
Overview This section of the provider manual addresses the respective responsibilities of participating physicians.

Primary Medical Offices Primary Care Providers (PCPs) provide comprehensive primary medical services to Plan members. Primary care offices participating in the Plan's provider network receive the following benefits:

- Full support of Provider Relations, Member Services, Claims, and Health Services;
- Information on discharge planning;
- Access to the medical resources of the participating network of providers, hospitals, and ancillary services;
- Enhanced reimbursement; and
- Newsletters.

Assignment of Primary Care Provider All Plan members must choose their PCP, or they will be assigned to a PCP within the Plan's network. To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs from providing primary care services to coordinating referral to specialists and providers of ancillary or hospital services.

Primary Care Provider Responsibilities Following is a summary of responsibilities specific to PCPs who render services to Plan members. Please also refer to the listing of "Responsibilities for All Providers" in this section. Additional information can be found in the provider agreement.

- Coordinate, monitor, and supervise delivery of primary care services to each member;
- Initiate referrals and/or authorization/pre-certification for specialty care and other medically necessary services to both in-

network and out-of-network providers as necessary. Response time for consults between PCPs and specialists should occur within 14 calendar days and should be expedited based upon the severity of the patient's condition;

- Maintain continuity of each member's health care;
- Assure the availability of provider services to members in accordance with "Appointment Scheduling" as outlined in this section;
- Arrange for on-call and after hours coverage in accordance with the "After-Hours Service" as outlined in this section. While this arrangement may also include formalized relationships with other PCPs to meet this requirement, the PCP shall be ultimately responsible for the above listed activities;
- Provide access to the Plan or its designee, to thoroughly examine the primary care offices, books, records, and operations of any related organization or entity. A related organization or entity is defined as: having influence, ownership, or control and either a financial relationship or a relationship for rendering services to the Primary Care office;
- Submit an encounter for each visit where the provider sees the member or the member receives a Health Plan Employer Data and Information Set (HEDIS[®]) service;
- Submit encounters on a CMS 1500 or electronically via EDI in the 837P file format.

In-network providers shall fully immunize their members according to the most recent immunization recommendations designated by the state agency. All in-network providers must enroll and must 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.

MO HealthNet Managed Care Marketing Guidelines

The Plan may educate and conduct marketing campaigns for MO HealthNet managed care members, subject to the restrictions and definitions outlined by the State of Missouri. Education activities are efforts directed to current members to provide knowledge or skills. Marketing campaigns are efforts directed to an audience of members and potential Plan members to retain or increase Plan membership. The Plan and subcontractors shall not influence member enrollment. All providers and subcontractors must adhere to the consumer protection guidelines of the MO HealthNet program and the Plan. All marketing and educational material shall maintain a member's right to confidentiality and must be submitted to the Plan for Plan and Agency approval prior to use.

The following marketing guidelines, as defined by the state of Missouri Medicaid Contract, must be adhered to at all times:

Marketing Guidelines

Excerpted from MO HealthNet Managed Care Contract B3Z06118

2.6.1 MO HealthNet Managed Care Marketing Guidelines: The health plan may educate and conduct marketing campaigns for 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. 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 and subcontractors shall not influence member enrollment.

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- a. **Marketing Guidelines:** The health plan shall:
- 1) 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 should 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 time frames for the use, and the media to be used for distribution if approved. All written materials must be at a 6th grade reading level or less. 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.
 - 2) The health plan's marketing material shall include a listing of their in-network providers identified by specialty and location, as appropriate, for the document submitted for approval.
 - 3) The health plan's marketing and education materials shall include the

member's rights and responsibilities to assistance in obtaining all covered services.

- 4) 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.
- 5) Not display or distribute any marketing materials in any manner at Family Support Division (FSD) offices or health plan provider sites, unless the health plan has received prior written permission to do so from the state agency. Only approved member handbooks and provider network listings may be distributed to local FSD offices. The health plan shall supply current materials and remove their outdated materials in public areas at the FSD offices.
- 6) Review all education and marketing 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 education and marketing material.
- 7) Submit to the state agency, for prior written approval, 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.

