handshy, Jennifer	Responsible for encounter related activities on the implementation plan.

Please refer to Attachment 20 in Volume 2 of our response – Implementation Plan in section 4.4.17i.



4.4.17b. A staffing gap analysis and a plan with a timeline for hiring and training necessary personnel;

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(b).

All positions required in Section 2.2.1 are currently filled with qualified staff. As outlined in the Implementation Plan and in Section 4.4.11, four of these positions will be moved to Missouri prior to the effective date of the contract. Figure 4.4- 10, Staffing Gap Analysis, outlines the key milestones documented in the Implementation Plan for hiring and training the staff that will be moved to Missouri.

Figure 4.4- 10: Staffing Gap Analysis

Position Moving to Missouri	Timeline for Hiring and Training	
Required Positions in Section 2.2.1		
Dental Consultant [2.2.2(d)]	Recruitment: Training:	Nov. 8, 2011 – Feb 29, 2012 Mar. 1, 2012 – Apr. 30, 2012
Case Management Supervisor for Behavioral Health [2.2.2(h)]	Recruitment Training Parallel Coverage	Feb. 1, 2012 – Apr. 16, 2012 Apr. 16 – May 15, 2012 May 1, 2012 – Jun. 15, 2012
Member Services Staff (Call Center) [2.2.2(k)]	Recruitment Training Parallel Phone Coverage	Feb 6, 2012 – Mar. 22, 2012 Mar. 26, 2012 – May 25, 2012 May 28, 2012 – Jun. 11, 2012
Provider Services Staff (Call Center) [2.2.2(l)]	Recruitment Training Parallel Phone Coverage	Feb 6, 2012 – Mar. 22, 2012 Mar. 26, 2012 – May 25, 2012 May 28, 2012 – Jun. 11, 2012
Other Gaps Due to New RFP Requirements or Enhanced Service Offerings		
Co-Located Behavioral Health Staff in Kansas City and Jefferson City, MO	<ul style="list-style-type: none"> • Recruitment • Training • Parallel Coverage 	Feb. 1, 2012 – Apr. 16, 2012 Apr. 16 – May 15, 2012 May 1, 2012 – Jun. 15, 2012
Care Coord. Member Outreach Transition of Care [2.5.9(a)] Health Home [4.5.2(e)]	<ul style="list-style-type: none"> • Recruitment • Training • Parallel Coverage 	Feb. 1, 2012 – Apr. 16, 2012 Apr. 16 – May 15, 2012 May 1, 2012 – Jun. 15, 2012



4.4.17c. Process for communicating with new members, including methods, materials, and timeframes;

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(c).

Figure 4.4- 11, Summary of New Member Communication Plan, provides an overview of HealthCare USA’s proposed approach for communicating with new members. Our approach includes communication processes specific to contract changes as a result of this proposal as well as continued existing new member communication processes. As an existing MCO in all three regions, our implementation plan only includes the additional member communication processes that will be implemented as a result of this procurement as outlined in Attachment 20, Implementation Plan, in Volume 2 of our response. Our ongoing member communication strategies outlined in Sections 4.5.2 b3, 4.5.2d1 and 4.5.2d2 will continue.

Figure 4.4- 11: Summary of New Member Communication Plan

Member Communication Processes for Potential New Members			
Strategy	Method Description	Materials	Timeframes
Community Partner Education (Community Based and Faith Based Organizations, Schools, etc.)	Educate community and faith-based organizations about new benefits, requirements and innovative programs offered by HealthCare USA under the contract. Ask these Community Partners to educate our existing and potential new members regarding these changes, including their need to select a health plan during any Open Enrollment period.	Updated “Who is HealthCare USA” Presentation HealthCare USA Informational Folder; which contains a HealthCare USA and Kids Health brochure, Bear Facts Member Newsletter, Website information, BIB and Asthma incentive brochures, Transportation form and Post Partum depression informational. Mailing with summary of key facts and changes Face-to-Face Meetings to review changes State approved Member Education Materials including, but not limited to, Bear Facts Newsletter and Noodle Soup one page informational handouts.	March 1, 2012 and targeted ongoing activity



Member Communication Processes for Potential New Members			
Strategy	Method Description	Materials	Timeframes
State and County Agency Education	Educate Family Service Division and Social Service staff about benefits, new requirements and programs offered by HealthCare USA under the contract and the importance of selecting a health plan once approved and during any open enrollment period.	Updated “Who is HealthCare USA” Presentation HealthCare USA Informational Folder; which contains a HealthCare USA and Kids Health brochure, Bear Facts Member Newsletter, Website information, BIB and Asthma incentive brochures, Transportation form and Post Partum depression informational.	March 1, 2012 and targeted ongoing activity
Provider Education	Educate Providers and staff about new benefits, contractual requirements and programs offered by HealthCare USA under the contract.	“Who is HealthCare USA “ power point presentation. HealthCare USA informational folder Additional transportation forms HealthCare USA poster	March 1, 2012 and targeted ongoing activity
Health Fairs and Large Community Events	Sponsor health fairs and participate in large community events to offer information on new benefits, contractual requirements and programs offered by HealthCare USA under the contract.	Sponsorship or participation fees promotional items New brochures and literature referencing new contractual requirements New marketing banners/signs reflecting new benefits and programs.	March 1, 2012 and targeted ongoing activity
Feet on the Street Campaign	Targeted marketing campaign to provide educational outreach to key community influencers and community resource centers in order to	Additional staff in order to saturate the county and outreach to community. Develop new HealthCare USA ready reference materials for	March 1, 2012 and targeted ongoing activity



Member Communication Processes for Potential New Members			
Strategy	Method Description	Materials	Timeframes
	provide education regarding new contractual requirements, new HealthCare USA benefits and programs and the importance of selecting a health plan and primary care provider.	quick information, visible and easily accessible. Update HealthCare USA literature to reflect new benefits, programs and contractual requirements.	
New Member Doc Bear Lunch-n-Learns	Orientation with new members to discuss their benefits, programs, requirements and network options in their local counties. Review the new member materials received in Welcome Packet. One meeting will be held in each region (Western, Central and Eastern) each month.	“Who is HealthCare USA” Power point presentation Member Handbook Promotional items Lunch	Within 1 Month of Enrollment
Outbound Calls: Transition of Care	Health Service staff call member to determine previous plan, assess conditions and assist member in selecting a PCP best able to meet their unique needs	Outbound telephonic call	Within 3 days of enrollment
Outbound Calls: Special Needs	Health Service staff call member to determine previous plan, assess conditions and assist member in selecting a PCP best able to meet their unique needs	Outbound telephonic call	Within 60 days of identification of member as special needs



Member Communication Processes for Potential New Members			
Strategy	Method Description	Materials	Timeframes
Outbound Calls: Health Home	Case Management staff call to member to inform that member meets qualifications for participation in State Health Home program, assess satisfaction with current PCP and desire to change to Health Home PCP	Outbound telephonic call	Within 60 days of enrollment for members with qualifying conditions
Continued Existing New Member Communication Processes			
Method	Description	Materials	Timeframes
New Member Welcome Packet	Letter welcomes members to HealthCare USA and provides critical information including Member Services phone number, Member Handbook, Rights and Responsibilities, HIPAA Privacy Notice, ID Card, and how to access information on the member website.	Member Welcome Letter Member ID Card Member web site Member Handbook Member Sticker HIPAA Privacy Notice Rights and Responsibilities	Within 5 days of enrollment
ID Card Sticker Request	Sticker placed on the ID card requests call to Member Services toll-free phone line. When the member calls, the representative obtains updated demographic information, reviews PCP assignment and assesses member's understanding of available benefits.	Inbound telephonic call	Ongoing, as call received
Outbound New	Outbound call to new	Outbound telephonic	Within 60



Member Communication Processes for Potential New Members			
Strategy	Method Description	Materials	Timeframes
Member Calls	member obtains updated demographic information, reviews PCP assignment and assess member's understanding of available benefits.	call	days of enrollment

4.4.17d. Process for communicating with providers regarding implementation and expectations, including methods, materials, and timeframes;

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(d).

Figure 4.4- 12, Summary of Provider Communication Plan, provides an overview of HealthCare USA's proposed approach for communicating new contract requirements, HealthCare USA benefits and service offering changes with our contracted providers as a result of this procurement. As an existing MCO in all three regions, our implementation plan only includes the additional provider communication processes that will be implemented as a result of this procurement as outlined in Attachment 20 -Implementation Plan. Our ongoing provider communication strategies outlined in Sections 4.5.2 b2, 4.5.2b3 and 4.5.2c1-2 will continue.

Figure 4.4- 12: Summary of Provider Communication Plan

Provider Communication Processes			
Strategy	Method Description	Materials	Timeframes
Award Announcement: Mass Media and Provider Letter	A press release announcing MO HealthNet's renewal of HealthCare USA's contract will be distributed to local media.	Press Release	Within 1 week of award
	Letters announcing HealthCare USA's award of business will be sent to all participating providers.	Letter to Providers Fact Sheet with Key Changes (Benefits, New Contract Requirements, Acquisition of Family Health Partners in Western region, Award to 3 MCOs per region, New Programs and Approaches)	Within 1 week of award



Provider Communication Processes			
Strategy	Method Description	Materials	Timeframes
Meetings with medical providers in their office	Face-to-face meetings with key providers in each region (every provider type including hospitals, large groups, FQHC/RHC, ancillary, safety net providers, PCPs, high volume specialists) to review changes, discuss transition of care, assess understanding of key points, answer any questions and explain open enrollment process	Fact Sheet with Key Changes (Benefits, New Contract Requirements, Acquisition of Family Health Partners in Western region, Award to 3 MCOs per region, New Programs Member materials for new programs and incentives	February 15 – June 30, 2012
Meetings with dental providers in their office	Face-to-face meetings with key dental providers in each region to review changes, discuss transition of care, assess understanding of key points, and answer any questions	Fact Sheet with Key Changes (Benefits, New Contract Requirements, Acquisition of Family Health Partners in Western region, Award to 3 MCOs per region, New Programs Member materials for new programs and incentives	February 15 – June 30, 2012
Meetings with behavioral health providers in their office	Face-to-face meetings with key behavioral health providers in each region to review changes, discuss transition of care, assess understanding of key points, and answer any questions	Fact Sheet with Key Changes (Benefits, New Contract Requirements, Acquisition of Family Health Partners in Western region, Award to 3 MCOs per region, New Programs Member materials for new programs and incentives	February 15 – June 30, 2012



Provider Communication Processes			
Strategy	Method Description	Materials	Timeframes
Provider Newsletters	Include a series of articles in the Provider Newsletter that explain key changes, including contract requirements that have been added to the Provider Manual. These newsletters will also be posted on the Provider Portal and Website under the current news section.	Article on new member benefits Article on new member incentives and related programs Article summarizing changes in provider manual Article explaining key changes in the MO HealthNet contract Article on coordination with Health Home program Article on partnership with Missouri Telehealth Network Article regarding key facts on Integrated Pediatric Network (Western region only)	February 15 – June 30, 2012
Provider Manual	As part of their contract with HealthCare USA, providers are required to adhere to all provisions outlined in our provider manual. The Provider Manual will be updated to reflect changes required by the new contract and will then be distributed to network providers and posted on our web portal for non-participating providers.	Provider Manual hard copy Provider Manual on web portal Provider Manual on CD	April 15 – April 20
Meetings with Health Home Providers (Section 2703)	Face to face meetings between providers participating in the State's Health Home	Case Management Process Overview Disease and Condition Management Process	March 1 to June 30, 2012



Provider Communication Processes			
Strategy	Method Description	Materials	Timeframes
	with HealthCare USA medical management and provider relations staff. Purpose will be to educate providers on HealthCare USA processes and train applicable provider staff on website tools and reports available to assist them in managing their patient's care.	Overview Transition of Care Overview HealthCare USA PCP Health Home Assignment Process Flow Training materials for Provider Suite of Tools including Gaps in Care and One Page Member History reports Member utilization and history reports List of potential webinar/seminar topics for Health Home providers	

4.4.17e. Process for identifying, tracking, and resolving issues during the first sixty (60) days of implementation including triaging priority issues;

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(e).

Attachment 20 – Implementation Plan documents a comprehensive list of all tasks required to meet these deliverables. HealthCare USA’s implementation team will be lead by Kathy Whaley, our Vice President Operations and a certified Project Management Professional (PMP). In conjunction with our cross-function project team, Kathy will employ internationally recognized project management techniques to ensure a smooth and successful implementation of the new contracts requirements and delivery of proposed methods and performance guarantees documented in our response. These processes are already in progress and will be maintained during the life cycle of the project as well as during the first 60 days of the implementation.

Risk Identification & Planning

Prior to submitting our response, we performed an implementation risk assessment to identify, document and assess any potential risks for this project. Triggers or warning signs for when these risks will occur were also identified. Each risk was scored based upon the probability or likelihood of its occurrence, and the impact that risk would have on the project. These risk scores were then ranked based upon the severity of risk score, from highest to lowest. All of



these risks were compiled into a risk register for this project as seen in Attachment 21 – Implementation Risk Register for B3Z12055, included in Volume 2 of our response.

Risks identified as being unacceptable were further analyzed to determine if a mitigation strategy or contingency plan should be developed. For those risks where a mitigation strategy is being employed, additional actions have been included on the implementation plan to either reduce, avoid or eliminate the likelihood or impact of the risk. A contingency plan was developed for any tasks that could not be fully mitigated. Contingency plans will be implemented when the trigger for a risk occurs. Each of these tasks has been assigned an owner and will be monitored throughout the implementation. Acceptable risks remain on the Risk Register and will be closely tracked and monitored throughout the implementation for changes to status, likelihood or impact of the risk.

Issue Management & Resolution

Starting in January 2012 our implementation team will meet on a weekly basis and will include representation from each functional department. The meeting format will include a dialogue to identify current issues and potential barriers that might impede our ability to implement any of the implementation tasks on time. Solutions for these issues will be identified within the project team meeting, when possible. For more complex issues, separate problem solving meetings with impacted functional areas will be quickly assembled to develop an action plan.

All issues, their accompanying resolution and decisions made related to the issue will be logged on the Issue Log or Decision Grid as appropriate. Our implementation plan will be updated on a weekly basis to reflect status and to incorporate any newly identified tasks that stem from the issue resolution process. For easy accessibility to data, the Risk Register, Issue Log and Decision Grid will be maintained as separate tabs on an integrated Excel spreadsheet accessible to all implementation team members on an intranet website. This transparency will facilitate communication across functional departments to ensure that all team members are kept abreast of the most current information.

Risk Management

Critical items on the Risk Register will also be monitored for current status and trigger point occurrence. Additional risks identified at any point during the implementation will be added to the Risk Register and scored. On a monthly basis the implementation team will re-assess the risk register to identify additional risks, reassess the likelihood and impact of each risk and identify changes mitigation or contingency strategies. Focus will center on risks new risks with an unacceptable risk score as well as previously identified risks with increased risk scores. Immediate actions will be taken to review mitigation strategies to identify additional opportunities to reduce, eliminate or avoid the likelihood or impact of the risk. Contingency plans will be developed for items where the risk can not be fully mitigated. All risks will continue to be monitored during implementation meetings.

Overall project status will be communicated with HealthCare USA's CEO and senior Coventry Health Care Medicaid leadership on a bi-weekly basis. These status reports will include summary of overall implementation progress, key risks and status of associated mitigation



activities or contingency planning. These routine updates will ensure that any additional resources needed for a successful implementation are quickly brought to bear on the project.

Project Closure

As demonstrated in our implementation plan, HealthCare USA anticipates that the majority of the tasks on our implementation plan will be closed before the contract effective date. Tasks with a due date after the contract effective date will remain an agenda item on HealthCare USA's weekly senior leadership meetings until all items have been delivered and/or successfully integrated into our core operating procedures. We anticipate holding a lessons learned session within 60 days of the contract effective date to identify opportunities to continuously improve our implementation processes.

4.4.17f. A list and description of tasks critical to a successful implementation which have been completed as of the submission of this proposal;

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(f).

As an existing MCO in all three regions, there are a limited number of tasks that must be undertaken for successful implementation of this contract. Tasks already completed include:

- Contracted and credentialed primary care, specialty care, behavioral health, dental, hospital, FQHC, RHC, local public health, family planning, durable medical equipment, transportation and other ancillary care with adequate capacity and accessibility to support HealthCare USA's existing membership and additional membership anticipated by limiting the contract award to three MCOs in each region.
- Established policies and procedures for all aspects of the business including but not limited to case and disease management, utilization management, quality improvement, transition of care and care coordination, human resources, compliance, member and provider grievances, complaints and appeals, fraud waste and abuse, enrollment processes including PCP assignment, member outreach processes, claims processing, provider credentialing, network access and availability monitoring and subcontractor oversight.
- All policies and procedures requiring state approval have been submitted and approved under our current contract. Only minor changes are required to meet new contractual requirements reflected in this procurement.
- Knowledgeable, trained staff familiar with requirements outlined in the MO HealthNet contract, Managed Care Policy Statements, that understand the member's traditional patterns of care and provider referral patterns, are able to connect members with community partners to eliminate real and perceived barriers to care and to connect members with services that are not covered under the MO HealthNet program.
- Information systems that successfully interface with the State's eligibility, encounter, Cyber Access and provider systems for HealthCare USA, our subcontractors; DentaQuest, Medical Transportation Management, and March Vision, and our affiliate MHNNet. We are able to



successfully exchange files in the state required formats for COB, health risk assessments, provider demographics and financial reporting.

- Ability to generate timely and accurate reports that meet all state reporting requirements in the required state format.
- Positive, trusted, effective relationships with community partners in all regions (Western 200, Central 325 and Eastern 250) where we work congruently to improve access by removing real and perceived member barriers to care.
- Established call center scripts, processes and with documented library with answers to common member and provider questions to aid new call center representatives.
- Established Member Grievance Processes that meet state requirements for HealthCare USA members to file and resolve grievances and appeals.
- Subcontractors that have experience servicing the MO HealthNet population.
- NCQA Health Plan Commendable Accreditation effective through August 2014.
- Effective, efficient and timely claims processing processes ranked in an American Medical Association study as “the most accurate claims processing.” Through October 2011 88.7% of the claims HealthCare USA processed were received via EDI with an 84% auto adjudication rate. 95.2% of these claims were processed in 15 days and 99.4% in 30 days.
- Fully functional IVR system to verify member eligibility and check claims status.
- Fully functional member and provider web sites and secure provider portal.

As a result of our experience and knowledge regarding the MO HealthNet Managed Care program, we have also been able to complete a number of the new requirements as evidenced by the percent complete column for implementation activities listed in Attachment 20 – Implementation Plan.

4.4.17g. A list and description of tasks critical to a successful implementation which the offeror expects to complete prior to the contract award n date and the proposed dates of completion;

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(g).

For purposes of our response to this RFP, we have assumed a contract award date of February 1, 2012. As noted in Attachment 20-Implementation Plan, we expect to complete all tasks with a Finish Date earlier than February 1 prior to contract award.

4.4.17h. A list and description of tasks critical to a successful implementation which you expect to complete prior to the contract effective date (July 1, 2012) and the proposed dates of completion; and

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(h).



As noted in Attachment 20-Implementation Plan, we expect to complete all tasks before the contract date of July 1, 2012.

4.4.17i. A list and description of significant tasks which will be completed after the contract effective date (July 1, 2012), along with the proposed date of completion and an explanation as to why these tasks will not be completed by the contract effective date.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.17(i).

All contractual requirements of the proposal with required dates on or before July 1, 2012 will be implemented prior to the contract effective date. Contractual requirements with effective dates after July 1, 2012 will be implemented by the due date outlined in the contract, such as ICD-10 conversion. Additionally, HealthCare USA’s proposed solutions and performance guarantees for the first, second or third year of the contract will be implemented after the July 1, 2012 contract effective date. Figure 4.4- 13– Summary of Tasks Completed After Contract Effective Date provides additional detail on these items. Attachment 22 – HealthCare USA Year 1-2-3 Deliverables Plan, in Volume 2 of our response, outlines our plan to monitor activities during the life of the contract to ensure compliance with these elements.

Figure 4.4- 13: Summary of Tasks Completed After Contract Effective Date

Task	Due Date	Rationale for Due Date
Ensure claims submitted after January 1, 2013 contain NPI of referring or ordering provider	January 1, 2013	This contract requirement is not due until January 2013. HealthCare USA will prepare for the changes and notify providers in Quarter 3 2012, modify claims processing systems and monitor provider readiness during Quarter 4 2102.
Automated Home Health Assignment process	June 1, 2013	This item is not a requirement of the contract. This task is not critical to successful implementation but will improve our internal operational efficiency by replacing the manual processes proposed to be put in place prior to the July 1, 2012 effective date.
ICD-10 Conversion	October 1, 2013	HealthCare USA started preparing for ICD-10 conversion in January 2010. We have completed 3 of the 7 phases of this project and are on track for completing the conversion by the federal deadline on October 1, 2013.
Achieve NCQA Cultural Competency	April 30, 2014	This item is not a requirement of the contract, but a performance guarantee HealthCare USA is making to MO



Task	Due Date	Rationale for Due Date
Certification		HealthNet to obtain this certification within the 2 nd year of the contract (July 1, 2013 – June 30, 2014).

4.4.18 References

The offeror shall submit references that can attest to the offeror’s, subcontractor’s, and benefit management organization’s qualifications for fulfilling the requirements described herein. At least one (1) reference shall relate to a state Medicaid contract or other large similar government or large private industry contract. The reference list shall include, for each reference, the name of a contact person, the person’s title and organization affiliation, contact information (telephone number and e-mail address), and the relationship with the offeror. Each reference shall be from contracts within the past five (5) years.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.4.18

HealthCare USA References

Name of Contact Person	Title	Organization Affiliation	Contact Information Telephone #	Contact Information E-mail Address	Relationship with the Offeror
Judith A Muck	Acting Executive Director	Missouri Consolidated Health Care Plan	(573) 526-4014	judith.muck@mchcp.org	Previous overseer of MO HealthNet Contract to Health Plan
Vivianne Chaumont	Director	Nebraska Division of Medicaid & Long-Term Care	(402) 471-2135	vivianne.chaumont@nebraska.gov	Primary contact with health plan
Mary Mitchell	Manager, Managed Care Programs	Virginia Department of Medical Assistance Services	(804) 786-3594	mary.mitchell@dmas.virginia.gov	Primary contact with health plan
Kathleen Stiffler	Contract Project Manager	Michigan Managed Care Plan Division, Department of Community Health	(517) 241-7933	stifflerk@michigan.gov	Primary contact with health plan



DentaQuest References

Name of Contact Person	Title	Organization Affiliation	Contact Information Telephone #	Contact Information E-mail Address	Relationship with the Offeror
Dr. Robert Birdwell	Dental Director	AZ Health Care Cost Containment System	602-417-5198	robert.birdwell@azahccs.gov	Primary contact with health plan
Susan Kwon	AVP, Ancillary Services	Healthfirst	212-801-1505		Primary contact with health plan
James Christian	VP, Network Development and DC Healthcare Alliance	Chartered Health Plan	202-216-2304		Primary contact with health plan

MTM References

Name of Contact Person	Title	Organization Affiliation	Contact Information Telephone #	Contact Information E-mail Address	Relationship with the Offeror
Colleen Sonosky	Contract Analyst	District of Columbia Department of Health Care Finance	202-442-5913	Colleen.sonosky@dc.gov	Primary Contact
Rebecca Cobb	Director, Member Services	MDwise	317-822-7201	rcobb@mdwise.org	Primary Contact
Kevin Holt	Section Chief, Workforce Development	Hamilton County Ohio Department of Job and Family Services	513-946-1840	holtk@jfs.hamilton-co.org	Primary Contact

McKesson References

Name of Contact Person	Title	Organization Affiliation	Contact Information Telephone #	Contact Information E-mail Address	Relationship with the Offeror
Donna Peters, RN	Program Leader, Clinical Services Management	BCBS Massachusetts	617-246-8240	Donna.peters@bcbsma.com	Vendor contact
Lisa Randolph	Contract Manager, Vendor Contracting	CareFirst BlueCross and BlueShield	410-872-3517	Lisa.Randolph@carefirst.com	Vendor contact
Dr. Jennifer Nuovo	Chief Medical Director	Health Net California	916-935-1989	Jennifer.A.Nuovo@healthnet.com	Vendor Contact



March Vision References

Name of Contact Person	Title	Organization Affiliation	Contact Information Telephone #	Contact Information E-mail Address	Relationship with the Offeror
Cassie Hawkins	Director of Network Development, National Network Operations	Aetna Better Health	813-758-5166	hawkinsc@aetna.com	Client contact
Tory Vazquez	Manager National Contracting	Molina Healthcare, Inc.	562-435-3666 x 111062	Tory.vazquez@molinahealthcare.com	Client contact
Zina Clover	Chief Operating Officer	Alameda Alliance for Health	510-747-6243	zglover@alamedaalliance.org	Client contact

CareCore References

Name of Contact Person	Title	Organization Affiliation	Contact Information Telephone #	Contact Information E-mail Address	Relationship with the Offeror
Lori West	National Radiology Director	AmeriChoice (United Healthcare Community and State)	561-451-0872	Lori_L_West@uhc.com	CareCore Customer Contact
Lance Small	Director, Contracting	Affinity Health Plans	718-794-3134	LSmall@affinityplan.org	CareCore Customer Contact
Joan Cieslak	Imaging Management Program Administrator	HealthPlus of Michigan	810-733-1938	jcieslak@healthplus.org	CareCore Customer Contact

MHNet References

Name of Contact Person	Title	Organization Affiliation	Contact Information Telephone #	Contact Information E-mail Address	Relationship with the Offeror
Mark Weinstein	President & CEO	Independent Colleges and Universities Benefits Association, Inc. (ICUBA)	407.354.4646	4850 Millenia Boulevard, Suite 329 Orlando, FL 32839 mweinstein@icuba.org	client
Marc Love	Director of Florida Managed Care	Positive Healthcare Partners & Positive Healthcare Florida (AHF MCO of Florida, Inc)	954.522.3132	110 SE 6th Street Suite 1960 Fort Lauderdale, FL 33301 Marc.love@positivehealthcare.org	client



Name of Contact Person	Title	Organization Affiliation	Contact Information Telephone #	Contact Information E-mail Address	Relationship with the Offeror
Thomas Cleare	Chief Managed Care Officer	Healthy Palm Beaches	561.804.5865	2601 10th Avenue North, Suite-100 Palm Springs, FL 33461-3133 tcleare@hcdpbc.org	client



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4.5 SUBJECTIVE EVALUATION



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4.5 Subjective Evaluation

The Subjective Evaluation consists of analysis of information submitted by the offeror in four (4) operational and administrative areas: (1) organizational experience; (2) method of performance; (3) quality; and (4) access to care.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.

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4.5.1 Organizational Experience

The offeror’s organizational experience and the offeror’s health care service subcontractors’ organizational experiences will be considered subjectively in the evaluation process. Therefore, the offeror shall submit information, in response to the requirements below, to document the offeror and the proposed health care service subcontractors’ experiences in past/current performances, especially those performances related to the requirements of this RFP. As applicable, an offeror’s response to requirements below shall include the offeror’s parent organization, affiliates, and subsidiaries. The offeror shall address any current/previous managed care experiences operating in the State of Missouri.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.1.

The HealthCare USA Team averages 13.5 years of experience each in public health programs across the nation – and 6.34 years of experience with MO HealthNet in particular. Our breadth and depth of experience offer MO HealthNet low-risk contracting via 1) corporate commitments to improving government health programs; 2) best practices brought from our other Medicaid contracts to Missouri; and 3) proven solutions to MO HealthNet for nearly any issue that arises throughout the contract.

This entire answer is applicable to all three regions.

HealthCare USA has been serving Missouri’s Medicaid population for 16 years. With an accomplished team of partners experienced in government health, as Figure 4.5- 1 highlights, HealthCare USA is assured success in achieving MO HealthNet’s goals.

Figure 4.5- 1: HealthCare USA Team Experience

Team Member	Government Health Experience	MO-Specific Experience
HealthCare USA and MHN Net affiliate Program Management; BH care	16 yrs 9 Medicaid state contracts Medicare Advantage Plans Public health 25% business	16 yrs, all 3 regions for MO HealthNet URAC awards for program practices, Doc Bear Other MO contracts, U of Missouri 1,200 employees live, work here
DentaQuest <i>Dental care</i>	12 yrs 12M Medicaid and CHIP members Has offered \$25M in grants to promote oral health	12 years Covers 362k members statewide
March Vision <i>Specialty care/ ophthalmologist</i>	10 yrs 3M members across 16 states and DC	4 years Covers 329k members statewide
CareCore <i>Specialty</i>	14 states, 4M lives URAC and NCQA accredited	5 years Covers @1M members statewide,



Team Member	Government Health Experience	MO-Specific Experience
<i>care/diagnostic imaging, other</i>		mostly Medicaid
MTM <i>Non-emergency transportation services</i>	16 years 3M members across 24 states and DC Over 40 contracts	16 years Covers 409k members statewide
McKesson <i>Nurse Line</i>	14 years 9 Medicaid contracts Business in all 50 states ROI of 3.4:1	15 years

Low-Risk Contracting - Our team’s Missouri-specific and expansive experience in government health programs nationwide offers MO HealthNet low-risk contracting and a commitment to success. In addition to our successful performance with MO HealthNet in meeting its needs, MO HealthNet can be assured that we have proven solutions to nearly any issue that will arise during this contract based on Coventry’s experience across our other Medicaid contracts.

While each state has unique demographics, politics, and challenges, our team also knows that all states face many of the same challenges (e.g., doing more with less, addressing the dynamic nature of the programs, varying needs from federal and state requirements, and more). And among the breadth and depth of experience we offer in publicly funded managed care programs, we have solutions for those challenges.

Corporate Commitments to Success - Our team is backed by the corporate commitment to success with MO HealthNet and Medicaid programs, investing millions of dollars in solutions to continue to help public clients meet their challenges. These are reflected in our MO HealthNet bid in the over \$300 million dollars spent on systems to support HealthCare USA, and in the very foundation of some of our subcontractors, such as March Vision, which was founded by two ophthalmologists who wanted to reduce disparities in healthcare based on socioeconomic issues. DentaQuest offered grants to promote oral health to Haven of Grace and Missouri Mission of Mercy in 2011.

Best Practices - Finally, our team’s experience also offers MO HealthNet best practices that have been leveraged across our Medicaid contracts. These are just a few of the best practices we have or will implement for MO HealthNet leveraged from our other Medicaid work:

- NICU face to face visits at hospital for enrollment in the NICU Condition Management Program from our corporate Medicaid Chief Medical Officer
- High-risk OB Home visitation program from our corporate Medicaid Chief Medical Officer
- Readmission avoidance program from our corporate health services team
- HEDIS flag for Customer Service from our sister plan in Michigan
- HEDIS reminder postcards from our sister plan in Michigan



- MHNNet's face-to-face discharge planning
- Dental ED Diversion program designed through collaboration with our subcontractor DentaQuest

We are well-prepared to meet MO HealthNet's needs today and tomorrow. Below, we summarize the team's individual organizational relevant experience, followed by answers to the subparts of this Question.

Overview of Our Company: HealthCare USA

This offeror, HealthCare USA, is a wholly-owned subsidiary of Coventry Health Care, Inc. (Coventry). We are backed by all the resources and experience of our parent company in Missouri in all three regions. For MO HealthNet, our claims, information systems, disease management, and behavioral health services are all from corporate resources and affiliates (e.g., MHNNet, Coventry's behavioral health subsidiary, supports MO HealthNet's behavioral services needs and will continue to do so).

Coventry is a national managed health care company operating health plans, insurance companies, network rental companies and workers' compensation companies in all 50 states. Coventry's full range of services supports nearly 5 million members including Medicaid, Medicare Advantage, and private insurance. More than 25% of Coventry members are enrolled in government-sponsored programs, including Medicaid, Medicare, and the Federal Employees Health Benefit Plan.

Current/Previous Managed Care Experience Operating in Missouri

MO HealthNet well knows HealthCare USA's success in Medicaid. Since 1995, HealthCare USA has improved Missouri's Medicaid access, quality of services and reduced costs. We have expanded services to include all three regions, and have:

- Improved HEDIS scores across the board, including a 5% improvement from 2010 to 2011
- Added 10 benefits beyond MO HealthNet's required coverage over the years
- Expanded disease management programs, including High Risk OB and Asthma, to name a few

Our *Executive Summary* and the information throughout *Sections 2 and 4* highlight the many other ways we have improved services to Missouri's Medicaid members in our 16 years. Other Coventry experience includes our University of Missouri contract, which covers 43,000 members; and the fact that more than 1,200 Coventry employees live and work here.

Other Documented Experience in Medicaid

Since the start of our Missouri program, Coventry has expanded its government health program support and today, with subsidiaries administering Medicaid programs covering nearly 690,000 TANF, ABD, Foster Children and CHIP beneficiaries in eight customized Medicaid managed care programs in the following regions and states *in addition to Missouri*:

- **Midwest:** Kentucky, Michigan, Nebraska
- **Southeast:** Florida, Virginia, West Virginia



- **Northeast:** Maryland, Pennsylvania

In early 2012 , we anticipate adding Kansas into the Coventry Medicaid family.

Recent honors HealthCare USA has earned include NCQA *Commendable* Accreditation in 2011 and URAC 2010 Best Practices Awards in Health Care Consumer Empowerment and Protection for three programs offered for MO Health Net:

- Baby Bears Club NICU Disease Management Program
- Beary Important Bundle High-Risk OB Program
- Beary Important Breath Asthma Program

Dental Health Subcontractor: DentaQuest

DentaQuest is HealthCare USA’s dental subcontractor across all three regions and the largest dental contractor for MO HealthNet health plans. DentaQuest administers dental benefits to more than 12 million Medicaid and CHIP members nationwide, and another 3 million overall to corporate partners. Over the last 12 years, the DentaQuest Foundation has invested more than \$25 million to promote oral health; in 2010, the Foundation awarded \$4.1 million in oral health grants, and will award another \$7 million in 2011 including Haven of Grace and Mission of Mercy in Missouri.

Current/Previous Managed Care Experience Operating in Missouri

DentaQuest has been HealthCare USA’s subcontractor supporting MO HealthNet for 7 years. DentaQuest serves all three regions with 710 provider access points. They also bring access to the members by providing in-school, in-PCP, and other services—for example, in 2010 alone, DentaQuest provided over 108,000 services to children at their school.

Non-Emergent Transportation Subcontractor: Medical Transportation Management, Inc. (MTM)

MTM provides non-emergency transportation (NEMT) for the medically fragile, disabled, underserved, elderly, and other transportation disadvantaged populations served by state and county government programs and health plans. Since their inception 16 years ago, MTM has grown to become one of the largest transportation managers in the country, with more than 40 contracts spanning 28 states and the District of Columbia, encompassing more than 3 million members, nearly all of them Medicaid.

Current/Previous Managed Care Experience Operating in Missouri

MTM has been HealthCare USA’s NEMT subcontractor supporting MO HealthNet since the beginning of managed care in Missouri, and in 2010 alone, MTM’s transportation vendors have provided 100,000 trips to HealthCare USA members. MTM is a Missouri-certified Women-owned Business Enterprise.



Specialty Care/Vision Benefit Subcontractor: March Vision Care Group, Inc.

March Vision Care Group, Incorporated (“MARCH”) was founded in 2001 by two ophthalmologists with a passion for closing the health disparities gap for socioeconomically disadvantaged populations. Through proprietary technology tools and our member-focused approaches, they have assisted their health plan clients in:

- Achieving lower overall medical cost ratios
- Facilitating better provider communications
- Accomplishing goals of healthier member outcomes

MARCH administers vision benefits for over 3 million members in 16 states and the District of Columbia. Benefit administration includes both routine vision and vision services within the scope of licensure for an optometrist, based upon contractual agreements.

Current/Previous Managed Care Experience Operating in Missouri

March has been HealthCare USA’s vision subcontractor supporting MO HealthNet since January 1, 2011. March serves all three regions with 1384 provider contracts. March offers eyeSynergy, a web-based stand-alone software tool that collects and centralizes patient care data, enabling physicians to coordinate patient care, reduce duplication, and ensure better outcomes. March is a Missouri-certified Minority Business Enterprise.

Care Management Subcontractor: McKesson

McKesson is the leading provider of 24 hour a day, 7 day a week nurse triage services, covering the most lives in the industry at more than 29 million. McKesson’s programs, accredited by NCQA, JCAHO and URAC, empower members with solid information and advice to make good healthcare decisions, including in-depth counseling and decision support for complex health problems

Current/Previous Managed Care Experience Operating in Missouri

McKesson has been HealthCare USA’s nurse advice line subcontractor supporting MO HealthNet since July 2007. McKesson serves all three regions. McKesson's Nurse Advice Services provide members with the best healthcare information possible, helping them choose the appropriate time and place for care.

Specialty Benefits Management Subcontractor: CareCore

CareCore National, a specialty benefit management company, supports nearly 4M Medicaid lives in 14 states (and nearly 22 million total lives nationwide) through evidence-based medical management solutions for high-cost healthcare segments. These include:

- Radiology
- Medical Oncology
- Cardiology ; cardiac implant devices





- Radiation Therapy
- Specialty Lab services—genetic, molecular, musculoskeletal

CareCore’s services improve quality and reduce inappropriate utilization for outpatient advanced diagnostic imaging, with a keen focus on advanced imaging technologies including: MRI, MRA, CT, PET, Nuclear Medicine and Nuclear Cardiology. CareCore National is a URAC-accredited and NCQA-certified licensed utilization review agent.

Current/Previous Managed Care Experience Operating in Missouri

CareCore manages the prior authorization of advanced diagnostic imaging for nearly 1 million lives in Missouri, about 208,000 Medicaid lives, and an estimated 550,000 non-Medicaid lives. CareCore has been a subcontractor for HealthCare USA since April 15, 2010.

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- 4.5.1a. In a table format, the offeror shall identify all of the offeror’s publicly-funded managed care contracts for Medicaid, CHIP and/or other low-income individuals within the past five (5) years.
- b. In a table format, the offeror shall identify the offeror’s five (5) largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid, CHIP, and/or other low-income individuals within the past five (5) years.
- c. If the offeror has not had any publicly-funded managed care contracts for Medicaid, CHIP, and/or other low-income individuals within the past five (5) years, the offeror shall identify the offeror’s ten (10) largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid, CHIP, and/or other low-income individuals within the past five (5) years.
- d. For each prior experience identified above, the offeror shall provide a brief description of the scope of work (including whether the offeror was responsible for the provision of physical health and/or behavioral health services), the duration of the contract, contract name and telephone number, the number of enrollees and the population types, the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any.
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HealthCare USA understands and shall comply with the requirements of Sections 4.5.1 (a–d).

For responses to 4.5.1 (a–d), see Figure 4.5- 2 (please note that not all columns of this table are complete; and that we’ve included all information our subcontractors provided).

Coventry Health, HealthCare USA’s parent company, has supported 14 publicly-funded managed care contracts for Medicaid, CHIP, and/or other low-income individuals for 10 states nationwide in the past five years. Coventry’s extensive experience with 10 state programs ensures we understand government managed care challenges, and have met them

Our subcontractors are also highly qualified, covering in some cases all 50 states.

Coventry has managed some programs for more than 10 years. Our clients hire us time and time again to help them meet the challenges they face today and in the future. MO HealthNet has experienced such successes with us firsthand, and their experience reflects the Coventry operates as a corporation.

- Nearly all Coventry’s repeat contracts are capitated, demonstrating success in delivering results in the same cost structure



- Coventry routinely manages subcontractors to effectively deliver specialized services and work with us as a whole to meet members' needs.

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Figure 4.5- 2: Table-Formatted Responses to 4.5.1 (a) through (d)

4.5.1(a) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
HealthCare USA	Missouri MO HealthNet managed care program contract - Full Medicaid/CHIP benefits, excluding pharmacy, for all three managed care regions	1995–present	Julie G. Creach (573) 751-6922	190,000	TANF, Pregnant Women, CHIP, Foster Care Children	TANF, Pregnant Women, CHIP, Foster Care Children	Dental, transportation, vision and behavioral
CareNet (Southern Health Services)	Virginia Medallion II/FAMIS managed care program contract - Full Medicaid/CHIP benefits, excluding dental	Entered program in 1996 Current Contract Duration: July 1, 2011 through June 30, 2012	Mary Mitchell Mgr, Managed Care Programs 804-786-3594	24,400	TANF, Pregnant Women, ABD, CHIP	Capitated	Behavioral health, pharmacy, vision, and transportation
Coventry Nebraska (Coventry Health Care of Nebraska)	Nebraska Medicaid/CHIP managed care program contract - Full Medicaid/CHIP benefits (excluding behavioral health, dental, and pharmacy) for all ten managed care counties	April 2, 2010 through June 30, 2013	Vivianne Chaumont (402) 471-2135	49,600	TANF, Pregnant Women, ABD, CHIP, Foster Care Children	Capitated	Transportation, vision
CoventryCares (HealthAmerica Pennsylvania)	Pennsylvania HealthChoices physical health managed care program contract - Full Medicaid benefit for Southeast Zone (Philadelphia area), excluding behavioral health	January 1, 2010 through December 31, 2014 (HealthAmerica began servicing members 4/1/10, current contract period is 7/1/11 through 6/30/12)	Joanie Morgan (717) 772-6303	15,900	TANF, Pregnant Women, ABD including Medicare, Foster Care Children	Capitated	Dental, pharmacy, vision
CoventryCares of Kentucky	Kentucky Cabinet for Health and Family Services, Department for Medicaid Services Medicaid Managed Care program contract - Full Medicaid benefit,	Enrollees became effective with the health plan on 11/1/11 and the initial term of the Contract is 3 years. Thereafter,	Carrie Banahan (502) 564-9592 Neville Wise (502) 564-4321	221,000	TANF, Pregnant Women, ABD, KCHIP, Dual Eligibles and Foster Care Children	Capitated	Behavioral Health, dental, pharmacy, vision, and chiropractic



4.5.1(a) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
	excluding Region 3	the contract may be renewed for up to four (4) additional one (1) year periods upon the mutual agreement of the Parties.					
The Diamond Plan (Coventry Health Care of Delaware)	Maryland HealthChoice managed care program contract - Full Medicaid/CHIP benefits excluding dental for children under age 21 and pregnant women, specialty mental health, and transportation	Entered program in 2003 Current Contract Duration: July 1, 2011 through June 30, 2012	Nadine Smith (410) 767-1483	14,000	TANF, Pregnant Women, ABD, CHIP, Foster Care Children	Capitated	Pharmacy, substance abuse, vision, adult dental
OmniCare Health Plan	Michigan Medicaid managed care program contract - Full Medicaid benefit, excluding dental, substance abuse & inpatient mental health, for Oakland and Wayne counties	Entered program in 1979 First Coventry contract in 2004 Current Contract Duration: October 1, 2009 through September 30, 2012	Charlene Hyde 517-335-5282	46,650	TANF, Pregnant Women, ABD	Capitated	Pharmacy, transportation, vision and non-chronic outpatient mental health
OmniCare Health Plan	Michigan MICHild managed care program contract - Full CHIP benefit excluding behavioral health and dental	Entered program in 2010 Current Contract October 1, 2011 through September 30, 2012	Julie Blazic (517) 335-5286	450	CHIP	Capitated	Pharmacy, vision
VISTA (Coventry Health Care of Florida and Coventry Health Plan of Florida)	Florida Medicaid managed care program contract - Full Medicaid benefit excluding transportation	Entered program in 1985 Coventry acquired in 2007 Current Contract Duration: September 1, 2009 through August 30,	Jim Singleton (850) 412-4307 Katie Oskowis (850) 412-4066	41,900	TANF, Pregnant Women, ABD, Foster Care Children	Capitated	Behavioral health, dental, pharmacy



4.5.1(a) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
		2012					
VISTA (Coventry Health Care of Florida and Coventry Health Plan of Florida)	Florida Healthy Kids managed care program contract - Full CHIP benefit	Entered program in 1993 Coventry acquired in 2007 Current Contract Duration: October 1, 2008 through September 30, 2009 with three 1-year renewals through September 30, 2012	Jennifer Lloyd (850) 701-6108	23,800	CHIP	Capitated	Behavioral health, pharmacy
VISTA (Coventry Health Care of Florida)	Florida Nursing Home/LTC Diversion program contract	Entered program in 1999 Coventry acquired in 2007 Current Contract Duration: September 1, 2011 through August 31, 2012	Cliff McMillan (850) 414-2000	1,000	LTC	Capitated	Long Term Care Services, Acute Care Services/Dental/Vision/Hearing
Coventry Health Care of Iowa	Iowa Medicaid managed care program contract - Full Medicaid benefit for three counties in Waterloo area	Entered program in 1998 Last Contract Duration: July 1, 2006 through January 31, 2009	Contact was Dennis Janssen; Iowa Medicaid Enterprise Main Number: (515) 256-4600	4,600	TANF, Pregnant Women	Capitated	N/A
HealthAssurance Pennsylvania	Pennsylvania HealthChoices behavioral health managed care program contract - Full BH benefit for five counties in Harrisburg area	Entered program in 2001 Last Contract Duration: October 1, 2006 through June 30, 2008	Helen Shuman (717) 772-7226	107,000	TANF, ABD	Capitated	BH: CBHNP
WellPath of North Carolina	North Carolina pilot Medicaid managed care program contract - Full Medicaid benefit for Mecklenburg County	Entered program in 1999 Last Contract Duration: August 13, 2003 through	Contact was Jeffrey Simms; NC DHHS Division of Medical Assistance (DMA) Main Number: (919)	6,600	TANF, Pregnant Women, Blind & Disabled, Foster Care Children	Capitated	N/A



4.5.1(a) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
		July 31, 2006	855-4100				
CHCcares of South Carolina (WellPath of South Carolina)	South Carolina Medicaid managed care program contract for 16 counties primarily in Midlands region - Full Medicaid benefit excluding: behavioral health services beyond initial assessment adult vision dental services non-urgent transportation	April 1, 2007 through August 31, 2009	Beverly Hamilton (803) 898-4614	4,200	TANF, Pregnant Women, ABD	Capitated	Pharmacy, vision

4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
MailHandlers Benefit Plan	Claims, UM, Network	10 Yrs Effective 1/1/08	Al DiLeo (630) 737-7726	284,482	MailHandler Employees	Fee for Service	N/A
Rural Letters Carriers Benefit Plan	Claims, UM, Network, Customer Svs Provider Svs	50+ Yrs	Pam Flinigan (704)834-6807	55,305	RLC Employees	Fee for Service	N/A



4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
University of Missouri	Claims, UM, Case & Disease Management, Network	Since 1998	Kelly Stuck (573)884-3222	43,741	University & Medical Ctr Employees	ASO	Behavioral Health
Foreign Service Benefit Plan	Claims, UM Disease Management Network Customer Svs	50+ years	Pam Flinigan (704)834-6807	41,633	International	Fee for Service	N/A
Duke University	Medical ASO, Pre-cert, Enrollment Network	Since 1996	Jane Walbrun (919)681-4668	39,536	University & Medical Ctr Employees	Fee for Service & Capitated	N/A

4.5.1(c)
 HealthCare USA has not had any publicly-funded managed care contracts for Medicaid, CHIP, and/or other low-income individuals within the past five years.



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
DentaQuest							
Maricopa Managed Care Systems (MMCS) - Medicare - Arizona	Dental benefits	2004 - present	Betsey Bayless, 602-344-8700	3,205	Medicare		
Maricopa Managed Care Systems (MMCS) - Arizona	Dental benefits	2004 - present	Betsey Bayless, 602-344-8700	55,149	Medicaid/CHIP		
BC Life and Health Insurance Company - CA	Dental benefits	2005 - present	Murphy Duckett, 805-384-3929	56,118	Medicaid/CHIP		
Unison Health Plan of the Capital Area - District of Columbia	Dental benefits	2008 - present	Lynn Bobby, 412-856-5240	58,200	Medicaid/CHIP		
Chartered Health Plan - District of Columbia	Dental benefits and Vision benefits	2010 - present	Bob Watkins, 202-408-3972	110,397	Medicaid/CHIP		
Better Health, LLC - FL	Dental benefits and Vision benefits	2006 - present	Sergio Covas, 305-408-5725	32,654	Medicaid/CHIP		
CarePlus Health Plan - FL (Medicaid)	Dental benefits	2003 - present	Ana Bazo, 305-441-9400 x 1021575	17,086	Medicaid/CHIP		
CarePlus Health Plan - FL (Medicare)	Dental benefits	2003 - present	Ana Bazo, 305-441-9400 x 1021575	37,738	Medicare		
State of Florida Agency for Health Care Administration	Dental benefits	2006 - present	Jan Crespo, 786-466-8238	178,711	Medicaid/CHIP		
Florida Healthy Kids	Dental benefits	2009 - present	Paula Kiger, 850-224-5437 x 6102	120,273	Medicaid/CHIP		
Humana - Florida - FL	Dental benefits	2006 - present	Stephanie Steele, 305-626-5693	4,553	Medicaid/CHIP		
Independent Living Systems - FL	Dental benefits	2009 - present	Myrna Betancourt, 305-262-1292	1,334	Medicaid/CHIP		
Jackson Health System Division - FL	Dental benefits	2010 - present	Cynthia Gregoire, 305-575-3681	2,339	Medicare		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
Jackson Health System Division - FL	Dental benefits	2010 - present	Cynthia Gregoire, 305-575-3681	15,209	Medicaid/CHIP		
Medica Health Plans of Florida, Inc.	Dental benefits	2009 - present	Maria Eugenia Duran, 305-460-0624	5,710	Medicaid/CHIP		
Medica Health Plans of Florida, Inc.	Dental benefits	2009 - present	Maria Eugenia Duran, 305-460-0624	35,371	Medicare		
Molina Healthcare of Florida, Inc.	Dental benefits	2008 - present	Stephen Bennett, 407-637-1579	61,150	Medicaid/CHIP		
Personal Health Plan (Healthy Palm Beaches, Inc.) FL	Dental benefits	2008 - present	Jan Crespo, 786-466-8238	12,707	Medicaid/CHIP		
Simply Healthcare Plans Florida	Dental benefits	2010 - present	Sergio Covas, 305-408-5725	5,821	Medicaid/CHIP		
Wellcare Health Plans - FL	Dental benefits	2005 - present	Patricia Laurenzi, 800-860-2530 x 6189	20,797	Medicare		
Advantage by Peach State Health Plan - GA	Dental benefits	2009 - present	Debra Peterson-Smith, 678-556-4842	600	Medicare		
GA WellCare Medicare Advantage	Dental benefits	2005 - present	Dana French, 678-327-0939 x 3028	10,839	Medicare		
GA Peach State	Dental benefits	2009 - present	Debra Peterson-Smith, 678-556-4842	297,616	Medicaid/CHIP		
GA - Wellcare	Dental benefits	2005 - present	Dana French, 678-327-0939 x 3028	558,292	Medicaid/CHIP		
BCI SNP ID- Medicare (True Blue) Idaho	Dental benefits	2007 - present	Gwen Ohlson, 208-286-3717	642	Medicare		
BCI of Idaho	Dental benefits	2007 - present	Gwen Ohlson, 208-286-3717	223,136	Medicaid/CHIP		



4.5.1(a), 4.5.1(b) and 4.5.1(d)

Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
Wellcare Health Plans-IL	Dental benefits	2011 - present	Gina Swehla, 217-524-7185	9,978	Medicare		
IL Aetna Integrated Care	Dental benefits	2010 - present	Gina Swehla, 217-524-7185	12,965	Medicaid/CHIP		
Centene Illinicare	Dental benefits	2010 - present	Gina Swehla, 217-524-7185	13,367	Medicaid/CHIP		
Harmony Health Plan of IL, Inc. Medicaid	Dental benefits	2011 - present	Gina Swehla, 217-524-7185	28,796	Medicaid/CHIP		
Illinois Medical Assistance Program	Dental benefits	1999 - present	Gina Swehla, 217-524-7185	2,687,022	Medicaid/CHIP		
CeltiCare Health Plan of Massachusetts	Dental benefits	2009 - present	Susan Harris, 314-725-4477	5,340	Medicaid/CHIP		
MA Senior Whole Health	Dental benefits	2006 - present	Michael Snyder, 860-214-3922	7,872	Medicare		
Neighborhood (MA)	Dental benefits	2006 - present	Michael Nickey, 617-772-5744	19,437	Medicaid/CHIP		
Network Health MA	Dental benefits	2006 - present	Michele Johnson, 781-393-3134	21,104	Medicaid/CHIP		
Boston Medical (MA)	Dental benefits	2006 - present	Koren Odierna, 617-748-6437	22,378	Medicaid/CHIP		
MassHealth	Dental benefits	2006 - present	Dr. Brent Martin, 617-847-3747	1,290,444	Medicaid/CHIP		
MD AMERIGROUP Community Care (Medicare)	Dental benefits	2004 - present	Vincent Anacona, 410-859-5850	1,423	Medicare		
Coventry Diamond Plan (MD)	Dental benefits	2006 - present	Iris Rudman, 410-910-7124	6,379	Medicaid/CHIP		
Bravo Health MidAtlantic - MD	Dental benefits	2006 - present	Scott Keim, 410-864-	12,119	Medicare		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
			4492				
Amerigroup - Maryland	Dental benefits	2004 - present	Vincent Anacona, 410-859-5850	47,818	Medicaid/CHIP		
UnitedHealthcare-MD	Dental benefits	2009 - present	Shelly Lehner, 410-767-1489	54,215	Medicaid/CHIP		
Maryland Physicians Care MCO	Dental benefits	1997 - present	Linda Dietsch, 410-907-4052	54,698	Medicaid/CHIP		
Priority Partners (MD)	Dental benefits	2001 - present	Gitu Mirchandani, 410-424-4685	66,483	Medicaid/CHIP		
Maryland Healthy Smiles Dental Program	Dental benefits	2009 - present	Vince McKee, 410-767-1691	566,434	Medicaid/CHIP		
MN South County Health Alliance	Dental benefits	2005 - present	Leota Lind, 507-444-7772	25,685	Medicaid/CHIP		
UCare of Minnesota (Medicare)	Dental benefits	2001 - present	Margie Lindberg, 612-676-3312	52,931	Medicare		
UCare of Minnesota (Medicaid)	Dental benefits	2001 - present	Margie Lindberg, 612-676-3312	134,117	Medicaid/CHIP		
Wellcare Health Plans-MO	Dental benefits	2011 - present	Carole Ouimet, 314-444-7514	1,486	Medicare		
Harmony Health Plan of MO, Inc. Medicaid	Dental benefits	2011 - present	Carole Ouimet, 314-444-7514	13,405	Medicaid/CHIP		
Blue Advantage-Plus	Dental benefits	1996 - present	Judy Brennan, 816-395-2421	29,487	Medicaid/CHIP		
Missouri Care Health Plan	Dental benefits	2008 - present	Tony Gutierrez, 573-441-2134	50,652	Medicaid/CHIP		
Molina Healthcare of Missouri	Dental benefits	2010 - present	Anna Mannion, 314-819-5313	78,369	Medicaid/CHIP		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
HealthCare USA	Dental benefits	1997 - present	Susan Lavin, 314-444-7902	188,673	Medicaid/CHIP		
Mississippi Centene Magnolia	Dental benefits	2011 - present	David Buchanan, 866-912-6285 x 66718	30,375	Medicaid/CHIP		
Windsor Health Plan, Inc-Dental NATIONAL	Dental and Vision benefits	2009 - present	Jenifer Mariencheck, 615-429-0608	40,865	Medicare		
Healthfirst (NJ) Medicare	Dental benefits	2008 - present	Susan Kwon, 212-801-1505	5,591	Medicare		
Healthfirst (NJ) Medicaid	Dental benefits	2008 - present	Susan Kwon, 212-801-1505	27,187	Medicaid/CHIP		
NM-AMERIGROUP Community Care (Medicare)	Dental benefits	2004 - present	Laura Hopkins, 505-875-4375	1,986	Medicare		
NM-AMERIGROUP Community Care of New Mexico	Dental benefits	2004 - present	Laura Hopkins, 505-875-4375	19,609	Medicaid/CHIP		
NM-BLUESALUD	Dental benefits	2008 - present	Karen Smoot, 505-816-2163	24,315	Medicaid/CHIP		
NM-Lovelace Community Health Plan	Dental benefits	2000 - present	Steve DeSaulniers, 505-232-1932	79,887	Medicaid/CHIP		
NM-Presbyterian Salud, New Mexico	Dental benefits	1997 - present	Mary Eden, 505-923-5970	155,984	Medicaid/CHIP		
NM-Molina Healthcare of New Mexico	Dental benefits	1997 - present	Luana Markel, 505-348-1527	261,192	Medicaid/CHIP		
VISION-NV AMERIGROUP Community Care	Vision benefits	2010 - present	Janice Bradley, 757-473-2737 x 32289	84,631	Medicare		
Empire BlueCross BlueShield NY	Dental benefits	1999 - present	Anthony Naccorato, 718-312-4439	56,265	Medicaid/CHIP		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
Fidelis 1199 NY	Dental benefits	2001 - present	Matthew Heusten, 518-445-3928	28,687	Medicaid/CHIP		
Fidelis Care New York	Dental benefits	2001 - present	Matthew Heusten, 518-445-3928	93	Medicare		
Fidelis Care New York	Dental benefits	2001 - present	Matthew Heusten, 518-445-3928	561,798	Medicaid/CHIP		
Managed Health Inc. NY	Dental benefits	2004 - present	Joseph Dicks, 212-908-8893	94,930	Medicare		
MetroPlus Health Plan, Inc. (Medicaid) NY	Dental benefits	2004 - present	Joseph Dicks, 212-908-8893	52,970	Medicaid/CHIP		
MetroPlus Health Plan, Inc. (Medicare) NY	Dental benefits	2004 - present	Joseph Dicks, 212-908-8893	5,327	Medicare		
NY - Healthfirst	Dental benefits	2004 - present	Susan Kwon, 212-801-1505	484,938	Medicaid/CHIP		
NY - Neighborhood Health Providers	Dental benefits	2009 - present	Dov Bash, 212-808-4775	206,088	Medicaid/CHIP		
NY Senior Whole Health	Dental benefits	2007 - present	Michael Snyder, 860-214-3922	807	Medicare		
Advantage by Buckeye Community Health Plan (HMO SNP) OH	Dental benefits	2004 - present	Jay Avner, 866-246-4356 x 24555	739	Medicare		
WellCare of Ohio (Medicare)	Dental benefits	2006 - present	Karen Desotell, 216-901-4154	3,013	Medicare		
Wellcare of Ohio, Inc (Medicaid)	Dental benefits	2006 - present	Karen Desotell, 216-901-4154	99,468	Medicaid/CHIP		
Unison Health Plan of Ohio, Inc.	Dental benefits	2007 - present	Lynn Bobby, 412-856-5240	118,622	Medicaid/CHIP		
Buckeye Health Plan - Ohio	Dental benefits	2004 - present	Jay Avner, 866-246-	156,385	Medicaid/CHIP		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
			4356 x 24555				
Molina Healthcare of Ohio	Dental benefits	2005 - present	Lisa Hatton, 614-781-4307	240,483	Medicaid/CHIP		
Aetna Better Health Kids PA	Dental benefits	2010 - present	Michael McGarrigle, 215-282-3504	27,068	Medicaid/CHIP		
Aetna Better Health PA	Dental benefits	2010 - present	Michael McGarrigle, 215-282-3504	49,163	Medicaid/CHIP		
Amerihealth Mercy Health Plan (PA)	Dental benefits	2000 - present	Donald Shields, 717-651-3567	102,863	Medicaid/CHIP		
Bravo Health PA	Dental benefits	2009 - present	Gail Guisewhite, 570-214-2734	52,025	Medicare		
Bravo Health Senior Partners PA	Dental benefits	2007 - present	Gail Guisewhite, 570-214-2734	742	Medicare		
CoventryCares PA	Dental benefits	2009 - present	Karen Hinson, 717-526-2721	14,154	Medicaid/CHIP		
Geisinger Health Plan CHIP PA	Dental benefits	2011 - present	Gail Guisewhite, 570-214-2734	7,895	Medicaid/CHIP		
Health Partners, Philadelphia PA	Dental benefits	1996 - present	George Seeds, 215-991-4033	157,375	Medicaid/CHIP		
KidzPartners PA	Dental benefits	2000 - present	George Seeds, 215-991-4033	2,706	Medicaid/CHIP		
South Carolina-Healthy Connections	Dental benefits	2010 - present	Steve Boucher, 803-898-2938	766,945	Medicaid/CHIP		
TN AMERIGROUP Community Care (Medicare)	Dental benefits	2008 - present	Niki McKnight, 901-348-2205	1,828	Medicare		
CoverKids TN	Dental benefits	2008 - present	Stephanie Dickerson, 615-253-8572	46,043	Medicaid/CHIP		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
National Guardian Life (NGL) Utah	Dental benefits	2010 - present	Emma Chacon, 801-538-6577	13,305	CHIP		
VA Smiles for Children	Dental benefits	2005 - present	Daniel Plain, 804-786-1567	853,060	Medicaid/CHIP		
WI- UCare for Seniors	Dental benefits	2006 - present	Paula Lucier, 414-847-1766	2,271	Medicare		
Managed Health Services WI	Dental benefits	2010 - present	Paula Lucier, 414-847-1766	3,745	Medicaid/CHIP		
Abri Health Plan WI	Dental benefits	2010 - present	Paula Lucier, 414-847-1766	35,429	Medicaid/CHIP		
March Vision							
Aetna Better Health – Connecticut	Administer routine vision benefit	September 2008 – present		Approx 100,100	CHIP		
Aetna Better Health – Illinois	Administer routine vision benefit	May 1, 2011 – present		16,500			
Missouri Care	Administer routine vision benefit	January 1, 2011		52,400			
Aetna Better Health – Pennsylvania	Administer routine vision benefit	April 2010 – present		56,300			
Alameda Alliance for Health	Administer routine vision benefit	February 2009 – present		4,100			
Care 1 st Health Plan	Administer routine vision benefit	2001 - present		102,000			
Molina Healthcare of CA	Administer routine vision benefit	2001 - present		309,000			
Molina Healthcare of FL	Administer routine vision benefit	December 2008 - present		66,000			
Molina Healthcare of MI	Administer routine vision benefit	2005 - present		157,000			



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
Molina Healthcare of MO	Administer routine vision benefit	October 2008 - present		78,900			
Molina Healthcare of NM	Administer routine vision benefit	2006 - present		79,200			
Molina Healthcare of OH	Administer routine vision benefit	2005 - present		251,000			
Molina Healthcare of WA	Administer routine vision benefit	2005- present		330,525			
UnitedHealthcare Community Plan located in DC	Administer routine vision benefit	August 2010 - present		55,600			
UnitedHealthcare Community Plan located in DE	Administer routine vision benefit	August 2010 – present		56,000			
UnitedHealthcare Community Plan located in MD	Administer routine vision benefit	August 2011 – present		152,000			
UnitedHealthcare Community Plan located in NJ	Administer routine vision benefit	June 2011 – present		413,000			
UnitedHealthcare Community Plan located in PA	Administer routine vision benefit	January 2011 – present		258,279			
UnitedHealthcare Community Plan located in SC	Administer routine vision benefit	August 2010 – present		75,320			
CommunityConnect Health Plan	Administer routine vision benefit	September 2010 – present		12,000			
CareCore National							
Aetna	2/1/2002 – Current	Prior Authorization for Radiology, Cardiology, Radiation Therapy	Bill McDonnell 215-775-4670	859,000 radiology; 854,000 cardiology; 382,000	Radiology: Commercial, Medicare, ASO		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
		and Sleep		RT; 382,000 oncology; 382,000 sleep	Cardiology: commercial, Medicare Radiation Therapy: Commercial, Medicare Sleep: Commercial, Medicare		
Affinity – NY	Prior Authorization for Radiology	8/1/2009 - Current	Kim David 718-794-5917	267,844	Medicaid, CHP, FHP		
AmeriChoice AZ, TN, MD, NY, NE, RI	Prior Authorization for Radiology	12/1/2009 - Current	Lori West 763-797-7140	1,426,000	Medicaid, CHP, FHP		
CIGNA	Oncology	1/1/2008 – Current	Shalini Wittstruck 425-338-0394	9,500,000	Oncology: Commercial		
Coventry – MO, MI	Prior Authorization for Radiology	4/1/2010 - Current	Angela Easterwood 434-951-2521	238,457	Medicaid, CHP, TANF, SSI		
Excellus – NY	Prior Authorization for Radiology	9/1/2007 - Current	Cindy Drexler 585-339-7903	201,729	Medicaid, CHP		
Healthfirst – NY, NJ	Prior Authorization for Radiology	4/1/2005 - Current	Chuck Damaso 212-497-4358	542,745	Commercial, Medicaid, CHP, FHP		
HealthPlus of Michigan – MI	Prior Authorization for Radiology	12/1/2005 - Current	Joan Cieslak 810-733-1938	67,036	Medicaid		
Horizon BCBS of New Jersey	Prior Authorization for Radiology, Cardiology, Musculoskeletal, Radiation Therapy and Oncology.	1/1/2005 – Current	Doug Vasquez 973-466-5660	2,760,000 radiology; 1,600,000 MSM; 1,002,000 radiation	Radiology: Commercial, Medicare Cardiology: Commercial, Medicare Musculoskeletal: commercial, Medicare, SHBP		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
				therapy; 1,600,000 oncology	Radiation Therapy: Commercial, Medicare Oncology: Commercial, Medicare		
EmblemHealth – NY	Prior Authorization for Radiology and Cardiology. Prior Authorization for Radiation Therapy to be implemented 2012.	7/1/2001 - Current	Jim Graff 646-447-7621	131,902 105,442	Radiology: Medicaid, CHP, FHP Cardiology: Medicaid, FHP		
Oxford	Prior Authorization for Radiology, Cardiology and Radiation Therapy	5/1/1999 – Current	Allyson Bogen 203-734-7514	1,053,000 radiology; 971,009 cardiology; 1.45 million Radiation Therapy	Radiology: Commercial, Medicare Cardiology: Commercial Radiation Therapy: Commercial, Medicare		
Rocky Mountain Health Plan – CO	Prior Authorization for Radiology	4/1/2010 - Current	Beth Wilcox 970-248-5030	19,684	Medicaid, CHP		
United Healthcare	Notification for Radiology and Cardiology Prior Authorization for Radiology and Cardiology	8/23/2006 – Current 2/15/2010 - Current	Laura Fischer 952-992-5675	12 million radiology; 13.3 million cardiology 1.6 million radiology; 967,000 cardiology; 35,000 (pilot, more lives to come)	Radiology: Commercial Cardiology: Commercial Radiology: Medicare Cardiology: Medicare		
Univera – NY	Prior Authorization for Radiology	9/1/2007 - Current	Cindy Drexler 585-339-7903	54,678	Medicaid, CHP		



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
WellCare – GA, FL, NY, OH, MO, IL, KY	Prior Authorization for Radiology	3/1/2011- Current	Jim Puckett 813-206-6038	1,291,708	Medicaid, CHP, FHP		
MTM							
Aetna Better Health - WI	Non Emergency Transportation	5/1/11 – 5/1/13	Eric Campbell 801-766-0870	13,544			Vehicles & Transportation
Arcadian Health Plan	Non Emergency Transportation	1/1/2009 – 12/31/11	Chase Milbrandt 928-777-9226	27,229			Vehicles & Transportation
Blue Advantage Plus - MO	Non Emergency Transportation	1/1/1996 – 3/31/12	Judy Brennan 816-395-2421	30,899			Vehicles & Transportation
Care Improvement Plus	Non Emergency Transportation	1/1/2007 – 1/1/2012	Karl J. Broussard 954-778-0224	93,377			Vehicles & Transportation
Children's Mercy Family Health Partners - MO	Non Emergency Transportation	1/1/1996 – 6/30/12	Cindy Mense 816-559-9472	56,091			Vehicles & Transportation
Children's Special Health Care Services - MI	Non Emergency Transportation	10/4/2004 – 1/1/12	Policy & Program Dev. Manager 313-966-7038	828			Vehicles & Transportation
Coventry Nebraska - NE	Non Emergency Transportation	8/1/2010 – 6/30/12	Cassandra Price 402-995-7177	47,119			Vehicles & Transportation
Essence HealthCare	Non Emergency Transportation	1/1/2011 – 1/1/2012	Susan Wilson 314-209-2845	30,540			Vehicles & Transportation
Gateway Health Plan	Non Emergency Transportation	1/1/2009 – 6/30/12	Angela Jackson 412-255-4296	26,858			Vehicles & Transportation
Harmony Health Plan of Illinois - IL	Non Emergency Transportation	2/1/2002 – 12/31/11	Gretchen Stephenson 618-236-8055	12,879			Vehicles & Transportation
Harmony Health Plan of Missouri - MO	Non Emergency Transportation	7/1/2006 – 12/31/11	Gretchen Stephenson 618-236-8055	16,936			Vehicles & Transportation



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
HealthCare USA - MO	Non Emergency Transportation	9/1/1995 – 6/30/12	Kathy Whaley 314-444-7914	190,198			Vehicles & Transportation
Healthplan of Michigan/Meridian - MI	Non Emergency Transportation	11/1/2010 – 1/1/12	Kelly Kramer 313-324-3726	283,562			Vehicles & Transportation
Kaiser Foundation Health Plan of Colorado	Non Emergency Transportation	1/1/2009 – 12/31/2011	Deborah Gordon 303-358-3520	5,040			Vehicles & Transportation
MDWise - IN	Non Emergency Transportation	12/01/2010 – 12/31/12	Julie Ulrich 317-822-7109	246,183			Vehicles & Transportation
Missouri Care Health Plan - MO	Non Emergency Transportation	9/1/1998 – 12/31/11	Ed Williams	49,928			Vehicles & Transportation
Molina Healthcare of Florida - FL	Non Emergency Transportation	5/1/09 – 12/31/11	Steve Bennet 407-637-1579	24,237			Vehicles & Transportation
Molina Healthcare of Missouri (formerly Mercy Care Plus) - MO	Non Emergency Transportation	2/9/1997 – 12/31/11	Christine Cybulski 314-819-5162	56,332			Vehicles & Transportation
OmniCare Health Plan - MI	Non Emergency Transportation	10/1/2004 – 7/01/12	Sandra McGriff 313-465-1552	50,258			Vehicles & Transportation
United (formerly Unison) Health Plan of Ohio - OH	Non Emergency Transportation	11/1/2005 – 12/31/11	Tim Binkley 614-410-7927	119,087			Vehicles & Transportation
Wellpoint Wisconsin (Community Connect Healthplan) - WI	Non Emergency Transportation	09/01/2010 – 8/31/12	Terri Maccani 805-910-6238	7,307			Vehicles & Transportation
McKesson							
MD Care Health Plan, California							
Easy Choice Health Plan, California							
United Healthcare Dual							



4.5.1(a), 4.5.1(b) and 4.5.1(d)							
Contract	Scope of Services	Contract Duration	Contact Name and telephone #	# of Enrollees	Population Types	Contract Type	Role of Subs, if any
Complete, Pennsylvania							
Citizens Choice Healthplan, California							
Molina Healthcare of Michigan							
Blue Cross-Blue Shield MS	Nurse Advice Line			256,234			
Care 1 st Health Plans	Nurse Advice Line			256,728			
Children's Mercy Family Health Partners	Nurse Advice Line			44,760			
Healthy Way LA – Los Angeles County	Nurse Advice Line, Disease Management			76,685			
Community Health Plan – Los Angeles County	Nurse Advice Line, Disease Management, and Care Coordination			205,937			
Health Net of California				951,392			
Federal Employee Program	Nurse Advice, Disease Management			5,222,625			

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4.5.2 Method of Performance [2.7.10, 2.16.2]

The offeror's method of performance will be considered subjectively in the evaluation process. Therefore, the offeror shall submit information, in response to the requirements below, to document that the offeror has the infrastructure, systems and procedures to effectively deliver services and monitor member care. Accordingly, the offeror shall address the following within the proposal.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2.

4.5.2a. Economic Impact to Missouri

The offeror shall describe the economic advantages that will be realized as a result of the offeror performing the required services. The offeror shall respond to the following:

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(a).

HealthCare USA's operations over the next contract period are expected to contribute approximately \$1.5 billion to the local Missouri economy. This contribution will be through salaries, taxes, provider payments, purchases, and in-kind contributions, among other monies.

This answer applies to all three regions.

HealthCare USA understands that Missouri, like most states nationwide, is facing significant budget shortfalls and is more focused than ever in supporting fiscal responsibility in reducing care gaps.

MO HealthNet achieves significant economic advantages through HealthCare USA's performance of this contract. The state's requirement for a physical presence in Missouri for many of our operations contributes to state economy, but the manner in which HealthCare USA is embedded into our local communities to support this and other contracts goes well beyond those requirements.

- Smooth implementation of FHP merger
- Ensuring Child CAHPS overall scores will exceed Quality Compass Medicaid National Average
- Maintaining HEDIS prenatal scores in the 75th percentile
- Obtaining the NCQA Multicultural Distinction
- Improving HEDIS scores in breast cancer screening year over year
- Improving HEDIS scores of post-partum visits by 2% year over year
- Increasing the use of telemedicine by 5% year over year
- Increasing use of anti-rheumatoid drugs by 3% each year

Accountability through Performance Guarantees

HealthCare USA enhances our commitment to quality through performance guarantees. Totalling \$500,000 annually and addressing everything from operational management/smooth implementation of the FHP merger to maintaining our CAHPS and HEDIS scores, we attach these performance guarantees:

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Figure 4.5- 3: Performance Guarantees

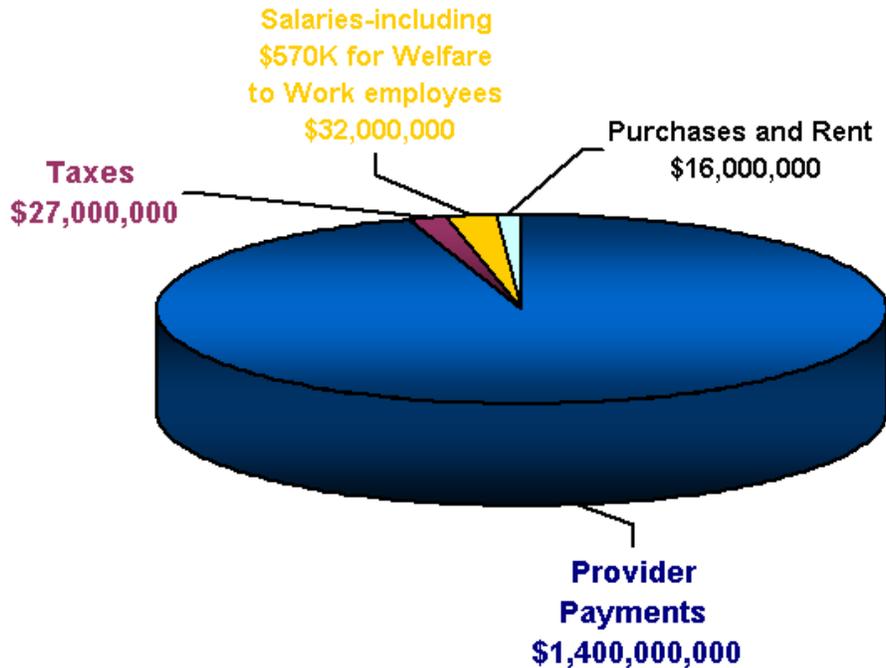
Description	Year 1	Year 2	Year 3	Total	Measurement
Smooth FHP Implementation - If 1 measurement criteria is met 67% of \$\$\$s will be paid - If 2 measurement criteria are met 33% of \$\$\$s will be paid - If all 3 measurement criteria are met, no \$\$\$ will be paid	\$100K			\$100K	Retain the following metrics post integration: * Claims payment timeliness - state prompt pay law * Call abandonment rate - 5% or less * ID Card Issuance - 10 business days or less
Ensure Child CAHPS overall score will exceed Quality Compass Medicaid National Average - for every point below the national average, we will pay \$10k with a maximum payout of \$100k/year	\$100K	\$100K	\$100K	\$300K	NCQA Quality Compass Medicaid National Average
Retain HEDIS prenatal at the 75th percentile - for every point below 75th percentile, we pay \$10k with maximum payout of \$100k	\$100K	\$100K	\$100K	\$300K	HEDIS Score
NCQA Multicultural Distinction Year 1 - Apply Year 2 - Achieve	\$75K	\$100K		\$175K	Application in Year 1 Achievement in Year 2
Improve the rate for use of anti-rheumatoid drugs by 3% each year up to 9% improvement for the contract period - If 1% improvement is achieved, 67% of \$\$\$s will be paid - If 2% improvement is achieved, 33% of \$\$\$s will be paid	\$50K	\$50K	\$50K	\$150K	Measure: HEDIS Score Baseline: HEDIS Reporting Year for 2011 for Calendar Year 2010 Results in Year 1; Subsequent years reset based on actual, but not to exceed 3% in a given year
Improve the rate for breast cancer screening by 2% each year up to 6% improvement for the contract period - if 1% improvement is achieved, 50% of \$\$\$s will be paid	\$50K	\$50K	\$50K	\$150K	Measure: HEDIS Score Baseline: HEDIS Reporting Year for 2011 for Calendar Year 2010 Results in Year 1; Subsequent years reset based on actual, but not to exceed 2% in a given year
Improve post partum visit rates by 2% each year up to 6% improvement for the contract period - if 1% improvement is achieved, 50% of \$\$\$s will be paid	\$50K	\$50K	\$50K	\$150K	Measure: HEDIS Score Baseline: HEDIS Reporting Year for 2011 for Calendar Year 2010 Results in Year 1; Subsequent years reset based on actual, but not to exceed 2% in a given year
Improve utilization of telemedicine by 5% each year - if 1% improvement is achieved, 80% of \$\$\$s will be paid - if 2% improvement is achieved, 60% of \$\$\$s will be paid - if 3% improvement is achieved, 40% of \$\$\$s will be paid - if 4% improvement is achieved, 20% of \$\$\$s will be paid	\$25K	\$50K	\$50K	\$125K	Measure: Claims data Baseline: Calendar Year 2011
Totals	\$550K	\$500K	\$400K	\$1,45M	

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The state’s requirement for a physical presence in Missouri for many of our operations contributes to state economy, but the manner in which HealthCare USA is embedded into our local communities to support this and other contracts goes well beyond those requirements.

Health Care



Both HealthCare USA and our Missouri-based affiliates maintain strong physical presences in Missouri.

HealthCare USA ‘s 105 employees occupy three offices in the state, one located in downtown St. Louis, one in Jefferson City and one in Kansas City Missouri, which all contribute to the local economy. Coventry’s other Missouri-based affiliates add in excess of 1,100 additional employees and six offices through out the state, further contributing to positive economic impact.

Just as important, too, is our commitment to MO HealthNet and their members. As introduced in the *Executive Summary* and later here, some members are our families and indeed they are us— one of Coventry’s corporate leaders is a former public assistance recipient. We propose a Welfare-to-Work program that will employ at least 5 recipients on this contract. It is this kind of economic impact, where we are moving members from public assistance to work, that is meaningful beyond just the dollars.



4.5.2.a.1 Provide a description of the proposed services to be performed and/or the proposed products that will be provided by Missourians and/or Missouri products.

This answer applies to all three regions.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(a)1.

Proposed Services to Be Performed by Missourians

We propose performing these services in Missouri:

1. Program administration including all top line key personnel

Health Plan Administrator	Medical Director
Chief Financial Officer	Behavioral Health Coordinator
QA&I Coordinator	Special Programs Coordinator
2. Physician services, all four provider types
3. Hospital inpatient and outpatient services; includes telemedicine
4. UM, including prior authorization and concurrent review services, case management, and disease management, complaints, grievances, and appeals
5. IT services
6. Member and provider services, face-to-face relations and education
7. Community outreach

We anticipate growth in our service operations (e.g., employees) in the next contract period, which will positively impact the state via salaries, taxes and spending. We anticipate increasing employment by 135 employees:

- **Acquisition** of Children's Mercy Family Health Partners in the Western region (addition of approximately 100 + employees)
- **Addition of in-state member service** operations as required by the RFP (25 employees)
- **Welfare-to-Work program:** We will work with the Family Support Division, Division of Employment Security, Department of Labor and Industrial Relations and community influencers to identify qualified candidates for open positions. At a minimum, for every 50,000 members, we will hire one qualified candidate for an open position in one of our Missouri operations. This equates to 5 new hires, with a total compensation of about \$570K including salary and benefits over the contract (about \$38,000 annually per hire).
- **Internships:** We have extended internship and externship programs available in St. Louis area. Our student practicum program is fully certified by the St. Louis University School of Social Work.

Our Missouri employees also provide other services beyond this contract. Coventry and HealthCare USA encourage community involvement, and our current 1200+ employees are projected to contribute more than \$900,000 in volunteer hours over the next contract period to



support various HealthCare USA outreach activities (e.g., back-to-school fairs, United Way) and their own personal volunteer interests. Community engagement fosters trust with members and a greater understanding of their diverse needs. Working in the community also gives us an opportunity to meet our members face-to-face to educate them regarding their benefits and services HealthCare USA provides them.

The economic benefit of all these services provided by HealthCare USA and its Missouri affiliates is significant, as shown in Figure 4.5- 4:

Figure 4.5- 4: Services Performed in Missouri by HealthCare USA and Our Affiliates = \$6.4 Billion in Impact

Service Economic Contribution Type	\$ Value For Contract Period
Provider payments <i>Assumes acquisition of Children’s Mercy Family Health Partners</i>	\$5.7B
Salaries, reflecting 10% growth with acquisition; impact in Western Region	\$410M
Purchases / Services	\$280M
Missouri Taxes	\$ 27M
Totals	\$6.4B+

Additionally, the positive economic impact goes well beyond just provider payments, salaries, and purchases, but the outcomes of our service delivery. For example, research from the Center of Information Technology Leadership indicates that telemedicine saves \$850 dollars in related transportation and health care costs for every visit .

HealthCare USA commits to increasing telemedicine use over the contract period and backs this up with a performance guarantee of \$125,000. In addition to the performance guarantee, HealthCare USA will also work with Missouri Telehealth Network to provide grant funding up to \$100,000 over the term of our state contract to assist participating rural practices in all three regions with the procurement of telehealth devices. By offering these grants, HealthCare USA's goal is to expand the use of non traditional service delivery methods in order to improve improve the quality of care of members who live in rural areas by increasing access to specialty care and improving patient outcomes by decreasing delays in diagnosis and treatment

Regarding improved healthcare outcomes, as Section 4.5.3 indicates, we anticipate improvements via excellent service delivery, care coordination and management, health homes— all the services coming together to support improved healthcare outcomes for members, and equating to millions of dollars in savings. For example, in 2010 alone Well-Child visits met HEDIS and measures saved more than \$335,000— an this is just one year of one measure for one program. Savings result from:

- Reduced ED use



- Reduced inpatient admissions
 - Reduced readmissions
 - Reduced complications
 - Minimized advances in illness or conditions
 - Increased wellness and prevention activities
- and more.

Proposed Products to be Provided by Missouri/Missouri Products

HealthCare USA and our Missouri affiliates propose purchasing these Missouri products and products provided by Missouriians

- Printing supplies for provider/member education and marketing materials.
- Advertising through public transit venues and local media outlets.
- Purchase of equipment and maintenance services.
- Office supplies
- Other

We project purchases made by HealthCare USA and our affiliates totaling an anticipated \$280 million over the contract.

HealthCare USA supports the Division of Purchasing and Materials Management obligations under Executive Order 05-30 by agreeing to purchase at least \$21 million of goods and services from Missouri-certified Minority Business Enterprise (MBE) and Women Business Enterprises (WBE) over the next three-year contract period.

4.5.2.a.2 Provide a description of the economic impact returned to the State of Missouri through tax revenue obligations.

This answer applies to all three regions.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(a)2.

HealthCare USA and our current Missouri-based affiliates estimate tax payments in excess of \$27 million to the State of Missouri over the contract period. Projected tax payments are:

- \$7 million in corporate income tax
- \$1 million in franchise and sales tax
- \$19 million in premium tax.

This does not take into account the millions in tax-based revenue dollars associated with the Missouri-based businesses that we support just by living and working here.





4.5.2.a.3 Provide a description of the company’s economic presence within the State of Missouri (e.g., type of facilities: sales offices; sales outlets; divisions; manufacturing; warehouse; other), including Missouri employee statistics.

This answer applies to all three regions.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(a)3.

HealthCare USA has offices in all three MO HealthNet regions to support this contract. Our primary office is at 10 South Broadway, Suite 1200, in downtown St. Louis, Missouri. We also maintain offices in Jefferson City and Kansas City, Missouri. In total, HealthCare USA and our affiliate companies rent about 320,000 square feet of building space in the state, with rental values totaling \$20 million across all our facilities for the three-year contract period. Figure 4.5-5 provides a description of our presence, including employee statistics.

Figure 4.5- 5: Missouri Affiliates and Proposed Acquisition Locations

Office Location	Company	Region	# of Employees
St. Louis-Downtown	HealthCare USA	EMO	90
Jefferson City	HealthCare USA	CMO	15
Kansas City	HealthCare USA Coventry Health Care of Kansas Family Health Partners (Potential Acquisition)	WMO	288 105
Springfield	HealthCare USA Member Services GHP MHP	CMO / WMO	122
St. Louis – Maryville Centre	MHNet GHP Corp IT	EMO	500
Chesterfield	MHNet GHP	EMO	83
Hazelwood	Worker’s Comp	EMO	100
Columbia	GHP	CMO	2



Our presence in Missouri contributes over \$60 million in positive economic impact from rent alone over the three-year contract period.

4.5.2b. Program Administration

- The offeror shall:
- 1. Describe the offeror’s proposed process for monitoring service delivery including, at a minimum, the offeror’s process for evaluating the adequacy, sufficiency, and appropriateness of provided services and monitoring patient outcomes.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(b)1.

Sufficient breadth and depth in our infrastructure, new proprietary systems and tools, and a highly-integrated process for monitoring that connects the dots from all plan functions help us ensure adequacy, sufficiency, and appropriateness of services, including patient outcomes.

This answer applies to all three regions unless otherwise noted.

HealthCare USA was founded specifically for the Missouri Medicaid contract. Our infrastructure, systems, and processes are custom-made to best monitor service delivery for MO HealthNet.

