Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Missouri Focused Program Integrity Review

Final Report

May 2016

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Missouri to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing its corrective action plan (CAP) from CMS's last program integrity review in July 2010.

Background: State Medicaid Program Overview

The Department of Social Services (DSS) administers the Missouri Medicaid program which is known as MO HealthNet. As of July 2015, Missouri's current Medicaid enrollment was 926,289 beneficiaries. Of that total, approximately 453,000 were enrolled in three MCOs and the remaining beneficiaries were served on a fee-for-service (FFS) basis. Missouri's total Medicaid expenditures in calendar year 2014 were approximately $8.92 billion. The Federal Medical Assistance Percentage was 63.45%.

Located within the DSS, the MO HealthNet Division has oversight of Missouri's Medicaid managed care program and its contractors. Program integrity functions reside within Missouri Medicaid Audit and Compliance (MMAC) which is a separate unit within the DSS that reports directly to the director of DSS. The state has operated its Medicaid managed care program under a 1915(b) waiver since 1995 and currently contracts with three MCOs servicing three geographical locations. Managed care providers are not required to enroll with the state as Medicaid providers. The total number of actively enrolled managed care providers in state fiscal year (SFY) 2015 was 30,502.

Methodology of the Review

In advance of the onsite visit, CMS requested that Missouri complete a managed care review guide that provided the CMS review team detailed insight to the operational activities of the areas that were subject to the focused review. A four-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

The team met with the various staff from the three Missouri MCOs to discuss their program integrity activities. The current MO HealthNet MCOs are Home State Health, Missouri Care, and HealthCare USA/Aetna Better Health of Missouri. All of the MCOs' current contracts with the state became effective in January 2015.

Results of the Review

The team identified several areas of concern with the state's managed care program integrity activities and managed care oversight, thereby creating risk to the Medicaid program. These issues and CMS's recommendations for improvement are described in detail in this report. CMS

will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible.

Section 1: Managed Care Identified Risks

42 CFR 455.104: Ownership and disclosure information
The regulation at 42 CFR 455.104(b)(1) requires that a provider, fiscal agent, or MCO, must disclose to the state Medicaid agency the name, address, date of birth, and Social Security Number of each person or entity with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of five percent or more. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCO must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCO as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCO in which a person with an ownership or control interest in the disclosing entity, fiscal agent, or MCO has an ownership or control interest. As set forth under 455.104(c), the state Medicaid agency must collect the disclosures from disclosing entities, fiscal agents, and MCOs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCO.
The state is not in compliance with this regulation.
Missouri contracted with three MCOs effective January 2015. The state could not verify if the ownership and disclosure information, as required under 42 CFR 455.104, was obtained from the three MCOs prior to signing the contracts.
Recommendation: Develop process to ensure the collection of ownership and disclosure information at the time of contracting.

Section 2: Managed Care Program Integrity

Summary Information on the Plans Reviewed

Previously, Missouri contracted with all MCOs that met state qualifications ("any willing plan"). However, in calendar year 2012, Missouri imposed a cap on the number of organizations with which it contracted and restricted participating MCOs to three for the entire state. Subsequently, the state selected its current three MCOs based on a competitive bidding process and set rates using an actuarial process that adjusts expected costs based on demographic factors. Home State Health is located in Chesterfield, Missouri. HealthCare USA is located in St. Louis, Missouri. Missouri Care is located in Columbia, Missouri.

Table 1. Summary Data for MO HealthNet MCOs

MCO	Medicaid Enrollees *	Medicaid Contracted Providers*	Size and Composition of Special Investigations Unit (SIU)	Medicaid Expenditures (SFY 2012-2014)
Home State Health	76,420	14,700	5 SIU staff managers investigators analysts clinical reviewers	2012: $ 98.0 million 2013: $191.5 million 2014: $204.0 million
Missouri Care	111,894	16,012	10 SIU staff: senior director managers investigators medical coding auditors clinical nurse senior analyst	2012: $203.2 million 2013: $243.8 million 2014: $234.7 million
Health Care USA	264,938	16,065	13 SIU staff: nurses certified pharmacy technician certified professional coders investigators medical director	2012: $580.7 million 2013: $578.0 million 2014: $548.3 million

MCO Program Integrity Activities

Investigations/Referrals

The current Missouri managed care contract includes program integrity guidelines for the MCOs. The guidelines provide direction on implementing internal controls, and policies and procedures designed for identifying, reporting, investigating, and referring suspected fraud, waste, and abuse. The contractual requirements provide direction to the MCOs for practices which ultimately lead to the prosecution of fraud, waste, and abuse activities by providers. The MCOs are required to report to the state Medicaid agency, within one business day of receiving such information, any information concerning member fraud, waste, and abuse. The MCOs are also required to report any suspected case(s) of provider fraud, waste, and abuse to the state Medicaid agency within one business day initiating an investigation, and report all instances of suspected provider fraud, abuse, or waste on a quarterly basis.