- A list of all health plans with which they have contracts;
- 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;
- A display of all contracted health plan logos in an equal fashion;
- A listing of all contracted health plan phone numbers;
- Access to all contracted health plan directories and member handbooks as a member resource but not for distribution; and
- Displaying enrollment helpline phone number.

The in-network provider shall provide equal representation of all contracted health plans and shall not favor one health plan over another in displayed information.

- 8) Show the date the state agency approved the material in the lower right-hand corner of all materials.
- 9) 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, including but not limited to: notices, pamphlets,

press releases, research, reports, signs and public notices prepared by or for the health plan shall be released only with prior written approval by the state agency.

- 10) Not 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.
- 11) Not 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.
- 12) Develop MO HealthNet managed care marketing plans and materials that are accurate and shall not mislead, confuse, defraud, or deceive MO HealthNet managed care eligibles, or otherwise violate Federal or State consumer protection laws or regulations. MO HealthNet managed care benefits must be listed according to the current MO HealthNet managed care contracts. The health plan may not verbally or in writing identify or portray covered benefits as enhanced, additional or free.
- 13) Not practice door-to-door, face-to-face, telephonic, or other "cold call" marketing. The offerings of cash, prizes, other items for material gain or other insurance products as an award for enrollment are prohibited. However, the health plan may offer additional health benefits to their

members. If the health plan offers additional health benefits, the health plan must 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.

- 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.

14) 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.

- Community activities are defined for the purpose of this document as: An activity where people come together to learn about or question 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.
- 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.

- 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 (i.e. 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, 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, it 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.
- 15) Not offer raffles or conduct lotteries. Door prizes may be offered within the parameters and limits specified for participation in community activities, programs or events.
- 16) Request state agency-prepared, mandatory MO HealthNet-managed care materials from the state agency. The health plan and its subcontractors should make the general public aware of the MO HealthNet program by providing any of the following:
- General MO HealthNet eligibility information; or

- MO HealthNet applications to complete and mail.
- 17) Not conduct or participate in health plan enrollment, disenrollment, transfer or opt-out activities. The health plan and the providers shall not influence a member's enrollment. Prohibited activities include:
- Requiring or encouraging the member to apply for an assistance category not included in MO HealthNet managed care;
 - Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits;
 - Mailing or faxing health plan enrollment forms;
 - Aiding the member in filling out health plan enrollment forms;
 - Photocopying blank health plan enrollment forms for potential members;
 - Distributing blank health plan enrollment forms;
 - Participating in three-way calls to the MO HealthNet managed care enrollment helpline;
 - Suggesting a member transfer to another health plan; or
 - 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).

- 18) Advise the health plan's subcontractors of these marketing guidelines and ensure that subcontractors adhere to them. No subcontract shall operate to relieve the health plan of its obligations. The health plan shall have written procedures to ensure subcontractor notification and compliance with these marketing guidelines.
- 19) Use pre-approved MO HealthNet managed care information and materials for presentations or interviews with print and electronic media.
- 20) Not use testimonial materials and/or celebrity endorsements.
- 21) Insert new language in the educational and marketing 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.
- 22) 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 Family Support Division offices, such as WIC sites, Head Start centers, health fairs, etc.
- 23) Make member education available on an ongoing basis to provide guidance on how to use a health plan and how to assert certain rights with their health plan, if necessary.

- 24) Market to the entire service area
- 25) All marketing and educational material shall maintain a member's right to confidentiality. In particular, post cards must be folded to protect the confidentiality of the member.
- 26) Not develop marketing materials that contain any assertion or statement (whether written or oral) that:
 - The recipient must enroll with the health plan in order to obtain benefits or in order not to lose benefits.
 - The health plan is endorsed by CMS, the federal or state government or similar entity.

Medical Necessity Medically Necessary is defined by the State of Missouri, MO HealthNet Managed Care contract as:

“A service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of disability; or to attain, maintain or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could not have been omitted without adversely affecting the member’s condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services must be sufficient in amount, duration, and scope to reasonable achieve their purpose and may only be limited by medical necessity.

- a. *In reference to medically necessary care, mental health services shall be provided in accordance with a process of mental health*

assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of mental health assessment shall include distinct criteria for children and adolescents.