For this contract, we propose several new systems and tools—already tested and in use—that support our ability to evaluate adequacy, sufficiency, and appropriateness of services, and monitor patient outcomes. For example, one new system generates provider-specific analyses (including HEDIS scores at that level). Another new system generates member-specific, one-page reports that quickly identify missing services and support care coordination by reporting on PCP and specialty care services and ED visits, both reports available for the member visit.

Figure 4.5- 6 summarizes many elements of our approach (not inclusive); our infrastructure, systems, and processes are detailed following it.

Figure 4.5- 6: HealthCare USA’s Program Administration Supports Ongoing Monitoring of Service Delivery and Outcomes to Ensure Optimal Care in the Most Cost-Efficient Manner

Function	How Evaluate/Process	System	Infrastructure to support
Provider network contracting	Semi-annual review of network size and composite; CAHPS scores, HEDIS, Provider Scorecards for service delivery	Gouaches; CAHPS statewide and regional results, Proprietary HEDIS monitoring system, Proprietary Network Decision Support and Provider Services	4 positions to physically oversee network contracting, located in Western and Eastern regions; 3 positions for provider data administration and



Function	How Evaluate/Process	System	Infrastructure to support
		Support Tools	analysis in Eastern
Compliance	Complaints, grievances, appeals; overturned decisions and monthly analysis by type, category, region identifies provider-specific issues, systemic issues, benefits issues	Navigator	Compliance Officer is former Deputy Director of MO HealthNet, intimately knows requirements and standards to meet
QI and UM	Reported health outcomes analyzed and trended by region, provider, condition, demographics; HEDIS, EQRO report; state input	Proprietary case management tool, Navigator Care,. Proprietary HEDIS monitoring system including Missing Services Tool, Data Warehouse	Staff geographically dispersed in field in all regions
Claims	Trending by provider type, condition type, ED overuse, more	Proprietary IDX Managed Care Application and Data Warehouse	Centralized at corporate to leverage shared resources
Community partners	Frequent communications and feedback	Minutes from Community Development Team meetings, database to log visits and follow-up actions	Management position to support; community relations staff geographically dispersed in field in all regions
Member and provider services	Effectiveness of communication strategies based on analysis of change in behavior	Navigator, Navigator Care, HEDIS and proprietary monitoring system, CAHPS, Provider surveys, Data Warehouse	Telephonic member and provider services will join existing field service representatives in Missouri by contract effective date. Member Advisory Council, Provider Advisory Group; Board of Managers, includes member and provider representative



All the above evaluate adequacy, sufficiency, and appropriateness of service delivery and outcomes monitoring. For example, outcomes results might indicate the need for new/different provider types in a certain region, additional provider and/or member education, or the addition of a benefit to help support behavioral changes that can influence healthcare outcomes.

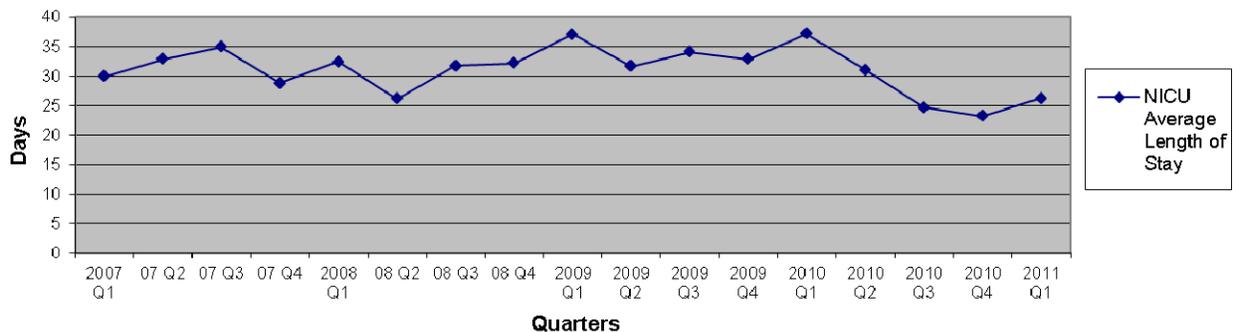
Proof of our success is evident in our August 2011 NCQA *Commendable* Accreditation status, our state documentation of adequacy and sufficiency and our HEDIS scores at or above the Medicaid 75th percentile in a number of areas such as

- Prenatal and Postpartum timeliness of care
- Antidepressant medication management (acute and continuation phases)
- Appropriate testing for children with pharyngitis
- Chlamydia screening in women (upper and lower age stratification and total measure)
- Emergency department visits/1000 members
- Use of spirometry testing in the assessment and diagnosis of COPD

Our success is also evident in our improved outcomes, such as the reduction in NICU average length of stay (ALOS) from birth to first discharge by 9 days from Q1 2009 to Q1 2011, and the corresponding increase in the percentage of full-term births from 88.5% to 89.8% over the same time period. These efforts have not only improved the health of our members, but have generated annual savings of more than \$19,000,000:

- At a current average cost/day for a NICU stay of \$1912, the decrease in ALOS stays resulted in \$17,208 in savings per NICU admission and totaled \$12,655,088 in savings for 2010.
- Avoiding NICU admissions by increasing full-term births by 1.3% has saved an additional \$6,462,560 in NICU admission costs per year.

Figure 4.5- 7: NICU Average Length of Stay (ALOS)—Birth to First Discharge





HROB Success Story

T.C. , 26 year old member, was enrolled in the High Risk OB Program She met high-risk criteria because of first trimester bleeding, diabetes, high blood pressure, previous preterm birth and reported issues with depression. The HROB RN coordinated services to ensure the member was receiving 17P injections weekly as ordered by her doctor. The member delivered a well, full-term baby on 6/3/11—her first child out of seven born full-term.

The High Risk OB Social Worker assisted the mother with getting in-home counseling, which was coordinated through the MHNet. The Social Worker also assisted her with getting various items she needed for the baby, including car seats and beds for all of her kids, by referring her to community resources. Financial issues also caused the mom about keeping housing for the family, but the CMP social worker also helped her by referring her to community resources.

NICU Cost Avoidance \$ Saved: \$49,712

Infrastructure for Monitoring Service Delivery

Our infrastructure supports our process for monitoring service delivery in several significant ways (See Figure 2.4 in Section 2.2.1 for our organizational structure; not repeated here per RFP Amendment):

Our infrastructure for service delivery monitoring includes:

- **Dedicated team members to enhance and ensure quality service delivery.** As Figure 4.5-8 illustrates, these positions support monitoring of service delivery across the regions and from various aspects.

Figure 4.5- 8: Dedicated Team Members to Provide More Monitoring and Ensure Quality Service Delivery

Position	Supports Service Delivery Monitoring
3 Medical Directors (1 lead)	Ensures adequate, timely access to the provider community for utilization management decisions, peer-to-peer consults, clarification on clinical processes and procedures, adverse event review, and face-to-face training with provider groups. These directors also ensure quality service delivery by actively participating and leading quality-related committees such as Credentialing and Peer Review, Quality Management Committee and Member Appeals Committee
VP of Operations	Ensures efficient and effective functioning of day to day operations, including oversight of MIS, to support communications and interfaces with members, providers and community partners.



Position	Supports Service Delivery Monitoring
VP of Network Development, Directors and Manager Contracting; located in Western and Eastern region	Adequacy, sufficiency, appropriateness of the size and composition of the network for all regions, at all times
Community Development Manager and Team	Ensures we have the right partners in place at all times to extend service delivery and customize approach to engage our populations (e.g., cultural competency)
Compliance Team	Ensures compliance with MO HealthNet contract, state and federal regulations, provides subcontractor/affiliate oversight, administers our fraud, waste and abuse program, ensures adherence to privacy laws and provides compliance and business risk assessment for the organization
MIS Director	Ensures systems we use to deliver and monitor services are operating at all times (e.g., a breakdown in one of these systems could adversely affect service delivery and outcomes)

- **Integrated Physical and Behavioral Health Directors** to promote

Holistic services

Integrated review monitoring service delivery

Outcomes (including but not limited to case and disease management)

Our organizational structure facilitates communication between the physical and behavioral health directors, as well as the dental consultant. Appropriate medical director staffing increases provider community accessibility for day-to-day medical interactions. It also enables us to routinely provide face-to-face discussions and education in the provider's office on topics such as potential changes to clinical criteria and guidelines.

- **Team members are located in the region** they support for functions that meet with members, providers and community on a daily basis. These team members regularly spend up to 75% of their job meeting with or engaging members, providers and community partners face-to-face. This includes:

Network Management/Contracting

Provider Relations

Community Development

Case and Disease Management

Inpatient Certification Review

Quality

Administrative support staff (Finance,



Operations, Compliance, Complaints and Grievance)

All are centralized in our St Louis or leverage corporate support such as Claims Processing and Prior Authorization.

- **Corporate resources are leveraged**, including claims, IT, finance, HR, and contracts so that our operational staff can be dedicated solely to monitoring service delivery, instead of dividing attention between service delivery and back-office functions. Another critical corporate function is bio-statistical/analytical support staff, who help analyze our ongoing data collection and monitoring outcomes compared to member-specific needs, state metrics, and national metrics.
- Finally, structurally, we have many **components, systems, and processes to monitor service delivery**.

Our **Board of Managers**—which we propose include at least one member and one provider (positions to be rotated annually to represent all regions)—enables corporate oversight and monitoring of HealthCare USA’s work to ensure company-wide best practices are employed, get access to additional resources as needed, and discuss shared resource and system improvements as they relate to MO HealthNet’s needs. As indicated in Section 4.5.3.C, some of our quality initiatives are corporate wide (e.g., for this year goals include HEDIS improvements in Breast Cancer Screening, Diabetic Eye Exam and Post Partum Visits) so the Board reviews healthcare outcomes as they compare to our corporate goals.

Our **Quality Management Committee**, comprised of 7 network physicians, is delegated by our Board of Managers to oversee the quality of our programs and service offerings. Related entities overseen by the QMC Committee are our

- Credentialing and Peer Review Committee
- Member Advisory Council
- Practice Management Advisory Committee,
- Community Partner Advisory Committee
- Physician Advisory Council

which all provide us stakeholder input to assure the utmost in service delivery.

Our **Health Plan Executive Team Meeting** monitors service delivery by coordinating input from every department and function on a weekly basis to continually ensure adequacy, sufficiency, and appropriateness of our resources and programs in delivering services that achieve the best outcomes. The team examines data from our systems, numerous provider and member feedback touch points to identify opportunities for continuous improvement.

Intra-department meetings enable us to monitor service delivery

- At the functional/task level
- Through department- and task-specific metrics



The information from these weekly meetings enables data to flow up during our weekly Health Plan Executive Team Meeting meetings so we can identify outliers before they become problems and resolve issues quickly. Particularly because our departments and staff are located across all regions, we can receive direct information about what is happening in the field to monitor service delivery and outcomes and respond accordingly.

Our participation in quarterly state meetings and more informal, frequent conversations between top-line managers and MO HealthNet help us monitor service delivery by incorporating nearly real-time feedback related to adequacy, sufficiency, and appropriateness. We track and trend all inquiries and correspondence from the state to ensure each item receives timely resolution. We also analyze these inquiries on a quarterly basis to identify trends and opportunities for improvement.

Systems for Evaluating Service Delivery and Monitoring Outcomes

HealthCare USA uses off-the-shelf and proprietary systems to support service delivery monitoring and to evaluate the adequacy, sufficiency, and appropriateness of services and monitor outcomes. Their use is reflected throughout our Concept of Operations Diagram, Figure 4.5- 10.

Proprietary Systems

HealthCare USA leverages *Navigator Care*, our corporate management tool, for case and disease management, and our One-Page Missing Services Report to monitor outcomes. Section 2.26.1 describes in detail our systems and how they communicate to each other. Briefly:

- *Navigator Care* tracks condition/disease management and complex case management. Navigator Care monitors ongoing participation and contact with health plan case managers. Programs supported include:
 - 14 Disease Types (Asthma, Diabetes, etc.)
 - Case Management and Condition Management
 - Member Reminders (Flu Shots, disease-specific, etc.)
 - Medicaid Wellness (EPSDT)Navigator Care contains 70+ member assessment questions that are used as detailed analytic tools for monitoring member goals and self-management. Case managers conduct goal planning with members to support member self-management. This information is available to providers via www.directprovider.com. A member's provider has the ability to update/comment on the member's progress and suggest alternative goals/objectives.
- Our **HEDIS monitoring system, A480**, summarizes monthly administrative HEDIS data by individual HEDIS measure against prior year reporting on a statewide, regional and provider basis. These early indicators are used to monitor effectiveness of our service delivery and assess the need for changes in strategy, interventions or re-education for our members and providers.



- **Navigator** is our non-clinical documentation system that is used to track member grievances and appeals, provider complaints, member and provider calls and issues identified by other departments when interfacing with members or providers. Data entered into these contact systems is trended by type, category, provider and region to identify trends and systemic issues for process improvement.
- Our new **Coventry Suite of Tools**, Network Decision Support and Provider Support Tool, provide data specific to the HEDIS-like and STARS-like measures in the contract. The Network Decision Support provides data as it is rolled up to the practice level and the Provider Support Tool provides data at the individual physician level. Both tools can be used to track progress and assist in identifying opportunities on a more timely basis.
- The **Network Decision Support Tool** analyzes information regarding the following, which is rolled up in a Provider Report Card posted semi-annually and reviewed in detail with the provider:

Cost of care and quality of care managed by primary care networks

Episode-based profiles to examine performance of specialty care physicians

Monitor clinical and financial performance indicators of inpatient facilities

Track measures that identify appropriate care outcomes across the delivery spectrum.

Understand patterns in service use and costs for different types of services and providers

Identify key diseases and conditions

Understand the costs and utilization for these patient populations

Understand the impact of relevant co-morbidities.

Monitor trends in costs by condition

Assess compliance with evidence-based guidelines on appropriate care

Track differences in health risk within our membership and changes in risk over time

- The **Provider Support Tool** provides HealthCare USA with insight into provider quality of care, as well as more detailed information to improve the case and disease management identification process. Our IT department uses health risk assessment, lab, member, and provider data and medical and CyberAccessSM pharmacy claims data to create various models and reports, including:

Avoidable Admissions Report informs Primary Care Physicians of every potentially avoidable admission that occurred over the requested timeframe for their panel of members. This report can be sorted by member ID and includes date of admission, inpatient facility, and primary diagnosis listed on the claim for the admission.

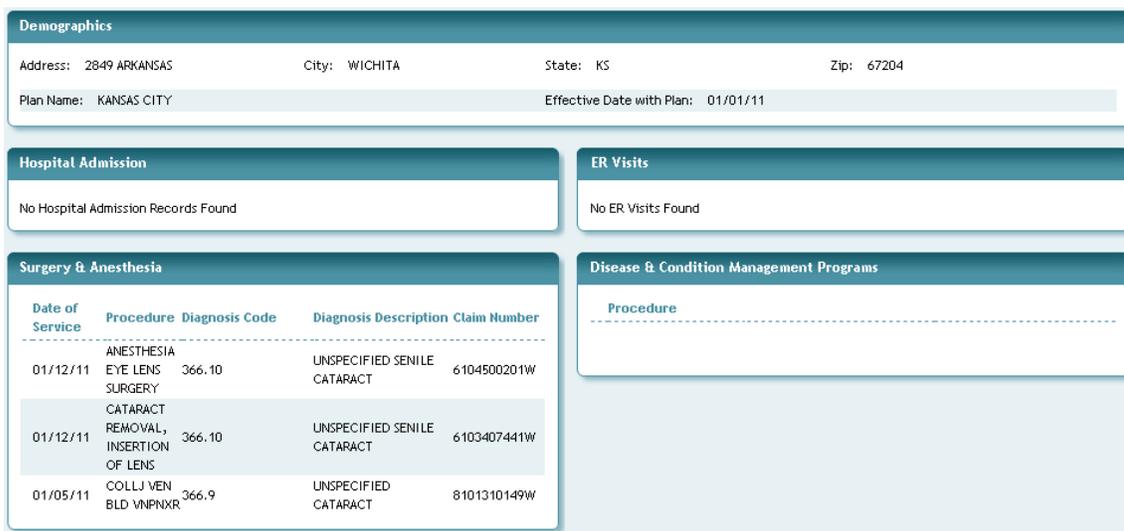
Avoidable Emergency Department Visits Report informs Primary Care Physicians of every potentially avoidable emergency department visit that occurred over the requested timeframe for their panel of members. Although this report is based upon Coventry-designated criteria for potentially avoidable ED visits, the report matches over 95% of the MO HealthNet designated LANE codes. This report includes member ID, number of visits per member, emergency department visit dates, facility name, and indicates the



three primary diagnoses included on the claim. This report helps providers identify members that would benefit from additional education regarding how to recognize and emergency and where to go for care. Urgent care visits are also designated on the report in a separate section so that the PCP understands where a member is accessing care and can reinforce the practice’s availability for after hours care.

The Missing Services Report (Figure 4.5- 9) ensures members receive all indicated medical and behavioral health care and screenings they need to achieve favorable long-term health outcomes. The data—provided in a one-page, user-friendly report— describes quality gaps in care, medication compliance, members ED utilization (including avoidable ED visits), and hospitalizations (including ambulatory sensitive conditions) by member. This report is accessed by a provider online for immediate download and used at the point of care. This report can also be run for a PCP’s entire membership on a specific gap in care, such as breast cancer screening.

Figure 4.5- 9: HealthCare USA’s Proprietary 1-Page Report (Quickly Monitors What Services Are Needed to Support Positive Outcomes)



Off-the-Shelf Systems

To evaluate the adequacy, sufficiency, and appropriateness of the network (which affects both service delivery and outcome), we use GeoNetworks® software. Reports from these systems are run and assessed semi-annually to ensure we retain sufficient coverage, and build to meet new/upcoming demands. When we receive notification of a change in our network such as termination of a hospital or large provider group, we utilize this software to perform impact analyses.

And we use Avaya’s telephone system monitoring capabilities to ensure member and provider service delivery are in accordance with performance standards (see Sections 4.5(c) and (d) for more information).



Business Objects Analysis is applied to the front-end of our data warehouse to provide our functional departments, actuarial and medical economics teams the ability to define, generate, and store reports to provide comparative analyses with less dependence on IT resources. Queries can be stored and shared, ensuring baseline and comparative reporting for targeted service delivery evaluations are performed on the same basis.

Process for Monitoring Service Delivery and Patient Outcomes

Our infrastructure and systems lend support to the adequacy evaluation process for service delivery sufficiency and appropriateness and for monitoring patient outcomes. Figure 4.5- 10 on the following page illustrates our process in detail and the unique ways we support and monitor each point in the process, for high-quality, cost-efficient services.

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Figure 4.5- 10: Concept of Operations Diagram



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4.5.2.b2. Describe the offeror's proposed process for monitoring provider performance and the strategies proposed to be implemented, including but not limited to ongoing educational opportunities and corrective action plans to provide needed support.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(b)2.

HealthCare USA's 17 ways to monitor provider performance with quantitative thresholds to trigger corrective response has resulted in low numbers of member grievances regarding providers and both high CAHPS scores and high provider retention rates.

This response applies to all regions.

Figure 4.5- 11 details the 17 ways HealthCare USA monitors provider performance with clearly-defined thresholds that trigger support to ensure MO HealthNet continuous quality provider service delivery. Our rate of member grievances regarding providers (1.6 per 1000 members for 2010 versus 2.9 in 2009) is proof that our process works, as is our CAHPS scores of 12.824 out of 13.000 possible points in our last reporting period, and our provider retention rates of 94.5% and 95% for 2010 and 2011, respectively.

If we identify a provider issue that is widespread and clinical (for example., many complaints or grievances on a particular clinical issue, or for a particular region of providers, or trends of quality of care concerns), our QI and clinical staff leads root cause analysis and identifies how to improve a process, system, tool, or program. The improved solution is then disseminated to providers via Webinars, updates on our Provider Portal, blast faxes, provider newsletter, hotline updates on our automated recording/notices, explanation of payment notices; and personal education or training when needed. Ongoing monitoring occurs after retraining to ensure the solution is effective in broad practice.

If the provider issue is narrowly-focused and clinical (one provider, one practice), our Medical Directors or Health Services staff provide personal/focused provider analysis, retraining, and monitoring until a sustained period of resolution/under threshold is quantified. If the issue is narrowly focused and administrative (e.g., billing issues, prior authorization request issues), our Provider Relations staff administers focused training at the provider site (developed after root cause analysis). In all cases (clinical and administrative), our Compliance department ensures that issues are resolved. Formal corrective action plans are developed for repeated non-compliance.

Please also see our response to Section 4.5.2©2, Ongoing Training and Education Activities for Providers, including frequency and type.

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Figure 4.5- 11: 17 Ways We Monitor Provider Performance with Clearly Defined Thresholds That Trigger Support to Assure MO HealthNet of Continuous Quality Provider Service Delivery

Process(es)	How Implemented/Monitored	Threshold Triggers Support, CAP	Provider Support/CAP
Provider credentialing	<ol style="list-style-type: none"> Maintain licensures or debarment Board Disciplinary action Ongoing monitoring to ensure not on Office of Inspector General(OIG) Excluded Parties List System (EPLS) or state-related OIG list 	0% for all	Termination for failure to maintain licensure, listed on EPLS; reporting in accordance with state regulations and contractual requirements
Provider personal communications	<ol style="list-style-type: none"> Contractual compliance Provider hotline tracking (type and number of requests by provider) Field representative personal, one/one relations and feedback Webinar, online tutorial scores 	<p>0% for most;</p> <p>For provider hotline tracking, >3 calls/ provider or issue</p> <p>Webinars threshold by topic (70% - 100% score required)</p>	<p>Increased provider hotline calls by provider would result in focused training/ re-education to the provider</p> <p>Increased provider hotline calls by issue = provider retraining (en masse) after internal review of training and other education disseminated, root cause analysis, and system improvements</p>
Quantitative analysis	<ol style="list-style-type: none"> Hospital Acquired Conditions (HAC) and never events Quality of care issues (patient safety, HAC, never-events; severity, frequency) HEDIS scores at PCP level Over/under use trended via prior auth, claims info; ED use data; grievance and appeals, hotline complaints, quality of care issues 	<p>0% for HAC, never events, Quality of Care issues; All investigated, if issue validated threshold crossed</p> <p>HEDIS; > 2 standard deviations below HealthCare USA score for any measure where >100 members in denominator</p>	<p>HAC, never events, Quality of Care issues: After QI Staff investigation and focused provider analysis, retraining and monitoring occurs</p> <p>For HEDIS and Over/Under Use: Root cause analysis/provider-specific, with focused provider-specific re-training, process re-</p>



Process(es)	How Implemented/Monitored	Threshold Triggers Support, CAP	Provider Support/CAP
	<p>identified</p> <p>NPI number matches requested service type during utilization management, claims payment (can identify fraud)</p>	<p>For over/under use, >2 standard deviations differential from peers 0%</p>	<p>engineering support, other</p> <p>Authorization or claim is not processed until there is a match to our system records</p>
Member input	<p>12. Member Grievances/Appeals</p> <p>13. Complaints/Appeals</p> <p>14. CAHPS</p>	<p>Grievances, appeals, Complaints, >25% increase in category</p> <p>CAHPS: >3% decrease in provider-specific questions</p>	<p>If investigation finds issues, provider-focused re-training and monitoring, including involvement of clinical/medical team;</p> <p>CAHPS: provider-focused re-training and monitoring; or root cause analysis and internal improvements, followed up with revised/improved systems and materials</p>
State input	<p>17. State-provided feedback and/or requests</p>	<p>0% All investigated, if issue validated threshold is crossed</p>	<p>Root cause analysis to determine if provider or systemic issue; if provider issue, one/one problem-resolution</p> <p>If systemic, cross-functional team to correct; leads to new or re-training for all providers on new solution</p>



4.5.2.b3. Describe the strategies the offeror will implement to obtain member and provider feedback, to track and monitor identified issues, to identify systemic issues, and to make programmatic improvements based upon identified systemic issues.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(b)3.

HealthCare USA’s strategies for programmatic improvement have ultimately improved not only our own plan; but have in some cases helped MO HealthNet improve the program as a whole.

This response is applicable to all regions.

Figure 4.5- 12 summarizes HealthCare USA’s approach to obtaining feedback, monitoring concerns to resolution, identifying systemic issues, and making programmatic improvements. Details of our approach follow.

Figure 4.5- 12: HealthCare USA’s Thorough and Scientific Approach to Improvements Assures MO HealthNet of Ongoing Enhanced Quality of Service

Feature of HealthCare USA Approach	Benefit to MO HealthNet
1. 4-pronged strategy to obtain feedback includes formal and informal methods (see following subsection for details)	<ul style="list-style-type: none"> High provider and member satisfaction -- “Voices” heard. 87% of our providers and members gave our health plan the highest satisfaction ratings.
2. 0% threshold for all issues; every issue addressed until resolution; do not wait for patterns to appear	<ul style="list-style-type: none"> Fast, thorough resolution of issues
3. Proprietary systems for documenting and tracking issues to resolution; data comes together at Quality, cross-departmental meetings to identify systemic issues	<ul style="list-style-type: none"> Legal support with clear documentation High provider and member satisfaction
4. Stratification of issues by severity level and frequency to identify systemic issues and how to address them	<ul style="list-style-type: none"> High quality of service Low stakeholder “noise”
5. Deming’s Plan-Do-Check-Act (PDCA) model to make programmatic improvements	<ul style="list-style-type: none"> Thorough, complete follow-through Cost efficiencies help reduce program rate increases
6. Proven programmatic improvements not only at HealthCare USA level, but also MO HealthNet program level	<ul style="list-style-type: none"> High quality of service Cost efficiencies help reduce program rate increases

Strategies to Obtain Member and Provider Feedback

HealthCare USA employs four strategies to obtain member and provider feedback. These strategies enable us to gather, track, trend and resolve issues in a way that provides daily feedback to each stakeholder while making improvements to the root cause of the issue to the system and Plan as a whole when issues are systemic.



The four strategies for obtaining feedback are as follows:

- 1) formal feedback forums (e.g., committees and surveys);
- 2) pointed information-gathering (e.g., ad hoc forums, program-specific surveys);
- 3) informal information-gathering (e.g., answering questions face-to-face with providers or members); and
- 4) information-gathering as part of routine operations (e.g., hotlines, grievances and appeals).

Results of all our activities are reviewed by an inter-departmental workgroup that includes compliance, provider relations, medical management, and claims/member service to review negative trends and develop creative methods toward improvement.

From these combined strategies, we have identified issues and addressed them to make systemic improvements. Figure 4.5- 13 highlights just a few of these. Details showing our implementation of these four strategies follows Figure 4.5- 13.

Figure 4.5- 13: Our Feedback Strategies & Process to Resolving Identified Issues Have Made Systemic Improvements Supporting Enhanced Access to Care, Provider Retention, and Cost Avoidance

Strategy	Issue Identified	Resolution	Benefit to MO HealthNet
Formal Feedback Forum -- Quality Management Committee	<u>Behavioral Health Coordination:</u> From PCP feedback, behavioral health outpatient treatment record notification process	Process and documentation improvement resulted in concise, meaningful behavioral health outpatient treatment notification to member's PCP.	Improved holistic care of member
Member Advisory Council	<u>Member Updates:</u> Keep members better updated with changes	Ad-hoc focus group meetings in community settings where large numbers of members congregate such as WIC clinics, Head Starts and faith-based organizations	Higher quality of care
Pointed Information-Gathering -- Member Ad Hoc Forums	<u>Non-Emergency Transportation:</u> Concerns from rural members about transportation mileage reimbursement form	Worked with MTM, our transportation vendor to make form easier to understand; educated local community partners on form use and completion; and had provider representatives review form with providers	Enhanced access to care resulting in a 26% increase in mileage reimbursements
Informal Information Gathering -- Question and Answers at provider seminars	<u>Coordination of Benefits (COB):</u> Member's other insurance coverage available to providers without	COB/other insurance coverage details made available to providers via web portal at time provider's office confirms member eligibility and PCP data	\$17 million savings to MO HealthNet Division and taxpayers, of which \$7 million



Strategy	Issue Identified	Resolution	Benefit to MO HealthNet
	contacting provider service line		was actual cash recoveries
Routine operations -- Provider hotline	Claims: Increased calls re: ambulance transportation claims paid incorrectly.	Cross-departmental team identified root cause resulting in recoded claims system and reprocessing/payment of claims	Provider Retention
Formal Feedback Forum -- Quality Management Committee	Behavioral Health Coordination: From PCP feedback, behavioral health outpatient treatment record notification process	Process and documentation improvement resulted in concise, meaningful behavioral health outpatient treatment notification to member's PCP.	Improved holistic care of member
Member Advisory Council	Member Updates: Keep members better updated with changes	Ad-hoc focus group meetings in community settings where large numbers of members congregate such as WIC clinics, Head Starts and faith-based organizations	Higher quality of care

Formal Feedback Forums: Committees and Surveys

Committees: Both members and providers sit on several committees in relation to our Oversight and Quality Committees structure.

Oversight Committees – Under a new proposal, we will invite members and providers to sit on our Board of Managers committee -the Plan’s highest administrative oversight committee. Input at the highest decision-making level helps ensure policies and procedures not only reflect our stakeholders’ needs, but are also developed with them.

Also delegated by the Board is the Quality Management Committee, which is comprised of 7 different providers types who help support our Plan’s policies and practices.

Quality Committees - There are a handful of Quality committees for both members and providers. For example, Advisory Councils for members and providers include about eight representatives for each council in each of the three regions (for providers, representation is regional and by highest volume specialty). The councils provide input reflecting a regional viewpoint on communications, education, and service offerings to members; and utilization and medical management policies to providers.

Newly proposed for the upcoming contract are special Member Advisory Committees to target different membership representations: a Multi-Cultural MAC and a Teen Mom MAC.

Providers have two additional forums, one for Credentialing and Peer Review and the other for Practice Management. Both forums have primary care and specialty care providers represented from all regions. The Credentialing and Peer Review committee is critical to network management, as it makes decisions about approving a practice into the network. The Practice Management Advisory Council, our largest provider forum, is



made up of about 30 providers (10 from each region) representing high-volume primary and specialty provider types including the FHQCs and RHCs. The council meets three times annually per region (9 meetings statewide), and the agenda is the same across regions. This enables plan-level provider feedback throughout the year.

Surveys: We also obtain feedback from members and providers through surveys on an ongoing basis. Annually, we survey members via mail (CAHPS); and providers via mail and phone (Provider Satisfaction survey).

We also survey members and providers more frequently. For example, every time a member calls in to activate a new-member card, a telephonic survey is prompted. At community events, we offer Benefits and Policy surveys. Providers satisfaction surveys are leave-behinds after every face-to-face provider relations visit.

Pointed Information-Gathering

Separate ad-hoc forums for members and providers enable input on proposed changes prior to implementation and offer smaller-group communication forums to provide feedback on specific issues. Via ad-hoc forums, for example, we helped a family get dental care, including the transportation to get there. These member ad-hoc forums are routinely held with community partners, so we work as a cohesive team to provide member-specific support.

We also use mail surveys to obtain specific information, such as the Provider Case Management and Disease Management Satisfaction Survey.

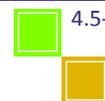
Informal Information-Gathering

Every time we are at a community outreach event or wellness event, we obtain member feedback. Every provider relations visit and provider educational seminar is an opportunity to obtain feedback. Obtaining feedback in these less-formal settings enhances our relationships with each member and provider and lets them know how much we care. Additionally, one-on-one question and answer sessions are effective means of communicating messages (vs mass communication); and often, encourage others to speak up.

Routine Operations Allow for Feedback

As indicated above, we use every opportunity to obtain feedback during the course of routine operations. Every issue called into both member and provider hotlines is captured, documented, and monitored to resolution (see next subsection).

Critical to systemic improvements is information obtained from members and providers via the Complaints, Grievances, and Appeals process. Every issue is captured, stratified (severity and frequency); monitored, and addressed to resolution. Depending on the severity and frequency, resolution might be member/provider-specific or a systemic improvement. See the next subsections for more information.





Strategies to Track and Monitor Identified Issues

HealthCare USA has a 0% threshold for identified issues. Every issue that comes to us—regardless of the strategy or avenue for feedback—is documented and monitored through resolution. We track and monitor identified issues in the following manner:

1. **Issues are initially captured and documented electronically** in relevant HealthCare USA systems. Member/provider hotline calls and Complaints, Grievances and Appeals are documented in our proprietary Navigator Care system (in separate modules); Survey results are compiled in our local area network dedicated for the Missouri contract. (See Section 2.XX for a full description of our integrated MIS).
2. **Once issues are captured, they are stratified by severity level and frequency.** This facilitates resolution by identifying what is appropriate to the issue at hand and who among the team is best to resolve it. It also facilitates identification of systemic issues. It only takes one incident about a never-event, for example, to institute remedial action of that incident and start a review of broader problems either with the provider or system; while it might take five documented incidences of members not having ID cards at time of appointment – a more frequent but lower severity level - for the issue to warrant a broader review (again, our 0% tolerance policy means we would address every incidence one-on-one). Figure 4.5- 14 summarizes how we assign severity levels, but in general, they are assigned dependent on severity of affecting healthcare outcomes:

Figure 4.5- 14: Issue Stratification Facilitates The Right Resolution and ID of Systemic Problems

Issue Type	Severity Level
Never event	High
State correspondence that indicates an issue through Governor's office (same with Senator or Representative)	High
Lack of reliability of transportation vendor to pick up members to make appointments on time; multiple complaints	Medium
Provider claim dispute; member losing ID card	Low

3. **Regardless of stratification, issues are tracked** by department in department-specific systems and modules. All tracking across departments provides for:
 - Issue capture date and resolution date
 - Issue type, severity level, and frequency (single incident, high-severity; single incident, low-severity; multiple incidences, medium severity level, etc.)



- Actions to resolve issue (each department has escalation procedures. For example, the member and provider services' hotlines have call routing procedures that vary for crisis response versus representative handling versus management or supervisor intervention versus warm transfers to another department)
 - Assigned staffer responsible for issue resolution, including management oversight
 - Resolution status by hour, day, or week depending on severity level and issue complexity (and date documentation to accompany status updates)
 - Member/provider feedback on resolution
 - Monitoring status after issues resolution to ensure issue resolved
 - Compliance office sign-off issue that is closed.
4. **Status updates are provided** daily as needed by the staffer and manager responsible for resolution; weekly at department meetings and our Plan Executive Committee (senior leadership team comprising all top-line key personnel – see Section 2.X for organizational chart – and representatives from all departments) until issue resolution. See the next subsection for systemic issue resolution. Resolution also is monitored at the Quality Management Committee (Plan-oversight) level monthly.

Strategies to Identify Systemic Issues

As indicated above, issue stratification for every incidence brought to our attention enables us to identify systemic issues. Other strategies for identifying systemic issues are cross-functional reviews and in-depth analyses to identify patterns and trends that indicate broad problems.

As indicated above, our Executive Plan Committee receives weekly updates from every department so that we can easily identify cross-departmental systemic issues. Multiple calls to the provider hotline on a specific issue, combined with complaints, grievances, or appeals on the same issue, indicate systemic issues. Member survey responses and complaints or grievances also might indicate a systemic issue.

For example, an increased number of appeals from a large multi-specialty provider in the Eastern Region over one quarter identified the appeals were related to a recently implemented coding edit that resulted in claims being denied. An investigation determined the edit had been improperly applied. An appropriate change was made to the claims coding to properly handle this edit. All claims subject to the incorrect processing for this provider *and others* were identified and reprocessed under the correct rules.

Once an issue is identified as potentially systemic, we conduct further analysis to determine if patterns and trends exist, if a system-wide issue may exist and the extent of issue. Analyses are done by:

- Issue
- Region
- Provider type and provider



- Condition/disease/other
- Demographics (age, sex, etc.)
- Other

The next subsection discusses system changes to resolve issues.

Strategies to Make Programmatic Improvements on Identified Systemic Issues

HealthCare USA uses Deming's Plan-Do-Check-Act (PDCA) quality improvement model, as many healthcare organizations do, to make programmatic improvements.

Specifically, once a systemic issue is identified, a cross-functional team is created to lead the issue to resolution. The cross-functional team will include clinical, quality, and provider or member (depending on the issue) staffers, plus others such as IT, as the issue warrants. The team conducts root-cause analyses to determine the reason for the issue, including data manipulations, process flows, and other techniques.

Once the root cause is identified, we develop a plan for making programmatic improvements. *Planning* starts with identification of the gap from where we are now to where we want to be; identifies the steps needed to be completed to close that gap – including risk mitigation -- and determines quantitative metrics for success. We might incorporate provider and member feedback into our planned approach via one of the forums identified above and retool accordingly.

Doing sets up all the processes, tools, systems, and policies that will be required to achieve that improvement, include beta-testing or piloting. *Checking* monitors the beta-testing and initial implementation efforts to ensure we are meeting the goals we set out to achieve. Sometimes, despite best planning efforts, the reality of implementation identifies glitches in the plan that need adjustment.

Finally, *Acting* implements fully our programmatic improvements. The cross-functional team, Executive Plan Committee/Senior leadership committee; and our Board-overseen Quality Management Committee monitor implementation and resolution to ensure that improvements produce accurate, repeatable, and verifiable enhanced results.

Once improvement results are verified as valid, we disseminate resultant actions, policies, procedures, forms, etc. to providers and members via our routine communication channels with each stakeholder. These include the various forums cited above in Section 4.5.2b1; routine hard copy and electronic communications such as Web site updates, newsletters, etc; "town-hall" type meetings and educational seminars; and communications via our community partners through established channels.

In addition to the examples in Figure 4.5- 13 at the beginning of this response, HealthCare USA has made many other programmatic improvements, including those that are not only Plan wide, but MO HealthNet wide and that have not only improved quality of care, but have helped save the state more than \$25M annually across plans:



Figure 4.5- 15: HealthCare USA’s Plan and MO HealthNet Wide Programmatic Improvements Have Improved Quality and Saved \$25M+ Annually

Initiative	Increased Access	Improved Quality	Reduced Costs
1. COB reimbursements initiated			X <i>In 2010 alone, cost avoidance of \$17M; \$7M in recoveries just for us/one plan*</i>
2. Reduction from 30 days to 7 for case management for pregnancies identified after trending and analyses of an increase in NICU claims; Cross-functional teams implementing PDCA as described above identified via root cause analyses where the tipping point was in pregnancy management that led to an increase in NICU	X	X	X <i>Cost avoidance of \$28,000 per baby not in NICU</i>
3. Cover 17P after ongoing review of updated evidence-based research indicated appropriateness of coverage		X	X

**EXTRAPOLATION OF THIS FIGURE TO ALL PLANS ANNUALLY RESULTS IN TENS OF MILLIONS OF DOLLARS RECOUPED/YEAR*

4.5.2.b 4. Describe the offeror’s proposed strategies for in partnering with stakeholders (e.g. community-based service providers, local public health agencies, schools, state agencies, FQHCs, consumer groups, etc).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(b)4.

HealthCare USA was the first Plan to use partnering with stakeholders to expand access to care and today, propose improvements to our successful, fivefold strategy.

This answer applies to all regions; regional differences are noted.

HealthCare USA was the first Plan to initiate community partnerships as one of our founding strategies in 1995; before it was a contractual requirement. We have a five-point strategy to expand access to care via strategic partnerships and collaborative efforts within the county and local community that includes:

- **Mapping to Shared Goals:** In the counties/communities where our members live, we search for partnerships and collaborations with organizations that share our common goals for improving our population’s health outcomes.



- **ID of Demographics:** We analyze the demographics of our service area in terms of relates to race, ethnicity and language; we identify potential barriers our members may experience due to those backgrounds; we also review HEDIS statistics for our membership in that area to identify what health services we need to address.
- **Identify Gaps, Seek Partners to Fill Them:** Using our gather demographic information, we closely align our strategy with specific community partners who share goals for health outcomes, provide enhanced access to targeted health services, and understand or serve the ethnicity of that community.
- **ID of Economic Trends and Other Trends.** We also track the economic and industrial trends in theses counties and communities, as changes to these dynamics can quickly shift the resources and our member's ability to access services. When this occurs, we reassess and add partnerships or increase/decrease emphasis with existing partners as necessary.
- **Effectiveness Reviews:** We conduct semi-annual effectiveness reviews to ensure that our partners are meeting the goals we've set out . Reviews include member input from our Member Advisory Committee and our Board of Managers to identify member and community disparities. We also work with a cross-functional HEDIS Improvement Workgroup to link our work with HEDIS results that also help us identify gaps in care for specific counties/communities. From all this data, we develop revised initiatives (including quantitative metrics); then implement, and monitor them.

Because enrollment changes so frequently (members come on and off; new members added, etc.), we conduct the first four activities in an ongoing manner. Our Community Development Team meets weekly to discuss new member dynamics, economic changes in the community, and to review topics including trends in accessing care, barriers in receiving care, cultural and ethnic health disparities, gaps in care and noncompliant members in need of health care (primary, specialty, dental, and behavioral health).

This partnership information is shared with our case managers and health services team to better serve our members and fill those gaps. For example, enrollment in Pettis County dropped, and upon further analysis, we identified the need to better support the Hispanic population. We have built relationships with faith-based organizations to reach Hispanics, and are now reporting positive enrollment trends. We will leverage these partnerships to support a proposed QI project to increase breast cancer screening in the next contract; see *Section 4.5.3.f* for details.

Success From Our Strategies

Our strategies have proven effective, as Figure 4.5- 16 highlights. These examples are just a few of the many successes we have had with our partnerships in the Western (250), Central (200) and Eastern(300) regions.



Figure 4.5- 16: HealthCare USA’s Partnerships Have Improved Access to All Provider Types

Region	Identified Needs <i>(Not Inclusive)</i>	Recent Examples of Successful Partnerships
Eastern	Identified large number of EPSDT/Immunization non-compliant members in 63106, 63107 zip codes	<p>Improved Access: EPSDT/Immunization Services (FQHC)</p> <p>Identified Grace Hill Water Tower Health Center (FQHC) as partner (location is on two bus lines and within walking distance of many of our targeted members)</p> <ul style="list-style-type: none"> • Grace Hill called non-compliant members and scheduled after hour appointments at clinic • Participants received back pack, dental kit and opportunity to visit with Community Development Team member to help them understand how to access transportation and language services. • Grace Hill Health Clinic, an FQHC, to provide EPSDT, immunizations and dental services to adolescent members. • More than 300 individuals received services
Central	Established of Triad of Care to identify barriers to dental care in Hannibal, MO community (Marion County): Eugene Field Elementary School DentaQuest Reach Out mobile dental unit HealthCare USA	<p>Improved Access: Dental Services in Schools</p> <p>School nurses identified nearly 87%(162) of the children at this school were in need of dental services.</p> <ul style="list-style-type: none"> • Organized 2 day dental clinic, but was extended to a 3rd day when dental providers experienced the need and saw how well the program was coordinated • Participating children received a dental bag containing a toothbrush, floss and toothpaste and Doc Bear coloring book (all items supplied by partners) • HealthCare USA Community Development Team member and hygienist reviewed oral care with the kids • 37 HealthCare USA members, 38 additional MO HealthNet (MCO and FFS) members received services • As a follow-up we worked with school nurse to help those families find a dental



Region	Identified Needs <i>(Not Inclusive)</i>	Recent Examples of Successful Partnerships
		home in Marion County. <ul style="list-style-type: none"> • Additional 2012 dental clinics are being scheduled to target the remaining underserved children.
Western	Jackson County: Identified pocket of membership not accessing preventive services in 64108 zip code where there is a lack of resources. Predominantly African American population with history of seeking services only in emergencies.	<i>Removing Cultural Barriers—Building Trust</i> Established partnership with faith-based organization in area, Bethel AME Church to better understand barriers. <ul style="list-style-type: none"> • Developed health fair to offer preventive screening services (BMI, blood pressure, diabetes, HIV, etc.) • HealthCare USA leveraged relationships with Samuel Rodgers (nearby FQHC) and Black Health Care Coalition to provider clinicians for the event • HealthCare USA Community Development team member discussed importance of establishing a health care home versus accessing the ED, reasons to get needed preventive services and how to access transportation assistance • Foundation laid for future collaborations with these partners to change member behaviors in seeking preventive services with an established health care home.

Doc Bear

Indeed, our plan brand, Doc Bear (as seen at the top of our proposal’s pages) is highly successful when used in stakeholder partnering. *Section 4.5.3* discusses the ways we use Doc Bear with stakeholders for quality improvement initiatives involving children. Essentially, when Doc Bear comes out, everyone knows HealthCare USA is working to improve healthcare outcomes with our partner.

Unique Partnerships

We also work with unique partners to support educational and non-health but relevant wraparound services, such as our alliances with

- Healthy Kids Institute (Jackson County—Western Region)
- Calvary Baptist Church (Boone County—Central Region)



- Community Health Ministry Team of First United Methodist Church (Audrain County—Central Region)
- Ministerial Alliance (Montgomery County—Eastern Region)
- Casa de Salud (rural Washington, Franklin, Warren, St. Charles and Lincoln Counties—Eastern Region)
- NECAC (Pike County—Eastern Region)

to transport members to WIC, Legal Aid and other non-covered services that indirectly affect healthcare outcomes for members and their families. Our community partners also serve as hosts for “town-hall” type meetings that were requested by members and are now delivered throughout the state to explain major policy and other changes.

Beyond Partnerships

Beyond simply partnering with stakeholders, we use a Triads of Care approach to engage us, partners, and providers. Triads of Care are community stakeholders working with HealthCare USA and a local provider to effectively monitor care and deliver services to HealthCare USA’s members. HealthCare USA has established Triads of Care in all regions; see Figure 4.5- 17.

Figure 4.5- 17: Triads of Care Go Beyond Simple Partnerships to Help Monitor and Deliver Services

Region	HealthCare USA’s Triads of Care Partners & Goals
Western	<ul style="list-style-type: none"> • Community: Kansas City and Jackson County (Urban) Triad Partner: Kansas City School District School nurses and school counselors, local HealthCare USA providers Goal: Increase preventative health awareness, provide screenings, education on importance of establishing a health and dental home, assistance in choosing a PCP provider and education on when to utilize the ED for services. • Community: Henry, St Clair & Johnson Counties (Rural) Triad Partner: Girls on the Run, local HealthCare USA primary care physician Goal: Assist participants in program access primary care provider and receiving regular checks ups; including BMI’s to address obesity, physical fitness and behavioral health (self esteem and character development). • Community: Cass County (suburbs of Kansas City) Triad Partners: Belton Dental Clinic and WIC provider Goal: Provide dental services to non-compliant members and to those participating in the WIC program to ensure a full scope of services. Education on importance of establishing a health and dental home. • Community: Jackson County (Urban) Triad Partners: The Guadalupe Center and local HealthCare USA



Region	HealthCare USA's Triads of Care Partners & Goals
	<p>providers Goal: Assist expectant teen moms in accessing prenatal care, dental care, mental wellness and choosing a primary care physician for the newborn.</p> <ul style="list-style-type: none"> • Community: Polk County (Rural) Triad Partner: Alpha House, HealthCare USA Polk County physicians and dental providers] Goals: Assist Alpha House teen moms access prenatal care, dental care, mental wellness and choose primary care physician for the newborn.
Central	<ul style="list-style-type: none"> • Community: Audrain County (Rural) Triad Partners: Health Ministry Team of United Methodist Church, local HealthCare USA providers Goal: Assist families in choosing a primary care physician, scheduling an appointment for a well child examination, update immunizations and schedule a dental visit. • Community: Marion County (Rural) Triad Partners: Douglas Community Action Agency, DentaQuest Goal: Provide dental education and dental tool kits to low-income community members in Marion County. • Community: Cole County (Urban) Triad Partners: Jefferson City Daycare, Magical Smiles dental office Goal: Assist families in accessing dental health services and finding a dental home. Provide bus passes to help members keep their scheduled appointments. • Community: Hannibal, MO and Marion County (Rural) Triad Partners: Eugene Field Elementary School, DentaQuest, Reach Out mobile unit Goal: Identify dental health service barriers, provide dental screenings and dental care at the school.
Eastern	<ul style="list-style-type: none"> • Community: St. Louis City (Urban) Triad Partners: Matthews Dickey Boys and Girls Club, local HealthCare USA health care & dental providers Goal: Identify non-compliant members in need of EPSDT, immunization and dental services. Connect member to health care provider to receive services and establish a health and dental home. • Community: Warren County (Rural) Triad Partners: Holy Rosary Elementary School (Nurse/Principal), local HealthCare USA providers Goal: Provide education to families regarding importance of well child examinations, dental health, and proper use of the ED. • Community: St. Louis City and St. Louis County (Urban) Triad Partners: Nurses for Newborns, local HealthCare USA



Region	HealthCare USA's Triads of Care Partners & Goals
	<p>network pediatrician and OB provider. Goal: Provide mom with access to prenatal care, identify a pediatrician for the newborn, schedule and attend prenatal appointments, assist mom with post partum appointment.</p> <ul style="list-style-type: none"> Community: Franklin County (Rural) Triad Partners: Franklin County Head Start, local dental clinic Goal: Assist parents/guardians access health and dental services for their children enrolled in the head start program and provide education regarding proper ED usage. Community: St. Louis City (Urban) Triad Partners: Grace Hill Settlement House and Clinics (FQHC), Head Start Early Childhood Program Goal: Ensure all children enrolled in Head Start program receive well child examinations, vision exam, immunizations and dental services

Our team members also rely on community partners to extend access to care, which in turn, promotes positive healthcare outcomes. For example, DentaQuest partners with community-based organizations such as Missouri Health Advocacy Alliance, child advocacy groups such as CMCA Head Start and Youth in Need; and other stakeholders such as Missouri Coalition for Oral Health that provides grants via its Foundation arm to promote oral health.

Newly Proposed

For the next contract, we propose expanding our partnerships in several ways:

- Expand the school-based dental services from our pilot in the Central region to statewide; we anticipate this will reach an additional 200 children per year that are not currently accessing their preventive dental screenings or needed services.
- Establish new Triads of Care between select FQHCs and RHCs in partnership with Head Start programs to improve HEDIS/EPST/Immunization/Dental/Wellness Exam compliance for early childhood members.
- Expand our teen pregnancy partnerships by creating Triads of Care between school-based teen parenting programs in each region to increase access to prenatal care and preventive dental care for pregnant teens. Initial Triad targets include:
 - Eastern-St. Louis City Community: ThriVe , Haven of Grace (two homeless teen pregnancy centers) and St. Louis Public Schools teen parenting program
 - Central-Cole County: Pregnancy Resource Center, Jefferson City Public School teen parenting program
 - Western-Jackson County: Operation Breakthrough and Kansas City School District teen parenting program



- Expand member benefits to include participation fee in YMCA and Girls on the Run in Kansas City area to combat childhood obesity. Additional information on these programs can be found in Sections 2.7.11 and 4.5.2b6.

More information about how we effectively use partnerships is included throughout Section 4, such as Section 4.5.4.B.5 and other responses.

4.5.2.b5. Describe the offeror’s proposed process for monitoring and tracking complaints, grievances, appeals, and denials.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(b)5.

Healthcare USA’s score of 100% for six consecutive years on our EQRO Report of Complaints, Grievances, and Appeals proves we are fair, accessible, and responsive.

This answer applies to all three regions.

HealthCare USA’s process for monitoring and tracking complaints, grievances, appeals and denials for MO HealthNet is well-established and a proven success over the past 16 years.

The process includes all the best standard practices, involving Quality Committee oversight, responsiveness, and regulatory compliance reporting; and we measure our results to NCQA standards.

Also significant in demonstrating success is our low rates for appeals, complaints, and grievances. In 2011 HealthCare USA received:

Complaints, Appeals, and Grievances	
Provider Appeals per 1,000 Claims	2.62
Provider Complaints per 1,000 Claims	0.33
Member Appeals per 1,000 Members	1.05
Member Grievance per 1,000 Members	6.03

Processes for Tracking and Monitoring Complaints, Grievances and Appeals

HealthCare USA’s proprietary online tracking system, Navigator, enables us to identify, track, and monitor through resolution each complaint, grievance and appeal from the time of notification through closure to ensure we and MO HealthNet have the documentation needed to support member and provider satisfaction; and to support litigation successfully, should that be necessary. Moreover, Navigator also enables us to trend in many ways to make programmatic improvements.



Summarily, both members and providers have multiple avenues for reporting an issue (respective hotlines, secure email; via outreach teams/provider relations or member and community relations); we capture issues regardless of how they come to us in the same system for comprehensive reporting, and use the same process for tracking, monitoring, and responding are (see the flowcharts in Figure 4.5-18 through 4.5-22 at end of this response for details):

- Our Complaints, Grievances, and Appeals department investigates complaints in conjunction with other functional areas to ensure a complete and thorough investigation
 - For patient safety or quality concerns, the investigation is conducted by our QI clinical staff.
 - For other clinical issues, the Medical Director or clinical staff are involved.
- Our Compliance Officer—a former MO HealthNet Deputy Director who brings intimate knowledge of the state’s standards and requirements for this function—ensures whatever the resolution is (see various options below), that the loop is closed

This process is similar across our team. We monitor subcontractors’ work through the same committees we monitor our own (see below) for aggregate plan performance, including the Board-designated Quality Management Committee and through monthly subcontractor/affiliate reviews.

Capturing Reporting Data

Our system, which is MO HealthNet-specific (separate from other Coventry plans) tracks the following 20 fields to monitor and track the actions in response to the issue through resolution (e.g., reporting purposes). The required fields are readily changed when changes occur in the program or the maturity of our information evolves requiring more or sometimes less data. Required fields drives consistent data entry at the front end of our processes, which in turn provide the data required to perform necessary analytics:

- | | | | | |
|------------------------|---------------------------------|-----------------|-----------------|-----------------|
| • Received Date | • Assigned to | • Age | • Issue ID# | • Member ID |
| • Region | • Contact From | • Member ID | • Status | • Reason |
| • Letter Sent Date | • Level of appeal, or grievance | • Par Provider | • Category | • Reviewer |
| • MD original decision | • Extension Request Date | • Resolved Date | • Provider Name | • Status Detail |

Using this system, we will report to the state by provider and member the open and closed complaints/grievances (respectively); and open and closed appeals.



Trending for Improvements

For provider and systemic improvements, we track the following by physician and physician group to identify patterns of behavior (provider-specific or systemic):

- Region, including urban and rural
- Issue (categorize)
- Severity level (see information in Section 4.5.2.B.3 above regarding stratification of issues)
- Member condition, disease, etc.
- Member demographics
- Date of issue

Our Complaint, Grievance and Appeal Coordinator (Coordinator), who is ultimately accountable for our process, also can design and run reports to track and trend complaints, grievances, and appeals per region or for the entire program.

Our QI committee structures also help identify trends and monitor responsiveness to them to ensure the utmost in service delivery and positive healthcare outcomes. Our *Complaint, Grievance and Appeal Committee* meets monthly to identify patterns in grievances and appeals that form the basis for corrective actions, such as training or even a process change.

The Board-designated Quality Management Committee also reviews our performance through trend reports concerning complaints, grievances, and appeals. In doing so, they may request additional research into a trend, make operational recommendations, and determine appropriate corrective action. See Section 4.5.2(b)1 for more information about these committees.

Ultimately, if trends indicate a need for corrective action at the provider, program or member level, we make changes as indicated above in Section 4.52(b)3. Changes may include

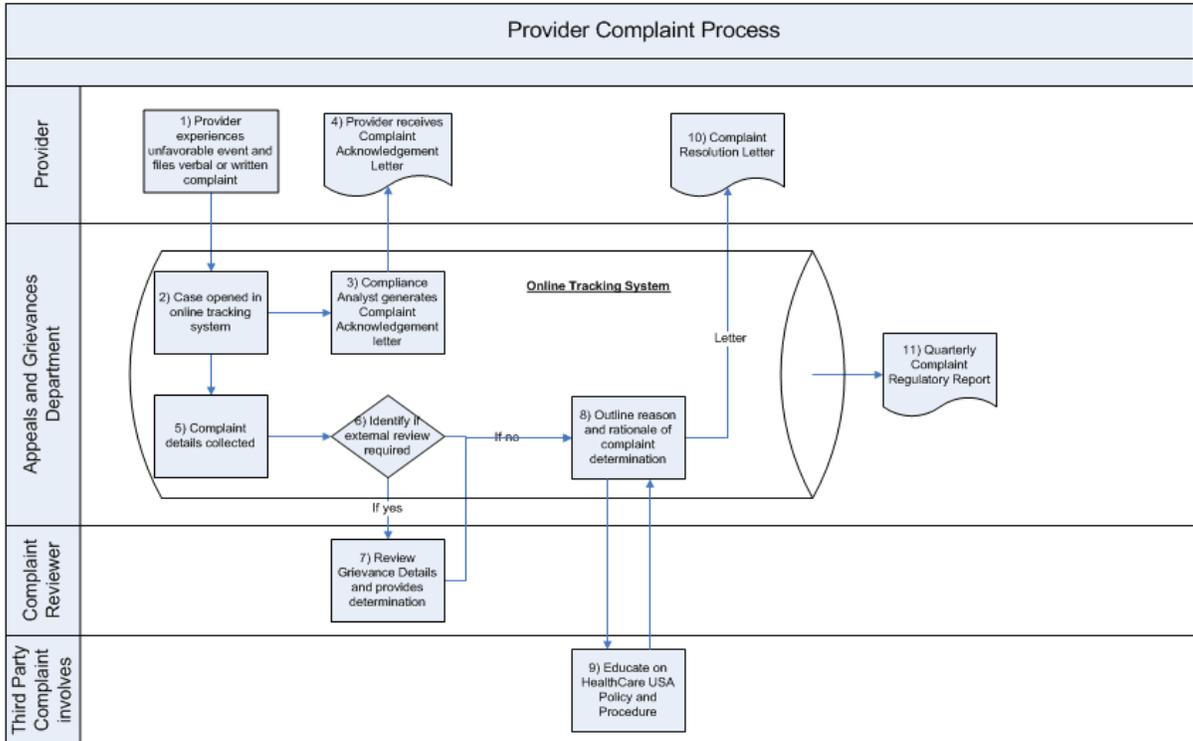
- Termination, depending on the severity level; and subsequent re-contracting to replace provider coverage in that area
- Provider-specific attention and focused monitoring
- Broad-based provider retraining for entire provider type, region, etc. (via Webinars, 24/7 online training and Website updates; other communication channels)
- Plan-wide or system-wide improvement (policy/benefit change; procedural change, etc.), results of which are disseminated to providers and members through routine communication channels
- Member enhanced education (town hall meetings, MAC, other communication channels including Website updates, newsletter, etc.; plus enhanced education via our community partners).



Figure 4.5- 18 through Figure 4.5- 22 show the provider complaint, member grievance, member appeal and provider appeal:

Provider Complaint

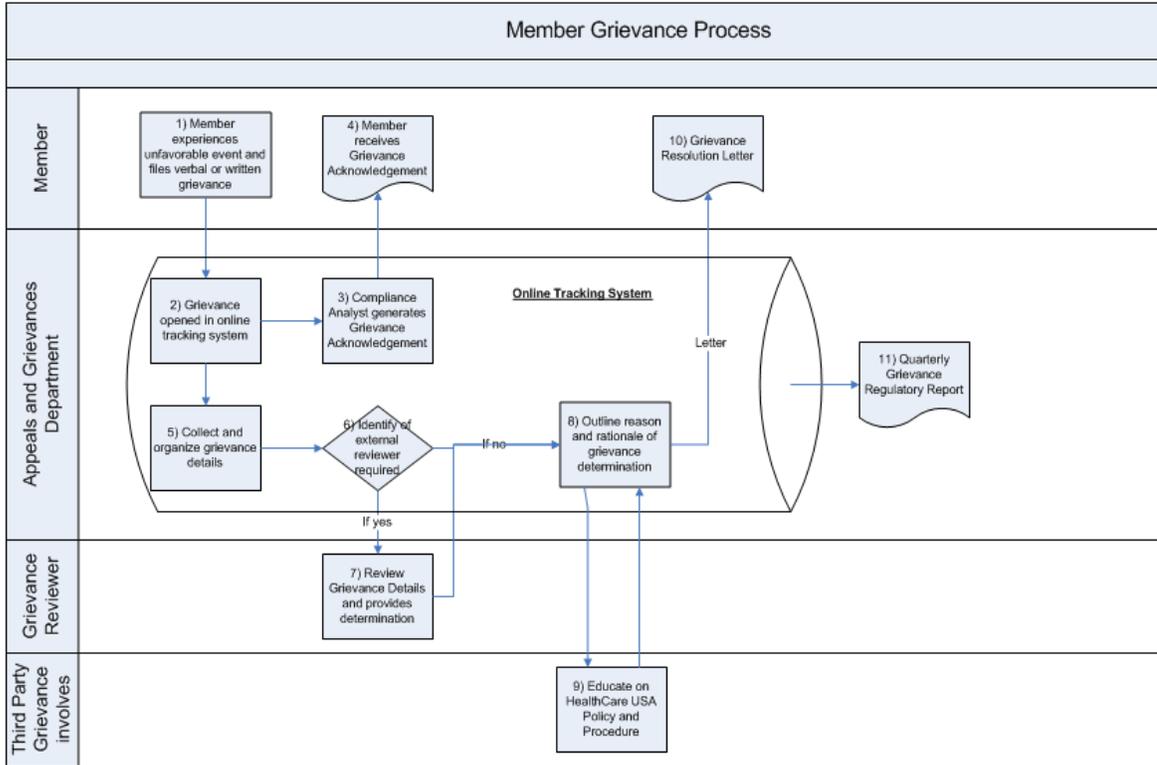
Figure 4.5- 18: HealthCare USA Provider Complaint Process





Member Grievance

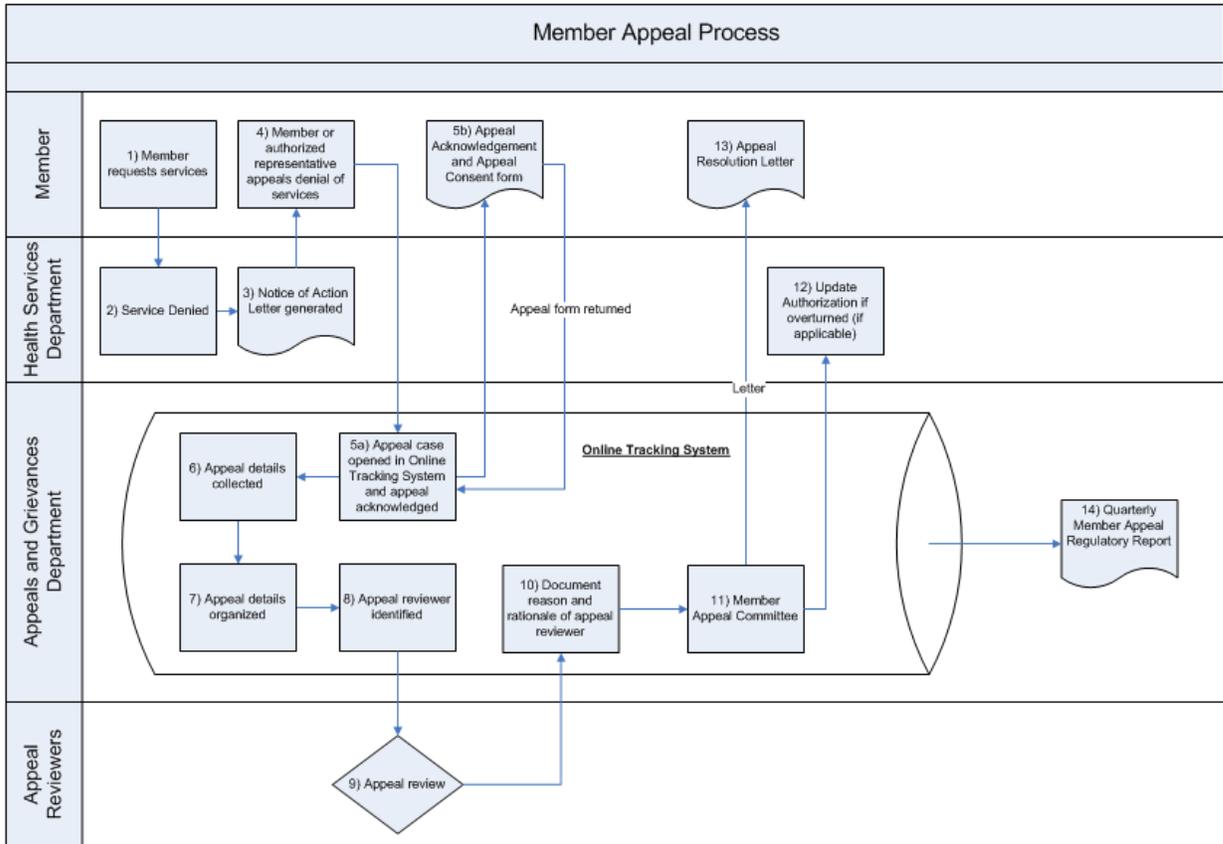
Figure 4.5- 19: HealthCare USA Member Grievance Process





Member Appeals (Medical, Administrative, or Expedited)

Figure 4.5- 20: HealthCare USA Member Appeals Process

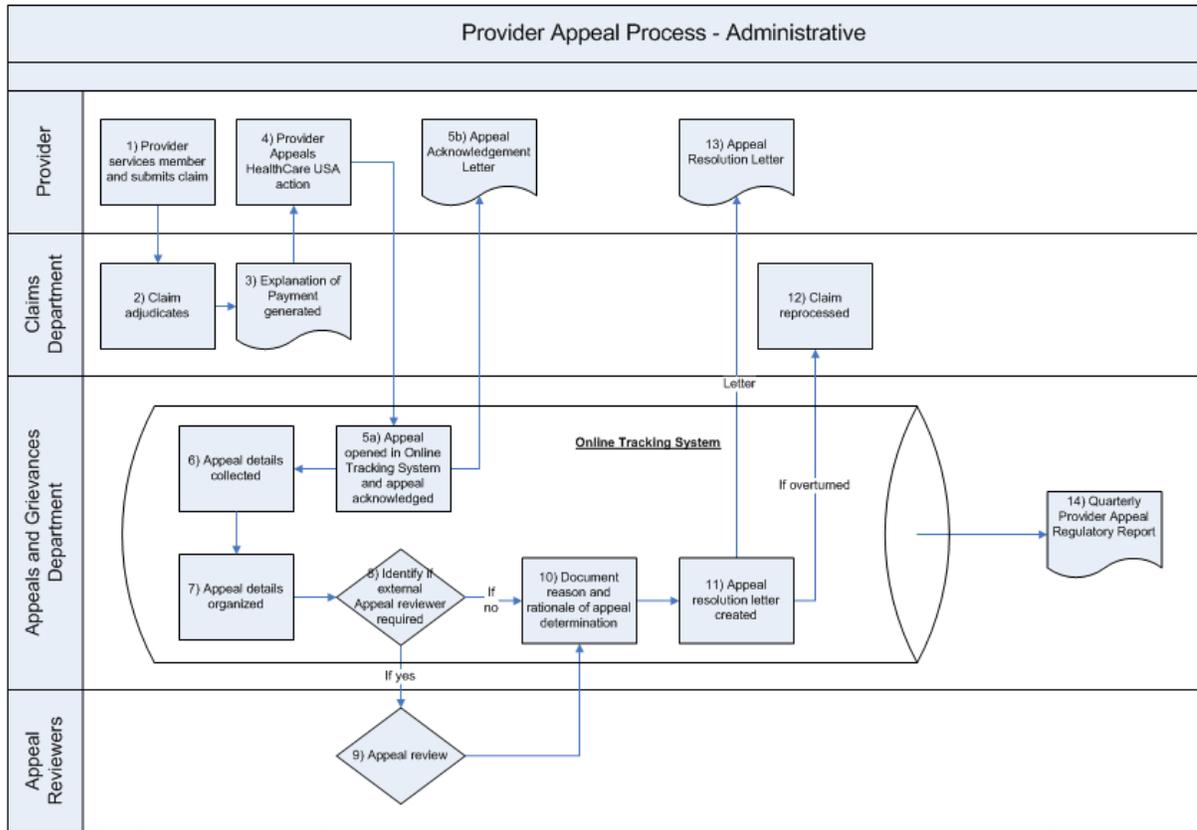


(Note: Member Expedited Appeals follow the same process as Medical Appeals)



Provider Appeals Process - Administrative

Figure 4.5- 22: HealthCare USA Provider Appeal Process—Administrative



Denials

HealthCare USA's utilization management program ensures that both inpatient and outpatient resources are used efficiently and cost-effectively. Medical management decisions are based on sound medical evidence reviewed at least annually and updated as new criteria are released or new CMS and State determinations are provided.

To assist in making determinations, HealthCare USA uses McKesson's InterQual® criteria, the same evidence-based clinical decision support criteria used by thousands of health care professionals in hospitals, health plans and government agencies.

HealthCare USA Medical Directors are available to work with individual members and providers to review their cases and make final determinations. Same or similar provider practice expertise is available to the Medical Directors for review of situations involving specialists through contracts with a physician review organization. Adverse medical necessity determinations are only made by a HealthCare USA Medical Director. Four key attributes of the healthcare USA decision-making process are:

- Consistency



- Objectivity
- Evidence-based decisions
- Unbiased cost considerations

HealthCare USA manages care processes and resources using standardized criteria that foster the practice of evidence-based medicine and patient safety, while avoiding medically unnecessary care to protect MO HealthNet's program dollars.

4.5.2b6. Provide a listing, description, and conditions under which the offeror will offer additional health benefits to its members. Examples of such additional health benefits are non-emergency transportation (NEMT) for those members who do not have NEMT as part of their benefit package; or sponsorship in youth programs such as Boy Scouts or YMCA. This is not an exhaustive list of such services but only provides examples of the types of services that may qualify as an additional health benefit. (2.7.11)

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(b)6.

For further details on Section 4.5.3(b)6, see Section 2.7.10.

4.5.2c Provider Services

The offeror shall:

1. Describe the offeror's proposed process for evaluating the effectiveness of communication strategies (provider materials, newsletters, bulletins, website, education sessions, etc) and maintaining and updating the accuracy of information. At a minimum, the offeror's response shall include how the offeror will address specific program areas including EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.
-

Ultimately, effectiveness of communications strategies is measured through increased quantitative healthcare outcome metrics.

This answer applies to all regions.

HealthCare USA's process for evaluating the effectiveness of communication strategies relies on HEDIS score comparisons from previous years. We also employ other quantitative measures, such as:

- Participation rates
- Decreased complaints and grievances
- CAHPS results
- Case Management (CM) and Disease Management (DM) program metrics other than HEDIS



as well as claims data that indicates increased appropriate use of medically-necessary services across all targeted populations.

Related to communications accuracy, we maintain and update information as routine responsibilities of relevant departments (e.g., ensuring the website is up-to-date). This includes provider input to ensure the messaging we want to get across is doing its job prior to mass dissemination via our three regional Provider Advisory Councils. Satisfaction survey results and trending of complaints and grievances also help us monitor communications effectiveness through end-result outcomes.

Communication Strategies for Specific Programs

For specific programs, HealthCare USA has developed carefully crafted strategies and communication plans with evaluation methods, goals and timeframes to ensure the effectiveness of our communications.

The following addresses the specific program areas of EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

EPSDT

Provider Communication Strategies

- **HEDIS/EPSDT work group:** A multidisciplinary, multi-regional group meets monthly to increase EPSDT participation ratios to 80% or higher for all three regions. The group develops a work plan for improvement of all EPSDT and HEDIS measures and continues to review and update the plan at its meetings. The group modifies activities on the work plan as is appropriate for each of the three regions. Educational and communication strategies aimed at providers are included in the work plan.
- **Provider monthly mailings:** A form is mailed to PCP offices informing them of members assigned to their office who have recently missed an EPSDT screening time period. The form includes the member's home telephone to assist the provider's office in following-up with the member's parents to arrange an appointment.
- **Provider education activities:** Originally initiated in 2001, our EPSDT-focused education and orientation training program continues as a valuable tool. Educational visits concentrating on all aspects of EPSDT are covered in every face to face contact with providers by the local field Provider Relations representative.
- **Vaccines for Children Program:** All appropriate providers are informed of the program by their PR representative and assisted with registering for the Vaccines for Children's Program.
- **Provider Newsletters:** EPSDT related articles are included in the bi-monthly provider newsletters on a regular and ongoing basis.



- **Provider Web Portal:** www.directprovider.com includes reports on the status of member's compliance with a variety of HEDIS measures including well child visits, immunization, lead screening and annual dental visits. These reports are scheduled for an update in 2012 with the goal of specifically offering more data choices to Medicaid providers.

Evaluation of Effectiveness

We use EPSDT participation ratios of eligible members receiving initial and periodic screenings; and HEDIS scores for adolescent well care visits and for well child visits in the first 15 months of life. These three measures are closely related to EPSDT/HCY.

Lead

Provider Communication Strategies

Communication strategies for lead include focused emphasis of articles in the Provider Newsletters, education seminars and review and oversight by the Physician Advisory Committee and Practice Management Committee.

The HealthCare USA website includes reports on the status of member's compliance with a variety of HEDIS measures including well child visits, immunization, lead screening and annual dental visits.

Provider Relations field representatives provide copies of the state-mandated HCY Lead Risk Assessment Guide and educate providers on how to request materials on lead from the Missouri Department of Health and Senior Services.

Evaluation of Effectiveness

Lead communications materials are deemed successful through specific measures with Provider communication/collaboration with HealthCare USA's lead case manager and PCP visits to ensure proper lead testing follow-up.

Provider Seminar Evaluations are collected by Provider Relations and analysis is done to evaluate the effectiveness of the seminar and information provided.

Ongoing monitoring of use of the provider portal, including analysis and trending of questions received from providers in the secure message portal.

Children with Special Care Needs

Provider Communication Strategies

Communication strategies for children with special care needs include dedicated information within the Provider Manual, focused emphasis of articles in the Provider Newsletters, fax blasts, education seminars and review and oversight by the Physician Advisory Committee and Practice Management Committee.



Evaluation of Effectiveness

Special health care needs communications materials are deemed successful if they:

- Increase special needs referrals from the state agency (measured by referral rates)
- Decrease avoidable utilization of inpatient and outpatient services by these members, measured by claims data
- Increase utilization of preventative services (measured by claims data indicating use rates for preventive services)

Asthma

Provider Communication Strategies

Communication strategies for asthma programs include dedicated information within the Provider Manual, focused emphasis of articles in the Provider Newsletters, fax blasts, education seminars and review and oversight by the Physician Advisory Committee and Practice Management Committee.

We also provide financial incentives to providers for performing asthma education visits and provide financial incentives to member who:

- Attend PCP visits
- Fill their prescribed asthma medications
- Identify a rescue person

Evaluation of Effectiveness

Communication effectiveness is measured through provider participation (currently approximately 42%) and member information. Additional criteria for measurement of program success includes:

- Decrease ED and inpatient utilization costs
- Members benefit by decreasing avoidable ED and avoidable inpatient stays for asthma related diagnosis
- Increase outpatient pharmacy use of control medications
- Increase PCP and asthma education visits
- Increase usage of member incentive
- Increase usage of provider incentive
- Demonstrate completion of pre and post tests for educational modules in the member record for those members involved in the provider centric program
- Increase satisfaction scores on provider surveys
- Increase HEDIS rates



Pre-Natal Care

Provider Communication Strategies

Communication strategies for prenatal care programs include dedicated information within the Provider Manual, focused emphasis of articles in the Provider Newsletters, fax blasts, education seminars and review and oversight by the Physician Advisory Committee and Practice Management Committee.

Evaluation of Effectiveness

Pre-natal communications materials are deemed successful if they:

- Decrease OB triage and inpatient utilization, based on claims data.
- Increase OB/GYN visits, also based on claims data and provider encounter data
- Increase usage of member incentive
- Increase HEDIS rates

Dental Visits

Provider Communication Strategies

Provider Seminars communicate information on benefit coverage, importance of member education and HealthCare USA's HEDIS dental metrics for each region. HealthCare USA's dental subcontractor, DentaQuest, provides staff to participate and lead the dental section of the seminar.

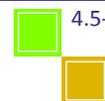
They educate providers about the member's dental benefits and network availability to assure they know how to refer members for dental services. Providers are advised to use HealthCare USA's provider portal in anticipation of a member's visit to assess gaps in care including an annual dental visit.

Community Development staff coordinates a process with participating FQHCs/dental providers to improve annual dental visit compliance.

DentaQuest's local provider relations representative can provide one on one assistance and valuable feedback regarding questions or concerns that may arise. Finally, the Provider Web Portal (PWP) includes a secure messaging system where providers may submit feedback directly to DentaQuest. The PWP also maintains all documents for easy provider reference.

Evaluation of Effectiveness

HealthCare USA uses HEDIS rates to measure effectiveness of provider outreach. Additionally, Provider Seminar Evaluations are collected by Provider Relations and analysis is done to evaluate the effectiveness of the seminar and information provided. Ongoing monitoring of use of the provider portal and DentaQuest's Provider Web Portal (PWP) helps us assess communication effectiveness.





HealthCare USA and DentaQuest conduct annual provider surveys to evaluate improvements that we can make to our provider communications and other systems. These surveys are reviewed by our respective Quality Improvement committees and action plans are developed in accordance with the results of the surveys. Results of surveys and improvement action plans are shared with HealthCare USA's Quality Management Committee.

Behavioral Health

Provider Communication Strategies

Communication strategies for behavioral health program needs include dedicated information within the Provider Manual, focused emphasis of articles in the Provider Newsletters, fax blasts, education seminars and review and oversight by the Physician Advisory Committee and Practice Management Committee.

Additionally, Web-based behavioral health information is available to Primary Care Physicians including FAQs, Clinical Practice Guidelines, and behavioral health articles. This information also includes both administrative and clinical key educational pieces as well as provider tools. Administrative information includes:

- Information on how to access MHNet services
- Program updates
- How to obtain authorizations
- Outpatient Treatment Request and Psych Testing forms
- Claim submission guidelines and forms
- Provider manual/quick reference guide
- Provider newsletters

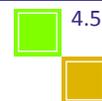
Online clinical educational material includes Clinical Practice Guidelines, behavioral health articles/library, news from the MHNet Medical Director (i.e. Use of Atypical Antipsychotics), and patient safety information.

MHNet also coordinates closely with us and attends on-site provider seminars. These on-site services present strong opportunities for feedback on MHNet operations. Targeted provider office visits provide education on our policy and procedures, contracting related discussions and direction related to the submission of claims and written treatment authorization requests.

Evaluation of Effectiveness

Behavioral health communications materials are deemed successful if they:

- Decrease member ED and inpatient utilization, measured by claims data
- Increase psychiatry/psychology provider visits, measured with claims and encounter data





- Increase outpatient pharmacy utilization, measured with claims data.

Reduction of Inappropriate Utilization of Emergent Services

Provider Communication Strategies

Communication strategies for emergent services include dedicated information within the Provider Manual, focused emphasis of articles in the Provider Newsletters, fax blasts, education seminars, review and oversight by the Physician Advisory Committee and Practice Management Committee, and educational onsite visits by Provider Relations staff to providers that have a high number of members that inappropriately utilize the ED.

Emergency Department Utilization workgroups, a multidisciplinary/multiregional team, meets quarterly to determine reduction strategies of inappropriate utilization of emergent services. The team reviews reports and current interventions for effectiveness including educational and communication strategies aimed at providers.

Evaluation of Effectiveness

Various reporting strategies measure effectiveness, within the provider ED area. These reports include:

- HealthCare USA ED Visits/1000 Members
- Emergency Department Usage-Most Frequent Diagnoses
- Emergency Department Usage-Frequent Flyer Average Count of Visits/Claims

From November 2010 through June 2011, the average visit per member data indicates a downward trend in all three regions. We also review trends for the most common diagnosis groups that present to the ED for non-emergent reasons.

Reduction of Racial and Ethnic Health Care Disparities to Improve Health Status

Provider Communication Strategies

Communication strategies for racial and ethnic health care disparities include dedicated information within the Provider Manual, focused emphasis of articles in the Provider Newsletters, fax blasts, education seminars, review and oversight by the Physician Advisory Committee and Practice Management Committee, and educational onsite visits by Provider Relations staff to providers.

Evaluation of Effectiveness

Improved health status communications materials are deemed successful if they:

- Result in quantitative reduction in the racial gap, measured by HEDIS scores
- Report increased usage of the language line, measured by line statistics provided to us



- Report increased number of on-site interpretation services for office visits, measured by interpretative services reports.
- Are not reflected or reflection is reduced related to member grievances regarding any racial or ethnic disparities.

4.5.2c2 Describe the offeror's proposed ongoing training and education activities for providers, including frequency and type. At a minimum, the offeror's response shall include how it will address specific program areas including EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

Frequent messaging in multiple ways ensures we reach all providers and their varying information-mapping and retention preferences to improve access and quality.

This answer applies to all regions.

The HealthCare USA Provider Services Department, physically located in all three regions, executes ongoing training and education to suit regional needs. Multiple communication mediums are employed in support of the MO HealthNet program. Ranging from newsletters, website, fact sheets, provider manual, provider committees and seminars to the ongoing presence of PR Representatives, HealthCare USA recognizes the importance of ongoing training and communication with the providers and their staff.

Our provider communication and education plan includes:

- Outreach and visits to provider offices by local provider relations representatives
- Development, distribution and review of a comprehensive Provider Manual
- Quick reference guides
- Newsletters
- Online education via the provider Internet portal
- Provider educational materials
- Annual regional provider seminar/town hall meetings
- Provider webinars to reach those offices with limited staffing

Training and Education Activities

Figure 4.5- 23 summarizes our routine communications by type and frequency.



Figure 4.5- 23: HealthCare USA’s Ongoing Routine Provider Communications Through Multiple Channels Ensures Messages Are Retained to Improve Access, Quality

Type	Frequency
New Provider Orientation, including provider manual	1/provider within 30 days of joining; held ongoing Annual provider manual updates or more as necessary
Face-to-face visits	a minimum of 4 visits with PCP providers per year
On-site Provider seminars	At least annually per region
Webinars and 24/7 online training	24/7 availability via provider portal; Webinars are at least 1/quarter; in 2011, nearly 3/quarter
Newsletters	Every other month
Web portal	24/7; can verify member eligibility, check claims history, submit claims and authorizations with attachments, check on the status of claims and authorizations and access to all provider documents. This web portal also provides access to all provider materials

Specific program education activity

The communication and education materials include information regarding the program areas of EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status. Specific program areas of the MO HealthNet program are addressed in directed communication and training efforts. Figure 4.5- 24 identifies the education sources and the targeted special program for provider communications.

Figure 4.5- 24: MO HealthNet Special Program provider communications.

Education Source	Frequency	Specific MO HealthNet Programs								
		EPSD T	Lead	Special Needs Children	Asthma	Pre-Natal	Dental	Behavioral Health	ED Utilization	Health Care Disparities
Provider Manual	Online On Demand	X	X	X	X	X	X	X		X
New Provider Orientation	Initial within 30 days	X			X	X	X	X	X	X
Newsletter	Monthly Ad hoc	X	X	X	X	X	X	X	X	
Onsite	Quarterl	X	X	X	X	X	X	X	X	X



		Specific MO HealthNet Programs								
Education Source	Frequency	EPSDT	Lead	Special Needs Children	Asthma	Pre-Natal	Dental	Behavioral Health	ED Utilization	Health Care Disparities
Education	As needed									
Web Portal	Online	X	X	X	X	X	X	X	X	X
1:1 Meetings	As needed	X	X	X	X	X	X	X	X	X
Provider Relations Staff	As needed	X	X	X	X	X	X	X	X	X
Medical Management	As needed	X	X	X	X	X	X	X	X	X
HEDIS Reports	As needed	X	X	X	X	X	X	X	X	X

A number of special programs will receive directed communication efforts to heighten their awareness, improve provider and member knowledge, and ensure effective program operations.

HealthCare USA has a tradition of providing participant outreach services and information in a culturally diverse manner. We ensure that members and providers, regardless of language preference or any sensory challenges, fully understand the services of the MO HealthNet program. HealthCare USA will ensure that all member and provider educational materials are easy to read and culturally sensitive and state approved, if applicable

4.5.2.c3 Describe the activities proposed to monitor and track compliance with provider toll-free telephone line performance standards as described herein. (2.16.2)

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.2(c)3.

For further detail of Section 4.5.2(c).3, refer to Section 2.16.2.

4.5.2d. Member Services

The offeror shall:

1. Describe how the offeror proposes to update members as information in the member handbook changes. The description shall address, at a minimum, the offeror's strategies to ensure that members are informed of changes in a timely manner. The response shall also include how the offeror will address specific program areas including EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services,



behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

HealthCare USA understands and will comply with the requirements in Section 4.5.2(d)1.

Multiple messaging through 16 channels including current ones such as mass-texting programs ensure our members know what is available to increase access and healthcare quality.

HealthCare USA announces changes to the member handbook through a number of communication means. The quarterly member newsletter serves as the primary method to notify members when changes are made to the Member Handbook as the newsletter is mailed directly to each member. However, HealthCare USA assures meeting the regulatory requirement of notification of any significant change within 30 days of the change by written notification to members. Additionally, the newsletter and the updated member handbook are posted on the HealthCare USA website along with a summary of changes appearing in the *What's New* section of the HealthCare USA website.

We are also investigating the use of new technologies such as:

- *Alert Now!* a mass- texting program used by local public schools to inform parents of important information and events, the use of
- Social media outlets (Facebook, Twitter, Google Chrome)
- Coventry Mobile App “Coventry Health Care”

Our communication methods employ any one or a combination several of these tools to reach all our membership:

- Altering “on hold” messaging for our Member Services hotline
- Member Services representatives reviewing recent changes with members upon receipt of a call from a member
- Case/disease management staff outreach
- “Feet on the street”/face-to-face campaigns such as wellness events and health fairs with our community partners
- Focus group meetings with members arranged through community partner Triads of Care
- Member Advisory Council (MAC) meetings
- Community Partner Advisory Council (CPAC) meetings
- Doc Bear Lunch and Learn orientation meetings
- Member Newsletters and the HealthCare USA website
- County Agency meetings
- Meetings with members participating in our after school programs





Boys and Girls Clubs Boy Scouts
 Girl Scouts 4-H
 Discovering Option Girls, Inc.
 LINC

- Educating our providers
- Utilizing our subcontractors

Specific Program

Our communication and education materials include information on MO HealthNet program areas such as:

- EPSDT
- Behavioral health
- Prenatal care
- Children with special health care needs
- Reduction of racial and ethnic health care disparities to improve health status
- Lead
- Asthma,
- Dental services
- Reduction of inappropriate utilization of emergent services

Specific program areas of the MO HealthNet program are addressed in directed communication and training efforts. Figure 4.5- 25 identifies the education sources and the targeted special program for member communications.