All three of the MO HealthNet MCOs have an SIU and are required to have a compliance program that is responsible for investigating fraud, waste, and abuse. Each MCO is contractually

* Figures based on data reported by the plans as of June 2015.

required to implement measures to prevent fraud, waste, and abuse.

Compliance Plan

The Missouri managed care contract requires the MCOs to comply with the regulation at 42 CFR 438.608. The compliance requirements of 42 CFR 438.608 require that MCOs have specific administrative and management procedures designed to guard against fraud and abuse. Missouri's MCOs are required to submit a compliance plan yearly. The MO HealthNet reviews the MCOs' annual compliance plans. In 2014, the MMAC began performing yearly onsite audits with the MCOs. These audits focus on the MCOs' compliance with the fraud, waste, and abuse portions of the contract. During SFY 2015, the audits were extended to include investigative cases conducted by the MCOs. The contract also requires MCOs and their subcontractors to fully cooperate in any state or federal reviews or investigations. The state's managed care contract includes language prohibiting affiliations with individuals debarred by federal agencies as required by 42 CFR 438.610(c).

Meetings and Training

The state does not meet regularly with the MCOs. They hold meetings on an as needed basis. The state has not, to date, conducted any training for the MCOs.

Encounter Data

Encounter data is used by the state for rate setting and quality improvement evaluation. Before MCO encounter claims data can be used, it is necessary to establish the extent to which the data for critical fields is complete, accurate, and valid. The completeness of the state encounter claims database is verified by comparing the data to the medical records of members. A random sample of medical records is used for the comparison of the encounter data. State paid encounter claims are then compared with MCO records of paid and unpaid claims. The MCOs are required by contract to send encounter data to the state on, at least, a monthly basis. Missouri has stringent contractual requirements for the submission and handling of encounter data. However, the managed care contract does not specifically require or prohibit the use of encounter data for the identification of aberrant claims. The managed care contract requires the MCOs to have fraud, waste, and abuse detection activities in place, including false billing practices, but there are no directives on the methodology.

During the onsite review, the MMAC indicated that it does not have access to MCO encounter data. This lack of accessibility to important managed care data could impact Missouri's ability to analyze fraud, waste, and abuse in their Medicaid managed care program.

Overpayment Recoveries, Audit Activity, and Return on Investment

Missouri's managed care contract states 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 to establish rates. If, however, the fraudulent billing and recovery is done in a period where cost reports have not been submitted by the MCO for that service period, then the recovery shall go to the MCO and the plan shall not report any of the medical costs associated with the fraudulent billings in the cost report." However, when an MCO refers a suspected case of fraud, waste, or abuse to the state Medicaid agency, the MCO can take no action to recoup or otherwise offset any suspected overpayments until the state Medicaid agency provides written notice to the MCO that the fraud, waste, or abuse case has been closed or otherwise resolved. "Then, after conducting a cost benefit analysis to determine if such action is warranted, the health plan should attempt to recover any overpayments identified."

Home State Health policies and procedures identify three types of referrals for investigations:

- *Reactive investigations* - Originate from hotline calls, press coverage reviews, and use of explanation of benefits responses.
- *Proactive referrals/reviews* - Potentially fraudulent, wasteful, or abusive patterns are identified by computer software.
- *Systematic referrals* - Reviews conducted after a claim has been paid.

Home State Health stated that they prefer to conduct pre-payment reviews rather than attempt the pay-and-chase model. Home State's parent company monitors the savings per member per month (PMPM). This is calculated by dividing the savings (claims submitted but not paid, recoveries, educational trends, etc.) by the number of members per month. There has been a total recovery of $7,793 for four providers in the past three fiscal years; however, they are not identified as overpayments since they might affect the rates negotiated and contracted with the state.