- b. The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid provide medically necessary services to children from birth through age 20, which are necessary to treat or ameliorate defects, physical or; mental illness 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."*

Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the member or the convenience of the health care provider or hospital;
- Not primarily custodial care unless custodial care is a covered service or benefit under the member's evidence of coverage.

For more details, see our Utilization Management section of this manual.

Emergency Services

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. An emergency medical condition is a medical or mental health 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 mental health of the individual in serious jeopardy. With respect to a pregnant woman, who is having contractions, the health of the woman and her unborn child);
 - When there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - When transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.
- Serious impairment to bodily functions;
- Serious dysfunction of any body organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency; or
- Injury to self or bodily harm to others; or
- Inadequate controlled pain.

Members are advised to seek emergency care at the nearest hospital or by calling 911.

Once the member's condition is stabilized, the Plan may require pre-certification for hospital admission or prior authorization for follow-up care.

**Payment for
Out-of Network
Emergency
Services and Post-
Stabilization Care
Services**

The Plan shall pay out-of-network providers for emergency services at the current Missouri Medicaid program rates in effect at the time of service unless the Plan and provider have negotiated a mutually acceptable rate.

The Plan is financially responsible for post-stabilization care services obtained within or outside the Plan whether pre-approved or not by a Plan provider or other Plan representative so long as it is administered to maintain, improve, or resolve the enrollee's stabilized condition.

The Plan shall negotiate mutually acceptable payment rates and payment time frames with out-of-network providers for post-stabilization services for which the Plan has financial responsibility.

Dental Services

The Plan will provide coverage for medically necessary dental services provided by a dentist, doctor of medicine, osteopathy or dentistry, including any medications prescribed by a dentist for MO HealthNet Managed Care health Plan members. The Plan is not responsible for dental services that are exclusively for cosmetic reasons.

Optical Services

The Plan will provide medically necessary optical services for members as described herein:

- Optical services for children under the age of 21 and pregnant women with medical eligibility (ME) codes 18, 43, 44, 45, and 61 include but are not limited to eye exams, office visits, treatment, prosthetic eyes, eyeglasses and HCY/EPSTDT optical screens and services. (Pregnant women with ME cods 18, 43, 44, 45, and 61 who are twenty-one (21) years of age and over do not receive eyeglasses except for one pair following cataract surgery. Eyeglasses for these pregnant women are covered through the fee-for-service program);

Medically necessary optical procedures performed in an inpatient or outpatient hospital facility, emergency

room, or ambulatory surgical center, including the facility charges and ancillary services associated with the optical procedure.

Transportation Services

Harmony will provide emergency (ground or air) medical transportation and necessary non-emergency medical transportation (NEMT) for members accessing health care services included in the comprehensive benefit package as well as health-care services that are carved out of the MO HealthNet managed care contract. The Plan will provide these services to members who do not have access to free transportation or the ability to transport themselves. Also, the Plan will not provide NEMT services to Durable Medical Equipment providers that provide free delivery or mail order services.

NEMT services are not covered for those MO HealthNet enrollees with ME Codes 71 through 75.

Family Planning Services

The Plan provides freedom of choice to its members for family-planning services, including but not limited to oral contraceptives, depo-provera injections, norplant insertion, IUD and tubal ligations. Family-planning services may be obtained from any Medicaid provider or clinic that provides such services (no referral required).

A signed Sterilization Consent form is required 30 days prior to performing a tubal ligation. A sample form is contained in the **Forms** section of this manual.

WIC Referrals

Providers should document and refer eligible members for WIC services. As part of the initial assessment of members, and as part of the initial evaluation of newly pregnant women, the provider 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 to the WIC program.

**Out-of-Network
Transplant Related
Services**

Reimbursement to out-of-network providers of transplant support services must be no less than the current Medicaid program rates in effect at the time of the services.

The 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.

**Mental Health and
Substance Abuse
Services**

To ensure the continuity of care and the transition of members who have received mental health and substance abuse services from an out-of-network provider prior to enrollment with the Plan, the Plan shall authorize out-of-network providers until such time the member has been transferred appropriately to an in-network provider.

**Eligibility
Verification**

A member's eligibility status can change at any time. Therefore, all providers should verify a member's eligibility at each visit by completing one of the following:

- www.EMOMED.com
- State of Missouri IVR, 1-573-635-8908
- Medifax

Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is never a guarantee of coverage or payment. See your Provider Agreement for additional details.