Figure 4.5- 25: MO HealthNet Special Program member communications.

Education Source	Frequency	Specific MO HealthNet Programs								
		EPSD T	Lead	Special Needs Childre n	Asthm a	Pre-Nata l	Denta l	Behavior al Health	ED Utilizatio n	Health Care Disparitie s
Member Manual	Online On Demand	X	X	X	X	X	X	X		X
HealthCare USA website	Online	X	X	X	X	X	X	X	X	X
Newsletter	Monthly Ad hoc	X	X	X	X	X	X	X	X	



Education Source	Frequency	Specific MO HealthNet Programs								
		EPSDT	Lead	Special Needs Children	Asthma	Pre-Natal	Dental	Behavioral Health	ED Utilization	Health Care Disparities
Member Services Call Center	As needed	X	X	X	X	X	X	X	X	X
Member Meetings (MAC, CPAC, County)	Monthly As needed	X	X	X	X	X	X	X	X	X
Feet on the Street campaigns	As needed	X	X	X	X	X	X	X	X	X
Provider Relations Staff	As needed	X	X	X	X	X	X	X	X	X
Subcontract or Training	As needed	X	X	X	X	X	X	X	X	X

A number of special programs will receive directed communication efforts to heighten their awareness, improve provider and member knowledge, and ensure effective program operations.

4.5.2d2. Describe the offeror’s proposed process for evaluating the effectiveness of communication strategies (member materials, newsletters, bulletins, website, education sessions, member handbook, etc) and maintaining and updating the accuracy of information. At a minimum, the offeror’s response shall include how it will address specific program areas including EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

HealthCare USA understands and will comply with the requirements in Section 4.5.2(d)2.

Ultimately, we measure communications effectiveness from improved HEDIS and other improved healthcare outcome scores.

Our process for evaluating the effectiveness of our member communication is based on quantitative measures that prove changes to member behavior positively improve healthcare outcomes. We ensure member communications are accurate through ongoing internal clinical and other reviews and updates as information changes.

We build in effectiveness and accuracy through focus group reviews of the material (interdepartmental and member groups) and MO HealthNet revisions and approval of materials prior to dissemination. This includes addressing cultural competency



regardless of language preference or any sensory challenges. On the back end, trending of member complaints and appeals, for example, helps us evaluate communication effectiveness.

Related to program-specific communications, HealthCare USA, in collaboration with our subcontractors, supplies our members with specific education on the special programs of MO HealthNet through directed communication and training efforts. The communication and education materials include the program areas of EPSDT, lead, children with special health care needs, asthma, pre-natal care, dental services, behavioral health, reduction of inappropriate utilization of emergent services, and reduction of racial and ethnic health care disparities to improve health status.

HealthCare USA's Community Development Team evaluates the effectiveness of each communication strategy via:

- **Direct Member Survey** at MAC meetings, Doc Bear Lunch and Learns, Doc Bear Town Hall meetings and After School Programs
- **Website utilization tracking** of the members who access the website and tracking of the number of Coventry Mobile Apps that are downloaded
- **Avenues of how we've reached them;** such as tracking prenatal members who sign up for Text for Baby and those who receive pre- and post-natal care by our health services
- **Feedback from community partners,** often the frontlines for our members, on what is working and what's not.

We also use HEDIS and CAHPS scores, as well as results of our Case Management (CM) and Disease Management (DM) programs addressing the above issues, to evaluate effectiveness. Finally, how effective we are with our provider communication strategies for the same programs influences member effectiveness. Please see our response to *Section 4.5.2(c)* for information.

4.5.2d3. Describe the offeror's proposed activities to monitor and track compliance with toll-free telephone line performance standards as described herein.

HealthCare USA understands and will comply with the requirements in Section 4.5.2(d)3.

HealthCare USA's monitoring and tracking system via Symposium has facilitated our ability to meet MO HealthNet performance standards.

Daily, weekly and monthly, HealthCare USA monitors compliance to performance metrics for member inquiries. We adhere not only to the performance measures set by the state, but to our own internal goals. Performance tracking metrics are in place for all member service telephone lines. Using Symposium, our call tracking system, HealthCare USA captures and reports a number of call servicing metrics, including the MO HealthNet program requirements of average speed to answer, abandonment rate, average hold times and call blockage rate.



These methods have enabled us to meet most performance standards, as indicated in Figure 4.5- 26.

Figure 4.5- 26: 2011 YTD Customer Service Performance Summary report.

Performance Measure	MO HealthNet Standard	HealthCare USA 2011 Results*
% Calls Answered in 30 Seconds	90%	92%
Average Hold Time	<120 seconds	9 seconds
Blocked Call Rate	0%	0%
Abandonment Rate	<5%	1.0%

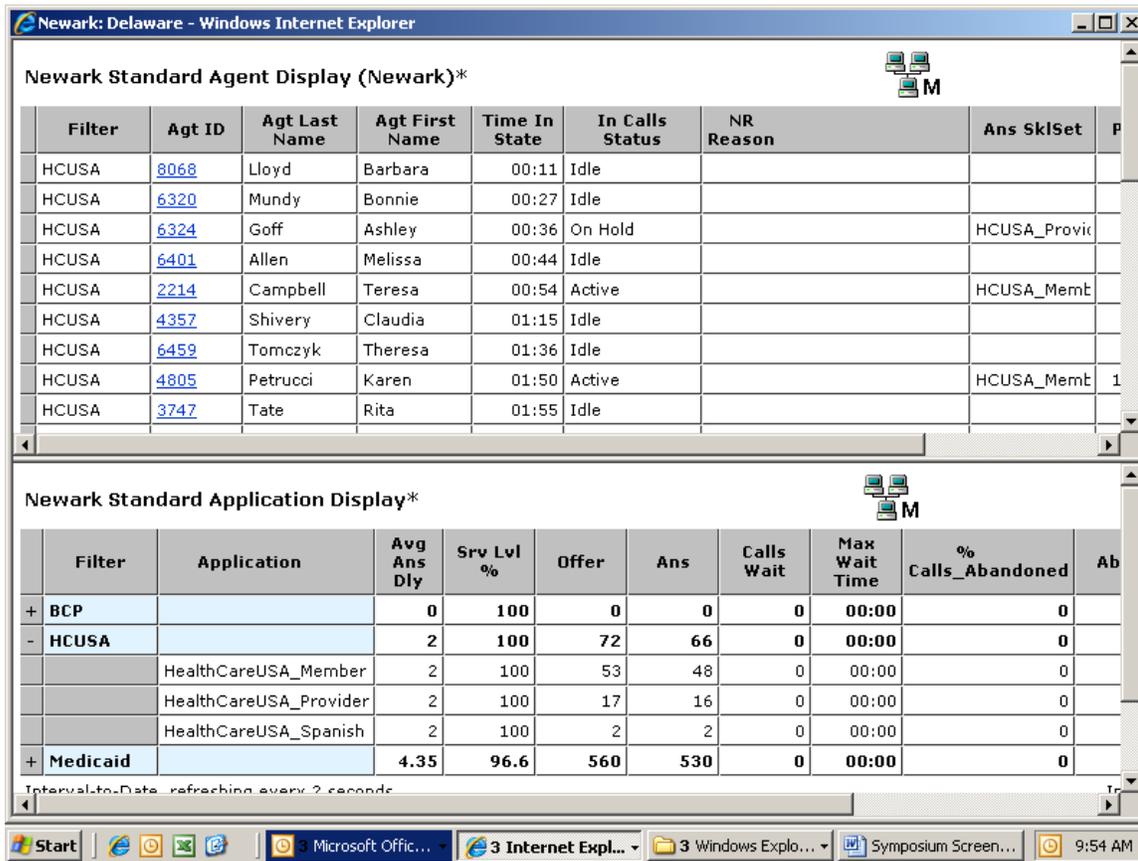
HealthCare USA has demonstrated the ability to meet performance requirements for the MO HealthNet program.

Monitoring

Our dedicated Member Services supervisors monitor the performance results to ensure all standards are in line with program requirements. The supervisor or team lead, is able to allocate resources depending on call volumes, service levels and hold times. Symposium provides extensive details for all call activity, call queues, talk times and metrics for performance service levels. Symposium reports are also employed to scrutinize average talk time, schedule availability, average hold time and after call work. The findings are used as both educational and to assess call types received throughout the day. The management team reviews the reports generated from Symposium, as shown in Figure 4.5- 27, to analyze staffing, call activity and identify opportunities for resource balancing.



Figure 4.5- 27: Symposium Call Monitoring screen.



Symposium provides HealthCare USA with an immediate view of all activity in the call center to balance staff and ensure service levels are maintained for all callers.

Daily team collaboration meetings ensure appropriate staffing to support daily business needs. Supervisors also align their team to ensure the appropriate staff is available to attain performance measures,, taking into account

- Breaks
- Meal breaks
- Vacations
- Absenteeism
- Historical trending data

to staff appropriately to meet performance standards (higher call volume times during a day, month, or season).

During telephone interactions, supervisors can monitor both a staff person’s call content and computer screen simultaneously for quality monitoring of call content, information accessed in the system during the call and the documentation entered about the call.



This creates a complete view of the member's call experience. Through use of this system, call center supervisors identify opportunities for staff to improve their technique and provide recognition of well-handled calls.

HealthCare USA also relies on historical data to gauge call volumes based on weekly, monthly and yearly results. Depending on the analysis, additional resources are proactively added to support the member service team.

Tracking

Symposium, the HealthCare USA call tracking system, is configured to ensure optimum performance and uptime of all telephone systems and services supporting the MO HealthNet call center. Symposium provides real-time and historical reporting for the call center, including program metrics for:

- ASA
- Abandonment
- Hold times
- Blocked calls

During monthly reviews we also monitor telephone statistics of our program subcontractors through a formal subcontractor/affiliate oversight process. This is particularly important for our 24-hour-a-day, 7 day-a-week nurse line subcontractor, McKesson.

Any issues noted with the performance standards are discussed. Actions are then assigned, and issues are followed until resolved. If subcontractors are not meeting the required compliance standards, HealthCare USA implements a Corrective Action Plan (CAP) and requires vendors to actively submit reports more frequently until program statistics can meet the MO HealthNet standards.

4.5.2d4. Describe how the offeror proposes to route calls among staff to ensure timely and accurate response to member inquiries, including procedures for referring the calls to supervisors and/or managers.

HealthCare USA understands and will comply with the requirements in Section 4.5.2(d)4.

HealthCare USA resolves nearly all calls during the initial call, making member services highly responsive and helpful to our stakeholders, just as it should be.

We route calls among staff to ensure timely and accurate responses via our Symposium system, which has enabled us to help maintain 94.7% resolution during the initial call over nearly 30,000 inquiries monthly (2010 statistics).

Specifically, from 8:00 a.m. to 5:00 p.m. CT, the HealthCare USA call center handles inbound calls from members to answer questions and provide information about the program. Incoming calls from participants are routed using Symposium, which also documents relevant call statistics.



Experienced and trained on the wide range of common member program service topics, our representatives assist the majority of members with their questions without transferring calls to another area.

Telephone Transfers

When a member needs further assistance or a transfer within HealthCare USA, our member services specialists perform a “warm transfer”, staying on line until all of the member’s questions are answered. In this process, the department or functional area is conferenced into the telephone conversation, allows a member with multiple questions to make only one call to HealthCare USA and receive “one-stop support” for call resolution.

When callers are connected to a Member Services Specialist and need to speak with a different department (such as case management or escalation of a specific matter) the Member Services department provides the member with the appropriate telephone number (in case of disconnection) and then warm-transfers the call to ensure the member is connected and receives the assistance needed.

When a member requests to speak to a supervisor, the Member Services specialist documents the issue in Navigator, our member contact and call documentation system, providing as much detail as possible to the supervisor, and then warm-transfers the member to the on-call supervisor or manager. The Member Services specialist ensures the member and supervisor or manager are both on the line before leaving the call. The supervisor or manager addresses the issue and documents the discussion and resolution in Navigator. Once resolved, the supervisor or manager reviews the documentation of the initial call and, depending on the nature and specifics of the escalated call, determines if any training or coaching is required to prevent future escalations.

If the caller is not satisfied with the resolution, or requests to speak with a director or above the issue is handled through the Executive Inquiry Team (EIT). The appropriate department (AD) or functional area (FA) is then tasked with issue research and resolution. The EIT provides written or telephone confirmation to the caller acknowledging receipt of the escalated issue. The AD/FA confirms receipt of the issue to the EIT and contacts the caller within two hours of receipt of the escalated issue to confirm. The AD/FA then goes on to work with supporting departments to obtain full resolution of the caller’s issue.

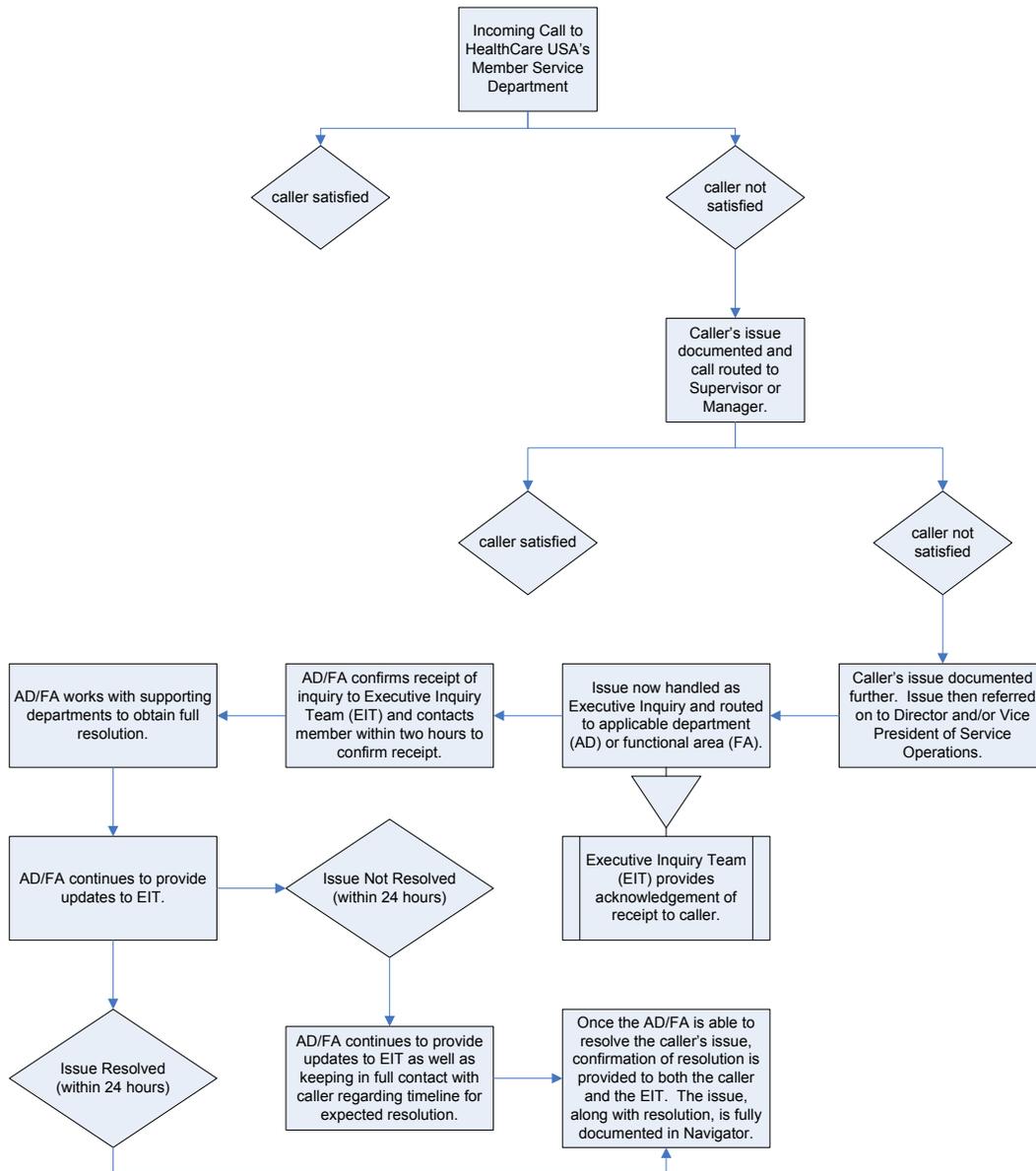
The AD/FA continues to provide updates to the EIT regarding the research and resolution of the caller’s issue.

- *If the issue can be resolved within 24 hours*, confirmation of the resolution is provided to both the caller and the EIT
- *If the issue cannot be resolved within 24 hours*, the AD/FA continues to provide updates to the EIT while keeping in full contact with the caller to provide an updated timeline on expected resolution

As shown in Figure 4.5- 28, an escalated call is tracked, reported and—once the issue has been resolved—its resolution is fully documented in Navigator.



Figure 4.5- 28: Member Services Call Resolution Process



HealthCare USA ensures prompt, effective resolution of Member Services calls with escalation available to management and EIT oversight improving satisfaction to members of the Program.

Crisis Calls

In the event a member calls the Member Services Department and indicates they are in need of immediate medical attention or they are having thoughts of harming themselves or others, the Member Services specialist immediately notifies management and informs



the member that we are getting an additional personal on the call to assist them. Depending upon the severity of the issue, the Member Services Specialist contacts a physical or behavioral health representative. The Member Services Department specialist provides the member with the appropriate telephone number and warm-transfers the call to ensure the member connects to and receives the assistance needed.

HealthCare USA may then contact local emergency services to further assist the member. These escalated crisis calls are recorded and Member Services specialists document the incident. An electronic follow-up notification is then tasked to HealthCare USA's Outreach Department for follow-up with MO HealthNet. Follow-up tasks are tracked until closure, with the goal to resolve all issues within 48 hours.

All calls are documented in Navigator, making it possible for any Member Services specialist to assist a member with an existing issue and avoid a future callback.

Timely Response

When a call enters the system, the member is prompted to request assistance in Spanish, English, other language or TTY support.

To supplement their language skills, our telephone center staff uses Language Line Services for instant access to qualified interpreter services, so they can interact with participants who are not proficient in English. After the member makes a selection from the telephone menu, Symposium identifies the first-available Member Services specialist and routes the member call to that staff member. Symposium is configured with critical reliability architecture to ensure optimum performance and uptime of all telephony systems and services needed to support our 24-hour-a-day, 7-day-a-week call center.

Calls received after business hours will provide members with information on what to do in case of an emergency, provide the MFCU fraud and abuse hotline number, and give the option to route the calls immediately to talk directly with a nurse or behavioral health crisis worker. The 24-hour-a-day, 7-day-a-week Nurse Advice Line provides access to a registered nurse for after-hours health questions, advice and triage. The behavioral health crisis worker, a Qualified Behavioral Healthcare Professional (QBHP), is available 24 hours a day, 7 days a week. *Voicemail messages are not taken for these services* — a live professional is always available.

Additionally, the system provides the member with instructions on leaving a message for Member Services and advises that the message will be returned by the close of business the following business day. Symposium provides adequate voicemail storage capability to accommodate the volume of after-hours messages received.

Accurate Response

Member Services staff are specifically trained on program needs, and tested and audited on comprehensive answers and assistance to all members who call. In addition to the training elements of the program, training also includes, but is not be limited to:

- Program Overview and Requirements
- Medicaid Standards and Protocols



- HIPAA
- Cultural Sensitivity
- Telephone Etiquette
- Services for those with Limited English Proficiency
- Services for those with Hearing and/or Visual Impairments
- Participant and Provider Complaints
- Fraud and Abuse
- Quality Standards and Monitoring
- Handling Crisis Calls

All calls received by the Member Services are recorded for quality assurance audit purposes. Our goal is to monitor at least 2–3 calls per customer service representative per week. We adjust the frequency of monitoring as necessary, per call volume fluctuations or individual audit results.

Quality Foundation

To establish a quality foundation, our new hires meet weekly with our quality staff to listen to calls, review program guidelines and receive coaching. This takes place for at least one month or until quality scores are above 95% for new hires. Employees are required to meet or exceed normal call quality standards after 60 days on the team. Following these quality sessions, customer service specialists meet with Quality Auditors (QAs). Monthly, QAs review scores and receive coaching. They are responsible for providing immediate feedback, fostering self-correcting techniques and promoting continuous improvement.

Quality

To ensure accuracy, compliance and member satisfaction, HealthCare USA maintains call quality success measures through accurate and consistent data and trend analysis. The team captures and communicates call trends for specific areas of improvement or outstanding behaviors, consistent with the MO HealthNet program objectives. As indicated above in the previous response, all call center staff can be monitored during a telephone call.

The time call center managers dedicate to providing constructive feedback to individual member service specialists is crucial to the success of the call quality process. The telephone Quality Development Team delivers consistent call monitoring with coaching and frequent feedback to the member service specialists, effectively improving behaviors. The Verint system records 100% percent of voice interaction between the Member Services specialist and the caller, along with a 30 %t capture of the corresponding computer desktop activity. The system then synchronizes voice and data capture during replay, allowing our leadership to observe and analyze complete customer interactions as they actually occurred. Verint stores corresponding audit and screens for 365 days; to support program compliance and administrative follow-up, all audio recordings are stored for four years.



4.5.2e. Health Plan Coordination with Section 2703 Designated Health Home

HealthCare USA have been actively involved in the development of the State's Health Home Initiative with the State, Missouri Foundation for Health, the Missouri Primary Care Association, the Missouri Coalition of Community Mental Health Centers and various primary care practices. We are therefore well-positioned to immediately assist the state and the providers identified as a Health Home to ensure the success of this initiative.

The offeror shall:

1. Specify what measures, if any, the offeror proposes to put in place to meet the health home requirements described herein. The offeror's response shall include the specific tasks and timeframes for completing each task.

HealthCare USA understands and will comply with the requirements in Section 4.5.2(e)1.

HealthCare USA offers a successful history in implementing the Health Home requirements on time. Given our supplemental and coordinating role to the Health Home, we can leverage already existing and successful programs, reports, and materials to adapt for the Health Home in supporting program goals.

HealthCare USA understands our supplemental role to health homes and will support them and their members with additional data and analyses; services and interventions; education, and community resource networking. We view our role as both integrally coordinated with the Health Home in holistically supporting our members; and as wrap-around-type of service to supplement where the Health Home does not have the resources or programs in place that we do, to the extent we do, to best serve the member. At the end of this Section provides a hypothetical full-case scenario for how we envision working with the health homes, including reports we will provide for them.

Quickly, for example, HealthCare USA's corporate analytics department will provide Health Home with advanced analytics via predictive modeling—information regarding a member's future risk of hospitalization and future costs—to help the Health Home PCP proactively manage his/her HealthCare USA membership.

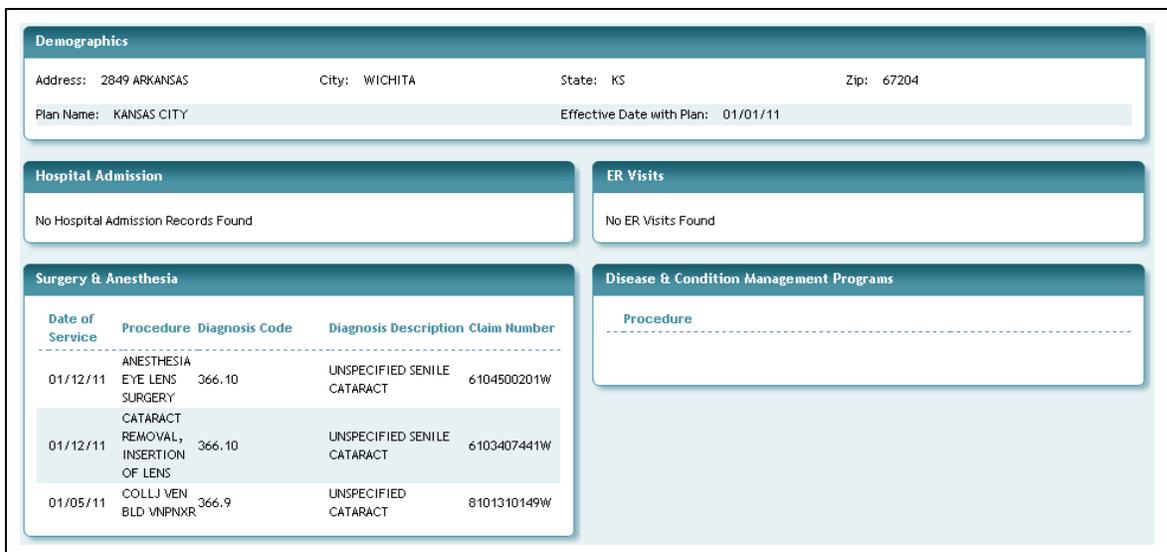
Another advanced analytical tool we will offer in supplementing and supporting the Health Home is a one-page snapshot report, our *Home Health Report and Missing Services Report* that gives Health Home providers claims-based utilization and demographic data easily to support service delivery and member relationships at the time of visit and ongoing in developing a care plan. The report comprises the following types of data (see sample in Figure 4.5- 29)

- Missing EPSDT examinations
- Missing Lead screenings
- Missing HEDIS related encounters



- Missing dental care
- Missing vision care
- Adolescent immunization rates
- Missing annual influenza/flu vaccines
- Excessive Emergency Department utilization
- Hospital readmission
- Identify members whose primary language is not English
- Identify members that have been found, through HealthCare USA concurrent review or social worker staff, to have unique case management needs based on ethnic, cultural or religious identities.

Figure 4.5- 29: Home Health Summary Report



This report, provider through the web portal, provides immediate availability to patient information, and program utilization for ED and DM services.

Reports are currently available to all HealthCare USA providers via the online provider portal to ensure our members receive all indicated medical and behavioral health care and screenings they need to achieve favorable long term outcomes. The report can be customized to best meet the needs of a specific HealthCare USA Health Home.

These are just some of the many advances tools we have to supplement the Health Home provider in meeting improved healthcare outcomes objectives of the program. Our sophisticated case management and disease management programs, community partnerships, and other activities also can be leveraged to support Health Home providers, as detailed in this response below.

Given that we are leveraging existing programs and tools for the Health Home, very little will need to be developed from scratch to meet the new requirement. Figure 4.5- 30 indicates the revisions or additions we will make to existing processes, systems,



programs, and materials to support Health Home requirements. Our timeline for implementation follows.

Figure 4.5- 30: HealthCare USA Will Leverage Existing, Proven Processes To Support The New Initiative

Comprehensive care management	Encourage Health Home to become part of our network to streamline care coordination activities/member/avoid duplication of services Hire additional case managers to meet additional demands in providing supplemental/wrap-around services to the Health Home Designated Point of Contact(PoC) per Health Home to coordinate our services and theirs; how to supplement, not duplicate Health Home-specific education on our programs
Care coordination and health promotion	Additional data analysis to the Health Home Supplemental support for targeted initiatives such as reducing inappropriate ED use and hospital readmits (support ranging from data provision to face-to-face interventions with Health Home member) Development of one-page, member-specific Missing Services reports per Health Home and its members for health promotion
Comprehensive transitional care, including follow-up from inpatient and other settings	Develop new reports such as ambulatory sensitive report to support providers in timely (within 24 hr of patient admit) data Develop process with Health Home to coordinate follow-up care and discharge planning/actions to ensure what's needed is in place
Patient and family support	Provision of wraparound services such as transportation, in-home services (already in place in our benefits; will educate Health Home on availability of them and implement process for coordination of)
Referral to community and support services	Identify for Health Home relevant community and support services based on location and member demographics and needs

The Timeline below in Figure 4.5- 31 identifies specific tasks and timelines for Health Home integration with current HealthCare USA processes:

Figure 4.5- 31: Health Home Integration

Measure/Task	Start Date	Completion Date	Executive Leader
Education of providers regarding HealthCare USA Complex Case Management programs	current process	6/30/2015	Lisa Fillback, VP Health Services Resmi Schrieber, Director of Provider Relations



Measure/Task	Start Date	Completion Date	Executive Leader
Education of providers regarding HealthCare USA Disease Management programs	current process	6/30/2015	Lisa Fillback, VP Health Services Resmi Schrieber, Director of Provider Relations
Development of Member materials regarding the Health Home project	1/1/2012	4/30/2012	Tasha Smith, RN, Manager Health Services
Identification of Health Home providers	N/A	12/1/2011	Mo HealthNet
Identification of Health Home providers currently in HealthCare USA network	11/1/2011	12/31/2011	Resmi Schrieber, Director of Provider Relations
Start Contract negotiations with and Health Home provider not currently in HealthCare USA network	3/1/2012	6/30/2012	Resmi Schrieber, Director of Provider Relations; Gene Poisson, VP, Network Management
Hiring of new CM Staff as needed	4/1/2012	12/31/2012	Lisa Fillback, VP Health Services
Designation of a clinical HCUSA Point Person for each Health Home in network	4/1/2012	6/30/2012	Tasha Smith, RN, Manager Health Services
HealthCare USA meeting with each Health Home in network to review current CM/DM processes, member utilization history, utilization data and missing services reports	4/1/2012	Ongoing	Rob Profumo, MD, Medical Director; Lisa Fillback, VP Health Services Resmi Schrieber, Director of Provider Relations Gene Poisson, VP, Network Management Laurel Ruzas, Director of Quality
Identification of HealthCare USA members who are enrolled in a Health Home	7/1/2012	6/31/2015	Lisa Fillback, VP Health Services
Identification of current HealthCare USA members eligible for Health Home services not identified by MO HealthNet	7/1/2012	6/30/2015	Lisa Fillback, VP Health Services
Outreach and education of members who may be eligible for Health Home services but not identified by State (if	7/1/2012	6/30/2015	Lisa Fillback, VP Health Services



Measure/Task	Start Date	Completion Date	Executive Leader
allowed by MO HealthNet)			
Health Home enrollment of members who are eligible for Health Home services but not identified by State (if allowed by MO HealthNet)	7/1/2012	6/30/2015	Kathleen Whaley, VP Operations Lisa Fillback, VP Health Services

Working directly with MO HealthNet, HealthCare USA will implement the Health Home Program to support the eligible members in early 2012.

The remainder of this response addresses the Health Home program elements and how we support each of those (in addition to the analytics and reporting tools introduced above).

Comprehensive Care Management

HealthCare USA will assist the Health Home case managers by providing timely and accurate data. Such data includes hospital admissions and readmissions and emergency department utilization. The HealthCare USA Medical Directors and Complex Case Managers will collaborate with the Health Home team to optimize the member’s health care experience. Medical Directors are always available to partner with the PCP to assist in care planning and coordination.

To prevent duplication of services and maximize the coordination of care for our members, HealthCare USA will coordinate with the State-designated Health Homes on the care and case management strategies of the HealthCare USA enrolled members. HealthCare USA will invite all Section 2703 designated health home treating physicians—both medical and behavioral health—and advance practice nurses and clinical practices to become part of the HealthCare USA provider network. This process will begin immediately following the identification of Section 2703 designation health homes by the State.

As providers are identified and members become enrolled into the Section 2703 practices, HealthCare USA will designate a single person as the “contact point” for each of the State’s Health Home sites. This person will work with HealthCare USA case managers and social workers who will review the monthly State reports of the HealthCare USA members who are receiving health home services through the State program. Each of these State health home members will have a designated contact person, who will augment and provide assistance as needed each HealthCare USA health home member to allow for coordination of a member’s services. Such contact will be made to the practices care coordinators or the PCP as desired by the Health Home practice. This will prevent HealthCare USA and the State Health Home from providing duplicative case management services.

The HealthCare USA CM team will augment the Health Home staff as needed for identified members with complex medical and/or behavioral health needs. This team approach to case management can encourage and empower the member to be an active



participant in the Health Home team and encourage them to become an active participant in their own health care. The HealthCare USA Case Management team is currently in place across the State of Missouri. HealthCare USA will expand the size of this team as is necessary to meet the multiple medical issues and challenges faced by these members.

Care Coordination and Health Promotion

HealthCare USA will support Health Home through existing care coordination and health promotion programs and staff.

Care Coordination. HealthCare USA will provide support to the Health Home in several ways to promote care coordination and health promotion.

First, we will continue to enroll eligible Health Home members into our chronic Care and Disease Management (DM) programs. Upon determination by the Health Home of the member's care needs, our multidisciplinary team will coordinate services and educate the members on health conditions, serving as liaisons between members, the PCP and Health Home, and appropriate community agencies.

Second, to further support the PCP and Health Home, HealthCare USA will notify the Health Home providers about their members with hospital re-admissions to facilitate interventions by the Health Home. This might include enrollment into complex case management; partnering with hospital discharge planners to ensure medication reconciliation and appropriate follow-up with the PCP, behavioral health provider or specialist; and/or face-to-face case management with the member prior to discharge.

All of these measures are implemented with the goal of redirecting members back to their health home, facilitating communication with the member's PCP, and reinforcing the provider's treatment plan, including medication compliance. Our face-to-face program in particular has been successful in the Coventry Health Care's Medicare and Medicaid SSI product lines, and early experience with HealthCare USA members has been welcomed by members and providers.

Third, HealthCare USA will help the Health Home reduce inappropriate Emergency Department use by providing data on ED use of its members and providing supporting interventions through supplemental HealthCare USA case managers. Our teams will work with the Health Home and member to identify potential unmet medical/behavioral health needs, ensure the member understands his benefits through MO HealthNet and HealthCare USA, and educate the member on the Health Home role.

As is done with all HealthCare USA members with unnecessary ED utilization, the member will be provided educational materials to help him/her treat minor medical conditions at home, and reminded of the HealthCare USA 24-hour nurse advice line to counsel the member if ED care is necessary and if not, how to access their PCP for an



office visit and education on self-care until that time. This program exemplifies the HealthCare USA motto “to engage, educate and empower.”

Health Promotion. To promote and encourage preventive health care HealthCare USA will provide the Health Home demographics of members with missing preventative services or situations that can lead to health care disparity, such as:

- Missing EPSDT examinations
- Missing Lead screenings
- Missing HEDIS related encounters
- Missing dental care
- Missing vision care
- Identify members whose primary language is not English
- Identify members that have been found, through HealthCare USA concurrent review or social worker staff, to have unique case management needs based on ethnic, cultural or religious identities.

Well-coordinated care and support are necessary to achieve the best possible outcome—getting the right care in the right setting at the right time.

Comprehensive transitional care including follow-up from inpatient and other settings

HealthCare USA will support the medical home in all aspects of care transition. We will inform Health Home providers of all inpatient admissions, overnight observation stays, and hospital (medical and behavioral health) discharges of the Health Home member within 24 hours.

An “ambulatory sensitive hospitalization” report will be available for the Health Home based on the current daily HealthCare USA inpatient census. This will aid in the timely notification of hospitalizations to Health Home providers. Such reporting will allow the Health Home care managers to:

- Use the hospitalization episode to locate and engage persons in need of health home services and case management;
- Ensure continuity of care coordination between inpatient and outpatient services;
- Coordinate with the hospital regarding discharge needs; and
- Reduce the rate of avoidable admissions.

HealthCare USA concurrent review and case management teams will provide assistance to the Health Home case management team to coordinate follow-up care with specialists. These nurses will also ensure that all discharge needs are considered and in place, from transportation to durable medical equipment. If identified as needed, home based services such as personal care and/or nursing will be arranged to be performed by one of our many in-network providers.



All of the described care transition functions are currently in place at HealthCare USA. The Health Home directed inpatient report is currently under development and will be available June 1, 2012.

Patient and family support

HealthCare USA can augment the efforts of the Health Home to support the member and family in a variety of ways. This includes home-based services (e.g., personal care, cleaning and cooking services, etc) and transportation services, both critical to help the family and member transition through changes in the member's medical condition and ensure the member gets what he needs; while the family also gets what it needs (e.g., caregiver relief).

Home-based services and transportation are currently provided to eligible HealthCare USA members; these services will be offered as needed to our members enrolled in a Health Home.

Referral to community and support services

HealthCare USA Complex Case Managers and with Social Workers utilize available "wrap-around" services such as community resources, school administrators, family and/or the parents/guardians. By facilitating communication between all of these critical components, the Complex Case Manager can support the member's relationship with their community and the health home.

4.5.2e2. Specify the offeror' proposed process to assign members to a health home

HealthCare USA understands and will comply with the requirements in Section 4.5.2(e)2.

Leveraging our existing PCP assignment process to assign to an Health Home ensures quick enrollment in the new program.

In the Section 2703 designated Health Home, Qualifying Chronic Conditions are defined as follows:

- Asthma
- Diabetes
- Cardiovascular Disease, Including Hypertension
- Overweight (BMI>25)
- Developmental Disabilities
- Smoking or Diabetes as "At Risk Of" Triggers
- Diagnosed with a serious and persistent mental health condition (adults with SMI and children with SED);
- Diagnosed with a mental health condition and substance use disorder; or





- Diagnosed with a mental health condition and/or substance use disorder, and one other chronic condition (diabetes, COPD, cardiovascular disease, overweight (BMI > 25), tobacco use and developmental disability).

Members joining HealthCare USA, who are identified by the State as being eligible to participate in the Health Home initiative, will be assigned to a designated Health Home in the HealthCare USA network.

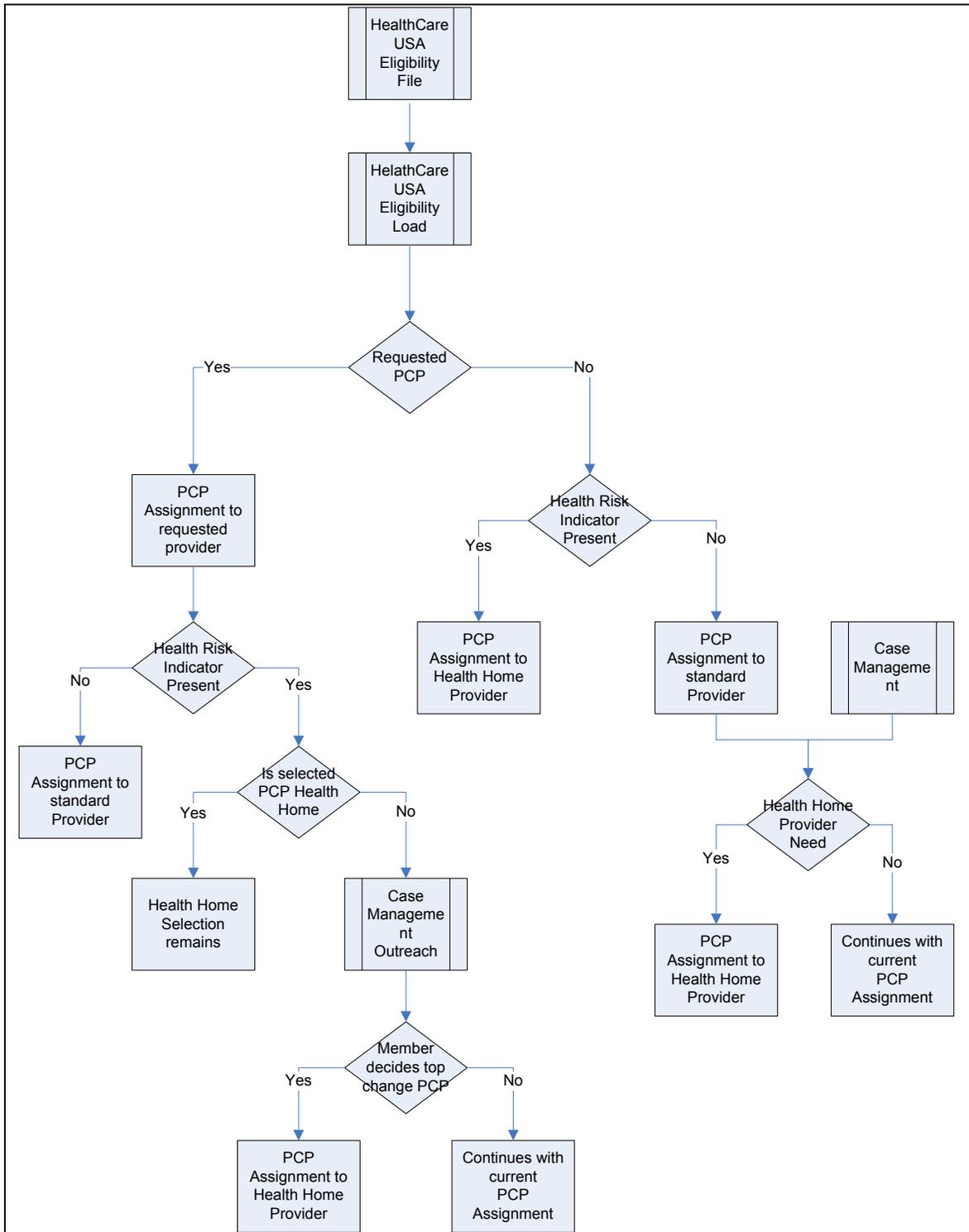
These HealthCare USA members identified will be notified of the enhanced services available to them. The specific process steps taken by HealthCare USA are outlined in Figure 4.5- 32 below.

Current HealthCare USA members who have a designated Health Home as their PCP, but not identified by the State as a Health Home participant, if acceptable to the State and the Health Home provider, will be contacted and educated regarding the Health Home initiative.

For those who are currently HealthCare USA members and already assigned to a PCP, efforts will be made to move them into a designated Health Home, if acceptable to the State and the Health Home provider. HealthCare USA members with any of the conditions noted above will be identified via claims data, Health Risk Assessments, Case Management files, and concurrent review of inpatient admissions.



Figure 4.5- 32: Health Home Member Assignment Process



The processes needed to identify these eligible members will be in place by June 1, 2012. Materials designed to notify and educate our members on the existence; services and



advantages of a health home will be developed and approved by MO HealthNet by January 31, 2012. The PCP assignment processes illustrated above are current processes.

4.5.2e3. Describe the strategies the offeror proposes to implement and monitor the effectiveness of health homes.

HealthCare USA understands and will comply with the requirements in Section 4.5.2(e)3.

HealthCare USA monitors effectiveness based on nationally recognized, quantitative data and rewards it with two types of financial bonuses to encourage Health Home membership and aggressive program participation.

HealthCare USA will employ both informal and formal monitoring strategies to monitor the effectiveness of health homes. We will reward effectiveness with financial bonuses.

Strategies to Monitor

Informally and ongoing, our PoC for each Health Home will be meeting with the Health Home as needed/per case, and at least monthly to review not only outcomes effectiveness per member (such as successful adherence to a discharge plan) and the Health Home as a whole (see Formal Monthly Utilization Reviews below) but also *process* effectiveness. Particularly because this is a new initiative for all of us, we encourage early and open communications with the Health Home (and the State) to revise our processes to best support the program.

Formally and at formal intermittent periods, we will monitor the effectiveness of health homes based on quantitative healthcare outcome improvements and adherence to process outcome measures via:

- HEDIS
- Other outcomes measures (quantitative measures for our DM programs, chart audits, other)
- Health Home's own goals.

Our use of nationally recognized metrics will enable both us and MO HealthNet to recognize best practices for the Health Home, and replicate them across the program.

Monthly, we will review utilization data the Health Home. Measures of success of the Health Home will include:

1. Decrease in inpatient days per thousand (acute inpatient hospital days);
2. Decrease in inpatient readmission rates;
3. Decrease in number of inappropriate ED visits/1000 members;
4. Decrease in individual practice medical expenditures;
5. Decrease reliance on long-term care facilities

Quarterly HEDIS, DM, Measures. Quarterly, we will issue HEDIS reports to the Health Home level. Specific quality and utilization measures (see Figure 4.5- 33) are based on the member's qualifying condition that will be used for members assigned to a health home.



Figure 4.5- 33: Recognized Quantitative Metrics Support HealthCare USA’s Best Practices Program

Qualifying Chronic Condition	Quality indicators	Utilization indicators
Asthma	HEDIS: appropriate medications for asthma medication reconciliation post-discharge flu shots for adults pneumonia vaccination status in adults	ED visits for asthma Inpatient admissions for asthma Readmissions for asthma
Diabetes	HEDIS: comprehensive diabetes management medication reconciliation post-discharge flu shots for adults pneumonia vaccination status in adults	ED visits for diabetes Inpatient admissions for diabetes Readmissions for diabetes
Special Needs Children	EPSDT rates HEDIS: well-child visits childhood/adolescent immunization rate Lead screenings Annual dental visits	ED visits Inpatient admissions Inpatient readmissions
Cardiovascular disease/hypertension (CVS/HTN)	HEDIS cholesterol management medication reconciliation post-discharge	ED visits for CVS/HTN Inpatient admissions for CVS/HTN Readmissions for CVS/HTN
Overweight	HEDIS: 1. adult BMI assessment	ED visits for non-emergent issues
Serious or persistent mental health condition and/or substance abuse	HEDIS antidepressant medication management follow up after hospitalization for mental illness medication reconciliation	ED visits for psychiatric issues/drug seeking/withdrawal Inpatient admissions for psychiatric issues/withdrawal



Qualifying Chronic Condition	Quality indicators	Utilization indicators
	post-discharge	Readmissions for psychiatric issues/withdrawal

Each Health Home’s HEDIS results will be reported in relation to national Medicaid standards and the Health Home goals.

Annually, we will monitor effectiveness through member satisfaction survey results and chart audits to ensure process effectiveness that can affect healthcare outcomes.

Rewarding Effectiveness

HealthCare USA has a two-pronged financial rewards program for health homes achieving MO HealthNet’s goals. First, those Health Home achieving Level 3 NCQA Health Home Accreditation will receive additional reimbursement. Upon proof of accreditation, each provider will be paid a \$25.00 premium for each annual physical exam performed on HealthCare USA members enrolled in the health home practice. Second, we will implement performance-based financial incentives. These goals will be based on past practice results and mutually agreed upon performance improvement goals. Such goals will be based not only on improved utilization, but also include agreed upon quality measures. At this time HealthCare USA is exploring alternate bonus payment methodologies, including FFS enhancements or other types of incentive payments.

Performance goals will be based on:

- EPSDT examination rates
- Selected HEDIS rates as compared to national Medicaid results, including immunization rates
- Rates of dental or vision care for eligible members
- Emergency Department utilization for Low Acuity
- Hospital readmission rates, for both medical and behavioral care

4.5.2e4. Describe offeror’s proposed process for ensuring timely exchange of member electronic health information: (1) between the offeror and the members’ health homes, and (2) between providers.

HealthCare USA understands and will comply with the requirements in Section 4.5.2(e)4.

HealthCare USA will ensure timeliness of Health Home member information exchange among all parties through processes that promote provider buy-in upfront and monitor progress throughout the contract on multiple fronts.

Our process for ensuring timely exchange of member electronic health information between us, the health home, and other providers is fourfold.



First, since this process is new, and governments and plans are still defining how to support EMR, given the incompatibility of the various systems in use today, we recommend hosting a series of Health Home provider forums to develop a solution to timely exchange information with providers. One of the goals of these forums is to get upfront provider buy-in of the proposed solution. We envision these forums to be ongoing throughout at least the first year in defining the processes, definitions of timeliness, and resources needed to meet all stakeholders' needs in addressing state requirements. (Note HealthCare USA is already involved in the Missouri MO-HITECH program that seeks to have all providers on a common/compatible EMR platform, but this is a long-term solution not applicable at contract start.)

Second, a significant premise of the forums is that we will inform all Health Home practices the importance of using the DMH/DSS-provided EHR patient registry in a timely manner, inputting information within 7 days of a member visit; and train them in its use if need be.

On our end, HealthCare USA will contribute to the registry with utilization data to fill in the gaps of missing information.

The use of the registry and HealthCare USA data will provide a complete detailed medical profile of our members, which will reduce duplication of services, increase coordination of care, and provide the highest quality of care in the most cost effective manner.

Specifically, the registry shall be used for:

- Patient tracking
- Input annual metabolic screening results
- track and measure care of individuals
- automate care reminders
- Patient risk stratification
- produce exception reports for care planning
- Analysis of patient population health status and individual patient needs
- Reporting as specified by DMH

Third, we will monitor compliance with 100% use of the registry for every member in the Health Home and for every Health Home during our monthly reviews. If there is a gap in compliance not only in use, but in timeliness of information being entered to exchange, we will work with each Health Home to help support full use, identifying barriers and addressing them.

Fourth, our PoC for each Health Home /or the case manager/disease manager/care coordinator responsible for the member will, as part of their routine duties, ensure that both us and other providers such as specialty referrals are inputting in the registry within 7 days of member encounter or otherwise providing us with EMR within that timeframe for timely exchanges of information. If they are not participating in the registry, we will ensure that the EMR information they provide to us is input in the



registry 7 days of receipt of information to maintain an up-to-date and complete record on each Health Home member.

Internally, we will monitor compliance with our staff in doing this through monthly random sample audits and other measures.

4.5.2e5. Describe how the offeror proposes to inform members about and enroll members in case management and disease management programs

HealthCare USA understands and will comply with the requirements in Section 4.5.2(e)5.

Multiple outreach touch points starting at the time of plan enrollment, inform members about enrolling in case and disease management programs.

Member and providers are educated about HealthCare USA's case and disease management programs from the time they enroll with us via the Member Handbook, Provider Manual, member/provider newsletters, HealthCare USA staff and community outreach activities. Thereafter, they are informed about member-specific programs and enrollment in the following manner:

Enrolling Members

HealthCare USA informs members about enrollment into case/disease management by conducting outreach to the members once they are identified as candidates for enrollment. Members are identified and/or referred for case/disease management through:

- Acute care admissions (including multiple readmissions, admit/discharge data and/or hospital discharge planner referral)
- Claims/encounter data analysis
- Complex case and disease management program referrals
- Emergency department log review
- HealthCare USA staff (including, but not limited to, pre-authorization, concurrent review, Medical Directors, social workers, behavioral health case managers and Customer Service staff)
- Health risk assessment (HRA) review
- Pharmacy data analysis
- Providers and/or practitioners referrals
- Member/caregiver referrals
- 24-Hour Nurse Line call log review
- Review of the State enrollment file health risk assessment



- Receipt of OB global forms and/or the state OB risk assessment form

Members identified for case management activities can be enrolled immediately upon identification; for disease management, we run further assessments to stratify their needs by evidence-based clinical practice guidelines and criteria. The stratification group and the member's needs determine the type and frequency of interventions the member receives, and thus, the DM program.

Members are notified about their candidacy for enrollment via outreach calls or mailings if several telephone attempts are unsuccessful. If we still do not receive a response, we try to reach them through their assigned PCP or other provider (DME, home health, etc) identified from claims that have provided services to the member.

Informing Members

In addition to the initial member-sign on mailings that detail case and disease management program offerings, we provide individualized education to members once they agree to enrollment:

- education about HealthCare USA benefits
- telephonic education about their diagnosis
- educational material in the mail about their diagnosis
- referral to community resources
- coordination of healthcare needs including behavioral health
- development of a case plan which is mailed to the member and their provider
- assistance with social needs by a HealthCare USA social worker

A member can also request case/disease management assistance at anytime by calling member services who can transfer them to the case/disease management department. A provider can also refer their patients to HealthCare USA to receive case management services.

Finally, members have the right to decline participating or disenroll from any case/disease management program and/or service offered by HealthCare USA at any time. This is discussed with the member at time of enrollment.

4.5.2e6. Describe how the offeror proposes to educate providers about disease management and case management programs, program requirements, and provider expectations.

HealthCare USA understands and will comply with the requirements in Section 4.5.2(e)6.

Health Home provider education is both practice-specific and inclusive of our entire provider education program for case and disease management. Hitting Health Home providers with the same messaging in multiple ways, including one/one, supports program understanding and participation with success.



HealthCare USA has a significant provider relations team and physical presence in all three regions to educate providers about our programs, including DM and CM.

We will educate our Health Home providers about these services, the requirements, and provider expectations through all our routine channels. These include Website and the provider portal; Provider Advisory Council; other provider forums including ad-hoc and other QI committees; face-to-face personal visits and education during those; and provider mailings.

In addition, HealthCare USA will develop educational sessions specifically directed to our Health Home providers, with topics such as

- Case management techniques for those members with multiple co-morbid conditions
- Cultural sensitivity
- Interaction between behavioral and physical health issues;
- Screening tools to identify depression in chronically ill members
- Identification and resources for members with drug/alcohol abuse
- HEDIS processes, utilization metrics and other skills to aid the Health Home in being successful

Once an Health Home provider has members participating in our programs, we will continually educate and inform the provider about member status and recommended provider actions via recurring reports of each member. On an on-going basis, the case manager communicates telephonically with the PCP regarding the patient's participation and progress in these programs.

4.5.2e7. Describe the strategies the offeror proposes to implement to: (1) monitor disease management and case management program outcomes and the effectiveness of the intervention; (2) monitor health status; and (3) determine needed program interventions.

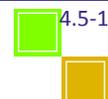
HealthCare USA understands and will comply with the requirements in Section 4.5.2(e)7.

We help ensure healthcare outcomes are achieved through CM and DM programs via ongoing quantitative and analyses to identify and improve service delivery early, where needed.

Monitoring Program Outcomes and Health Status

We will monitor program outcomes and health status in the same manner described above in our response to #3 of this section. Summarily, we will use ongoing monthly, quarterly, and annual reports from internal reviews to HEDIS reporting. Additionally, when Health Homes agree to participate the program, they agree to participate in CMS and state-required evaluation activities. These include reports related to:

- Primary care health home activities;





- Efforts and progress in implementing primary care health home services (e.g., monthly clinical quality indicators reports utilizing clinical data in disease registries, breakdown of primary
- Care health home service staff time and activities

HealthCare USA will supplement these required reports with both clinical utilization data and quality outcomes as described above. As currently managed with HealthCare USA DM and CM programs, results will be tracked and trended and reported to MO HealthNet. Results of this monitoring will be presented to the Quality Management Committee, and changes to the programs are made as necessary to ensure our members benefit from these programs.

Program Intervention

If Health Homes appear to have increasing utilization and/or decreased quality scores over time, we will collaborate to improve performance. We will work closely with the Health Home PCP to identify drivers of unfavorable results. HealthCare USA can provide actuarial and financial analysis not typically available at a Health Home practice, as indicated in the introduction to this Home Health Response. Barriers to improvement will be identified and eliminated, in partnership with the Health Home. Examples of such activities may include:

- HealthCare USA will provide provider education regarding HEDIS-related measures, including appropriate coding practices
- Increase focused CM support the Health Home team
- Provide/support face-to-face case management interventions as needed
- Develop co-branded member educational materials and appointment reminder cards
- Provide more detailed utilization and/or quality reports to better identify a provider's unique needs
- Develop member incentive programs to address common, ongoing issues
- Work with Health Home teams to develop effective member outreach strategies
- Engage Provider Services to develop activities and promotions to increase member engagement with their Health Home PCP

Our financial incentives/pay-for-performance help encourage providers to positively participate in the program to meet improvement goals.





Section 4.5.2.e – Example 1

Hypothetical Health Home Patient Scenario

Mr. John Smith is a single, 50 year old male with a history of diabetes (since age 25 yrs old) and bipolar disorder (since 30 years old). He is 5'9" tall and weighs 300 pounds. Within the past 90 days he has been admitted to the hospital four times (two inpatient behavioral health admissions and two inpatient medical admissions for uncontrolled diabetes). There have been previous attempts by HealthCare USA to enroll the member in case management (CM) but these have not been successful due to an inability to contact the member. Mr. Smith has not seen a medical or behavioral health provider on an outpatient basis in the past six months nor has he completed scheduled follow up from his hospitalizations.

Engagement into the Health care home and HealthCare USA notifications/coordination

HealthCare USA is notified by the State that Mr. Smith has been identified as a member eligible for the Community Mental Health Center (CMHC) Home Health program at ABC CMHC. As with each Health Home, HealthCare USA has designated a case manager as the primary point of contact for the ABC CMHC. The CM contacts ABC to discuss how HealthCare USA can support the Health Home CM program done by ABC.

The HealthCare USA Diabetic CM reviews with the ABC CM team Mr. Smith's medical history, his apparent non-compliance with his medications and what appear to be unnecessary hospitalizations due to suboptimal control of his diabetes. Non-compliance is evidenced via review of the Missouri CyberAccess system. This review shows that Mr. Smith has not filled any diabetic prescriptions since his recent discharge.

The HealthCare USA Diabetes CM also involves our Behavioral Health CM, who is co-located in the HealthCare USA office, to discuss the BH case management which has occurred to date and how this process will continue moving forward. This is critical to avoid duplication of CM resources.

Both HealthCare USA case managers (diabetes and behavioral health) share all demographic information they have for Mr. Smith with the ABC CM team. The diabetes CM notes that outreach to Mr. Smith has been ineffective as the telephone number HealthCare USA has on file is not a working number. The ABC team received a new telephone number from the State Health Home enrollment information—this is shared with the HealthCare USA team. Both teams agree to have the ABC CM team attempt initial contact with the new demographic information.

HealthCare USA sends ABC our HEDIS missing information data for Mr. Smith and the Home Health Data report. This one page report (below) summarizes utilization and quality indicators for HealthCare USA members enrolled at ABC CMHC. A meeting is scheduled with the ABC PCP to customize this report to her specifications.

The next week, HealthCare USA is alerted via its Home Health Inpatient Notification Report that Mr. Smith has been admitted in the last 24 hours for uncontrolled diabetes. HealthCare USA alerts ABC of this admission via our designated contact person. The HealthCare USA diabetes CM is also made aware of the admission.



After coordination with ABC, it is decided that the HealthCare USA diabetic CM will visit the hospital today and have a face-to-face CM session with Mr. Smith. This is an effective tool to establish rapport with our member and ensure we can hear from the member himself as to how we can best serve him and communicate to him how HealthCare USA can support his medical and behavioral health needs.

A comprehensive face-to-face CM assessment is conducted to gather information about the member ability to complete ADLs, advanced directive status, clinical history including medication usage and behavioral and social needs. During this assessment, the CM asks about his apparent non-compliance with prescription medications. Mr. Smith tells us that he does not have transportation to the pharmacy so he can't fill the medications, and can't get to the doctor's office for appointments. So, he calls the ambulance whenever he feels sick. This typically results in an admission to improve his diabetic control.

The CM educates the member regarding the HealthCare USA transportation benefit to medical appointments. The member is asked if he will allow the CM to call his PCP and schedule a follow-up appointment for him to be seen after discharge. The member agrees. The case manager also provides Mr. Smith with information regarding the HealthCare USA 24-hour nurse advice line and our Diabetic Disease Management program. The HealthCare USA CM also learns that Mr. Smith has a new address and cell phone, and gives us this new demographic information.

The HealthCare USA CM then asks about the member's behavioral health needs. The ABC CMHC Health Home and the services they offer are discussed. Mr. Smith is very pleased to hear this, as he likes to go to the CMHC as they "really seem to care about me." Mr. Smith is given the name of the ABC CM assigned to him, and is asked if he will allow the ABC CM to contact him to assist with services available under the CMHC health home program. He readily agrees. He says his bipolar is well controlled "as long as I can get my medication."

The CM calls the ABC Health Home office and provides them with Mr. Smith's new demographic information. ABC gives the CM the name of preferred medical provider to follow Mr. Smith's diabetes and other medical needs. ABC, the HealthCare USA CM and Mr. Smith schedule an appointment at ABC three days after discharge. They also schedule a BH provider visit that same day in the same location, to assess and ensure adequate treatment for Mr. Smith's bipolar disease. Next the HealthCare USA CM contacts MTM to schedule transportation to get him to his appointment. A trip to the pharmacy will be included in the transportation request to ensure there is no further barrier to the member getting his medication. The CM asks the member if he would like to be enrolled in ongoing diabetic case management. He agrees.

Before the diabetes CM visit ends, a future date is scheduled for her to follow up with Mr. Smith. He has also agreed to home visits by a home health nurse to further educate him regarding diabetes medications, diet and exercise to better manage his condition.

The diabetes CM compiles a case plan that was developed while they were on the telephone. A copy of this plan is mailed to the member and the ABC CMHC CM team. This plan is formulated by the CM and member and includes self management goals to help the member become more active in his medical well being.

One day after discharge, an ABC CMHC case manager contacts the member to complete the mental health assessment and ensure follow-up. Medications reconciliation is completed—Mr. Smith has enough medications for both his bipolar disease and diabetes. During the assessment



the member agrees to receive help to address his bipolar disorder and other behavioral health needs. A follow-up appointment with ABC CMHC is confirmed, as is transportation.

Over the next two months, the ABC staff informs HealthCare USA that Mr. Smith is keeping both his medical and behavioral health appointments. CyberAccess shows that his is getting his medications on time. There have been no emergency department visits or hospitalizations. But a new issue has been identified. Mr. Smith told the CHMC CM that he does not have air conditioning, and sometimes his electricity is shut off. Since insulin requires refrigeration, the ABC CM team contacted HealthCare USA for assistance and coordination to address this need. The HealthCare USA social worker is engaged by our diabetic case manager. The HealthCare USA social worker reaches out to community resources to get an air conditioner donated for Mr. Smith. Also, she contacted the electric company to make them aware that Mr. Smith has a medical condition that requires electricity. They agreed not to shut off his power and will work with him on a payment plan over time.

Figure 4.5- 34: Health Home Patient Summary Report Layout

Patients	Quality Profile	Manage Access Requests	My Profile	Administration	Log Out		
Print	Diagnosis Summary	Procedures	Medication	Lab Tests	Patient Reported	Care Team	Medical Home Patient Summary
Add to List	John Smith Entry Patient ID: 123-456-788 Age: 60 y DOB: 10/2/81 Phone: 673-556-1234 Sex: Male						
New Search							
1. Demographics							
** Indicates an item that is still open and needs further research or may still need to be mapped to a data element. These items are subject to change as details are finalized.							
2. Hospital Admission * Includes prior 12 months and last 4 occurrences							
Date of Admission	Date of Discharge	Diagnosis	Hospital	Potentially Avoidable	Date of Visit	Diagnosis	Hospital
6/25/11	6/26/11	Diabetic Ketoacidosis	St Mary's	Y	6/25/11	Diabetic Ketoacidosis	St Mary's
5/25/11	5/26/11	Diabetic Ketoacidosis	St Mary's	Y	5/25/11	Diabetic Ketoacidosis	St Mary's
4/10/11	4/15/11	Diabetic Ketoacidosis	St Mary's	Y	4/27/11	Bipolar Disease	Columbia Regional
					4/10/11	Diabetic Ketoacidosis	St Mary's
3. Surgery & Anesthesia * Includes prior 12 months and last 4 occurrences							
Date of Service	Procedure	Diagnosis Description	Claim Number	Includes up to 6 programs			
12/09/10	wound debridement	Diabetic Foot Ulcer	967-894-321	** Program			
				Diabetes CM Unable to Reach 4/20/11			
				Diabetes CM Unable to Reach 5/30/11			
				Diabetes CM Unable to Reach 7/1/11			
4. Pharmacy Adherence * Includes prior 12 months and last 4 occurrences							
Drug	Date	Dosage	Qty	Days Supply	Supply End	Possession Ratio	Condition
Insulin Regular	3/15/11	35 U qd	10 cc	30	5/15/11	N/A	Diabetes
Septin	12/03/10	500 mg	30	10	12/30/10	N/A	Infection
months and last 4 occurrences							
** Condition				** Measure			
Diabetes Care				Dilated Eye Exam			
Diabetes Care				Foot Exam			
Diabetes Care				Hemoglobin A1c Measurement			
Effectiveness of Care				Adult Flu Immunization			
8. Provider Seen List * Includes prior 12 months and last 4 occurrences							
Name	Specialty	Phone	Date of Visit	Procedure			
D. Bear, MD	FP	573-555-3421	3/13/11	Check-up/Diabetes care			
I. Cutler, MD	Surgery	573-555-5555	12/9/10	wound debridement			
7. Last Physical Exam (Display will include one record)							
Date	Procedure	Doctor	Phone Number				
3/13/11	Check-up/Diabetes care	D. Bear, MD	573-555-3421				
12. PCP (Will display one record)							
Name	Address	City	State				
D. Bear, MD	123 Main Street	Jefferson City	MO				
** 13. HRA (Display will include 4 lines)							
** HRA Details							
HRA Completed: NO **							
Probability of Repeated Admissions Score (High z: .0400): <0.10> **							
Frailty Score (High z: .0500): .065+ **							
Depression Score (High z 2): 2 **							



4.5.3 Quality [2.18.9]

The offeror's ability to provide quality care and improve patient outcomes, as documented in current programs and the proposed programs, will be considered subjectively in the evaluation process. Therefore, the offeror shall address the following within the proposal.

HealthCare USA was the first MO HealthNet plan to receive third-party quality accreditation (URAC) back in 2007. Our high-quality service continues: NCQA provided a "Commendable" accreditation to us this year, and for the new contract, we commit to attaining NCQA Multicultural Health Care Distinction, backed by a performance guarantee of \$175,000.

4.5.3a. NCQA Accreditation

The offeror shall indicate if the offeror is NCQA-accredited. If so, list the states in which the offeror is NCQA-accredited, indicate the accreditation status by product line and include a copy of the applicable NCQA report cards for the offeror. The offeror shall include the offeror's parent organization, affiliates, and subsidiaries. (2.18.9)

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.3(a).

For further details on Section 4.5.3(a), see Section 2.18.9.

4.5.3b. Accreditation Status Adjusted, Suspended or Revoked

The offeror shall indicate if the offeror ever had its accreditation status (e.g., NCQA, URAC, or AAAHC) in any state for any product line adjusted down, suspended, or revoked. If so, identify the state and product line and provide an explanation. The offeror shall include the offeror's parent organization, affiliates, and subsidiaries.

HealthCare USA understands and will comply with the requirements in Section 4.5.3(b).

HealthCare USA Has Never Had Accreditation Status Downgraded

In the course of business over 10 health plans and many years of operation, it is inevitable that one plan or another may have accreditation status downgraded.

But this has never happened at HealthCare USA. We have never had status suspended or revoked, but two other Coventry plans have:

- Coventry's West Virginia Commercial product line was downgraded in 2010 from Excellent to Commendable; Factors that contributed to the adjustment were the CAHPS satisfaction survey and the overall HEDIS® scoring
- Virginia's Medicaid product line scored an NCQA accreditation rating of Excellent. In 2009, the rating was Commendable; the factors that contributed to the adjustment were the CAHPS satisfaction survey and the overall HEDIS® scoring, but in 2010, the rating returned to Excellent.



4.5.3c. HEDIS Measures

Provide, in table format, the offeror's results for the following HEDIS measures for years 2007, 2008, and 2009 for each of the offeror's Medicaid contracts (every state): Annual Dental Visits (combined), Adolescent Well Care Visits, Follow-up After Hospitalization for Mental Illness Within 7 Days of Discharge, Well Child Visits in the First 15 Months of Life – 6+ Visits, and Emergency Department Visits. If the offeror does not have results for a particular measure or year, provide the results that are available. If the offeror does not have the results for a Medicaid product line in a state where you have a Medicaid contract, provide the results for your Medicare (preferred) or commercial product line in that state (and indicate which product line the results apply to). If the offeror does not have results for every measure or year, provide the results available. If the offeror has measures for a Medicare or commercial product line in a particular state but you do not have such information for your Medicaid contract, provide that information. The offeror shall explain any missing information (measure, year, or Medicaid contract). Offerors operating in Missouri shall address their Missouri experience.

HealthCare USA understands and will comply with the requirements in Section 4.5.3(c).

HealthCare USA continues to serves MO HealthNet members since MO HealthNet's program inception in 1996. Quality is always fluid and so is HealthCare USA's quest to improve member's health status through new technology, methods and processes. HealthCare USA's 16 years of knowledge regarding MO HealthNet's members is also a valuable asset to the State in terms of knowing the needs of members and finding innovative approaches to meeting those needs.

Each region of the MO HealthNet program is demographically different and presents different and unique challenges to the members we serve. Through the commitment to quality by HealthCare USA, we use NCQA approved software to calculate HEDIS measures, our Care Management Tool (CMT) provides predictive modeling for case management, disease management, and provider profiling, and the Coventry Data Warehouse to capture data to improve the modeling for member health status. Quality is not just about taking the data and turning it into meaningful information but also about finding ways to better serve our members and improve their health status.

The results of all three regions are in tables as seen below. Before reviewing the outcomes, it is important to understand the background of each of the measures the State wished to review as part of this response and the steps HealthCare USA took to meet the goals. In addition to the Missouri specific experience, we have also included the measures from our other Medicaid plans as well.

Dental

Overall, for all three regions, HealthCare USA increased the Annual Dental Visit rate from 2007-2009 through our participation in a required state-wide Oral Health Performance Improvement Project. HealthCare USA also set an overall 3 percentage rate increase starting in 2009. HealthCare USA has met the goal of increased participation in the dental program by assessing barriers through a barrier analysis and establishing solid interventions to make continuous improvement strides for the delivering dental care to our members. For example, one barrier the



team identified is the lack of parental knowledge about the importance of a dental exam every six months. The intervention to address the barrier is including a dental message with birthday reminders and missed visit reminders. Understanding the need to communicate and educate the members, HealthCare USA mailed over 200,000 birthday and missed appointment reminders in 2009. Overall, the key to the oral health initiative was communication and education for the members regarding dental benefits and the importance of good dental health. In addition to member education, providers were educated regarding dental benefits for our members.

Adolescent Well Care

From 2007 through 2009, HealthCare USA participated in a Performance Improvement Project for Adolescent Well Care for all three regions. We assessed barriers to adolescent well care and set strategies to improve members' health for this measure.

For example, one we found a barrier is that providers have limited ability to identify members without annual visits. We can provide each provider with a list of HealthCare USA members and the status of each patient's annual visit. This list is now part of a provider mailing and Coventry's Customer Service Organization now flags non-compliant members' files. When a non-compliant member calls into the Customer Service Organization for any reason, the call center staff uses a scripted message to educate the member and/or parent and encourage setting up a well-visit for the adolescent member. HealthCare USA also deploys intervention of including a well-care visit into the Birthday and Missed Visit Reminder mailings. This type of intervention yielded over 200,000 mailings in 2009. Of special note, HealthCare USA developed a plan to make outreach calls to non-compliant members in the Western region due to the low rate in 2007. The Western region did show improvement of approximately four percent in Adolescent Well Care member compliance. In addition to the mailings, HealthCare USA also implemented the ability for a provider to identify non-compliant well visit members through our provider web portal (www.directprovider.com). The provider's office has immediate access to member information through the portal.

Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge

MHNet is HealthCare USA's behavioral health provider and an affiliate of HealthCare USA. Since 2006, MHNet focused on improving its HEDIS FUH (follow-up after hospitalization) rate through the ongoing development of a performance improvement project (PIP).

The objective of a PIP is to improve member adherence to mental health visits post hospitalization. MHNet has developed outreach activities aimed at the member as well as at the behavioral health provider. Examples of outreach efforts include: key MHNet staff meet weekly with the Clinical Supervisor to review cases of non-compliant members to identify and remove barriers to treatment; and MHNet distributed a Provider Newsletter to educate behavioral health providers about the importance of ambulatory follow-up with a behavioral health practitioner to assist them in encouraging members to obtain optimal care. The partnership between HealthCare USA and MHNet is paramount to the success of integration of behavioral health and physical health but also in enhancing the member's health status through the cooperation and team effort of MHNet and HealthCare USA.



Well-Child Care Visits first 15 months of life – 6+Visits

HealthCare USA participated in a corporate QI workgroup on young child preventive visits including EPSDT. The workgroup created a letter designed as a mailer to enhance provider education on this measure. Additionally HealthCare USA sends a monthly form to providers informing them of members who are behind on their well child visits. In addition to the written form, this information is available to the provider on our provider web portal (www.directprovider.com).

Emergency Department Visits

HealthCare USA saw improvements in Emergency Department (ED) Visits for this time period with an overall downward trend from 2007 for the Central regions. The ED Visit measure includes all ED claims and is not dependent on diagnosis or outcome.

HealthCare USA put a PIP in place with the goal of reducing avoidable ED utilization. HealthCare USA instituted a multiregional and interdepartmental team that meets quarterly to review PIP activities and data and resolve any barriers to care that resulted in an avoidable ED visit. One barrier identified was a lack of member education regarding appropriate use of the ED. In response to that need, an educational letter was created along with two brochures "First Aid Tips" and "Understanding How to Get the Right Health Care." These three documents are mailed to members that have been identified as high-ED utilizers.

HEDIS Results by Program

HealthCare USA submits the following tables for not only the Medicaid populations served in Missouri but also other Coventry Medicaid programs.

Western Region

HealthCare USA – (Current MO HealthNet Contract) Western Region – Missouri			
	2007	2008	2009
Annual dental Visits (combined)	30.29%	33.42%	41.94%
Adolescent Well Care	32.56%	30.32%	34.89%
Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge	35.53%	44.85%	54.68%
Well-Child Care Visits first 15 months of life – 6+Visits	46.06%	41.41%	41.05%
Emergency Department Visits	88.36%	87.48%	90.60%

Highlights from the Western region:

- Increased annual dental visit rate by 11.62%
- Increased the adolescent well care rate by 2.33%



- Increased follow-up after hospitalization for mental illness within 7 days of discharge shows by 19.15%

Central Region

HealthCare USA (Current MO HealthNet Contract) – Central Region – Missouri			
	2007	2008	2009
Annual dental Visits (combined)	35.08%	40.33%	47.44%
Adolescent Well Care	40.19%	39.12%	39.83%
Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge	42.65%	45.88%	53.68%
Well-Child Care Visits first 15 months of life – 6+Visits	71.36%	70.89%	64.63%
Emergency Department Visits (Visits/1,000 member months)	74.26%	69.04%	70.13%

Highlights from the Central region:

- Increased annual dental visit by 12.36%
- Decreased adolescent well care by less than 1%
- Increased follow-up after hospitalization for mental illness within 7 days of discharge by 11.03%
- Decreased ED visits by 4.13%

Eastern Region

HealthCare USA – (Current MO HealthNet Contract) Eastern Region Missouri			
	2007	2008	2009
Annual Dental Visits (combined)	34.61%	37.16%	40.54%
Adolescent Well Care	40.35%	45.14%	44.13%
Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge	30.59%	40.79%	44.46%
Well-Child Care Visits first 15 months of life – 6+Visits	42.90%	49.54%	52.63%
Emergency Department Visits	72.68%	75.88%	82.19%

Highlights for the Eastern region:

- Increased HealthCare USA annual dental Visits by 6%



- Increased Annual Adolescent Well Care by 4%
- Increase Adolescent Well Care of 4%
- Increased Follow-up after Hospitalization for Mental Illness within 7 days of Discharge of 13.87%

In addition to the Missouri Medicaid plans, here are the measures for the other Coventry Medicaid plans.

Carelink Health Plans * West Virginia			
	2007	2008	2009
Annual dental Visits (combined)	NR	NR	NR
Adolescent Well Care	36.42%	37.96%	39.58%
Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge	NR	NR	NR
Well-Child Care Visits first 15 months of life – 6+Visits	58.28%	61.61%	61.63%
Emergency Department Visits	77.41%	74.66%	81.70%

CareNet * NCQA Accredited Medicaid Plan Virginia			
	2007	2008	2009
Annual dental Visits (combined)	NR	NR	NR
Adolescent Well Care	36.20%	35.65%	46.76%
Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge	15.71%	29.28%	43.65%
Well-Child Care Visits first 15 months of life – 6+Visits	46.58%	36.80%	48.94%
Emergency Department Visits (Visits/1,000 member months)	70.71%	73.60%	80.30%

Diamond Health Plan Delaware			
	2007	2008	2009
Annual dental Visits (combined)	33.87%	NR	32.87%
Adolescent Well Care	44.59%	49.67%	50.55%



Diamond Health Plan Delaware			
Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge	N/A	NR	NR
Well-Child Care Visits first 15 months of life – 6+Visits	56.44%	57.58%	52.45%
Emergency Department Visits (Visits/1,000 member months)	86.99%	88.01%	94.62%

OmniCare Michigan			
	2007	2008	2009
Annual Dental Visits (combined)	NR	NR	NR
Adolescent Well Care	51.39%	52.55%	59.16%
Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge	N/A	NR	NR
Well-Child Care Visits first 15 months of life – 6+Visits	55.79%	59.26%	59.33%
Emergency Department Visits (Visits/1,000 member months)	79.04%	77.40%	83.61%

Coventry Health Care of Florida			
	2007	2008	2009
Annual dental Visits (combined)	NR	NR	NR
Adolescent Well Care	41.61%	47.24%	46.30%
Follow-up After Hospitalization for Mental Illness Within 7 days of Discharge	9.38%	47.24%	46.30%
Well-Child Care Visits first 15 months of life – 6+Visits	35.04%	31.64%	25.29%
Emergency Department Visits (Visits/1,000 member months)	49.82%	52.86%	58.48%

Although CoventryCares is a Medicaid program located in Pennsylvania, this program was not established until first quarter 2010, so we do not have any historical data to report.



4.5.3d. Improving Health Outcomes

Provide, in a table format, the offeror's strategies for improving the MO HealthNet population health outcomes for the following HEDIS measures for contract years one (1), two (2) and three (3): Annual Dental Visits (combined), Adolescent Well Care Visits, Follow-up After Hospitalization for Mental Illness Within 7 Days of Discharge, Well Child Visits in the First 15 Months of Life – 6+ Visits, and Emergency Department Visits.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.3(d).

Quality is continuous and HealthCare USA's strategic plan reflects continuous review and monitoring of not only existing HEDIS measures and PIPs, but also new measures and processes. Our method —Plan, Do, Check and Act (also known as the Deming Cycle)—is the iterative four-step management method used in business for process control and continuous improvement.

Cost Savings

HealthCare USA's partnership with the state began in 1996. During this time we have worked together to establish different quality initiatives, review results and continue the program, meeting the ever-evolving needs of our members while working to reduce the cost of health care to the members.

- Annual Dental Visit combined measure (HEDIS measure)
Save \$184/child per year if they have a visit
(Source: *The Children's Dental Health Project*)
- Adolescent Well Care visits measure (HEDIS measure)
Not applicable
- Follow- Up after hospitalization for Mental Illness Within 7 days of Discharge (HEDIS measure)
\$2900 per stay savings
Cost avoidance of a MH inpatient readmission if member has a follow-up outpatient visit
(Source: *HealthCare USA/MHNet data*)
- Well child visits – 6+ visits (HEDIS measure)
If a child receives 6 visits in the first 15 months of life
For a child with 6 or more well child visits, the average inpatient cost per stay is \$2979 vs. \$6925 for children with less than 6 visits
In 2010, HealthCare USA had 8,696 children statewide who were included in this HEDIS measure
Savings per child of \$38.60



8696 children times \$38.60 is \$335,665 savings if all children got 6 visits
(Source: This is calculated using 2010 HealthCare USA data)

- ED visits is a part of ambulatory care (HEDIS measure)
Avoidance of the highest level of care /ED Diversion
Cost of ED visit \$350.00
Cost of urgent care visit \$242
Savings in 2010 of \$383,000 - 108 times number of episodes
(Source: This is calculated using 2010 HealthCare USA data)

Progressive Strategies and Innovative Initiatives

We are progressive, instituting new technology such as our Care Management Tool and the Coventry Data Warehouse, as well as with stringent processes and procedures to ensure the quality of our data. Data is a tool in the overall picture of HealthCare USA's quality program. It was what HealthCare USA does with the data in terms of improving the health status of members through improved HEDIS measures, targeting vulnerable populations, and implementing process improvements. Most importantly, quality is also about caring and showing that we care for our members.

The following tables provide a snapshot our strategies for positive outcomes for the three year term of this contract. Keeping in mind, as we enter into new territory with the increasing Medicaid population and in order to meet those needs, our strategy will evolve to accommodate those needs and to improve the health status of our members.

Strategic Plan <i>Year 1: July 2012–June 2013 (All Regions)</i>
<p>Annual Dental Visits (Combined)</p> <p>All regions</p> <ul style="list-style-type: none"> • Send member postcard notification of available dental clinics for appointments • Doc Bear Days • Produce and send postcard/mailer emphasizing importance of annual dental exam to members who have not had a dental exam • Conduct community outreach • Continue the Oral Health PIP and advisory committee • Send provider newsletter and fax blast regarding dental coverage • Send monthly EPSDT birthday reminder to parents • Send member newsletter with dental care information



Strategic Plan
Year 1: July 2012–June 2013 (All Regions)

Adolescent Well Care Visits

All Regions

- Send biannual reminder postcard regarding needed exams
- Create reminders (message about the need to complete this exam) build into the software program utilized by call center/member services and clinical staff allowing them to address this measure with a member when the member contacts HealthCare USA for assistance.
- Alert providers of gaps in care through our provider web portal (directprovider.com) so providers can track members' compliance with well visit activities and other HEDIS measures while checking member eligibility, enabling intervention during a visit.

Follow up after hospitalization for Mental Illness within 7 Days of Discharge

All Regions

- Internal discharge process team dedicated to improving adherence to follow-up visits - researches barriers; develops interventions
- Produce monthly, facility report cards on compliance rate with scheduling ambulatory follow-up appointments for members including comparative data for geographic area
- Encourage the use of 900 codes for day of discharge appointments for discharge plan review with member thus increasing member's adherence to plan.
- Contract (MHNet) a number of contracted facilities to utilize a discharge bridge service to review discharge and treatment plans with member and encourage continued attendance at appointments. This service occurs post-discharge.
- Create new member brochure on subject.
- Publish Provider newsletter article
- Conduct follow-up reminder calls and schedule visits
- Contact by case manager while inpatient helps to support member treatment plan compliance.
- Utilize (MHNet) home-based therapy services and telemedicine services as a means of eliminating access barriers for members with increased difficulty getting to an office location for various reasons.
- Attend (MHNet) inter-agency meetings with high risk members who have a history of not following through with treatment plans in order to better support members in achieving treatment objectives and to coordinate care with other key treatment/support systems.

Well Child Visits in the First 15 months of Life-6+ Visits

All Regions

- Send monthly mailing of EPSDT/HCY birthday reminder to members in all three regions
- Create reminders (message about the need to complete this exam) built into the software program utilized by call center/member services and clinical staff allowing them to address this measure with a member when the member contacts HealthCare USA for assistance



Strategic Plan
Year 1: July 2012–June 2013 (All Regions)

- Publish more articles in member newsletter
- Alert providers to gaps in care through our provider web portal (directprovider.com); provider can track members' compliance with well visit activities and other HEDIS measures while checking member's eligibility, enabling intervention during visit.

Emergency Department Visits

All Regions

- Continue ED PIP and the advisory panel
- Conduct regular mailings of “First Aid Tips” brochure, “Understanding How to get the Right Healthcare” brochure to frequent ED utilizers
- Provide members and providers with current lists of contracted urgent care centers and convenience care clinics through our website
- Receipt of ED logs from key hospitals and distribute to case/disease managers for follow-up with members enrolled in case or disease management
- Educate providers about urgent care options
- Implement mailing of Urgent care brochure to educate members about the appropriate use and availability of Urgent Care, Walgreen’s Take Care Clinics and CVS Minute Clinics
- Establish a process with a contracted vendor to make outreach telephone calls to member with high ED usage. As part of the outreach, questions will be included to determine if there is a behavioral health problem, such as depression, is the root cause or contributing factor to the high ED usage. Based on the results, the ED outreach vendor (with the member’s permission) will provide the member’s information to MHNNet and inform the member that he or she will be receiving a follow-up telephone call. MHNNet will reach out to the member and implement appropriate interventions.