The Missouri Care SIU performs its own audits for fraud, waste, and abuse investigations, but uses a subcontractor to identify overpayments and pursue recoveries. The MCO regularly reviews paid claims as part of their provider relations and health services work. The SIU also uses data mining technologies to proactively identify potential fraud and abuse. Missouri Care's parent company utilizes post-pay reviews and occasional pre-pay reviews to identify and deny improperly billed claims. However, the SIU does not currently calculate cost avoidance. The MCO indicated that it has recovered $14,171 in overpayments from providers since its acquisition on April 1, 2013.

The HCUSA has a SIU team dedicated to Medicaid investigations. At the time of the 2015 review, the MCO responded that it had 58 providers on pre-pay review for the last complete FFY. The MCO calculates return on investment (ROI)/cost avoidance based on system edits that are applied to the claims process. These system capabilities use historical claims information to detect and correct questionable billing practices and assist in identifying fraudulent and abusive patterns. This MCO reported identified overpayments for the last two complete FFYs (2013 and 2014) totaling $12,101,678.

As of July 2015, at least half of Missouri's Medicaid beneficiaries were enrolled with one of the three MCOs contracted with the state. According to the information gathered during the 2015

program integrity review, Missouri's MCOs' program integrity efforts vary considerably between the three MCOs when it comes to protecting Medicaid dollars. The team considered the two complete FFYs prior to the review (2013 and 2014) in which all three MCOs were active in the state. Two of the MCOs only reported overpayment recoveries totaling $21,964. This is only a minute fraction of the approximate $8.92 billion spent for Medicaid expenditures in FY 2014 alone. As the Missouri Medicaid managed care program continues to grow in both beneficiary and provider enrollment, it is evident that Missouri needs to work with its MCOs to oversee the improvement of the program integrity efforts.

The tables below indicate the number of investigations by all MCOs and the overpayments identified and collected by each of the MCOs for the past four SFYs.

Table 2A: Home State Health Investigations and Overpayments

SFY	Number of Preliminary Investigations	Number of Full Investigations	Amount of Overpayments Identified	Amount of Overpayments Collected
2011	N/A*	N/A*	N/A*	N/A*
2012	50	37	N/A*	N/A*
2013	233	29	N/A*	N/A*
2014	257	36	N/A*	N/A*

*N/A denotes that the MCO identified no overpayments nor did they collect any monies.

Table 2B: Missouri Care Investigations and Overpayment

SFY	Number of Preliminary Investigations	Number of Full Investigations	Amount of Overpayments Identified	Amount of Overpayments Collected
2011	N/A**	N/A**	N/A**	N/A**
2012	N/A**	N/A**	N/A**	N/A**
2013	2	2	$2,516	$2,516
2014	3	3	$11,655	$11,655

**N/A denotes there were no figures as the MCO was not active in the state until April 2013.

Table 2C: HCUSA Investigations and Overpayments

SFY	Number of Preliminary Investigations	Number of Full Investigations	Amount of Overpayments Identified	Amount of Overpayments Collected
2011	10	21	$7,943,321	$9,814,895
2012	20	62	$7,218,559	$11,173,707
2013	27	29	$5,898.634	$9,574,854
2014	93	36	$6,203,044	$8,333,108

Payment Suspensions

The Missouri managed care contract states that "If the DHHS suspends payments to a provider while governmental authorities investigate a credible allegation of fraud (as determined by DHHS), then the MCO may suspend the provider and payments for covered services provided by the provider during the period of the DHHS suspension payments." The MCOs will suspend payment only if specifically instructed to do so by the state. No providers have been placed under payment suspension by the SIU as a result of credible allegations of fraud, waste, and abuse since April 1, 2013.

The state contract does not completely mirror 42 CFR 455.23. The MCOs will suspend payment only if specifically instructed to do so by the state. Case sampling did not show that the providers sampled had been placed on payment suspension or terminated by the plan for fraud, waste, or abuse.

Terminated Providers and Adverse Action Reporting

The managed care contract requires the MCOs to exclude providers from the MCO network that have been identified as having U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG) sanctions failing to renew license or certification registration, having a revoked professional license of certification, or have been terminated by the state Medicaid agency.

The table below shows the number of terminated providers reported by each of the MCOs.

Table 3: Provider Terminations in Managed Care

Selected MCOs	Number of Providers Disenrolled or Terminated in Last 3 Completed FFYs	Number of Providers Terminated for Cause in Last 3 Completed FFYs
Home State	2012: 214 2013: 411 2014: 485	2012: 0 2013: 22 2014: 30
Missouri Care	2012: N/A* 2013: 11 2014: 63	2012: N/A* 2013: 0 2014: 0
HC USA	2012: 1,094 2013: 920 2014: 897	2012: 21 2013: 50 2014: 15

*The MCO was not active in Missouri prior to April 2013.

