Title 13—DEPARTMENT OFSOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 1—Organization

PROPOSED AMENDMENT

13 CSR 70-1.010 Organization and Description. The division is amending section (2)

PURPOSE: This amendment updates the MO HealthNet Division's organization to include additional units within the division and to update the description of units.

(2) Organization and Operations. The MHD is located in Jefferson City at 615 Howerton Court. MHD can be contacted by writing to the division at PO Box 6500, Jefferson City, MO 65102-6500. MHD is divided into five (5) major organizational components—administration and four (4) sections—finance, information services, operations, and clinical review, development, and performance.

(A) Administration. The director's office provides the overall guidance and direction for the division and is responsible for establishing the agency's goals, objectives, policies, and procedures. The director's office is also responsible for providing legislative guidance on Medicaid and health care related issues, overseeing the distribution of federal and state resources, planning, analyzing and evaluating the provision of Medicaid services for eligible Missourians, and final review of the budget. In Missouri, "MO HealthNet" can be described as "Medicaid," "Title XIX," or "medical assistance."

1. Transformation. The Transformation program is a combination of initiatives with the goal of transforming Missouri's Medicaid program. The initiatives are wide-ranging, and include operational improvements as well as larger more transformational changes.

(B) Finance. The Finance section is divided into the following units:

1. Budget, Financial Services, and Rate Development.

A. Budget. This unit is responsible for developing and tracking the division's annual budget request and subsequent appropriations. The unit is responsible for preparation of quarterly estimates and expenditure reports required by the Centers for Medicare and Medicaid Services (CMS). During the legislative session, the unit is also responsible for reviewing all bills affecting the division, preparing fiscal notes, and attending hearings as assigned.

B. Financial Services. This unit is responsible for managing the financial procedures and reporting of the Medicaid claims processing system, creating expenditure reports for management and budget purposes, coordinating the production and mailing of provider remittance advices, checks and automatic deposits, and reviewing and approving provider 1099 information. The unit is also responsible for processing adjustments to Medicaid claims, receiving and depositing payments, and managing provider account receivables.

C. Rate Development. This unit is responsible for developing the capitation rates for the Medicaid Managed Care Program, the Nonemergency Medical Transportation Program, and the Program of All Inclusive Care for the Elderly (PACE). The group works closely with the contracted actuary in evaluating Medicaid fee-for-service expenditures to determine the financial impact of implementing policy alternatives and evaluating the cost effectiveness of Managed Care and PACE;

D. Premium Collections. This group is responsible for managing the lock box, automatic withdrawals, and cash deposits for the State Children's Health Insurance Program premium cases and Spenddown pay-in cases. The group manages the financial procedures and reporting

for these programs in the state's computer system and in the electronic Medicaid Management Information System (eMMIS) to ensure the collection accurately establishes the Medicaid eligibility record and to ensure that client notices are accurate and timely;

2. Institutional Reimbursement. This unit is divided into the following groups:

A. Federally Qualified Health Center (FQHC) and Independent Rural Health Clinic (IRHC) Reimbursements. This group is responsible for the audit of the FQHC and IRHC cost reports including the calculation of final settlements relating to those cost reports and the review and processing of Managed Care Supplemental Interim Payments for FQHCs and IRHCs. The group is also responsible for the administration of state regulations, state plan amendments, and responses to inquiries regarding reimbursement issues relative to these programs; and

B. Nursing Home Policy and Reimbursement. This group is responsible for determining and carrying out the policy and reimbursement functions of the MO HealthNet nursing facility program and the Nursing Facility Reimbursement Allowance (NFRA) provider tax program. The nursing facility duties include overseeing audits of nursing facility cost reports, determining reimbursement rates, analyzing nursing facility data, determining and establishing reimbursement methodologies, and overseeing the preparation of the nursing facility Upper Payment Limit (UPL) demonstration. The NFRA duties include determining and collecting the NFRA, preparing various NFRA reports, and reconciling the NFRA fund balance. The group is also responsible for the review and analysis of proposed bills and preparation of fiscal notes, the administration of state regulations and state plan amendments, representing the division in litigation, and responding to inquiries regarding nursing facility reimbursement and NFRA issues. The group oversees and monitors contractors to ensure nursing facility cost report audits and the nursing facility UPL demonstration are completed in a timely manner and in accordance with state and federal rules. The group works closely with the contractors in developing audit plans, evaluating nursing facility reimbursement issues, collecting and preparing data for the UPL demonstration, and implementing any changes to these processes;