Strategic Plan
Year 2: July 2013–June 2014

Annual Dental Visits (Combined)

All regions

- Review of Doc Bear Days effectiveness at dental clinics to determine whether to continue or make revisions
- Review of postcard mailers and continue distribution in all three regions
- Explore Community Outreach for additional venues while continuing existing sites
- Continue dental PIP and the advisory panel
- Continue dental articles in member newsletter
- Continue articles in provider newsletters and/or fax blasts
- Review mailers for revisions and continue mailing if appropriate



**Strategic Plan
Year 2: July 2013–June 2014**

- Enhance our member web portal “My Online Services” to inform a member of needed service and allows the member to respond to their personal message
- Continue educating health home providers regarding dental care

Adolescent Well Care Visits

All regions

- Review/revise postcards and continue mailing to all three regions.
- Review/revise/continue member reminder system
- Review/revise/continue provider web portal (directprovider.com) reporting options for this measure
- Enhance our member web portal “My Online Services” to informs a member of needed service and allows the member to respond to their personal message
- Continue member education activities
- Continue provider education activities

Follow up after hospitalization for Mental Illness within 7 Days of Discharge

All Regions

- Continue discharge process team
- Review/revise/continue facility report cards
- Review code usage; continue if appropriate
- Review/revise/ continue outreach telephone calls
- Review/revise/expand program as appropriate
- Continue use of brochure
- Continue to provide provider education on subject
- Continue to seek additional home-based therapies or other innovative ways to overcome members' access barriers
- Continue to attend inter-agency meetings with high risk members

Well Child Visits in the First 15 months of Life – 6+ Visits

All Regions

- Continue mailing birthday reminders to members in all three regions
- Review/revise/continue member reminder system during telephone calls
- Enhance provider web portal (directprovider.com) reporting options will offer providers more flexibility in following non compliant members
- Plan upgrade to Navigator/HEDIS software module, HealthCare USA will be able to timely monitor key services provided to members under 2 years old. This improved knowledge of services received will enable more targeted outreach to young children who are lacking health care services such as timely well child visits



**Strategic Plan
Year 2: July 2013–June 2014**

- Enhance “My Online Services” (member portal)—scheduled to include the ability for members to see needed services such as this and to respond to the message

Emergency Department Visits

All Regions

- Continue ED PIP and its advisory panel
- Review/revise/continue brochure mailings in all three regions
- Continue urgent care listing; review options for provider and member portals
- Continue educational opportunities on contracted urgent care centers, Walgreen’s Take Care Clinics, and CVS Minute Clinics
- Explore status of health information exchanges across State and options for transferring data from ED to FQHCs and larger practices and medical homes
- Continue ED outreach to high-usage members, along with behavioral health component and follow-up
- Review rates and determine the interventions that are making an impact and eliminate the activities that are not

**Strategic Plan
Year 3: July 2014–June 2015**

Annual Dental Visits (Combined)

All Regions

- Explore new opportunities to work with dental clinics and community cultural events
- Review of postcard mailers and continue distribution in all three regions
- Explore Community Outreach for additional venues while continuing existing sites
- Continue dental PIP and the advisory panel
- Continue dental articles in member newsletter
- Continue articles in provider newsletters and/or fax blasts
- Review mailers for revisions and continue mailing if appropriate
- Enhance our member web portal “My Online Services” to inform a member of needed service and allows the member to respond to their personal message.
- Continue to work with health home providers regarding dental care

Adolescent Well Care Visits

All Regions

- Review/revise postcards and continue mailing to all three regions
- Review/revise/continue member reminder system



**Strategic Plan
Year 3: July 2014–June 2015**

- Review/revise/continue provider web portal (directprovider.com) reporting options for this measure
- Review/revise/continue “My Online Services” HEDIS education opportunities
- Continue to provide more member education activities
- Continue to provider more provider education activities

Follow up after hospitalization for Mental Illness within 7 Days of Discharge

All Regions

- Continue discharge process team
- Review/revise/continue facility report cards
- Review code usage; continue if appropriate
- Review/revise/expand program as appropriate
- Review/revise/continue use of brochure
- Conduct Provider education on subject
- Work with organizations and members to identify cultural barriers
- Seek additional home-based therapies or other innovative ways to overcome members' access barriers
- Continue to attend inter-agency meetings with high risk members
- Research opportunities related to health information exchanges

Well Child Visits in the First 15 months of Life – 6+ Visits

All Regions

- Continue mailing birthday reminders to members in all three regions
- Continue member reminder system during telephone calls
- Continue provider web portal (directprovider.com) reporting for non-compliant members
- Explore new young child monitoring opportunities; adjust outreach as appropriate
- Explore new “My Online Services” member education on needed services

Emergency Department Visits

All Regions

- Continue ED PIP and its advisory committee
- Review/revise/continue member education brochure mailings in all three regions
- Continue urgent care listing; review options for provider and member portals
- Coordinate ED log request with "G" health information exchanges and modify as appropriate.
- Continue urgent care outreach and education on contracted urgent care centers,



Strategic Plan Year 3: July 2014–June 2015
Walgreen’s Take Care Clinics, and CVS Minute Clinics
<ul style="list-style-type: none"> Continue ED outreach to high-usage members with behavioral health component

4.5.3e. External Quality Review Report

Provide (as an attachment) a complete copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Act) for the offeror’s Medicaid contract that had the largest number of enrollees as of January 1, 2010. In addition, provide a copy of any corrective action plan(s) requested of the offeror (including the offeror’s parent organization, affiliates, and subsidiaries) in response to the report.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.3(e).

The 2009 EQRO, Attachment 24, is another example of exemplary service HealthCare USA provides to MO HealthNet members. HealthCare USA continues to maintain improvements to achieve near 100% compliance in all sections of the protocol for the fourth year. Upon review and interviews HEALTHCARE USA’s commitment to quality is paramount in the continued success of the MO HealthNet Program. The quality scores are:

- Enrollee Rights and Protections 100.00%
- Quality Assessment and Performance Improvement: Access Standards 100.00%
- Quality Assessment and Performance Improvement: Structure and Operation Standards 90.90%
- Grievance Systems 100.00%

Documentation and interviews of HealthCare USA employees show dedication and compassion for our members. The interviews at the on-site review indicated a commitment by HealthCare USA to provide quality healthcare services to its members meeting the member’s cultural and language needs. HealthCare USA continues to enhance preventative services; creating new approaches to providing access to services, such as the development of after-hours clinics; obtaining member input on issues; engaging provider input regarding improving and delivering services effectively; and responding to prior authorizations and grievances in a timely and efficient manner. HealthCare USA continues to create an environment of collaboration between themselves, members, providers, and community partners.



The three Process Improvement Performances (PIP) reviewed by the state were

- HEDIS 2009 Annual Dental Visits
- HEDIS 2009 Adolescent Well-Care Visits
- HEDIS 2009 Follow-Up After Hospitalization for Mental Illness

The 2009 EQRO audit findings did not require any corrective action plans. Recommendations regarding PIP format were incorporated and the improvement was noted in the 2010 onsite audit—no matter the quality issue, HealthCare USA strives to be proactive in solving it.

The 2009 EQRO report is included as Attachment 24 for your review.

*HealthCare USA Receives
100% Rating for
Grievance and Appeals
6 Years in a Row*

4.5.3f. Proposed Quality Assessment and Improvement Programs

The offeror shall address the Quality Assessment and Improvement Programs proposed to be implemented. The offeror shall address how the proposed Quality Assessment and Improvement Programs will expand the quality improvement services beyond what the offeror is currently providing and the difference between the offeror's current programs and the proposed programs. The offeror shall also indicate how the proposed Quality Assessment and Improvement Program will improve the health care status of the MO HealthNet population. The offeror shall address the rationale for selecting the particular programs including the identification of particular health care problems and issues within the MO HealthNet population that each program will address and the underlying cause(s) of such problems and issues. The proposed Quality Assessment and Improvement programs may include, but is not necessarily, limited to the following:

1. New innovative programs and processes.
2. New contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts.

HealthCare USA understands and will comply with the requirements in Section 4.5.3(f)1-2.

Throughout this response, HealthCare USA demonstrates an exceptional commitment to quality, obtaining URAC and NCQA certification that we operate within the highest standards with the oversight and the seal of approval of respected third party organizations. Commitment to Quality and the improvement of member's health status is everyone's responsibility which HealthCare USA takes seriously. This response is for all regions unless otherwise noted.

HealthCare USA is taking Quality to a new level. With improvement tools to mine and analyze the data such as the Care Management Tool, HealthCare USA is able to perform such activities as Predictive Modeling in order to manage the program effectively. The strategies around what we are proposing and how we are going to do this are as follows:



Figure 4.5- 35: Quality Improvement Strategies

Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
<p>New Add a Physician and Member to the HealthCare USA Board of Managers, this represents "a true voice"</p>	<p>Inviting and embracing members and physicians is the best way to hear and know what is going on and how to effectively improve the health status of our members.</p> <p>Partner with: The provider and member community</p>	<p>These voices and the input gives the health plan the ability to understand the needs and enables the health plan to make better decisions regarding programs, provider and member issues.</p>	<p>Provider and Member input will bring value to our programs.</p>
<p>New Smiling Stork Program</p>	<p>The program is designed to raise awareness of the consequences associated with oral disease to women of childbearing age specifically pregnant women. The program educates the members on:</p> <ul style="list-style-type: none"> - The importance of being screened for periodontal disease during pregnancy. - The value of establishing good oral health habits for their babies. - How to access covered dental 	<p>In 2006 this program was implemented by a health plan in another state. The results were:</p> <ul style="list-style-type: none"> - That State's overall experience was 14.4% preterm deliveries. - The health plan participating in Smiling Stork experienced 13.1% preterm deliveries and - Members who had 	<p>Over the past eight to ten years there has been increasingly compelling evidence relating the presence of periodontal (gum) disease in pregnant women to increased incidence of pre-term, low-birth-weight births (PTLBW). Evidence has shown that pregnant women with periodontal disease</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>services during pregnancy.</p> <p><u>The program will include:</u></p> <ul style="list-style-type: none"> -Member education and outreach -Dental provider education and outreach -Physician education & outreach -HealthCare USA Case and Disease manager education - Community group education <p>Currently the case and disease managers inform members they have dental coverage during pregnancy, but do not offer a formal education program. This program fills this gap.</p> <p><u>Partner with:</u> DentaQuest</p>	<p>cleanings 12.2% pre term deliveries</p> <ul style="list-style-type: none"> - Members who did <u>not</u> have cleanings had 15.3% pre term deliveries <p>Based on the above results, Smiling Stork has the potential to improve the health of pregnant women and the oral health of their babies.</p>	<p>are seven times more likely to have a PTLBW birth. When women with periodontal disease receive treatment for the disease, the increased likelihood of PTLBW births drop in half, to just 3.5 times.</p> <p>A significant proportion of HealthCare USA membership (75 to 85%) are either children or pregnant women thus a large percentage of members have the potential to be affected by this program.</p>
<p>New Achieve NCQA Multicultural Health Care (MHC) Distinction Status, backed by a performance guarantee totaling up to</p>	<p>Obtain the NCQA Multicultural Health Care (MHC) Distinction status. NCQA awards the status of Distinction in MHC to</p>	<p>HealthCare USA is committed to assuring improvement in quality of healthcare for</p>	<p>It is HealthCare USA's belief that obtaining the NCQA seal of Distinction for</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
<p>\$175,000.</p>	<p>organizations that meet or exceed its standards for Distinction in MHC. The status of Distinction is awarded for a two year period by NCQA.</p> <p>Partner with: Beverly Tremain of Public Health Consulting, a certified MBE/WBE.</p>	<p>members in linguistic, racial and ethnic minority groups. Cultural competency is a necessary component of a high quality health care system.</p>	<p>Multicultural Health Care will be a differentiator for HealthCare USA and will demonstrate to MO HealthNet the plan's commitment to cultural competency.</p>
<p>New Establish a narrow network of "gold practices" for referral of special needs children by Case Managers to a PCP that will best meet the child's needs as identified.</p>	<p>This process will assist the member to find a PCP that is skilled with special needs children. It will be done by Case Managers who have identified the best PCP to meet the child's needs. This is an internal process, i.e., the Case Managers will steer the member (if the member is agreeable).</p> <p>Partner with: Select Providers</p>	<p>Special needs children and their parents and/or caregivers need immediate placement with a PCP before an urgent or emergent situation arises and forces them into the ED or other forms of inappropriate care. This also gives the parent/caregiver the ability to converse and ask questions about PCPs and this program</p>	<p>Special needs children have health issues that require expertise and it is important for the parents to establish a good relationship with a PCP to meet the ongoing needs of these children.</p>
<p>New Rheumatoid Arthritis Program - "Insight," backed by a</p>	<p>The "Insight" program will assign members to specific clinical staff</p>	<p>Use of a DMARD will impact the current and</p>	<p>Rheumatoid Arthritis (RA) is a serious &</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
<p>performance guarantee totaling up to \$175,000.</p>	<p>members (Case Managers) who will be responsible for contacting members & establishing a relationship with them to assure they are not only on a Disease-Modifying Anti-Rheumatoid Drug (DMARD), but are also refilling their prescriptions and maintaining their treatment regimen.</p> <p>The "Insight" program will provide a level of member outreach & education that is not currently provided to members with RA.</p> <p>Currently, HealthCare USA measures DMARD usage via a HEDIS measure. However, there is no proactive outreach to members not taking a DMARD as planned with "Insight."</p> <p>Partner with: Arthritis Foundation and/or Rheumatology consultant.</p>	<p>future quality-of-life and productivity of RA members.</p> <p>Living with a chronic disease requires coping skills, disease education, emotional support and tips on daily living. The "Insight" program will endeavor to improve living with arthritis for HealthCare USA members with RA. .</p>	<p>chronic disease. Early medical intervention has been shown to be important in improving outcomes. RA treatment is guided by the principle of early & tight control.</p> <p>The state is responsible for the pharmacy costs but HealthCare USA is still responsible for the overall health care of the member.</p> <p>Therefore it is important for HealthCare USA to establish a program for this disease & use of appropriate medications.</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
<p>Enhanced Integration of Behavioral Health and Physical Health with co-location of staff in all three regions</p>	<p>HealthCare USA is already structurally designed to support integration of physical and behavioral health. We will continue to deliver our behavioral health services via our sister company MNet. The fact that this is not subcontracted out to another corporation inherently ties our services together and gives us better access to behavioral health information.</p> <p>This contract period, we are improving on that integration in two ways. First, we are physically co-locating in all three regions, compared to the one region where that exists today. While today's technologies make it easy for workers to associate without physical proximity, when it comes to healthcare, there is nothing more effective than simply being there. MNet and HealthCare USA Case Managers will work side by side to initiate,</p>	<p>Studies show that holistic treatment of behavioral health and physical health improves the health status of people. The treatment of both simultaneously contributes to a speedier recovery or better quality of life</p>	<p>Many disease conditions have a behavioral health component and it is important for Case Managers to collaborate and coordinate care for both.</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>monitor, and re-evaluate a member's status. This will occur upon contract award.</p> <p>Second, we will be more proactive in providing integrated screening tools for our providers and community partners to ensure a holistic approach to health at every turn. We will also train all parties on the various types of screening tools and the role each type of provider plays in the holistic wellness of our members.</p> <p><u>Partner with:</u> MHNNet</p>		
<p>Enhanced Enhanced Breast Cancer Screening Program, backed by a performance guarantee totaling up to \$150,000.</p>	<p>HealthCare USA will partner with mobile vans and facilities to endeavor to establish locations where geo access indicates our members are concentrated and advertise to members the date, time and location of a mobile van in their area. The plan is to advertise the event as "HealthCare USA Day" at the</p>	<p>If we can make progress with a cancer screening program in a vulnerable population, we can make progress in the fight against breast cancer.</p> <p>Mammograms are not perfect, but it is the</p>	<p>The Susan G. Komen Foundation found that one-third of women qualifying for screening under today's guidelines are not being screened due to lack of access, education or awareness.</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>van. This will assist members with understanding where to go, when to go, and possibly address any access issues.</p> <p>A Provider listing " Directory type" providing the name, address and telephone number of all mammogram testing facilities and mobile vans per their region (EMO, CMO & WMO) will be sent to each member who has not had a mammogram so they have specific information on where the service is provided.</p> <p>The expanded member outreach program will provide a level of member outreach & education that is not currently provided to members who have not had a mammogram.</p> <p>Performing geo-access analysis and partnering with mobile vans and/or facilities and advertising this access to members related to their specific geographic area</p>	<p>best tool for early detection and successful treatment of this disease.</p> <p>Starting mammograms at age 40 could reduce breast cancer death by 24% according to a study published in the <i>Journal of Radiology</i> in October 2010.</p>	<p>(Reference: Susan G. Komen Foundation™)</p> <p>Review of the HealthCare USA specific data suggests that an opportunity exists for HealthCare USA to improve the HEDIS rate for Breast Cancer Screening.</p> <p>For the cost of treating an episode breast cancer (without pharmacy cost), 31 mammograms can be provided per HealthCare USA data.</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>greatly expands the current member outreach program. Providing a Directory type listing of Mammogram testing locations is new and will educate members on these facilities in an enhanced manner.</p> <p>Partner with: Mobile Mammography Vans and other Mammogram facilities.</p>		
<p>Enhanced Expansion of Asthma Disease Management Program</p>	<p>The asthma program will expand beyond the current asthma program to specifically target members who are identified to be non-compliant with the HEDIS measure for asthma medications. The targeted members will receive an in-home face-to-face visit from the HealthCare USA asthma nurse who will do a comprehensive environmental assessment. Another enhancement to the current program will be a multidisciplinary team to ensure</p>	<p>The proposed program will improve the health status of the MO HealthNet population by improving compliance with asthma medication use of the targeted members. Also, the proposed program, as a result of improved asthma medication compliance, is expected to result in a reduction in</p>	<p>The asthma program was selected to be expanded because there is an opportunity to improve outcomes for members with asthma. This is a diagnosis that can be controlled with proper adherence to the plan of care developed by the member and the provider.</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>all facets of the member’s care are addressed. The team will consists of the HealthCare USA asthma nurse, Coventry pharmacist, HealthCare USA Social Worker, MHNNet, and the asthma healthcare provider.</p> <p><u>Partner with:</u> MHNNet and an Interdisciplinary Team</p>	<p>inappropriate ED utilization and inpatient admissions.</p> <p>With the collaboration of the multidisciplinary team, members with asthma can have an improved quality of life</p>	
<p>New Rerouting Emergency Dental Care Program</p>	<p>Currently HealthCare USA is assessing emergency department visits based upon reporting from the hospitals. DentaQuest will utilize their proprietary emergency department diagnosis code list to extract emergency department visits for dental reasons directly from claims data. A coordinated staff who have experience and training in how to handle dental emergencies will conduct member outreach.</p> <p><u>Pre-Implementation</u></p>	<p><u>Expected Outcomes:</u></p> <ul style="list-style-type: none"> - Improvement in oral care IQ - Understanding of how to access emergency dental care - Decrease in ED Usage – overall and especially repeat offenders - Increase in dental utilization especially after ED visit 	<p>Managing dental emergencies in hospital emergency department is not cost effective and can be draining on the already short resources in many emergency departments. Many members use emergency departments as a walk in dental clinic and never see a dentist for follow up</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>Prior to implementing the ED program, HealthCare USA and DentaQuest established a baseline of the number of members who used the emergency department for non-traumatic dental care.</p> <p><u>Post-Implementation</u></p> <p>Twelve months after the implementation of the program, DentaQuest will analyze utilization data to determine:</p> <ul style="list-style-type: none"> - Decreases in emergency department utilization for non-traumatic dental care - Increases in the number of members seeing dentists for post emergency department care - Increases in utilization for preventive services <p><u>Partner with:</u> DentaQuest</p>		<p>care after an emergency department visit. The use of the ED for non-emergency, primary dental care can be more appropriately and economically treated in an office setting.</p>
<p>Enhanced On-line notification to Member Service Representatives</p>	<p>Member Services representatives have tools that identify gaps in care by member,</p>	<p>Every interaction is an opportunity for members to</p>	<p>Educating members on preventive care services that are</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
of gaps in care	so that every time a member calls, we can use that as a touch point for highly personalized reminders to get immunizations, breast and cervical cancer screenings, well child care exams, etc. The Member Service representative will also offer to assist the member to make an appointment or arrange transportation.	understand the level of care they should be receiving and from which provider.	relevant to them when they contact us, overcomes the challenge of reaching members. Tailoring the message to services relevant to the member, increases the relevancy of the message.
<p>New Implementation of Post Partum Visit Incentive Program, backed by a performance guarantee totaling up to \$150,000.</p>	<p>Develop a Focus Study related to a new member incentive program to increase the HEDIS rate for post partum visit rate. According to MO HealthNet policy, the member incentive will be a \$30 Walgreens' gift card that will be restricted for purchases of tobacco and alcohol. Walgreens does not sell firearms or ammunition. The Focus Study will be submitted to MO HealthNet for approval in the first quarter of 2012.</p>	<p>Increase in postpartum visits will increase the number of women screened for potential problems related to the pregnancy such as post partum depression.</p>	<p>Postpartum care is critical for all new moms. At these visits, issues such as post-partum depression and assistance with adjustment to the new baby can be offered. There is a lack of understanding among members as to the importance of these visits. Incentive programs,</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<u>Partner with:</u> Walgreens		emphasizes the importance to members.
New Provider education enhanced with 24/7 training via webinars, online tutorials	Using a best practice developed by MHNNet, we will expand our current methodologies for provider education to include non-traditional methods such as hosting webinars and on- line tutorials (via our provider portal) 24/7. <u>Partner with:</u> MHNNet	Education of providers gives provider and their staff more information to treat members effectively and appropriately	Providers and their staff are very busy treating patients, HealthCare USA is finding innovative ways to educate providers and their staff thus minimizing the time away from their practice.
New Use of Coventry Care Management Tool (CMT).	The Coventry Care Management Tool (CMT) is a healthcare information solution that allows for better insight into factors that affect the member's health. CMT uses strong theoretical framework, clinical knowledge, rigorous empirical evidence and evidence-based medicine. Case Managers use that information as part of their assessment for Case Management, e.g., to determine	Enables us to identify potential candidates for case management and disease management at an early stage which improves members health outcomes	Identifying members who are highly likely to experience a major medical episode before that episode, potentially reduces the severity of the illness or disease.



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>members who are at high risk for future admissions and utilization as well as identifying gaps in care.</p> <p>The CMT tool allows for a “360° Member View” including condition-specific and “actionable” priority care alerts available to Coventry’s Care Management team.</p>		
<p>New Enhance Substance Abuse Program for High Risk OB (HROB) Members</p>	<p>Expand the HROB program beyond the current program by improving coordination of services for pregnant women related to substance abuse. Currently, the member is identified for substance abuse and mental health issues by the Global Risk form completed by the OB provider. Then when appropriate the member is referred to the MNet case manager. With the enhancement, the member will have a more immediate assessment of their needs conducted by the HROB</p>	<p>The proposed program will improve the health status of the MO HealthNet population by providing a more immediate assessment and coordination of substance abuse and mental health needs in pregnant women.</p>	<p>This program will improve outcomes during the member’s pregnancy which should result in a reduction in the number of low birth weight babies, premature deliveries, and an improvement in the coordination of postpartum depression services. By identifying and treating these members earlier,</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>nurse instead of the member waiting to have a detailed assessment of their substance abuse and mental health needs by MHNNet.</p> <p>To help the HROB staff remain current with the issues of substance abuse and mental health in pregnancy, continuing education seminars are provided/ conducted by MHNNet. The staff education consists of information they should discuss with pregnant women who are identified to have a history of or current substance abuse and mental health issues.</p> <p><u>Partner with:</u> MHNNet</p>		<p>access to treatment will occur earlier in the pregnancy.</p>
<p>New Enhancement to our Current Readmission Case Management Program</p>	<p>The expanded program will be patterned after the existing Coventry Transition of Care program that is currently in use for Medicaid ABD membership. This readmission program involves identification of</p>	<p>This program improves the health status of the members by building a relationship with the member up front, and then meeting with them face-to-face to further</p>	<p>HealthCare USA's current readmission rate for members in case management is 8.7% of which 60% of the readmissions have the same or</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>members that have a Potential Readmission Diagnosis (PRD) based on HealthCare USA's highest readmission diagnoses. These members are also likely to benefit from intense care coordination activities. Member evaluation and assessment will be performed by a multi-disciplinary team (RN, social worker, Medical Director and pharmacist) with the goal of assisting the member while experiencing the hospitalization crisis for the first 30 days thereafter.</p> <p>The Readmission case manager will provide telephonic outreach to the member at 7 days, 14 days and 28 days post-discharge. Follow-up conversations will reassess the components reviewed during the home visit, adjust goals as needed, and provide support.</p>	<p>the relationship while identifying environmental and social barriers to self-management. The approach is collaborative and multi-disciplinary and focuses on resolving barriers to complying with treatment, education and routine follow-up. This allows the member to fully understand their condition and the steps they must take to manage it to prevent further readmission.</p>	<p>similar diagnosis as the initial admission. Intense care coordination and face-to-face visits will reduce unnecessary readmissions while also reducing inpatient and emergency department utilization. This, in turn, will allow members to be better educated on their conditions and allow for better self-management of the condition.</p>
<p>New HEDIS analyzed and</p>	<p>Prepare and distribute an annual</p>	<p>As providers become</p>	<p>Providers want to</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
<p>discussed at more granular practice level to provide focused provider education</p>	<p>HEDIS report card to physician groups in the Medical Home project and PCPs with a member panel \geq 100 members.</p> <p>Partner with: Health home project participants and high volume PCPs</p>	<p>aware of any weak HEDIS scores in their practice, they will make adjustments within their office. This will lead the providers to track and promote preventive services to members.</p>	<p>provide high quality care, but have limited options for comparing themselves to others. By providing our larger practices with their key HEDIS scores and comparative benchmarks, these groups will be able to adjust their practice patterns or outreach efforts to improve weak areas.</p>
<p>Enhanced Improving HEDIS scores</p>	<p>Emphasize select HEDIS measures to improve scores in each region by new creative outreach efforts. HealthCare USA will commit to improve by 2% annually in each region for each year of the contract the breast cancer screening and postpartum visit measures. For breast cancer screening, HealthCare USA will work with</p>	<p>Many HEDIS measures are designed to count the receipt of standard, quality health care especially preventive. By improving these scores, there is a reduction in related diseases or health care problems thus</p>	<p>A) Breast cancer screening Several studies have shown that mammograms help find early, more easily treated stages of breast cancer. By developing targeted programs for geographically related members and</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>community groups to arrange a mammography van visit at locations where large groups of members have not had a mammogram. Prior to the van visit, HealthCare USA will have identified members in that area and reached out to them to inform them of the van visit. For postpartum, HealthCare USA is developing a new member incentive program specific to postpartum visits.</p> <p>Partner with: Community groups and mammography van providers.</p>	<p>improving MO HealthNet member's health status.</p>	<p>including the mammogram service, many of the barriers such as access should be reduced for these members</p> <p>B)Postpartum visits Postpartum care is critical for all new moms. At these visits, issues such as post-partum depression and assistance with adjustment to the new baby can be offered. There is a lack of understanding among members as to the importance of these visits. Incentive programs, emphasizes the importance to members.</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
<p>Enhanced Child CAHPS Scores to remain above the quality compass Medicaid national average, backed by a performance guarantee totaling up to \$300,000.</p>	<p>Employ continuous quality improvement processes with HealthCare USA Member Services, Provider Relations, and Claims Processing to recognize barriers members encounter in their relationship with HealthCare USA. As part of the process, standards and policies that affect members will be reviewed and improved. Efforts on maintaining a strong relationship with the members are expected to result in above average Child CAHPS overall scores annually by region.</p>	<p>CAHPS measures members satisfaction with the care and treatment they have received. Efforts to improve these scores should also positively affect some of the barriers members have in receiving, timely care thus improving their health status.</p>	<p>Member satisfaction is important to the overall success of the health plan. MO HealthNet members feedback through the CAHPS survey provides HealthCare USA with key drivers that can be addressed to improve satisfaction.</p>
<p>Enhanced Retain HEDIS Prenatal Care at the 75th percentile, backed by a performance guarantee totaling up to \$300,000.</p>	<p>HealthCare USA will do refresher education to our OB/GYN physicians to assure they are aware of our Beary Important Bundle (BIB) member incentive program for prenatal care. The Quality Department will work with Provider Relations to distribute the incentive program information to the providers who in turn can</p>	<p>Routine prenatal care, as prescribed by an OB provider, can help improve birth outcomes and decrease morbidity and mortality for both the mother and the unborn child.</p>	<p>This member incentive plan encourages members to seek necessary OB care. Refresher education for providers and community stakeholders are avenues that will help</p>



Proposed Programs beyond current offering	Differences of new programs/new partnerships	How to improve health care status of MO HealthNet population	Rationale for selecting programs and identify the particular problems and issues that each program will address and underlying causes of problems and issues.
	<p>distribute to HealthCare USA expectant mothers. Our goal is assure that our members seek the appropriate prenatal care and increase the rate of participation in the BIB program. The Quality Department will also collaborate with Community Development to do refresher education on the BIB program to various agencies, health departments, and other community partners. The member incentive is the \$30 Walgreens gift card that is programmed to restrict the purchase of alcohol and tobacco. Walgreens doesn't sell ammunition or firearms.</p> <p>Partner with: OB/GYN Providers, Provider Relations, Community Development, Community Partners, and Walgreens.</p>		<p>us educate our members.</p>

In addition to the above, you will see the overall commitment of our parent company, Coventry, in terms of improving certain health issues annually. This year Coventry is committed to improving HEDIS rates for Diabetic Eye Exams, Breast Cancer Screening, and Postpartum Visits.

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4.5.3g. Focus Studies and Process Improvement Projects

The offeror shall provide a description of focus studies performed, and quality improvement projects and any other improvements the offeror has implemented and their outcomes. Such outcomes shall include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions shall address such activities since 2008. The offeror shall address how issues and root causes were identified, and what was changed.

HealthCare USA understands and will comply with the requirements in Section 4.5.3(g).

HealthCare USA's special attention to Focus Studies and Process Improvement Projects and the methodology we use is an asset to the overall quality and continuous improvement of the entire organization.

We have the systems to gather, compile, and analyze data to generate functional, useable information. Our employees have a strong skills at not only reviewing data but also comparing it with what they know about the different regions and their members. We work diligently to hire employees with specific skill sets such as analysis and statistics in addition to clinical knowledge and experience. We also conduct continuing education in subjects such as quality improvement, clinical updates, and compliance issues.

Detailed information is provided on:

Focus Studies

- Asthma Around the World Member Incentive
- Beary Important Bundle Member Prenatal Incentive
- Postpartum Depression
- Welcome Program

Performance Improvement Projects

- ED utilization
- Attention Deficit Disorder
- Grievance and Appeals
- Mental Health Follow-up After Hospitalization
- Readmissions
- Statewide Adolescent Well Care
- Statewide Annual Dental Visit
- Synagis®

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FOCUS STUDIES

Asthma Around the World Member Incentive

***Region: EMO, CMO, WMO**

***Years: 2008-2011**

***Issue and Root Cause identified** - According to the National Heart Lung Blood Institute (NHLBI) and National Asthma Education and Prevention Program (NAEPP) clinical practice guidelines for asthma, the cornerstone of asthma care is control of asthma symptoms. Because more than half of all dollars spent on asthma care is related to hospital costs, programs aimed at reducing ED visits and hospitalization have produced a reduction in overall asthma care costs. In 2007 and 2008, asthma remained one of the most prevalent and costliest diagnoses in the HealthCare USA member population, with more than 14,000 members or 10% identified by claims as having asthma.

*** Cost Savings Realized - Our ROI on Asthma is 1.56. In one year, we saved \$75k from shorter inpatient stays and fewer ED visits**

*** Process efficiencies** - Better access to information for patients through education of member and education of provider

*** Improvements to member health status** - The HealthCare USA HEDIS rates for Use of Appropriate Medications for People with an Asthma are as follows; Western is 3/10^{ths} of a percent away from meeting the 75th percentile. Both Eastern and Central are less than 1% away from the 50th percentile, which is 88.6%. The St Louis area has a significantly higher number of asthma patients than the national average. The number of asthma patients is one of the highest in the United States and in January 2009, The Asthma and Allergy Foundation ranked St Louis the “most challenging” place for asthma sufferers to live. Thus, having the region meet at least the 50th percentile in med usage is important to the member’s quality of life.

Beary Important Bundle (BIB) Member Prenatal Incentive

***Years 2008-2011**

***Issue and Root Cause identified** – Pregnancy care management is a high-volume service provided to HealthCare USA members. Routine prenatal care, as prescribed by an OB provider, can help improve birth outcomes and decrease morbidity and mortality for both the mother and the unborn child. This member incentive plan encourages members to seek necessary OB care.

*** Cost Savings Realized** – In 2010 there were 599 babies admitted to the NICU (5.6% of births). The cost avoidance for



FOCUS STUDIES

each baby born full term and well versus born into the NICU is \$28K. **Reduction of NICU admission in 2010 worth more than \$200,000.**

* **Process efficiencies** – The number of gift cards distributed in 2010 increased by 104 cards from 2009. HealthCare USA Provider relations staff and Condition manager nurses continue to ensure that pregnant members are aware of the BIB program. Members who participated in the BIB program in 2010 had a higher average gestational age of 38.50 compared to an average gestational age of less than 38 in 2009.

* **Improvements to member health status** - The BIB program objective is to encourage member to seek prenatal care early and regularly which may have resulted in the increased gestational age average among participants. A longer gestational stay results in a healthier infant without the complications of a premature birth. The BIB incentive program not only offers incentive cards to pregnant women who seek regular prenatal care but also provides an educational brochure that educates the member on the importance of prenatal and the resources available they may utilize to help promote healthy pregnancies for example dental care and transportation to providers if needed.

Postpartum Depression

***Region:** EMO, CMO, WMO

***Years:** 2009 - 2011

***Issue and Root Cause identified** - Depression in new mothers can significantly impact the health and well-being of the mother, infant and other children in the family. Studies show that infants and children of mothers with depression are more likely to have frequent hospital admissions, poor hygiene and delays in cognitive and emotional development. Depressed mothers are less likely to engage in home safety and prevention practices, follow medical instructions for themselves and their infants and are more likely to experience problems with mother-child bonding. Any member who is pregnant or 6 months post delivery is open to screening and/or inclusion based on referral. The at risk population is screened for and identified as high risk based on the use of mood stabilizer or antipsychotic medications as reported by the referral source or as identified in claims. Members may also be identified as high risk based on clinical judgment (ex. knowledge that mental illness has significantly impaired member's activities of daily living and health, member has history of suicide attempts).

* **Cost Savings Realized** –**At minimum, 1% of new moms require hospitalization for postpartum depression. Using this data, preventing an inpatient stay equals a savings of \$272,600 per year.**

* **Process efficiencies** – To obtain the best outcomes, early identification of co-morbid behavioral health disorders with



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medical conditions allows for early intervention. Early intervention can decrease utilization of higher levels of care and increase compliance with outpatient preventive care. The identification process includes risk assessments submitted by OBs, referrals from complex case and/or disease management, and referrals from concurrent review nurses. Identified members are then screened for high risk criteria: use of antipsychotic and/or mood stabilizers and/or knowledge of a significant and impairing mental health history (one which does not otherwise qualify them for MHNNet intensive case management). High risk members receive outreach from the HealthCare USA social worker and the non high risk members receive outreach from MHNNet

***Improvements to member health status** – The mother’s behavioral health is improved which also positively impacts the infants’ quality of life due to the mother’s engagement in activities such as safety. In addition, the overall physical and behavioral health of the children are improved as well experiencing less delays in cognitive and emotional development

Welcome Program to Improve Member Demographic information

***Region:** EMO, CMO, WMO

***Years:** 2008-2009

***Issue and Root Cause identified** – Outreach, education and close monitoring are critical to promote access to services and education. Member demographic data is not always accurate, resulting in return rates on mailings ranging from 14 to 44%, and a successful telephone call contact rate of only 25%.

*** Cost Savings Realized** – N/A for this.

*** Process efficiencies** – Calls received in response to the sticker ranged from 4–8% of total calls received by member services. The number of calls ranged from 2,500 to 5,000 calls per quarter.

*** Improvements to member health status** – Reaching and communicating with members is essential to improving the status of our members. The communications, both written and oral, are instrumental in the educating and guiding the member to services and providers to enhance their health care.



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Attention Deficit Disorder (ADD)

***Region:** EMO, CMO, WMO

***Years:** 2009 - 2011

***Issue and Root Cause identified** –ADD is one of the five most prevalent behavioral health diagnoses among all members served by HealthCare USA. Relevance regarding ADD as a preventive health program becomes even more substantiated since children ages 0 to12 rank second in the utilization of behavioral health services. Even though the children receive services through a provider, we want to ensure that parents/caregivers are also accessing necessary services.

*** Cost Savings Realized** – N/A – more appropriate care – children do better in school which equates to higher future earnings

*** Process efficiencies** –Baseline measurement is the HEDIS 2009 results for Follow-Up Care for Children Prescribed ADD Medications which identifies children ages 6 to 12 years who are newly prescribed ADD medication. Adherence with the Initiation Phase indicates there was one follow-up visit with a provider during the first 30 days after the medication was prescribed. Continuation and Maintenance Phase is at least two additional follow-up visits within 9 months after the Initiation Phase has ended

*** Improvements to member health status** –HEDIS measures are updated in order to monitor members effectively. Medication management and follow up visits are paramount to the success of treating ADD. 2010 and 2011 HEDIS rates for both the Initiation Phase and the Continuation and Maintenance Phase have increased compared to the 2009 baseline. Interventions began initially in April of 2009 with members identified as newly prescribed on ADD medication and ages 6 to 12. Outcomes will be measured for each month's identified newly prescribed members and their adherence to visits within 30 days and 9 months after the medication began

ED Utilization

***Region:** EMO, CMO, WMO

***Years:** 2008 - 2011

***Issue and Root Cause identified** – HealthCare USA identified an increase in utilization of the ED for all emergent and non-emergent/avoidable cases. Non-urgent and avoidable ED utilization affects the quality of care and long-term health outcomes for members and seems to indicate a lack of a health care home.



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* **Cost Savings Realized** – In 2010, there was a savings of \$383,000 from diverting ED visits to urgent care. On average, utilization of urgent care instead of ED saves \$108 per visit

* **Process efficiencies** – The 2011 HEDIS rate for ED utilization decreased in all three regions from the previous year. The Eastern region decreased from 82.19% in 2010 to 80.55% in 2011. The Western region decreased from 90.60% in 2010 to 82.37% in 2011. The Central region decreased from 70.13% in 2010 to 67.32% in 2011. The HEDIS ED Utilization rate is calculated per NCQA HEDIS technical specifications. The HEDIS rate includes all ED claims and is not dependant on diagnosis or outcome. The HealthCare USA ED Visits/1000 Members rate in all three regions has trended downward since third quarter 2009. There was an increase in all three regions in 2011 Q1. We are experiencing a decline in ED for all regions for the past three years. The ED Visits/1000 members will continue to be monitored to see if this indicates a pattern of seasonal variation.

* **Improvements to member health status** – Members seeks appropriate care and stay out of the ED experience less waiting times in a traditional provider office setting, the engagement of the provider and the office staff, more information regarding community services from the provider's office, and experience a holistic approach to their health care by staying out of the ED.

Grievance and Appeals

***Region:** EMO, CMO, WMO

***Years:** 2008 - 2009

***Issue and Root Cause identified** – HealthCare USA reviewed the 2006 process and outcomes data related to member grievances and appeals, and provider complaints, grievances and appeals. As a result, an opportunity to reduce the number of member and provider concerns, reduce the overturn rate, and improve timeliness was identified. Interventions were reviewed specifically for the impact on reducing the number of complaints, grievances and appeals, decreasing the overturn rate, and improving timeliness.

* **Cost Savings Realized** – N/A

* **Process efficiencies** – The number of member appeals resolved in a timely manner improved to 100% in January 2009 and has remained at 100% since then. In the past members requesting an extension were tracked as not timely if not completed within 30 days consistent with other appeals. This has been corrected to be 45 days and still timely, which has resulted in 100% compliance with timeliness.



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* **Improvements to member health status** - Data on grievances and appeals can be used as a feedback tool to evaluate utilization management and utilization review (UM/UR) protocols. Percentage of overturns may also indicate a need for modification of UM/UR processes or a need for additional staff education to consistently and accurately apply UM/UR protocols.

Mental Health Follow up after Hospitalization

***Years: 2008 - 2011**

***Issue and Root Cause identified** – Compliance with planned aftercare has proven to play a major role in decreasing the rate of re-hospitalization of mentally ill persons. Studies have shown that patients are more likely to comply with their aftercare treatment and attend their follow-up appointments if the following occur:

Assistance is provided in making the initial aftercare appointment, the appointment is scheduled for patients, the patient and family members receive education about their illness and medications, and they receive a follow-up call within 48-hours of discharge.

Though there was a decrease in the ambulatory follow-up rates for all regions overall for 2010, there was improvement noted in the after those interventions listed below were put into place. As a result, MHNet expects this upward trend will continue.

***Cost Savings Realized** – in 2010 there were **25 fewer members readmitted for a savings of \$72,500.**

***Process efficiencies** - providing assistance to members has been a process improvement to improve outcomes

* **Improvements to member health status** - appropriate outpatient care with medication management has an overall improvement to a member's health and well-being.

Readmissions

Years: 2008 - 2011

***Issue and Root Cause identified** – There are many contributing factors to hospital readmissions. Studies suggest re-hospitalizations can be prevented by identifying patients at risk for readmission before hospital discharge, follow-up strategies after discharge and sufficient payment for management of chronic diseases with office-based services and drugs need to occur.

* **Cost Savings Realized** – in 2010, we avoided **306 readmissions which equates to a savings of \$1.7million.**

* **Process efficiencies** –



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Beginning in the second quarter of 2010 and continuing on readmission rates have met or exceeded goal. Readmission rates have met the goals of 6.97 for less than 90 days and 3.91 for less than 30 days. There have been signs of seasonality in the data. However, there has been a downward trend since 2009 Quarter 1.

* **Improvements to member health status** - assuring appropriate follow-up care prevents an exacerbation of their illness.

Statewide Adolescent Well Care

***Years: 2008 - 2010**

***Issue and Root Cause identified** – Reasons for low adherence with Adolescent Well Care annual visits appears to be lack of education to providers and members regarding the importance of well-care visits, no distribution of preventive health guidelines to members and practitioners and lack of member transportation to provider offices.

* **Outcomes Realized – HEDIS rate for 2010 compared to 2011 of 10%age points.**

* **Process efficiencies** – During the PIP, HealthCare USA continued to make improvements in its HEDIS rates related to Adolescent Well Care Visits. There was an increase in all three regions of the State for each of the four years. The Western region had the largest increase in 2008. HealthCare USA anticipates this increasing trend to continue into 2009

* **Improvements to member health status** - More timely preventive care allows for earlier diagnosis of health problems

Statewide Annual Dental Visit

***Years: 2009 - 2011**

***Issue and Root Cause identified** – Oral health is an integral component of children’s overall health and well-being. Dental care is the most prevalent unmet health need among children. Statistics from the Centers for Disease Control and Prevention (CDC) reveal that over two-thirds of children have decay in their permanent teeth. The Kaiser Commission suggests that “oral disease has been linked to ear and sinus infection and weakened immune system, as well as diabetes, and heart and lung disease. Studies found that children with oral diseases are restricted in their daily activities and miss over 51 million hours of school each year”. The connection between oral health and general health is not often made by Medicaid recipients who frequently encounter other socio-economic challenges. Many Medicaid participants have traditionally approached dental care in an episodic rather than preventive manner. Access to dental services is an ongoing nationwide challenge for many health plans serving the Medicaid population. More than half of the children on Medicaid received no dental service in 2007. During this same time period in Missouri, the rate of dental service utilization was 27.9%.



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* **Cost Savings Realized** – in 2010 there was a savings of \$1,594,912 by increasing the number of exams statewide.

* **Process efficiencies** – EMO increased the ADV rate from the base year in 2008 of 34.61% to 41.72% in 2011 (HEDIS years), a growth from the baseline year of 7.11 points or 20.54%. CMO increased the ADV rate from 35.08% in 2008 to 48.26% in 2011, a growth from the baseline year of 13.21 points or 37.57%. WMO increased the ADV rate from 30.29% in 2008 to 43.62% in 2011, a growth of 13.33 points or 44.01%. The STWD data shows an increase in the ADV rate from 34.85% in 2008 to 43.10% in 2011, a growth of 8.25 points and an increase over the base year of 23.67%.

* **Improvements to member health status -**

Synagis®

***Region:** _EMO, CMO, WMO

***Years:** 2008 - 2010

***Issue and Root Cause identified** – RSV is the most common cause of bronchiolitis and pneumonia in infants and children under one year of age. 0.5–2% of all children diagnosed with RSV require hospitalization. The majority of children hospitalized are under six months of age, and 1–2% of those children hospitalized will die (CDC; Division of Viral Diseases). The AAP recommends that prophylaxis for the prevention of RSV be initiated just before the onset of the RSV season.

The 2007-2008 RSV season data for HealthCare USA members showed a positive impact and significant reduction in the number of members who acquired an RSV infection if they received prophylactic Synagis®. HealthCare USA data further displays that members who received some, but not all of the five Synagis® injections, still had a reduced rate of hospitalization for RSV-related illness than other members who appeared to qualify but received none. While the data collected in 2007-2008 season was not complete, analysis of what was collected suggests that there were missed opportunities to provide Synagis® vaccinations to members who qualified.

* **Cost Savings Realized** – From our experience, the savings realized from 2008-2010 was a total of \$602,610

* **Process efficiencies** – The 2007-2008 RSV season data for HealthCare USA members showed a positive impact and significant reduction in the number of members who acquired an RSV infection if they received prophylactic Synagis®. HealthCare USA data further displays that members who received some, but not all of the five Synagis® injections, still had a reduced rate of hospitalization for RSV-related illness than other members who appeared to qualify but received none. Comparing the 2008-2009 season to the 2007-2008 season there was a 28% increase in requests approved. The number of compliant increased from 106 to 287, which was 75% of the members who received Synagis® in 2008-2009. In 2008-2009



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only 30% of the members were compliant with the Synagis[®] program.

* **Improvements to member health status** - The avoidance of RSV a common respiratory illness in very young children which can cause hospitalization and even death.

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4.5.4 Access to Care – Primary Care

4.5.4a. Primary Care Networks

The offeror shall demonstrate adequate provider networks to fulfill MO HealthNet requirements.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a).

4.5.4.a1. The offeror shall submit documentation demonstrating that the offeror's networks comply with travel distance access standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. The offeror shall also submit documentation for those providers not addressed under 20 CSR 400-7.095, ensuring members will have access to those providers within thirty (30) miles unless the offeror can demonstrate that there is no licensed provider in that area, in which case the offeror shall ensure members have access to those providers within sixty (60) miles. For any demonstrated access that differs from these standards, the offeror shall submit proof of approval of the differences by the Department of Insurance, Financial Institutions & Professional Registration.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)1.

HealthCare USA has developed a comprehensive, statewide provider network to meet travel distance and network adequacy requirements as required by MO HealthNet and Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP) in 20 CSR 400-7.095. Our Missouri provider network includes hospitals, primary care, specialty care physicians, advance practice nurses, FQHCs, RHCs, local health departments, family planning/STD clinics, vision providers, ancillary, behavioral health, substance abuse, dental health and emergent/non emergent transportation providers. HealthCare USA also includes provider types and specialties in our network such as dental health providers that are not specified in the 20 CSR 400-7.095 to ensure a comprehensive network of providers to care for our members.

This comprehensive network covers the 54 counties in the MO HealthNet Central, Eastern and Western service areas. Also, HealthCare USA is licensed in 51 additional counties outside the current service area and we have contracts with providers in the 24 contiguous counties to the service area. Our extensive network presence in Missouri will facilitate any future program expansion as a result of the implementation of the Patient Protection and Affordable Care Act (ACA). Further, as we demonstrate in the sections that follow, our current network is capable of providing care to any additional new membership we may acquire following award of this contract.

The table below presents a snapshot of our provider network throughout the 54 MO HealthNet counties as well as the contiguous counties outside the service area.



Figure 4.5- 36: Provider Networks - Overall Counts by Category

Provider Type	In the 54 MO HealthNet Counties				In MO Counties Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
	Hospital	20	32	20		
Ancillary	267	360	139	766	136	902
PCP	537	878	341	1756	440	2196
Specialist	1284	4187	1271	6742	641	7383
Dental	87	153	193	433	123	556
Behavioral Health	313	955	615	1865	261	2126
FQHC*	8	18	5	31	55 (RHC/FQHC)	193
RHC*	65	29	13	107		
Local Public Health**	25	13	13	51	4	55
Family Planning/STD Treatment**	2	5	1	8	3	8

* These numbers are also included in the number of PCPs.
 ** These numbers are Included in ancillary counts
 FQHC, RHC, LPH, Family Planning providers are broken out separately in this grid as they are listed on Attachments to RFP)

DATA SOURCE: COVENTRY PROVIDER DATABASE MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Documentation of Travel Distance Standards

On March 1 of each year, HealthCare USA files an annual network access plan with DIFP as required by 20 CSR 400-7.095. The attached documentation from the DIFP shows that HealthCare USA complies with network capacity and travel distance standards for all provider types and specialties as required by 20 CSR 400-7.095. Specifically, this is evidenced by the first paragraph in the DIFP Network Adequacy Approval letter, dated June 6, 2011, indicating that the 2010 Network Access Plan for HealthCare USA was approved.



As the DIFP documentation illustrates, our networks have achieved **100% compliance** with network capacity and travel distance standards.

Note: HealthCare USA submits a provider file to DIFP of our dental provider network for evaluation, (which is a MO HealthNet requirement and not actually a part of the DIFP regulation) Because distance standards do not exist in the DIFP regulation for Dental providers, the following standards are used to evaluate the dental network:

- Urban county: 15 miles
- Basic county: 30 miles
- Rural county: 60 miles

DIFP has also evaluated our dental network and we have achieved **100% compliance** for dental network capacity and travel distance standards.

Geo Access Reports

In addition to the DIFP documentation, HealthCare USA conducts its own review of provider networks as part of our ongoing monitoring of travel distance and access for our membership.

We are also including a series of Geo Access maps and summary reports as Attachment 25, showing the distribution of network provider locations in relation to our current membership and evidence that our geographic distribution of providers covers the entire service area for all three regions. A separate map showing locations within a 30-mile and 60-mile radius is presented for the following provider categories, covering some of key high volume areas of concern to our population:

- RHC and FQHC
- Child PCP
- Adult PCP
- OB/GYN
- Pediatrics
- Dental
- Adult Behavioral Health
- Child Behavioral Health
- High Volume Specialist

As demonstrated in the Geo-Access maps and summary reports, HealthCare USA's vast provider network covers the entire 54 county service area and we are in **100% compliance*** with network capacity and travel distance standards.

*Data Source: Geo-Access Mapping Software, Coventry Provider Database, HealthCare USA Member Eligibility File
Measurement Period: October 31, 2011



4.5.4.a2. The offeror shall provide documentation verifying that the offeror's network has adequate capacity. Such documentation shall include, but it is not limited to, appointment availability, 24 hours/7 days a week access, sufficient experienced providers to serve special needs populations, waiting times, open panels, and PCP to member ratios.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)2.

In the paragraphs that follow, we describe our network capacity for the Primary Care network. This description contains an assessment of appointment availability, 24/7 access, providers serving special needs populations, open panels and waiting times in provider offices. Unless otherwise specified, the reporting period for these network compliance indicators is the end of the calendar year 2010. The reporting period for the number of providers shown in each of the tables below and on the Geo Access maps and summary reports is as of October 31, 2011.

Adequate Network Capacity and Monitoring Access to Services

Over the course of our 16 years as a managed care organization in Missouri, HealthCare USA has developed, enhanced and utilized several policies, procedures and processes to monitor our provider, subcontractor and affiliate networks to ensure adequate network capacity, accessibility for our members, and accuracy in our provider listings. Further, our network activities are designed to achieve the ultimate goal of connecting our members with a health care home so they can obtain services in the most effective and appropriate setting.

In addition to using Geo-Access for distance reviews, we use additional monitoring activities for each network category including:

- Conducting telephonic provider secret shopper surveys regarding appointment and after-hours access for primary, maternity and high volume specialty care.
- Reviewing providers' panel status to confirm if new members can be assigned and if provider has reached capacity or referral limits.
- Reviewing PCP to member ratios by provider type and by region to ensure an adequate number of primary care providers are available.
- Following up and resolving member concerns related to access or appointment availability.
- Reviewing quarterly analysis and trending of member grievances to identify any potential availability or accessibility access issues; perform root cause analysis and develop corrective action plans, if necessary.
- Case managing members identified as utilizing the emergency department (ED) for non-emergent conditions.
- Making weekly updates to online Provider Directories to reflect changes in open/closed panels.



- Reviewing monthly provider network and recruitment activities of dental and behavioral health networks.
- Initiating independent oversight by in-network physicians that participate on HealthCare USA's Quality Management Committee of network access and availability studies conducted for primary care, specialty care, emergent care, dental and behavioral health.

In instances where a network provider cannot meet access or appointment availability standards, HealthCare USA and our subcontractor and affiliate Provider Relations teams:

- Conduct provider education regarding the standards
- Work with the provider to resolve the issues
- Locate additional providers to meet the member's need
- Conduct recruitment efforts to add additional providers if the need arises

Any providers who do not meet standards are educated and re-surveyed within 30 days of the initial survey to ensure compliance with access and availability standards.

Primary Care Networks

The table below illustrates the number of Healthcare USA primary care providers by region, including those counties outside the service area.

Figure 4.5- 37: Primary Care Provider Counts by PCP Category

PCP Category	Within the 54 MO HealthNet Counties and in Contiguous Counties			Outside of Service Area	Total
	Central	Eastern	Western		
Family Medicine/ General Practice	255	258	635	201	836
Internal Medicine	75	224	380	65	445
Pediatrics	68	235	382	32	414
Physician Extenders	66	114	222	86	308
PCP Clinics	73	47	138	55	193
Total	537	878	1757	439	2196

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011



PCP-to-Member Ratio

HealthCare USA utilizes the following PCP and physician extender (nurse practitioner, physician assistant) to member standards in order to measure provider capacity in our medical provider network across all three regions:

Provider Type	PCP to Member Standard
Primary care providers	1:2,000
Physician extenders (Nurse practitioners, Certified Nurse Midwives, Physician Assistants)	1:1,000

To demonstrate the strength of our PCP network, we examined not only the PCP to member ratios for our current membership, but also for a projected expanded membership encompassing all MO HealthNet eligibles. To arrive at a total projected membership, we combined our current enrollment with the membership of the next largest Medicaid provider participating in the MO HealthNet program, assuming we may acquire that membership following contract award.

As the tables below illustrates, our PCP network exceeds the PCP to member ratios across the overall region and in each PCP category, both for our current membership and for a projected expanded membership consisting of all MO HealthNet managed care eligibles and due to health care reform.

Figure 4.5- 38: Overall PCP to Member Ratio (Standard = 1:2000)

Using	Western	Central	Eastern	Overall
Current Membership	65	43	137	238
Growth Membership *	187	87	201	424
HealthCare Reform Membership **	215	114	265	545
*Adding membership of next largest MCO in each region ** Adding the Healthcare reform membership estimated for current ME codes to Growth membership (current HealthCare USA plus membership of next largest MCO)				

DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE
 MEASUREMENT PERIOD: AS OF OCT. 31, 2011



Figure 4.5- 39: PCP to Member Ratio by PCP Specialty - Current Membership (Standard = 1:2000)

PCP Specialty	Western	Central	Eastern	Overall
Family Medicine/GP	175	88	466	228
Internal Medicine	48	39	81	62
Pediatrics	301	324	455	393

DATA SOURCE: COVENTRY PROVIDER DATABASE; HEALTHCARE USA MEMBER ELIGIBILITY FILE
 MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Figure 4.5- 40: PCP to Member Ratio by PCP Specialty – Growth* Membership (exit of Next largest MCO) (Standard = 1:2000)

PCP Specialty	Western	Central	Eastern	Overall
Family Medicine/GP	500	180	680	1492
Internal Medicine	274	77	121	796
Pediatrics	247	667	662	738
*Adding membership of next largest MCO in each region				

DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE

MEASUREMENT PERIOD: AS OF OCT. 31, 2011



Figure 4.5- 41: PCP to Member Ratio by PCP Specialty Healthcare Reform Membership* (ADULTS) (Standard = 1:2000)

PCP Specialty	Western	Central	Eastern	Overall
Family Medicine/GP	580	236	898	523
Internal Medicine	295	262	279	243

* Adding the Healthcare reform membership estimated for current ME codes to Growth membership (current HealthCare USA plus membership of next largest MCO)

*DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE
MEASUREMENT PERIOD: AS OF OCT. 31, 2011*

In order to monitor compliance with this standard, HealthCare USA’s Provider Relations team conducts PCP capacity survey with PCP offices to determine the capacity level for taking additional members and ensure the provider’s panel status is listed correctly in our online provider directory. A detailed review of practitioner staffing and member concerns regarding quality of service is reviewed annually for large panel practices (>1000 member) to ensure these PCPs can meet all access guidelines and to ensure our members experience no barriers to receiving health care. The report of findings is submitted to the HealthCare USA Quality Management Committee (QMC) for review and recommendations.

On an ongoing basis, HealthCare USA also monitors provider capacity through the review of member grievances, member satisfaction surveys, quality improvement activities and by our case management team. When quality of service issue trends are identified, HealthCare USA or the provider may request to close the provider’s panel until additional practitioner(s) have been added or the office hours have been extended to allow more capacity

Appointment Availability

HealthCare USA recognizes the need to identify and remove any barriers for our members related to access to care. In order to ensure that our members have adequate access to providers, HealthCare USA requires participating providers, subcontractors and our affiliate to follow appointment and availability standards as required by MO HealthNet. This information is published in the Member Handbook and Provider Manual, reviewed with providers during orientations and quarterly provider visits, and sent periodically via the provider newsletters. HealthCare USA closely monitors our subcontractors and affiliate to ensure compliance with these standards by reviewing the results of their monitoring efforts during quarterly subcontractor/affiliate oversight meetings. The table below shows our most current PCP compliance at 100% with appointment standard requirements.



Figure 4.5- 42: PCP Compliance Rate

Appointment Standards	Central	Eastern	Western
Urgent care appointments for illness and injury within 24 hours	100%	100%	100%
Routine symptomatic care appointments within one week or five business days, whichever is earlier	100%	100%	100%
Routine asymptomatic care appointments within 30 calendar days	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010
 MEASUREMENT PERIOD: 2010

24/7 Access to Care

HealthCare USA requires all PCPs providers to be available to direct care for our members 24 hours a day, seven days a week. Our health plan periodically conducts random surveys of providers to confirm their after-hours access meets the 24 hour access to care standards. PCPs are required to maintain telephonic access for after-hours access to care. Providers are required to provide direct access, use a call coverage service or utilize a nurse triage line. In addition, HealthCare USA standards require the provider to refrain from directing members to call 9-1-1 as the only option for after-hours access. The table below indicates the PCP after-hours access survey results for 2010.

Figure 4.5- 43: PCP Compliance Rate

	Central	Eastern	Western
24/7 After-Hours Access	95%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010
 MEASUREMENT PERIOD: 2010

Providers to Serve Special Needs Populations

HealthCare USA’s Medical Directors direct the Special Needs program. They work in conjunction with the supervisor of case management, a Missouri-licensed registered nurse, who oversees nurse clinicians and social workers who function as special needs coordinators. These nurse clinicians are familiar with a variety of social service programs and collaborate with stakeholders and providers in all three regions. The special needs coordinators serve as a point of contact for members, their representatives, providers, State agencies and local public health agencies.

Recognizing that each child and family is unique and deserving of focused attention, our special needs program has evolved into a family-centered, culturally-sensitive approach that is individualized for the child and his/her parents and/or guardians.

Please see the table in the Specialty Care Network section which shows a sampling of providers across the three regions who are contracted to provide services to meet to our special needs populations across the state.



Waiting Times in PCP Offices

Our PCPs are required to comply with the waiting time standard not to exceed one hour from the scheduled appointment time. This includes time spent in the lobby and the examination room prior to being seen by the provider. Exceptions are allowed to this standard when the provider “works in” urgent care appointments; when a serious problem is identified or when the member has an unknown need or condition that requires more services or education than was described at the time the appointment was made.

Because HIPAA privacy regulations restrict the review of patient appointment data, our Provider Relations representatives are unable to evaluate actual documented waiting times in providers’ offices. To monitor compliance with the waiting time standards, HealthCare USA uses feedback from member grievances and complaints. We consider the provider to be compliant with the waiting times standard when the reported feedback reveals the absence of any grievances or complaints. As shown in the table below, based on our most recent analysis of member grievances, there have been very few complaints of excessive waiting times in PCP provider offices (beyond one hour from scheduled appointment).

Figure 4.5- 44: PCP Compliance Rate (Measured by the Number of Member Grievances for Prolonged Wait time)

Office Waiting Time Standard	Central	Eastern	Western
Waiting times for appointments (not to exceed one hour from scheduled appointment time)	0	4	1

DATA SOURCE: HEALTHCARE USA NAVIGATOR REPORT ON PROVIDER QUALITY OF SERVICE ISSUES. MEASUREMENT PERIOD: 2010

Open/Closed PCP Practices

HealthCare USA monitors PCP panel status and annually reviews PCPs who are listed with a closed. 92% of the PCP network had open panels across all three regions.

As of December 2010, percentages of open panels for PCPs in each region were as follows:

Open Panels	Central	Eastern	Western
Primary Care	97%	90%	91%

DATA SOURCE: HEALTHCARE USA ACCESSIBILITY SURVEY. MEASUREMENT PERIOD: 2010



4.5.4.a3. The offeror shall describe how tertiary care providers including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists will be available twenty-four (24) hours per day in the region. If the offeror does not have a full range of tertiary care providers, the offeror shall describe how the services will be provided including transfer protocols and arrangements with out of network facilities.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)3.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4.

HealthCare USA maintains and monitors the participating provider network in accordance with DIFP network adequacy criteria. HealthCare USA is in compliance with these tertiary care requirements.

Our tertiary care provider network includes:

- Trauma centers
- Burn centers
- Level III (high risk) nurseries
- Rehabilitation facilities
- Medical sub-specialists (Pediatric subspecialty, Perinatology, Neonatology, etc)

In all three regions, our provider network maintains a full-range of tertiary care providers. Our contracted facilities are staffed with all necessary medical subspecialty providers to provide all necessary tertiary care services 24 hours a day.

The figure below shows the tertiary care hospitals located within HealthCare USA's managed care service Area, by region shows all contracted tertiary care facilities, trauma centers, burn centers and rehabilitation facilities available in the HealthCare USA participating provider network.



Hospital	Contracted with HCUSA	Trauma Center	Level III Nursery	Peri-natology Services	Cancer Services	Cardiac Services	Pediatric Sub-specialty	Burn Center	Rehab Facilities
Western Missouri Region									
Children's Mercy Hospital	Y	Level I	Y			Y	Y	Y	Y
Citizen's Memorial Hospital	Y	Level III							
Liberty Hospital	Y	Level II	Y				Y		
Saint Joseph Medical Center	Y		Y	Y		Y			
St. John's Regional Health Center (Springfield)	Y	Level I	Y	Y	Y	Y	Y	Y	
St. Luke's Hospital of Kansas City	Y	Level I	Y		Y	Y	Y		Y
Saint Mary's Medical Center	Y		Y		Y				
Truman Medical Center Hospital Hill	Y	Level I	Y						
Central Missouri Region									
Boone Hospital Center	Y		Y			Y			Y
Bothwell Regional Health Center	Y				Y				
Hannibal Regional Hospital	Y				Y				
Capital Region Medical Center	Y			Y	Y	Y			
Lake Regional Health System	Y	Level III				Y			
Rusk Rehabilitation Center	Y								Y
Phelps County Regional Medical Center	Y	Level III			Y				
Saint Mary Health Center	Y			Y	Y	Y			
University of Missouri Hospital & Clinics	Y	Level I	Y		Y	Y	Y	Y	Y
Eastern Missouri Region									
Barnes-Jewish Hospital	Y	Level I	Y		Y	Y	Y	Y	Y
Christian Hospital	Y				Y	Y			
Mercy Hospital - St. Louis	Y	Level I	Y	Y	Y	Y	Y	Y	Y
Missouri Baptist Medical Center	Y				Y	Y			
Saint Louis University Hospital	Y	Level I			Y	Y			
Saint Lukes Hospital	Y			Y		Y	Y		
SSM Cardinal Glennon Children's Hospital	Y	Level I	Y						Y
SSM DePaul Health Center	Y	Level II		Y	Y	Y			
SSM Rehab	Y								Y
SSM St. Joseph Health Center	Y	Level II		Y	Y	Y			
SSM St. Joseph Hospital West	Y	Level III		Y					
SSM St. Mary's Health Center	Y		Y	Y	Y	Y			Y
St. Anthony's Medical Center	Y	Level II			Y	Y			
St. John's Mercy Hospital	Y	Level III							
St. Louis Children's Hospital	Y	Level I	Y				Y	Y	Y
The Rehab Institute of St. Louis	Y								Y

DATA SOURCE/MEASUREMENT PERIOD: MARCH 2011 DIFP FILING

Although HealthCare USA has a full range of contracted tertiary hospitals in each region, we also understand the importance of providing primary, secondary and tertiary levels of care at hospitals that are out-of-area (“out-of-network”). If a member requires specialty care from a tertiary hospital that cannot be provided by Missouri-based tertiary hospital, HealthCare USA has written protocols for allowing members to obtain tertiary level services out of network. HealthCare USA manages these cases whether care is provided in Missouri or outside the state.

4.5.4.a4. The offeror shall complete and submit Exhibit A, documenting each FQHC, RHC, CMHC, and Safety Net Hospital proposed to be included in the offeror’s provider network.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)4.

HealthCare USA meets and exceeds the requirement to contract with at least one Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Community



Mental Health Center (CMHC) and Safety Net Hospital in each region. In conjunction with our subcontractors and affiliate we have long recognized the key services provided by these entities in underserved areas of Missouri and have established collaborative relationships with them.

The tables below reflect a summary of HealthCare USA contract status with each FQHC, RHC, CMHC and Safety Net Hospitals listed in Exhibit A. The completed Exhibit A is included in Volume 2 of our response.

Figure 4.5- 45: Total Number Contracted FQHC, RHC, CMHC and Safety Net providers from Exhibit A

	Central	Eastern	Western	Totals
FQHC	6	6	2	14
RHC	47	28	28	103
CMHC	6	5	5	16
Safety Net Hospitals	1	3	2	6

4.5.4b. Primary Care Access Issues

The offeror shall respond to each of the requests for information below (1-5) as it relates to each of the areas of evaluation: Primary Care, Specialty Care, Dental Services, and Behavioral Health Care.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b).

4.5.4.b1. The offeror shall describe the tailored methods proposed to meet the health care needs of MO HealthNet members. The offeror shall address how the offeror will tailor programs, business processes, and strategies for improvement to address the unique needs of the members in each region and ensure that all populations in each region have access to services. Accordingly, the offeror should not describe the following in its responses:

- Notices, mailings, information in the Member Handbook, etc. that are required under the Performance Requirements specified herein;
- Distribution of literature, practice guidelines, etc. to providers; and
- Presence at local health fairs and other typical health-and-wellness events.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)l.



HealthCare USA recognizes the unique needs of members throughout the state and has tailored our approach to providing care in each region based on those needs. We tailor programs based on the member population (children vs. adult) and based on the demographics of the region. We also give consideration to other important regional differences such as special needs, geographic conditions, socio-economic levels, cultural barriers, language needs, as well as network composition and availability of community resources.

We target local provider partners with a range of specialized expertise who are familiar with the clinical needs of our population, along with the cultural, socio-economic, and religious backgrounds of our members. This in-depth, local understanding helps us provide services in ways that address each region's specific needs.

In the paragraphs that follow, we describe the tailored programs, business processes and improvement strategies we have implemented to address the unique needs of members in each region to ensure members have access to services.

Programs

Central Region

The focus of our programs in the Central region is on the rural nature of the region. Because the Central region is predominately rural, programs in this region often address transportation needs and the difficulties members have in getting to medical appointments. Providers are located in a broad geographic distribution in the Central Region, therefore members must travel longer distances to reach a provider. In addition, many members in the Central region avoid seeking care, not only because of the challenge of the geographical distances but also because they do not acknowledge the benefit of periodic routine or preventive care. Our case managers not only arrange transportation, but also provide additional education emphasizing the need for these periodic routine or preventative care appointments.

HealthCare USA ensures our network includes a variety of social service providers that help bridge the gap by providing conveniently available services to members who would not otherwise seek care. For example, a simple task such as completing the necessary paperwork for food stamps can be daunting. Having a community or faith-based organization help with such a task increases the likelihood members will follow through with administrative requirements and ultimately get the services they need. Our Community Development Specialists are active in the community providing needed education on ways to access services. We also partner with community organizations such as Head Start, Parent as Teachers (PAT), parenting programs, faith-based initiatives, multi-lingual organizations, as well as a large network of primary care physicians and FQHCs/RHCs who provide primary care services in underserved and remote areas.

HealthCare USA has recently implemented a school-based/early childhood program called Triads of Care. The "triad" includes the HealthCare USA Community Development Specialist, a school nurse and a school counselor or social work/health coordinator. The role of the triad is to help a family through the process of accessing care





by arranging medical appointments, coordinating transportation and assisting with follow-up and future appointments. As results of this intervention become available, our goal is to expand the program throughout the state.

Eastern Region

With the presence of a refugee settlement agency in St. Louis, the Eastern region contains ethnic populations from Russia, Romania, Bosnia, China and Vietnam. To meet the needs of these various ethnic groups, we tailor our PCP assignment program to match members with providers who speak their language. We also provide interpreter services as necessary for non-English speaking members and refer members to the Language Access Metro Project (LAMP) for help with language issues. In addition to supplying members with written materials in their spoken language, we provide a more personalized connection for them through community resources. These community resources are an important element in providing culturally sensitive services for members who often feel unfamiliar or alienated in an environment that is very different from that of their homeland. Examples of our partnerships with community service organizations include the Redeem Project, a faith-based organization, 27th Ward Infant Mortality Coalition, an early pregnancy care program; after school programs such as Boys and Girls Clubs, Girls, Inc. and Discovery Options.

Western Region

The Western region is comprised of both rural and urban areas with 70% of the population residing in urban areas. In addition, the Western region contains a large pediatric and obstetrical population. To provide care to this population, HealthCare USA will become part of a new contractual relationship with Children's Mercy Hospital known as the Integrated Pediatric Network (IPN). The IPN will cover members ages 20 and under (including pregnant women) located in 13 counties. Members will be assigned to the IPN according to the location of the member's PCP. The IPN will assign a team to each PCP including a resource nurse, care manager and educator/health coach for asthma and diabetes. By providing these resources, we anticipate improved health outcomes including HEDIS results. The IPN will include community pediatricians and family physicians. Their practices will benefit with standardization of payment policies, utilization policies and credentialing. Health Information Technology tools including electronic medical records (EMR) and health information exchange (HIE) will also be available.

Business Processes

All Regions

Although the two business processes noted below are not tailored specifically by region, we believe they are significant enough to mention here as they are important elements in helping our providers render quality medical care.

- **Clinical Notification Program.** Our Member Services team uses every call with a member as an opportunity to educate the member about missing or needed



preventive services through a process known as the Clinical Notification Program. When members call our service center, the Member Services Representative can view the member's medical claim history and advise the member of any preventive services that are due, assist with primary care and specialty appointment scheduling, and coordinate transportation requests.

- **Coventry Provider Performance Monitoring Tools.** Beginning in 2012, the new suite of Provider Performance Monitoring tools allows HealthCare USA to obtain reports specific to our members that supports predictive modeling, performance for health home, medical management, actuarial performance and provider network management. HealthCare USA will gain functional capabilities and reports which will allow us to better communicate with primary care practices; work together to improve access for needed services and identify opportunities for targeted outreach. There are three tools which are available:

Provider Support Tool (PST). This monitoring tool addresses the need for HealthCare USA to communicate critical health information about our members to providers. The PST is web-based and provides comprehensive and targeted information to primary care practices to support care and health improvement. For example, the PST provides a "one page snapshot report" to PCPs to identify members who have HEDIS gaps in care, over utilization of ED visits and avoidable hospital admissions. In addition, our providers will have the ability to send information back to HealthCare USA to close any relevant gaps in care based on information in their medical records. We have implemented the use of this PST with our Pilot Primary Care Medical Home program. We plan to expand the use of the PST by training and providing access to the MO HealthNet Health Home providers.

Coventry Care Management Tool (CMT). The CMT addresses the need for HealthCare USA to have an episode based predictive modeling and case management analytics solution, so that HealthCare USA can use clinical, risk, and administrative data to facilitate better targeted health care services to members who will benefit the most. For example, the CMT allows for "360 degree member view" including condition-specific and actionable priority alerts to our Case and Disease Management Team via our medical management system, NavCare. The CMT has improved algorithms which allow for the improved member stratification and identification of high risk members based on a single characteristic as well as a combination of multiple risk attributes and clinical indicators. This will be used by our Case and Disease Management teams for improved care coordination activities.

Network Decision Support Tool (NST). The NST allows HealthCare USA to profile our network providers. The NST will create groups of physicians by specialty and identify the most efficient and highest quality providers. The NST will be utilized for the specific purpose of developing an internal referral process to refer our special needs population to a highly effective narrow network of providers to ensure quality outcomes for this at risk population.



Strategies for Improvement

All Regions

HealthCare USA has identified the following two initiatives designed to improve access to care and channel members to the appropriate level of care.

- **Western region - Implementation of ACO/Global Risk arrangement with Children's Mercy's Integrated Pediatric Network (IPN).** HealthCare USA has identified the following initiative which is designed to improve access to care and channel members to the appropriate level of care. Our new contractual relationship with Children's Mercy Hospital's IPN will expand network access through the addition of key pediatric PCP practices. Included in the IPN are Resource Nurses, Care Managers, and Educator/Health Coaches, who will channel members to the appropriate level of care. The team of professionals will work with PCP offices using key metric reports to identify barriers to access for members. The reports will determine solutions to ensure access to the appropriate level of care. Implementation of ACO/Global Risk arrangement with Children's Mercy's IPN will begin when the acquisition of Children's Mercy Family Health Partners closes. This is anticipated to take place on December 31, 2011.
- **Promoting the Use of Convenience Clinics, Urgent Care Centers and After Hours Clinics.** We are addressing the need to reduce unnecessary high-cost emergency department visits and have implemented a member education campaign designed to promote the use of urgent care clinics in lieu of visits to hospital emergency department. HealthCare USA will educate members on the difference between convenient care and urgent care clinics so that our members can use them as an alternative to the Emergency department if their PCP is not available. In 2005 HealthCare USA expanded the provider network of convenience clinics and urgent care clinics. To provide education to our members, we have developed a letter and a member brochure (pending state approval) which includes a list of locations of all convenience clinics, urgent and after care clinics in all three regions.

In the Eastern Region, during the 2nd Quarter of 2012, HealthCare USA will pilot a partnership with Walgreen's Take Care Clinics (WTCC). WTCC will expand hours of operation at five locations. In order to determine if this strategy has an impact, we will measure our baseline emergency department visits on members within a 5 mile radius of the WTCC locations prior to the expansion of hours. We will then monitor the Emergency department visits and alternative care site utilization rates. If this initiative is proven to be successful in reducing emergency department visits we will consider expanding this program to the other regions in Missouri. WTCC has 23 locations in Eastern region and 23 in Western Region.
- **Member Incentive Programs.** HealthCare USA uses a variety of Member Incentive Programs approved by MO HealthNet to encourage members to seek medical care. The program awards members with a \$30.00 gift card when they access specific types of care such as prenatal and post-partum care and asthma medication follow-up within a specific timeframe.



4.5.4.b2. Given differences between urban and rural areas (e.g. population needs, access to care issues), the offeror must address how the offeror's orientation programs, education strategies, and interventions for providers and members in rural areas will differ from those used in more urban areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)2.

Over the course of the last 16 years, an integral part of our provider communication strategy has been to identify and cultivate collaborative relationships with rural providers. We have refined our processes over time to ensure that our provider and member orientation, education and communication strategy addresses the needs of providers in all settings. For HealthCare USA, whether providers are in a rural setting or an urban setting, HealthCare USA's goal is to build collaborative relationships by providing well trained, responsive and accessible Provider Relations representatives who are familiar with the unique aspects of office practice.

HealthCare USA understands that operating a healthcare delivery system in both urban and rural settings requires a different approach to programs for providers and members. For providers, conditions such as geography, local employment market conditions and access to technology affect the way they operate their practices. For members, access barriers such as lack of transportation and scarcity of providers affect their ability to get care. Based on these differences, we have tailored our Provider Relations and Member Relations programs in ways to address these differences.

The table below outlines the differences in our approach for urban and rural areas regarding orientation programs, education strategies and interventions for providers and members.

Figure 4.5- 46: Primary Care

Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
HealthCare USA team members	Regional office locations in Eastern region (St. Louis) and Western region (Kansas City) Network management, quality improvement coordinators, case/disease management and concurrent review and community development team	Regional office location in Central region (Jefferson City) Network management, quality improvement coordinators, case/disease management and concurrent review and community development team. This model ensures our team members are within reasonable



Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
		travel distance for outreach with rural providers.
Provider Relations Program <ul style="list-style-type: none"> • Representative Assignments 	By zip code due to the density of providers	By County
<ul style="list-style-type: none"> • Frequency of Visits 	In person visits are held at least quarterly.	In person visits are held at least quarterly.
<ul style="list-style-type: none"> • Provider Office Staff Training 	<p>Urban practices tend to have an office manager who funnels information to other staff within the practice.</p> <p>Provider representatives tailor their education to help the office manager understand which resource materials are of most help to billing staff versus staff that handle authorizations versus claims.</p> <p>Urban practices frequently have additional administrative offices and utilize external billing companies. To accommodate this decentralized approach to practice operations, our provider relations team will schedule additional meetings with those external entities, in order to keep all parties informed of plan policies and changes.</p>	<p>Individual visits are scheduled for each provider within the community during the same day/week to obtain a complete picture of any challenges faced within the community. This allows our staff to better understand any opportunities to effect quick and efficient resolution.</p> <p>Practices in rural communities face more resource challenges and typically cross-train their staff on multiple duties. Provider representatives offer training to the entire staff on all aspects of the program.</p>
Regional Provider Seminars	Hosted at large urban hospitals allowing maximum face-to-face	Hosted in locations such as Bolivar, Hannibal and Macon,





Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
	<p>participation and participation from the majority of our affiliated PCP practices</p>	<p>Missouri. Recognizing travel distance impact on practice efficiency, annual provider seminars will also be offered as webinars. HealthCare USA hosts regional provider seminars in rural locations such as Bolivar and Macon, MO where multiple provider groups within a one hour area may attend. MTM participates as vendor to conduct in-service and answer questions.</p>
<p>Provider Visits</p>	<p>Outreach to high volume providers to review new information and/or resolve issues. A provider relations representative is available for every provider in the network. All representatives have access to wireless technology to ensure visits and issues are efficiently handled.</p>	<p>Outreach to high volume providers to review new information and/or resolve issues. A provider relations representative is available for every provider in the network. When scheduling visits in a rural setting, representatives make every effort to meet or drop by as many offices in the area to ensure they stay in touch. All representatives have access to wireless technology to ensure visits and issues are efficiently handled.</p>
<p>Proposed Provider Education</p>	<p>On-line tutorials will be added to provider portals.</p>	<p>On-line tutorials will be added to provider portals.</p>



Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
	Webinars	Webinars
Member Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
Education Concerning Member Transportation Benefit	<p>Many members have access to public transportation but fewer have cars. All modes of transportation are discussed. Emphasis placed on member process to request public transport or pickup, need for member to call MTM from doctor's office to arrange for additional trip for same day tests or pharmacy pickup.</p> <p>Less emphasis on mileage reimbursement program.</p> <p>Joint HealthCare USA/MTM in-service presentations for large hospital or physician practice groups to explain processes and procedures.</p>	<p>Most members have a car or relative with a care. All modes of transportation are discussed. Emphasis placed on member process to obtain mileage reimbursement, showing office staff where to access form in case member forgets and physician office staff needs to sign reimbursement form acknowledging provider visit.</p>

4.5.4.b3. The offeror shall describe how its approach to service delivery will achieve optimal outcomes for the populations in each region proposed. The offeror shall describe the implications of the regional demographic data to their service delivery strategies (refer to Attachment 1).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)3.



Achieving Optimal Outcomes for Each Population

HealthCare USA, in our 16 years of serving MO HealthNet in Missouri, understands that having a provider network that complies with the access and availability standards are only the baseline. Getting members the right services, at the right time, in the right setting, to ensure optimal outcomes, requires much more. In particular, we must:

- Create provider networks to match the needs of population groups – providers best suited for the needs of one population group may not be those who are ideal for another group. This crosses multiple boundaries of service type, provider expertise, language, ethnicity, age, sex, and health status.
- Connect members to providers who meet their needs – having the right providers available in the network is the first step, but we go beyond this by working to understand the unique and individual needs of each member, then helping them choose and connect to providers to meet those needs.
- Help members communicate with providers – even with the right providers in the network, language and communication barriers can hamper effective engagement of the member in their health care. We provide the right tools and services to ensure that members can communicate – not just with customer service, *but with providers at the point of care.*
- Build cultural competency throughout the health plan and network – while choosing the right providers and connecting members to those providers is a great start, we recognize the need to evolve cultural understanding and appreciation throughout our health plan, our subcontractors, affiliate, and our network. We do so through a combination of policies, training, and ongoing efforts to improve our understanding of the populations we serve.
- Address disparities in care for population groups – all of the prior steps help generally improve awareness of the needs of member groups and individual members, but we do more by examining information on health care disparities that exist for population groups and creating initiatives to address those.

In the following sections, we highlight our approach to each of these challenges, and show how we overcome them with creative solutions to ensure that members are connected to care and engaged in understanding and participating in their treatment.

Creating a Provider Network to Match the Needs of Population Groups

HealthCare USA already has a large provider network across all three regions of the Missouri. To provide for the services of mothers and children, we have a very large obstetrics/gynecology network and a large pediatric care network. In addition, all of the children's hospitals within the service area are in the HealthCare USA network. *In the new contract*, this network will be enhanced with the merger of Children's Mercy Family Health Partners, particularly in the Western region.

The HealthCare USA Community Development Team identifies cultural health care access trends in all managed care counties. By collaborating with faith-based organizations and community outreach centers who serve a diverse congregation and



parish, we learn who provides health care for members of those organizations, help those members find a HealthCare USA provider, and help them access interpretation and transportation assistance for appointments. For example, in the Eastern region, our Community Development Team works with CASA De Salud, a Spanish-speaking clinic that serves immigrants who have recently arrived in the St. Louis area. We help these immigrants find health care services and connect them to a primary care provider.

We also work with our Provider Relations Representatives to identify network providers who can match the member's cultural needs. For example, in the Central Region, we work with Centro Latino to match our members in Boone County with a trusted Hispanic health care provider and an interpreter to go to the appointment with them. Through our partnerships with our community resources, we can provide our members a community mentor to help them find seeking transportation, interpretation, and other services.

In the Western Region, Primera Iglesia Bautista Church helps our members in accessing their benefits and contacting the physician's office to schedule an appointment. They will also help the member keep their appointment and overcome any last-minute barriers.

Connecting Members to Providers Who Meet Their Needs

The HealthCare USA Community Development Team serves as a reference and referral point for our membership in identifying network providers and visiting their primary care provider on an annual basis. We also list the language of the provider in the provider directory for easy accessibility by both members and other providers who need to make referrals for a member. However, if the desired provider is not a HealthCare USA network provider, we will refer the provider to our Provider Relations Team to offer the provider an opportunity to join the Healthcare USA provider network.

For members who do not choose a PCP during enrollment, our auto-assignment algorithm will consider, among other elements, the member's primary language (if supplied on the enrollment file) and will use this information in matching the member to a PCP.

The HealthCare USA Community Development Team uses our partners and relationships within our communities to match our members to a provider and find a health home. Often, faith-based organizations serve as a conduit between member population groups and our plan and providers. For example, in the Eastern region, the Korean Presbyterian Church connects HealthCare USA to the Korean population; similarly, Immanuel Lutheran connects HealthCare USA to the Chinese population. In the Western region, Shiloh Baptist Church connects Healthcare USA to the Hispanic community. In the Central region, the Ministerial Health Alliance connects HealthCare USA to the Hispanic population.



Helping Members Communicate with Providers (Translation/Interpretation)

Once HealthCare USA connects a member to the appropriate provider, we need to make sure that all of the member's interactions – whether with our health plan or the provider – are conducted in a way that is easily understood by the member. Doing this helps the member understand his or her available options for health care treatment and how to follow the treatment plan prescribed by the provider.

Interpreter Services

HealthCare USA makes interpreters available to ensure that members are able to communicate with HealthCare USA representatives, providers, and receive covered benefits, at no cost. These are available both for member services questions to HealthCare USA, as well as for member appointments with providers.

Language LineSM Helps Connect a Member to Case Management

A 53 year old member was referred to case management by a HealthCare USA Concurrent Review Coordinator after admission to the hospital. The member had a diagnosis of unstable angina, myocardial infarction, stent placement, hypertension and diabetes. The case manager contacted the Language Line to coordinate interpreter services so the case management program could be explained and a full assessment performed. The member was enrolled into our case management program in November 2009. Prior to the member leaving the HCUSA plan in May 2010, they were not admitted again for a related diagnosis.

Interpretation Facilitates Assessment of Member Needs

A 35 year old female member was referred to disease management through the OB Global Risk Assessment form submitted by the OB provider due to advanced maternal age and diabetes. The member had a history of 7 previous pregnancies with only 4 living children. She spoke only limited English and needed interpreter services. The case manager contacted the Language Line and arranged to have a Bosnian interpreter assist with their communication, which allowed the HealthCare USA nurse to complete a full assessment of the member's needs and explain the disease management program and its benefits. The member was willing to participate in the program and was enrolled in May 2010. Despite her risk factors, the member delivered a healthy baby in October 2010.

Member Services – Language Line Services

To access interpreter services for general information, member benefits, and eligibility questions, we ask the member or member's authorized representative and/or provider to call 1-800-566-6444 and ask for an interpreter. HealthCare USA has on-site staff to service both English and Spanish-speaking members. We recruit fluent bi-lingual Member Service Specialists. These specialists know and understand our business best. However, if all bi-lingual specialists are currently on calls, or the member needs an interpreter in another language, the Language LineSM Translation Service provides interpreters 24 hours a day, seven days a week.

With over 25 years of experience and translation available in over 190 languages, the Language LineSM Translation Service is a leader in telephone interpretation services. Language LineSM has a proprietary quality



assurance program developed by leading academic experts in the field of language testing and interpreter training and reflects HealthCare USA’s commitment to service excellence. At Language LineSM, each request for telephonic translation is routed according to skill-based routing techniques, thus ensuring that each member is matched with a translator who speaks his/her requested language.

We help callers speaking on behalf of a member while maintaining HIPAA compliance. For our hearing impaired members, HealthCare USA maintains a toll-free TTY/TDD telephone relay function manned by specially trained specialists.

Provider Appointments—Language Line or Face-to-Face Interpretation

For our provider offices, over-the-phone interpretation is a quick, easy way to communicate with a member who does not speak English when the provider’s facility does not have bi-lingual resources. Over-the-phone interpretation helps us provide excellent service to members who have limited English speaking skills. Additionally, it helps eliminate the stress and frustration often experienced during language-complicated encounters. The provider can simply call the number above and request an interpreter to access this service.

However, for some medical appointments, it can be more effective to have an interpreter present in person. Using third party vendors, HealthCare USA provides face-to-face interpretation services. Members or providers can request interpreters by calling the Member Services Department or faxing their requests directly to the agencies as directed below:

Figure 4.5- 47: Face-to-Face Interpretation Services are Available in All Missouri Regions

Region	Translation Source
Central	Language Access Metro Project (LAMP) Jewish Vocational Services (JVS)
Eastern	Language Access Metro Project (LAMP)
Western	Jewish Vocational Services (JVS)

We also provide interpretation services for medical appointments for the hearing impaired through third-party vendors. All interpreters are certified by the State of Missouri. Members or providers can request interpreters by calling the Member Services Department or by contacting the agencies as shown in the table below.



Figure 4.5- 48: Interpretation Services for the Hearing Impaired are Available in All Missouri Regions

Region	Translation Source
Central	Deaf Way
Eastern	Deaf Way Deaf Inter-Link
Western	Deaf Expression, Inc.