Interviews with the MCOs revealed that they are required to report adverse actions to the state and do so. Based on the information provided in Table 4, the program activities related to adverse actions vary between the three MCOs contracted with Missouri. For instance, only two

of the three MCOs provided evidence of for cause termination in their program. It is not clear whether the for cause terminations were initiated by the MCO or the state.

MCO Federal Database Checks

Missouri does not have language in their managed care contract requiring the MCOs to comply with the requirements of 42 CFR 455.436. The state's current policy statement mandates database checks at the time of credentialing, re-credentialing, and monthly against the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), the National Plan and Provider Enumeration System (NPPES), the Missouri Professional Registration Board website, and any other databases as the state agency may prescribe. The state policy statement requires the MCO to screen all health care service subcontractors to determine if the subcontractor and any of its employees or subcontractors are excluded from participation in Medicare, Medicaid, CHIP, or any other federal health care program. As described below, the team found that Missouri's three MCOs were exceeding the requirements of the state's current managed care policy statement.

Health Care USA (HCUSA) is checking the LEIE, System for Award Management (SAM), Social Security Administration's Death Master File (SSADMF), and the NPPES at credentialing and re-credentialing and checking the LEIE and EPLS monthly on their network providers. The HCUSA makes sure its subcontractors are doing the same for the large provider groups.

Missouri Care and Home State Health both comply with this regulation. Missouri Care and Home State Health also credential and re-credential providers every three years within the plan. They search the LEIE, SAM, SSADMF, and NPPES, as well as state databases, for enrolling practitioners.

Section 3: Status of Corrective Action Plan

Missouri's last comprehensive program integrity report was issued in calendar year 2010 which contained multiple compliance issues and vulnerabilities related to the state's Medicaid managed care program. The state submitted a CAP in May 2011. The CAP issues and their current statuses are listed below.

Compliance Issues:

Issue 1 - The DSS does not capture all of the required ownership, control, and relationship information from FFS providers, the fiscal agent, non-emergency medical transportation (NEMT) broker, and MCOs. *(uncorrected partial repeat finding).*

> **Issue 1 - Current Status: Uncorrected partial repeat finding**
> The state now requires managed care providers to complete a supplemental ownership, control, and relationship form with the credentialing form. The implementation of a

supplemental form, as part of the credentialing process, was to ensure the collection of complete ownership, control, and relationship information.

Missouri contracted with three MCOs effective January 2015. As indicated above, the state could not verify if the required ownership and disclosure information was obtained from these MCOs prior to signing the contracts. Therefore, Missouri only partially meets the requirements under 42 CFR 455.104. This issue remains an uncorrected partial repeat finding.

Issue 2 – The DSS provider enrollment agreements and NEMT contracts do not require providers to disclose certain business transactions. *(uncorrected partial repeat finding)*

Issue 2 - Current Status: Corrected
Missouri has modified its MCO contracts and provider agreements to require disclosure.

Issue 3 - The DSS does not capture the disclosure of criminal conviction information for owners, agents, and managing employees of individual FFS providers, the NEMT brokers, and MCOs. *(uncorrected partial repeat finding)*

Issue 3 - Current Status: Corrected
As part of the 2011 CAP, the state implemented a supplemental form to its provider application to require providers to report criminal convictions of owners, agents, and managing employees, as required by 42 CFR 455.106. Also, the managed care contracts and enrollment forms have been revised to include the requirements of 42 CFR 455.106.

Issue 4 - The DSS does not report to HHS-OIG adverse actions taken on provider applications or actions to limit the ability of providers to continue participating in the Medicaid program. *(uncorrected partial repeat finding)*

Issue 4 - Current Status: Corrected
Missouri has modified their managed care contract to require notification to the state when adverse actions are taken against a provider's participation in the program. Missouri has developed procedures to report to HHS-OIG all adverse actions taken against providers enrolled or applying for participation in the program.

Issue 5 – The state was not ensuring that it excludes certain managed care entities from participation if these entities could be subject to HHS-OIG exclusions.

Issue 5 - Current Status: Corrected
The state has updated its managed care contract to include language to ensure that the state will terminate any contract with the health plan if it determines at any time that the health plan has been excluded by HHS-OIG.