3. Hospital Reimbursement Unit. This unit is divided into the following groups:

A. Hospital Policy and Reimbursement. This group is responsible for determining and carrying out the policy and reimbursement function of the MO HealthNet program for hospitals. This includes the day-to-day activities of hospital reimbursement such as *[auditing hospital cost reports,]***overseeing the hospital cost report audits, overseeing the Disproportionate Share Hospital (DSH) audits,** calculating hospital per diem rates, **updating the hospital per diem rates in the electronic Medicaid Management Information System (MMIS),** calculating hospital payments (i.e., *[Direct Medicaid, Disproportionate Share Hospital (DSH),]***supplemental payments, DSH payments, and** Graduate Medical Education (GME) payments), calculating Federal Reimbursement Allowance (FRA) **hospital** provider tax, ***[****calculating final settlements or Outpatient Settlements,]* **processing the hospital payments and tax each financial cycle,** providing litigation support, conducting FRA program tracking, and handling hospital rate adjustment requests. The group is also responsible for the administration of state regulations, state plan amendments, and responses to inquiries regarding hospital reimbursement issues;

B. Children's Outliers and Provider Based Rural Health Clinic (PBRHC) Reimbursements and Settlements. This group is responsible for calculating children's outlier payments for hospitals, **calculating the PBRHC reimbursement rate,** updating the PBRHC reimbursement payment rate in *[electronic Medicaid Management Information System* (] eMMIS [*)]*, **and** calculating **and processing** the final settlements for PBRHCs**.** *[, calculating the MC+ interim payment adjustments for PBRHCs.]* The group is also responsible for the administration of state regulations, state plan amendments, and responses to inquiries regarding reimbursement and settlement issues**.** *[; and]*

[C. Premium Collections. This group is responsible for managing the lock box, automatic withdrawals, and cash deposits for the State Children's Health Insurance Program premium cases and Spenddown pay-in cases. The group manages the financial procedures and reporting for these programs in the state's computer system and in the eMMIS to ensure the collection accurately establishes the Medicaid eligibility record and to ensure that client notices are accurate and timely;]

4. The Cost Containment and Audit Compliance unit is divided into the following groups: Medicare, Recoveries, and Pharmacy Rebate.

A. Medicare **Savings Program**: This group is responsible for ensuring that Medicare funds are utilized whenever possible in providing medical services to Medicaid clients. This is accomplished by the identification of those recipients who are, or who might be, Medicare eligible, the recovery of funds paid as Medicaid services for these clients, and the administration of Medicare Part **A and** B premiums.

B. Recoveries: This group ensures that all potential, legally liable payers of medical services pay up to their liability to offset Medicaid expenditures. This is accomplished through cost avoidance and post-payment recovery (pay-and-chase or cash recovery).

(I) Cost avoidance occurs when the group receives information that a third-party payer is responsible for payment prior to Medicaid payment. The Third Party Liability (TPL) unit verifies commercial health insurance after receiving the information from multiple sources. The insurance data is entered into participant eligibility files, which are connected to the Medicaid claims payment processing system, and serve as a source of editing to determine claim payment or denial. Cost avoidance also occurs through the Health Insurance Premium Payment (HIPP) program. If a participant has access to employer-sponsored health insurance, Medicaid will purchase the commercial health insurance if it is determined to be cost effective.

(II) Post-payment recovery occurs when the unit determines that a third-party payer is potentially responsible for payment when a participant receives medical services. Data matches and the Medicaid claims processing system determine potential recovery sources. TPL personnel are responsible for the following recovery activities: burial plans, personal funds, estates, and trauma (includes personal injury, product liability, malpractice, traffic accidents, worker's compensation, and wrongful death). A contractor is primarily responsible for recovery of commercial health insurance payments.

(III) These activities ensure that Medicaid funds are used only after all other potential resources available to pay have been exhausted.

C. Pharmacy Rebate: This group is responsible for the collection of rebates from pharmaceutical manufacturers contracted with CMS to participate in the Medicaid Drug Rebate Program, and for collection of supplemental rebates from manufacturers participating in the state's Supplemental Rebate Program. The group invoices manufacturers quarterly for products dispensed during the period. As payments are received, disputes are identified and the unit researches any product disputed by the manufacturer. Disputes are resolved with the manufacturer to collect the greatest rebate possible. This unit is also responsible for collecting rebates for the Missouri Rx Program.

(C) Information Services. This section is responsible for managing the operations, development, and implementation of the information system that the division uses to administer MO HealthNet Programs. This includes the various components of the eMMIS which are hosted, developed, operated, and maintained by multiple information technology vendors and multiple vendor systems and services related to health information exchange. The Information Services Unit is also responsible for managing quality, integrity, and use of the MO HealthNet program data. The

information services unit is also responsible for securing enhanced federal funding related to allowable system implementation and operation costs. The Information Services section is divided into the following units: Project Management Office, Business Systems, Data Management Office, Information Services Funding, and Health Information Technology Programs.