Members are informed of availability of interpreter services through the Member Handbook; Member Services Department toll-free number; educational presentations; HealthCare USA tri-fold brochure available in English/Spanish/Bosnian, entitled *Language Assistance Services*, and on our website under Member Rights & Responsibilities. All interpreter services are provided at no charge to the member.

Figure 4.5- 49: Face-to-Face Interpretation Services are Regularly Used by HealthCare USA Members for Many Languages

Language	FY11 Q1	FY11 Q2	FY11 Q3	FY11 Q4	Total
Spanish	574	612	587	546	2319
Nepali	234	179	143	210	766
Arabic	142	112	140	161	555
Somali	71	76	101	91	339
Burmese	85	98	90	41	314
Vietnamese	87	80	75	71	313
Bosnian	44	59	53	47	203
Russian	24	26	39	26	115
Swahili	6	12	15	30	63
Karen	3	2	31	19	55
Mandarin	15	17	8	14	54
Korean	3	13	20	15	51
Farsi	14	15	8	3	40
Cantonese	8	5	7	5	25
Albanian	4	4	3	13	24
Kirundi	1	3	13	5	22



Language	FY11 Q1	FY11 Q2	FY11 Q3	FY11 Q4	Total
Tigrinya	2	4	4	10	20
Kurdish	5	3	6	5	19
Dari	1	3	3	6	13
French	0	6	2	4	12
May May	0	2	6	1	9
Hindi	0	0	1	3	4
Pashtu	1	3	0	0	4
Uzbek	0	0	3	0	3
Chin	0	0	2	0	2
Kunama	0	0	0	1	1
Turkish	0	1	0	0	1
Totals	1324	1335	1360	1327	5346

SOURCE: HEALTHCARE USA INTERPRETATION SERVICES - 2011

Building Cultural Competency Through the Health Plan and Provider Network

Building Overall Cultural Competency

HealthCare USA goes beyond translation and interpretation to build cultural competency into our health plan organization and all of our relationships, processes, and transactions with members. Indeed, several our subcontractors were selected because of their commitment to reducing healthcare disparities as a result of socioeconomic and racial differences (see Executive Summary for more information).

Our demonstration of commitment to cultural competency is our proposal to attain the *NCQA Multicultural Health Care Distinction* designation in support of cultural competency and reducing healthcare disparities. A Performance Guarantee of \$30K further demonstrates our commitment (\$15K for Year One to apply; \$15K in Year Two to obtain). Moreover, MHNet is currently developing a comprehensive cultural competency program that meets the requirements of the Distinction.

Specifically, our program considers five different aspects of cultural competency:

- Philosophy.** HealthCare USA honors members' beliefs; we believe that every member deserves to receive respect, understandable communications about their health care, and care that is compatible with their cultural beliefs. We value cultural diversity and inclusion as essential to developing a more effective system of care. Cultural competence is a core part of our organization and values, permeating every action we take and every interaction with members and providers.



- **Policy.** Our cultural competency philosophy is incorporated into formal company policies, administrative processes and decisions, and delivery of services. We reflect that policy through our ongoing efforts to recruit staff who represent the demographics of the member populations that we serve. HealthCare USA also has a written strategic plan, updated annually, that describe our goals, policies, operational plans, and management oversight to provide culturally and linguistically appropriate services.
- **Education.** Hiring a diverse workforce helps, but every employee of HealthCare USA needs to fully understand, appreciate, and internalize our philosophy and policy about cultural competency. Each employee must also know: “what is the right thing to do in this situation?” To help educate our team, we provide annual diversity training to all employees. Our program, *Footprints*, is an online course about respecting the differences of others in the workplace. The presentation includes slides, case studies, and questions that challenge and enhance each employee’s understanding of the importance of valuing and respecting differences. We also offer training to providers – a two-hour e-learning course on Cultural Competency, which offers Continuing Medical Education credit through a vendor, Quality Interactions. HealthCare USA has also augmented our internal training with in-service sessions, such as the following:

Thirty-five management and staff employees participated in a Poverty Simulation exercise for HealthCare USA employees conducted by the Community Action Agency of St. Louis County (CAASTLC).

Hosting a joint staff and community provider in-service on Cultural Diversity and its Impact on Health Care Delivery. This session was conducted by Joseph Betancourt, M.D., Director of the Disparities Solutions Center and the program director for Multi-cultural Education at Massachusetts General Hospital, and an assistant professor of medicine at Harvard Medical School.

Completed an all-clinician (nurses and medical directors) pain management beliefs assessment and followed up with an in-service about the impact of personal beliefs and culture on treatment of chronic pain. The in-service was presented by Dr. Elliott Gellman, Medical Director for BJC Healthcare Palliative Care Program.

- **Analysis.** We use data from various sources, including the U.S. Census, MO Health Net, and others as available, to best understand the populations we are serving. These data sources and reports help us understand the general demographic, cultural, and epidemiological profiles of the community, as well as the race, ethnicity, and primary spoken and written languages of members who are enrolled in our plan. We analyze this data to assist us in planning all aspects of our plan administration and operations, including network needs, requirements for written materials, potential quality improvement projects needed to address health care disparities, and others.
- **Partnership.** Building cultural competency involves building relationships and trust with the community. HealthCare USA has established strong relationships with community agencies and organization who are dedicated to improving the lives of



minority cultures and disparate populations throughout Missouri. We also recognize that there are important differences between urban and rural regions in access to services and member needs; therefore, we have strengthened our partnerships in rural areas by attending monthly community agency action meetings and participating in local events. These include Back-to-School Fairs in counties throughout the state, which help us reach child members and their parents in a community setting.

Overcoming Disparities in Care for Specific Population Subgroups

As described in the previous sections, HealthCare USA, our affiliate, MHNet and our subcontractor, DentaQuest will work to identify and understand the needs of the various population groups, build networks to meet those service needs, and work to communicate effectively with members and providers to connect and engage members in the system of care. Despite our work, there are still disparities in health outcomes for various population groups. In this section, we describe three such disparities and the actions we plan to take to address those. These disparities are:

- Lower rates of breast cancer screening (mammography) for African-American women
- Lower rates of routine dental care for African-American and Hispanic/Latino children
- Greater rates of behavioral health episodes, with lower treatment rates, among African-Americans

Breast Cancer Screenings (Medical)

African American women have lower mammography rates as compared to Caucasian women. Research (e.g. Moy B et al, 2006) shows that the presence or absence of insurance coverage is not necessarily the barrier. Instead, from literature searches and other research, we find the following barriers to African American women receiving mammograms:

- **Fatalistic belief**—The individual perceives that if she has breast cancer there is nothing she can do about it; that is, death is perceived as the inevitable result.
- **Social Issues**—The individual believes that there are other things that are more important in her life right now than getting a mammogram such as work, family, relationships, etc.
- **Self-Exams**—African-American women conduct self-exams at a greater rate than any other group. Unfortunately, this reinforces the belief that other testing and screening is not needed unless the individual finds something during the self-exam.
- **Low return rate for repeat/annual exams**—African-American women have the highest rates of initial exams. However, the rate drops dramatically for follow-up screening or yearly repeat exams. Researchers believe this is linked to the fatalistic belief. “I was fine the first time and don’t need another exam.” It may also be indicative of a response to community pressures and norms to be screened, then



returning back to the fatalistic belief that “I am fine, it won’t happen to me and if it does it was meant to be.”

Approach

To address this disparity, HealthCare USA will enhance and improve our outreach efforts to all appropriate female members regarding breast cancer screenings. We will follow the Susan G Komen, American Cancer Society and National Cancer Institute’s recommendations (see table below). Our enhanced effort will tailor part of the initiative to African-American women.

Figure 4.5- 50: Breast Cancer Screening Recommendations for Women at Average Risk

Screening Type	Susan G. Komen for the Cure®	American Cancer Society	National Cancer Institute	U.S. Preventive Services Task Force
Mammography	Every year beginning at age 40	Every year beginning at age 40	Every 1-2 years beginning at age 40	Every 2 years ages 50-74
Clinical Breast Exam	At least every 3 years ages 20-39	Every 3 years ages 20-39	No specific recommendation	Not enough evidence to recommend for or against
	Every year beginning at age 40	Every year beginning at age 40		
Note: Women at higher risk may need to get screened earlier and more frequently than recommended here.				

SOURCE: SUSAN G. KOMEN FOUNDATION WEBSITE.

Our enhanced outreach effort will have three parts, as follows:

- **Member Identification.** We will identify female members who are of African-American descent, are within the required age range, and who have not had a mammogram according to the recommended schedule. We will then map the addresses of these members to maximize opportunities for access to mobile mammography vans. Given this geographic knowledge, we will seek faith or community based partners in those areas of the state, with whom we can partner on outreach and education activities.
- **Refining Our Understanding.** Social issues are often cited as a general barrier for women as the reason why they do not receive yearly mammograms. In this enhanced



program, we will survey members to determine why they have not received a mammogram. Given this knowledge, we can better understand the barriers that members are facing, and then develop programs to address those specific barriers.

Education and Screenings. To address the fatalistic belief and self-examination barriers, HealthCare USA will work with faith-based partners in the mammography campaigns. Activities conducted with faith-based partners may include hosting a mammography van, providing education specific to members of that organization, or other activities that help address the disparity and will be effective in engaging members in understanding the importance of screenings. We will choose these partners based on their proximity to pockets of HealthCare USA members who have not had a mammogram within the last year.

4.5.4.b4. The offeror shall describe targeted initiatives proposed to meet the requirements of the contract. The offeror shall describe how the offeror will meet members' physical and behavioral health care needs in a coordinated and integrated manner as described per the contract requirements regarding provider network, access standards, quality assessment and improvement, case management, disease management, behavioral health and dental services.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)4.

Targeted Initiatives

HealthCare USA strives to continuously improve member health outcomes while using health care resources wisely and being cognizant of the need to manage costs effectively. Accordingly, we have had various ongoing initiatives that address member needs for coordination and integration of physical and behavioral health care. We will continue many of these initiatives and launch others to continue to improve quality. In this section, we describe initiatives with respect to the providers and members served:

- Primary and specialty care: reducing inappropriate emergency department utilization
- Specialized Providers: Initiatives for Members with Special Health Care Needs

For the initiatives described in this section, we address various considerations, including those for the provider network, access to care and connecting members to the right provider, assessing and improving quality, coordinating and integrating care through effective case management and disease management, and ensuring access to and coordination of behavioral health and dental services.

Primary Care: Reducing Inappropriate Emergency Department Utilization

Inappropriate utilization of emergency departments (EDs) by Medicaid members is a serious problem. Aspects of the problem include:



- **Saturation of capacity.** In a 2006 Urgent Matters report, 62% of EDs in the country reported being at or over capacity. This causes undue delays in treating patients, as well as diverting critical cases to other EDs. (Burgess & Kiplinger, 2006)
- **Inappropriate use of resources.** Only 13% of ED visits resulted in admission. The American Hospital Association estimates that some 40% of ED visits are for non-emergent reasons.
- **Cost.** Treatment in the ED setting may cost as much as 50% more than in the urgent care setting, on average, and may be two to three times higher than a regular outpatient visit.
- **Disruption of care.** Members who seek care in the ED setting bypass the appropriate relationship with a medical home that oversees and coordinates their care. Furthermore, without significant additional effort, the PCP in the medical home may be completely unaware of the ED visit and thus unprepared to render appropriate follow-up care or reinforce good health habits and preventive care strategies with the member.

HealthCare USA has been working on a multi-year initiative to address this challenging problem, and we plan to continue this initiative, with additional enhancements, during the contract. This is critical: many of the conditions for which members visit the ED can be treated most effectively in a primary care setting, with some also appropriate in a specialty care setting.

Understanding Inappropriate ED Utilization

HealthCare USA has performed extensive analysis of inappropriate ED utilization to help us understand how best to address the problem. We identified fourteen categories of conditions that were non-emergent or avoidable through proper care and conformance to treatment, as follows:

- Abdominal pain (non-emergent)
- Asthma (Avoidable)
- Back pain (non-emergent)
- Bronchitis (non-emergent)
- Contusions (non-emergent)
- Dental issues (non-emergent/advanced dental caries or abscesses are avoidable)
- Gastroenteritis (non-emergent)
- Headache/migraine (non-emergent)
- Otitis media (non-emergent)
- Pharyngitis (non-emergent)
- Sprain (non-emergent)
- Unspecified viral infection (non-emergent)

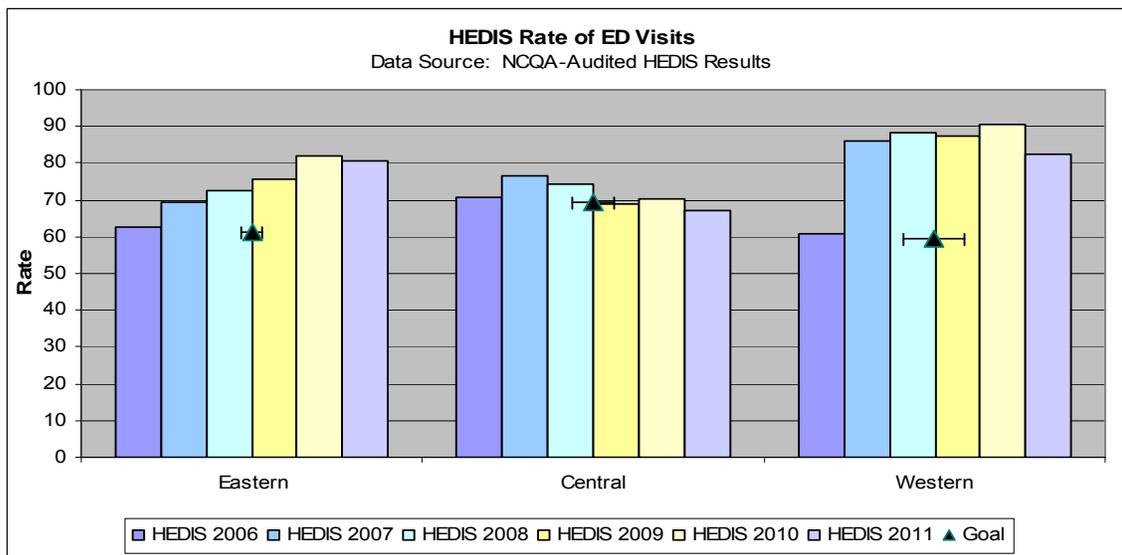


- Upper respiratory infection (non-emergent and/or avoidable with early intervention)
- Urinary tract infection (non-emergent)

While any member might go to the ED at one time or another, we wanted to focus our efforts on those members who have a habit of using the ED as their primary source of care. Given the list of non-emergent conditions, we analyzed claims data to identify those members who visited the emergency department three or more times in a rolling six-month period; these are the *frequent flyers*.

Figure 4.5- 51 shows the HEDIS rate of ED visits from the 2006 submission through the 2011 submission. Our interventions (described in the next section) began in 2007. While we have shown a decrease in the HEDIS rate of ED visits for 2011, the generally stable trend shows that this is a difficult problem. We have set aggressive goals for ED utilization; these are indicated by the triangle on the chart.

Figure 4.5- 51: HEDIS Rate for ED Visits by Region from 2006 through 2011



Existing Interventions for Inappropriate ED Utilization

To address the issues in inappropriate ED utilization, HealthCare USA has done the following:

- **Education of Members.** Frequent Flyers have been sent State-approved mailings that include first aid tips and instructions on when to go to the ED; information on understanding true medical emergencies; explanation of the role of the PCP as the primary provider; explanation of the appropriate use of urgent care centers; and a letter of concern that notes the member’s use of the ED, the appropriate use of the ED, and telephone numbers to call if the member has any questions. These materials are sent quarterly. We also make a list of urgent care centers available on our website.



- **Education of Providers.** Our Provider Relations Representatives visit providers who have a number of Frequent Flyers as part of their HealthCare USA member panel. We discuss these members and suggest ways in which the provider might help reduce avoidable ED use. For example, these might include contacting the member to schedule preventive care screenings on a regular basis, or following up with the member to be sure they understand the proper use of their medications (such as for asthma). We give providers the same educational materials that are sent to members. Finally, providers also can access the list of urgent care centers on our website, and the Provider Relations Representative will discuss these urgent care centers with the provider.
- **Collaboration with Hospitals.** We are working with hospitals to receive a census of members who have visited the ED within two to three days after the visit. When received, we distribute the census to Case Management and Disease Management for review and follow up with members who are enrolled in those programs.

A designated multidisciplinary ED Utilization Team has been meeting on a regular basis to review data on ED utilization, to analyze whether the interventions are working, and to develop new interventions.

Results from Interventions

Figure 4.5- 51, above, shows the HEDIS rates for ED utilization from 2006 through 2011 submissions. In addition, HealthCare USA has identified the following:

- ED usage decreased from 967.0 episodes per thousand members in 2009 to 882.1 episodes per thousand in 2010 and 883.1 episodes per thousand in 2011; hence, we have seen a net decrease in ED utilization as a result of the intervention
- Urgent care usage increased from 439.4 episodes per thousand members in 2009 to 459.8 episodes per thousand in 2010 and 479.3 episodes per thousand in 2011; indicating that more members are choosing to use urgent care centers
- Top Five Condition Categories: these are abdominal pain, asthma, acute dental, otitis media, and upper respiratory infection.
- Seasonality: using data from November 2007 through June 2010, we find that the Frequent Flyers have seasonal behavior in use of the ED. Each year, the number of Frequent Flyers peaks in March, April, and May; the number then decreases until November, when the upward trend resumes. Reasons for this seasonal variation are unclear and are under investigation.

We will continue to monitor HEDIS, ED visits per thousand members, Frequent Flyer average visits per member, total Frequent Flyer visits, and Frequent Flyer diagnoses to assess the ongoing impact of this initiative and the new interventions (described below).



New Interventions for Inappropriate ED Utilization

In the first quarter of 2012, HealthCare USA plans to expand the scope of the ED Utilization initiative and add a new initiative.

Expanding Existing ED Initiative

In expanding the scope of the current ED Utilization initiative, we will target child members (age less than or equal to 18 years) who arrive at the ED and are diagnosed with gastrointestinal or upper respiratory infections. To intervene with these members, HealthCare USA will use the process shown in Figure 4.5- 52.

Figure 4.5- 52: HealthCare USA will Expand the Process for Curbing Inappropriate ED Utilization

Step	What HealthCare USA Does
1	HealthCare USA receives the daily ED census from facility (established under existing agreement).
2	Our Case Management Team will review the census to identify members who meet the criteria (member, age ≤ 18 years, gastrointestinal or upper respiratory infection diagnoses). A pediatric nurse Case Manager will be assigned to follow up with those members.
3	<p>The assigned Case Manager will call each member, on the same day the ED census was received. In this call, the Case Manager will:</p> <ul style="list-style-type: none"> • Ask the member (or member’s parent, as appropriate) if he or she knows his PCP • Ask why the member did not contact the PCP about the illness. • Review the member’s understanding of the following: <ul style="list-style-type: none"> • HealthCare USA benefits • ED discharge instructions • Medication instructions and importance of complying with those instructions • Availability of the 24-hour Nurse Line for follow up questions • Follow-up appointment with PCP
4	The Case Manager will try to call the member at least twice.
5	After the outreach call attempts, HealthCare USA will send the member an educational mailing packet that includes information on the appropriate use of the ED, as well as information on first aid.
6	We will continue to review the member’s claims data for three months after the ED visit, to look for other ED visits or other inappropriate patterns of utilization.

To monitor the success of this expanded intervention, we will measure ED, PCP, and pharmacy utilization.



Much of our ability to effectively engage the member in a discussion about appropriate use of the ED relies on receiving census data from facilities. While we have been successful in using this information so far, we will explore the opportunity of getting this information more quickly as health information exchanges are established. By reducing the time between the member's trip to the ED and our outreach call to educate the member, we believe we can be more effective in having an impact as the episode is more recent and relevant.

New ED Initiative

HealthCare USA also will enhance efforts to reduce inappropriate ED use by working with providers to extend their after-hours care with financial incentives for extending office hours beyond normal business hours. The initiative would provide additional reimbursement for after-hours and weekend visits when billed with the proper CPT codes.

Specialized Providers: Initiatives for Members with Special Health Care Needs

Members with Special Health Care Needs represent the most complex spectrum of health care needs. These members often have multiple chronic, co-morbid conditions; use services overall at a higher rate than the general member population; and may use emergency department services at a higher rate than the general member population because of instability in their physical and behavioral health status. By creating specific initiatives to meet the needs of this population, we can stabilize or improve their overall status, potentially improve their well-being and social functioning, and realize improved cost control as a result, using health care resources in the most effective way. HealthCare USA's initiatives for this population address the following:

- Network – designing a health care network to address the specialized provider requirements for Members with Special Health Care Needs
- Case Management – ensuring that we quickly identify and assess Members with Special Health Care Needs and quickly connect them to the appropriate services for their needs

In the following sections, we address these two aspects within the primary service area needs: medical, dental, and behavioral health.

Medical Needs

Provider Network

HealthCare USA has developed a comprehensive provider network that includes the specialties needed to serve Members with Special Health Care needs. Our Network Management Team has a listing of highly specialized providers by region readily available for all staff. These lists are also available to providers for referrals. These provider types include, for example:



- Pediatric Specialty Hospitals
- Autism Centers
- Complex Rehab/Mobility
- DME
- Orthotics/Prosthetics
- PT/OT/ST
- Home Health Care
- Private Duty
- Neurology
- Neonatology
- Craniofacial
- Behavioral health
- Dentists/Orthodontics

See the Provider grid in Section 4.5.4.a.2 for more information. Throughout the contract, we will continue to look for opportunities to further enhance and expand our network to include specialized provider types to serve member needs.

Moreover, we will identify a narrow network of Primary Care Physicians that focus on providing care to Special Needs patients. This network will consist of high-performance, high-quality PCPs, including those participating in MO HealthNet's Health Home program, that have the ability to meet the complex needs of the special needs members and are recognized for their clinical excellence.

In addition, we will identify a develop a “Gold” Special Needs network, a narrow network which is composed of high-performance, high-quality specialty, ancillary and tertiary care providers that have the ability to meet the complex needs of the special needs members. Our Case management team will utilize this information to connect special needs populations with the highly specialized and most effective providers in order to achieve optimal outcomes.

Case Management

Monthly, the HealthCare USA Case Management Department receives the state report that identifies new members who have special health care needs. We will contact each member to:

- Confirm the special needs conditions
- Identify behavioral health needs
- Educate the member on his or her available benefits, including those specifically associated with the special needs conditions, as well as transportation benefits





- Confirm his or her choice PCP, including assignment to a PCP who has specified expertise in treating special health care needs, or assigning a specialist as PCP where appropriate
- Assess the member for enrollment in case or disease management programs.

HealthCare USA will work with the state agency to include the member’s diagnoses/special needs conditions on the monthly report. This inclusion will assist HealthCare USA staff to meet the member’s needs and coordinate in a more timely and efficient manner.

Our case managers work to coordinate services for these members. To enhance this coordination of care process, we will link members with special health care needs to network providers who have specific expertise in treating those needs. We will do this using a list of high-performing providers created by our Network Management Department.

For behavioral health needs, our case management staff will refer the member to MHNet; and to DentaQuest for dental needs as necessary. The HealthCare USA case manager will retain overall responsibility and ensure coordination of services between medical, behavioral and dental to ensure optimal outcomes.

4.5.4.b5. The offeror shall describe the approach/strategy for each of the requests for information below. If the described approach/strategy is one currently in use, the offeror shall indicate in which program/state the approach/strategy is being used, the length of time the approach/strategy has been in effect, and the target population. If the offeror is currently operating in Missouri, the offeror shall speak to their existing experience in Missouri as well as how they will modify and expand upon these strategies for future service delivery.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5.

4.5.4.b5 – Bullet 1 How the offeror will ensure that children receive needed dental services. The offeror shall identify and describe the approach(es) that the offeror plans to implement in relatively more urban counties and contrast these with interventions that the offeror plans to use in more rural areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 1.

Under EPSDT, primary care providers provide at least a dental screening and need to assure referral to a dentist for care. We educate our primary care providers about the importance of their role of member’s being referred for dental care.

Please see the response to 4.5.4.b.5, Bullet 1 in the Dental Care Network section.

4.5.4.b5 - Bullet 2 The cost effective approaches the offeror will implement, aside from transportation, to ensure that members in relatively remote counties are able to access



specialty care. The offeror shall also describe the strategies the offeror will implement to outreach to specialty care providers. The offeror shall describe how the offeror will facilitate and encourage the use of non-traditional service delivery approaches, such as regional clinics utilizing shared office space and equipment with local providers on a scheduled basis, by specialty care providers. The offeror shall describe how the offeror will monitor the effectiveness of such strategies.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 2.

This question is not applicable to the Primary Care network. Please see the response to 4.5.4.b.5, Bullet 2 in the Specialty Care Network section.

4.5.4.b5 – Bullet 3 How the offeror will utilize telemedicine in rural areas of the State. At a minimum, the description shall include the specific strategies that will be used, purposes for which telemedicine will be used, targeted populations and conditions, and providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 3.

Telemedicine may be as simple as two health professionals discussing a case over the telephone, or as complex as using satellite technology and videoconferencing equipment to conduct a real-time consultation between medical specialists in two different countries. Telemedicine generally refers to the use of communications and information technologies for the delivery of clinical care.

Telemedicine, frequently referred to as Telehealth, is the use of electronic technologies to provide and support health care services when distance separates the physician and patient. Telemedicine services are medical services provided via telephone, the Internet or other communications networks or devices, that do not involve direct in-person patient contact. There are applicable federal and state regulations governing the practice of telemedicine.

The FDA has defined the term ‘telemedicine’ as the delivery and provision of healthcare and consultative services to individual patients, and the transmission of information related to care, over distance, using telecommunications technologies, and incorporating:

- Direct clinical, preventive, diagnostic, and therapeutic services and treatment
- Consultative and follow-up services
- Remote monitoring
- Rehabilitative services
- Patient education

Telehealth services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another, using telecommunications technologies. These services may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.



Benefits of Telemedicine for HealthCare USA MO HealthNet Members

- Improved access to equitable and timely access to primary and specialty care for patients who live in a medically underserved area have difficulty traveling to healthcare facilities
- Improves provider education by increasing access to continuing medical education (CME) and removing geographic and financial barriers for providers in rural and underserved areas. This can help increase the skills and expertise of rural practicing PCPs since they can take part in the consultative process during the telehealth encounter with the specialist versus sending a patient to a specialist for a visit and getting a report back of the findings. This may allow some PCPs to gain confidence in certain types of referred services and allow them over time to make management and decisions on their own.
- Improve the quality of care of members who live in rural areas by increasing access to specialty care and improve patient outcomes by decreasing delays in diagnosis and treatment
- Reduction of ED admits/referrals by reducing delays in diagnostic testing and evaluations
- Reducing patient travel by providing access to specialists at a local site like their PCP or Rural Health Clinic office. This helps reduce costs related to transportation and lost time from work/school for the member.

Applications for Telemedicine in Rural Areas of Missouri

HealthCare USA will use telemedicine in the rural and underserved parts of Missouri in the following ways:

- **Primary Care Consultations.** Consultations by primary care providers/rural health clinics with specialty care providers not available in remote/underserved areas. Services may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan.
- **Specialist Referral Services.** Specialists assisting a general practitioner in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to a specialist for viewing later.
- **Imaging/Radiology Procedures.** Radiology makes the greatest use of telemedicine with thousands of images "read" by remote providers each year.
- **Specialty Consultations.** Specialty consultations may include dermatology, ophthalmology, mental health, cardiology and pathology.
- **Remote Patient Monitoring.** This application uses devices to remotely collect and send data to a monitoring station for interpretation. Such "home telehealth" applications might include a specific vital sign, such as blood glucose or heart ECG or



a variety of indicators for homebound patients. Such services can be used to supplement the use of visiting nurses.

- **Medical Education** provides continuing medical education credits for health professionals and special medical education seminars for targeted groups in remote location.
- **Consumer medical and health information** includes the use of the Internet for consumers to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

Telemedicine Delivery Mechanisms

As of Oct 2011, our network contains 88 Missouri Telehealth Network sites, 69 of which are within the service area.

- Networked programs link tertiary care hospitals and clinics with outlying clinics and community health centers in rural or suburban areas. In Missouri, University of Missouri’s Missouri Telehealth Network, is leading this effort and has developed end point connections with almost 200 providers across the state. As of Oct 2011, there are 87 providers in the Missouri Telehealth Network that are in the HealthCare USA and MHNet networks within the 54 counties and 21 outside of the service area.
- Connections using private networks used by hospitals and clinics that deliver services directly or contract out specialty services to independent medical service providers at ambulatory care sites. Radiology, mental health and even intensive care services are typically being provided under contract using telemedicine to deliver the services.
- Primary care to the home connections involves connecting primary care providers, specialists and home health nurses with patients over single line phone-video systems for interactive clinical consultations.

Targeted Populations

Members in the following Missouri counties have access to Missouri Telehealth network providers. Counties shown in italics are considered rural:

Region	Counties
Eastern	St Louis, <i>St Francois, Madison</i>
Central	<i>Callaway, Gasconade, Phelps, Dent, Pulaski, Boone, Howard, Randolph, Macon, Adair, Sullivan, Linn, Chariton, Saline, Carroll, Cooper, Pettis, Morgan</i>
Western	Jackson, <i>Buchanan, Henry, Cedar, Polk, Dallas</i>



Conditions

The table below shows the types of medical and behavioral health conditions for which telemedicine services may be used.

Medical Conditions	Behavioral Health
Autism Clinic Burn Clinic Child Health Dermatology Endocrinology Genetics Follow-up Hip & Knee Follow-up Internal Medicine Medical Ethics Consultations Neurology Orthopedics Physical Medicine & Rehabilitation Provider Consultations with Geriatric Specialist Radiology Rheumatology Spine Follow-up Surgical Follow-up	Adolescent Medicine (eating disorders) Children with Special Needs (Dept. of Health Psych) Psychiatry

Providers

Based on a review of the two telehealth directories in Missouri (Missouri Telehealth Directory and the NE Missouri Telehealth directory), 87 providers within the 54 counties and 21 providers outside the service area are participating providers in the network for HealthCare USA. These providers include: acute care hospitals, critical care hospitals, FQHCs, RHCs, CMHCs, public health departments, rehabilitation centers and specialty care providers.

Proposed Activities in Support of Telemedicine in Missouri

HealthCare USA has already commenced a dialogue with the Missouri Telehealth Network for the purpose of developing a collaborative process to engage with independent rural health clinics to promote the benefits of telemedicine services and increase the availability across rural parts of Missouri within the service area. As part of this proposed collaboration, HealthCare USA intends to:

- Engage in discussions with critical access hospitals and behavioral health facilities regarding their plans to invest in telehealth systems to increase access to specialty care services and increase rapid diagnosis and treatment thru their ED departments.



- Engage in discussions with independent rural health clinics (not currently in the Missouri Telehealth Network) concerning their interest investing in telehealth systems and promoting the information available through Missouri Telehealth Network Resource Center
- Promote/increase the awareness of rural practicing providers of Missouri Telehealth Network continuing medical education (CME) programs such as Grand Rounds for Health Ethics, Compliance and Quality, Oncology, Psychiatry, Cardiovascular Medicine, Internal Medicine, Orthopedics, Child Health which are currently available.

For the new contract, we commit up to \$125,000 in performance guarantees of increasing use of telemedicine by 5% year over year (based on claims data) throughout the contract. Specifically, we commit to performance guarantees of \$25,000 in Year 1; \$50,000 in Year 2; and \$50,000 in Year 3 to achieve our goal.

In addition to the performance guarantee, HealthCare USA will also work with Missouri Telehealth Network to provide grant funding up to \$100,000 over the term of our state contract to assist participating rural practices in all three regions with the procurement of telehealth devices. By offering these grants, HealthCare USA's goal is to expand the use of non traditional service delivery methods in order to improve improve the quality of care of members who live in rural areas by increasing access to specialty care and improving patient outcomes by decreasing delays in diagnosis and treatment .

4.5.4.b5 - Bullet 4 The specific measures the offeror will take to ensure that children and women identified as substance abusers are screened for depression and other co-occurring behavioral health conditions. The offeror shall identify the case management activities and other strategies the offeror will use to link these members to appropriate resources, including behavioral health resources. The offeror shall describe how the offeror will monitor effectiveness of care strategies. The offeror shall describe how the efforts on behalf of members in rural areas will differ from those targeted to members in more urban areas.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 4.

HealthCare USA recognizes that major depression is a serious illness affecting 15 million Americans. Unlike normal emotional experiences of sadness, loss or passing mood states, major depression is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity and physical health. Among all medical illnesses, major depression is the leading cause of disability in the U.S. and many other developed countries. Without treatment, the frequency of depressive illness, as well as the severity of symptoms tends to increase over time. Left untreated, depression can lead to suicide.

Provider and member knowledge related to the diagnosis and management of major depression is identified in the literature as the most prevalent reasons for poor adherence to evidence based clinical practice guidelines. HealthCare USA understands that because of their disadvantaged state, the Medicaid population experiences additional



challenges and barriers to adhering to provider recommendations that are not present in other populations.

Case Management

Every HealthCare USA member being assessed for case or disease management is screened for substance abuse and depression. These assessment questions are built into each diagnosis-specific assessment in the NavCare documentation system. HealthCare USA staff refers members with depression and substance abuse to the co-located MHNNet Case Managers for assessment, interventions and follow-up. The on-site MHNNet Case Managers screen members to determine the urgency and type of services that are needed on a case-by-case basis. Referrals to treatment as well as a variety of community-based services and supports are arranged for the member. MHNNet makes appointments for members with providers and arranges for transportation services (as needed) to reduce member access barriers. Follow-up is provided to confirm members received the services they needed, and if not MHNNet continues to provide assistance in making additional provider appointments and referrals to treatment, community-based services, and other supportive services.

HealthCare USA recognizes that clinical treatment of behavioral health disorders is tailored to address the individual member's diagnosis, symptom expression, and personal circumstances. For this reason, the management interventions are tailored to the acuity of each member. These interventions include:

- **Member Education and Awareness Materials.** MHNNet has developed and implemented two new member education and awareness programs driven by the specific needs of the HealthCare USA membership. These programs are tailored to meet the educational needs of members with higher-risk behavioral health disorders, and were identified using data analytical methods specific to the Healthcare USA population. Educational initiatives related to members with Bipolar and Psychotic Disorders have been developed and approved for members. MHNNet also distributes educational information to providers as part of this initiative. Provider education is driven by the prescribing practitioner and is not limited to behavioral health practitioners, but may include Primary Care Providers and other behavioral and medical specialties. In addition to these programs, MHNNet has a long-standing member educational program related to a high-volume diagnosis: Attention Deficit Disorders. The National Institute of Mental Health (NIMH) reports that attention deficit hyperactivity disorder (ADHD) is the most commonly diagnosed disorder of children. It is estimated to affect 3–5% of school age children, with 9% lifetime prevalence in 9 to 13 year olds, at least one child in every classroom. Treatment of members with ADHD and their families is relevant to MHNNet and HealthCare USA because the diagnosis represents a high volume illness. MHNNet identified this activity as an opportunity to promote the continuity and coordination of member care between behavioral healthcare providers. Identified members receive an outreach from MHNNet, providing education and resources on ADHD, as well as promoting engagement in family therapy. MHNNet also notifies the current behavioral health provider of this outreach to the member they are treating as well as



receiving a copy of the educational materials. This notification encourages the provider to review the information with the member, as well as encouraging participation in family therapy for behavior modification and parent training services – both of which are supported by clinical treatment guidelines / best practices.

- **Integrated member case management.** On-site MHNNet Case Managers screen members who have been identified from various sources, including HealthCare USA medical Case Managers, having potential behavioral health symptoms to determine the nature and severity of their needs. The screening process is not limited to substance abuse and depression, but encompasses all behavioral health symptoms (substance abuse, depression, ADHD, anxiety, post-partum depression, and other behavioral disorders) in order to capture all members with co-morbid treatment needs. Screening is initially performed telephonically by MHNNet followed by clinically appropriate treatment and service referrals based on the individual member's needs. Referrals are made to the MHNNet provider network, CSTAR programs, and other community-based services and supports. Non-treatment related referrals also are frequently made for members with needs related to housing, utilities, child care, and a range of other requests. MHNNet Case Managers follow up with members to ensure they have accessed needed care/services, and offer additional assistance as necessary.
- **Members who have been identified as higher risk** (i.e., pregnant with substance abuse problems, recent hospitalizations, risk/history of self-harm) are supported to engage into an Intensive Case Management (ICM) or specific health care initiatives program. These programs provide significantly more comprehensive member outreach and education, and allow MHNNet Case Managers to connect with members in order to support their healthy lifestyle choices and treatment plan development/adherence. MHNNet Case Managers who are co-located the HealthCare USA location closely coordinate these ICM and initiative case referrals with MHNNet ICM Case Managers to ensure there is a successful transition from coordination of care protocols to longer-term intensive case management activity.
- **PCP education and awareness campaign.** HealthCare USA and MHNNet acknowledges the importance of care coordination between medical and behavioral health treatment services. In response, MHNNet has developed and implemented the following relevant coordination of care activities that keeps Primary Care Physicians informed of the behavioral health services their members are receiving:

MHNNet mails PCPs member clinical information that highlights key clinical information as they receive services from Outpatient behavioral health provider services. The Outpatient Treatment Request form (OTR) is mailed to PCPs and provides the following information:

- Member demographic information
- Diagnosis (Axis I – III)
- Description of symptoms
- Severity rating of symptoms



- Medication information
- Type of services received
- Health status (i.e. if member is pregnant)
- BH Provider information

MHNet sends PCPs notification and information when HealthCare USA members discharge from a behavioral health admission. We view this as a vital piece of information for the primary care provider to possess. The PCP Discharge Letter shares key information that includes: member name, DCN#, Provider Facility information, date of admission/discharge, and diagnosis. The objective is to keep HealthCare USA PCPs informed of their member treatment status, particularly those members who have accessed the most acute/emergent level of care.

MHNet distributes annual newsletters to PCPs on relevant mental health topics. A 2009 newsletter focused on the treatment of depression by PCPs. Our 2011 PCP newsletter contained detailed information about the treatment of depression and included important facts about the HEDIS quality indicator regarding follow-up after hospitalization. PCPs can view our newsletters on the MHNet website at www.mhnet.com.

Future Initiatives

HealthCare USA and MHNet are developing new initiatives related to reducing unnecessary emergency department (ER) access by implementing screening protocols for members identified as having an ED experience. The screening will include an assessment of depression and other mental health/substance abuse concerns. Those members who screen positive will receive outreach communication from MHNet to identify if members have accessed BH treatment services or, if not, to assess their treatment needs and support them in accessing needed treatment and other support services.

Monitoring Program Effectiveness

HealthCare USA will use the following mechanisms to monitor program effectiveness regarding for depression and other behavioral health conditions in children and woman identified as substance abusers:

- Behavioral Health HEDIS indicators
- Overall behavioral health utilization
- NCQA indicators
- Antidepressant medication management
- Effective acute phase treatment
- Effective continuation phase treatment





- Follow-up care for children prescribed ADHD medication
- Initial phase
- Continuation and management phase
- Follow-up after hospitalization for mental illness – 7 day
- Quarterly report on disease management program for depression

Differences on Behalf of Members in Rural vs. Urban Areas

Our case management activities to address substance abuse and depression in this population are the same across all three regions.

4.5.4.b5 - Bullet 5 How the offeror will ensure that Medicaid and CHIP children have access to child psychiatrists and psychologists for behavioral health services. The offeror shall describe how the offeror will ensure appropriate case management and coordinate behavioral health services with the delivery of other services under the EPSDT benefit.

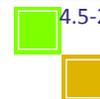
HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 5.

Our Team-based Approach

HealthCare USA and MHNet, our affiliated mental health provider, uses a team-based approach in arranging and coordinating services that address the needs of each member and family as a whole. Our combined team consists of HealthCare USA's nurse case managers, special needs coordinator, concurrent review nurses and nurse disease managers, along with MHNet's case managers, discharge case manager assistants, and customer service representatives. This team works to identify barriers that impede effective treatment and devises plans to help members overcome these barriers. To further the effectiveness of our care team, team members are co-located at the HealthCare USA regional office. This approach has improved ongoing communication with the care team and provides support for developing and following a holistic plan of care.

Monitoring Access and Availability

On a monthly basis, the Joint Operations Oversight Committee and the Plan Quality Improvement Committee review behavioral health provider access and availability. As part of this review, MHNet provides updates on ongoing network development activities across regions for all provider types, including facility-based services, Community Mental Health Centers (CMHC), independent practitioners (psychiatrists, nurse practitioners, psychologists, counselors and social workers) and school-based counseling services.





Expanded Access Initiatives

The largest identified behavioral health access challenge statewide is related to child psychiatry access. To address this need, we have implemented the following initiatives to expand access to behavioral health services for children enrolled in Medicaid and CHIP programs:

- Enhancing services to specialty advanced nurse practitioners who have collaborative practice arrangements with child psychiatrists. MHNet has been contracting with advanced nurse practitioners for the past three years. This intervention was escalated in early 2010 to increase access and availability for our members.
- Making increased use of innovative and available telemedicine services, particularly for members with rural and other access based limitations. This creative approach increases access to both child psychiatry and child psychologist services. We have utilized telemedicine services since 2009 resulting in an increase of member access seen mainly in rural areas of the Central region. We are currently collaborating with the University of Missouri Telemedicine program to expand this important treatment alternative in the Central Region.
- Expanding network availability with additional CMHC services. While we are presently in full compliance with the contract concerning CMHC access, growth with CMHC services will take on a renewed focus during 2012 with the addition of more CMHC providers and alternative services in each region. It is MHNet's intent to expand available services to all CMHCs in the Eastern, Central, and Western regions during 2012.
- Ongoing network development activity. MHNet expands access and availability to the behavioral health network on a monthly basis with a consistent trend over the past three years of network development.
- Enhanced clinical and administrative processes focused on strategies for identifying members in need of treatment and other supportive services and assisting members with access.
- Network expansion initiatives emphasizing increased use of faith-based and ethnic organizations to better address cultural diversity needs among the membership.
- MHNet is committed to dedicating resources to a new Community Liaison Resource role by 2nd quarter 2012 with the objective of increased on-the-ground service delivery development/expansion efforts, especially for service needs in more rural counties, but also to coordinate with the CMHCs and FQHCs to identify what additional creative services could be developed to promote better access and availability for members.

In addition to these expanded access initiatives, MHNet has also implemented the following strategies to strengthen our relationships with our providers by offering higher reimbursement and reducing their administrative burden.

- **Enhanced Provider Fee Schedules.** MHNet has implemented non-standard and enhanced provider fee schedules in effort to improve provider motivation to open more of their schedules to our membership. This review process has occurred over



the past years with the most recent adjustments taking place throughout the 2010 – 2011 calendar years.

- **Simplified Administrative Requirements.** Physicians no longer need to prior authorize medication management, psychiatric consultation, and certain hospital-based professional service visits (phased in from July 2010). We have streamlined our Outpatient Treatment Request (OTR) form and process to significantly reduce provider frustration (phased in from September 2010).
- **Increased Use of Home-Based Services.** MHNet is a leader in the support and use of home-based treatment services which has been proven to improve member community tenure, reduce readmission events, and improve the rate at which members follow-up with treatment after hospitalization (ongoing intervention).

Case Management and Coordination with EPSDT Services

Behavioral health members who are most at risk of poor health outcomes are those with a history of serious illness and prior hospitalizations. Access to child psychiatry and therapy services is an absolute necessity for these members. MHNet has incorporated a dedicated staff role focused on coordinating obtaining follow-up appointments for members prior to their discharge. This information is shared with the facility provider (and at times with the member in-person) to ensure the member leaves the facility with an appointment in hand. MHNet also reaches out to discharged members and their provider offices to confirm their appointment was kept. If it was not kept, MHNet will reach out to the member to assist with rescheduling their appointments. This added attention allows us to act as a personal navigator for members and improves both treatment adherence and access to needed services resulting in improved health outcomes.

Case Management programs involve active outreach to members, family/guardians, and their care providers. MHNet implements intensive case management initiatives and reaches out to higher risk members to identify and remove barriers to care, coordinate treatment services, make appointments for members, and provide education and support services. The most recent member educational initiatives occurred during the third quarter 2011 with the addition of our health care initiatives for Bipolar and Psychotic Disorders. As part of our coordination of care efforts, PCPs receive notification letters for members that have been discharged from a behavioral health admission. The PCP also receives MHNet's OTR forms which provide valuable clinical information related to the behavioral health treatment our members are receiving. This notification program was implemented during 2010. These activities pull the PCP into the care plan and foster a more integrated and holistic approach at delivering the best standard of care.

As part of the HealthCare USA Healthy Children and Youth/Early and Periodic Screening, Diagnostic and Treatment (HCY/EPSDT) well child visits and screening visit services, all identified behavioral health concerns are referred (as appropriate) to a behavioral health specialist provider, including child psychiatrists and psychologist, for follow-up diagnostic and treatment services to ameliorate any behavioral health-related issues.



The HCY/EPSTDT well child visits include comprehensive health and developmental history, assessments of both physical and behavioral health developmental progress, comprehensive exams, age-appropriate immunizations, laboratory services, health education, lead/dental/vision/hearing screening, developmental and mental health screening, and fine/gross motor evaluations.

When any developmental and/or mental health concerns are identified, members are referred to an appropriate MHNet provider for further assessment and diagnostic services, including various psych testing procedures, to develop and implement a comprehensive treatment plan. Additionally, to ensure the member's PCP remains informed of behavioral health interventions and treatment services, MHNet coordinates with PCPs by sending clinical information from the behavioral health providers Outpatient Treatment Request (OTR) form to the PCP.

4.5.4.b5 - Bullet 6 How the offeror will address the strategies the offeror will use to identify, reduce, and monitor inappropriate hospital readmissions. The offeror shall describe to what extent these measures will differ according to populations, geographic locations, and health conditions.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 6.

Hospital admissions are the most costly medical services in Medicaid programs. Hospital readmissions are a concern due to the additional burden for patients and family members and the implications for cost and quality of care. The HHS Agency for Health Care Research and Quality shows particularly high readmission rates for Medicaid patients.

- Among non-maternal adults ages 45-64 years old, Medicaid patients are re-hospitalized about 60% more often than uninsured patients and about twice as frequently as privately insured patients, regardless of the readmission period (30 day, 14 day and 7 day).
- Maternal readmission rates are about 50% higher for uninsured and Medicaid patients than for privately insured patients across all time periods.
- Medicaid and privately insured pediatric patients are re-hospitalized within 7 and 14 days at a similar rate and more frequently than uninsured patients irrespective of the readmission period.

There are many contributing factors to hospital readmissions. Studies suggest re-hospitalizations can be prevented by identifying patients at risk for readmission before hospital discharge. Follow-up studies after discharge and sufficient payment for management of chronic diseases with office-based services and drugs need to occur.

Current Process

These interventions target members in all regions:



- **Morbidity Assessment Database – Implemented in 2007.** HealthCare USA has developed a process to identify opportunities which would assist in decreasing member readmissions that were either in case or disease management programs. The database is used by case and disease management staff to collect data on readmissions. The database tracks the number of days between admission and previous discharge. The database also tracks reason for readmission and whether or not there are actionable barriers that can be addressed to prevent future readmissions.

The morbidity assessment database has been revised a few times in past year to improve the quality of the data collected and ease of use. It was most recently updated this year to reflect changes that had been made to the disease management programs in Q3 2010.

- **Multiple Admission Report (MAR) – Implemented in 2008.** Coventry developed the Multiple Admission Report (MAR) to identify and track members who have more than one admission with the same or similar diagnosis. The data is pulled from the IDX referral system, and an electronic report, specific for HealthCare USA members, is generated daily through the NavCare case management system. The MAR process alerts the case managers when a member meets this criterion. The case management staff then reviews admission and claims data to confirm the readmission. Once confirmed, the concurrent review nurse assigned to that facility receives an electronic notification initiated in the NavCare system to alert them that the member's hospitalization is a readmission. During the concurrent review nurse's analysis of the member's clinical information, he/she attempts to identify barriers that could have led to the readmission.

The member is also referred to a case manager for assessment of possible enrollment into the case management program with a goal to prevent further avoidable admissions and improved health outcomes. If the member is already enrolled in a case or disease management program, then the nurse managing that member is alerted via their NavCare work list. The case manager then begins the readmission assessment to identify the member's needs, barriers, possible interventions and community referrals. The assessment includes a screening for behavioral health and substance abuse conditions. The co-located MHNet staff assists in the coordination of behavioral health/substance abuse services and medical service to meet the member's needs.

The MAR process has been revised in recent years in order to improve the identification of members with readmissions. The revisions have resulted in the increase of identified members who could benefit from either case or disease management.

- **Co-located MHNet Staff – Implemented 2009.** HealthCare USA initiated a co-location pilot for MHNet, our behavioral health affiliate, at HealthCare USA's offices. Having a behavioral health staff onsite has improved the early identification of co-morbid discharge needs and planning and referrals to the case, disease or behavioral health staff for medical co-morbid conditions. The co-located MHNet staff participates in case rounds when appropriate. HealthCare USA & MHNet will be



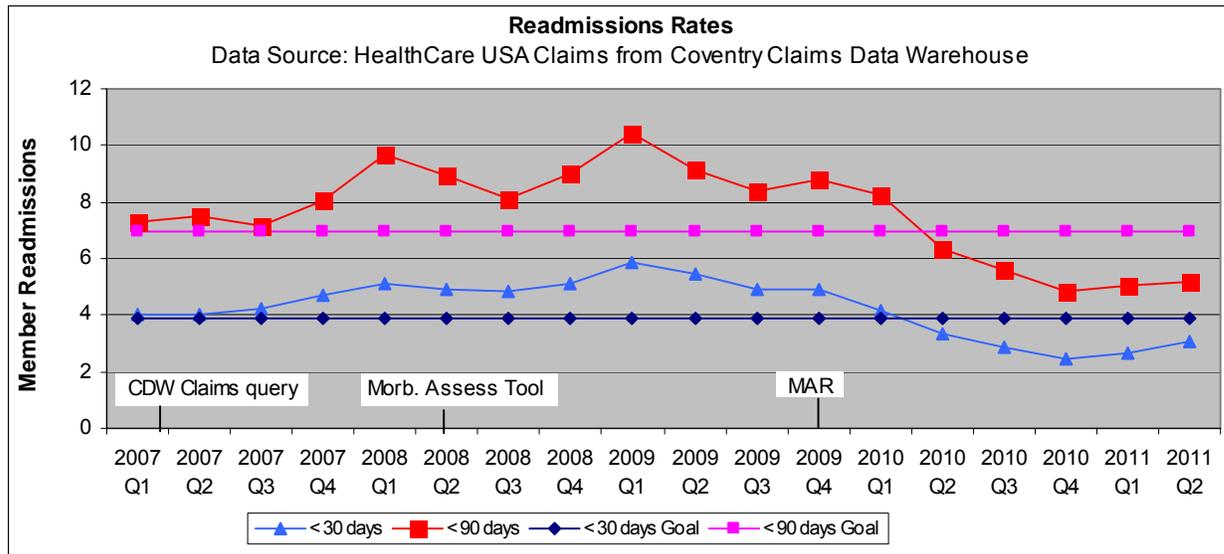
expanding this initiative in 1stQ 2012 and adding co-located staff in our Central and Western region offices.

- **Re-Admission Reviews** – Implemented 2011. HealthCare USA has implemented a process by which the concurrent review nurses review all readmitted members with the Medical Directors regardless of if they are meeting InterQual® criteria. This collaboration focuses on identification of barriers that may have resulted in the readmission such as lack of outpatient follow up or failure to fill/refill medication(s) and possible interventions to prevent future readmissions. The team also looks for opportunities to reach out to the attending physician to discuss the barriers, progression of care and necessary discharge planning well in advance of the anticipated discharge.

Experience

Missouri's 30-day hospital readmission rate as a percentage of admissions was 18.3 in 2006-2007. HealthCare USA's goal is a 2% decrease from our 2006 rate. HealthCare USA's 30, 60 and 90 day hospital readmission rates were increasing in 2007 and 2008. In 2008, the top three diagnosis groups for readmissions within 30 days were acute bronchitis, hereditary hemolytic anemia (e.g. sickle cell disease) and general symptoms (e.g., fever and malaise).

With the implementation of the interventions mentioned above, readmissions began to decrease after peaking in Q1 2009. In 2009, the top three diagnosis groups for readmissions within 30 days were hereditary hemolytic anemia, acute bronchitis and asthma. Today, the top diagnosis groups continue to be diseases of the respiratory system, diseases of the blood and diseases of the digestive system. The disease management programs continued to be revised during that time to maximize their impact on the membership. Several of the interventions were adjusted during the year, including the MAR and Morbidity Assessment Database, and have contributed to this decline.



DATA SOURCE: HEALTHCARE USA CLAIMS DATA WAREHOUSE
MEASUREMENT PERIOD: Q12007-Q22011

Future Modifications

HealthCare USA is planning an expansion of the current readmission process beginning January 2012. This process involves the identification of members most likely to benefit from intense hospital care coordination activities. Member evaluation and assessment will be performed by a multi-disciplinary team (e.g., nurse, social worker, Medical Director and pharmacist) with the goal of assisting the member while experiencing hospitalization crisis and for the first 30 days thereafter.

HealthCare USA plans to have a case manager contact the readmitted member while they are still in the hospital and schedule a home health visit to be completed within the first three days post-discharge. The home health nurse will perform the following activities with the member, face-to-face:

- Review/access current health status.
- Review reasons for admission with contributing factors.
- Ensure compliance with prescribed medications, identify barriers and provide solutions.
- Ensure PCP follow-up appointment has been made. If not, identify barriers and provide solutions.
- Educate member on disease state.
- Refer to HealthCare USA case management, disease management and/or behavioral health/substance abuse (MHNet) programs as necessary.



After the initial home visit has been completed, telephonic outreach will be performed by a HealthCare USA case manager at 7 days, 14 days and 28 days post-discharge. The goals of these calls will include a reassessment and follow-up of the interventions mentioned above. Emergency department, readmission rates and PCP visits will be tracked for outcomes as part of this initiative.

4.5.4.b5 - Bullet 7 Identify the tools the offeror will use to monitor emergency department utilization and determine over utilization, and the measures the offeror proposes to combat/reduce emergency department overuse. The offeror shall describe specific measures the offeror will take in years one (1), two (2), and three (3) of the contract (assuming that the contract is extended over a three (3) year period).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 7.

The following sections describe the mechanisms employed by HealthCare USA regarding use of emergency department services and the strategies in place to reduce emergency department overuse.

Performance Improvement Project (PIP)

Performance Improvement Project: Objective: Decrease Non-Emergent/Avoidable ED Utilization

Time Period: 2007–Present

Regions: Central, Eastern and Western

In 2007, HealthCare USA began a performance improvement project (PIP) to decrease the rate of non-emergent/avoidable emergency department (ER) utilization through member education and removing barriers to the use of a health care home. The target populations for this improvement project are those members who utilize the ED for non-emergency care more than three times in a rolling six month timeframe for the following conditions.

- Abdominal pain (non-emergent)
- Asthma (Avoidable)
- Back pain (non-emergent)
- Bronchitis (non-emergent)
- Contusions (non-emergent)
- Dental issues (non-emergent/advanced dental caries or abscesses are avoidable)
- Gastroenteritis (non-emergent)
- Headache/migraine (non-emergent)
- Otitis media (non-emergent)



- Pharyngitis (non-emergent)
- Sprain (non-emergent)
- Unspecified viral infection (non-emergent)
- Upper respiratory infection (non-emergent and/or avoidable with early intervention)
- Urinary tract infection (non-emergent)

In addition to the PIP, HealthCare USA formed the Emergency Department Utilization Team. This multidisciplinary team, consisting of staff from our Quality Improvement, Provider Relations and Health Services teams, offers a forum to review for all activities related to ED utilization.

Monitoring Tools

HealthCare USA uses the following tools to monitor ED utilization:

- Quarterly Reports of ED Utilization
- HEDIS Software
- ED Morbidity Database

Strategies to Reduce ED Overuse (Beginning in 2007 to present)

Research completed by the Integrated Health Network showed that the three top reasons people in the Metropolitan St. Louis region go to the ED for non-emergent/avoidable symptoms is because of a lack of knowledge about first aid and/or healthcare and because the member either doesn't know their PCP or does not view the PCP as a first step for all well and sick healthcare treatment. As a result of this information, HealthCare USA implemented the following interventions:

- **Develop and Distribute Member Education Material.** Two brochures and an informational letter were created to educate members as to the proper use of the emergency department. All materials are State approved.

“First Aid Tips.” This brochure provides the member with basic first aid information as well as instructions as to when to go to the emergency department and a telephone number to call the nurse hotline.

“Understanding How to Get the Right Healthcare.” This brochure provides the member with information to help identify true medical emergencies. It also reinforces the importance of the relationship with the primary care provider (PCP) and the use of urgent care centers.

Informational Letter. This letter notifies the member that HealthCare USA is aware of their frequent emergency department visits. The letter provides information defining a true emergency situation and provides member with telephone numbers to call with questions.



This brochure was mailed to the same ED frequent visit group at least every 3 months and was distributed at community events. In addition, on-going periodic education occurred in the member and provider newsletters. The brochure is also distributed at member health fairs.

- **Strengthen Member Outreach.** In an effort to enhance member outreach, a process was started to obtain weekly ED visit logs directly from hospitals. The Case Management and Disease Management nursing staff receive the logs for review and to follow up with any member enrolled in a program who is also included on an ED visit log from a hospital. Provider Relations representatives continue to work with other hospitals to obtain additional logs.
- **Obtain ED Census.** Our Case Managers collaborate with hospitals to receive ED census and diagnosis within 2-3 days of visit and distribute those lists to our Case Management, Certified Case Manager and Disease Management staffs for review and follow up with those enrolled in any of these programs.
- **Create ED Morbidity Tracking Database.** The ED Case Manager anecdotally identified consistent barriers to members' ability to complete discharge instructions and/or to complete PCP instructions that may have prevented an ED visit. As a result, a database was created to identify, track and trend these reasons.
- **Update Member Website.** We updated our member website to ensure members have the most current information on the locations, hours of operation, telephone numbers of Urgent Care Centers and the types of services provided at each facility.
- **Establish Project Workgroups.** Regular ED project workgroups have been established to problem-solve and intervene.
- **Enhance Provider Relations Program.** Our Provider Relations Representatives educate providers about urgent care centers available in their area, hours of and types of services provided. They also visit providers whose patients make frequent emergency department visits to suggest ways the provider may assist in reducing the number of emergency department visits by their patients.

Future Initiatives

HealthCare USA is planning an expansion of the current ED Utilization monitoring process through the Case Management Department beginning in the first quarter of 2012. This process will target pediatric members (\leq 18 years old) that come to the ED with a gastrointestinal or upper respiratory infection diagnoses. Member evaluation and assessment will be performed by the case management team to ensure that the member understands discharge instructions, is compliant with prescribed medications and has information on accessing HealthCare USA's 24-Hour Nurse Line. In addition to telephone outreach, we will follow up with a mailing that includes HealthCare USA's ED and First Aid brochures.

The table below outlines plans for expanding our ED diversion program over Years One, Two and Three of the contract:



Year 1 (July 2012 -June 2013)	Year 2 (July 2013 - June 2014)	Year 3 (July 2014-June 2015)
Continue ED PIP and its advisory committee	Continue ED PIP and its advisory committee	Continue ED PIP and its advisory committee
Regular mailings of “First Aid Tips” brochure, “Understanding How to Get the Right Healthcare” brochure to frequent ED utilizers in all three regions	Review/revise/continue brochure mailings in all three regions	Review/revise/continue brochure mailings in all three regions
Through HealthCare USA website, provide both members and providers with current lists of contracted urgent care centers.	Continue urgent care listing; review options for provider and member portals	Continue urgent care listing; review options for provider and member portals
Receive ED logs from key hospitals and distribute to case/disease mangers for follow-up with any members enrolled in programs.	Coordinate ED log request with case management health information exchanges and modify as appropriate.	Coordinate ED log request with case management health information exchanges and modify as appropriate.
Provider Relations reps educate providers about urgent care options in their area.	Continue educational opportunities on contracted urgent care centers.	Continue educational opportunities on contracted urgent care centers.
Implement mailing of Urgent Care brochure to educate members about the appropriate use & availability of Urgent Care and Convenience Care clinics.	Explore status of health information exchanges across State and options for transferring data from ED to FQHCs and larger practices and medical homes	Continue and expand this effort as exchanges mature.
Implement expansion of the current ED Utilization monitoring process through the Case Management Department.	Continue the monitoring process through the Case Management Department and modify as appropriate.	Continue the monitoring process through the Case Management Department and modify as appropriate.



4.5.4.b5 - Bullet 8 How the offeror will utilize safety net providers (e.g. FQHCs, public health departments, CMHCs) to facilitate access to needed services (including measures for identifying when safety net providers are needed and outreach to public providers). The offeror shall also address how these strategies will differ between rural and urban areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 8.

HealthCare USA has maintained a long-standing relationship with many safety net providers across the State. This network consists of FQHCs in urban areas, RHCs in rural areas and local public health departments located in both urban and rural areas. FQHCs and RHCs function as primary care providers for approximately 20% of our membership in each region, as shown in the table below:

Figure 4.5- 53: FQHC and RHCs PCP Assignment Rates

	Percent of HealthCare USA Membership			
	Central	Eastern	Western	All Regions
PCP Assignment to FQHCs and RHCs	18%	21%	22%	21%

We consider our safety net providers to be among our high volume providers and as such, provide them with all the services we afford to all other high volume providers. For example, our Provider Relations Representatives make quarterly visits to safety net providers to ensure they receive the necessary support to resolve issues and get answers to questions. Our case managers provide the full range of coordination activities to ensure assigned members have access to the care they need.



4.5.4 Access to Care – Specialty Care

4.5.4a. Specialty Care Networks

The offeror shall demonstrate adequate provider networks to fulfill MO HealthNet requirements.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a).

HealthCare USA has developed a comprehensive, statewide provider network to meet travel distance and network adequacy requirements as required by MO HealthNet and Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP) in 20 CSR 400-7.095. Our Missouri provider network includes hospitals, primary care, specialty care physicians, advance practice nurses, FQHCs, RHCs, local health departments, family planning/STD clinics, vision providers, ancillary, behavioral health, substance abuse, dental health and emergent/non emergent transportation providers. HealthCare USA also includes provider types and specialties in our network such as dental health providers that are not specified in the 20 CSR 400-7.095 to ensure a comprehensive network of providers to care for our members.

This comprehensive network covers the 54 counties in the MO HealthNet Central, Eastern and Western service areas. Also, HealthCare USA is licensed in 51 additional counties outside the current service area and we have contracts with providers in the 24 contiguous counties to the service area. Our extensive network presence in Missouri will facilitate any future program expansion as a result of the implementation of the Patient Protection and Affordable Care Act (ACA). Further, as we demonstrate in the sections that follow, our current network is capable of providing care to any additional new membership we may acquire following award of this contract.

The table below presents a snapshot of our provider network throughout the 54 MO HealthNet counties as well as the contiguous counties outside the service area.

Figure 4.5- 54: Provider Networks - Overall Counts by Category

Provider Type	In the 54 MO HealthNet Counties				In MO Counties Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Hospital	20	32	20	72	10	82
Ancillary	267	360	139	766	136	902
PCP	537	878	341	1756	440	2196
Specialist	1284	4187	1271	6742	641	7383



Provider Type	In the 54 MO HealthNet Counties				In MO Counties Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Dental	87	153	193	433	123	556
Behavioral Health	313	955	615	1865	261	2126
FQHC*	8	18	5	31	55 (RHC/FQHC)	193
RHC*	65	29	13	107		
Local Public Health**	25	13	13	51	4	55
Family Planning/ST D Treatment**	2	5	1	8	3	8

* These numbers are also included in the number of PCPs.
 ** These numbers are Included in ancillary counts
 FQHC, RHC, LPH, Family Planning providers are broken out separately in this grid as they are listed on Attachments to RFP)

DATA SOURCE: COVENTRY PROVIDER DATABASE. MEASUREMENT PERIOD: AS OF OCT. 31, 2011

4.5.4.a1. The offeror shall submit documentation demonstrating that the offeror’s networks comply with travel distance access standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. The offeror shall also submit documentation for those providers not addressed under 20 CSR 400-7.095, ensuring members will have access to those providers within thirty (30) miles unless the offeror can demonstrate that there is no licensed provider in that area, in which case the offeror shall ensure members have access to those providers within sixty (60) miles. For any demonstrated access that differs from these standards, the offeror shall submit proof of approval of the differences by the Department of Insurance, Financial Institutions & Professional Registration.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a) 1.



Documentation of Travel Distance Standards

On March 1 of each year, HealthCare USA files an annual network access plan with DIFP as required by 20 CSR 400-7.095. The attached documentation from the DIFP shows that HealthCare USA complies with network capacity and travel distance standards for all provider types and specialties as required by 20 CSR 400-7.095. Specifically, this is evidenced by the first paragraph in the DIFP Network Adequacy Approval letter, dated June 6, 2011, indicating that the 2010 Network Access Plan for HealthCare USA was approved. Our networks have achieved **100% compliance** with network capacity and travel distance standards.

Note: HealthCare USA submits a provider file to DIFP of our dental provider network for evaluation, (which is a MO HealthNet requirement and not actually a part of the DIFP regulation) Because distance standards do not exist in the DIFP regulation for Dental providers, the following standards are used to evaluate the dental network:

- Urban county: 15 miles
- Basic county: 30 miles
- Rural county: 60 miles

DIFP has also evaluated our dental network and we have achieved **100% compliance** for dental network capacity and travel distance standards.

Geo Access Reports

In addition to the DIFP documentation, HealthCare USA conducts its own review of provider networks as part of our ongoing monitoring of travel distance and access for our membership.

We are also including a series of Geo Access maps and summary reports as Attachment 25, showing the distribution of network provider locations in relation to our current membership and evidence that our geographic distribution of providers covers the entire service area for all three regions. A separate map showing locations within a 30-mile and 60-mile radius is presented for the following provider categories, covering some of key high volume areas of concern to our population:

- RHC and FQHC
- Child PCP
- Adult PCP
- OB/GYN
- Pediatrics
- Dental
- Adult Behavioral Health
- Child Behavioral Health
- High Volume Specialist





As demonstrated in the Geo-Access maps and summary reports, HealthCare USA's vast provider network covers the entire 54 county service area and we are in **100% compliance** with network capacity and travel distance standards.

Data Source: Geo-Access Mapping Software, Coventry Provider Database, HealthCare USA Member Eligibility File
Measurement Period: October 31, 2011

4.5.4.a2. The offeror shall provide documentation verifying that the offeror's network has adequate capacity. Such documentation shall include, but it is not limited to, appointment availability, 24 hours/7 days a week access, sufficient experienced providers to serve special needs populations, waiting times, open panels, and PCP to member ratios.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)2.

In the paragraphs that follow, we describe our network capacity for the Specialty Care network. This description contains an assessment of appointment availability, 24/7 access, providers serving special needs populations, open panels and waiting times in provider offices. Unless otherwise specified, the reporting period for these network compliance indicators is the end of the calendar year 2010. The reporting period for the number of providers shown in each of the tables below and on the Geo Access maps and summary reports is as of October 31, 2011.

Adequate Network Capacity and Monitoring Access to Services

Over the course of our 16 years as a managed care organization in Missouri, HealthCare USA has developed, enhanced and utilized several policies, procedures and processes to monitor our provider and subcontractor/affiliate networks to ensure adequate network capacity, accessibility for our members, and accuracy in our provider listings. Further, our network activities are designed to achieve the ultimate goal of connecting our members with a health care home so they can obtain services in the most effective and appropriate setting.

In addition to using Geo-Access for distance reviews, we use additional monitoring activities for each network category including:

- Conducting telephonic provider secret shopper surveys regarding appointment and after-hours access for primary, maternity and high volume specialty care.
- Reviewing providers' panel status to confirm if new members can be assigned and if provider has reached capacity or referral limits.
- Reviewing PCP to member ratios by provider type and by region to ensure an adequate number of primary care providers are available.
- Following up and resolving member concerns related to access or appointment availability.





- Reviewing quarterly analysis and trending of member grievances to identify any potential availability or accessibility access issues; perform root cause analysis and develop corrective action plans, if necessary.
- Case managing members identified as utilizing the emergency department (ED) for non-emergent conditions.
- Making weekly updates to online Provider Directories to reflect changes in open/closed panels.
- Reviewing monthly provider network and recruitment activities of dental and behavioral health networks.
- Initiating independent oversight by in-network physicians that participate on HealthCare USA’s Quality Management Committee of network access and availability studies conducted for primary care, specialty care, emergent care, dental and behavioral health.

In instances where a network provider cannot meet access or appointment availability standards, HealthCare USA and our subcontractor and affiliate Provider Relations teams:

- Conduct provider education regarding the standards
- Work with the provider to resolve the issues
- Locate additional providers to meet the member’s need
- Conduct recruitment efforts to add additional providers if the need arises

Any providers who do not meet standards are educated and re-surveyed within 30 days of the initial survey to ensure compliance with access and availability standards.

Specialty Care Networks

The table below shows the total number of specialty care providers by region within the service area and outside the service area.

Figure 4.5- 55: Total Specialty Care Network

	In the 54 MO HealthNet Counties				Counties Outside Service Area	Total Across MO Counties
	Central	Eastern	Western	Total		
All Specialties	1,284	4,187	1,271	6,742	641	7,383

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011



The table below illustrates the number of Healthcare USA high-volume specialty care providers by region within the service area and outside the service area.

Figure 4.5- 56: Total High Volume Specialists by Region

Specialty Category	In the 54 MO HealthNet Counties and the Contiguous Counties				Counties Outside Service Area	Total Across MO Counties
	Central	Eastern	Western	Total		
Cardiovascular Disease	41	138	51	230	4	234
Dermatology	13	34	8	55	5	60
Maternal Fetal Medicine	4	34	12	50	3	53
Ob-GYN	75	232	64	371	38	409
Ophthalmology	33	110	44	187	13	200
Optometry	92	190	41	323	18	341
Orthopedic Surgery	48	148	31	227	23	250
Otolaryngology (ENT)	27	62	17	106	7	113
Pediatric Cardiology	4	23	15	42	2	44
Surgery, General	79	130	52	261	36	297

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Specialty Provider to Member Ratio

The table below shows the current HealthCare USA provider to member ratios for high volume specialty providers. To demonstrate the strength of our specialty care network , we examined not only the provider to member ratios for our current membership, but also for a projected expanded membership encompassing all MO HealthNet eligibles. To arrive at a total projected membership, we combined our current enrollment with the membership of the next largest Medicaid provider participating in the MO HealthNet program, assuming we may acquire that membership following contract award.

As the data indicates, our specialty care network exceeds the ratio standards for each high volume specialty for both our current and projected expanded membership.



Figure 4.5- 57: Member to High Volume Specialist Ratio for Current Membership

HV Specialty	Standard	CMO	EMO	WMO	Overall
Cardiovascular Disease	1 for every 20,000 members	758	908	614	815
Dermatology	1 for every 40,000 members	2007	3684	3479	3178
Maternal Fetal Medicine	1 for every 40,000 members	6822	3578	2237	3531
OB/GYN	1 for every 40,000 members	319	474	337	411
Ophthalmology	1 for every 20,000 members	793	1128	681	953
Optometry	1 for every 20,000 members	316	656	746	559
Orthopaedic Surgery	1 for every 15,000 members	517	846	870	763
Otolaryngology (ENT)	1 for every 30,000 members	1003	2020	1842	1687
Pediatric Cardiology	1 for every 20,000 members	5685	5445	2088	4333
Surgery, General	1 for every 15,000 members	328	942	522	642

DATA SOURCES: COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE. MEASUREMENT PERIOD: AS OF OCT. 31, 2011



Figure 4.5- 58: Member to High Volume Specialist Ratio for Growth Membership*

HV Specialty	Standard	CMO	EMO	WMO	Overall
Cardiovascular Disease	1 for every 20,000 members	1550	1326	1715	1454
Dermatology	1 for every 40,000 members	4103	5381	9721	5670
Maternal Fetal Medicine	1 for every 40,000 members	13951	5227	6249	6300
OB/GYN	1 for every 40,000 members	652	693	941	733
Ophthalmology	1 for every 20,000 members	1622	1648	1902	1701
Optometry	1 for every 20,000 members	646	958	2083	998
Orthopedic Surgery	1 for every 15,000 members	1057	1236	2430	1361
Otolaryngology (ENT)	1 for every 30,000 members	2052	2951	5146	3011
Pediatric Cardiology	1 for every 20,000 members	11626	7954	5833	7732
Surgery, General	1 for every 15,000 members	671	1376	1458	1145

*Adding membership of next largest MCO in each

DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE.
MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Figure 4.5- 59: Member to High Volume Specialist Ratio for Healthcare Reform Membership*

HV Specialty	Standard	CMO	EMO	WMO	Overall
Cardiovascular Disease	1 for every 20,000 members	2034	1750	2036	1867



HV Specialty	Standard	CMO	EMO	WMO	Overall
Dermatology	1 for every 40,000 members	5385	7101	11537	7280
Maternal Fetal Medicine	1 for every 40,000 members	18309	6898	7416	8089
OB/GYN	1 for every 40,000 members	856	915	1116	941
Ophthalmology	1 for every 20,000 members	2129	2175	2257	2184
Optometry	1 for every 20,000 members	848	1264	2472	1281
Orthopedic Surgery	1 for every 15,000 members	1387	1631	2884	1747
Otolaryngology (ENT)	1 for every 30,000 members	2693	3894	6108	3866
Pediatric Cardiology	1 for every 20,000 members	15258	10497	6922	9928
Surgery, General	1 for every 15,000 members	880	1815	1731	1471
* Adding the Healthcare reform membership estimated for current ME codes to Growth membership (current HealthCare USA plus membership of next largest MCO)					

DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE
 MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Appointment Availability

The tables below show our most current specialty care compliance with appointment standard requirements. The first table illustrates compliance with the maternity care appointment standard and the second table illustrates compliance with appointment standards for all other specialty care.



Figure 4.5- 60: Maternity Care Appointment Compliance Rate

Appointment Standards	Central	Eastern	Western
First Trimester appointments with 7 days of first request	100%	100%	100%
Second Trimester appointments with 7 days of first request	100%	100%	100%
Third Trimester appointments within 3 days of request	100%	100%	100%
High Risk Pregnancies within 3 days of identification or immediately if emergency exists	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010
 MEASUREMENT PERIOD: 2010

Figure 4.5- 61: Specialty Care Compliance Rate

Appointment Standards	Central	Eastern	Western
Urgent care appointments within 24 hours	100%	100%	100%
Routine symptomatic care appointments within one week or five business days, whichever is earlier	100%	100%	100%
Routine asymptomatic care appointments within 30 calendar days	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010
 MEASUREMENT PERIOD: 2010

24/7 Access to Care

HealthCare USA requires specialty care providers to be available to direct care for our members 24 hours a day, seven days a week. Our health plan periodically conducts random surveys of providers to confirm their after-hours access meets the 24 hour access to care standards. Providers are required to provide direct access, use a call coverage service or utilize a nurse triage line. In addition, HealthCare USA standards require the provider to refrain from directing members to call 9-1-1 as the only option for after-hours access. The table below indicates the maternity care and specialty care after-hours access survey results for 2010.



Figure 4.5- 62: Maternity Care Compliance Rate

	Central	Eastern	Western
24/7 After-Hours Access	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010
MEASUREMENT PERIOD: 2010

Figure 4.5- 63: Specialty Care Compliance Rate

	Central	Eastern	Western
24/7 After-Hours Access	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010
MEASUREMENT PERIOD: 2010

Providers to Serve Special Needs Populations

Although our special needs population is heavily concentrated among children, our specialty care providers also serve adult members in this population. Our provider network includes the following highly specialized provider types to address the healthcare challenges of our special needs members as shown in the table below:

Figure 4.5- 64: Providers to Serve Special Needs Population

Provider Type	In the 54 MO HealthNet Counties				Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Childrens Hospitals	1	1	1	3	N/A	3
Pediatric Specialty Hospitals	N/A	1	N/A	1	N/A	1
Tertiary care Hospitals	6	16	7	29	N/A	29
Complex Rehab/Mobility Providers	3	6	2	11	3	14
DME (Ostomy, Diabetic Supplies, Inhalers)	44	42	25	111	12	123
Orthotics/Prosthetics	5	9	4	18	4	22
PT/OT/ST	47	66	25	138	17	155



Provider Type	In the 54 MO HealthNet Counties				Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Private Duty Nursing	36	75	33	144	23	167
Home Infusion	1	5	1	7	2	9
Home Health Care	13	34	6	53	11	64
Pediatric Allergy/Immunology	7	12	8	27	1	28
Pediatric Pulmonologist	4	10	6	20	N/A	20
Pediatric Endocrinology	5	11	8	24	2	26
Maternal Fetal Medicine	4	34	12	50	3	53
Ob-Gyn	75	232	64	371	34	405
Neurology	30	132	25	187	14	201
Ocular Implant Providers	N/A	2	N/A	2	N/A	2
Craniofacial/Cleft Palate Clinics	10	2	1	13	N/A	13
Pediatric Cardiology	4	23	15	42	2	44
Neonatology	11	48	38	97	8	105
Speech and Hearing Devices (implants, communication devices and hearing aids)	21	51	12	84	6	90
Autism/Neurodevelopment Providers	58	76	54	188	N/A	188
Autism Centers	1	1	1	3	1	4
Adult Psychiatrists	51	102	78	231	N/A	309
Child Psychiatrists	24	99	64	187	N/A	251
Allied Health BH Professionals (Social Workers, Counselors, etc)	377	996	680	2053	N/A	2733



Provider Type	In the 54 MO HealthNet Counties				Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
General Dentists	9	14	9	32	6	38
Pediatric Dentists	1	6	18	25	4	29
Endodontic	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontists	N/A	N/A	N/A	N/A	N/A	N/A
Oral Surgeon	1	N/A	N/A	1	1	1
Specialized Transport Vendors (Handicap accessible)	72	122	102	296	N/A	296

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011

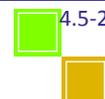
The table below shows a sampling of providers across the three regions who are contracted to provide services to our special needs populations across the state. This is not an all inclusive listing.

Figure 4.5- 65: Providers Contracted for Special Needs Populations

Provider Type	Region	Provider Name
Pediatric Specialty Hospital	Eastern	Ranken Jordan
Children’s Hospital & Pediatric Subspecialists	Eastern	St. Louis Children’s Hospital Cardinal Glennon Children’s Hospital Washington University SLUCare Mercy Medical Group
Children’s Hospital & Pediatric Subspecialists	Central	University of Missouri’s Women & Children’s Hospital University of Missouri Hospitals & Clinics
Children’s Hospital & Pediatric Subspecialists	Western	Children’s Mercy Hospital & Clinics



Provider Type	Region	Provider Name
Hearing/Speech	Eastern	Center for Hearing and Speech; Central Institute for the Deaf; The Moog Center for Deaf Education
Hearing/Speech	Central	Horizon Hearing Services
Hearing/Speech	Western	Midwest Ear Institute
Communication Device	All Regions	Dynavox
Complex Rehab/Mobility	All Regions	Alliance Seating and Mobility
Complex Rehab/Mobility	All Regions	United Seating and Mobility
Ocular Prostheses	Eastern/All Regions	Bruce Cook Prosthetics; Mager and Gougelman of St. Louis
Missouri Autism Center	Eastern	SSM: Knights of Columbus Development Center
Missouri Autism Center	Central	University of Missouri: Thompson Center for Autism & Neurodevelopmental Disorders
Missouri Autism Center	Eastern/Contiguous	Southeast Missouri State University: Autism Center for Diagnosis and Treatment
Missouri Autism Center	Western	Children's Mercy Hospital and Clinics: Developmental and Behavioral Sciences
Autism Treatment Center	Eastern	Touch point Autism Services
Cleft Palate	Eastern	Cardinal Glennon: St. Louis Clef-Craniofacial Center; St. Louis Children's Hospital: Cleft Palate and Craniofacial Institute; St. Johns Mercy: Cleft Palate and Craniofacial Deformities Center
Cleft Palate	Central	University of Missouri Healthcare: Cleft Lip and Palate/Orofacial team
Cleft Palate	Western	Children's Mercy Hospital: Cleft Palate/Craniofacial Clinic





Provider Type	Region	Provider Name
Specialty Infusion	All Regions	Critical Care Systems
Specialty Infusion	All Regions	Coram
Private Duty/Home Health	Eastern	First Steps Pediatrics Home Health
Private Duty/Home Health	Central	Pyramid Home Health
Private Duty/Home Health	Western	Firstat Nursing Services
Orthotics and Prosthetics	Central	Snyder Brace
Orthotics and Prosthetics	All Regions	Hanger Prosthetics and Orthotics

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Waiting Times in Specialty Care Offices

Our specialty care providers are required to comply with the office waiting time standard not to exceed one hour from the scheduled appointment time. As with our PCP networks, appointment waiting times for specialty care are monitored by investigating any provider quality of service complaints regarding prolonged wait time for appointments. We consider the provider to be compliant with the waiting times standard when the reported feedback reveals the absence of any grievances or complaints. As shown in the table below, based on our most recent analysis of member grievances, no complaints of excessive waiting times in specialty care provider offices (beyond one hour from scheduled appointment) were reported.

Figure 4.5- 66: Specialty Care Compliance Rate (Measured by the Number of Member Grievances for Prolonged Wait Time)

Office Waiting Time Standard	Central	Eastern	Western
Waiting times for appointments (not to exceed one hour from scheduled appointment time)	1	2	0

DATA SOURCE: HEALTHCARE USA NAVIGATOR REPORT ON PROVIDER QUALITY OF SERVICE ISSUES MEASUREMENT PERIOD: 2010

- 4.5.4.a3. The offeror shall describe how tertiary care providers including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists will be available twenty-four (24) hours per day in the region. If the offeror does not have a full range of tertiary care providers, the offeror shall describe how the



services will be provided including transfer protocols and arrangements with out of network facilities.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)3.

Specialty Care Networks

The table below shows the total number of specialty care providers by region within the service area and outside the service area.

Figure 4.5- 67: Specialty Care Providers by Region

Total Specialty Care Network						
	In the 54 MO HealthNet Counties				Counties Outside Service Area	Total Across MO Counties
	Central	Eastern	Western	Total		
All Specialties	1,284	4,187	1,271	6,742	641	7,383

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011

The table below illustrates the number of Healthcare USA high-volume specialty care providers by region within the service area and outside the service area.

Figure 4.5- 68: High-Volume Specialty Care Providers by Region

Total High Volume Specialists by Region						
Specialty Category	In the 54 MO HealthNet Counties and the Contiguous Counties				Counties Outside Service Area	Total Across MO Counties
	Central	Eastern	Western	Total		
Cardiovascular Disease	41	138	51	230	4	234
Dermatology	13	34	8	55	5	60
Maternal Fetal Medicine	4	34	12	50	3	53
Ob-GYN	75	232	64	371	38	409
Ophthalmology	33	110	44	187	13	200
Optometry	92	190	41	323	18	341
Orthopedic Surgery	48	148	31	227	23	250



Total High Volume Specialists by Region						
Specialty Category	In the 54 MO HealthNet Counties and the Contiguous Counties				Counties Outside Service Area	Total Across MO Counties
	Central	Eastern	Western	Total		
Otolaryngology (ENT)	27	62	17	106	7	113
Pediatric Cardiology	4	23	15	42	2	44
Surgery, General	79	130	52	261	36	297

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Specialty Provider to Member Ratio

The table below shows the current HealthCare USA provider to member ratios for high volume specialty providers. To demonstrate the strength of our specialty care network, we examined not only the provider to member ratios for our current membership, but also for a projected expanded membership encompassing all MO HealthNet eligibles. To arrive at a total projected membership, we combined our current enrollment with the membership of the next largest Medicaid provider participating in the MO HealthNet program, assuming we may acquire that membership following contract award.

As the data indicates, our specialty care network exceeds the ratio standards for each high volume specialty for both our current and projected expanded membership.

Figure 4.5- 69: Member to High Volume Specialist Ratio for Current Membership

HV Specialty	Standard	CMO	EMO	WMO	Overall
Cardiovascular Disease	1 for every 20,000 members	758	908	614	815
Dermatology	1 for every 40,000 members	2007	3684	3479	3178
Maternal Fetal Medicine	1 for every 40,000 members	6822	3578	2237	3531
OB/GYN	1 for every 40,000 members	319	474	337	411
Ophthalmology	1 for every 20,000 members	793	1128	681	953
Optometry	1 for every 20,000	316	656	746	559



HV Specialty	Standard	CMO	EMO	WMO	Overall
	members				
Orthopaedic Surgery	1 for every 15,000 members	517	846	870	763
Otolaryngology (ENT)	1 for every 30,000 members	1003	2020	1842	1687
Pediatric Cardiology	1 for every 20,000 members	5685	5445	2088	4333
Surgery, General	1 for every 15,000 members	328	942	522	642

DATA SOURCES: COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE

MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Figure 4.5- 70: Member to High Volume Specialist Ratio for Growth Membership*

HV Specialty	Standard	CMO	EMO	WMO	Overall
Cardiovascular Disease	1 for every 20,000 members	1550	1326	1715	1454
Dermatology	1 for every 40,000 members	4103	5381	9721	5670
Maternal Fetal Medicine	1 for every 40,000 members	13951	5227	6249	6300
OB/GYN	1 for every 40,000 members	652	693	941	733
Ophthalmology	1 for every 20,000 members	1622	1648	1902	1701
Optometry	1 for every 20,000 members	646	958	2083	998



HV Specialty	Standard	CMO	EMO	WMO	Overall
	members				
Orthopedic Surgery	1 for every 15,000 members	1057	1236	2430	1361
Otolaryngology (ENT)	1 for every 30,000 members	2052	2951	5146	3011
Pediatric Cardiology	1 for every 20,000 members	11626	7954	5833	7732
Surgery, General	1 for every 15,000 members	671	1376	1458	1145
*Adding membership of next largest MCO in each					

DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Figure 4.5- 71: Member to High Volume Specialist Ratio for Healthcare Reform Membership*

HV Specialty	Standard	CMO	EMO	WMO	Overall
Cardiovascular Disease	1 for every 20,000 members	2034	1750	2036	1867
Dermatology	1 for every 40,000 members	5385	7101	11537	7280
Maternal Fetal Medicine	1 for every 40,000 members	18309	6898	7416	8089
OB/GYN	1 for every 40,000 members	856	915	1116	941



HV Specialty	Standard	CMO	EMO	WMO	Overall
Ophthalmology	1 for every 20,000 members	2129	2175	2257	2184
Optometry	1 for every 20,000 members	848	1264	2472	1281
Orthopedic Surgery	1 for every 15,000 members	1387	1631	2884	1747
Otolaryngology (ENT)	1 for every 30,000 members	2693	3894	6108	3866
Pediatric Cardiology	1 for every 20,000 members	15258	10497	6922	9928
Surgery, General	1 for every 15,000 members	880	1815	1731	1471
* Adding the Healthcare reform membership estimated for current ME codes to Growth membership (current HealthCare USA plus membership of next largest MCO)					

DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, COVENTRY PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE
 MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Appointment Availability

The tables below show our most current specialty care compliance with appointment standard requirements. The first table illustrates compliance with the maternity care appointment standard and the second table illustrates compliance with appointment standards for all other specialty care.