Enrollment

The Plan accepts members without consideration of the applicant's health condition, gender, race, religious belief, national origin, or handicap.

Upon enrollment in the Plan, members are provided with the following:

- Description of covered services;
- Information about PCPs; such as location, telephone number, and office hours;
- Information regarding Out-of-Plan emergency services; and
- Grievance and disenrollment procedures.

**Enrollment of
Program
Newborns**

The Plan has written policies and procedures for enrolling the newborn children of members effective with the Plan on the date of the child's birth. Newborns of members enrolled at the time of the child's birth shall be automatically enrolled with the mother's health plan.

The Plan shall refer newborns to the Family Support Division 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.

In the case of an administrative lag in enrolling the newborn, and costs are incurred during that period, the Plan and Provider shall hold the member harmless for those costs.

**Hospitalization at
the Time of
Enrollment or
Disenrollment**

With the exception of newborns, the 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 Medicaid 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 newborns, 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 newborns, who are hospitalized in an acute setting, shall not be disenrolled from the Plan until an appropriate acute inpatient hospital discharge, unless the member is no longer Medicaid or MO HealthNet managed-care eligible.

Hearing Impaired, Interpreter, Multilingual, TDD, and Sign Language Services

Hearing impaired, interpreter and sign language services are available to Plan members through the Customer Service department. PCPs should coordinate these services for Plan members and contact the Plan's Customer Service department if assistance is needed.

Please refer to the **Quick Reference Guide** for the Customer Service telephone numbers.

Adult Health Screening

Adult health screening should be performed by a provider to assess the health status of a member 21 years of age or older. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

HCY/EPSDT Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally-mandated, comprehensive child health program for Medicaid recipients from birth through 20 years of age. It is designed to identify physical and mental defects and provide treatment or referral when indicated, to correct or ameliorate defects and chronic conditions. In the state of Missouri, the EPSDT program is referred to as Healthy Children and Youth (HCY).

Documentation for the HCY/EPSDT Screen should be incorporated into the medical record. When the patient receives HCY/EPSDT screen components, or when the patient is referred elsewhere to receive components, it is imperative that the patient record reflects the components that were given as well as

the components, if any, that were referred elsewhere.

Each provider must provide the full HCY/EPSDT service to all eligible children and young adults under 21 years of age, and conduct and document well child visits (screenings) using the State HCY/EPSDT screening form as needed.

The HCY/EPSDT screening form, the Missouri Medicaid Provider Manuals, Forms, List of Forms, Healthy Children and Youth Screening (HCY/EPSDT screening) may be found at: <http://manuals.momed.com>.

The Plan conducts outreach and education of children eligible for the HCY/EPSDT program in our membership population. For more information on this process, contact your provider services representative.

Members with Disabling Conditions or Chronic Illness

Members with chronic conditions are defined as adults and children who have:

- Any ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities;
- An expected duration of at least 12 months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is normally considered routine.

Following is a summary of responsibilities specific to providers who render services to plan members who have been identified with chronic or life-threatening conditions:

- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing referrals to specialists or specialty care centers, as

appropriate for the member's conditions or needs;

- Allow members with disabling conditions or chronic illnesses to request that their specialist become their PCP. If the specialist agrees to perform all the functions of the PCP, Harmony will ensure a standing referral or grant the request of the specialist as PCP; or
- Providers should continue to verify eligibility at each visit.

Pre-certification

Providers must refer members to participating Plan providers for services not provided in the office. Pre-certification must be obtained from the Plan's Health Services Department for certain medical services. Please refer to the **Quick Reference Guide** of this manual.

The following information is required when requesting pre-certification:

- Member's complete name;
- Member's date of birth;
- Clear description of the member's medical condition, outpatient surgery or procedure(s) to be performed, type of home health services requested and proposed treatment plan;
- Diagnosis and proposed date(s) of service; and
- Treating provider's name.

Requests for pre-certification are requested at least five business days before the scheduled admission or service. Failure to coordinate medical care with or to obtain pre-certification from Harmony may result in denial of payment for these services.