Issue 6 - The DSS does not provide required notifications about excluded providers.

Issue 6 - Current Status: Corrected
The state developed procedure by which excluded individuals are reported as required under 42 CFR 1002.210 and 42 CFR 1002.212. The managed care contract language was revised to include contractual requirements addressing the reporting of excluded providers.

Issue 7 - During the 2010 Missouri Comprehensive Program Integrity Review, the State Agency had not complied with the State Plan requirement to review providers' policies and employee handbooks pertaining to the False Claims Act.

Issue 7 - Current Status: Corrected
The state has developed plan to identify providers with $5 million or more payments for the fiscal year and to monitor their compliance with the False Claims Act.

Vulnerabilities:

1. Not collecting managing employee information on FFS and MCO provider enrollment forms.

   Vulnerability 1. - Current Status: Corrected
   Missouri has updated its managed care contracts to address the issue of the collection of complete ownership, control, and relationship information as required by 42 CFR 455.104.

2. Not requiring MCOs to conduct routine verification of services with beneficiaries.

   Vulnerability 2. - Current Status: Corrected
   The managed care contract was revised to include a contractual requirement that MCOs routinely perform random verification of services with Medicaid beneficiaries.

Recommendations for Improvement in Managed Care

- Develop a process to ensure the collection of ownership and disclosure information at the time of contracting.
- Develop a clear process and contract requirements for MCOs to follow regarding payment suspensions in cases where there are credible allegations of fraud according to 42 CFR 455.23.
- Improve communications at both the state and MCO levels through routinely scheduled meetings. Both MO HealthNet and MMAC should meet on a regular basis. Likewise, the state should schedule frequent one-on-one meetings with the MCOs to review the status of their program integrity activities and the MCOs' conformance with contractual requirements, such as, but not limited to, audit work plans, results of audits and investigations, and any subsequent actions taken, such as reporting terminated providers and recovery of overpayments. Meetings should occur on at least a quarterly basis.
- State contracts with MCOs should require plans to ensure that all compliance department and SIU staff are receiving appropriate training in identifying and investigating potential fraudulent billing practices by providers. The state may assist in providing some of the training that is unique to their policies, but training needs could also be met through professional organizations and through the MCOs' own compliance departments. Costs for such training need not require additional funding and are included in the administrative fees that the plans already receive. Training should be provided on at least a quarterly basis. MO HealthNet staff would also benefit from program integrity training.
- Given the limited audit work in at least two MCOs, along with the low number of overpayments and terminations that the MCOs reported, the state should ensure that any managed care entity with which it contracts has an established and functioning program integrity infrastructure that includes adequate systems and staff to prevent, detect, and investigate provider fraud.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Missouri to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Missouri based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.

- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Missouri review the effective and noteworthy practices in program integrity and consider emulating these practices as appropriate.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

CMS supports Missouri's efforts and encourages it to look for additional opportunities to improve overall program integrity. The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with Missouri to build an effective and strengthened program integrity function.

Official Response from Missouri
June 2016

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KINKADE, DIRECTOR

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June 3, 2016

Mr. Mark Majestic
Centers for Medicare and Medicaid Services
Center for Program Integrity
7500 Security Boulevard, Mail Stop AR-21-55
Baltimore, Maryland, 21244-1850

Dear Mr. Majestic:

Attached please find Missouri's corrective action plan, provided in response to your letter dated May 5th, 2016, detailing the findings of the Investigations and Audits Group focused review of Missouri's Medicaid program integrity procedures and processes.

Specifically, the focused review determined the extent of state program oversight in the managed care program and assessed the program integrity activities performed by selected Managed Care Organizations (MCOs) under contract with the state. The review also included a follow up on the state's progress in implementing the corrective action plan that resulted from CMS's last program integrity review in 2010.

Missouri's corrective action plan addresses the findings and recommendations contained in the May 2016 final report, and responds to the corrective action plan item identified during the 2010 review which remained uncorrected. Our plan addresses how our agency will ensure the deficiencies will not recur, including the timeframes for each correction along with specific steps we will take. Any areas in which we have already taken action to correct the identified risk areas will be identified, as well. The plan includes information regarding our plans to monitor performance to make sure the solutions are sustained, when appropriate.

If you have any questions please contact Jay Ludlam, Deputy Division Director, at 573-751-6922.

Sincerely,

Joseph Parks, M.D.
Director

JP/jl
Attachment

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