Figure 4.5- 72: Maternity Care Appointment Compliance Rate

Appointment Standards	Central	Eastern	Western
First Trimester appointments with 7 days of first request	100%	100%	100%
Second Trimester appointments with 7 days of first request	100%	100%	100%
Third Trimester appointments within 3 days of request	100%	100%	100%
High Risk Pregnancies within 3 days of identification or immediately if emergency exists	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010 MEASUREMENT PERIOD: 2010

Figure 4.5- 73: Specialty Care Compliance Rate

Appointment Standards	Central	Eastern	Western
Urgent care appointments within 24 hours	100%	100%	100%
Routine symptomatic care appointments within one week or five business days, whichever is earlier	100%	100%	100%
Routine asymptomatic care appointments within 30 calendar days	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010 MEASUREMENT PERIOD: 2010

24/7 Access to Care

HealthCare USA requires specialty care providers to be available to direct care for our members 24 hours a day, seven days a week. Our health plan periodically conducts random surveys of providers to confirm their after-hours access meets the 24 hour access to care standards. Providers are required to provide direct access, use a call coverage service or utilize a nurse triage line. In addition, HealthCare USA standards require the provider to refrain from directing members to call 9-1-1 as the only option for after-hours access. Figure 4.5- 74 and Figure 4.5- 77 indicate the maternity care and specialty care after-hours access survey results for 2010.



Figure 4.5- 74: Maternity Care Compliance Rate

	Central	Eastern	Western
24/7 After-Hours Access	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010
MEASUREMENT PERIOD: 2010

Figure 4.5- 75: Specialty Care Compliance Rate

	Central	Eastern	Western
24/7 After-Hours Access	100%	100%	100%

DATA SOURCE: HEALTHCARE USA PROVIDER ACCESSIBILITY SURVEY -2010
MEASUREMENT PERIOD: 2010

Providers to Serve Special Needs Populations

Although our special needs population is heavily concentrated among children, our specialty care providers also serve adult members in this population. Our provider network includes the following highly specialized provider types to address the healthcare challenges of our special needs members as shown in Figure 4.5- 79:

Figure 4.5- 76: Providers to Serve Special Needs Population

Provider Type	In the 54 MO HealthNet Counties				Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Childrens Hospitals	1	1	1	3	N/A	3
Pediatric Specialty Hospitals	N/A	1	N/A	1	N/A	1
Tertiary care Hospitals	6	16	7	29	N/A	29
Complex Rehab/Mobility Providers	3	6	2	11	3	14
DME (Ostomy, Diabetic Supplies, Inhalers)	44	42	25	111	12	123
Orthotics/Prosthetics	5	9	4	18	4	22
PT/OT/ST	47	66	25	138	17	155



Provider Type	In the 54 MO HealthNet Counties				Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Private Duty Nursing	36	75	33	144	23	167
Home Infusion	1	5	1	7	2	9
Home Health Care	13	34	6	53	11	64
Pediatric Allergy/Immunology	7	12	8	27	1	28
Pediatric Pulmonologist	4	10	6	20	N/A	20
Pediatric Endocrinology	5	11	8	24	2	26
Maternal Fetal Medicine	4	34	12	50	3	53
Ob-Gyn	75	232	64	371	34	405
Neurology	30	132	25	187	14	201
Ocular Implant Providers	N/A	2	N/A	2	N/A	2
Craniofacial/Cleft Palate Clinics	10	2	1	13	N/A	13
Pediatric Cardiology	4	23	15	42	2	44
Neonatology	11	48	38	97	8	105
Speech and Hearing Devices (implants, communication devices and hearing aids)	21	51	12	84	6	90
Autism/Neurodevelopment Providers	58	76	54	188	N/A	188
Autism Centers	1	1	1	3	1	4
Adult Psychiatrists	51	102	78	231	N/A	309
Child Psychiatrists	24	99	64	187	N/A	251
Allied Health BH Professionals (Social Workers, Counselors, etc)	377	996	680	2053	N/A	2733



Provider Type	In the 54 MO HealthNet Counties				Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
General Dentists	9	14	9	32	6	38
Pediatric Dentists	1	6	18	25	4	29
Endodontic	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontists	N/A	N/A	N/A	N/A	N/A	N/A
Oral Surgeon	1	N/A	N/A	1	1	1
Specialized Transport Vendors (Handicap accessible)	72	122	102	296	N/A	296

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011

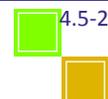
The table below shows a sampling of providers across the three regions who are contracted to provide services to our special needs populations across the state. This is not an all inclusive listing.

Figure 4.5- 77: Providers Contracted to Provide Services to Our Special Needs Populations

Provider Name	Region	Provider Type
Ranken Jordan	Eastern	Pediatric Specialty Hospital
St. Louis Children’s Hospital; Cardinal Glennon Children’s Hospital Washington University SLUCare Mercy Medical Group	Eastern	Children’s Hospital & Pediatric Subspecialists
University of Missouri’s Women & Children’s Hospital University of Missouri Hospitals & Clinics	Eastern	Children’s Hospital & Pediatric Subspecialists
Children’s Mercy Hospital &	Western	Children’s Hospital &



Provider Name	Region	Provider Type
Clinics		Pediatric Subspecialists
Center for Hearing and Speech; Central Institute for the Deaf; The Moog Center for Deaf Education	Eastern	Hearing/Speech
Horizon Hearing Services	Central	Hearing/Speech
Midwest Ear Institute	Western	Hearing/Speech
Dynavox	All Regions	Communication Device
Alliance Seating and Mobility	All Regions	Complex Rehab/Mobility
United Seating and Mobility	All Regions	Complex Rehab/Mobility
Bruce Cook Prosthetics; Mager and Gougelman of St. Louis	Eastern/All Regions	Ocular Prostheses
SSM: Knights of Columbus Development Center	Eastern	Missouri Autism Center
University of Missouri: Thompson Center for Autism & Neurodevelopmental Disorders	Central	Missouri Autism Center
Southeast Missouri State University: Autism Center for Diagnosis and Treatment	Eastern/Contiguous	Missouri Autism Center
Children's Mercy Hospital and Clinics: Developmental and Behavioral Sciences	Western	Missouri Autism Center
Touch point Autism Services	Eastern	Autism Treatment Center
Cardinal Glennon: St. Louis Cleft-Craniofacial Center; St. Louis Children's Hospital: Cleft Palate and Craniofacial Institute; St. Johns Mercy: Cleft Palate and Craniofacial Deformities Center	Eastern	Cleft Palate





Provider Name	Region	Provider Type
University of Missouri Healthcare: Cleft Lip and Palate/Orofacial team	Central	Cleft Palate
Children’s Mercy Hospital: Cleft Palate/Craniofacial Clinic	Western	Cleft Palate
Critical Care Systems	All Regions	Specialty Infusion
Coram	All Regions	Specialty Infusion
First Steps Pediatrics Home Health	Eastern	Private Duty/Home Health
Pyramid Home Health	Central	Private Duty/Home Health
Firstat Nursing Services	Western	Private Duty/Home Health
Snyder Brace	Central	Orthotics and Prosthetics
Hanger Prosthetics and Orthotics	All Regions	Orthotics and Prosthetics

DATA SOURCE: COVENTRY PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Waiting Times in Specialty Care Offices

Our specialty care providers are required to comply with the office waiting time standard not to exceed one hour from the scheduled appointment time. As with our PCP networks, appointment waiting times for specialty care are monitored by investigating any provider quality of service complaints regarding prolonged wait time for appointments. We consider the provider to be compliant with the waiting times standard when the reported feedback reveals the absence of any grievances or complaints. As shown in Figure 4.5- 78, based on our most recent analysis of member grievances, no complaints of excessive waiting times in specialty care provider offices (beyond one hour from scheduled appointment) were reported.



Figure 4.5- 78: Specialty Care Compliance Rate (Measured by the Number of Member Grievances for Prolonged Wait Time)

Office Waiting Time Standard	Central	Eastern	Western
Waiting times for appointments (not to exceed one hour from scheduled appointment time)	1	2	0

DATA SOURCE: HEALTHCARE USA NAVIGATOR REPORT ON PROVIDER QUALITY OF SERVICE ISSUES MEASUREMENT PERIOD: 2010

4.5.4.a4. The offeror shall complete and submit Exhibit A, documenting each FQHC, RHC, CMHC, and Safety Net Hospital proposed to be included in the offeror's provider network.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)4.

HealthCare USA meets and exceeds the requirement to contract with at least one Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Community Mental Health Center (CMHC) and Safety Net Hospital in each region. In conjunction with our subcontractors and affiliate we have long recognized the key services provided by these entities in underserved areas of Missouri and have established collaborative relationships with them.

The tables below reflect a summary of HealthCare USA contract status with each FQHC, RHC, CMHC and Safety Net Hospitals listed in Exhibit A. The completed Exhibit A is included in Volume 2 of our response.

Figure 4.5- 79: Total Number Contracted FQHC, RHC, CMHC and Safety Net Providers

	Central	Eastern	Western	Totals
FQHC	6	6	2	14
RHC	47	28	28	103
CMHC	6	5	5	16
Safety Net Hospitals	1	3	2	6



4.5.4b. Specialty Care Access Issues

The offeror shall respond to each of the requests for information below (1-5) as it relates to each of the areas of evaluation: Primary Care, Specialty Care, Dental Services, and Behavioral Health Care.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b).

4.5.4.b1. The offeror shall describe the tailored methods proposed to meet the health care needs of MO HealthNet members. The offeror shall address how the offeror will tailor programs, business processes, and strategies for improvement to address the unique needs of the members in each region and ensure that all populations in each region have access to services. Accordingly, the offeror should not describe the following in its responses:

- Notices, mailings, information in the Member Handbook, etc. that are required under the Performance Requirements specified herein;
- Distribution of literature, practice guidelines, etc. to providers; and
- Presence at local health fairs and other typical health-and-wellness events.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)1.

Please see the response provided in 4.5.4(b)1 in the Primary Care Network section.

4.5.4.b2. Given differences between urban and rural areas (e.g. population needs, access to care issues), the offeror must address how the offeror's orientation programs, education strategies, and interventions for providers and members in rural areas will differ from those used in more urban areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)2.

Over the course of the last 16 years, an integral part of our provider communication strategy has been to identify and cultivate collaborative relationships with rural providers. We have refined our processes over time to ensure that our provider and member orientation, education and communication strategy addresses the needs of providers in all settings. For HealthCare USA, whether providers are in a rural setting or an urban setting, HealthCare USA's goal is to build collaborative relationships by providing well trained, responsive and accessible Provider Relations representatives who are familiar with the unique aspects of office practice.

HealthCare USA understands that operating a healthcare delivery system in both urban and rural settings requires a different approach to programs for providers and members. For providers, conditions such as geography, local employment market conditions and access to technology affect the way they operate their practices. For members, access



barriers such as lack of transportation and scarcity of providers affect their ability to get care. Based on these differences, we have tailored our Provider Relations and Member Relations programs in ways to address these differences.

The table below outlines the differences in our approach for urban and rural areas regarding orientation programs, education strategies and interventions for providers and members.

Figure 4.5- 80: Specialty Care

Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
HealthCare USA team members	Regional office locations in Eastern region (St. Louis) and Western region (Kansas City) Network management, quality improvement coordinators, case/disease management and concurrent review and community development team	Regional office location in Central region (Jefferson City) Network management, quality improvement coordinators, case/disease management and concurrent review and community development team. This model ensures our team members are within reasonable travel distance for outreach with rural providers.
Provider Relations Program Representative Assignments	By zip code due to the density of providers	By County
Frequency of Visits	In person visits are held at least quarterly.	In person visits are held at least quarterly.
Provider Office Staff Training	Urban practices tend to have an office manager who funnels information to other staff within the practice. Provider representatives tailor their education to help the office manager understand which	Individual visits are scheduled for each provider within the community during the same day/week to obtain a complete picture of any challenges faced within the community. This allows our staff to better understand any



Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
	<p>resource materials are of most help to billing staff versus staff that handle authorizations versus claims.</p> <p>Urban practices frequently have additional administrative offices and utilize external billing companies. To accommodate this decentralized approach to practice operations, our provider relations team will schedule additional meetings with those external entities, in order to keep all parties informed of plan policies and changes.</p>	<p>opportunities to effect quick and efficient resolution.</p> <p>Practices in rural communities face more resource challenges and typically cross-train their staff on multiple duties. Provider representatives offer training to the entire staff on all aspects of the program.</p>
Regional Provider Seminars	Hosted at large urban hospitals allowing maximum face-to-face participation and participation from the majority of our affiliated PCP practices	<p>Hosted in locations such as Bolivar, Hannibal and Macon, Missouri. Recognizing travel distance impact on practice efficiency, annual provider seminars will also be offered as webinars.</p> <p>HealthCare USA hosts regional provider seminars in rural locations such as Bolivar and Macon, MO where multiple provider groups within a one hour area may attend. MTM participates as vendor to conduct in-service and answer questions.</p>
Provider Visits	Outreach to high volume providers to	Outreach to high volume providers to



Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
	<p>review new information and/or resolve issues.</p> <p>A provider relations representative is available for every provider in the network.</p> <p>All representatives have access to wireless technology to ensure visits and issues are efficiently handled.</p>	<p>review new information and/or resolve issues.</p> <p>A provider relations representative is available for every provider in the network.</p> <p>When scheduling visits in a rural setting, representatives make every effort to meet or drop by as many offices in the area to ensure they stay in touch.</p> <p>All representatives have access to wireless technology to ensure visits and issues are efficiently handled.</p>
Proposed Provider Education	<p>On-line tutorials will be added to provider portals.</p> <p>Webinars</p>	<p>On-line tutorials will be added to provider portals.</p> <p>Webinars</p>
Member Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
Education Concerning Member Transportation Benefit	<p>Many members have access to public transportation but fewer have cars. All modes of transportation are discussed. Emphasis placed on member process to request public transport or pickup, need for member to call MTM from doctor's office to arrange for additional trip for same day tests or pharmacy pickup.</p>	<p>Most members have a car or relative with a care. All modes of transportation are discussed. Emphasis placed on member process to obtain mileage reimbursement, showing office staff where to access form in case member forgets and physician office staff needs to sign reimbursement form</p>



Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
	Less emphasis on mileage reimbursement program. Joint HealthCare USA/MTM in-service presentations for large hospital or physician practice groups to explain processes and procedures.	acknowledging provider visit.

4.5.4.b3. The offeror shall describe how its approach to service delivery will achieve optimal outcomes for the populations in each region proposed. The offeror shall describe the implications of the regional demographic data to their service delivery strategies (refer to Attachment 1).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)3.

Achieving Optimal Outcomes for Each Population

HealthCare USA, in our 16 years of serving MO HealthNet in Missouri, understands that having a provider network that complies with the access and availability standards are only the baseline. Getting members the right services, at the right time, in the right setting, to ensure optimal outcomes, requires much more. In particular, we must:

- Create provider networks to match the needs of population groups—providers best suited for the needs of one population group may not be those who are ideal for another group. This crosses multiple boundaries of service type, provider expertise, language, ethnicity, age, sex, and health status.
- Connect members to providers who meet their needs—having the right providers available in the network is the first step, but we go beyond this by working to understand the unique and individual needs of each member, then helping them choose and connect to providers to meet those needs.
- Help members communicate with providers—even with the right providers in the network, language and communication barriers can hamper effective engagement of the member in their health care. We provide the right tools and services to ensure that members can communicate—not just with customer service, *but with providers at the point of care.*
- Build cultural competency throughout the health plan and network—while choosing the right providers and connecting members to those providers is a great start, we recognize the need to evolve cultural understanding and appreciation throughout our



health plan, our subcontractors, affiliate, and our network. We do so through a combination of policies, training, and ongoing efforts to improve our understanding of the populations we serve.

- Address disparities in care for population groups—all of the prior steps help generally improve awareness of the needs of member groups and individual members, but we do more by examining information on health care disparities that exist for population groups and creating initiatives to address those.

In the following sections, we highlight our approach to each of these challenges, and show how we overcome them with creative solutions to ensure that members are connected to care and engaged in understanding and participating in their treatment.

Creating a Provider Network to Match the Needs of Population Groups

HealthCare USA already has a large provider network across all three regions of the Missouri. To provide for the services of mothers and children, we have a very large obstetrics/gynecology network and a large pediatric care network. In addition, all of the children's hospitals within the service area are in the HealthCare USA network. *In the new contract*, this network will be enhanced with the merger of Children's Mercy Family Health Partners, particularly in the Western region.

The HealthCare USA Community Development Team identifies cultural health care access trends in all managed care counties. By collaborating with faith-based organizations and community outreach centers who serve a diverse congregation and parish, we learn who provides health care for members of those organizations, help those members find a HealthCare USA provider, and help them access interpretation and transportation assistance for appointments. For example, in the Eastern region, our Community Development Team works with CASA De Salud, a Spanish-speaking clinic that serves immigrants who have recently arrived in the St. Louis area. We help these immigrants find health care services and connect them to a primary care provider.

We also work with our Provider Relations Representatives to identify network providers who can match the member's cultural needs. For example, in the Central Region, we work with Centro Latino to match our members in Boone County with a trusted Hispanic health care provider and an interpreter to go to the appointment with them. Through our partnerships with our community resources, we can provide our members a community mentor to help them find seeking transportation, interpretation, and other services.

In the Western Region, Primera Iglesia Bautista Church helps our members in accessing their benefits and contacting the physician's office to schedule an appointment. They will also help the member keep their appointment and overcome any last-minute barriers.

Connecting Members to Providers Who Meet Their Needs

The HealthCare USA Community Development Team serves as a reference and referral point for our membership in identifying network providers and visiting their primary care provider on an annual basis. We also list the language of the provider in the provider



directory for easy accessibility by both members and other providers who need to make referrals for a member. However, if the desired provider is not a HealthCare USA network provider, we will refer the provider to our Provider Relations Team to offer the provider an opportunity to join the Healthcare USA provider network.

For members who do not choose a PCP during enrollment, our auto-assignment algorithm considers, among other elements, the member's primary language (if supplied on the enrollment file) and uses this information in matching the member to a PCP.

The HealthCare USA Community Development Team uses our partners and relationships within our communities to match our members to a provider and find a health home. Often, faith-based organizations serve as a conduit between member population groups and our plan and providers. For example, in the Eastern region, the Korean Presbyterian Church connects HealthCare USA to the Korean population; similarly, Immanuel Lutheran connects HealthCare USA to the Chinese population. In the Western region, Shiloh Baptist Church connects HealthCare USA to the Hispanic community. In the Central region, the Ministerial Health Alliance connects HealthCare USA to the Hispanic population.

Helping Members Communicate with Providers (Translation/Interpretation)

Once HealthCare USA connects a member to the appropriate provider, we need to make sure that all of the member's interactions—whether with our health plan or the provider—are conducted in a way that is easily understood by the member. Doing this helps the member understand his or her available options for health care treatment and how to follow the treatment plan prescribed by the provider.

Interpreter Services

HealthCare USA makes interpreters available to ensure that members are able to communicate with HealthCare USA representatives, providers, and receive covered benefits, at no cost. These are available both for member services questions to HealthCare USA, as well as for member appointments with providers.

Language LineSM Helps Connect a Member to Case Management

A 53 year old member was referred to case management by a HealthCare USA Concurrent Review Coordinator after admission to the hospital. The member had a diagnosis of unstable angina, myocardial infarction, stent placement, hypertension and diabetes. The case manager contacted the Language Line to coordinate interpreter services so the case management program could be explained and a full assessment performed. The member was enrolled into our case management program in November 2009. Prior to the member leaving the HCUSA plan in May 2010, they were not admitted again for a related diagnosis.



Member Services—Language Line Services

To access interpreter services for general information, member benefits, and eligibility

Interpretation Facilitates Assessment of Member Needs

A 35 year old female member was referred to disease management through the OB Global Risk Assessment form submitted by the OB provider due to advanced maternal age and diabetes. The member had a history of 7 previous pregnancies with only 4 living children. She spoke only limited English and needed interpreter services. The case manager contacted the Language Line and arranged to have a Bosnian interpreter assist with their communication, which allowed the HealthCare USA nurse to complete a full assessment of the member's needs and explain the disease management program and its benefits. The member was willing to participate in the program and was enrolled in May 2010. Despite her risk factors, the member delivered a healthy baby in October 2010.

questions, we ask the member or member's authorized representative and/or provider to call 1-800-566-6444 and ask for an interpreter. HealthCare USA has on-site staff to service both English and Spanish-speaking members. We recruit fluent bi-lingual Member Service Specialists. These specialists know and understand our business best. However, if all bi-lingual specialists are currently on calls, or the member needs an interpreter in another language, the Language LineSM Translation Service provides interpreters 24 hours a day, seven days a week.

With over 25 years of experience and translation available in over 190 languages, the Language LineSM Translation Service is a leader in telephone interpretation services. Language LineSM has a proprietary

quality assurance program developed by leading academic experts in the field of language testing and interpreter training and reflects HealthCare USA's commitment to service excellence. At Language LineSM, each request for telephonic translation is routed according to skill-based routing techniques, thus ensuring that each member is matched with a translator who speaks his/her requested language.

We help callers speaking on behalf of a member while maintaining HIPAA compliance. For our hearing impaired members, HealthCare USA maintains a toll-free TTY/TDD telephone relay function manned by specially trained specialists.

Provider Appointments—Language Line or Face-to-Face Interpretation

For our provider offices, over-the-phone interpretation is a quick, easy way to communicate with a member who does not speak English when the provider's facility does not have bi-lingual resources. Over-the-phone interpretation helps us provide excellent service to members who have limited English speaking skills. Additionally, it helps eliminate the stress and frustration often experienced during language-complicated encounters. The provider can simply call the number above and request an interpreter to access this service.



However, for some medical appointments, it can be more effective to have an interpreter present in person. Using third party vendors, HealthCare USA provides face-to-face interpretation services. Members or providers can request interpreters by calling the Member Services Department or faxing their requests directly to the agencies as directed below:

Figure 4.5- 81: Face-to-Face Interpretation Services Available in All Missouri Regions

Region	Translation Source
Central	Language Access Metro Project (LAMP) Jewish Vocational Services (JVS)
Eastern	Language Access Metro Project (LAMP)
Western	Jewish Vocational Services (JVS)

We also provide interpretation services for medical appointments for the hearing impaired through third-party vendors. All interpreters are certified by the State of Missouri. Members or providers can request interpreters by calling the Member Services Department or by contacting the agencies as shown in the table below.

Figure 4.5- 82: Interpretation Services for the Hearing Impaired Available in All Missouri Regions

Region	Translation Source
Central	Deaf Way
Eastern	Deaf Way Deaf Inter-Link
Western	Deaf Expression, Inc.

Members are informed of availability of interpreter services through the Member Handbook; Member Services Department toll-free number; educational presentations; HealthCare USA tri-fold brochure available in English/Spanish/Bosnian, entitled *Language Assistance Services*, and on our website under Member Rights & Responsibilities. All interpreter services are provided at no charge to the member.

Figure 4.5- 83: Face-to-Face Interpretation Services for Many Languages

Language	FY11 Q1	FY11 Q2	FY11 Q3	FY11 Q4	Total
Spanish	574	612	587	546	2319
Nepali	234	179	143	210	766



Language	FY11 Q1	FY11 Q2	FY11 Q3	FY11 Q4	Total
Arabic	142	112	140	161	555
Somali	71	76	101	91	339
Burmese	85	98	90	41	314
Vietnamese	87	80	75	71	313
Bosnian	44	59	53	47	203
Russian	24	26	39	26	115
Swahili	6	12	15	30	63
Karen	3	2	31	19	55
Mandarin	15	17	8	14	54
Korean	3	13	20	15	51
Farsi	14	15	8	3	40
Cantonese	8	5	7	5	25
Albanian	4	4	3	13	24
Kirundi	1	3	13	5	22
Tigrinya	2	4	4	10	20
Kurdish	5	3	6	5	19
Dari	1	3	3	6	13
French	0	6	2	4	12
May May	0	2	6	1	9
Hindi	0	0	1	3	4
Pashtu	1	3	0	0	4
Uzbek	0	0	3	0	3
Chin	0	0	2	0	2
Kunama	0	0	0	1	1
Turkish	0	1	0	0	1
Totals	1324	1335	1360	1327	5346

DATA SOURCE: HEALTHCARE USA LANGUAGE INTERPRETATION REPORT 2011



Building Cultural Competency Through the Health Plan and Provider Network

Building Overall Cultural Competency

HealthCare USA goes beyond translation and interpretation to build cultural competency into our health plan organization and all of our relationships, processes, and transactions with members. Indeed, our affiliate, MHNet and our subcontractor, DentaQuest were selected because of their commitment to reducing healthcare disparities as a result of socioeconomic and racial differences (see Executive Summary for more information).

Our demonstration of commitment to cultural competency is our proposal to attain the NCQA *Multicultural Health Care Distinction* designation in support of cultural competency and reducing healthcare disparities. A Performance Guarantee of \$30K further demonstrates our commitment (\$15K for Year One to apply; \$15K in Year Two to obtain). Moreover, MHNet is currently developing a comprehensive cultural competency program that meets the requirements of the Distinction.

Specifically, our program considers five different aspects of cultural competency:

- **Philosophy.** HealthCare USA honors members' beliefs; we believe that every member deserves to receive respect, understandable communications about their health care, and care that is compatible with their cultural beliefs. We value cultural diversity and inclusion as essential to developing a more effective system of care. Cultural competence is a core part of our organization and values, permeating every action we take and every interaction with members and providers.
- **Policy.** Our cultural competency philosophy is incorporated into formal company policies, administrative processes and decisions, and delivery of services. We reflect that policy through our ongoing efforts to recruit staff who represent the demographics of the member populations that we serve. HealthCare USA also has a written strategic plan, updated annually, that describe our goals, policies, operational plans, and management oversight to provide culturally and linguistically appropriate services.
- **Education.** Hiring a diverse workforce helps, but every employee of HealthCare USA needs to fully understand, appreciate, and internalize our philosophy and policy about cultural competency. Each employee must also know: "what is the right thing to do in this situation?" To help educate our team, we provide annual diversity training to all employees. Our program, *Footprints*, is an online course about respecting the differences of others in the workplace. The presentation includes slides, case studies, and questions that challenge and enhance each employee's understanding of the importance of valuing and respecting differences. We also offer training to providers—a two-hour e-learning course on Cultural Competency, which offers Continuing Medical Education credit through a vendor, Quality Interactions. HealthCare USA has also augmented our internal training with in-service sessions, such as the following:



Thirty-five management and staff employees participated in a Poverty Simulation exercise for HealthCare USA employees conducted by the Community Action Agency of St. Louis County (CAASTLC).

Hosting a joint staff and community provider in-service on Cultural Diversity and its Impact on Health Care Delivery. This session was conducted by Joseph Betancourt, M.D., Director of the Disparities Solutions Center and the program director for Multi-cultural Education at Massachusetts General Hospital, and an assistant professor of medicine at Harvard Medical School.

Completed an all-clinician (nurses and medical directors) pain management beliefs assessment and followed up with an in-service about the impact of personal beliefs and culture on treatment of chronic pain. The in-service was presented by Dr. Elliott Gellman, Medical Director for BJC Healthcare Palliative Care Program.

- **Analysis.** We use data from various sources, including the U.S. Census, MO Health Net, and others as available, to best understand the populations we are serving. These data sources and reports help us understand the general demographic, cultural, and epidemiological profiles of the community, as well as the race, ethnicity, and primary spoken and written languages of members who are enrolled in our plan. We analyze this data to assist us in planning all aspects of our plan administration and operations, including network needs, requirements for written materials, potential quality improvement projects needed to address health care disparities, and others.

Partnership. Building cultural competency involves building relationships and trust with the community. HealthCare USA has established strong relationships with community agencies and organization who are dedicated to improving the lives of minority cultures and disparate populations throughout Missouri. We also recognize that there are important differences between urban and rural regions in access to services and member needs; therefore, we have strengthened our partnerships in rural areas by attending monthly community agency action meetings and participating in local events. These include Back-to-School Fairs in counties throughout the state, which help us reach child members and their parents in a community setting.

Overcoming Disparities in Care for Specific Population Subgroups

As described in the previous sections, HealthCare USA, our affiliate, MHNet and our subcontractor, DentaQuest will work to identify and understand the needs of the various population groups, build networks to meet those service needs, and work to communicate effectively with members and providers to connect and engage members in the system of care. Despite our work, there are still disparities in health outcomes for various population groups. In this section, we describe three such disparities and the actions we plan to take to address those. These disparities are:

- Lower rates of breast cancer screening (mammography) for African-American women



- Lower rates of routine dental care for African-American and Hispanic/Latino children
- Greater rates of behavioral health episodes, with lower treatment rates, among African-Americans

Breast Cancer Screenings (Medical)

African American women have lower mammography rates as compared to Caucasian women. Research (e.g. Moy B et al, 2006) shows that the presence or absence of insurance coverage is not necessarily the barrier. Instead, from literature searches and other research, we find the following barriers to African American women receiving mammograms:

- **Fatalistic belief**—The individual perceives that if she has breast cancer there is nothing she can do about it; that is, death is perceived as the inevitable result.
- **Social Issues**—The individual believes that there are other things that are more important in her life right now than getting a mammogram such as work, family, relationships, etc.
- **Self-Exams**—African-American women conduct self-exams at a greater rate than any other group. Unfortunately, this reinforces the belief that other testing and screening is not needed unless the individual finds something during the self-exam.
- **Low return rate for repeat/annual exams**—African-American women have the highest rates of initial exams. However, the rate drops dramatically for follow-up screening or yearly repeat exams. Researchers believe this is linked to the fatalistic belief. “I was fine the first time and don’t need another exam.” It may also be indicative of a response to community pressures and norms to be screened, then returning back to the fatalistic belief that “I am fine, it won’t happen to me and if it does it was meant to be.”

Approach

To address this disparity, HealthCare USA will enhance and improve our outreach efforts to all appropriate female members regarding breast cancer screenings. We will follow the Susan G. Komen, American Cancer Society and National Cancer Institute’s recommendations (Figure 4.5- 84). Our enhanced effort will tailor part of the initiative to African-American women.



Figure 4.5- 84: Breast Cancer Screening Recommendations for Women at Average Risk

Screening Type	Susan G. Komen for the Cure®	American Cancer Society	National Cancer Institute	U.S. Preventive Services Task Force
Mammography	Every year beginning at age 40	Every year beginning at age 40	Every 1-2 years beginning at age 40	Every 2 years ages 50-74
Clinical Breast Exam	At least every 3 years ages 20-39	Every 3 years ages 20-39	No specific recommendation	Not enough evidence to recommend for or against
	Every year beginning at age 40	Every year beginning at age 40		
Note: Women at higher risk may need to get screened earlier and more frequently than recommended here.				

SOURCE: SUSAN G. KOMEN FOUNDATION WEBSITE

Our enhanced outreach effort will have three parts, as follows:

- **Member Identification.** We will identify female members who are of African-American descent, are within the required age range, and who have not had a mammogram according to the recommended schedule. We will then map the addresses of these members to maximize opportunities for access to mobile mammography vans. Given this geographic knowledge, we will seek faith or community based partners in those areas of the state, with whom we can partner on outreach and education activities.
- **Refining Our Understanding.** Social issues are often cited as a general barrier for women as the reason why they do not receive yearly mammograms. In this enhanced program, we will survey members to determine why they have not received a mammogram. Given this knowledge, we can better understand the barriers that members are facing, and then develop programs to address those specific barriers.

Education and Screenings. To address the fatalistic belief and self-examination barriers, HealthCare USA will work with faith-based partners in the mammography campaigns. Activities conducted with faith-based partners may include hosting a mammography



van, providing education specific to members of that organization, or other activities that help address the disparity and will be effective in engaging members in understanding the importance of screenings. We will choose these partners based on their proximity to pockets of HealthCare USA members who have not had a mammogram within the last year.

4.5.4.b4. The offeror shall describe targeted initiatives proposed to meet the requirements of the contract. The offeror shall describe how the offeror will meet members' physical and behavioral health care needs in a coordinated and integrated manner as described per the contract requirements regarding provider network, access standards, quality assessment and improvement, case management, disease management, behavioral health and dental services.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)4.

Targeted Initiatives

HealthCare USA strives to continuously improve member health outcomes while using health care resources wisely and being cognizant of the need to manage costs effectively. Accordingly, we have had various ongoing initiatives that address member needs for coordination and integration of physical and behavioral health care. We will continue many of these initiatives and launch others to continue to improve quality. In this section, we describe initiatives with respect to the providers and members served:

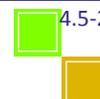
- Specialty care: reducing inappropriate emergency department utilization
- Specialized Providers: Initiatives for Members with Special Health Care Needs

For the initiatives described in this section, we address various considerations, including those for the provider network, access to care and connecting members to the right provider, assessing and improving quality, coordinating and integrating care through effective case management and disease management, and ensuring access to and coordination of behavioral health and dental services.

Specialty Care: Reducing Inappropriate Emergency Department Utilization

Inappropriate utilization of emergency departments (EDs) by Medicaid members is a serious problem. Aspects of the problem include:

- **Saturation of capacity.** In a 2006 Urgent Matters report, 62% of EDs in the country reported being at or over capacity. This causes undue delays in treating patients, as well as diverting critical cases to other EDs. (Burgess & Kiplinger, 2006)
- **Inappropriate use of resources.** Only 13% of ED visits resulted in admission. The American Hospital Association estimates that some 40% of ED visits are for non-emergent reasons.





- **Cost.** Treatment in the ED setting may cost as much as 50% more than in the urgent care setting, on average, and may be two to three times higher than a regular outpatient visit.
- **Disruption of care.** Members who seek care in the ED setting bypass the appropriate relationship with a medical home that oversees and coordinates their care. Furthermore, without significant additional effort, the PCP in the medical home may be completely unaware of the ED visit and thus unprepared to render appropriate follow-up care or reinforce good health habits and preventive care strategies with the member.

HealthCare USA has been working on a multi-year initiative to address this challenging problem, and we plan to continue this initiative, with additional enhancements, during the contract. This is critical: many of the conditions for which members visit the ED can be treated most effectively in a primary care setting, with some also appropriate in a specialty care setting.

Understanding Inappropriate ED Utilization

HealthCare USA has performed extensive analysis of inappropriate ED utilization to help us understand how best to address the problem. We identified fourteen categories of conditions that were non-emergent or avoidable through proper care and conformance to treatment, as follows:

- Abdominal pain (non-emergent)
- Asthma (Avoidable)
- Back pain (non-emergent)
- Bronchitis (non-emergent)
- Contusions (non-emergent)
- Dental issues (non-emergent/advanced dental caries or abscesses are avoidable)
- Gastroenteritis (non-emergent)
- Headache/migraine (non-emergent)
- Otitis media (non-emergent)
- Pharyngitis (non-emergent)
- Sprain (non-emergent)
- Unspecified viral infection (non-emergent)
- Upper respiratory infection (non-emergent and/or avoidable with early intervention)
- Urinary tract infection (non-emergent)

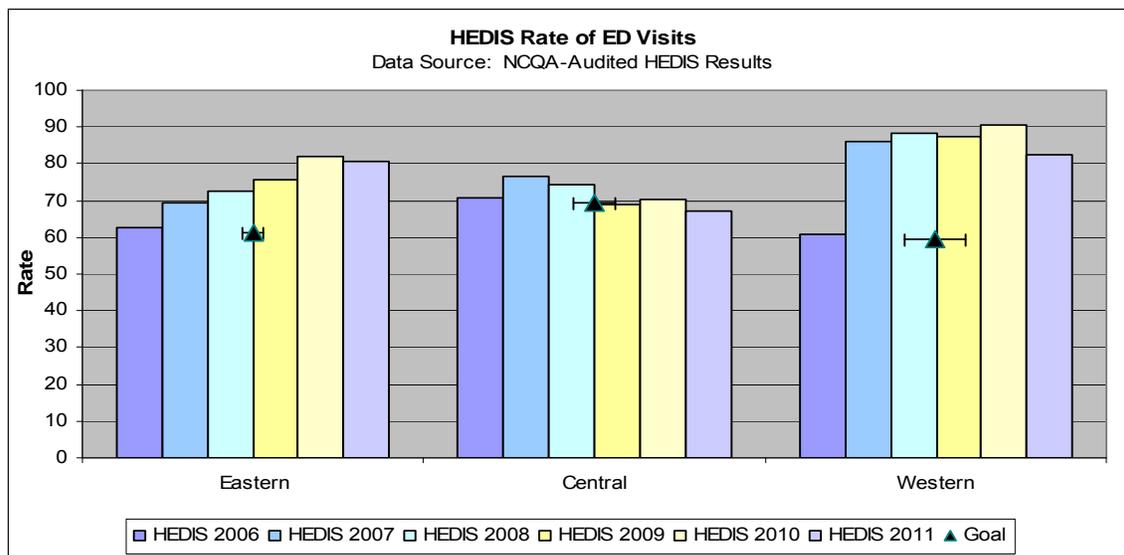
While any member might go to the ED at one time or another, we wanted to focus our efforts on those members who have a habit of using the ED as their primary source of care. Given the list of non-emergent conditions, we analyzed claims data to identify



those members who visited the emergency department three or more times in a rolling six-month period; these are the *frequent flyers*.

Figure 4.5- 85 shows the HEDIS rate of ED visits from the 2006 submission through the 2011 submission. Our interventions (described in the next section) began in 2007. While we have shown a decrease in the HEDIS rate of ED visits for 2011, the generally stable trend shows that this is a difficult problem. We have set aggressive goals for ED utilization; these are indicated by the triangle on the chart.

Figure 4.5- 85: HEDIS Rate for ED Visits by Region from 2006–2011



Existing Interventions for Inappropriate ED Utilization

To address the issues in inappropriate ED utilization, HealthCare USA has done the following:

- Education of Members.** Frequent Flyers have been sent State-approved mailings that include first aid tips and instructions on when to go to the ED; information on understanding true medical emergencies; explanation of the role of the PCP as the primary provider; explanation of the appropriate use of urgent care centers; and a letter of concern that notes the member’s use of the ED, the appropriate use of the ED, and telephone numbers to call if the member has any questions. These materials are sent quarterly. We also make a list of urgent care centers available on our website.
- Education of Providers.** Our Provider Relations Representatives visit providers who have a number of Frequent Flyers as part of their HealthCare USA member panel. We discuss these members and suggest ways in which the provider might help reduce avoidable ED use. For example, these might include contacting the member to schedule preventive care screenings on a regular basis, or following up with the member to be sure they understand the proper use of their medications (such as for



asthma). We give providers the same educational materials that are sent to members. Finally, providers also can access the list of urgent care centers on our website, and the Provider Relations Representative will discuss these urgent care centers with the provider.

- **Collaboration with Hospitals.** We are working with hospitals to receive a census of members who have visited the ED within two to three days after the visit. When received, we distribute the census to Case Management and Disease Management for review and follow up with members who are enrolled in those programs.

A designated multidisciplinary ED Utilization Team has been meeting on a regular basis to review data on ED utilization, to analyze whether the interventions are working, and to develop new interventions.

Results from Interventions

Figure 4.5- 85, above, shows the HEDIS rates for ED utilization from 2006 through 2011 submissions. In addition, HealthCare USA has identified the following:

- ED usage decreased from 967.0 episodes per thousand members in 2009 to 882.1 episodes per thousand in 2010 and 883.1 episodes per thousand in 2011; hence, we have seen a net decrease in ED utilization as a result of the intervention
- Urgent care usage increased from 439.4 episodes per thousand members in 2009 to 459.8 episodes per thousand in 2010 and 479.3 episodes per thousand in 2011; indicating that more members are choosing to use urgent care centers
- Top Five Condition Categories: these are abdominal pain, asthma, acute dental, otitis media, and upper respiratory infection.
- Seasonality: using data from November 2007 through June 2010, we find that the Frequent Flyers have seasonal behavior in use of the ED. Each year, the number of Frequent Flyers peaks in March, April, and May; the number then decreases until November, when the upward trend resumes. Reasons for this seasonal variation are unclear and are under investigation.

We will continue to monitor HEDIS, ED visits per thousand members, Frequent Flyer average visits per member, total Frequent Flyer visits, and Frequent Flyer diagnoses to assess the ongoing impact of this initiative and the new interventions (described below).

New Interventions for Inappropriate ED Utilization

In the first quarter of 2012, HealthCare USA plans to expand the scope of the ED Utilization initiative and add a new initiative.

Expanding Existing ED Initiative

In expanding the scope of the current ED Utilization initiative, we will target child members (age less than or equal to 18 years) who arrive at the ED and are diagnosed with gastrointestinal or upper respiratory infections. To intervene with these members, HealthCare USA will use the process shown in Figure 4.5- 86.



Figure 4.5- 86: HealthCare USA will Expand the Process for Curbing Inappropriate ED Utilization

Step	What HealthCare USA Does
1	HealthCare USA receives the daily ED census from facility (established under existing agreement).
2	Our Case Management Team will review the census to identify members who meet the criteria (member, age ≤ 18 years, gastrointestinal or upper respiratory infection diagnoses). A pediatric nurse Case Manager will be assigned to follow up with those members.
3	<p>The assigned Case Manager will call each member, on the same day the ED census was received. In this call, the Case Manager will:</p> <ul style="list-style-type: none"> • Ask the member (or member’s parent, as appropriate) if he or she knows his PCP • Ask why the member did not contact the PCP about the illness. • Review the member’s understanding of the following: <ul style="list-style-type: none"> ○ HealthCare USA benefits ○ ED discharge instructions ○ Medication instructions and importance of complying with those instructions ○ Availability of the 24-hour Nurse Line for follow up questions ○ Follow-up appointment with PCP
4	The Case Manager will try to call the member at least twice.
5	After the outreach call attempts, HealthCare USA will send the member an educational mailing packet that includes information on the appropriate use of the ED, as well as information on first aid.
6	We will continue to review the member’s claims data for three months after the ED visit, to look for other ED visits or other inappropriate patterns of utilization.

To monitor the success of this expanded intervention, we will measure ED, PCP, and pharmacy utilization.

Much of our ability to effectively engage the member in a discussion about appropriate use of the ED relies on receiving census data from facilities. While we have been successful in using this information so far, we will explore the opportunity of getting this information more quickly as health information exchanges are established. By reducing the time between the member’s trip to the ED and our outreach call to educate the member, we believe we can be more effective in having an impact as the episode is more recent and relevant.

New ED Initiative

HealthCare USA also will enhance efforts to reduce inappropriate ED use by working with providers to extend their after-hours care with financial incentives for extending



office hours beyond normal business hours. The initiative would provide additional reimbursement for after-hours and weekend visits when billed with the proper CPT codes.

Specialized Providers: Initiatives for Members with Special Health Care Needs

Members with Special Health Care Needs represent the most complex spectrum of health care needs. These members often have multiple chronic, co-morbid conditions; use services overall at a higher rate than the general member population; and may use emergency department services at a higher rate than the general member population because of instability in their physical and behavioral health status. By creating specific initiatives to meet the needs of this population, we can stabilize or improve their overall status, potentially improve their well-being and social functioning, and realize improved cost control as a result, using health care resources in the most effective way. HealthCare USA's initiatives for this population address the following:

- Network-designing a health care network to address the specialized provider requirements for Members with Special Health Care Needs
- Case Management , ensuring that we quickly identify and assess Members with Special Health Care Needs and quickly connect them to the appropriate services for their needs

In the following sections, we address these two aspects within the specialty care service area needs.

Medical Needs

Provider Network

HealthCare USA has developed a comprehensive provider network that includes the specialties needed to serve Members with Special Health Care needs. Our Network Management Department has a listing of highly specialized providers by region readily available for all staff. These lists are also available to providers for referrals. These provider types include:

- Autism Centers
- Home Health Care
- Neonatology
- Dentists/Orthodontic
- Pediatric Specialty Hospitals
- DME
- Orthotics/Prosthetics
- Private Duty
- Craniofacial
- PT/OT/ST
- Neurology
- Behavioral health
- Complex Rehab/Mobility



See the Provider grid in Section 4.5.4.a.2 for more information. Throughout the contract, we will continue to look for opportunities to further enhance and expand our network to include specialized provider types to serve member needs.

Moreover, we will identify a narrow network of Primary Care Physicians that focus on providing care to Special Needs patients. This network will consist of high-performance, high-quality PCPs, including those participating in MO HealthNet's Health Home program, that have the ability to meet the complex needs of the special needs members and are recognized for their clinical excellence.

In addition, we will identify a develop a “Gold” Special Needs network, a narrow network which is composed of high-performance, high-quality specialty, ancillary and tertiary care providers that have the ability to meet the complex needs of the special needs members. Our Case management team will utilize this information to connect special needs populations with the highly specialized and most effective providers in order to achieve optimal outcomes

Case Management

Monthly, the HealthCare USA Case Management Department receives the state report that identifies new members who have special health care needs. We will contact each member to:

- Confirm the special needs conditions
- Identify behavioral health needs
- Educate the member on his or her available benefits, including those specifically associated with the special needs conditions, as well as transportation benefits
- Confirm his or her choice PCP, including assignment to a PCP who has specified expertise in treating special health care needs, or assigning a specialist as PCP where appropriate
- Assess the member for enrollment in case or disease management programs.

HealthCare USA will work with the state agency to include the member’s diagnoses/special needs conditions on the monthly report. This inclusion will assist HealthCare USA staff to meet the member’s needs and coordinate in a more timely and efficient manner.

Our case managers work to coordinate services for these members. To enhance this coordination of care process, we will link members with special health care needs to network providers who have specific expertise in treating those needs. We will do this using a list of high-performing providers created by our Network Management Department.

For behavioral health needs, our case management staff will refer the member to MHNet; and to DentaQuest for dental needs as necessary. The HealthCare USA case manager will retain overall responsibility and ensure coordination of services between medical, behavioral and dental to ensure optimal outcomes.



4.5.4.b5. The offeror shall describe the approach/strategy for each of the requests for information below. If the described approach/strategy is one currently in use, the offeror shall indicate in which program/state the approach/strategy is being used, the length of time the approach/strategy has been in effect, and the target population. If the offeror is currently operating in Missouri, the offeror shall speak to their existing experience in Missouri as well as how they will modify and expand upon these strategies for future service delivery.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5.

4.5.4.b5 – Bullet 1 How the offeror will ensure that children receive needed dental services. The offeror shall identify and describe the approach(es) that the offeror plans to implement in relatively more urban counties and contrast these with interventions that the offeror plans to use in more rural areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 1.

All providers have been educated on the dental network and how to make a referral. Please see the response to 4.5.4(b).5, Bullet 1 in the Dental Care Network section.

4.5.4.b5 - Bullet 2 The cost effective approaches the offeror will implement, aside from transportation, to ensure that members in relatively remote counties are able to access specialty care. The offeror shall also describe the strategies the offeror will implement to outreach to specialty care providers. The offeror shall describe how the offeror will facilitate and encourage the use of non-traditional service delivery approaches, such as regional clinics utilizing shared office space and equipment with local providers on a scheduled basis, by specialty care providers. The offeror shall describe how the offeror will monitor the effectiveness of such strategies.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 2.

HealthCare USA will continue to use the following strategies to provide access to specialty care in remote counties:

- **Maintain a Comprehensive and Robust Specialty Care Network.** Our current specialty care network consists of more than 7,300 specialty care providers throughout the State in the full range of specialty categories. We continue to intensify our efforts to recruit additional specialty care providers in the remote counties and have recently signed a Letter of Intent (LOI) with Golden Valley Memorial Hospital. This important addition will expand access to specialty care services for members in Western Missouri.
- **Expand the Use of Urgent Care Centers, Convenience Clinics and After Hours Clinics.** HealthCare USA currently has arrangements with traditional and non-traditional facilities to provide readily available, convenient access to care to members in remote areas. As a way of reducing high-cost emergency department



utilization, HealthCare USA has implemented a member education campaign designed to promote the use of urgent care clinics in lieu of visits to hospital emergency departments. As part of this initiative, HealthCare USA will educate members on the difference between convenient care and urgent care clinics and why these facilities should be considered as an alternative to the Emergency department when their PCP is not available. HealthCare USA has had convenience clinics and urgent cares in our provider network since 2005. In an effort to provide our members with information on the locations of these facilities before they need to access services, we have developed a letter and a member brochure (pending state approval) which includes a listing of all convenience, urgent and after care clinics in all three regions.

In the second quarter of 2012, HealthCare USA will leverage Coventry HealthCare’s relationship with Walgreen’s Take Care Clinics, (TCC) by piloting a plan to expand hours of operation at five Take Care Clinic locations in the Eastern Region. In order to determine if this strategy has an impact, we will be measuring our baseline on members within a 5 mile radius prior to the expansion of hours and then will monitor the Emergency department and alternative care site utilization rates. If this initiative is proven to be successful we will consider expanding this program in other regions of Missouri. TCC has 23 locations in Eastern region and 23 locations in Western Region.

The table shows the current number of traditional and non-traditional Urgent Care Centers, Convenience Clinics and After Hours Clinics in our network:

	Traditional Facilities	Non-Traditional Facilities	
Central Region	12	--	--
Eastern Region	27	25	3
Western Region	7	35	5
Total	46	60	5

DATA SOURCE: HEALTHCARE USA, COVENTRY PROVIDER DATABASE OCTOBER 2011

To provide additional access to care after-hours, we have entered into agreements with many of our primary care providers to extend their office hours. These providers receive additional compensation for seeing patients after normal business hours.

- **Leverage Relationships with Large Urban Hospital Systems to Increase the Use of Shared Office Space.** We will continue to work with our large network hospitals that deploy specialty providers to rural locations. These include relationships with Children’s Mercy and St. Luke’s Health System in the Western Region; University of Missouri Hospitals and Clinics, St. John’s Mercy Springfield Hospitals and Clinics in the Central Region; and BJC Health System, SSM Health System, and St. John’s Mercy St. Louis Health System in the Eastern Region.
- **Expand the Use of Telemedicine.** As of Oct 2011, our network contains 88 University of Missouri Telehealth Network sites, 69 of which are within the service



area. We will continue to explore additional opportunities to implement telemedicine technology as follows:

- **Link tertiary care hospitals and clinics with outlying clinics** and community health centers in rural or suburban areas. In Missouri, University of Missouri's Missouri Telehealth Network, is leading this effort and has developed end point connections with almost 200 providers across the state. As of Oct 2011, there are 88 providers in the Missouri Telehealth Network that are in the HealthCare USA and MHNet networks.
- **Connect private networks used by hospitals and clinics** that deliver services directly or contract out specialty services to independent medical service providers at ambulatory care sites.

Outreach to Specialty Care Providers

HealthCare USA uses the following mechanisms to reach out to specialty care providers regarding expanding access in remote areas:

- **Provider Relations Program.** Our Provider Relations Representatives use every contact with specialty providers as an opportunity to discuss ways in which we can improve access to specialty care services in remote areas. We also conduct special provider education sessions to highlight new initiatives and encourage provider participation in those initiatives.
- **Provider Newsletters.** We regularly include articles in our provider newsletters concerning the challenges of serving members in remote areas.
- **Provider Webinars.** Beginning in 2012, HealthCare USA will offer webinars focusing on the use of telemedicine as a way to expand access to care.
- **Collaboration with the Missouri Telehealth Network (MTN).** HealthCare USA will soon distribute the first in a series of provider newsletters prepared jointly with MTN. We will continue to work closely with MTN to heighten provider awareness on the benefits of telemedicine.

Approach to Monitoring Effectiveness

To monitor the effectiveness of our efforts to expand access to specialty care in remote areas, we will examine utilization rates in traditional and non-traditional delivery facilities and further examine HEDIS results to look for improvements in outcomes of conditions for which members seek specialty care.

4.5.4.b5 – Bullet 3 How the offeror will utilize telemedicine in rural areas of the State. At a minimum, the description shall include the specific strategies that will be used, purposes for which telemedicine will be used, targeted populations and conditions, and providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 3.



Telemedicine may be as simple as two health professionals discussing a case over the telephone, or as complex as using satellite technology and videoconferencing equipment to conduct a real-time consultation between medical specialists in two different countries. Telemedicine generally refers to the use of communications and information technologies for the delivery of clinical care.

Telemedicine, frequently referred to as Telehealth, is the use of electronic technologies to provide and support health care services when distance separates the physician and patient. Telemedicine services are medical services provided via telephone, the Internet or other communications networks or devices, that do not involve direct in-person patient contact. There are applicable federal and state regulations governing the practice of telemedicine.

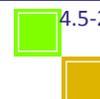
The FDA has defined the term ‘telemedicine’ as the delivery and provision of healthcare and consultative services to individual patients, and the transmission of information related to care, over distance, using telecommunications technologies, and incorporating:

- Direct clinical, preventive, diagnostic, and therapeutic services and treatment
- Consultative and follow-up services
- Remote monitoring
- Rehabilitative services
- Patient education

Telehealth services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another, using telecommunications technologies. These services may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

Benefits of Telemedicine for HealthCare USA MO HealthNet Members

- **Improved access to equitable and timely access to primary and specialty care** for patients who live in a medically underserved area have difficulty traveling to healthcare facilities
- **Improved provider education** by increasing access to continuing medical education (CME) and removing geographic and financial barriers for providers in rural and underserved areas. This can help increase the skills and expertise of rural practicing PCPs since they can take part in the consultative process during the telehealth encounter with the specialist versus sending a patient to a specialist for a visit and getting a report back of the findings. This may allow some PCPs to gain confidence in certain types of referred services and allow them over time to make management and decisions on their own.
- **Improved quality of care of members who live in rural areas** by increasing access to specialty care and improve patient outcomes by decreasing delays in diagnosis and treatment





- Reduction of ED admits/referrals by reducing delays in diagnostic testing and evaluations
- Reduction of patient travel by providing access to specialists at a local site like their PCP or Rural Health Clinic office. This helps reduce costs related to transportation and lost time from work/school for the member.

Applications for Telemedicine in Rural Areas of Missouri

HealthCare USA will use telemedicine in the rural and underserved parts of Missouri in these ways:

- **Primary Care Consultations.** Consultations by primary care providers/rural health clinics with specialty care providers not available in remote/underserved areas. Services may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan.
- **Specialist Referral Services.** Specialists assisting a general practitioner in rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to a specialist for viewing later.
- **Imaging/Radiology Procedures.** Radiology makes the greatest use of telemedicine with thousands of images "read" by remote providers each year.
- **Specialty Consultations.** Specialty consultations may include dermatology, ophthalmology, mental health, cardiology and pathology.
- **Remote Patient Monitoring.** This application uses devices to remotely collect and send data to a monitoring station for interpretation. Such "home telehealth" applications might include a specific vital sign, such as blood glucose or heart ECG or a variety of indicators for homebound patients. Such services can be used to supplement the use of visiting nurses.

Telemedicine Delivery Mechanisms

As of October 2011, our network contains 88 Missouri Telehealth Network sites, 69 of which are within the service area.

- Networked programs link tertiary care hospitals and clinics with outlying clinics and community health centers in rural or suburban areas. In Missouri, University of Missouri's Missouri Telehealth Network, is leading this effort and has developed end point connections with almost 200 providers across the state. As of Oct 2011, there are 87 providers in the Missouri Telehealth Network that are in the HealthCare USA and MHNNet networks within the 54 counties and 21 outside of the service area.
- Connections using private networks used by hospitals and clinics that deliver services directly or contract out specialty services to independent medical service providers at ambulatory care sites. Radiology, mental health and even intensive care



services are typically being provided under contract using telemedicine to deliver the services.

- Specialty care to the home connections involves connecting primary care providers, specialists and home health nurses with patients over single line telephone-video systems for interactive clinical consultations.
- Home to monitoring center links are used for cardiac, pulmonary or fetal monitoring, home care and related services that provide care to patients in the home. Often normal telephone lines are used to communicate directly between the patient and the center although some systems use the Internet.

Targeted Populations

Members in the following Missouri counties have access to Missouri Telehealth network providers. Counties shown in italics are considered rural:

Region	Counties
Eastern	St Louis, <i>St Francois, Madison</i>
Central	<i>Callaway, Gasconade, Phelps, Dent, Pulaski, Boone, Howard, Randolph, Macon, Adair, Sullivan, Linn, Chariton, Saline, Carroll, Cooper, Pettis, Morgan</i>
Western	Jackson, <i>Buchanan, Henry, Cedar, Polk, Dallas</i>

Conditions

The table below shows the types of medical and behavioral health conditions for which telemedicine services may be used.

Medical Conditions	Behavioral Health
Autism Clinic	Adolescent Medicine (eating disorders)
Burn Clinic	Children with Special Needs (Dept. of Health Psych)
Child Health	Psychiatry
Dermatology	
Endocrinology	
Genetics Follow-up	
Hip & Knee Follow-up	
Internal Medicine	
Medical Ethics Consultations	
Neurology	
Orthopedics	
Physical Medicine & Rehabilitation	
Provider Consultations with Geriatric	



Medical Conditions	Behavioral Health
Specialist Radiology Rheumatology Spine Follow-up Surgical Follow-up	

Providers

Based on a review of the two telehealth directories in Missouri (Missouri Telehealth Directory and the NE Missouri Telehealth directory), 87 providers within the 54 counties and 21 providers outside the service area are participating providers in the network for HealthCare USA. These providers include: acute care hospitals, critical care hospitals, FQHCs, RHCs, CMHCs, public health departments, rehabilitation centers and specialty care providers.

Proposed Activities in Support of Telemedicine in Missouri

HealthCare USA has already commenced a dialogue with the Missouri Telehealth Network for the purpose of developing a collaborative process to engage with independent rural health clinics to promote the benefits of telemedicine services and increase the availability across rural parts of Missouri within the service area. As part of this proposed collaboration, HealthCare USA intends to:

- Engage in discussions with critical access hospitals and behavioral health facilities regarding their plans to invest in telehealth systems to increase access to specialty care services and increase rapid diagnosis and treatment thru their ED departments.
- Engage in discussions with independent rural health clinics (not currently in the Missouri Telehealth Network) concerning their interest investing in telehealth systems and promoting the information available through Missouri Telehealth Network Resource Center
- Promote/increase the awareness of rural practicing providers of Missouri Telehealth Network continuing medical education (CME) programs such as Grand Rounds for Health Ethics, Compliance and Quality, Oncology, Psychiatry, Cardiovascular Medicine, Internal Medicine, Orthopedics, Child Health which are currently available.
- In addition, HealthCare USA has noted already in this RFP response the addition of a performance guarantee to increase the utilization of telemedicine by 5%. In addition to the performance guarantee, HealthCare USA will also work with Missouri Telehealth Network to provide grant funding up to \$100,000 over the term of our state contract to assist participating rural practices in all three regions with the procurement of telehealth devices. By offering these grants, HealthCare USA's goal is to expand the use of non traditional service delivery methods in order to improve improve the quality of care of members who live in rural areas by increasing



access to specialty care and improving patient outcomes by decreasing delays in diagnosis and treatment .

4.5.4.b5 - Bullet 4 The specific measures the offeror will take to ensure that children and women identified as substance abusers are screened for depression and other co-occurring behavioral health conditions. The offeror shall identify the case management activities and other strategies the offeror will use to link these members to appropriate resources, including behavioral health resources. The offeror shall describe how the offeror will monitor effectiveness of care strategies. The offeror shall describe how the efforts on behalf of members in rural areas will differ from those targeted to members in more urban areas.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 4.

We educate all provider on how to make appropriate referrals. Please see the response provided in 4.5.4.b.5, Bullet 4 in the Primary Care Network and Behavioral Health Care Network section.

4.5.4.b5 - Bullet 5 How the offeror will ensure that Medicaid and CHIP children have access to child psychiatrists and psychologists for behavioral health services. The offeror shall describe how the offeror will ensure appropriate case management and coordinate behavioral health services with the delivery of other services under the EPSDT benefit.

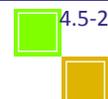
HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 5.

This question is not applicable to the Specialty Care network. Please see the response to 4.5.4.b5, Bullet 5 in the Primary Care Network and the Behavioral Health Care Network section.

4.5.4.b5 - Bullet 6 How the offeror will address the strategies the offeror will use to identify, reduce, and monitor inappropriate hospital readmissions. The offeror shall describe to what extent these measures will differ according to populations, geographic locations, and health conditions.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 6.

Refer to the response provided in 4.5.4.b.5, Bullet 6 in the Primary Care Network section.





4.5.4.b5 - Bullet 7 Identify the tools the offeror will use to monitor emergency department utilization and determine over utilization, and the measures the offeror proposes to combat/reduce emergency department overuse. The offeror shall describe specific measures the offeror will take in years one (1), two (2), and three (3) of the contract (assuming that the contract is extended over a three (3) year period).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 7.

Refer to the response provided in 4.5.4.b.5, Bullet 7 in the Primary Care Network section.

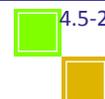
4.5.4.b5 - Bullet 8 How the offeror will utilize safety net providers (e.g. FQHCs, public health departments, CMHCs) to facilitate access to needed services (including measures for identifying when safety net providers are needed and outreach to public providers). The offeror shall also address how these strategies will differ between rural and urban areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 8.

Our contracted FQHCs and RHCs also provide access to many key specialty services such as obstetrical care, vision care, and dental services.

Many of our FQHCs in urban areas such as Kansas City and St. Louis offer direct access to prenatal care by OB-GYN providers and routine vision services by optometrists. Some facilities such as SWOPE Health Services in the Western region also provide dental and behavioral health services. In addition, many of our contracted FQHCs are linked very closely to tertiary care health systems such as the University of Missouri in the Central region and Washington University and SLUCare in the Eastern Region. Our FQHCs have longstanding and well-coordinated processes to provide access to needed specialty care services either through regularly scheduled appointments or by having specialists rotate through the FQHC clinics periodically.

Many of our RHCs in rural area provide access to specialty care through the use of telemedicine or through their relationships with major health systems like St. Luke's Health System in Western Missouri, University of Missouri and St. Johns Mercy—Springfield in Central Region, and BJC Health System and SSM HealthCare in the Eastern Region, all of whom send key specialists to remote areas to provide specialty care services.



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4.5.4 Access to Care – Dental Services

4.5.4a. Dental Networks

The offeror shall demonstrate adequate provider networks to fulfill MO HealthNet requirements.

HealthCare USA has developed a comprehensive, statewide provider network to meet travel distance and network adequacy requirements as required by MO HealthNet and Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP) in 20 CSR 400-7.095. Our Missouri provider network includes hospitals, primary care, specialty care physicians, advance practice nurses, FQHCs, RHCs, local health departments, family planning/STD clinics, vision providers, ancillary, behavioral health, substance abuse, dental health and emergent/non emergent transportation providers. HealthCare USA also includes provider types and specialties in our network such as dental health providers that are not specified in the 20 CSR 400-7.095 to ensure a comprehensive network of providers to care for our members.

This comprehensive network covers the 54 counties in the MO HealthNet Central, Eastern and Western service areas. Also, HealthCare USA is licensed in 51 additional counties outside the current service area and we have contracts with providers in the 24 contiguous counties to the service area. Our extensive network presence in Missouri will facilitate any future program expansion as a result of the implementation of the Patient Protection and Affordable Care Act (ACA). Further, as we demonstrate in the sections that follow, our current network is capable of providing care to any additional new membership we may acquire following award of this contract.

Figure 4.5- 87: presents a snapshot of our provider network throughout the 54 MO HealthNet counties as well as the contiguous counties outside the service area.

Figure 4.5- 87: Provider Networks - Overall Counts by Category

Provider Type	In the 54 MO HealthNet Counties				In MO Counties Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Hospital	20	32	20	72	10	82
Ancillary	267	360	139	766	136	902
PCP	537	878	341	1756	440	2196
Specialist	1284	4187	1271	6742	641	7383
Dental	87	153	193	433	123	556



Provider Type	In the 54 MO HealthNet Counties				In MO Counties Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Behavioral Health	313	955	615	1865	261	2126
FQHC*	8	18	5	31	55 (RHC/FQHC)	193
RHC*	65	29	13	107		
Local Public Health**	25	13	13	51	4	55
Family Planning/ST D Treatment**	2	5	1	8	3	8

* These numbers are also included in the number of PCPs.
 ** These numbers are Included in ancillary counts
 FQHC, RHC, LPH, Family Planning providers are broken out separately in this grid as they are listed on Attachments to RFP)

DATA SOURCE: COVENTRY PROVIDER DATABASE
 MEASUREMENT PERIOD: AS OF OCT. 31, 2011

4.5.4.a1. The offeror shall submit documentation demonstrating that the offeror's networks comply with travel distance access standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. The offeror shall also submit documentation for those providers not addressed under 20 CSR 400-7.095, ensuring members will have access to those providers within thirty (30) miles unless the offeror can demonstrate that there is no licensed provider in that area, in which case the offeror shall ensure members have access to those providers within sixty (60) miles. For any demonstrated access that differs from these standards, the offeror shall submit proof of approval of the differences by the Department of Insurance, Financial Institutions & Professional Registration.

Documentation of Travel Distance Standards

On March 1 of each year, HealthCare USA files an annual network access plan with DIFP as required by 20 CSR 400-7.095. The attached documentation from the DIFP shows that HealthCare USA complies with network capacity and travel distance standards for all provider types and specialties as required by 20 CSR 400-7.095. Specifically, this is



evidenced by the first paragraph in the DIFP Network Adequacy Approval letter, dated June 6, 2011, indicating that the 2010 Network Access Plan for HealthCare USA was approved.

Our networks have achieved **100% compliance** with network capacity and travel distance standards.

Note: HealthCare USA submits a provider file to DIFP of our dental provider network for evaluation, (which is a MO HealthNet requirement and not actually a part of the DIFP regulation) Because distance standards do not exist in the DIFP regulation for Dental providers, the following standards are used to evaluate the dental network:

- Urban county: 15 miles
- Basic county: 30 miles
- Rural county: 60 miles

DIFP has also evaluated our dental network and we have achieved **100% compliance** for dental network capacity and travel distance standards.

Geo Access Reports

In addition to the DIFP documentation, HealthCare USA conducts its own review of provider networks as part of our ongoing monitoring of travel distance and access for our membership.

We are also including a series of Geo Access maps and summary reports as Attachment 25, showing the distribution of network provider locations in relation to our current membership and evidence that our geographic distribution of providers covers the entire service area for all three regions. A separate map showing locations within a 30-mile and 60-mile radius is presented for the following provider categories, covering some of key high volume areas of concern to our population:

- RHC and FQHC
- Child PCP
- Adult PCP
- OB/GYN
- Pediatrics
- Dental
- Adult Behavioral Health
- Child Behavioral Health
- High Volume Specialist

As demonstrated in the Geo-Access maps and summary reports, HealthCare USA's vast provider network covers the entire 54 county service area and we are in **100% compliance** with network capacity and travel distance standards.

Data Source: Geo-Access Mapping Software, Coventry Provider Database, HealthCare USA Member Eligibility File



Measurement Period: October 31, 2011

4.5.4.a2. The offeror shall provide documentation verifying that the offeror's network has adequate capacity. Such documentation shall include, but it is not limited to, appointment availability, 24 hours/7 days a week access, sufficient experienced providers to serve special needs populations, waiting times, open panels, and PCP to member ratios.

In the paragraphs that follow, we describe our network capacity for the Dental Care network. This description contains an assessment of appointment availability, 24/7 access, providers serving special needs populations, open panels and waiting times in provider offices. Unless otherwise specified, the reporting period for these network compliance indicators is the end of the calendar year 2010. The reporting period for the number of providers shown in each of the tables below and on the Geo Access maps and summary reports is as of October 31, 2011.

Adequate Network Capacity and Monitoring Access to Services

Over the course of our 16 years as a managed care organization in Missouri, HealthCare USA has developed, enhanced and utilized several policies, procedures and processes to monitor our provider and subcontractor/affiliate networks to ensure adequate network capacity, accessibility for our members, and accuracy in our provider listings. Further, our network activities are designed to achieve the ultimate goal of connecting our members with a health care home so they can obtain services in the most effective and appropriate setting.

In addition to using Geo-Access for distance reviews, we use additional monitoring activities for each network category including:

- Conducting telephonic provider secret shopper surveys regarding dental provider appointment availability.
- Reviewing providers' panel status to confirm if new members can be assigned and if provider has reached capacity or referral limits.
- Reviewing dental provider to member ratios by provider type and by region to ensure an adequate number of primary care providers are available.
- Following up and resolving member concerns related to access or appointment availability.
- Reviewing quarterly analysis and trending of member grievances to identify any potential availability or accessibility access issues; perform root cause analysis and develop corrective action plans, if necessary.
- Case managing members identified as utilizing the emergency department (ED) for non-emergent conditions.
- Making weekly updates to online Provider Directories to reflect changes in open/closed panels.





- Reviewing monthly provider network and recruitment activities of dental health networks.
- Initiating independent oversight by in-network physicians that participate on HealthCare USA's Quality Management Committee of network access and availability studies conducted for primary care, specialty care, emergent care, dental and behavioral health.

In instances where a network provider cannot meet access or appointment availability standards, HealthCare USA and subcontractor/affiliate Provider Relations teams:

- Conduct provider education regarding the standards
- Work with the provider to resolve the issues
- Locate additional providers to meet the member's need
- Conduct recruitment efforts to add additional providers if the need arises

Any providers who do not meet standards are educated and re-surveyed within 30 days of the initial survey to ensure compliance with access and availability standards.

Figure 4.5- 88: illustrates the number of Healthcare USA dental care providers by region within the service area and outside the service area.

Figure 4.5- 88: Total Dental Care Providers by Region

Dental Care Category	In the 54 MO HealthNet Counties				Counties Outside Service Area	Total Across MO Counties
	Central	Eastern	Western	Total		
General Dentistry	75	258	149	482	149	631
Endodontic	1	2	2	4	0	5
Oral Surgery	1	7	13	21	2	23
Orthodontics	2	10	9	21	0	21
Pediatric Dentistry	1	6	19	26	4	30
Total	80	283	192	554	155	710

DATA SOURCE: DENTAQUEST WINDWARD PROVIDER DATABASE
MEASUREMENT PERIOD: OCTOBER 2011



Figure 4.5- 89: Dental Providers to serve Children by provider type

Provider Type	Central	Eastern	Western	Outside Service Area
General Dentists	75	258	149	149
Endodontic	1	2	2	0
Oral Surgeons	1	7	13	2
Orthodontists	2	10	9	0
Pediatric Dentists	1	6	19	4

DATA SOURCE: DENTAQUEST WINDWARD PROVIDER DATABASE
MEASUREMENT PERIOD: OCTOBER 2011

Dentist-to-Member Ratio

HealthCare USA applies the standard of one dentist for 1,500 members. The table below shows the provider to member ratio for our current dental care network and for a projected expanded membership consisting of all MO HealthNet managed care eligibles:

Figure 4.5- 90: Overall Dental Provider-to-Member Ratio Standard—1:1500

Using	Western	Central	Eastern	Overall
Current Membership	100	305	433	267
Growth Membership*	280	623	633	476
HealthCare Reform Membership**	332	817	835	612

* Adding membership of next largest MCO in each region
** Adding the Healthcare reform membership estimated for current ME codes to Growth membership (current HealthCare USA plus membership of next largest MCO)

DATA SOURCE: DENTAQUEST WINDWARD PROVIDER DATABASE; COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS MEASUREMENT PERIOD: OCTOBER 2011

Appointment Availability

The table below shows our most current dental care compliance with appointment standard requirements.



Figure 4.5- 91: Dental Care Compliance Rate

Appointment Standards	Central	Eastern	Western
Urgent care appointments within 24 hours	93%	98%	96%
Routine symptomatic care appointments within one week or five business days, whichever is earlier	90%	97%	98%
Routine asymptomatic care appointments within 30 calendar days	93%	98%	96%

DATA SOURCE: DENTAQUEST ACCESSIBILITY SURVEY
 MEASUREMENT PERIOD: Q2 2011

24/7 Access to Care

Individual dental providers in DentaQuest's network make their own arrangements for after-hours care. DentaQuest is not currently required to monitor after-hours access, however a new initiative to begin such monitoring is scheduled for 2012 as part of the ongoing quarterly accessibility surveys.

Providers to Serve Special Needs Populations

HealthCare USA maintains a roster of dental care providers who treat special needs children and adults. These providers will often continue to follow a special needs child through to adulthood in order to provide continuity of care. Examples of such cases are children with severe autism who require dental care beyond the usual childhood ages.

As part of the recruitment and credentialing process, DentaQuest identifies the capabilities of each provider office including determining if provider has the training and office to accommodate the treatment of members with special needs. Listed below is the percentage providers in the dental network who currently treat members with special needs:

- Central Region: 13%
- Eastern Region: 7%
- Western Region: 14%
- Contiguous Counties: 6%



Figure 4.5- 92: Dental Providers to Serve Special Needs Population by Provider Type

Provider Type	Central	Eastern	Western	Outside Service Area
General Dentists	9	14	9	6
Pediatric Dentists	1	6	18	4
Oral Surgeon	1			1
Total	11	20	27	11

DATA SOURCE: DENTAQUEST WINDWARD PROVIDER DATABASE
MEASUREMENT PERIOD: OCTOBER 2011

Waiting Times

Our dental subcontractor, DentaQuest, is required to comply with the waiting time standard not to exceed one hour from scheduled appointment time. This includes time spent in the lobby and the examination room prior to being seen by the provider. Exceptions are allowed to this standard when the provider “works in” urgent care appointments; when a serious problem is identified or when the member has an unknown need or condition that requires more services or education than was described at the time the appointment was made. As with our medical provider networks, appointment waiting times for dental care are monitored by investigating any provider quality of service complaints regarding prolonged wait time for appointments.

As shown in the table below, based on our most recent analysis of member grievances, no complaints of excessive waiting times in dental care provider offices (beyond one hour from scheduled appointment) were reported.

**Figure 4.5- 93: Dental Care Compliance Rate
(as Measured by Member Grievances for Prolonged Wait Time)**

Office Waiting Time Standard	Central	Eastern	Western
Waiting times for appointments (not to exceed one hour from scheduled appointment time)	0	1	1

DATA SOURCE: HEALTHCARE USA NAVIGATOR REPORT ON PROVIDER QUALITY OF SERVICE ISSUES MEASUREMENT PERIOD: 2010

Open/Closed Dental Practices

As of Q2 2011, 89 percent of the general dentist network had open panels across all three regions. By region, the percentage of open panels is:



Figure 4.5- 94: Open/Closed Dental Practices

Open Panels	Central	Eastern	Western
Dental	94%	86%	89%

DATA SOURCE: DENTAQUEST ACCESSIBILITY SURVEY
 MEASUREMENT PERIOD: Q2 2011

4.5.4.a3. The offeror shall describe how tertiary care providers including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists will be available twenty-four (24) hours per day in the region. If the offeror does not have a full range of tertiary care providers, the offeror shall describe how the services will be provided including transfer protocols and arrangements with out of network facilities.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4.

HealthCare USA maintains and monitors the participating provider network in accordance with DIFP network adequacy criteria. HealthCare USA is in compliance with these tertiary care requirements.

Our tertiary care provider network includes:

- Trauma centers
- Burn centers
- Level III (high risk) nurseries
- Rehabilitation facilities
- Medical sub-specialists (Pediatric subspecialty, Perinatology, Neonatology, etc)

In all three regions, our provider network maintains a full-range of tertiary care providers. Our contracted facilities are staffed with all necessary medical subspecialty providers to provide all necessary tertiary care services 24 hours a day.

The figure below shows the tertiary care hospitals located within Healthcare USA’s managed care service Area, by region shows all contracted tertiary care facilities, trauma centers, burn centers and rehabilitation facilities available in the HealthCare USA participating provider network.



Hospital	Contracted with HCUSA	Trauma Center	Level III Nursery	Perinatology Services	Cancer Services	Cardiac Services	Pediatric Sub-specialty	Burn Center	Rehab Facilities
Western Missouri Region									
Children's Mercy Hospital	Y	Level I	Y			Y	Y	Y	Y
Citizen's Memorial Hospital	Y	Level III							
Liberty Hospital	Y	Level II	Y				Y		
Saint Joseph Medical Center	Y		Y	Y		Y			
St. John's Regional Health Center (Springfield)	Y	Level I	Y	Y	Y	Y	Y	Y	
St. Luke's Hospital of Kansas City	Y	Level I	Y		Y	Y	Y		Y
Saint Mary's Medical Center	Y		Y		Y				
Truman Medical Center Hospital Hill	Y	Level I	Y						
Central Missouri Region									
Boone Hospital Center	Y		Y			Y			Y
Bothwell Regional Health Center	Y				Y				
Hannibal Regional Hospital	Y				Y				
Capital Region Medical Center	Y			Y	Y	Y			
Lake Regional Health System	Y	Level III				Y			
Rusk Rehabilitation Center	Y								Y
Phelps County Regional Medical Center	Y	Level III			Y				
Saint Mary Health Center	Y			Y	Y	Y			
University of Missouri Hospital & Clinics	Y	Level I	Y		Y	Y	Y	Y	Y
Eastern Missouri Region									
Barnes-Jewish Hospital	Y	Level I	Y		Y	Y	Y	Y	Y
Christian Hospital	Y				Y	Y			
Mercy Hospital - St. Louis	Y	Level I	Y	Y	Y	Y	Y	Y	Y
Missouri Baptist Medical Center	Y				Y	Y			
Saint Louis University Hospital	Y	Level I			Y	Y			
Saint Lukes Hospital	Y			Y		Y	Y		
SSM Cardinal Glennon Children's Hospital	Y	Level I	Y						Y
SSM DePaul Health Center	Y	Level II		Y	Y	Y			
SSM Rehab	Y								Y
SSM St. Joseph Health Center	Y	Level II		Y	Y	Y			
SSM St. Joseph Hospital West	Y	Level III		Y					
SSM St. Mary's Health Center	Y		Y	Y	Y	Y			Y
St. Anthony's Medical Center	Y	Level II			Y	Y			
St. John's Mercy Hospital	Y	Level III							
St. Louis Children's Hospital	Y	Level I	Y				Y	Y	Y
The Rehab Institute of St. Louis	Y								Y

DATA SOURCE/MEASUREMENT PERIOD: MARCH 2011 DIFP FILING

Although HealthCare USA has a full range of contracted tertiary hospitals in each region, we also understands the importance of providing primary, secondary and tertiary levels of care at hospitals that are out-of-area (“out-of-network”). If a member requires specialty care from a tertiary hospital that cannot be provided by Missouri-based tertiary hospital, HealthCare USA has written protocols for allowing members to obtain tertiary level services out of network. HealthCare USA manages these cases whether care is provided in Missouri or outside the state.

4.5.4.a4. The offeror shall complete and submit Exhibit A, documenting each FQHC, RHC, CMHC, and Safety Net Hospital proposed to be included in the offeror’s provider network.

HealthCare USA meets and exceeds the requirement to contract with at least one Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Community Mental Health Center (CMHC) and Safety Net Hospital in each region. In conjunction with our subcontractors and affiliate we have long recognized the key services provided



by these entities in underserved areas of Missouri and have established collaborative relationships with them.

The tables below reflect a summary of HealthCare USA contract status with each FQHC, RHC, CMHC and Safety Net Hospitals listed in Exhibit A. The completed Exhibit A is included in Volume 2 of our response.

Figure 4.5- 95: Total Number Contracted FQHC, RHC, CMHC and Safety Net providers from Exhibit A

	Central	Eastern	Western	Totals
FQHC	6	6	2	14
RHC	47	28	28	103
CMHC	6	5	5	16
Safety Net Hospitals	1	3	2	6

4.5.4b. Dental Services Access Issues

The offeror shall respond to each of the requests for information below (1-5) as it relates to each of the areas of evaluation: Primary Care, Specialty Care, Dental Services, and Behavioral Health Care.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b).

4.5.4.b1. The offeror shall describe the tailored methods proposed to meet the health care needs of MO HealthNet members. The offeror shall address how the offeror will tailor programs, business processes, and strategies for improvement to address the unique needs of the members in each region and ensure that all populations in each region have access to services. Accordingly, the offeror should not describe the following in its responses:

- Notices, mailings, information in the Member Handbook, etc. that are required under the Performance Requirements specified herein;
- Distribution of literature, practice guidelines, etc. to providers; and
- Presence at local health fairs and other typical health-and-wellness events.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)l.

HealthCare USA recognizes the unique needs of members throughout the state and has tailored our approach to providing care in each region based on those needs. We tailor programs based on the member population (children vs. adult) and based on the demographics of the region. We also give consideration to other important regional



differences such as special needs, geographic conditions, socio-economic levels, cultural barriers, language needs, as well as network composition and availability of community resources.

We target local provider partners with a range of specialized expertise who are familiar with the clinical needs of our population, along with the cultural, socio-economic, and religious backgrounds of our members. This in-depth, local understanding helps us provide services in ways that address each region's specific needs.

In the paragraphs that follow, we describe the tailored programs, business processes and improvement strategies we have implemented to address the unique needs of members in each region to ensure members have access to services.

Programs

Central Region

Because there is a lack of dental specialty providers in the Central Region, we have sought ways to facilitate member access to specialty services within our network of general dentists. We strongly encourage our general dentists to provide specialty services and provide them with administrative support to do so. One example of the administrative support is streamlining the authorization process. We also “promote” the list of general dentists who provide specialty care by circulating the list of these general dentists among our entire dental network.

Our collaboration with the unique soon-to-be available program at the A.T. Still University School of Dentistry in Kirksville, Missouri, will expand the availability of dental services throughout the Central region. This program trains dentists to provide care as part of community-based, dental public health. The program's Integrated Community Partnership (ICP) places students in community settings to complete a portion of their clinical training. Beginning in 2012, A.T. Still is planning to staff Northeast Missouri Dental Clinic, with students from this program. The clinic is located in Adair County and is planned to be built on the dental campus. There is a proposed plan to expand this initiative to 5 other safety net providers across the state. The sites include:

- Columbia/Jefferson City
- Jordan Valley Health Center in Springfield
- St. Louis
- SE Missouri (i.e. Great Mines Health Center)
- (Kansas City)

Eastern Region

Premier Dental Anesthesiology (PDA) contracted with DentaQuest and HealthCare USA in order to address the lack of operating room time available to dental providers in the Eastern Region. Premier Dental Anesthesiology provides in-office dental anesthesia





by board certified anesthesiologists. PDA is a St. Louis based company now serving counties across all three regions of the state of Missouri.

PDA anesthesiologists work with dentists in their dental office to provide safe sedation during dental procedures which would otherwise have to be delayed until an appropriate operating room could be scheduled for the member. Each case is personally performed by a board certified anesthesiologist and a nurse, nurse anesthetists or anesthesiologist assistant. PDA brings to the dental office the finest standard of anesthesia care, no less than expected at hospitals or ambulatory surgery centers.

DentaQuest also has agreements with a variety of critical dental specialists and safety net providers including:

- St. Louis County Department of Health
- Grace Hill Neighborhood Health Centers
- Myrtle-Hilliard Davis Health Centers
- People's Health Center, Health
- Dental Care for Kids
- Family Care Health Centers
- Great Mines Health Center
- Ste. Genevieve Health Center
- St. Louis University Center for Advanced Dental Education

In order to provide dental services within a school setting DentaQuest also contracts with the two dental mobile units currently in the Eastern region.

Western Region

The dental provider network in the Western region of Missouri includes key safety net providers such as:

- The University of Missouri Kansas City School of Dentistry
- Samuel U. Rogers
- Swope Health Services
- Jordan Valley Health Center
- Truman Medical Center
- Children's Mercy Family Health Partners

In addition to the traditional dental providers, we has contracts with three school-based mobile dental units in the urban counties of the Western region. DentaQuest actively collaborates with these providers and other community organizations such as Mid-America Head Start in order to ensure that the dental needs of urban members are addressed. In order to ensure access to as many dental providers as possible DentaQuest



has included providers in all contiguous counties throughout the Western region including providers as far south as McDonald County and north into Caldwell County.

Business Processes

All Regions

- **Network Analyses.** DentaQuest performs ongoing provider network monitoring and analysis. If provider network access gaps are identified, DentaQuest will conduct provider recruitment and utilize the Take 5 Program. DentaQuest is planning to initiate the Take Five program in Missouri. The Take 5 program is fully explained in this section under Strategies for Improvement. Below are some examples of processes utilized by DentaQuest with regards to network monitoring and analysis to ensure an adequate network is available.
- **Travel Distances.** On a quarterly basis, DentaQuest generates GEO Access reports for each region within Missouri to measure travel distance access and identify pockets of provider access need. Once the reports are analyzed, strategies are deployed to close access gaps and ensure network compliance, as needed. While most recent Geo Access reports for HealthCare USA members generated for Q2 2011 indicates that travel distance standards are in compliance for the dental network, DentaQuest continues to seek out additional opportunities for network development in all three regions.
- **Appointment Access Standards.** DentaQuest's process to ensure compliance regarding wait times for appointments begins with provider contracts, where providers are obligated to conform to appointment standards. In addition, providers are "blind" surveyed by telephone on a quarterly basis to ensure they are following standards for appointment wait times. When dental providers are not performing within appointment standards, they receive additional education and are re-surveyed the following quarter. If they continue to be non-compliant, they face corrective action up to termination.
- **Provider Network.** To address gaps in network and the statewide shortage of dental providers, DentaQuest currently adjusts provider fee schedules due to market considerations and network composition. In addition DentaQuest will be initiating the Take 5 program in 2012.
- **Dental and PCP Provider Care Coordination.** DentaQuest and HealthCare USA will partner in order to ensure better care coordination between PCP's and dentists. This will be accomplished in the following ways:
 - HealthCare USA will work with PCP offices to help them identify participating dentists in their community and feel comfortable providing direct referrals to their HealthCare USA patients.
 - DentaQuest will work with dentists to ensure access and availability for HealthCare USA PCP's seeking dental appointments for their patients.