**Living Will and
Advance Directive**

Members have the right to control decisions relating to their medical care; including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life.

The law provides that each Plan member (18 years of age or older, of sound mind), should receive information concerning this provision, and have the opportunity to sign an Advance Directive Acknowledgement Form to make their decisions known in advance.

This allows them to designate another person to make a decision should they become mentally or physically unable to do so. Forms should be made available in provider's offices, and discussion with the member as well as the completed forms should be documented and filed in the member's medical record.

At the time of enrollment, the Plan will provide a Member Handbook containing information regarding the member's rights under Missouri law. As part of re-credentialing, Harmony audits medical records of PCPs, hospitals, home health agencies, personal care providers and hospices to determine if the provider is following the policies related to Advance Directives.

A provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

**After-Hours
Services**

The PCP must be available after regular office hours to offer advice and to assess any condition that may require immediate care. This includes referral to the nearest hospital emergency room in the event of a serious illness. To assure after-hours accessibility and availability, PCPs must provide one of the following:

- An answering service with option to page or contact physician;

- An advice nurse with access to the physician or on-call physician;
- Answering system that provides an option to page the physician; or
- Answering system that pages the physician once the message is left.

Recorded messages are not acceptable.

**Provider Request
for a Member
Transfer**

A Plan provider or provider may not seek or request to terminate their relationship with a member, or transfer a member to another provider of care, based upon the member's medical condition, amount or variety of care required, or the cost of covered services required by the Plan's member. Membership acceptance must be without regard to color, gender, race, religious belief, national origin, or handicap of applicant.

Reasonable efforts should always be made to establish a satisfactory provider/member relationship in accordance with practice standards. The provider should provide adequate documentation in the member's medical record to support his/her efforts to develop and maintain a satisfactory provider/member relationship.

If a satisfactory relationship cannot be established or maintained, the provider shall continue to provide medical care to the Plan member until such time that written notification is received from the Plan stating that the member has been transferred from the provider's practice.

In the event a participating provider desires to terminate their relationship with a Plan member, the provider should submit adequate documentation to support that although they have attempted to maintain a satisfactory provider/member relationship, the member's non-compliance with treatment, or

uncooperative behavior, is impairing the ability to care for and treat the member effectively.

The provider should complete a “PCP Reassignment Request” form, attaching supporting documentation, and fax the form to the Member Services Department at the number on the form. A copy of the form is available in the Forms Section of this manual.

**Member
Disenrollment**

The state agency has sole authority for disenrolling members from the Plan. The Plan may request disenrollment of members from Plan providers, subject to the conditions described below:

- A persistent refusal of the member to follow prescribed treatments or to comply with Plan requirements that are consistent with federal and state laws and regulations, as amended;
- Consistently missed appointments without prior notification to the provider;
- Fraudulent misuse of the MO HealthNet managed care program, or abusive or threatening conduct;
- Request of a home birth service.

Members shall have the right to challenge a Plan-initiated disenrollment to both the state agency and the Plan through the appeal process within ninety (90) calendar days of the 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 Plan and the state agency continuing disenrollment procedures. Please refer to the Appeals and Grievances Section of this manual for appeal instructions.

**Disenrollment
Effective Date**

Member disenrollments outside of the open enrollment process shall become effective on the date specified by the state agency.

**Responsibilities
of All Providers**

The remainder of this section of the Handbook is an overview of responsibilities for which all Plan providers are accountable. Please refer to the Provider Agreement, or contact a Provider Relations Representative, for clarification on any of the following.

Providers must, in accordance with generally accepted professional standards:

Use physician extenders appropriately. Physician assistants (PA) and advanced registered nurse practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the State of Missouri and Plan guidelines.

The provider will assume full responsibility to the extent of the law when supervising PAs and ARNPs whose scope of practice should not extend beyond statutory limitations. ARNPs and PAs should clearly identify their titles to members, as well as to other health care professionals. Any member request to be seen by a physician, rather than a physician extender, must be honored at all times. Accept treatment for any member in need of health care services they provide.

Refer Plan members with problems outside of his/her normal scope of practice for consultation and/or care to appropriate specialists contracted with the Plan, except when they are not available, or in an emergency.

Admit members only to participating hospitals, SNFs, and other inpatient care facilities, except in an emergency.