DentaQuest will educate dentists about the importance of care coordination and providing feedback to the PCP regarding the oral health status of their HealthCare USA patients.

In order to facilitate this coordination of care DentaQuest and HealthCare USA will collaborate to implement a provider toolkit for distribution to both medical and dental providers. This toolkit will include at a minimum the following:

- American Academy of Pediatric Dentists (AAPD) anticipatory guidelines for children ages 0-18
- Educational information on the importance of establishing a dental home
- and resources to help both medical and dental providers connect together to provide coordinated care

Strategies for Improvement

All Regions

- **Take Five Program for Dental Services.** Access to care is the primary cause of healthcare disparities in oral health. To address this barrier DentaQuest has implemented the Take Five program. This program not only recruits new providers into the network, it also prepares both the provider and member for the office visit experience. The provider goes through training programs as a part of the contracting process and the members selecting or assigned to the dental home are educated in order to have a full rounded experience in accessing dental care services.

In the spirit of community and compassion, DentaQuest will ask prospective dental providers to serve the underserved by accepting five families enrolled in HealthCare USA each year. What we have seen from implementation of this program is that oftentimes dental providers are hesitant to become a participating Medicaid provider because of myths surrounding the members and the complexity of the program. The Take 5 program provides an introduction to new dental offices which often results in the offices expanding their Medicaid participation after they have had an opportunity to familiarize themselves with the 5 family patient base and with the administrative procedures offered by DentaQuest.

DentaQuest plans to implement the Take Five program in Missouri again starting in 2012.

- **Smiling Stork Program.** HealthCare USA will implement the Smiling Stork Program in the Q2 2012. This program focuses on pregnant women over the age of 21. The Program is designed to encourage pregnant women to seek dental care in order to avoid potential problems such as prematurity that can result from poor oral health.
- **Dental Rerouting Emergency Dental Care program.** Managing dental emergencies in hospital emergency department is not cost effective and can be taxing on the already short resources in many emergency departments. Many members use emergency departments as a walk in dental clinic and never see a dentist for follow





HealthCare USA is currently assessing emergency department visits based upon reporting from the hospitals and claim data. DentaQuest will extract emergency department visits for dental reasons directly from claims data utilizing our proprietary emergency department diagnosis code list. A coordinated staff who have experience and training in how to handle dental emergencies will conduct the member outreach

Program Description

DentaQuest's Rerouting Emergency Dental Care program (ED program) raises awareness about the importance of proper dental care. It informs members about:

- The importance of proper preventive care
- Available access emergency dental care
- Available access to a dentist for covered services

Member Education and Outreach

ED program member mailings emphasize the importance of preventive dental treatment and offer ways to access dental care in a dental emergency situation. HealthCare USA members who use the emergency department for dental services receive follow-up educational telephone calls to provide alternative options in dental emergency situations. Call center staff also recommend dental follow-up visits, provides dentist referrals, and sets up a dental appointment if the member is willing.

Reporting

Pre-Implementation

Prior to implementing the ED program, HealthCare USA and DentaQuest established a baseline of the number of members who used the emergency department for non-traumatic dental care.

Post-Implementation

Twelve months after the implementation of the program, DentaQuest will analyze utilization data to determine:

- Decreases in emergency department utilization for non-traumatic dental care
- Increases in the number of members seeing dentists for post emergency department care
- Increases in utilization for preventive services



4.5.4.b2. Given differences between urban and rural areas (e.g. population needs, access to care issues), the offeror must address how the offeror's orientation programs, education strategies, and interventions for providers and members in rural areas will differ from those used in more urban areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)2.

Over the course of the last 16 years, an integral part of our provider communication strategy has been to identify and cultivate collaborative relationships with rural providers. We have refined our processes over time to ensure that our provider and member orientation, education and communication strategy addresses the needs of providers in all settings. For HealthCare USA, whether providers are in a rural setting or an urban setting, HealthCare USA's goal is to build collaborative relationships by providing well trained, responsive and accessible Provider Relations representatives who are familiar with the unique aspects of office practice.

HealthCare USA understands that operating a healthcare delivery system in both urban and rural settings requires a different approach to programs for providers and members. For providers, conditions such as geography, local employment market conditions and access to technology affect the way they operate their practices. For members, access barriers such as lack of transportation and scarcity of providers affect their ability to get care. Based on these differences, we have tailored our Provider Relations and Member Services programs in ways to address these differences.

The table below outlines the differences in our approach for urban and rural areas regarding orientation programs, education strategies and interventions for providers and members.

Although the majority of our programs for providers and members are similar in both urban and rural areas, as illustrated in the table below, the differences between our lie mainly in the intensity and frequency of those efforts. For example, our Provider Relations Representatives make more frequent face-to-face visits to rural providers, since those providers do not have the supportive technology tools available to most urban providers. Rural providers typically have smaller staffs that are cross-trained in all aspects of the practice. These staffs require more in-depth training to keep them up-to-date with the latest program policies.

Member education and orientation activities are also more face-to-face with more frequent direct contact with programs such as the Doc Bear fairs, and the fluoride varnish program in schools. To implement our member education efforts, we rely more heavily on our community partnerships to help us bring services to members, such as the Preventive Services Program (PSP) in which dental hygienists travel to schools.



Figure 4.5- 96: Dental Care Approaches

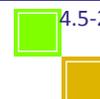
Provider Orientation/Education Strategies/Interventions	Urban Approach	Rural Approach
New Provider Orientation	New providers joining the network receive an in-service orientation to familiarize the office staff and dental provider with DentaQuest. This orientation includes a review of our Office Reference Manual (ORM), submission of claims and authorizations, member eligibility and the use of our provider web portal.	New providers joining the network receive an in-service orientation to familiarize the office staff and dental provider with DentaQuest. This orientation includes a review of our Office Reference Manual (ORM), submission of claims and authorizations, member eligibility and the use of our provider web portal.
Provider Webinar and Seminar training	DentaQuest engages in annual provider training and also provider ad hoc provider webinars as needed in order to address significant benefit or program changes.	DentaQuest engages in annual provider training and also provider ad hoc provider webinars as needed in order to address significant benefit or program changes.
Local Provider Relations Representative	DentaQuest maintains a local provider relations representative who is reasonable for developing a relationship with our Missouri dental providers. The purpose of the provider relations representative is to provide assistance with authorizations, claims, eligibility, credentialing, etc. As the provider relations representative works with individual provider offices they ensure appropriate education is provided on	DentaQuest maintains a local provider relations representative who is reasonable for developing a relationship with our Missouri dental providers. The purpose of the provider relations representative is to provide assistance with authorizations, claims, eligibility, credentialing, etc. As the provider relations representative works with individual provider offices they ensure appropriate education is provided on



Provider Orientation/Education Strategies/Interventions	Urban Approach	Rural Approach
	an ongoing basis.	<p>an ongoing basis.</p> <p>Our provider relations representative is located in the Central region of Missouri in order to be easily accessible to the rural providers within our network, the majority of which are located in the Central region.</p>
Office Reference Manual (ORM)	DentaQuest ensures that all new provider offices have a copy of the ORM. As updates are made to the ORM, DentaQuest notifies the provider network outreach to high volume offices in order to ensure that they have received the updated information.	DentaQuest ensures that all new provider offices have a copy of the ORM. As updates are made to the ORM, DentaQuest notifies the provider network outreach to high volume offices in order to ensure that they have received the updated information.
DentaQuest Provider Web Portal	Our provider web portal offers providers the ability to verify member eligibility, check claims history, submit claims and authorizations with attachments, check on the status of claims and authorizations and access to all provider documents.	Our provider web portal offers providers the ability to verify member eligibility, check claims history, submit claims and authorizations with attachments, check on the status of claims and authorizations and access to all provider documents.
Personalized URL (PURL)	The PURL site allows an additional form of secure communication between providers and DentaQuest.	The PURL site allows an additional form of secure communication between providers and DentaQuest.
Enhanced fee schedule for rural providers.	The greater number of dental providers in urban areas precludes the need for enhanced fee schedules.	DentaQuest acknowledges that it is more difficult for providers to establish and maintain a practice



Provider Orientation/Education Strategies/Interventions	Urban Approach	Rural Approach
		in a rural area and therefore offers a standard, enhanced fee schedule to all dental providers located in a rural county.
Member Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
Member Placement Department	In instances when additional help in locating a provider is required, DentaQuest utilizes member placement specialists. These specialists locate providers who can perform the required services, contacting the office directly to verify participation and appointment availability. Next, the specialist contacts the member via telephone with the provider's office on the line, and assists in scheduling an appointment.	In instances when additional help in locating a provider is required, DentaQuest utilizes member placement specialists. These specialists locate providers who can perform the required services, contacting the office directly to verify participation and appointment availability. Next, the specialist contacts the member via telephone with the provider's office on the line, and assists in scheduling an appointment.
Member Services Reporting	On a quarterly basis DentaQuest provides reports to HealthCare USA which measure the amount and type of dental services received by their members within that timeframe	On a quarterly basis DentaQuest provides reports to HealthCare USA which measure the amount and type of dental services received by their members within that timeframe
Member Outreach	Following the birth of new members, and after their first and second birthdays, DentaQuest mails a birthday card to the member's home. The card includes dental care	Following the birth of new members, and after their first and second birthdays, DentaQuest mails a birthday card to the member's home. The card includes dental care





Provider Orientation/Education Strategies/Interventions	Urban Approach	Rural Approach
	<p>instructions and information on how to contact a dentist.</p> <p>Community Development Team provides education and dental resources to members at school events and dental health month activities within the school districts in Western and Eastern regions.</p> <p>DentaQuest may also place outbound calls to members who have not accessed dental care six months following receipt of the mailings.</p>	<p>instructions and information on how to contact a dentist.</p> <p>Community Development Team provides education and dental resources to members at school events and dental health month activities within individual schools in the Central Region.</p> <p>DentaQuest may also place outbound calls to members who have not accessed dental care six months following receipt of the mailings.</p> <p>More frequent face-to-face contacts with members in the form of health fairs and dental programs in schools.</p>

4.5.4.b3. The offeror shall describe how its approach to service delivery will achieve optimal outcomes for the populations in each region proposed. The offeror shall describe the implications of the regional demographic data to their service delivery strategies (refer to Attachment 1).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)3.

Achieving Optimal Outcomes for Each Population

HealthCare USA, in our 16 years of serving MO HealthNet in Missouri, understands that having a provider network that complies with the access and availability standards are only the baseline. Getting members the right services, at the right time, in the right setting, to ensure optimal outcomes, requires much more. In particular, we must:

- Create provider networks to match the needs of population groups – providers best suited for the needs of one population group may not be those who are ideal for



another group. This crosses multiple boundaries of service type, provider expertise, language, ethnicity, age, sex, and health status.

- Connect members to providers who meet their needs – having the right providers available in the network is the first step, but we go beyond this by working to understand the unique and individual needs of each member, then helping them choose and connect to providers to meet those needs.
- Help members communicate with providers – even with the right providers in the network, language and communication barriers can hamper effective engagement of the member in their health care. We provide the right tools and services to ensure that members can communicate – not just with customer service, *but with providers at the point of care.*
- Build cultural competency throughout the health plan and network – while choosing the right providers and connecting members to those providers is a great start, we recognize the need to evolve cultural understanding and appreciation throughout our health plan, our subcontractors, affiliate, and our network. We do so through a combination of policies, training, and ongoing efforts to improve our understanding of the populations we serve.
- Address disparities in care for population groups – all of the prior steps help generally improve awareness of the needs of member groups and individual members, but we do more by examining information on health care disparities that exist for population groups and creating initiatives to address those.

In the following sections, we highlight our approach to each of these challenges, and show how we overcome them with creative solutions to ensure that members are connected to care and engaged in understanding and participating in their treatment.

Improving Dental Access

Our dental subcontract with DentaQuest represents the largest dental coverage among all Plans in MO HealthNet; and therefore maintains a provider network that can accommodate culturally diverse members. DentaQuest recruits providers in neighborhoods near the members' homes in rural and urban areas.

Providers are required to provide services to HealthCare USA members in a culturally competent manner through contractual obligations as well as through training materials provided to the provider community and their staff. In addition, DentaQuest provides ongoing resources such as specific Provider Newsletter articles on various cultural issues to ensure that we maintain a culturally competent provider network that is prepared to assist all HealthCare USA members, including those with limited English proficiency or reading skills, diverse cultural and ethnic background or physical or mental disabilities issues.





Expanding Access for Children and Members with Special Health Care Needs

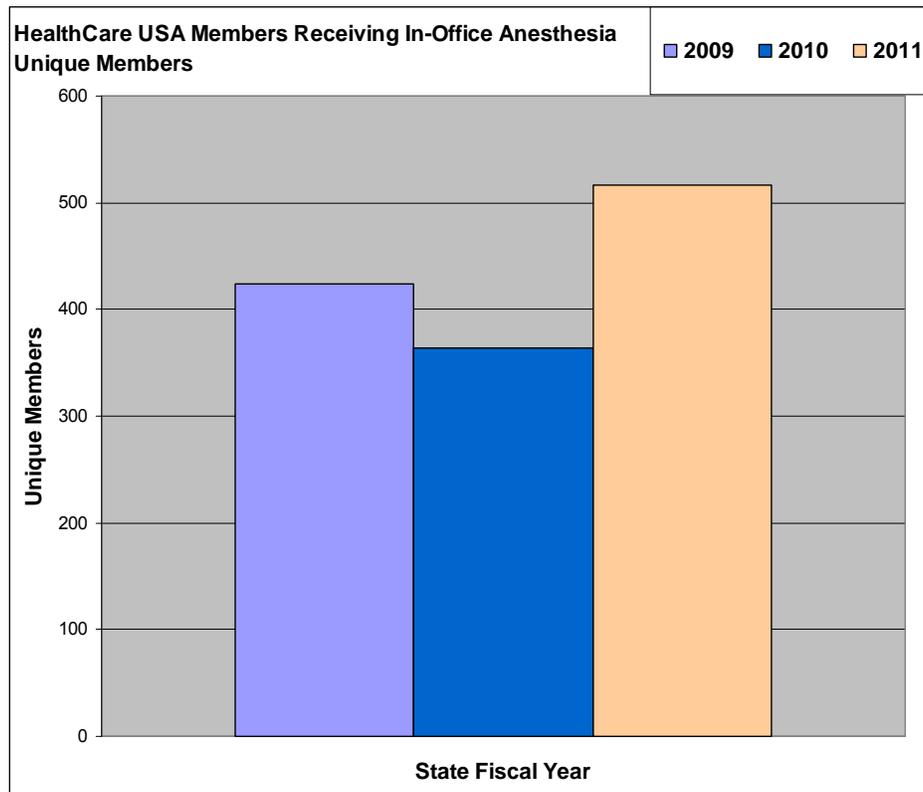
Dentists occasionally have experienced difficulty in gaining an equal opportunity to schedule operating room time. (See: American Academy of Pediatric Dentists: *Policy on Hospitalization and Operating Room Access for Dental care of Infants, Children, Adolescents, and Persons with Special Health Care Needs.*) This difficulty that dentists face in obtaining necessary operating room time often leads to the postponement or delay of medically necessary dental procedures in young children and members with special needs. HealthCare USA addresses this access issue in three ways:

- **We have brought services to members/children in their schools.** Through a community partner effort using our Triads of Care model (which connects us, providers such as DentaQuest, and community partners to provide services to our members; see Section 4.5.2.B.4 for more) more than 50 children received dental visits for one event alone in a Marion County school. As follow-up, we worked with the school nurse to help families find a dental home. We plan on expanding this program in the new contract.
- **We are actively participating in the statewide MO HealthNet collaborative Performance Improvement Project, Improving Oral Health.**
- **HealthCare USA and DentaQuest partner with Western Anesthesiology Associates in a new venture known as Premier Dental Anesthesiology** to address operating room access. As previously stated, Premier Dental Anesthesiology provides in-office dental anesthesia by Board-certified anesthesiologists. PDA is a St. Louis-based company now serving counties across all three regions of the state of Missouri.

PDA anesthesiologists work with dentists in their dental office to provide safe sedation during dental procedures which would otherwise have to be delayed until an appropriate operating room could be scheduled for the member. Each case is personally performed by a board-certified anesthesiologist and a nurse, nurse anesthetist, or anesthesiologist assistant. PDA brings to the dental office the finest standard of anesthesia care, no less than expected at hospitals or ambulatory surgery centers. See Figure 4.5- 97, which shows the number of unique HealthCare USA Missouri members served by this program from 2009–2011. Programs such as these ensure that we help create a network that matches the needs of members for timely and appropriate care.



Figure 4.5- 97: Unique HealthCare USA Missouri Members Served by Premier Dental Anesthesiology 2009 – 2011



SOURCE: DENTAQUEST CLAIM REPORT 2009–2011

Over the Last Three Years, a Partnership has Allowed Us to Facilitate Timely Delivery Dental Procedures Despite Limited Dental Operating Room Availability

Connecting Members to a Dental Home

In Section 4.5.4.b.4, we describe how we help members find an appropriate dental home. This includes DentaQuest’s Member Placement process, which helps connect members to appropriate and convenient dental providers even in the rare instance that there is not a provider available in the network.

Finding a Dental Provider to Stabilize a Family

DentaQuest received a member placement request from HealthCare USA’s Customer Service Department for two child members. These were sisters who were in danger of being removed from their home. Their parents had been informed by the Division of Family Services that they must take their children in for a comprehensive dental exam within the next week or face the probability that DFS would remove the sisters from the home and place them into state custody.

DentaQuest found a dental provider, Lincoln County Health Department, which was within the mileage requirements and could provide the dental services needed. However,



Lincoln County Health Department has a strict policy that they only provide dental services to member residing in Lincoln County; these members lived in the adjacent county. DentaQuest negotiated with the Lincoln County Health Department, explained the severity of the situation, and convinced the Health Department to make an exception. The sisters had their dental exams the following week, preventing them from being placed into foster care and aligning the family with a dental home for future dental needs.

Dental Interpretation and Translation

Our dental subcontractor, DentaQuest, makes providers aware of the availability of interpretation services provided by HealthCare USA. In addition, DentaQuest is working with specific provider offices on efforts to improve understanding about dental services among members. For example, a dental group in the Central region noticed that a significant number of their patients were coming from Sedalia, Missouri, which has a large Russian-speaking immigrant population. As the practice began to see more of these patients, the dentist realized that patient education efforts were not connecting effectively. This provider asked for feedback on how to communicate more effectively. It became apparent that parents were having trouble reading the patient education materials that the office sent home with them; these materials were written in English. The practice contacted a translation service and had all of their materials translated into Russian and Spanish at that time. Now the office is also more sensitive to all patients who have English as a second language and offers to have materials translated at no cost to the member.

Expanding Cultural Competency in Dental Services

DentaQuest has adopted a cultural competency philosophy and methodology that closely parallels that of HealthCare USA. In addition to translating member communications and education materials into English and Spanish, DentaQuest addresses the same elements as described for HealthCare USA above.

- **Philosophy.** At all levels of operations, DentaQuest acknowledges and promotes the importance of and respect for culture and language, the traditions and heritage associated with different peoples and communities, and assessment of cross-cultural relations, vigilance towards the dynamics inherent in cultural and linguistic differences, and the expansion of cultural and linguistic knowledge.
- **Policy.** DentaQuest maintains a cultural plan which is reviewed by the DentaQuest Quality Improvement Utilization Management Committee for review, recommendations and approval.
- **Education.** DentaQuest requires employees at all levels of the organization to complete an annual Cultural Competency training and evaluation. The training program objectives ensure that:

DentaQuest meets the unique diverse needs of all members in the population that we service.





The DentaQuest staff values diversity within the organization and for the member that we service.

Members with limited English proficiency have their communication needs met.

Participating providers fully recognize and are sensitive to the cultural and linguistic differences of the DentaQuest members they serve.

Employees at all levels of the organization are evaluated on their understanding of the training program and must pass all levels of the evaluation at 100 percent. If an employee does not score 100 percent on the evaluation, then the employee will receive additional education and training until he or she is able to meet this standard.

- **Analysis.** Annual evaluation of performance against the Cultural Plan is an integral part of DentaQuest’s program. In collaboration with HealthCare USA, DentaQuest regularly evaluates the needs of existing and prospective HealthCare USA members.
- **Partnership.** To aid our ability to maintain and recruit for a diverse workforce, DentaQuest has established ongoing partnerships and recruiting relationships with the following groups:
 - Urban League
 - Operation A.B.L.E
 - Esperanza Unida
 - AARP - recognized DentaQuest as one of the “best places to work” in 2004 and 2009
 - Department of Workforce Development
 - Diversity Websites

DentaQuest partners with community-based organizations, child advocacy groups and other oral health stakeholders. We work shoulder to shoulder with these groups to demonstrate our commitment to improve oral health care. The following table shows the groups with which DentaQuest currently partners in Missouri.

Figure 4.5- 98. DentaQuest Partners Helping Ensure Members Get the Right Care

Member Group	Provider Group
Missouri Health Advocacy Alliance	Missouri Dental Association
Missouri Coalition for Oral Health	Missouri Dental Hygienist’s Association
Mid-America Regional Council	Missouri Dental Assistant’s Association
Missouri Foundation for Health	MO HealthNet Dental Advisory Committee
YMCA of Greater Kansas City Head Start	Missouri Primary Care Association



Member Group	Provider Group
CMCA Head Start	UMKC School of Dentistry
Health Care Foundation of Greater KC	AT Still University
Reach Healthcare Foundation	Oral Health Network of Missouri
Youth In Need	Oral Health Plan State Taskforce

Routine Dental Checkups (Dental)

Minority children are least likely to see a dentist on a routine basis; they typically also exhibit longer intervals between visits. A study conducted in California by researchers from UCLA and the California Health Foundation found that racial and ethnic differences in dental care exist regardless of the presence of insurance, either public or private benefits. In the study, 39 percent of African American and 36 percent of Hispanic/Latino children participating in the Medicaid program had at least one dental visit in a 12-month period.

About 24 percent of children from both groups had never seen a dentist, falling well below the Healthy People 2020 goals. In addition, among African Americans and Hispanic/Latino populations the presence of decay and gum disease is significantly higher than that among Asian and Caucasian children.

The impact of tooth decay in children is significant. It includes additional medical costs for infection, poor nutrition, and poor school performance resulting from pain, lack of concentration and sleep. Chronic dental problems aggravate behavioral health conditions that are revealed through depression, aggressive behavior, embarrassment and isolation.

The latest Missouri-specific data reported to the Centers for Medicaid and Medicare in 2008 shows that the state falls below national averages for oral health for all groups. See the following table.

Figure 4.5- 99. Dental Services Rates in Missouri (Below National Average)

Dental Services	Missouri Average	National Average
Any Dental Service	25%	38%
Preventative Services	22%	34%
Dental Treatment	13%	19%

Barriers to Care

HealthCare USA’s experience reveals both similarities and differences among the barriers to care for all groups, which are directly related to the aggravating issue of poverty. The most obvious barrier to care is an insufficient network of providers who are willing to treat children in the Medicaid and CHIP programs. Additional barriers identified through our experiences are:



- Member's difficulty in making and keeping appointments
- Lack of sufficient numbers of African American and Hispanic/Latino Dentists
- Parental Fear of repercussion for failure to seek care for children i.e. legal action for neglect, children removed and placed into foster care.
- Lack of parental awareness of the need for dental care for young children
- Lack of parental awareness around preventative measures such as:
 - Breast feeding vs. bottle feeding
 - Not allowing children to sleep with a bottle of milk/juice
 - Need for routine dental care for everyone

Objectives and Measurement

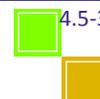
Our general objective is to improve the HEDIS measures for all population groups so that all children receive at least an annual dental visit. However, we will also consider the Healthy People 2020 measures for Oral Health, including:

- Increase the proportion of children, adolescents, and adults who use the oral health care system in the past 12 months. Baseline: 44.5 percent; ages 2 and above: Target 49 percent; Goal for all races 10 percent increase
- Increase the proportion of low-income children and adolescents who received any preventative dental services during the past year. Baseline: 26.7 percent ages 2-18 below 200 percent of poverty; Target 29.4 percent; Goal among all races 10 percent improvement.

Interventions

HealthCare USA will collaborate with our dental subcontractor, DentaQuest, to initiate the following interventions to reduce these disparities in dental care:

- Create and roll out an educational campaign directed at pregnant women and parents regarding good oral hygiene
- Provide support services to members through our social workers after Emergency Department visits for dental-related events. We will provide education and reassure parents that help is available, not punishment, if they take action
- Include a dental visit as part of a well-child campaign and routine prenatal care
- Supply children with toothbrushes
- Help members in making dental appointments
- Coordinate between members, dental providers, and transportation, as necessary to help members keep their dental appointments
- Conduct a campaign to increase the use of sealants for molars
- Facilitate use of dental hygienists in schools





- Increase the frequency of dental visits to every six months for high-risk groups
- Coordinate and work with the state and community agencies to increase the number of dental professionals who will participate in the Medicaid program

4.5.4.b4. The offeror shall describe targeted initiatives proposed to meet the requirements of the contract. The offeror shall describe how the offeror will meet members' physical and behavioral health care needs in a coordinated and integrated manner as described per the contract requirements regarding provider network, access standards, quality assessment and improvement, case management, disease management, behavioral health and dental services.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)4.

Targeted Initiatives

HealthCare USA strives to continuously improve member health outcomes while using health care resources wisely and being cognizant of the need to manage costs effectively. Accordingly, we have had various ongoing initiatives that address member needs for coordination and integration of physical and behavioral health care. We will continue many of these initiatives and launch others to continue to improve quality. In this section, we describe the following initiatives with respect to the providers and members served:

- Dental care: expanding dental services and access
- Specialized Providers: Initiatives for Members with Special Health Care Needs

For the initiatives described in this section, we address various considerations, including those for the provider network, access to care and connecting members to the right provider, assessing and improving quality, coordinating and integrating care through effective case management and disease management, and ensuring access to and coordination of behavioral health and dental services.

Dental Care: Expanding Dental Services and Access

Preventive dental care, particular for children and adolescents, has a significant impact on overall health status. By ensuring good oral health and quick treatment of problems, HealthCare USA can help prevent more serious acute care episode, for which many members might seek emergency care. To expand dental services and improve access for our members, we will collaborate with our dental network provider, DentaQuest, on three targeted initiatives:

- Recruiting additional pediatric dentists to improve access and availability of dental care for our members



- Introducing a new program, *Smiling Stork*, that helps address the known linkage between periodontal disease and pre-term labor through education, outreach, and screening
- Increases the impact of the *Smiling Stork* program through linkage to our existing well-pregnancy and high-risk pregnancy case management programs

Below, we describe each of these initiatives.

Recruiting Additional Pediatric Dentists

HealthCare USA already provides a significant advantage and benefit to our members by delivering an expanded dental provider network. In particular, our network includes providers in counties that are not part of our existing service area, but are contiguous to the service area. This gives members more choices: those dental providers might be closer to where they live or work, making it easier and more convenient for the member to get the services he or she needs.

To continue to improve access, we will be recruiting additional pediatric dentists. By doing so, we remove barriers – members can find care at the time and place that is best for them, which helps ensure they get the preventive and restorative services that they need, when they need them. Having a convenient provider makes it less likely that the member will delay care – which can often result in a trip to the emergency department when an abscessed or impacted tooth causes acute pain.

We will focus on recruiting pediatric dentists. In some instances, a pediatric dentist is the best choice for treating the member’s condition. Most often, this is to treat early childhood caries, also known as baby bottle tooth decay. Occasionally, children ages 0-3 have had little or no dental care either in a formal office setting or at home. This results in extensive decay, which requires outpatient dental surgery due to the severity of the decay and the age of the child.

Recruiting will be done by our dental network subcontractor, DentaQuest. As shown in Figure 4.5- 100 below, DentaQuest currently has 30 pediatric dental providers in the network. Most of these providers are in the Western region and are affiliated with Children’s Mercy Hospital in Kansas City, MO.

Figure 4.5- 100: Dental Providers within the Existing HealthCare USA Network

Provider Type	CMO	EMO	WMO	Contiguous to Service Area	Totals
General Dentists	75	258	149	149	631
Pediatric Dentists	1	6	19	4	30
Endodontists	1	2	2	0	5
Oral Surgeons	1	7	13	2	23
Orthodontists	2	10	9	0	21

DATA AS OF OCTOBER 31, 2011



DentaQuest will conduct targeted recruiting of pediatric dental providers. Our initial analysis, conducted by using data available from the American Academy of Pediatric Dentists, shows opportunities for recruitment in each region. See Figure 4.5- 101, below.

Figure 4.5- 101: Opportunities to Recruit Additional Dental Providers into the Network

Provider Type	CMO	EMO	WMO	Totals
Licensed Pediatric Dentists	6	26	24	56
Already in Current Network	1	6	19	26
Opportunity to Recruit	5	20	5	30

DATA AS OF OCTOBER 31, 2011

In addition to our pediatric dental network, DentaQuest has worked with our general dentists to ensure that they provide pediatric dental services within their capabilities. Most of our general dentists accept members ages 0-20 and can provide comprehensive dental services to children of all ages.

Addressing the Link between Periodontal Disease and Pre-Term Labor – Smiling Stork Program

Over the past eight to ten years, there has been increasingly compelling evidence that links the presence of periodontal (gum) disease in pregnant women to increased incidence of pre-term, low-birth-weight births (PTLBW). Data shows that pregnant women with periodontal disease are seven times more likely to have a PTLBW birth. When women with periodontal disease receive treatment, the incidence of PTLBW births is reduced by half. *That not only improves healthcare outcomes, it reduces costs: each PTLBQ costs \$28K in care.*

To increase awareness of the consequences associated with oral disease, our dental subcontractor, DentaQuest, has developed the *Smiling Stork* program. This program teaches women of childbearing age about:

- The importance of being screened for periodontal disease during pregnancy
- The value of establishing good oral health habits for their babies
- How to access covered dental services during pregnancy

In the program, DentaQuest and HealthCare USA will collaborate to do the following:

- Perform outreach and education
- Measure program results

Our approach to these is described in the following sections.

Outreach and Education

To engage and educate members and providers, we will pursue a five-part strategy, as follows:



- **Member Outreach and Education.** Pregnant members will receive mailings that include two brochures: A Pregnant Women’s Guide to Healthy Gums and A Guide to Your Young Child’s Oral Health. Members will also receive a reminder notice to schedule an appointment with the dentist.
- **Dental Provider Outreach and Education.** DentaQuest will mail letters to dentists that describe the Smiling Stork program’s objectives and the importance of screening pregnant women for periodontal disease. The dentist packets will include an article on the link between periodontal disease and pre-term babies. Also included will be a copy of the Smiling Stork member materials.
- **Physician Outreach and Education.** To bridge medical with dental care, DentaQuest will supply the plan with cover letters a research article on the link between periodontal disease and pre-term babies and educational materials.
- **HealthCare USA Case Management Training.** DentaQuest will train HealthCare USA case managers. This training will include an overview of the Smiling Stork program and its objectives, how oral health relates to overall health, and the link between periodontal disease and pre-term babies.
- **Community Organization Outreach.** Community based organizations provide an important link between members and HealthCare USA as they often have access to members in their homes and communities. Program brochures will be provided to the HealthCare USA to distribute to these organizations.

Figure 4.5- 102, below, shows a sample of the types of educational materials to be used.



Figure 4.5- 102: Sample Community Organization Outreach Educational Materials



Smiling Stork Program Materials show Members the Importance of Regular Dental Care in having a Healthy Pregnancy.

Reporting

Assessing program performance helps us understand which aspects are working and which are not. First, we will establish a baseline. Before implementing the program, DentaQuest will work with HealthCare USA to count how many pregnant women who were members had visited a dentist during their pregnancy and how many were treated for periodontal disease pre-implementation of this program. This will be done through analysis of claims and enrollment data.

Second, we will measure and analyze program performance. Twelve months after the implementation of the program, DentaQuest and HealthCare USA will compare the data from the period prior to implementing the program to the data gathered during the implementation of the Smiling Stork Program to determine whether (post-implementation) more pregnant women were:

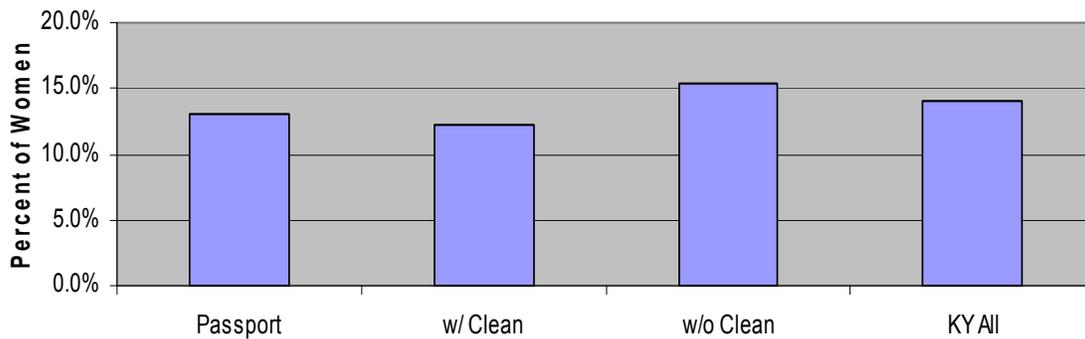
- Been by a dentist during pregnancy
- Treated for periodontal disease



Demonstrated Program Results

DentaQuest has used the Smiling Stork program in other Medicaid markets and has demonstrated statistically significant results. For example, in Kentucky, the state had an overall rate of 14.4% preterm deliveries (2006 data). However, a participating Medicaid health plan who had implemented the Smiling Stork program had a pre-term delivery rate of 13.1%. 12.2% of those with pre-term deliveries had dental cleanings; 15.3% of those with pre-term deliveries had not had dental cleanings.

Figure 4.5- 103: A Kentucky MCO Improvement in Pre-Term Deliveries with Smiling Stork Program

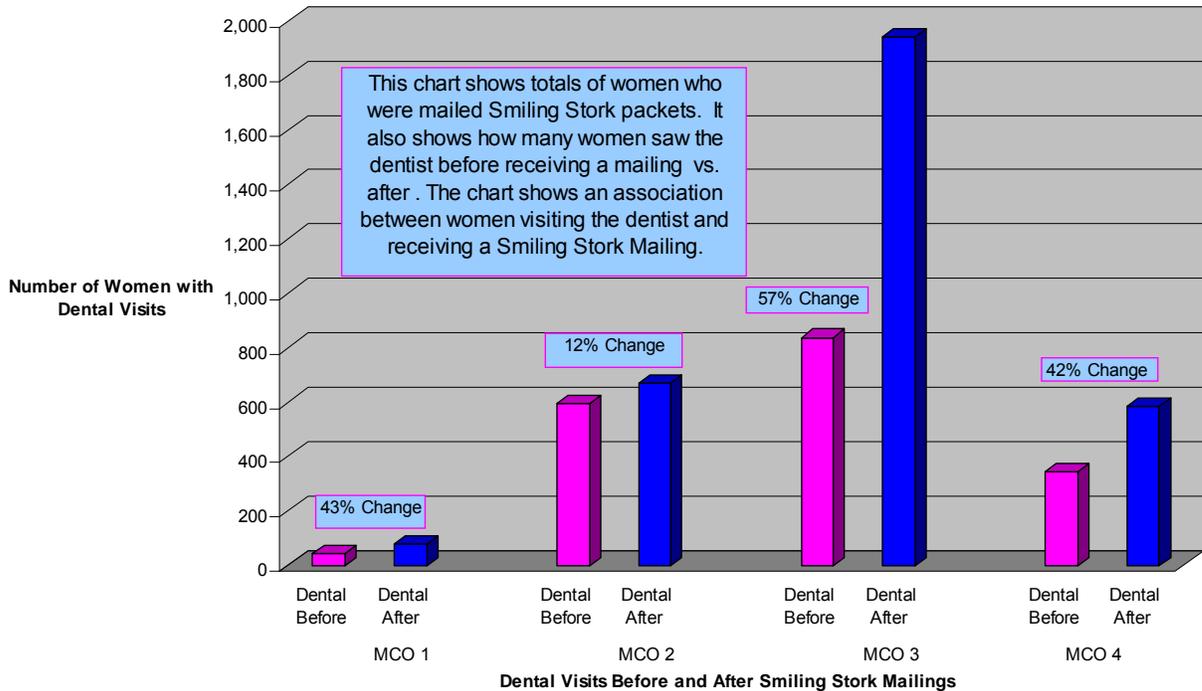


DATA SOURCE: DENTAQUEST ENTERPRISE SYSTEM REPORT 2006

DentaQuest has also conducted analysis to verify that the distribution of educational materials to qualifying members is effective. See Figure 4.5- 104, below. This figure shows the number of dental visits by women before and after they received a mailing about the Smiling Stork program, for four different managed care organizations. In each case, there was a significant increase in dental visits; most MCOs experienced a dramatic increase (greater than 40%).



Figure 4.5- 104: Educational Material Mailings Significantly Increased Dental Visit Rates



DATA SOURCE: DENTAQUEST ENTERPRISE SYSTEM REPORT Q3 2006

Mailing Educational Material to Women Significantly Increased the Rate of Dental Visits

Increasing the Impact of *Smiling Stork* through Case Management

HealthCare USA offers case management services to every member who we identify as being pregnant. We have both a high-risk pregnancy disease management program and a well-pregnancy case management program. The well-pregnancy program manages those members who do not meet the criteria to be in the high-risk program but still need the assistance of a case manager to ensure the best outcome for the mother and baby.

To enhance impact and member engagement for the Smiling Stork Program, DentaQuest will provide initial and ongoing training to the HealthCare USA case and disease management team. This training will include the following topics:

- Overview of the Smiling Stork program
- Objectives of the program
- How oral health relates to overall health
- Link between periodontal disease and pre-term babies.



To use this information effectively and increase member engagement with preventive care, we will do the following:

- **Assessment.** HealthCare USA case and disease managers will use the program knowledge to enhance their assessment of the member. For example, the case managers will ask the member about her brushing habits and whether she has had a recent dental checkup.
- **Education.** Case and disease managers will, in their educational outreach calls, will explain the importance of regular dental care to the member. The manager will explain, in easily-understandable terms, why preventing periodontal disease can help the member ensure she has a healthy pregnancy and increase the likelihood of delivering a healthy, full-term baby. The manager will also review how to achieve good oral health through regular brushing, flossing, and check-ups.
- **Communication.** Pregnant HealthCare USA members will also receive two mailings.
- **Connection.** Our case and disease managers will ask the member whether she has a regular dental provider. If the member says she does not, the case or disease manager will have access to DentaQuest's provider network information, will help the member identify a dental home, and will, if appropriate, assist the member in making an appointment.

Specialized Providers: Initiatives for Members with Special Health Care Needs

Members with Special Health Care Needs represent the most complex spectrum of health care needs. These members often have multiple chronic, co-morbid conditions; use services overall at a higher rate than the general member population; and may use emergency department services at a higher rate than the general member population because of instability in their physical and behavioral health status. By creating specific initiatives to meet the needs of this population, we can stabilize or improve their overall status, potentially improve their well-being and social functioning, and realize improved cost control as a result, using health care resources in the most effective way. HealthCare USA's initiatives for this population address the following:

- **Network** – designing a health care network to address the specialized provider requirements for Members with Special Health Care Needs
- **Case Management** – ensuring that we quickly identify and assess Members with Special Health Care Needs and quickly connect them to the appropriate services for their needs

In the following sections, we address these two aspects within the dental service area needs.





Dental Needs

Provider Network

DentaQuest has experience recruiting diverse providers and it is our goal to ensure that members with diverse needs have access to dental services. Therefore, during provider recruiting and credentialing process, DentaQuest identifies the capabilities of each provider office including:

- Languages spoken
- Accommodation for handicapped members
- Provider training and office design to accommodate the treatment of members with special needs.

DentaQuest works with community partners such as the Missouri Health Advocacy Alliance, Mid-America Regional Council, Youth in Need, and the YMCA of Greater Kansas City Head Start to help us identify prospective providers who can help us to meet the needs of HealthCare USA members.

Figure 4.5- 105: DentaQuest Dental Providers Equipped to Treat Members with Special Health Care Needs

Region	Total Provider Count	Special Needs Providers	Percent of Network
Central	82	11	13%
Eastern	284	20	7%
Western	190	27	14%
Contiguous Counties to Service Areas	155	10	6%

SOURCE: DENTAQUEST WINDWARD PROVIDER DATABASE Q2 2011

A Significant Portion of DentaQuest Dental Providers are Equipped to Treat Members with Special Health Care Needs

Case Management

Healthcare USA collaborates with DentaQuest to ensure that every member, including those with special health care needs, is connected to a dental home that can provide all routine preventive and acute dental services. When a member calls HealthCare USA about dental needs, the call is handled by our Customer Service Organization (CSO). The CSO has information about DentaQuest’s provider network, including those providers who will see special needs members. If the CSO cannot find a dental provider to meet the needs of the member within the mandated mileage, the customer service representative will contact DentaQuest’s Member Placement Department. The representative will provide the member’s information, specific dental needs, and urgency



of the placement. DentaQuest’s Member Placement Department will connect the member to a dental home as follows:

1. Check the DentaQuest participating provider network to verify that there is not a provider available.
2. If a participating provider is not available, check the secondary provider network. This is a network of non-participating dental providers that have provided services to HealthCare USA members in the past. These services would be addressed under a letter of agreement (LOA) with the provider.
3. If no provider is found, Member Placement will consult a list of licensed dentists within the mileage requirements. Member Placement will then contact one or more of these dentists to see if they are willing and able to provide the necessary dental services by executing a LOA. All dentists contacted and their responses are documented.

If Member Placement still cannot locate a provider, they identify the closest available dental provider is identified. This information is given to HealthCare USA’s CSO to communicate to the member. Our CSO will contact the member and give him or her the provider information, and will also assist in making an appointment or arranging transportation as needed.

4.5.4.b5. The offeror shall describe the approach/strategy for each of the requests for information below. If the described approach/strategy is one currently in use, the offeror shall indicate in which program/state the approach/strategy is being used, the length of time the approach/strategy has been in effect, and the target population. If the offeror is currently operating in Missouri, the offeror shall speak to their existing experience in Missouri as well as how they will modify and expand upon these strategies for future service delivery.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5.

4.5.4.b5 – Bullet 1 How the offeror will ensure that children receive needed dental services. The offeror shall identify and describe the approach(es) that the offeror plans to implement in relatively more urban counties and contrast these with interventions that the offeror plans to use in more rural areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 1.

HealthCare USA understands the first step in providing good access to dental services for children begins with a comprehensive dental network. Our entire dental network is available to provide care to children between the ages of 0 to 20 in the MO HealthNet program. Along with DentaQuest’s robust network of dental providers, we ensure that children receive needed dental services through a variety of community partnerships, outreach activities, and participation in special programs and school-based initiatives. In



the following sections, we discuss our approaches to providing these services in urban vs. rural areas of the State.

Partnerships with Professional and Community Organizations in Rural Areas

To augment the services provided by our traditional dental network, DentaQuest has developed important partnerships with professional and community organizations throughout the state. The table below lists the community organizations that support members and the professional organizations that support providers.

Member Group	Provider Group
Missouri Health Advocacy Alliance	Missouri Dental Association
Missouri Coalition for Oral Health	Missouri Dental Hygienist's Association
Mid-America Regional Council	Missouri Dental Assistant's Association
Missouri Foundation for Health	MO HealthNet Dental Advisory Committee
YMCA of Greater Kansas City Head Start	Missouri Primary Care Association
Central Missouri Community Action Head Start	UMKC School of Dentistry
Health Care Foundation of Greater KC	AT Still University
Reach Healthcare Foundation	Oral Health Network of Missouri
Youth In Need	Oral Health Plan State Taskforce

Programs in Rural Areas

We bring services to our rural communities through the following special programs and school-based programs:

- **Doc Bear's Dental Days.** At HealthCare USA, we make going to the dentist a lot of fun for the family. The HealthCare USA Community Development Team identifies members who lack access to dental services and offers them the opportunity to be a part of our "Doc Bear's Dental Days." At designated days, a Community Development Specialist and "Doc Bear" are present at a participating network dental office or at a FQHC/RHC to welcome our members, answer any questions and provide support during the office visit.

HealthCare USA piloted the 'Doc Bear Dental Day' program in Marion, Cole, Benton, Cass and St Louis counties and determined that 85% of the members keep their scheduled appointments when scheduled for "Doc Bear Dental Days. Based on



the success of the program, we plan to expand this program to all managed care counties, assisting members to access dental care and helping providers decrease “no shows.”

- **Mobile Dental Units.** This program became effective in 2003, targeting school aged children. Bringing mobile dental units to rural areas helps address the barriers to care frequently identified within urban communities. These barriers include: 1) a lack of transportation to and from dental appointments, 2) diminished comfort level with the traditional dental office and 3) the inability to attend appointments during regular business hours. In order to overcome these barriers, DentaQuest and HealthCare USA recognize the value of dental professionals providing care in school-based settings. To encourage such activities we have actively partnered with schools to provide comprehensive dental services directly to HealthCare USA members.
- **School-based Programs.** In order to overcome the above mentioned barriers, DentaQuest and HealthCare USA recognize the value of dental professionals providing care in school-based settings. To encourage such activities we have actively partnered with schools to provide comprehensive dental services directly to HealthCare USA members. We provide dental education and provider information to the school nurses and school counselors. We also provide each individual in attendance with a dental resource bag that includes a tooth brush, floss, educational “noodle soup” *Taking Care of Young Children’s Teeth*, and *The Importance of Baby Teeth and Children’s Oral Health Fact Sheet* (all marketing materials are State approved).
- **Collaboration with Dental Schools.** This program specifically targets children in the Kansas City metropolitan area. DentaQuest has successfully partnered with the University of Missouri Kansas City School of Dentistry to provide essential dental specialty services to HealthCare USA members. University of Missouri Kansas City School of Dentistry currently houses over 300 state of the art operatories ensuring patient comfort and quality of care.
- **Community-based Programs.** We partner with agencies such as the Salvation Army or the United Way provide tooth paste, and DentaQuest provides infant tooth brushes at our HealthCare USA Outreach events and Early Head Start educational programs in Boone, Cass, Henry and Franklin Counties.
- **Community Grant Projects.** DentaQuest provides services in rural communities through the following community grant projects:

Katy Trail Community Health Center, Sedalia MO. Katy Trail Community Health Center services as a health care home to HealthCare USA members in West Central Missouri. Katy Trail was founded in 1999 by concerned citizens who recognized the need for affordable care. Katy Trail provides comprehensive medical and dental services to members.

In 2010, DentaQuest provided sponsorship in Katy Trail’s Community Champions Program to assist Katy Trail in expanding the services that they can offer to community members.



Missouri Mission of Mercy, Springfield MO. Located in Greene county which is contiguous to our Western region, Mission of Mercy programs have been identified as a best practice across the country to deliver dental services to the underserved. In 2011 Missouri had our inaugural Mission of Mercy event; the Missouri Mission of Mercy (MOMOM). The MOMOM event was a charitable dental clinic whose goal is to provide needed care to the underserved.

Programs in Urban Areas

In urban counties across the State of Missouri, DentaQuest focuses efforts on securing a variety of dental providers in order to ensure access to the comprehensive dental benefit package available to HealthCare USA members. Along with our comprehensive network, we provide services in urban areas through the following programs:

- **Healthy Beginnings Program.** This program targets population: children ages 0-5. While HEDIS scores have dramatically improved for HealthCare USA members over the past three years, there is an opportunity for improvement with dental access for young children enrolled in HealthCare USA. DentaQuest's Healthy Beginnings Program provides member and provider education in order to demonstrate the importance of proper dental care for infants and children, provide education to parents/caregivers of members about preventing baby bottle decay and provide parents/caregivers of members with tools to locate a dentist.

School-based Programs. School-based, mobile dental units also play a critical role in the delivery of dental services especially for members living in densely populated urban centers.

4.5.4.b5 - Bullet 2 The cost effective approaches the offeror will implement, aside from transportation, to ensure that members in relatively remote counties are able to access specialty care. The offeror shall also describe the strategies the offeror will implement to outreach to specialty care providers. The offeror shall describe how the offeror will facilitate and encourage the use of non-traditional service delivery approaches, such as regional clinics utilizing shared office space and equipment with local providers on a scheduled basis, by specialty care providers. The offeror shall describe how the offeror will monitor the effectiveness of such strategies.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 2.

In conjunction with DentaQuest, HealthCare USA will introduce the following strategies to provide access to dental services in remote counties:

- **Partnership with A.T. Still University Dental School in Kirksville MO.** Our collaboration with the unique soon-to-be available program at the A.T. Still University School of Dentistry in Kirksville, MO will expand the availability of dental services throughout the region. This program trains dentists to provide care as part of community-based, dental public health. The program's Integrated Community Partnership (ICP) places students in community settings to complete a



portion of their clinical training. Beginning in 2012, A.T. Sill is planning to staff FQHCs in Adair County with students from this program.

- **Collaboration with Jordan Valley Health Center.** One of the difficulties noted across the state of Missouri are areas in which managed care counties and fee-for-service counties border each other. The primary issue is that often members living in new managed care counties are suddenly cut off from fee-for-service providers who have been instrumental in providing their care in the past. Greene County is such an area, in itself it is not a managed care county, but members in contiguous managed care counties are in a very rural area and often travel to Springfield in Greene County for services. With this in mind, DentaQuest has made great efforts in recruiting and retaining providers in Greene County. Since the introduction of managed care to this region, our dental provider network has grown from 20 providers in 2009 to 51 dental providers in 2011 in Greene County alone.

Jordan Valley Health Center is a particular success story in Greene County. DentaQuest is the only managed care dental benefits administrator contracted with Jordan Valley Health Center. Serving the third largest community in Missouri, Jordan Valley Health Center is an FQHC delivering comprehensive dental care to residents of the Southwest region of Missouri. DentaQuest will continue to work closely with Jordan Valley Health Center and the other dental providers in southwest Missouri to ensure that HealthCare USA members have access to dental services.

Outreach to Dental Providers

DentaQuest uses the following mechanisms to reach out to dental providers regarding expanding access in remote areas:

- **Local Provider Relations Representative.** The local provider relations representative can provide one on one assistance and valuable feedback to DentaQuest regarding questions or concerns that may arise.
- **Claim and authorization denial reports.** DentaQuest regularly monitors claim and authorization denial reports. If a particular denial occurs frequently for one or more providers this will result in additional training for the particular provider experiencing the denial issues and may result in additional training for the provider network in general depending upon the relevance to other providers.
- **Provider Services Call Center Quarterly Reports.** In addition to the Provider Services Call Center report required by MO HealthNet DentaQuest also monitors the nature of the calls coming into our provider call center. This allows us to provide additional education to our providers if, for instance, we notice an increase in calls regarding authorizations.
- **Quarterly Provider Appointment Telephone Surveys.** In addition to collecting appointment availability information and demographic information during our quarterly telephone calls DentaQuest representatives also inquire as to providers satisfaction and any additional education that they feel would be helpful.



- **Annual Provider Satisfaction Surveys.** DentaQuest conducts annual provider surveys in order to evaluate improvements that we can make to our provider communications and other systems. These surveys are reviewed by our Quality Improvement committee and action plans are developed in accordance with the results of the surveys.

DentaQuest Provider Web Portal. DentaQuest’s Provider Web Portal (PWP) includes a secure messaging system where providers may submit feedback directly to DentaQuest. The PWP also maintains all documents for easy provider reference.

4.5.4.b5 – Bullet 3 How the offeror will utilize telemedicine in rural areas of the State. At a minimum, the description shall include the specific strategies that will be used, purposes for which telemedicine will be used, targeted populations and conditions, and providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 3.

This question is not applicable to the Dental Care network, as dental services are not provided via telemedicine. Please see the response to 4.5.4.b.5, Bullet 3 in the Primary Care Network section.

4.5.4.b5 - Bullet 4 The specific measures the offeror will take to ensure that children and women identified as substance abusers are screened for depression and other co-occurring behavioral health conditions. The offeror shall identify the case management activities and other strategies the offeror will use to link these members to appropriate resources, including behavioral health resources. The offeror shall describe how the offeror will monitor effectiveness of care strategies. The offeror shall describe how the efforts on behalf of members in rural areas will differ from those targeted to members in more urban areas.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 4.

This question is not applicable to the Dental Care network. Please see the response to 4.5.4.b.5, Bullet 4 in the Primary Care Network section.

4.5.4.b5 - Bullet 5 How the offeror will ensure that Medicaid and CHIP children have access to child psychiatrists and psychologists for behavioral health services. The offeror shall describe how the offeror will ensure appropriate case management and coordinate behavioral health services with the delivery of other services under the EPSDT benefit.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 5.

This question is not applicable to the Dental Care network. Please see the response to 4.5.4.b5, Bullet 5 in the Behavioral Health Care Network section.



4.5.4.b5 - Bullet 6 How the offeror will address the strategies the offeror will use to identify, reduce, and monitor inappropriate hospital readmissions. The offeror shall describe to what extent these measures will differ according to populations, geographic locations, and health conditions.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 6.

This question is not applicable to the Dental Care network. Please see the response to 4.5.4.b.5, Bullet 6 in the Primary Care Network section.

4.5.4.b5 - Bullet 7 Identify the tools the offeror will use to monitor emergency department utilization and determine over utilization, and the measures the offeror proposes to combat/reduce emergency department overuse. The offeror shall describe specific measures the offeror will take in years one (1), two (2), and three (3) of the contract (assuming that the contract is extended over a three (3) year period).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 7.

This question is not applicable to the Dental Care network. Please see the response to 4.5.4.b.5, Bullet 7 in the Primary Care Network section.

4.5.4.b5 - Bullet 8 How the offeror will utilize safety net providers (e.g. FQHCs, public health departments, CMHCs) to facilitate access to needed services (including measures for identifying when safety net providers are needed and outreach to public providers). The offeror shall also address how these strategies will differ between rural and urban areas

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 8.

DentaQuest has contracted with safety net providers in our urban counties since the inception of our HealthCare USA contract in 1997. These provider relationships have continued to flourish and grow as more safety net providers have added dental clinics to their existing medical clinics. School-based, mobile dental units also play a critical role in the delivery of dental services especially for members living in densely populated urban centers.

The dental provider network in the Western region of Missouri includes key safety net providers such as the University of Missouri Kansas City School of Dentistry, Samuel U. Rogers, Swope Health Services, Jordan Valley Health Center, Truman Medical Center and Children's Mercy Family Health Partners. In addition to the traditional dental providers we have included three school-based mobile dental units in the urban counties of the Western region. DentaQuest actively collaborates with these providers and other community organizations such as Mid-America Head Start in order to ensure that the dental needs of urban members are addressed.





In all regions of the State of Missouri and regardless of whether the county is rural or urban DentaQuest understands the important role of safety net providers. Currently we contract with safety net providers across the State of Missouri and have aggressively sought contracts with safety net providers outside of the managed care health plan service area as well in order to ensure that HealthCare USA members have access to comprehensive dental services in each region across the state.

Urban Counties

DentaQuest's experience in working with safety net clinics in urban counties is that it is critical to establish a primary point of contact and regular meetings in order to ensure a clear line of communication and mutual understanding. Safety net providers truly have a passion for ensuring access to dental services for all community members and it is DentaQuest's role to provide support and assistance in order to ensure that the mission is fulfilled. To this end, DentaQuest has established regular meetings with our safety net providers to address any questions or concerns and to ensure that they are satisfied.

In the urban counties in the Eastern region DentaQuest contracts with a total of 134 safety net provider/locations available for members who reside in these counties. The services available are primarily general and pediatric dentistry and include FQHC's and hospitals.

The Western region of Missouri urban counties incorporates a total of 65 safety net providers ranging from health departments, FQHC's, hospitals and the dental school. HealthCare USA member has access to a wide variety of services including specialty services such as endodontics, orthodontics, pediatric dentistry, and oral surgery.

Rural Counties

Safety net providers are critical in order to ensure access in rural counties within the State of Missouri. As we see more and more FQHC's establish satellite clinics with dental services it is clear how important these clinics are for our provider network and for HealthCare USA's members. DentaQuest encourages the establishment of satellite dental clinics and works should to shoulder with FQHC's in rural areas. In a rural environment DentaQuest understands that it is important to acknowledge the distinction between the main site and the satellite clinics and to work closely with both facilities to ensure provider satisfaction.

In the Central region DentaQuest currently contracts with 43 provider/locations which are considered safety net providers including FQHC's and health departments. These providers cover the entire service area and extend into counties outside of the service area such as Adair and Webster. The providers at these locations offer a wide range of comprehensive dental services including specialty services such as oral surgery and pediatric dentistry.

DentaQuest contracts with safety net providers in the Eastern region of Missouri in rural counties including Franklin, Jefferson, Lincoln, St. Francois, Ste. Genevieve and Washington counties. These rural providers in the Eastern region also include FQHC's,





health departments and hospitals and offer HealthCare USA members specialty dental services such as oral surgery and pediatric dentistry.

The Western region rural providers with which we are contracted include FQHC's, RHC's, health departments and hospitals and total 79 unique provider/locations. These safety net providers are located in counties as far south as McDonald County and include border counties in the State of Kansas in order to increase accessibility and convenience for HealthCare USA members. There is a wide range of specialty dental services available at these clinics including orthodontics, oral surgery, endodontic, and pediatric dentistry.



4.5.4 Access to Care – Behavioral Health Care

4.5.4a. Behavioral Health Care Networks

The offeror shall demonstrate adequate provider networks to fulfill MO HealthNet requirements.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a).

HealthCare USA has developed a comprehensive, statewide provider network to meet travel distance and network adequacy requirements as required by MO HealthNet and Missouri Department of Insurance, Financial Institutions & Professional Registration (DIFP) in 20 CSR 400-7.095. Our Missouri provider network includes hospitals, primary care, specialty care physicians, advance practice nurses, FQHCs, RHCs, local health departments, family planning/STD clinics, vision providers, ancillary, behavioral health, substance abuse, dental health and emergent/non emergent transportation providers. HealthCare USA also includes provider types and specialties in our network such as dental health providers that are not specified in the 20 CSR 400-7.095 to ensure a comprehensive network of providers to care for our members.

This comprehensive network covers the 54 counties in the MO HealthNet Central, Eastern and Western service areas. Also, HealthCare USA is licensed in 51 additional counties outside the current service area and we have contracts with providers in the 24 contiguous counties to the service area. Our extensive network presence in Missouri will facilitate any future program expansion as a result of the implementation of the Patient Protection and Affordable Care Act (ACA). Further, as we demonstrate in the sections that follow, our current network is capable of providing care to any additional new membership we may acquire following award of this contract.

The table below presents a snapshot of our provider network throughout the 54 MO HealthNet counties as well as the contiguous counties outside the service area.

Provider Networks - Overall Counts by Category						
Provider Type	In the 54 MO HealthNet Counties				In MO Counties Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Hospital	20	32	20	72	10	82
Ancillary	267	360	139	766	136	902
PCP	537	878	341	1756	440	2196
Specialist	1284	4187	1271	6742	641	7383



Provider Networks - Overall Counts by Category						
Provider Type	In the 54 MO HealthNet Counties				In MO Counties Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Dental	87	153	193	433	123	556
Behavioral Health	313	955	615	1865	261	2126
FQHC*	8	18	5	31	55 (RHC/FQHC)	193
RHC*	65	29	13	107		
Local Public Health**	25	13	13	51	4	55
Family Planning/ST D Treatment**	2	5	1	8	3	8

* These numbers are also included in the number of PCPs.
 ** These numbers are Included in ancillary counts
 FQHC, RHC, LPH, Family Planning providers are broken out separately in this grid as they are listed on Attachments to RFP)

DATA SOURCE: COVENTRY PROVIDER DATABASE, AS OF OCT. 31, 2011

4.5.4.a1. The offeror shall submit documentation demonstrating that the offeror’s networks comply with travel distance access standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. The offeror shall also submit documentation for those providers not addressed under 20 CSR 400-7.095, ensuring members will have access to those providers within thirty (30) miles unless the offeror can demonstrate that there is no licensed provider in that area, in which case the offeror shall ensure members have access to those providers within sixty (60) miles. For any demonstrated access that differs from these standards, the offeror shall submit proof of approval of the differences by the Department of Insurance, Financial Institutions & Professional Registration.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)1.



Documentation of Travel Distance Standards

On March 1 of each year, HealthCare USA files an annual network access plan with DIFP as required by 20 CSR 400-7.095. The attached documentation from the DIFP shows that HealthCare USA complies with network capacity and travel distance standards for all provider types and specialties as required by 20 CSR 400-7.095. Specifically, this is evidenced by the first paragraph in the DIFP Network Adequacy Approval letter, dated June 6, 2011, indicating that the 2010 Network Access Plan for HealthCare USA was approved.

As the DIFP documentation illustrates, our networks have achieved **100% compliance** with network capacity and travel distance standards.

Note: HealthCare USA submits a provider file to DIFP of our dental provider network for evaluation, (which is a MO HealthNet requirement and not actually a part of the DIFP regulation) Because distance standards do not exist in the DIFP regulation for Dental providers, the following standards are used to evaluate the dental network:

- Urban county: 15 miles
- Basic county: 30 miles
- Rural county: 60 miles

DIFP has also evaluated our dental network and we have achieved **100% compliance** for dental network capacity and travel distance standards.

Geo Access Reports

In addition to the DIFP documentation, HealthCare USA conducts its own review of provider networks as part of our ongoing monitoring of travel distance and access for our membership.

We are also including a series of Geo Access maps and summary reports as Attachment 25, showing the distribution of network provider locations in relation to our current membership and evidence that our geographic distribution of providers covers the entire service area for all three regions. A separate map showing locations within a 30-mile and 60-mile radius is presented for the following provider categories, covering some of key high volume areas of concern to our population:

- RHC and FQHC
- Child PCP
- Adult PCP
- OB/GYN
- Pediatrics
- Dental
- Adult Behavioral Health
- Child Behavioral Health





- High Volume Specialist

As demonstrated in the Geo-Access maps and summary reports, HealthCare USA's vast provider network covers the entire 54 county service area and we are in **100% compliance** with network capacity and travel distance standards.

Data Source: Geo-Access Mapping Software, Coventry Provider Database, HealthCare USA Member Eligibility File
Measurement Period: October 31, 2011

4.5.4.a2. The offeror shall provide documentation verifying that the offeror's network has adequate capacity. Such documentation shall include, but it is not limited to, appointment availability, 24 hours/7 days a week access, sufficient experienced providers to serve special needs populations, waiting times, open panels, and PCP to member ratios.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)2.

In the paragraphs that follow, we describe our network capacity for the Behavioral Health Care network. This description contains an assessment of appointment availability, 24/7 access, providers serving special needs populations, open panels and waiting times in provider offices. Unless otherwise specified, the reporting period for these network compliance indicators is the end of the calendar year 2010. The reporting period for the number of providers shown in each of the tables below and on the Geo Access maps and summary reports is as of October 31, 2011.

Adequate Network Capacity and Monitoring Access to Services

Over the course of our 16 years as a managed care organization in Missouri, HealthCare USA has developed, enhanced and utilized several policies, procedures and processes to monitor our provider and subcontractor/affiliate networks to ensure adequate network capacity, accessibility for our members, and accuracy in our provider listings. Further, our network activities are designed to achieve the ultimate goal of connecting our members with a health care home so they can obtain services in the most effective and appropriate setting.

In addition to using Geo-Access for distance reviews, we use additional monitoring activities for each network category including:

- Conducting telephonic provider secret shopper surveys regarding appointment access for behavioral health providers.
- Reviewing providers' panel status to confirm if new members can be assigned and if provider has reached capacity or referral limits.
- Reviewing provider-to-member ratios by provider type and by region to ensure an adequate number of primary care providers are available.
- Following up and resolving member concerns related to access or appointment availability.





- Reviewing quarterly analysis and trending of member grievances to identify any potential availability or accessibility access issues; perform root cause analysis and develop corrective action plans, if necessary.
- Case managing members identified as utilizing the emergency department (ED) for non-emergent conditions.
- Making weekly updates to online Provider Directories to reflect changes in open/closed panels.
- Reviewing monthly provider network and recruitment activities of dental and behavioral health networks.
- Initiating independent oversight by in-network physicians that participate on HealthCare USA's Quality Management Committee of network access and availability studies conducted for primary care, specialty care, emergent care, dental and behavioral health.

In instances where a network provider cannot meet access or appointment availability standards, HealthCare USA and subcontractor/affiliate Provider Relations teams:

- Conduct provider education regarding the standards
- Work with the provider to resolve the issues
- Locate additional providers to meet the member's need
- Conduct recruitment efforts to add additional providers if the need arises

Any providers who do not meet standards are educated and re-surveyed within 30 days of the initial survey to ensure compliance with access and availability standards.

The tables below illustrate the number of physician and non-physician behavioral health providers by region within the service area and outside the service area.

Total Behavioral Health Network						
Provider Category	In the 54 MO HealthNet Counties				Counties Outside Service Area	Total Across MO Counties
	Central	Eastern	Western	Total		
Psychiatrists	75	201	142	418	53	471
Psychologists	70	165	171	406	78	484
Allied Health Professionals	307	831	509	1647	311	1958
Total	452	1197	822	2471	442	2913

DATA SOURCE: MHNET PRISIM PROVIDER DATABASE. MEASUREMENT PERIOD: OCTOBER 2011



Behavioral Health Providers Serving Children by Provider Type				
Provider Type	Western	Central	Eastern	Outside Service Area
Psychiatrist	64	24	99	
Psychologist	78	25	94	
Allied Health	218	152	530	
CMHC	5	6	5	6
Total	365	207	728	6

DATA SOURCE: MHNET PRISIM PROVIDER DATABASE. MEASUREMENT PERIOD: OCTOBER 2011

Provider-to-Member Ratio

To demonstrate the strength of our behavioral health network, we examined not only the behavioral health provider to member ratios for our current membership, but also for a projected expanded membership encompassing all MO HealthNet eligibles. To arrive at a total projected membership, we combined our current enrollment with the membership of the next largest Medicaid provider participating in the MO HealthNet program, assuming we may acquire that membership following contract award.

As the tables below illustrates, our behavioral health network exceeds the provider to member ratios across all regions, both for our current membership and for a projected expanded membership consisting of all MO HealthNet managed care eligibles and due to health care reform:

The tables below show the provider to member ratio standards for our behavioral health network provided by our affiliate, MHNnet using the standard of 1: 10,000 for behavioral health providers:

Overall Behavioral Health Provider to Member Ratio (Standard = 1:10,000)				
Using	Western	Central	Eastern	Overall
Current Membership	51	109	131	102
Growth Membership*	142	223	192	182
HealthCare Reform Membership**	169	292	253	234

*Adding membership of next largest MCO in each region
** Adding the Healthcare reform membership estimated for current ME codes to Growth membership (current HealthCare USA plus membership of next largest MCO)

DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, MHNnet PRISIM PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE. MEASUREMENT PERIOD: AS OF OCTOBER 2011



Behavioral Network Provider to Member Ratio by Provider Type (Standard = 1:10,000)			
	Current BH to Member Ratio	Growth* BH to Member Ratio	Reform** Growth Membership to BH Provider Ratio
Psychiatrists	82	167	219
Psychologists	308	451	595
Allied Health Professionals	19	53	63
Total	77	138	177

**Adding membership of next largest MCO in each region
 ** Adding the Healthcare reform membership estimated for current ME codes to Growth membership (current HealthCare USA plus membership of next largest MCO)

DATA SOURCES: COVENTRY MEDICAID HEALTHCARE REFORM MEMBERSHIP ANALYSIS, MHNET PRISIM PROVIDER DATABASE, HEALTHCARE USA MEMBER ELIGIBILITY FILE
 MEASUREMENT PERIOD: AS OF OCTOBER 2011

Appointment Availability

The table below shows our most current behavioral health compliance with appointment standard requirements. The benchmark listed is the MO HealthNet MCO HEDIS Average. The figures for seven-day follow-up appointments are based on HEDIS criteria that define members with a mental illness. The HEDIS criteria requires the measurement of the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

To improve these rates, MHNet will implement initiatives such as face-to-face discharge planning and forwarding profiles to high volume hospitals.



Behavioral Health Appointment Compliance Rate			
Appointment Standards	Central	Eastern	Western
MO HealthNet MCO HEDIS Average (Benchmark)	39.8%	42.7%	48.4%
After care appointments within 7 calendar days after hospital discharge	50%	47.55%	59.11%

DATA SOURCE: MHNNet COVENTRY DATA WAREHOUSE, HEDIS REPORT . MEASUREMENT PERIOD: 2010

24/7 Access to Care

MHNNet licensed Care Advocates are available 24 hours a day, 7 days a week to handle after-hours calls. This service includes a crisis hotline staffed by licensed clinicians to ensure members are supported and directed to appropriate services. MHNNet will begin monitoring provider after-hour availability in January 2012 by placing secret shopper calls to provider offices as part of their quarterly provider accessibility surveys.

Providers to Serve Special Needs Populations

MHNNet maintains a roster of behavioral care providers who treat special needs children and adults. These providers have training to handle many behavioral health conditions such as depression, bi-polar conditions, autism spectrum disorders, and ADHD.

As part of the recruitment and credentialing process, MHNNet identifies the capabilities of each provider office including determining if provider has the training and office to accommodate the treatment of members with special needs.

Behavioral Network Providers to Serve Special Needs Population						
Provider Type	In the 54 MO HealthNet Counties				Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Autism/Neurodevelopment Providers	58	76	54	188	N/A	188
Autism Centers	1	1	1	3	1	4
Adult Psychiatrists	51	102	78	231	N/A	309
Child Psychiatrists	24	99	64	187	N/A	251
Allied Health BH Professionals (Social)	377	996	680	2053	N/A	2733



Behavioral Network Providers to Serve Special Needs Population						
Provider Type	In the 54 MO HealthNet Counties				Outside of MO HealthNet Service Area	Total Across MO Counties
	CMO	EMO	WMO	Totals		
Workers, Counselors, etc)						

DATA SOURCE: MHNET PRISIM PROVIDER DATABASE; MEASUREMENT PERIOD: AS OF OCT. 31, 2011

Waiting Times

MHNet is required to comply with the waiting time standard not to exceed one hour from scheduled appointment time. This includes time spent in the lobby and the examination room prior to being seen by the provider. Exceptions are allowed to this standard when the provider “works in” urgent care appointments. As with our medical provider networks, appointment waiting times for behavioral care are monitored by investigating any provider quality of service complaints regarding prolonged wait time for appointments.

As shown in the table below, based on our most recent analysis of member grievances, no complaints of excessive waiting times in behavioral health provider offices (beyond one hour from scheduled appointment) were reported.

Behavioral Health Compliance Rate (as measured by member grievances for prolonged wait time)			
Office Waiting Time Standard	Central	Eastern	Western
Waiting times for appointments (not to exceed one hour from scheduled appointment time)	0	1	0

DATA SOURCE: HEALTHCARE USA NAVIGATOR REPORT ON PROVIDER QUALITY OF SERVICE ISSUE, MEASUREMENT PERIOD: 2010

Open/Closed Behavioral Health Practices

As of 2010, the percentages of open panels for MHNet’s behavioral health network were as follows:

Open Panels	Central	Eastern	Western
Psychiatrists	70%	79%	59%
Allied Health Practitioners	75%	90%	54%

DATA SOURCE: MHNET PRISIM PROVIDER DATABASE MEASUREMENT PERIOD: 2010



At times a provider may ask to be placed on a “Do Not Refer” (DNR) status due to vacation, illness or other circumstances that prevent him/her from accepting referrals on a short-term basis. The Provider Relations Specialist will make note of this DNR status in the Practitioner Database indicating an “until date” when that date is known.

Additionally, providers may require a long-term DNR status, defined as exceeding sixty (60) days. The Provider Relations Specialist will make the DNR note in the Practitioner Database with the “until date” to be flagged for follow-up to return the provider to full referral status.

Our Provider Relations Specialists regularly contact providers categorized as DNR with the goal of returning the provider to full referral status as quickly as possible.

4.5.4.a3. The offeror shall describe how tertiary care providers including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists will be available twenty-four (24) hours per day in the region. If the offeror does not have a full range of tertiary care providers, the offeror shall describe how the services will be provided including transfer protocols and arrangements with out of network facilities.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)3.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4.

HealthCare USA maintains and monitors the participating provider network in accordance with DIFP network adequacy criteria. HealthCare USA is in compliance with these tertiary care requirements.

Our tertiary care provider network includes:

- Trauma centers
- Burn centers
- Level III (high risk) nurseries
- Rehabilitation facilities
- Medical sub-specialists (Pediatric subspecialty, Perinatology, Neonatology, etc)

In all three regions, our provider network maintains a full-range of tertiary care providers. Our contracted facilities are staffed with all necessary medical subspecialty providers to provide all necessary tertiary care services 24 hours a day.

Figure 4.5- 106 below shows the tertiary care hospitals located within Healthcare USA’s managed care service Area, by region shows all contracted tertiary care facilities, trauma centers, burn centers and rehabilitation facilities available in the HealthCare USA participating provider network.





Figure 4.5- 106: Tertiary Care Hospitals

Hospital	Contracted with HCUSA	Trauma Center	Level III Nursery	Perinatology Services	Cancer Services	Cardiac Services	Pediatric Sub-specialty	Burn Center	Rehab Facilities
Western Missouri Region									
Children's Mercy Hospital	Y	Level I	Y			Y	Y	Y	Y
Citizen's Memorial Hospital	Y	Level III							
Liberty Hospital	Y	Level II	Y				Y		
Saint Joseph Medical Center	Y		Y	Y		Y			
St. John's Regional Health Center (Springfield)	Y	Level I	Y	Y	Y	Y	Y	Y	
St. Luke's Hospital of Kansas City	Y	Level I	Y		Y	Y	Y		Y
Saint Mary's Medical Center	Y		Y		Y				
Truman Medical Center Hospital Hill	Y	Level I	Y						
Central Missouri Region									
Boone Hospital Center	Y		Y			Y			Y
Bothwell Regional Health Center	Y				Y				
Hannibal Regional Hospital	Y				Y				
Capital Region Medical Center	Y			Y	Y	Y			
Lake Regional Health System	Y	Level III				Y			
Rusk Rehabilitation Center	Y								Y
Phelps County Regional Medical Center	Y	Level III			Y				
Saint Mary Health Center	Y			Y	Y	Y			
University of Missouri Hospital & Clinics	Y	Level I	Y		Y	Y	Y	Y	Y
Eastern Missouri Region									
Barnes-Jewish Hospital	Y	Level I	Y		Y	Y	Y	Y	Y
Christian Hospital	Y				Y	Y			
Mercy Hospital - St. Louis	Y	Level I	Y	Y	Y	Y	Y	Y	Y
Missouri Baptist Medical Center	Y				Y	Y			
Saint Louis University Hospital	Y	Level I			Y	Y			
Saint Lukes Hospital	Y			Y		Y	Y		
SSM Cardinal Glennon Children's Hospital	Y	Level I	Y						Y
SSM DePaul Health Center	Y	Level II		Y	Y	Y			
SSM Rehab	Y								Y
SSM St. Joseph Health Center	Y	Level II		Y	Y	Y			
SSM St. Joseph Hospital West	Y	Level III		Y					
SSM St. Mary's Health Center	Y		Y	Y	Y	Y			Y
St. Anthony's Medical Center	Y	Level II			Y	Y			
St. John's Mercy Hospital	Y	Level III							
St. Louis Children's Hospital	Y	Level I	Y				Y	Y	Y
The Rehab Institute of St. Louis	Y								Y

DATA SOURCE/MEASUREMENT PERIOD: MARCH 2011 DIFP FILING

Although HealthCare USA has a full range of contracted tertiary hospitals in each region, we also understands the importance of providing primary, secondary and tertiary levels of care at hospitals that are out-of-area (“out-of-network”). If a member requires specialty care from a tertiary hospital that cannot be provided by Missouri-based tertiary hospital, HealthCare USA has written protocols for allowing members to obtain tertiary level services out of network. HealthCare USA manages these cases whether care is provided in Missouri or outside the state.



4.5.4.a4. The offeror shall complete and submit Exhibit A, documenting each FQHC, RHC, CMHC, and Safety Net Hospital proposed to be included in the offeror’s provider network.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(a)4.

HealthCare USA meets and exceeds the requirement to contract with at least one Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Community Mental Health Center (CMHC) and Safety Net Hospital in each region. In conjunction with our subcontractors and affiliate we have long recognized the key services provided by these entities in underserved areas of Missouri and have established collaborative relationships with them.

The tables below reflect a summary of HealthCare USA contract status with each FQHC, RHC, CMHC and Safety Net Hospitals listed in Exhibit A. The completed Exhibit A is included Volume 2 of our response.

Total Number Contracted FQHC, RHC, CMHC and Safety Net providers from Exhibit A				
	Central	Eastern	Western	Totals
FQHC	6	6	2	14
RHC	47	28	28	103
CMHC	6	5	5	16
Safety Net Hospitals	1	3	2	6

4.5.4b. Behavioral Health Care Access Issues

The offeror shall respond to each of the requests for information below (1-5) as it relates to each of the areas of evaluation: Primary Care, Specialty Care, Dental Services, and Behavioral Health Care.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b).



4.5.4.b1. The offeror shall describe the tailored methods proposed to meet the health care needs of MO HealthNet members. The offeror shall address how the offeror will tailor programs, business processes, and strategies for improvement to address the unique needs of the members in each region and ensure that all populations in each region have access to services. Accordingly, the offeror should not describe the following in its responses:

- Notices, mailings, information in the Member Handbook, etc. that are required under the Performance Requirements specified herein;
- Distribution of literature, practice guidelines, etc. to providers; and
- Presence at local health fairs and other typical health-and-wellness events.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)1.

HealthCare USA recognizes the unique needs of members throughout the state and has tailored our approach to providing care in each region based on those needs. We tailor programs based on the member population (children vs. adult) and based on the demographics of the region. We also give consideration to other important regional differences such as special needs, geographic conditions, socio-economic levels, cultural barriers, language needs, as well as network composition and availability of community resources.

We target local provider partners with a range of specialized expertise who are familiar with the clinical needs of our population, along with the cultural, socio-economic, and religious backgrounds of our members. This in-depth, local understanding helps us provide services in ways that address each region's specific needs.

In the paragraphs that follow, we describe the tailored programs, business processes and improvement strategies we have implemented to address the unique needs of members in each region to ensure members have access to services.

Programs

- **Telemedicine.** Among the three regions, the Central region requires the presence of more specialized programs in order to ensure member access to care. Because the Central region is mostly rural with fewer available behavioral health providers, it is the area in which telemedicine is most often used. Our telemedicine technology provides a two-way live interactive session where the patient and provider meet in a private setting. Telemedicine services are provided through advanced telecommunications technology from one location to another. Assessment and treatment information is exchanged in real-time communication from an Originating Site (where the member is located) to a Distant Site (where the MHN provider is located) allowing participants to interact as if they are having a face-to-face, "hands-on" session.

The need for specialized regional programs is not as acute in the Eastern region due to the wider availability of resources in this Region. In the Western Region, the



wide range of mental health centers and community based programs in the Central region precludes the need for specialized programs.

Business Processes

- **Network Analyses.** Provider network expansion activity is routinely analyzed and continually enhanced to eliminate access barriers. MHNet uses Geo Access and network availability reporting to identify any potential network gaps and implements recruitment strategies to enhance behavioral health provider services. MHNet also tracks and trends the use of single-case agreements (used when a member accesses an out-of-network facility or practitioner). Any pattern of out-of-network access leads to provider outreach for contracting purposes. This strategy includes ongoing augmentation of psychiatry and advanced nurse practitioner services in all regions, in addition to ancillary and facility-based providers, to better meet the medication and treatment needs of our members.

Through our network analyses, MHNet recognizes behavioral health access variations between rural and urban areas, particularly related to psychiatry and home-based services. For this reason, MHNet has implemented innovative strategies to meet our rural members' needs and address ongoing access barriers. Telemedicine services have been increased to address access barrier issues for members requiring services in the more rural coverage locations where known provider shortages exist. To further integrate behavioral health provider network development with medical services, MHNet reports and reviews these activities monthly during operational oversight meetings between HealthCare USA and MHNet. Additional action planning and follow-up related to network needs also are addressed.

- **Case Manager Co-location.** MHNet case managers are physically co-located at HealthCare USA. This organizational co-mingling improves coordination of care activity for members with medical/behavioral health co-morbidity. Currently, two MHNet case managers are located in the Eastern HealthCare USA office. In 1st Quarter 2012, MHNet will co-locate clinical staff members in HealthCare USA offices in the Central and Western regions of the state.
- **Face-to-Face Member Discharge Planning Pilot Program.** MHNet recognizes the added barriers HealthCare USA members face in terms of appropriate access to care. These barriers sometime result in significant challenges with keeping our caring hands around our members in order to support their obtaining appropriate treatment services. In effort to enhance our ability to “touch” and support our highest risk members, MHNet coordinates with several high-volume behavioral health facilities and has implemented an on-site discharge planning program involving face-to-face communication with identified HealthCare USA members.

In mid 2011, MHNet implemented enhancements to the discharge planning process in response to the identification of higher risk/complexity members who frequently failed to make their post-discharge treatment appointments.



Strategies for Improvement

All Regions

- **Network Expansion.** Expansion efforts will include:
 - Expansion of CMHC Network.** In conjunction with the state of Missouri's initiative regarding designating CMHCs as health homes, MHNNet will conduct targeted network recruitment efforts with six community mental health centers (CMHC) in Central and Eastern regions.
 - Expansion of Allied Professional Network.** MHNNet will expand the network Physician Assistants (PAs) to provide outpatient care
 - Expansion of Faith-based Initiatives.** We will emphasize increased use of faith-based and ethnic organizations to better address cultural diversity needs among the membership
- **Co-location of Mental Health Case Managers.** Currently MHNNet co-locates two mental health case managers with medical case managers in the Eastern region and plans to expand the co-location into the Central and Western Regions in 1st Quarter 2012.
- **Behavioral Health Screening Tool.** HealthCare USA has introduced the use of a behavioral health screening tool designed to increase early identification of depression by PCPs, faith-based organizations, FQHCs and RHCs.

4.5.4.b2. Given differences between urban and rural areas (e.g. population needs, access to care issues), the offeror must address how the offeror's orientation programs, education strategies, and interventions for providers and members in rural areas will differ from those used in more urban areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)2.

Over the course of the last 16 years, an integral part of our provider communication strategy has been to identify and cultivate collaborative relationships with rural providers. We have refined our processes over time to ensure that our provider and member orientation, education and communication strategy addresses the needs of providers in all settings. For HealthCare USA, whether providers are in a rural setting or an urban setting, HealthCare USA's goal is to build collaborative relationships by providing well trained, responsive and accessible Provider Relations representatives who are familiar with the unique aspects of office practice.

HealthCare USA understands that operating a healthcare delivery system in both urban and rural settings requires a different approach to programs for providers and members. For providers, conditions such as geography, local employment market conditions and access to technology affect the way they operate their practices. For members, access barriers such as lack of transportation and scarcity of providers affect their ability to get



care. Based on these differences, we have tailored our Provider Relations and Member Relations programs in ways to address these differences.

Because of the geographic distances between providers and members in rural areas, MHNet collaborates with Community Mental Health Centers and uses telemedicine techniques to a greater extent in rural areas. Both our provider and member education activities place increased emphasis on these access to care modalities.

The table below outlines the differences in our approach for urban and rural areas regarding orientation programs, education strategies and interventions for providers and members.



Behavioral Health		
Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
	Distance Site.	<p>significant transportation concerns. Telemedicine effectively removes those access barriers.</p> <p>MHNet is in the process of expanding Telehealth services with the University of Missouri to further enhance access for members in rural Missouri.</p> <p>MHNet is also expanding CMHC services across all three regions as a means of improving rural area provider shortage services.</p>
Member Orientation/Education Strategies/Interventions	Urban Approach	Rural Approach
Member Education	MHNet provides HealthCare USA with behavioral health related topic information to include in member educational materials and web-based educational information.	MHNet provides HealthCare USA with behavioral health related topic information to include in member educational materials and web based educational information.
Quality Improvement Initiatives	MHNet collaborates closely with HealthCare USA on key Quality Improvement Initiatives that involve a member educational component, such as programs related to Bipolar Disorder, Psychotic Disorder and our Post Partum Depression program.	<p>MHNet collaborates closely with HealthCare USA on key Quality Improvement Initiatives that involve a member educational component, such as programs related to Bipolar Disorder, Psychotic Disorder and our Post Partum Depression program.</p> <p>MHNet is also expanding CMHC services across all three regions as a means of</p>



Behavioral Health		
Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
Provider Relations Program	New MHNet providers receive Welcome packets and a Quick Reference Guide which provides comprehensive information related to working with our organization.	New MHNet providers receive Welcome Packets and a Quick Reference Guide which provides comprehensive information related to working with our organization.
Provider Seminars	MHNet participates with HealthCare USA in both provider and member seminars across all three regions. Provider seminar topics include Care Coordination, Depression Screening and Behavioral Pharmacy Safety.	MHNet participates with HealthCare USA in both provider and member seminars across all three regions. Provider seminar topics include Care Coordination, Depression Screening and Behavioral Pharmacy Safety.
Provider Advisory Board	MHNet sponsors a Provider Advisory Board Council and Peer Review Meeting to both solicit input from our providers on ways we can improve our services, and collaborate with providers on challenging issues. These meetings have mainly involved providers from urban areas.	MHNet sponsors a Provider Advisory Board Council and Peer Review Meeting to both solicit input from our providers on ways we can improve our services, and collaborate with providers on challenging issues. MHNet is expanding these meetings to include key providers from rural service areas during 2 nd Q 2012.
Web-based Access to Information	All MHNet providers have access to our web-based information.	All MHNet providers have access to our web-based information.
Telemedicine	Telemedicine services are provided through advanced telecommunications technology from one location to another. Assessment and treatment information is exchanged in real-time communication from an Originating Site to a	Service enhancements were made several years ago to include Telemedicine programs. This is especially needed for members living in rural areas that have limited access to providers or have



Behavioral Health		
Provider Orientation/ Education Strategies/ Interventions	Urban Approach	Rural Approach
		improving rural area provider shortage services. Greater emphasis on ethnic and cultural diversity in network development activity will occur with this initiative.