Respond promptly to requests from the Plan or state agency for medical records in order to comply with regulatory requirements.

Inform the Plan in writing within 24 hours of any revocation or suspension of his/her Bureau of

Narcotics and Dangerous Drugs number, and/or suspension, limitation, or revocation of his/her license, certification, or other legal credential authorizing him/her to practice in the State of Missouri. Inform the Plan in writing immediately of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance, and any other change which would affect his/her status with the Plan.

Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in the Plan's Medical Records Requirements and Guidelines. Content must include 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 mental health screens, etc. All entries in the member record must identify the date and the provider. The Plan shall monitor the primary care providers' actions for compliance with Plan and MO HealthNet Managed Care Program policies.

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.

Maintain an environmentally safe office with equipment in proper working order to comply with city, state, and federal regulations concerning safety and public hygiene.

Communicate clinical information between Plan providers timely. Communication will be monitored during medical chart review. Upon request, provide timely transfer of clinical information to the Plan, the member, or the requesting party, at no charge.

Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis, and expected outcome of a recommended medical, surgical, and medication regimen. Do not discriminate in any manner between Plan members

and non-Plan members.

Fully disclose to members their treatment options and allow them to be involved in treatment planning. Inform member of specific health care needs which require follow-up and provide, as appropriate, training in self-care and other measures members may take to promote their own health.

Identify members that are in need of services related to children's health, domestic violence, pregnancy prevention, prenatal/postpartum care, smoking cessation, or substance abuse.

The provider will provide all of the following, where applicable, to members upon request:

- Information related to the health care specialty, and board certification, if applicable;
- The names of licensed facilities on the provider panel where the health care provider presently has privileges for the treatment, illness, or procedure that is the subject of the request;
- Information regarding the health care provider's participation in continuing education programs and compliance with licensure, certification, or registration requirements, if applicable.

A participating health care provider shall provide the following to Harmony:

- Upon request, Medical records for utilization management and/or quality improvement activities;
- Upon request, Proof of Ability to Perform and Sustain Services. Providers capitated by Harmony (excluding PCPs) shall submit financial information to Harmony, including, but not limited to audited annual financial statements. Financial statements shall include

balance sheet, income statement and cash flow statement. These documents are to be used for the purpose of Harmony's evaluation of Provider's financial ability to perform and sustain services of Provider as defined in Provider Agreement with Harmony;

- Provide immediate notification to the Plan of suspended license, including tax liability to the State of Missouri;
- Should a financial incentive arrangement exist between the provider and Plan, the provider shall immediately notify the plan of such change so the plan can meet its requirement to notify the state agency.

Ancillary / Specialist Responsibilities

Ancillary/Specialists are responsible for treating Plan members referred to them by the PCP and communicating with the Plan's Health Services department for authorizations. Specialists may not refer to another Plan specialist. Specialists should also:

- Provide only approved services as indicated by PCP;
- Notify the member's PCP if another specialist or health care provider is needed to evaluate and treat member's condition;
- Provide note of consultation to the member's PCP in writing of any recommended ongoing treatment program or elective inpatient admission within 24 hours for emergent or three days for urgent care.

Any inpatient or elective procedures are to be pre-certified by Harmony's Health Services department. Please refer to the Utilization Management Section of this manual for pre-certification instructions.

Appointment Scheduling

Providers must adhere to the following criteria to comply with the following waiting maximums and appointment requirements:

- Average waiting times for appointments should not exceed one hour from the scheduled appointment time;
- Provide medical coverage 24 hours a day, seven days a week;
- Schedule and see urgent care appointments within 24 hours;
- For routine care, without symptoms, appointments must be available within 30 calendar days (e.g., well child exams, routine physical exams);
- Schedule and see routine care patients, with symptoms, within one week or five business days, whichever is earlier;
- For mental health and substance services, after-care appointments shall occur within one week or five business days after hospital discharge, whichever is earlier;
- Schedule and see initial prenatal appointment within seven calendar days (for members in their first or second trimester);
- Schedule and see initial prenatal appointment within three calendar days (for members in their third trimester);
- Schedule and see members identified as high-risk pregnancies within three calendar days or immediately if an emergency exists.

**Confidentiality of
Member
Information and
Release of
Records**

All consultations or discussions involving the member, or his/her case, should be conducted discreetly and professionally in accordance with all applicable state and federal laws including the HIPAA Privacy and Security regulations.

Any data or information pertaining to the diagnosis treatment, or health of any enrollee obtained from such person or from any provider by any HMO shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of these regulations; or upon the express consent of the enrollee; or pursuant to statute or court order for the production of evidence or the discovery thereof or in the event of claim or litigation between such person and the HMO wherein privileges against such disclosure which the provider who furnished such information to the HMO is entitled to claim.

No health care provider may be penalized for considering, studying or discussing medically necessary or appropriate care with or on behalf of his or her patient.

All provider personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure that there is a: (i) Privacy Officer on staff; (ii) a policy and procedure in place for confidentiality of members' protected health information (PHI); and (iii) that the practice is following those procedures and/or obtaining appropriate authorization from members to release PHI where required by applicable state and federal law.

Policies and procedures should include protection against unauthorized/ inadvertent disclosure of all confidential medical information to include PHI.

All members have a right to confidentiality, and any health care professional or individual person who deals directly or indirectly with the member or his/her medical record must honor this right. Every practice is required to provide to members their Notice of Privacy Practice. Employees who have access to member

records and other confidential information are required to sign a “Confidentiality Statement.”

Some examples of confidential information includes:

- Any communication between a member and a provider;
- All PHI as defined under the federal HIPAA Privacy regulations;
- Any communication with other clinical persons involved in the member’s health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, social security number, etc.);
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental, or psychiatric problem; and
- Any communicable disease (such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

When an individual enrolls in the Plan, federal law permits the health care provider to release his/her medical records to the members of the provider network, or agencies conducting regulatory or accreditation reviews, and business associates.

The Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or Plan may use or disclose the members’ PHI. HIPAA regulations require each provider and Plan to provide a NPP to each new patient or member, accordingly.

Second Opinions

A member may request a second opinion at any time for determination of a medical decision or confirmation of a specific medical diagnostic procedure, treatment or surgical procedure. The PCP should recommend a qualified provider within the

network to accommodate this request. If no qualified provider is known, please contact the Plan for assistance.

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.

Covering Physicians

In the event participating providers are temporarily unavailable to provide care or referral services to Plan members, providers should make arrangements with another Plan-contracted and credentialed physician to provide services on their behalf unless there is an emergency. In non-emergency cases, should you have a covering physician who is not contracted and credentialed with the Plan, contact the Plan for approval.

The physician should be credentialed by the Plan, must sign an agreement accepting the negotiated rate and agree not to balance bill Plan members. For additional information, please contact the local Provider Relations department.

Provider Billing and Address Changes

Prior notice to the Plan is required for any of the following changes:

- 1099 mailing address;
- Tax Identification Number or Entity Affiliation (W-9 required) ;
- Group name or affiliation;
- Physical or billing address;
- Telephone and/or fax number

Provider Termination

In addition to the provider termination information included in your Provider Agreement with the Plan, the provider must adhere to the following terms:

Any contracted providers must adhere to the “without cause” termination provisions of your Provider Agreement. Please refer to your contract for the details regarding the specific required days for providing termination notice.

Unless otherwise provided in the termination notice, terminations occur on the last day of the month. For example: Required notice is 90 days. A termination letter is dated September 15. The required notice is 90 days. Termination is therefore effective December 31.

Providers who receive a termination notice from the Plan may submit an appeal. Please refer to the Appeals and Grievances Section of this manual for specific guidelines. The Plan, due to regulatory requirements, must notify in writing all appropriate agencies and/or members upon a provider termination as required by regulations and statutes.

Disclosure of Information

Periodically, members may inquire into the operational and financial nature of their health plan. In accordance with federal and state disclosure requirements, the Plan will provide this information to its members upon written or verbal request.

For more information on how to request this information, members should contact the Plan’s Member Services Department. The toll-free telephone number can be found on the member’s ID card for information on how to make a request.

Delegated Entities

All participating providers or entities delegated for Network Management and Network Development should meet all applicable standards and are held to the same standards as defined in this section. Reviews are performed and compliance is monitored on a regular basis.