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4.5.4.b3. The offeror shall describe how its approach to service delivery will achieve optimal outcomes for the populations in each region proposed. The offeror shall describe the implications of the regional demographic data to their service delivery strategies (refer to Attachment 1).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)3.

Achieving Optimal Outcomes for Each Population

HealthCare USA, in our 16 years of serving MO HealthNet in Missouri, understands that having a provider network that complies with the access and availability standards are only the baseline. Getting members the right services, at the right time, in the right setting, to ensure optimal outcomes, requires much more. In particular, we must:

- Create provider networks to match the needs of population groups – providers best suited for the needs of one population group may not be those who are ideal for another group. This crosses multiple boundaries of service type, provider expertise, language, ethnicity, age, sex, and health status.
- Connect members to providers who meet their needs – having the right providers available in the network is the first step, but we go beyond this by working to understand the unique and individual needs of each member, then helping them choose and connect to providers to meet those needs.
- Help members communicate with providers – even with the right providers in the network, language and communication barriers can hamper effective engagement of the member in their health care. We provide the right tools and services to ensure that members can communicate – not just with customer service, *but with providers at the point of care.*
- Build cultural competency throughout the health plan and network – while choosing the right providers and connecting members to those providers is a great start, we recognize the need to evolve cultural understanding and appreciation throughout our health plan, our subcontractors, affiliate, and our network. We do so through a combination of policies, training, and ongoing efforts to improve our understanding of the populations we serve.
- Address disparities in care for population groups – all of the prior steps help generally improve awareness of the needs of member groups and individual members, but we do more by examining information on health care disparities that exist for population groups and creating initiatives to address those.

In the following sections, we highlight our approach to each of these challenges, and show how we overcome them with creative solutions to ensure that members are connected to care and engaged in understanding and participating in their treatment.



Ensuring We Have the Right Behavioral Health Providers

MHNet's comprehensive Missouri behavioral health network has over 3,055 qualified providers to capture services for child and adult members:

- 1,408 providers in the Eastern Region
- 513 in the Central Region
- 822 in the Western Region
- 355 Behavioral Health providers in contiguous Missouri counties outside of the MO HealthNet service area.

The MHNet provider network strategy combines:

- Core behavioral health services at offices and facilities
- A continuously expanding network of both individual and group specialty providers
- Multiple Community Mental Health Centers (CMHCs) and FQHCs in each region
- Home-based services
- Treatment services located at schools for children

MHNet routinely performs network analyses to ensure that our provider network remains matched to member access needs. MHNet never considers network development to be completed—rather it is an ongoing and evolving process. We are committed to the maintenance, refinement, and expansion of the provider network to meet the needs of all plan members.

MHNet also targets recruitment efforts to meet identified population needs – such as languages spoken and ethnicity. When we gather this information during the credentialing process or through other means, it is captured into our provider database, which is easily accessible by our staff for use in matching members to providers.

We strongly support the use of local and community-based CMHC programs and services. MHNet currently has five CMHCs in the Eastern region, six in the Central region, and five in the Western region. CMHC services are vital components of the overall service delivery system, providing a wide array of behavioral health and support services to our member demographic across all regions.

One additional service that has become increasingly important to our comprehensive approach at delivering services to our members is the use of Telemedicine. This is particularly vital for behavioral health services due to health professional shortage and medically underserved areas in Missouri. Use of telemedicine services is most frequent in the Central region due to a member demographic which involves increased rural and remote access issues.

Facilitating Access to Appropriate Behavioral Health Services

MHNet, our Behavioral Health affiliate, provides intensive Case Management services to help ensure that members with high-risk, complex conditions are matched to all of the services they need to ensure an optimal outcome. Our physical health and behavioral





health case management team ensures that we address the full spectrum of physical and behavioral health needs. Below, we present four true stories (with member information shielded) showing the typical types of case management activities provided.

Averting a Crisis for a Mother and Her Children

A 28 year old female member in the Eastern region was in the HealthCare USA high-risk OB case management program, because she recently had a baby and was experiencing changes in her mental status, including paranoia. Our case manager consulted and coordinated with MHNet to further assess behavioral health needs. The member was so sensitive that she would not speak with a MHNet Intensive Case Manager until after she was admitted to the hospital for an evaluation and treatment. She became so anxious she took her children to St. Louis Children's Hospital because she thought that they were in harm's way. We coordinated care to make sure she was safely admitted to the hospital, and we also made arrangements to ensure her children were well cared for. The member was diagnosed with a post-partum psychotic disorder.

The HealthCare USA case manager coordinated the involvement of a MHNet Case Manager, who was able to earn the member's trust. Our integrated approach averted a possible poor outcome for the member and her children. We worked with the member and her treatment team to identify appropriate providers, and develop a safe treatment plan for her successful discharge. The plan included home-based behavioral health services, community based psychiatry, and support services for aftercare. The member has been following through with all treatment recommendations and has not been readmitted or suffered from any further psychotic symptoms. She is also effectively parenting her children.

Stabilizing an Adolescent Member

An adolescent male in the Eastern region was referred to the MHNet Intensive Case Management program subsequent to multiple psychiatric hospital admissions and a failure to follow through with his established treatment plan. The member had been home schooled because mother did not like public education. His behaviors became increasingly aggressive and unpredictable.

The assigned MHNet Case Manager maintained regular contact with the member's mother, who was very active in the case management program and appropriately concerned about obtaining needed services. These positive parenting characteristics were supported throughout the process as being vital to his ongoing recovery. One of the objectives in the case management treatment plan was to find appropriate external peer support and age appropriate socialization activities for the member. MHNet identified community supports and helped the member get engaged in church and other appropriate community based programs. For instance, MHNet referred the member to a program that taught how to repair bikes and computers, and then he received one of each. The MHNet Case Manager also coordinated with HealthCare USA to provide free vouchers for community activities. The Case Manager also educated the mother about the medications the member was prescribed to make sure she would support his continued adherence with treatment. The member successfully completed the Case



Management program and improved his level of functioning while avoiding additional psychiatric hospitalizations.

Addressing Multiple Behavioral and Substance Abuse Issues

This young adult female member was admitted to the MHNet Intensive Case Management program subsequent to a mental health-related hospital readmission and history of overdose attempts. She lived in a rural area in the Western Region. She was recently separated from her husband and was living with her mother who was a positive source of support.

The Case Manager supported her treatment plan with recommendations to decrease levels of care more slowly and engage in Partial Hospital and Intensive Outpatient services post discharge. Through ongoing communication with the member, the MHNet Case Manager found the member had a previously undisclosed substance abuse problem, which was inhibiting her ability to succeed in treatment. The Case Manager facilitated additional treatment with a local CSTAR Program, which the member successfully completed. The Case Manager also identified a more clinically appropriate therapist who was able to build trust and identified early childhood abuse/trauma issues that were never disclosed or addressed in previous treatment attempts. Her outpatient treatment was increased to multiple visits per week to support her through the process and to prevent the need for more acute services.

The member has reconnected with her husband and her child. MHNet continued case management based on the member's acute utilization history to ensure success. The member remains in recovery from substance abuse and has been adherent with her treatment plan.

Managing Cultural and Linguistic Needs in a Behavioral Health Case

This adult female member is married with four children. MHNet identified that the member needed case management due to hospital readmission for depression, psychosis, suicide ideation, and a suicide attempt by overdose. The member's family is from Jordan and she speaks Arabic with English as second language. She reported having no friends and no support system outside of the home. Compounding the problem, she felt shunned by the community and was having difficulty caring for her four children. In addition, she was not taking her depression medication on schedule.

As the Case Manager developed the member's care plan, an important objective was to develop a support system, as this was a major contributor to the member's depression. MHNet coordinated with the International Institute of St. Louis for support services including counseling, ethnic/culturally focused support groups, and English as Second Language classes. The member continues to receive support services from International Institute specifically for immigration issues. The Case Manager also connected her to Places for People, a community mental health agency, for targeted case management services. She participated in their ACT program, an intensive case management program in which she received in-home visits by nurses and social workers three times per week.

Other objectives of the member's care plan included regular attendance at her outpatient therapy appointments and improved adherence with treatment recommendations. The





Case Manager arranged interpreter services for each of the member’s therapy and psychiatry appointments to ensure she was able to communicate effectively with the providers. She was also supported with a home-based therapist for weekly visits. The MHNet Case Manager helped connect the member to housing assistance, transportation, and utility assistance resources and was actively involved with on-site agency case staffing meetings, which included the member.

The member continued to receive community based services with Places for People’s ACT program for intensive services. She also obtained low-income housing assistance. The member significantly improved her medication schedule (although at times she misses her daily dosing due to fasting, which is culturally motivated). The member has developed and maintained an appropriate support system and is much more comfortable explaining her symptoms. She continues to learn positive coping skills in therapy and has not been readmitted to the hospital.

Behavioral Health Interpretation and Translation

As our affiliate, MHNet uses the same Language LineSM service as HealthCare USA for telephonic communication with our members who do not speak English as their primary language. When a member needs individual therapy and MHNet is unable to match a member to a provider who speaks their primary language, MHNet contracts with an outside interpreter service to ensure there are no communication barriers.

Figure 4.5- 107: MHNet Members/Providers Speaking Non-English Primary Languages

Language other than English Spoken at Home	Other Primary Languages Spoken	Percentage of members who speak other languages	Percentage of MHNet Practitioners that speak this language
5.6%	Spanish	2.6%	1.5%
	Indo European Languages	1.8%	3.9%
	Asian and Pacific Languages	1.0%	0.8%
	All Others	0.3%	0.4%

MHNet Analysis of Percentages of Members and Providers Speaking Various Primary Languages (Other than English) in Missouri.



In 2010, MHNet continued to expand the number of practitioners speaking other languages to accommodate the growing variety of other primary languages spoken in Missouri.

Figure 4.5- 108: MHNet Providers in Missouri Who Speak Languages Other Than English

Other Primary Languages Spoken	2008	2009	2010
Spanish	73	83	89
Indo European Languages	212	227	228
Asian and Pacific Island	40	44	46
All Others	23	26	26

MHNet is Increasing the Number of Providers in Missouri who also Speak Languages Other than English

MHNet will continue to base provider recruiting on membership needs, including analysis of languages spoken by members. A practitioner database allows MHNet staff to match members to practitioners not only by gender, age, professional specialty, and geographical area, but also by cultural, ethnic and linguistic needs. MHNet trains staff to ensure these preferences are identified when a member calls for a provider referral.

Member satisfaction surveys indicate we are culturally competent, as well; in the most recent member satisfaction survey, the response to the question about whether the provider met their cultural, ethnic, and/or communication needs was 88 percent. MHNet continually recruits providers with specialty, language, ethnic, cultural, and religious sensitivity to match the current membership specifically in areas of new business to match the population needs.

Serving Behavioral Health Needs in a Culturally Competent Manner

As indicated earlier, MHNet is currently developing a comprehensive cultural competency program that meets the requirements of the NCQA Standards for Distinction in Multicultural Health Care. MHNet addresses other aspects of cultural competency, including the following:

- **Education.** Annually, all MHNet staff receive cultural competency training. Supervisors call monitor staff interactions with members to identify opportunities for improvement in service delivery. In 2012, MHNet will expand its training program to encompass community agencies and providers to enhance the service delivery model.
- **Analysis.** Thoughtful assessment of member population characteristics is needed for MHNet to meet the needs of a diverse population. These specialized needs define the



diversity of the member population. Member population diversity characteristics include age; gender; geographical location; employment; ethnicity; creed; educational level; language; previous and current physical and behavioral health disorders; health risks; and issues identified by the community. Once the diversity of the member population is defined, using multiple data sources, MHNet can assess the adequacy of its efforts to accommodate member diversity and can develop or modify activities to address identified deficiencies.

Behavioral Health Treatment Rates (Behavioral Health)

The most significant disparity in behavioral health is among African Americans. Per the Centers for Disease Control and Prevention (CDC), African Americans are more likely to experience a behavioral health disorder than other populations. African Americans are also less likely to seek treatment. When they do seek treatment, they are more likely to use the emergency department for behavioral health care and more likely to receive inpatient psychiatric care than Caucasians.

The most common barriers to treatment are: 1) stigma associated with being under treatment for a behavioral health condition; 2) individuals are unappreciative of treatments.

Interventions

To address this disparity, our behavioral health affiliate, MHNet, will initiate a program to decrease disparity. This program will include the following interventions:

- Partnership with community agencies and social organizations to promote education about behavioral health conditions with materials targeting African American audiences
- Increase minority provider recruitment efforts to encourage access to care
 - Conducting network development to address the broader ethnic diversity of members in the Eastern Region
 - Expanding both alternative and traditional services in the Central region to better address challenges related to rural and remote member access
 - Conducting analysis of needs, and developing the network for Spanish-speaking behavioral health providers in the Western region to engage this member group in needed behavioral health services
- Provide cultural competency provider training to help members feel more comfortable and confident in accessing care
- Provide ongoing MHNet staff and clinician training on cultural competency to provide better member support
- Measure the ratio of African Americans accessing care to identify further opportunities for improvement





4.5.4.b4. The offeror shall describe targeted initiatives proposed to meet the requirements of the contract. The offeror shall describe how the offeror will meet members' physical and behavioral health care needs in a coordinated and integrated manner as described per the contract requirements regarding provider network, access standards, quality assessment and improvement, case management, disease management, behavioral health and dental services.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)4.

Targeted Initiatives

HealthCare USA strives to continuously improve member health outcomes while using health care resources wisely and being cognizant of the need to manage costs effectively. Accordingly, we have had various ongoing initiatives that address member needs for coordination and integration of physical and behavioral health care. We will continue many of these initiatives and launch others to continue to improve quality. In this section, we describe initiatives in four major areas, with respect to the providers and members served:

- Behavioral Health: Expanding and Improving Access to Behavioral Health Services
- Specialized Providers: Initiatives for Members with Special Health Care Needs

For the initiatives described in this section, we address various considerations, including those for the provider network, access to care and connecting members to the right provider, assessing and improving quality, coordinating and integrating care through effective case management and disease management, and ensuring access to and coordination of behavioral health and dental services.

Behavioral Health: Expanding and Improving Access to Behavioral Health Services

MHNet, our co-located Behavioral Health affiliate, has developed and initiated several targeted and clinically tailored health care initiatives to improve coordination of care and health outcomes for the members of HealthCare USA. These initiatives are both data driven, (that is, based on diagnosis, cost, and utilization trends) and creatively relevant to specific member needs. There are eight specific initiatives, as follows:

- CALOCUS: Preventive Health Program
- Face-to-Face Member Discharge Planning Pilot Program
- Bipolar and Psychotic Member Safety and Clinical Intervention Programs
- Bipolar Children – Reduction in Admission Rates
- ADHD Quality Improvement Program
- Intensive Case Management for High-Cost Members
- Provider Network Expansion



- Integrated Physical and Behavioral Health Care Coordination

We describe these initiatives in the following sections.

CALOCUS: Preventive Health Program

The Child and Adolescent Level of Care Utilization System (CALOCUS) is a method of quantifying the behavioral health clinical severity and service needs of children and adolescents. MHNet will use CALOCUS to assess HealthCare USA children (under age 18) with psychiatric disorders, substance use disorders, or developmental disorders. We use the results to determine the appropriate level of care when services are requested.

MHNet has also developed an innovative approach in using two specific CALOCUS sections to identify members who are at risk of recidivism or poor treatment adherence, due to limited family support. During review of higher risk and mainly hospital-based cases, MHNet identified a key risk factor related to the effectiveness of the home environment. In response, MHNet initiated identification of members ≤ 18 years of age that have scored at Level 4 or higher on the CALOCUS for *Recovery Environment-Level of Stress* and *Recovery Environment-Level of Support*.

Interventions include outreach to these members and their families to offer additional education about available resources, case management support, behavioral health treatment services (including home-based services), and wrap-around community-based services. The program's goals are to identify at-risk children to reduce recidivism to acute levels of care, increase treatment compliance, and strengthen the family unit.

MHNet is currently working to measure outcomes from these interventions. However, there does appear to be a positive impact related to reduced readmissions and improved adherence to ambulatory treatment planning for the members in this program. Member satisfaction with case management is also high.

Face-to-Face Member Discharge Planning Pilot Program

We recognize the barriers that members face in terms of appropriate access to care – though providers might be readily available, members often do not know how to use the system appropriately, or face other challenges in getting care. Particularly with higher risk members, we must implement additional measures to support members in making healthy decisions. While MHNet's HEDIS follow-up after hospitalization rates are among the highest in Missouri, MHNet identified an opportunity to improve member access and thus the rate.

In mid-2011, MHNet implemented enhancements to the discharge planning process in response to the identification of higher risk/complexity members who frequently failed to make their post-discharge treatment appointments. By profiling members using these types of indicators, we can anticipate which members are less likely to adhere to recommended treatment. MHNet case managers, using these predictive indicators, conduct on-site visits with members and the treatment team at the hospital prior to discharge to review the treatment plan, remove any identified barriers, and ensure members and their support system understand and are engaged with the treatment plan. We also provide scheduled appointments so that members have appointment



information before they leave the facility. After the member has been discharged, the case manager contacts the member and the provider office to ensure follow-up occurred as planned.

To facilitate this process, MHNet coordinates with several high-volume facilities and has implemented an on-site discharge planning program that allows face-to-face communication with identified HealthCare USA members. Through direct contact with members, parents, families, and facility treatment staff, we can improve member adherence with the treatment plan and follow-up care. The result is an improvement in health outcomes and reduced readmissions/recidivism.

Specific actions and approaches of the initiative include the following:

- Personalize the case management process with face-to-face interaction with identified members to promote self-responsibility for positive outcomes and increase member engagement with the treatment plan.
- Analyze the needs of the member and family, and coordinate with the facility treatment team to provide appropriate referrals and resources that meet the member's specific needs.
- Promote the use of available community resources and self-help approaches.
- Collect relevant member demographic data that will be used in follow-up care and case management activity via continued telephone calls, letters, and e-mail (as appropriate).
- Improve goodwill between the hospitals and MHNet/HealthCare USA by giving assistance to facility Social Workers, Discharge Planners, and Utilization Review staff via on-site support with the discharge planning process.

Bipolar and Psychotic Member Safety and Clinical Intervention Programs

Based on a review of utilization and cost trends, MHNet identified Bipolar Disorders as one of the fastest growing diagnoses among HealthCare USA members. While many external studies have reported similar trends, this finding confirmed that a specific initiative would be appropriate for implementation in Missouri. To address this issue, MHNet has developed and implemented two creative interventions to address the growing trend and to ensure identified members receive the best practice treatment approaches.

Patient Safety Model – Outreach and Education

This program is focused on a patient safety model involving outreach and education to both providers and members. In this program, MHNet mails an approved member educational letter and brochure and a prescribing provider letter, for those members who are receiving mood-stabilizing medications. We target this outreach to both psychiatrists and non-behavioral health prescribing providers and their members for those members who are not receiving BH therapy services.

MHNet projects the first year total members impacted by this initiative will be approximately 500, and roughly 350 prescribing physicians. Objectives are to:



- Increase member penetration to appropriate ambulatory behavioral health therapy services
- Slightly increase some member access to intensive case management services
- Reduce overall readmission rates.

High-Risk Child Members

This program focuses on HealthCare USA child members who have been identified as having a Bipolar Disorder diagnosis and are high risk based on a history of access to acute behavioral health services and low adherence to their post-discharge treatment plan.

MHNet has partnered with a large residential treatment program to enhance treatment services for members who have been identified as complex, but not acute, for a variety of health, societal, or familial reasons. These members need more than the traditional acute intervention and require additional alternative treatment services to best meet their needs. Short-term residentially based programs provide that extra service and allows for a longer needs-assessment and treatment planning timeframe. This service encompasses a family educational and treatment component to ensure a systemic approach. We will also apply intensive case management services as appropriate to ensure coordination of the overall set of services.

Bipolar Children-Reduction in Admission Rates

In recent years, the rate of bipolar disorder diagnoses for children has been increasing. Most of these children have chronic behavioral issues that cannot effectively be treated in a traditional inpatient setting. MHNet has initiated a program for these members to be admitted to a residential facility for a period of 30 days. While in the residential facility, the member can attend individual therapy sessions, group therapy, family sessions, recreational activities, etc. to address specific issues. This intensive approach helps prevent chronic readmissions to inpatient hospitals. MHNet coordinates with the facility to gather current clinical information and ensure that member goals are being attained.

Our goal is to reduce the overall cost of care for the identified members by 20%. In the baseline year, 2010, we estimated that we would enroll 15 members into this program. The success of this program is measured not only by cost reduction for the members but also on their readmission rates after this intervention. Thus far, MHNet has enrolled 19 members into this program, with 6 members declining enrollment. As shown in Figure 4.5- 109, outcomes to date are very promising in terms of clinical impact and reduced admissions to acute care.

Figure 4.5- 109: Interventions with Children Who Have a Bipolar Diagnosis are Effective at Reducing Acute Care Admissions

Average Member Age	14 years
Gender	74% Male
Average # Inpatient	4.12



Admissions prior to intervention	
Average # of Inpatient Admissions post intervention	1.89
Admission Rate	Down 54%

ADHD Quality Improvement Program

Research shows that a combination of psychopharmacology and psychotherapy is most effective in treating psychological disorders including ADHD. National Institute for Mental Health NIMH reports that, for some outcomes that are important to a child’s daily functioning such as academic performance and familial relations, the combination of behavioral therapy and medication was necessary to produce improvements. Further, a combination program allows the child to be treated with somewhat lower doses of medication (NIMH, 1999). So, even when children are receiving services through MHNet, we want to ensure that their parents are accessing available assistance for coping with ADHD. By offering enhanced and comprehensive services to children with ADHD as well as their parents, we increase the efficacy of treatment for the affected children.

MHNet identified this activity as an opportunity to promote the continuity and coordination of member care between behavioral healthcare providers. MHNet receives pharmacy data from HealthCare USA regarding members who have filled a prescription for ADHD medication. Those members receive an outreach from MHNet, providing education and resources on ADHD, as well as promoting engagement in family therapy. MHNet also notifies the current prescribing provider of this outreach to the member, and sends the provider a copy of the educational materials. This notification improves engagement by encouraging providers to review the information with the member, as well as encouraging participation in family therapy. There are no differences in this program for members in rural vs. urban areas.

To measure the improvement, MHNet annually monitors the proportion of eligible ADHD families who complete an initial psychotherapy session **and**:

- At least one follow-up psychotherapy session with an in-network behavioral healthcare practitioner
- At least two follow-up psychotherapy sessions with an in-network behavioral healthcare practitioner
- Three or more follow-up psychotherapy sessions with an in-network behavioral healthcare practitioner

Intensive Case Management for High-Cost Members

Typically, a relatively small number of members use treatment services in a manner that increases costs, and may not provide the most effective outcomes. To address the needs



of these members, MHNet has implemented a health care initiative to intervene clinically with these members.

The initiative identifies HealthCare USA members with behavioral health spending of \$8,000 or more per quarter. These member's cases are referred to case management for review to ensure that each member is receiving behavioral health treatment services and care coordination most appropriate to his or her health care needs. Since the recent inception of this program, of the 22 HealthCare USA members identified as meeting the intervention threshold, 50 percent have engaged in the MHNet intensive case management program.

Provider Network Expansion

As part of ensuring that we minimize barriers to care for members, our behavioral health affiliate, MHNet, continually works to augment its behavioral health provider network. MHNet has several current initiatives:

- Recruitment of Physician Assistants (PAs) to provide outpatient care
- Expanding network availability with additional CMHC services in all regions
- Network expansion initiatives emphasizing increased use of faith-based and ethnic organizations to better address cultural diversity needs among the membership; this will include providing community partners with a screening tool to help them help us identify behavioral health issues. For example, religious leaders are often the first “go-to” for a member, especially depending on culture. Our tools will help leaders identify when to refer a member to us and/or recommend the member self-refer.

Integrated Physical and Behavioral Health Care Coordination

In 2008, we started a trial to co-locate a MHNet case manager at HealthCare USA, alongside our care management nurses and social worker. Since implementation we have added a second MHNet case manager in the Eastern HealthCare USA office. In 1st Quarter 2012, MHNet will co-locate clinical staff members in HealthCare USA offices in the Central and Western regions of the state, as well. This approach improves communication within the care team and provides support for developing and following a holistic plan of care that integrates for physical, behavioral, sociological, and pharmacological aspects of care.

We also understand that coordination of care between medical and behavioral health treatment services is important in addressing all of the member's needs. MHNet's coordination of care programs keep Primary Care Physicians informed of the behavioral health services their members are receiving. These programs include:

- Mailing PCPs the member's clinical information via the Outpatient Treatment Request form (OTR). This highlights key clinical information received from Outpatient behavioral health provider services. The OTR provides the following information:

Member demographic information



- Diagnosis (Axis I – III)
- Description of symptoms
- Severity rating of symptoms
- Medication information
- Type of services received
- Health status (i.e. if member is pregnant)
- BH Provider information

- Notifying the member’s PCP and sending him or her discharge information when a member is discharged from a behavioral health admission. The PCP Discharge Letter shares key information that includes: member name, DCN#, Provider Facility information, date of admission/discharge, and diagnosis. This keeps the PCP informed about the member’s treatment status, particularly for those members who have accessed the most acute/emergent level of care. Accordingly, the PCP can coordinate appropriate follow-up care or changes to the treatment plan to ensure that the member remains stable
- In addition to maintaining useful clinical and newsletter information in a dedicated PCP section of the MHNet website, MHNet and HealthCare USA will coordinate to distribute and make available to PCPs a Depression screening tool (Screening for Depression in the Primary Care Setting) to assist in identifying members with behavioral health concerns and how to make a referral for mental health provider assessment and treatment services. The screening tool is based on the current DSM criteria for Depression and includes an easy to use scoring mechanism to help drive referrals when appropriate.

MHNet
BEHAVIORAL HEALTH

Mental Health and Substance Abuse Services for Members

Screening for Depression
in the Primary Care Setting

- Persistent sad, anxious, or “empty” mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities
- Decreased energy, fatigue, being “slowed down”
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Thoughts of death or suicide or suicide attempts
- Restlessness, irritability

_____ **Total number of boxes checked**

If **five or more** of these symptoms are present every day for at least two weeks and interfere with routine daily activities such as work, self-care, and child care or social life, an evaluation for depression is indicated.

Physician Referral is not required
Members or Providers can contact MHNet directly for referral:
1-800-377-9096

Screening tool from National Institute of Mental Health (NIMH), with web: <http://www.ocrhs.us.gov> Mar, 2003

Specialized Providers: Initiatives for Members with Special Health Care Needs

Members with Special Health Care Needs represent the most complex spectrum of health care needs. These members often have multiple chronic, co-morbid conditions; use services overall at a higher rate than the general member population; and may use emergency department services at a higher rate than the general member population because of instability in their physical and behavioral health status. By creating specific initiatives to meet the needs of this population, we can stabilize or improve their overall status, potentially improve their well-being and social functioning, and realize improved cost control as a result, using health care resources in the most effective way. HealthCare USA’s initiatives for this population address the following:



- Network – designing a health care network to address the specialized provider requirements for Members with Special Health Care Needs
- Case Management – ensuring that we quickly identify and assess Members with Special Health Care Needs and quickly connect them to the appropriate services for their needs

In the following sections, we address these two aspects within the behavioral health service area needs.

Behavioral Health Needs

Provider Network

MHNet’s comprehensive Missouri behavioral health network has over 3,055 qualified providers to capture services for child and adult members:

- 1,408 providers in the Eastern Region
- 513 in the Central Region
- 822 in the Western Region
- 355 Behavioral Health providers in contiguous Missouri counties outside of the MO HealthNet service area.

The MHNet provider network strategy combines:

- Core behavioral health services
- A continuously expanding network of both individual and group specialty providers
- Multiple Community Mental Health Centers (CMHCs) and FQHCs in each region.

MHNet routinely performs network analyses to ensure that our provider network remains matched to member access needs. MHNet never considers network development to be completed—rather it is an ongoing and evolving process. We are committed to the maintenance, refinement, and expansion of the provider network to meet the needs of all plan members.

We strongly support the use of local and community-based CMHC programs and services. MHNet currently has five CMHCs in the Eastern region, six in the Central region, and five in the Western region. CMHC services are vital components of the overall service delivery system, providing a wide array of behavioral health and support services to our member demographic across all regions.

One additional service that has become increasingly important to our comprehensive approach at delivering services to our members is the use of Telemedicine. This is particularly vital for behavioral health services due to health professional shortage and medically underserved areas in Missouri.

Case Management

If HealthCare USA identifies that a member with special health care needs might need behavioral health services, we will contact MHNet. MHNet screens these members to



determine level of urgency and individual health needs. With the support of a licensed behavioral health clinician (Care Advocate), MHNet will assist the member by identifying a care management team composed of medical/behavioral health providers, community agencies, support services and family/friends. This organizational collaboration improves coordination of care activity for members with medical/behavioral health co-morbidity. This approach also facilitates improved ongoing communication with the care team and provides support for developing and following a holistic plan of care.

Our Care Coordination Program is a multi-pronged approach:

- Working with HealthCare USA, CMHCs, and other Behavioral Health Providers to identify, screen, and refer consumers who have:
 - Medical issues and also have co-morbid behavioral health issues
 - Behavioral health issues and also have associated medical complications
- Notification to providers of MH/SA admit or discharge

Behavioral Health Care Advocates interact daily with HealthCare USA medical Case Managers to ensure member care is coordinated and co-morbid conditions are addressed. The entire care management team is involved in planning and decision-making and kept apprised of treatment changes and progress. We currently have two on site Behavioral Health Care Advocates on site in our Eastern region office and starting in 1st Quarter 2012, will be adding additional personnel in our Central and Western region offices.

MHNet maintains a database of all behavioral health providers in the network. This database allows customer service and clinical staff to match members to providers using a variety of criteria, including:

- Gender
- Age
- Professional specialty
- Licensure level
- Geographical area
- Cultural, ethnic and linguistic needs

Members who present to HealthCare USA or MHNet with urgent or emergent situations are immediately connected with a case manager to assess the member's level of risk and facilitate appropriate intervention. This might include urgent or emergent services that can be arranged based upon the member's specific level of intensity and treatment needs.

Customer Service Representatives can facilitate routine services by screening members about the reason for their access and any desired provider preferences, and facilitate appointments based on provider demographics and specialty areas. Members may contact MHNet at any time after they have met with their providers to request a change if, for any reason, they are not satisfied with the provider.



4.5.4.b5. The offeror shall describe the approach/strategy for each of the requests for information below. If the described approach/strategy is one currently in use, the offeror shall indicate in which program/state the approach/strategy is being used, the length of time the approach/strategy has been in effect, and the target population. If the offeror is currently operating in Missouri, the offeror shall speak to their existing experience in Missouri as well as how they will modify and expand upon these strategies for future service delivery.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5.

4.5.4.b5 – Bullet 1 How the offeror will ensure that children receive needed dental services. The offeror shall identify and describe the approach(es) that the offeror plans to implement in relatively more urban counties and contrast these with interventions that the offeror plans to use in more rural areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 1.

This question is not applicable to the Behavioral Health Care network. Please see the response to 4.5.4.b.5, Bullet 1 in the Dental Care Network section.

4.5.4.b5 - Bullet 2 The cost effective approaches the offeror will implement, aside from transportation, to ensure that members in relatively remote counties are able to access specialty care. The offeror shall also describe the strategies the offeror will implement to outreach to specialty care providers. The offeror shall describe how the offeror will facilitate and encourage the use of non-traditional service delivery approaches, such as regional clinics utilizing shared office space and equipment with local providers on a scheduled basis, by specialty care providers. The offeror shall describe how the offeror will monitor the effectiveness of such strategies.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 2.

MHNet will partner with traditional providers (primary care physicians, psychiatrists, and therapists), community agencies, in-home services and technology-based services to ensure that members are able to meet their goals towards resiliency and recovery. MHNet will initiate a database of non-traditional programs to continue to increase access to care. MHNet will explore partnering with local organizations to ensure a variety of non-traditional services exist that meet the needs of the membership.

Network expansion activity will occur with Community Mental Health Centers (CMHC) in all regions to expand service availability. CMHC availability is increasingly important to the overall service delivery system for our members, now more than ever before due to the Health Home program being implemented for MO HealthNet members.





Outreach to Behavioral Health Providers

MHNet uses the following mechanisms to reach out to behavioral health providers regarding expanding access in remote areas:

- **Provider Reference Materials.** All new MHNet providers receive Welcome Packets and a Quick Reference Guide (Provider Manual) which provides comprehensive information related to working with our organization. MHNet providers can also access the Quick Reference Guide as well as other pertinent clinical and administrative provider information and our standard forms on our web site.
- **Service Enhancements.** Service enhancements have been, and continue to be, made involving the use of Telemedicine programs. These represent key and vital services for members living in rural areas that have limited access to providers or have significant transportation barriers. Telemedicine effectively removes those access barriers. MHNet is currently focusing on improving behavioral health provider access and availability for members in provider shortage areas through the use of Telemedicine services. Communication is currently underway with the University of Missouri Health System, one of the largest providers of telehealth services in mid Missouri, to enhance member access via our telemedicine programs in the Central Region.
- **Provider Seminars.** MHNet co-participates with HealthCare USA in both provider and member seminars across all three regions, including rural counties of the service area to better connect with the needs of members and providers in remote locations.
- **Provider Advisory and Peer Review Activities.** MHNet sponsors a Provider Advisory Board Council and Peer Review Meeting to both solicit input from our providers on strategies to improve services as well as collaborate with providers on challenging issues. These meetings will include key providers from rural service areas during 2012.
- **Expanded Relationships with CMHCs.** MHNet is expanding access to CMHC services across all three regions as a means of improving overall access and availability of both traditional and alternative services, and also to further close the access barriers in remote and rural areas.
- **Hands-on Operational Teams.** MHNet has local Provider Relations, Administrative, Clinical, and Management representatives that can assist providers one-on-one.
- **Provider Newsletters.** MHNet communicates with behavioral health providers and PCPs via relevant newsletters which offer education and information on key health related topics.
- **Web-based Education.** Behavioral health and PCPs also can access MHNet's web-based educational site for clinical practice guidelines and a library of mental health related topics.

Approach to Monitoring Effectiveness

MHNet examines the following indicators to monitor effectiveness:



- Use of provider and member complaint and grievance information
- Trending provider appeal data
- Information obtained from provider on-site educational visits
- Communication with provider office administrative staff has been a very useful method of identifying issues they experience
- Information obtained during provider recredentialing processes
- Annual Provider Satisfaction Survey
- Information obtained from HealthCare USA as we communicates with provider serving both the behavioral and medical needs of our members
- Geo access and DIPF analysis results to identify gaps in service coverage areas
- Dashboard utilization and penetration reports provide trends that can be drilled down as needed.

4.5.4.b5 – Bullet 3 How the offeror will utilize telemedicine in rural areas of the State. At a minimum, the description shall include the specific strategies that will be used, purposes for which telemedicine will be used, targeted populations and conditions, and providers.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 3.

Telemedicine has been used in many countries for the delivery of mental health care, particularly psychiatric services. Telepsychiatry (TPS) and telemedicine (including psychological services) in health care is an increasingly common method of providing expert psychiatric treatment to patients at a distance from the source of care. The reasons for this include barriers to care such as members in remote locations or in rural areas where psychiatric expertise is scarcer.

MHNet has made increasing use of telemedicine services as a valuable treatment tool for both children and adult HealthCare USA members since 2009. We have found Telemedicine to be an effective treatment method that helps to close both urban and rural access gaps for many members either living in provider shortage areas or who simply have difficulty getting to an office for health care services for a variety of other reasons.

Telemedicine services are provided through advanced telecommunications technology from one location to another. Assessment and treatment information is exchanged in real-time communication from an Originating Site (where the member is located) to a Distant Site (where the MHNet provider is located) allowing them to interact as if they are having a face-to-face, "hands-on" session.

The table below lists MHNet's current telemedicine locations:



County	Facility
Adair	Mark Twain Behavioral Health
Boone	Burrell Behavioral Health - Child & Adolescent
Boone	Missouri Psychiatric Center
Butler	Southeast Missouri Behavioral Health
Cedar	SWMO Psychiatric Rehabilitation Center
Cooper	Burrell Behavioral Health
Dent	Southeast Missouri Behavioral Health
Greene	Burrell Behavioral Health
Greene	Children's Center
Henry	Pathways Community Behavioral Healthcare
Jackson	Children's Mercy Hospital
Jackson	Swope Health Center
Marion	Mark Twain Behavioral Health
Morgan	Morgan County Burrell Behavioral Health
Pettis	Pettis County Burrell Behavioral Health
Randolph	Randolph County Burrell Behavioral Health
Saline	Saline County Burrell Behavioral Health
St. Francois	Southeast Missouri Behavioral Health
St. Louis	St. Anthony's Medical Center
St. Louis	St. John's Mercy Medical Center
Vernon	Nevada Regional Medical Center
Webster	Burrell Behavioral Health
City	Facility
St. Louis City	Family Care Health Centers
St. Louis City	Grace Hill Neighborhood Health Center
St. Louis City	Saint Louis University Hospital

Behavioral Health Applications in Telemedicine

MHNet offers the following behavioral health telemedicine services provided by psychiatrists, Advanced Registered Nurse Practitioners, and psychologists:

- Consultations made to confirm a diagnosis



- Evaluation and management services
- Diagnosis, therapeutic, or interpretative services
- Individual psychiatric or substance abuse assessment diagnostic interview examinations
- Individual psychotherapy; and
- Pharmacologic management services

Any covered behavioral health diagnosis must be appropriate for telemedicine services, so members with a wide array of presenting problems can be helped. MHNet allows all necessary medication management and therapy service codes to be billed using this creative and needed treatment approach.

Targeted Population

MHNet's experience with telemedicine services suggests the vast majority of members accessing are from rural areas and mainly located within the Central region service area. While the majority of access involves rural-based barriers, we also support this treatment method for members with other access barriers.

MHNet will continue focus in improving behavioral health provider access and availability for our members through the use of telemedicine services. Communication is currently underway with the University of Missouri Health System, one of the largest providers of telehealth services in mid Missouri, to enhance member access via our telemedicine programs in the Central Region. We will continue to evaluate regional variations with regard to access needs and implement both alternative and traditional strategies to eliminate barriers to care. Refer to the response to section 4.5.49(b)5 bullet 3 for the primary care write up for info on the performance guarantee.

4.5.4.b5 - Bullet 4 The specific measures the offeror will take to ensure that children and women identified as substance abusers are screened for depression and other co-occurring behavioral health conditions. The offeror shall identify the case management activities and other strategies the offeror will use to link these members to appropriate resources, including behavioral health resources. The offeror shall describe how the offeror will monitor effectiveness of care strategies. The offeror shall describe how the efforts on behalf of members in rural areas will differ from those targeted to members in more urban areas.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 4.

HealthCare USA recognizes that major depression is a serious illness affecting 15 million Americans. Unlike normal emotional experiences of sadness, loss or passing mood states, major depression is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity and physical health. Among all medical illnesses, major depression is the leading cause of disability in the U.S. and many other developed



countries. Without treatment, the frequency of depressive illness, as well as the severity of symptoms tends to increase over time. Left untreated, depression can lead to suicide.

Provider and member knowledge related to the diagnosis and management of major depression is identified in the literature as the most prevalent reasons for poor adherence to evidence based clinical practice guidelines. HealthCare USA understands that because of their disadvantaged state, the Medicaid population experiences additional challenges and barriers to adhering to provider recommendations that are not present in other populations.

Case Management

Every HealthCare USA member being assessed for case or disease management is screened for substance abuse and depression. These assessment questions are built into each diagnosis-specific assessment in the NavCare documentation system. HealthCare USA staff refers members with depression and substance abuse to the co-located MHNNet Case Managers for assessment, interventions and follow-up. The on-site MHNNet Case Managers screen members to determine the urgency and type of services that are needed on a case-by-case basis. Referrals to treatment as well as a variety of community-based services and supports are arranged for the member. MHNNet makes appointments for members with providers and arranges for transportation services (as needed) to reduce member access barriers. Follow-up is provided to confirm members received the services they needed, and if not MHNNet continues to provide assistance in making additional provider appointments and referrals to treatment, community-based services, and other supportive services.

HealthCare USA recognizes that clinical treatment of behavioral health disorders is tailored to address the individual member's diagnosis, symptom expression, and personal circumstances. For this reason, the management interventions are tailored to the acuity of each member. These interventions include:

- **Member Education and Awareness Materials.** MHNNet has developed and implemented two new member education and awareness programs driven by the specific needs of the HealthCare USA membership. These programs are tailored to meet the educational needs of members with higher-risk behavioral health disorders, and were identified using data analytical methods specific to the Healthcare USA population. Educational initiatives related to members with Bipolar and Psychotic Disorders have been developed and approved for members. MHNNet also distributes educational information to providers as part of this initiative. Provider education is driven by the prescribing practitioner and is not limited to behavioral health practitioners, but may include Primary Care Providers and other behavioral and medical specialties. In addition to these programs, MHNNet has a long-standing member educational program related to a high-volume diagnosis: Attention Deficit Disorders. The National Institute of Mental Health (NIMH) reports that attention deficit hyperactivity disorder (ADHD) is the most commonly diagnosed disorder of children. It is estimated to affect 3 to 5 percent of school age children, with 9 percent lifetime prevalence in 9 to 13 year olds, at least one child in every classroom. Treatment of members with ADHD and their families is relevant to MHNNet and



HealthCare USA because the diagnosis represents a high volume illness. MHNet identified this activity as an opportunity to promote the continuity and coordination of member care between behavioral healthcare providers. Identified members receive an outreach from MHNet, providing education and resources on ADHD, as well as promoting engagement in family therapy. MHNet also notifies the current behavioral health provider of this outreach to the member they are treating as well as receiving a copy of the educational materials. This notification encourages the provider to review the information with the member, as well as encouraging participation in family therapy for behavior modification and parent training services – both of which are supported by clinical treatment guidelines / best practices.

- **Integrated member case management.** On-site MHNet Case Managers screen members who have been identified from various sources, including HealthCare USA medical Case Managers, having potential behavioral health symptoms to determine the nature and severity of their needs. The screening process is not limited to substance abuse and depression, but encompasses all behavioral health symptoms (substance abuse, depression, ADHD, anxiety, post-partum depression, and other behavioral disorders) in order to capture all members with co-morbid treatment needs. Screening is initially performed telephonically by MHNet followed by clinically appropriate treatment and service referrals based on the individual member's needs. Referrals are made to the MHNet provider network, CSTAR programs, and other community-based services and supports. Non-treatment related referrals also are frequently made for members with needs related to housing, utilities, child care, and a range of other requests. MHNet Case Managers follow up with members to ensure they have accessed needed care/services, and offer additional assistance as necessary.
- Members who have been identified as higher risk (i.e., pregnant with substance abuse problems, recent hospitalizations, risk/history of self-harm, etc.) are supported to engage into an Intensive Case Management (ICM) or specific health care initiatives program. These programs provide significantly more comprehensive member outreach and education, and allow MHNet Case Managers to connect with members in order to support their healthy lifestyle choices and treatment plan development/adherence. MHNet Case Managers who are co-located the HealthCare USA location closely coordinate these ICM and initiative case referrals with MHNet ICM Case Managers to ensure there is a successful transition from coordination of care protocols to longer-term intensive case management activity.
- **PCP education and awareness campaign.** HealthCare USA and MHNet acknowledges the importance of care coordination between medical and behavioral health treatment services. In response, MHNet has developed and implemented the following relevant coordination of care activities that keeps Primary Care Physicians informed of the behavioral health services their members are receiving:
- MHNet mails PCPs member clinical information that highlights key clinical information as they receive services from Outpatient behavioral health provider services. The Outpatient Treatment Request form (OTR) is mailed to PCPs and provides the following information:



Member demographic information
Diagnosis (Axis I – III)
Description of symptoms
Severity rating of symptoms
Medication information
Type of services received
Health status (i.e. if member is pregnant)
BH Provider information

- MHNNet sends PCPs notification and information when HealthCare USA members discharge from a behavioral health admission. We view this as a vital piece of information for the primary care provider to possess. The PCP Discharge Letter shares key information that includes: member name, DCN#, Provider Facility information, date of admission/discharge, and diagnosis. The objective is to keep HealthCare USA PCPs informed of their member treatment status, particularly those members who have accessed the most acute/emergent level of care.
- MHNNet distributes annual newsletters to PCPs on relevant mental health topics. A 2009 newsletter focused on the treatment of depression by PCPs. Our 2011 PCP newsletter contained detailed information about the treatment of depression and included important facts about the HEDIS quality indicator regarding follow-up after hospitalization. PCPs can view our newsletters on the MHNNet website at www.mhnet.com.

Future Initiatives

HealthCare USA and MHNNet are developing new initiatives related to reducing unnecessary emergency department (ER) access by implementing screening protocols for members identified as having an ED experience. The screening will include an assessment of depression and other mental health/substance abuse concerns. Those members who screen positive will receive outreach communication from MHNNet to identify if members have accessed BH treatment services or, if not, to assess their treatment needs and support them in accessing needed treatment and other support services.

Monitoring Program Effectiveness

HealthCare USA will use the following mechanisms to monitor program effectiveness regarding for depression and other behavioral health conditions in children and woman identified as substance abusers:

- Behavioral Health HEDIS indicators
- Overall behavioral health utilization
- NCQA indicators



- Antidepressant medication management
- Effective acute phase treatment
- Effective continuation phase treatment
- Follow-up care for children prescribed ADHD medication
- Initial phase
- Continuation and management phase
- Follow-up after hospitalization for mental illness – 7 day
- Quarterly report on disease management program for depression

Differences on Behalf of Members in Rural vs. Urban Areas

Our case management activities to address substance abuse and depression in this population are the same across all three regions.

4.5.4.b5 - Bullet 5 How the offeror will ensure that Medicaid and CHIP children have access to child psychiatrists and psychologists for behavioral health services. The offeror shall describe how the offeror will ensure appropriate case management and coordinate behavioral health services with the delivery of other services under the EPSDT benefit.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 5.

Our Team-Based Approach

HealthCare USA and MHNet, our affiliated mental health provider, uses a team-based approach in arranging and coordinating services that address the needs of each member and family as a whole. Our combined team consists of HealthCare USA's nurse case managers, special needs coordinator, concurrent review nurses and nurse disease managers, along with MHNet's case managers, discharge case manager assistants, and customer service representatives. This team works to identify barriers that impede effective treatment and devises plans to help members overcome these barriers. To further the effectiveness of our care team, team members are co-located at the HealthCare USA regional office. This approach has improved ongoing communication with the care team and provides support for developing and following a holistic plan of care.

Monitoring Access and Availability

On a monthly basis, the Joint Operations Oversight Committee and the Plan Quality Improvement Committee review behavioral health provider access and availability. As part of this review, MHNet provides updates on ongoing network development activities across regions for all provider types, including facility-based services, Community Mental Health Centers (CMHC), independent practitioners (psychiatrists, nurse



practitioners, psychologists, counselors and social workers) and school-based counseling services.

Expanded Access Initiatives

The largest identified behavioral health access challenge statewide is related to child psychiatry access. To address this need, we have implemented the following initiatives to expand access to behavioral health services for children enrolled in Medicaid and CHIP programs:

- Enhancing services to specialty advanced nurse practitioners who have collaborative practice arrangements with child psychiatrists. MHNet has been contracting with advanced nurse practitioners for the past three years. This intervention was escalated in early 2010 to increase access and availability for our members.
- Making increased use of innovative and available telemedicine services, particularly for members with rural and other access based limitations. This creative approach increases access to both child psychiatry and child psychologist services. We have utilized telemedicine services since 2009 resulting in an increase of member access seen mainly in rural areas of the Central region. We are currently collaborating with the University of Missouri Telemedicine program to expand this important treatment alternative in the Central Region.
- Expanding network availability with additional CMHC services. While we are presently in full compliance with the contract concerning CMHC access, growth with CMHC services will take on a renewed focus during 2012 with the addition of more CMHC providers and alternative services in each region. It is MHNet's intent to expand available services to all CMHCs in the Eastern, Central, and Western regions during 2012.
- Ongoing network development activity. MHNet expands access and availability to the behavioral health network on a monthly basis with a consistent trend over the past three years of network development.
- Enhanced clinical and administrative processes focused on strategies for identifying members in need of treatment and other supportive services and assisting members with access.
- Network expansion initiatives emphasizing increased use of faith-based and ethnic organizations to better address cultural diversity needs among the membership.
- MHNet is committed to dedicating resources to a new Community Liaison Resource role by 2nd quarter 2012 with the objective of increased on-the-ground service delivery development/expansion efforts, especially for service needs in more rural counties, but also to coordinate with the CMHCs and FQHCs to identify what additional creative services could be developed to promote better access and availability for members.





- In addition to these expanded access initiatives, MHNet has also implemented the following strategies to strengthen our relationships with our providers by offering higher reimbursement and reducing their administrative burden.
- **Enhanced Provider Fee Schedules.** MHNet has implemented non-standard and enhanced provider fee schedules in effort to improve provider motivation to open more of their schedules to our membership. This review process has occurred over the past years with the most recent adjustments taking place throughout the 2010 – 2011 calendar years.
- **Simplified Administrative Requirements.** Physicians no longer need to prior authorize medication management, psychiatric consultation, and certain hospital-based professional service visits (phased in from July 2010). We have streamlined our Outpatient Treatment Request (OTR) form and process to significantly reduce provider frustration (phased in from September 2010).
- **Increased Use of Home-Based Services.** MHNet is a leader in the support and use of home-based treatment services which has been proven to improve member community tenure, reduce readmission events, and improve the rate at which members follow-up with treatment after hospitalization (ongoing intervention).

Case Management and Coordination with EPSDT Services

Behavioral health members who are most at risk of poor health outcomes are those with a history of serious illness and prior hospitalizations. Access to child psychiatry and therapy services is an absolute necessity for these members. MHNet has incorporated a dedicated staff role focused on coordinating obtaining follow-up appointments for members prior to their discharge. This information is shared with the facility provider (and at times with the member in-person) to ensure the member leaves the facility with an appointment in hand. MHNet also reaches out to discharged members and their provider offices to confirm their appointment was kept. If it was not kept, MHNet will reach out to the member to assist with rescheduling their appointments. This added attention allows us to act as a personal navigator for members and improves both treatment adherence and access to needed services resulting in improved health outcomes.

Case Management programs involve active outreach to members, family/guardians, and their care providers. MHNet implements intensive case management initiatives and reaches out to higher risk members to identify and remove barriers to care, coordinate treatment services, make appointments for members, and provide education and support services. The most recent member educational initiatives occurred during the third quarter 2011 with the addition of our health care initiatives for Bipolar and Psychotic Disorders. As part of our coordination of care efforts, PCPs receive notification letters for members that have been discharged from a behavioral health admission. The PCP also receives MHNet's OTR forms which provide valuable clinical information related to the behavioral health treatment our members are receiving. This notification program was implemented during 2010. These activities pull the PCP into the care plan and foster a more integrated and holistic approach at delivering the best standard of care.



As part of the HealthCare USA Healthy Children and Youth/Early and Periodic Screening, Diagnostic and Treatment (HCY/EPSDT) well child visits and screening visit services, all identified behavioral health concerns are referred (as appropriate) to a behavioral health specialist provider, including child psychiatrists and psychologist, for follow-up diagnostic and treatment services to ameliorate any behavioral health-related issues.

The HCY/EPSDT well child visits include comprehensive health and developmental history, assessments of both physical and behavioral health developmental progress, comprehensive exams, age-appropriate immunizations, laboratory services, health education, lead/dental/vision/hearing screening, developmental and mental health screening, and fine/gross motor evaluations.

When any developmental and/or mental health concerns are identified, members are referred to an appropriate MHNet provider for further assessment and diagnostic services, including various psych testing procedures, to develop and implement a comprehensive treatment plan. Additionally, to ensure the member's PCP remains informed of behavioral health interventions and treatment services, MHNet coordinates with PCPs by sending clinical information from the behavioral health providers Outpatient Treatment Request (OTR) form to the PCP.

4.5.4.b5 - Bullet 6 How the offeror will address the strategies the offeror will use to identify, reduce, and monitor inappropriate hospital readmissions. The offeror shall describe to what extent these measures will differ according to populations, geographic locations, and health conditions.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 6.

Recent studies validate inpatient mental health admissions remain the most costly and restrictive interventions for children and adolescents with severe emotional disorders (SED). As such, readmission is a key quality indicator and a target for the implementation of strategies to identify methods to reduce the incidence. Among the factors that are associated with higher re-hospitalization rates, perhaps the most important is the role of post-discharge service planning. MHNet has implemented a variety of important clinical and administrative activities aimed at helping members access the most appropriate and least restrictive levels of care while increasing the potential for community tenure post-discharge.

Some of the most consistent predictors and identifiers of readmission include:

- Diagnosis and symptom severity
- Co-morbidity
- Suicidal behaviors
- Parental involvement and family support
- Prior hospitalization and residential stays



- Lack of post-discharge treatment
- Longer lengths of stay, and
- Medication adherence/lack thereof

Current Processes to Reduce Readmission Rates

- **Discharge Planning.** MHNet assigns a case manager and a discharge planner role to every member hospital admission. Discharge planning is initiated at the time of admission to reduce the risk of members leaving the facility without having a formalized post-discharge treatment plan in place. Our case managers and discharge planners coordinate with the hospital to inform them of any prior treatment and current providers, schedule and communicate post-discharge treatment appointments and arrange transportation as needed. Post-discharge, the MHNet team will reach out by telephone to members to support their access to treatment, make additional appointments, and will confirm the member's attendance with the provider's office. If the member did not attend the appointment, our case manager will contact the member to assist in rescheduling appointments and offer additional assistance. Documentation in our information system related to Follow-Up After Hospitalization, a key HEDIS quality indicator, allows us to track and trend compliance with post-discharge treatment services. Our goal is to ensure every member has appointments scheduled with post-discharge services (psychiatry and therapy) prior to leaving the facility.
- **On-Site Discharge Planning.** In mid-2011, MHNet implemented enhancements to the discharge planning process in response to the identification of higher risk/complexity members who frequently failed to make their post-discharge treatment appointments. Many of these members fit the predictor profile described above. Profiling, using these types of indicators, allows us to anticipate which members are less likely to adhere to recommended treatment. MHNet case managers, using these predictive indicators, make on-site visits with members and the treatment team at the hospital prior to discharge to review the treatment plan, remove any identified barriers, and ensure members and their support system understand and are engaged with the treatment plan. We also provide scheduled appointments so that members have appointment information before they leave the facility. Once discharged, the member/provider office is contacted to ensure follow-up occurred as planned.
- **Care Management Program.** Members will be identified by clinical indicators and claims data by both Medical and Behavioral Health Clinicians. Clinical algorithms have been established for screening to identify members who are in need of additional support and demonstrate a readiness for change. Members are required to agree to be a part of the program as it is member driven. These members are assigned a licensed behavioral health clinician known as a Care Advocate, who works with members to support their treatment and other needs. This service involves contact with the member's friends, which the member identifies, in order to coordinate the delivery of health services. This team will potentially consist of medical/behavioral



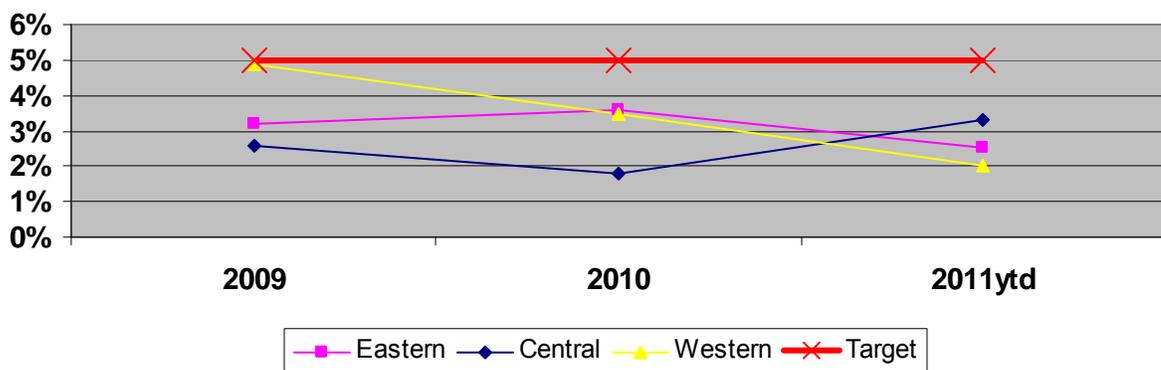
health providers, community agencies, support services, and family. The Care Advocate will assist the member with behavioral health appointments, transportation needs, community support services, health education, and care coordination. The Care Advocate also identifies barriers to care as well as safety issues, attends agency meetings with members and case workers and provides a range of other supportive services based on a member’s individual needs. MHNet will partner with traditional providers (Primary Care Physicians, Psychiatrists, and Therapists), community agencies, in-home and/or in-school services and technology-based services to ensure that members in all geographic areas are able to access services as well as meet their goal of resiliency and recovery.

MHNet will initiate a database of non-traditional programs to continue to increase access to care. MHNet will explore partnering with local organizations to ensure a variety of non-traditional services exist that meet the needs of the membership.

Behavioral Health Readmission Monitoring/Outcomes

MHNet utilizes a database whereby we document follow-up after hospitalization, a key HEDIS quality indicator that allows us to track and trend compliance with post-discharge treatment services. As illustrated in the graphs below, readmission data is within the performance goal for the 7 and 30 day measurement indicators during the past three years, with noted overall decreasing trends, (Central region has increased during 2011, however remains significantly better than Goal). The 90 day indicator has presented the most challenge with increases seen across all Regions during 2010. Increased focus on discharge planning and intensive case management activities have resulted in a marked and significant decreasing trend during 2011.

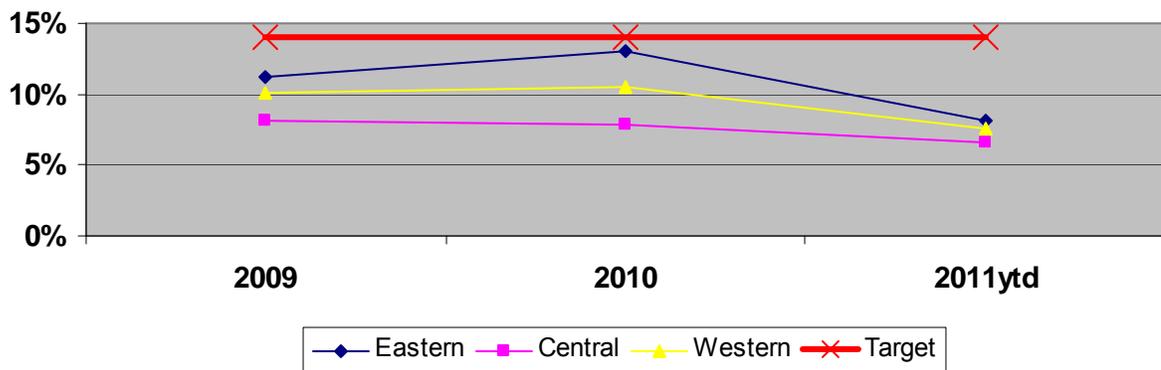
Figure 4.5- 110: BH Readmission Trend: 7 Day



DATA SOURCE: MHNET CLAIMS DATA WAREHOUSE/HEDIS REPORT
 MEASUREMENT PERIOD: 2009-YTD2011

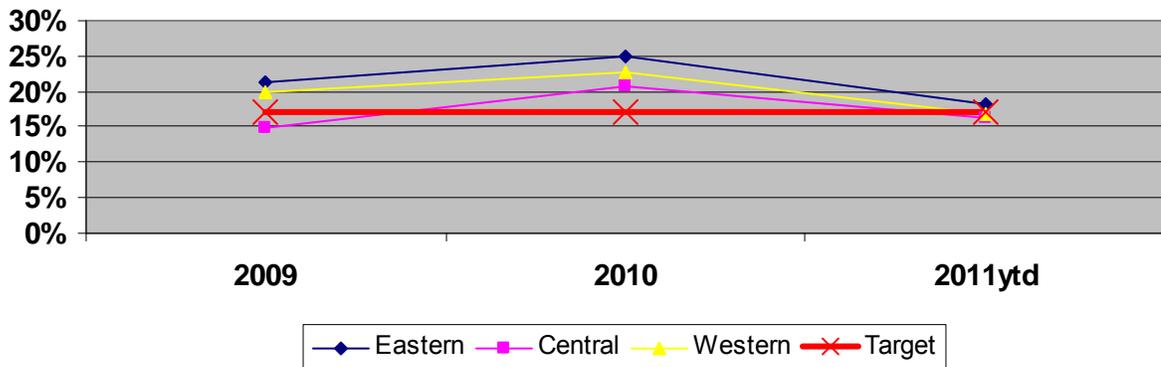


Figure 4.5- 111: BH Readmission Trend: 30 Day



DATA SOURCE: MHNET CLAIMS DATA WAREHOUSE/HEDIS REPORT
 MEASUREMENT PERIOD: 2009-YTD2011

Figure 4.5- 112: BH Readmission Trend: 90 Day



DATA SOURCE: MHNET CLAIMS DATA WAREHOUSE/HEDIS REPORT
 MEASUREMENT PERIOD: 2009-YTD2011

Future Initiatives

MHNet is committed to ensuring all members have access to the most appropriate levels and intensity of care when needed. Modifications are planned that will focus on:

- Increased provider access and availability to treatment and alternative services
- Enhancements to care coordination for members with co morbidities.

Network expansion activity will occur with CMHCs in all regions to expand service availability. CMHC availability is increasingly important to the overall service delivery system for our members, now more than ever before due to the Health Home program being implemented for MO HealthNet members. We also will communicate with local CMHCs to identify what additional value added services may be available to help our



members. These may include services such as on-site discharge planning and home-based case management programs.

4.5.4.b5 - Bullet 7 Identify the tools the offeror will use to monitor emergency department utilization and determine over utilization, and the measures the offeror proposes to combat/reduce emergency department overuse. The offeror shall describe specific measures the offeror will take in years one (1), two (2), and three (3) of the contract (assuming that the contract is extended over a three (3) year period).

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 7.

During early 2010, MHNet and HealthCare USA began collaborating on the implementation of a Health Care Initiative to address unnecessary member Emergency department utilization. In conjunction with HealthCare USA, MHNet's Emergency department Initiative program employs interventions for decreasing the frequency of emergency department visits by offering Intensive Case Management as well as assessing the need for behavioral health treatment, community services, and Medical Case Management. Through collaboration, HealthCare USA and MHNet can ensure these members receive referrals to the appropriate Behavioral Health Professional(s), community services, and potentially Medical Case Management; thus achieving reduced frequency of visits to emergency departments and reduced overall cost.

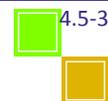
Identification of Members

MHNet in partnership with HealthCare USA will identify members as follows:

- Members who have two ED visits within one quarter, with a behavioral health diagnosis (primary, secondary, or tertiary)
- Members who have greater than four ED visits within one quarter, with no behavioral health diagnosis.

Targeted Interventions

- **Intensive Case Management.** MHNet offers this program to our identified “high risk” members. These members include, but are not limited to:
 - Members with multiple readmissions to an acute level of care
 - Members with complicating medical factors
 - Any member who has made a serious attempt to harm themselves or someone else
 - Members with complicating psychosocial factors
 - Referrals from the Health Plan
- **Behavioral Health Services.** We work with behavioral health providers to address the reason for increased emergency department services and reduce the frequency. If





therapy is currently in place, MHNet will identify additional region-specific community services that would be beneficial for the member.

- **Medical Case Management Services.** MHNet will assess the member's need for Medical Case Management services if there are relevant Axis III diagnoses that should be managed by the health plan. MHNet will refer the member to the Coordination of Care Managers at HealthCare USA for continued follow-up.

Outcome Measures

- Number of members identified based on frequency of ED visits
- Number/percent of members enrolled in Intensive Case Management as a result of ED visits
- Rate of ED visits for behavioral health diagnoses
- Rate of ED visits for non-behavioral health diagnoses
- Overall cost of care

Goals:

- To reduce the rate of ED visits by 20% for those members with a behavioral health diagnosis that do not result in a behavioral health admission
- To reduce the overall rate of ED visits by 10%

Evaluating the Program

Quarterly, MHNet will meet with HealthCare USA to review outcome measures. Interventions will be reviewed and evaluated for improvements and enhancements.

Future Initiatives

This program will be implemented for MO HealthNet members in 2012. Once the first year has been completed for this program, MHNet will re-evaluate the program criteria to determine if any modifications need to be made in order to include additional members and/or change the threshold for frequency of ED admissions. MHNet will also analyze the baseline data to determine common reasons the members are seeking emergency department services in order to identify targeted interventions to further reduce over-utilization of this service.

The table below outlines plans for expanding our ED diversion program over Years One, Two and Three of the contract:



Year 1 (July 2012 -June 2013)	Year 2 (July 2013 - June 2014)	Year 3 (July 2014-June 2015)
Re-establish and implement the behavioral health ED Reduction Health Care Initiative during Qtr 1 2012 in collaboration with HealthCare USA.	Analyze ED claim experience for prior year to identify trends related to member demographic and clinical variables to implement further management strategies that may include additional member health education activity such as member mailings.	Analyze ED claim experience for prior year to identify any additional trends that might lead to additional clinical and/or administrative management strategies.
Identify high risk members with behavioral health conditions to provide case management activity.	Identify high risk members with behavioral health conditions to provide case management activity.	Identify high risk members with behavioral health conditions to provide case management activity.
Outreach to members to provide appropriate treatment services.	Outreach to members to provide appropriate treatment services.	Outreach to members to provide appropriate treatment services.
Case Managers to coordinate with treating providers to identify reasons for ED access and implement strategies to reduce ED access in favor of more clinically appropriate services.	Case Managers to coordinate with treating providers to identify reasons for ED access and implement strategies to reduce ED access in favor of more clinically appropriate services.	Case Managers to coordinate with treating providers to identify reasons for ED access and implement strategies to reduce ED access in favor of more clinically appropriate services.
MHNet will coordinate with HealthCare USA medical case management on members with co-morbid behavioral and physical health conditions to provide a comprehensive management approach.	MHNet will coordinate with HealthCare USA medical case management on members with co-morbid behavioral and physical health conditions to provide a comprehensive management approach.	MHNet will coordinate with HealthCare USA medical case management on members with co-morbid behavioral and physical health conditions to provide a comprehensive management approach.



4.5.4.b5 - Bullet 8 How the offeror will utilize safety net providers (e.g. FQHCs, public health departments, CMHCs) to facilitate access to needed services (including measures for identifying when safety net providers are needed and outreach to public providers). The offeror shall also address how these strategies will differ between rural and urban areas of the State.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.5.4(b)5, bullet 8.

MHNet understands and acknowledges the key role local CMHCs play in providing valuable clinical and supportive services to our members. Safety net providers, such as CMHCs and FQHCs, are important components of the service delivery mental health system. This is a particular reality in rural counties where the potential for service fragmentation is at its highest. MHNet relies upon these provider agencies to support our members with a wide array of both clinical treatment, including behavioral health telemedicine services (a safety net product in itself) and basic needs supportive programs.

The behavioral health network presently consists of 16 safety net provider organizations, including several in each region. While there is not necessarily a “target population” which accesses services more than others, the safety net programs are most vital in rural areas where private practitioners are limited. This is especially the case when accessing child psychiatry services. In addition, members with a heightened need for supportive programs (i.e., food stamps, utility assistance, base care needs) also may benefit more from safety net type provider organizations than from a private practitioner network provider. Otherwise, all members with behavioral health concerns are appropriately served by these organizations. MHNet has contracted with both urban and rural-based CMHCs to address the full range of our members’ geographical needs.

Our experience with CMHC utilization has been extremely positive, with the only concern being related to their ability to manage more volume from Health Plan products, including MO HealthNet members. As a result, having a large individual, group, and facility network is necessary to address access limitations.

Going forward, MHNet’s strategy is to continue expanding the behavioral health network to reduce as many gaps as possible. This includes:

- Expanding network availability with additional CMHC services. While we are presently in full compliance with the contract as it relates to CMHC access, growth with CMHC services will take on a renewed focus during 2012 with the addition of more CMHC providers and alternative services in each region.
- Increasing use of innovative and available telemedicine services, particularly for members with rural and other access based limitations.
- Enhancing services to specialty advanced nurse practitioners who have collaborative practice arrangements with child psychiatrists.
- Partnering with CMHCs to enhance and create programs to improve access and outcomes (i.e., in-home case management, and on-site facility discharge planning services utilizing CMHC providers).



- Ongoing network development activity. MHNet expands access and availability to the behavioral health network on a monthly basis with a consistent positive trend over the past three years of network development.



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4.6 OBJECTIVE EVALUATION



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4.6.1 Evaluation of Offeror's Minority Business Enterprise (MBE)/ Women Business Enterprise (WBE) Participation

- a. In order for the Division of Purchasing and Materials Management (DPMM) to meet the provisions of Executive Order 05-30, the offeror should secure participation of certified MBEs and WBEs in providing the products/services required in this RFP. The targets of participation recommended by the State of Missouri are 10% MBE and 5% WBE of the total dollar value of the contract.
 1. These targets can be met by a qualified MBE/WBE offeror themselves and/or through the use of qualified subcontractors, suppliers, joint ventures, or other arrangements that afford meaningful opportunities for MBE/WBE participation.
 2. The services performed or the products provided by MBE/WBEs must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract. Therefore, if the services performed or the products provided by MBE/WBEs is utilized, to any extent, in the offeror's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.
 3. In order to be considered as meeting these targets, the MBE/WBEs must be "qualified" by the proposal opening date (date the proposal is due). (See below for a definition of a qualified MBE/WBE.)

HealthCare USA understands and shall comply with the requirements set forth in Section 4.6.1(a).

4.6.1b. The offeror's proposed participation of MBE/WBE firms in meeting the targets of the RFP will be considered in the evaluation process as specified below:

1. If Participation Meets Target: Offerors proposing MBE and WBE participation percentages that meet the State of Missouri's target participation percentage of 10% for MBE and 5% for WBE shall be assigned the maximum stated MBE/WBE Participation evaluation points.
2. If Participation Exceeds Target: Offerors proposing MBE and WBE participation percentages that exceed the State of Missouri's target participation shall be assigned the same MBE/WBE Participation evaluation points as those meeting the State of Missouri's target participation percentages stated above.
3. If Participation Below Target: Offerors proposing MBE and WBE participation percentages that are lower than the State of Missouri's target participation percentages of 10% for MBE and 5% for WBE shall be assigned a proportionately lower number of the MBE/WBE Participation evaluation points than the maximum MBE/WBE Participation evaluation points.
4. If No Participation: Offerors failing to propose any commercially useful MBE/WBE participation shall be assigned a score of 0 in this evaluation category.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.6.1(b).



4.6.1c. MBE/WBE Participation evaluation points shall be assigned using the following formula:

$$\begin{array}{rcccl}
 & & \text{Maximum} & & \\
 & & \text{MBE/W} & & \\
 & & \text{BE} & & \\
 & & \text{Particip} & & \\
 & & \text{ation} & & \\
 & & \text{Evaluati} & & \\
 & & \text{on} & & \\
 & & \text{points} & & \\
 & & \text{(10)} & & \\
 \text{Offeror's Proposed MBE \%} \leq 10\% + \text{WBE \%} \leq 5\% & \times & & = & \text{Assigned} \\
 & & & & \text{MBE/W} \\
 & & & & \text{BE} \\
 \text{State's Target MBE \% (10) + WBE \% (5)} & & & & \text{Particip} \\
 & & & & \text{ation} \\
 & & & & \text{points}
 \end{array}$$

HealthCare USA understands and shall comply with the requirements set forth in Section 4.6.1(c).

4.6.1d. If the offeror is proposing MBE/WBE participation, in order to receive evaluation consideration for MBE/WBE participation, the offeror must provide the following information with the proposal.

1. Participation Commitment - If the offeror is proposing MBE/WBE participation, the offeror must complete Exhibit B, Participation Commitment, by listing each proposed MBE and WBE, the committed percentage of participation for each MBE and WBE, and the commercially useful products/services to be provided by the listed MBE and WBE. If the offeror submitting the proposal is a qualified MBE and/or WBE, the offeror must include the offeror in the appropriate table on the Participation Commitment Form.
2. Documentation of Intent to Participate – The offeror must either provide a properly completed Exhibit C, Documentation of Intent to Participate Form, signed by each MBE and WBE proposed or must provide a recently dated letter of intent signed by each MBE and WBE proposed which: (1) must describe the products/services the MBE/WBE will provide and (2) should include evidence that the MBE/WBE is qualified, as defined herein (i.e., the MBE/WBE Certification Number or a copy of MBE/WBE certificate issued by the Missouri OEO).
NOTE: If the offeror submitting the proposal is a qualified MBE and/or WBE, the offeror is not required to complete Exhibit C, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.6.1(a).

For further information, refer to Exhibit C in Volume 2 of our response.

4.6.1e. Commitment – If the offeror’s proposal is awarded, the percentage level of MBE/WBE participation committed to by the offeror on Exhibit B, Participation Commitment, shall be interpreted as a contractual requirement.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.6.1(a).

For further information, refer to Exhibit B in Volume 2 of our response.



4.6.1f. Definition -- Qualified MBE/WBE:

1. In order to be considered a qualified MBE or WBE for purposes of this RFP, the MBE/WBE must be certified by the State of Missouri, Office of Administration, Office of Equal Opportunity (OEO) at the time of submission of the proposal.
 2. MBE or WBE means a business that is a sole proprietorship, partnership, joint venture, or corporation in which at least fifty-one percent (51%) of the ownership interest is held by minorities or women and the management and daily business operations of which are controlled by one or ore minorities or women who own it.
 3. Minority is defined as belonging to one of the following racial minority groups: African Americans, Native Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos, Aleuts, and other groups that may be recognized by the Office of Advocacy, United States Small Business Administration, Washington, D.C.
-

HealthCare USA understands and shall comply with the requirements set forth in Section 4.6.1(a).

For further information, refer to Exhibit C in Volume 2 of our response.

4.6.1g. Resources - A listing of several resources that are available to assist offerors in their efforts to identify and secure the participation of qualified MBEs and WBEs is available at the website shown below or by contacting the Office of Equal Opportunity (OEO) at:

Office of Administration, Office of Equal Opportunity (OEO)

Harry S Truman Bldg., Room 630

P.O. Box 809

Jefferson City, MO 65102-0809

Phone: (877) 259-2963 or (573) 751-8130

Fax: (573) 522-8078

Web site: <http://oa.mo.gov/oeo/>

HealthCare USA understands and shall comply with the requirements set forth in Section 4.6.1(a).

For further information, refer to Exhibit C in Volume 2 of our response.

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4.7 MISCELLANEOUS SUBMITTAL INFORMATION



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4.7.1 Preference for Organizations for the Blind and Sheltered Workshops

Pursuant to section 34.165, RSMo, a ten (10) bonus point preference shall be granted to offerors including products and/or services manufactured, produced or assembled by a qualified nonprofit organization for the blind established pursuant to 41 U.S.C. sections 46 to 48c or a sheltered workshop holding a certificate of approval from the Department of Elementary and Secondary Education pursuant to section 178.920, RSMo.

- a. In order to qualify for the ten bonus points, the following conditions must be met and the following evidence must be provided:
 1. The offeror must either be an organization for the blind or sheltered workshop or must be proposing to utilize an organization for the blind/sheltered workshop as a subcontractor and/or supplier in an amount that must equal the greater of \$5,000 or 2% of the total dollar value of the contract for purchases not exceeding \$10 million.
 2. The services performed or the products provided by an organization for the blind or sheltered workshop must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract. Therefore, if the services performed or the products provided by the organization for the blind or sheltered workshop is utilized, to any extent, in the offeror's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.
 3. If the offeror is proposing participation by an organization for the blind or sheltered workshop, in order to receive evaluation consideration for participation by the organization for the blind or sheltered workshop, the offeror must provide the following information with the proposal:
 - Participation Commitment - The offeror must complete Exhibit B, Participation Commitment, by identifying the organization for the blind or sheltered workshop and the commercially useful products/services to be provided by the listed organization for the blind or sheltered workshop. If the offeror submitting the proposal is an organization for the blind or sheltered workshop, the offeror must be listed in the appropriate table on the Participation Commitment Form.
 - Documentation of Intent to Participate – The offeror must either provide a properly completed Exhibit C, Documentation of Intent to Participate Form, signed by the organization for the blind or sheltered workshop proposed or must provide a recently dated letter of intent signed by the organization for the blind or sheltered workshop which: (1) must describe the products/services the organization for the blind/sheltered workshop will provide and (2) should include evidence of the organization for the blind/sheltered workshop qualifications (e.g. copy of certificate or Certificate Number for Missouri Sheltered Workshop).

NOTE: If the offeror submitting the proposal is an organization for the blind or sheltered workshop, the offeror is not required to complete Exhibit C, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

- b. A list of Missouri sheltered workshops can be found at the following internet address:
<http://www.dese.mo.gov/divspeced/shelteredworkshops/index.html>.
- c. The websites for the Missouri Lighthouse for the Blind and the Alhaphointe Association for the Blind can be found at the following internet addresses:
<http://www.lhbindustries.com> and <http://www.alhaphointe.org>
- d. Commitment – If the offeror's proposal is awarded, the participation committed to by the offeror on Exhibit B, Participation Commitment, shall be interpreted as a contractual requirement.



HealthCare USA understands and shall comply with the requirements set forth in Section 4.7.1. For further information, refer to Exhibits B and C in Volume 2 of our response.

4.7.2 Missouri Service-Disabled Veteran Business Preference

Pursuant to section 34.074, RSMo, a three (3) bonus point preference shall be granted to offerors who qualify as Missouri service-disabled veteran businesses and who complete and submit Exhibit D, Missouri Service-Disabled Veteran Business Preference with the proposal. If the proposal does not include the completed Exhibit D and the documentation specified on Exhibit D in accordance with the instructions provided therein, no preference points will be applied.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.7.2. For further information, refer to Exhibit D in Volume 2 of our response.

4.7.3 Affidavit of Work Authorization and Documentation

Pursuant to section 285.530, RSMo, if the offeror meets the section 285.525, RSMo, definition of a "business entity" (<http://www.moga.mo.gov/statutes/C200-299/2850000525.HTM>), the offeror must affirm the offeror's enrollment and participation in the E-Verify federal work authorization program with respect to the employees hired after enrollment in the program who are proposed to work in connection with the services requested herein. The offeror should complete applicable portions of Exhibit E, Business Entity Certification, Enrollment Documentation, and Affidavit of Work Authorization. The applicable portions of Exhibit E must be submitted prior to an award of a contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.7.3. For further information, refer to Exhibit E in Volume 2 of our response.

4.7.4 Miscellaneous Information

The offeror should complete and submit Exhibit G, Miscellaneous Information.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.7.4. For further information, refer to Exhibit G in Volume 2 of our response.

4.7.5 Proposal Security Deposit Required

The offeror must furnish a proposal security deposit in the form of an original bond (copies or facsimiles shall not be acceptable), check, cash, bank draft, or irrevocable letter of credit to the Office of Administration, Division of Purchasing and Materials Management by the proposal opening date and time. The Request for Proposal number must be specified on the proposal security deposit.

- a. The proposal security deposit must be made payable to the State of Missouri in the amount of \$500,000 for each proposed region.
- b. Any proposal security deposit submitted shall remain in force until such time as the offeror submits a performance security deposit pursuant to the contract requirements specified elsewhere herein. Failure to submit a performance security deposit in the time specified or failure



to accept award of the contract shall be deemed sufficient cause to forfeit the proposal security deposit.

- c. If the proposal security deposit is submitted in the form of cash or a check, it will be deposited. However, the Division of Purchasing and Materials Management shall issue a check in the same amount as the offeror's proposal security deposit to the offeror either once the performance security deposit is received if the offeror is awarded the contract, or at the time of award of the contract if the offeror is not awarded a contract.

HealthCare USA understands and shall comply with the requirements set forth in Section 4.7.5. For further information, refer to Attachment 26 in Volume 2 of our response. The original Security Bid Deposits are provided under separate envelope in Volume 1.

4.7.6 Business Compliance

The offeror must be in compliance with the laws regarding conducting business in the State of Missouri. The offeror certifies by signing the signature page of this original document and any amendment signature page(s) that the offeror and any proposed subcontractors either are presently in compliance with such laws or shall be in compliance with such laws prior to any resulting contract award. The offeror shall provide documentation of compliance upon request by the Division of Purchasing and Materials Management. The compliance to conduct business in the state shall include, but not necessarily be limited to:

- a. Registration of business name (if applicable)
- b. Certificate of authority to transact business/certificate of good standing (if applicable)
- c. Taxes (e.g., city/county/state/federal)
- d. State and local certifications (e.g., professions/occupations/activities)
- e. Licenses and permits (e.g., city/county license, sales permits)
- f. Insurance (e.g., worker's compensation/unemployment compensation)

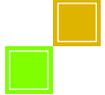
HealthCare USA understands and shall comply with the requirements set forth in Section 4.7.6. Copies of the above referenced licenses, registrations and certificates that are not already included with this submission are available upon request.

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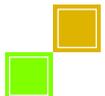
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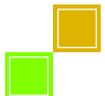


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5. PRICING PAGES





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5.1 Pricing Page: The following charts document the actuarially sound firm, fixed rates for providing all required services for all specified counties within a region pursuant to the requirements of this Request for Proposal. For each six month period represented on the Pricing Pages (July 1, 2012 through December 31, 2012 and January 1, 2013 through June 30, 2013), the offeror shall indicate with an “x” in Column 2 of the Pricing Page each region the health plan is proposing to provide services for each regional combination of Category of Aid and Age grouping, Supplemental Payment for each Delivery Event, and Supplemental Payment for each Neonatal Intensive Care Unit (NICU) Birth. All costs associated with providing the required services are included in the firm, fixed rates.

If the offeror is proposing to provide services in the Western region, the offeror must complete Column 2 on Pricing Page 5.2

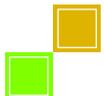
If the offeror is proposing to provide services for the Eastern region, the offeror must complete Column 2 on Pricing Page 5.3.

If the offeror is proposing to provide services for the Central region, the offeror must complete Column 2 on Pricing Page 5.4.

HealthCare USA understands and shall comply with the requirements set forth in Section 5.1. For further information, see Attachments 27, 28 and 29 in Volume 2 in our response.

5.1.1 Requirements promulgated by the federal government stipulate that the State of Missouri can only contract for services at rates that are actuarially sound. For each six month period represented on the Pricing Pages (July 1, 2012 through December 31, 2012 and January 1, 2013 through June 30, 2013), Column 1 lists the State’s Base Capitation Rate (prior to risk adjustment) for each Category of Aid, each Delivery Event, and each NICU Birth. Each rate listed in Column 1 is actuarially sound, compliant with federal regulations, and is the firm, fixed rate that the State will allow.

HealthCare USA understands and shall comply with the requirements set forth in Section 5.1.1.





- 5.1.2 To assist the offeror in review of the firm, fixed rates, the offeror should use the information provided in Attachment 9. However, the offeror is advised that this information should not be used as the only source of information in making pricing decisions. The offeror is solely responsible for research, preparation, and documentation of the offeror's proposal including the acceptance of the rates quoted on the Pricing Page.
- a. Any health plan considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the State. In addition to completing the Pricing Pages as indicated above, the health plan shall provide actuarial certification.
 - b. Requirements promulgated by the federal government stipulate that the State of Missouri can only contract for services at rates that are within actuarially sound rate ranges. The actuarial soundness of rates differing from those of the State shall be reviewed by the State of Missouri during the formal evaluation of the proposals.
 - c. The offeror must submit information which establishes and supports the actuarial soundness of the proposed rates and a certification of said soundness from an Associate of the Society of Actuaries (ASA), a Fellow of Society of Actuaries (FSA), or a Member of the American Academy of Actuaries (MAAA).
 - d. The offeror shall understand that the decision of the State of Missouri regarding whether or not a rate is within actuarially sound rate ranges shall be final and without recourse.

HealthCare USA understands and shall comply with the requirements set forth in Section 5.1.2(a-d).

- 5.1.3 The firm, fixed prices on the Pricing Pages reflect the following.
- a. The actuarially sound firm, fixed rates provided do not include:
 1. Estimates for services which are not the offeror's responsibility.
 2. Cost of marketing as an administrative expense associated with the start-up fees and costs to support expansion into Missouri Medicaid regions.
 - b. The actuarially sound firm, fixed rates provided are net of Third Party Liability recoveries.
 - c. The actuarially sound firm, fixed rates calculate medical expenses for each combination of Category of Aid and Age grouping and make adjustments for administrative, profit, and contingency and risk charges.
 - d. The offeror must accept the actuarially sound firm, fixed PMPM Base Capitation Rate for each combination of Category of Aid and Age grouping; firm, fixed Supplemental Payment for each Delivery Event; and firm, fixed Supplemental Payment for each NICU Birth. The State shall not consider awarding a contract to an offeror with any quoted rate which deviates from the State's firm, fixed rate listed in Column 1.

HealthCare USA understands and shall comply with the requirements set forth in Section 5.1.3(a-d).

For further information, see Attachment 30 in Volume 2 in our response.



W WESTERN REGION OFFICE
8320 Ward Parkway
Kansas City, MO 64114
Direct: 816-460-4934
Toll Free: 1-800-625-7602

C CENTRAL REGION OFFICE
2420 Hyde Park Road, Suite B
Jefferson City, MO 65109
Direct: 573-761-0544
Toll Free: 1-800-625-7602

E EASTERN REGION OFFICE
10 South Broadway, Suite 1200
St. Louis, MO 63102
Direct: 314-241-5300
Toll Free: 1-800-213-7792
TDD: 1-800-613-3087

Visit our Web site at www.hcusa.org