1. Project Management Office. This unit is responsible for managing procurement and implementation of the more advanced modifications to the eMMIS and of new eMMIS solutions. The implementation of a replacement enterprise data warehouse and business intelligence solutions is an example of a new eMMIS solution. The unit ensures that a structured approach is used so as not to disrupt the automated Medicaid claims processing and the information retrieval system currently in place.

2. Business Systems. This unit is responsible for oversight and monitoring of the operations of the eMMIS and management of the contracts with the information technology vendors responsible for hosting, developing, operating and maintaining the eMMIS systems. The unit is responsible for maintaining the claims processing system by reviewing claims payment issues, establishing corrective action plans, and designating specific tasks to the system vendors.

3. Data Management Office. This unit is responsible for managing the quality of the data contained in the enterprise data warehouse and establishing governance over the MO HealthNet data by determining information ownership, establishing data standard option processes, establishing and enforcing data integrity, and managing the data architecture and usage. This unit is also responsible for managing all data requests and data reporting and analysis.

4. Information Services Funding. This unit is responsible for creating and managing requests for federal funding related to eMMIS system operations, enhancements, and implementations, and maximizing federal participation in system costs. This unit is also responsible for processing invoices received from information technology vendors, ensuring the invoices are coded to the correct federal funding request, and tracking the budget to actual system costs.

5. Health Information Technology Programs. This unit is responsible for managing all federal programs and projects related to Health Information Technology and Health Information Exchange. This unit is also responsible for managing contracts with health information networks providing health information exchange services for MO HealthNet.

(D) Operations. The Operations section is divided into the following units: Home and Community-Based, School-Based, and Waiver Services, Medical Programs and Policy, and Managed Care, Constituent Services, and *[Strategic Initiatives.]***the Program of All-Inclusive Care for the Elderly (PACE).**

1. Home and Community-Based, School-Based, and Waiver Services: This unit has the following three groups:

A. Home and Community-Based In-Home Services Group. This group works closely with the Department of Health and Senior Services (DHSS) and CMS regarding several Home and Community-Based Services (HCBS) 1915(c) waivers and State Plan programs to ensure state and federal requirements are met. This group develops, amends, and renews HCBS waiver applications, and performs quality oversight activities, analysis and reporting for those programs. This group is also responsible for administration of state regulations and state plan amendments, along with research, program development, policy implementation, and program communications;

B. Home and Community-Based and School-Based Services Group. This group works closely with the Department of Mental Health (DMH) and CMS regarding several HCBS 1915(c) waivers and State Plan programs to ensure state and federal requirements are met. The group develops, amends, and renews HCBS waiver applications, and performs quality oversight activities, analysis, and

reporting for those programs. This group is responsible for coordination of state plan amendments, policy implementation, and regulations drafted to reflect program changes. In addition, this group administers the School-Based Service programs including invoice processing, program compliance activities, federal reporting, and contract oversight;

C. [*Money Follows the Person (MFP)]* **Show Me Home** Group: The *[MFP]***Show Me Home** program was designed to reduce reliance on Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF/MR) for individuals who are aged or those who have a disability, while providing resources for individuals wishing to transition to a quality community-based long-term care setting. The *[MFP]* **Show Me Home** group works closely with DHSS, DMH, and CMS to ensure that federal *[MFP]* **Show Me Home** program requirements are met. This group is responsible for oversight and coordination of *[MFP]* **Show Me Home** program implementation across the three (3) state agencies, formulating a program budget each calendar year, evaluating the program on a semi-annual basis, marketing, and continually looking for best practices for improvement.

2. Medical Programs and Policy: This unit divides the responsibilities for MHD's medical programs and their policies among three (3) areas dedicated to each's assigned programs. The first group focuses primarily on hospital providers, the second group focuses primarily on physicians, clinics, and hospice providers, and the third group focuses primarily on nursing facilities, durable medical equipment, and non-emergency medical transportation. Programs and policies regarding all other enrolled medical providers are also managed by one (1) of the three (3) groups.

A. The unit is responsible for research, analysis, development, implementation, and monitoring various benefit programs within the division, including the prior authorization process for approval of medically necessary items. Personnel in this unit also interact with advisory committees to obtain guidance regarding complicated health care issues, coordinate and assist in the development of training packages, write and revise program manuals and bulletins pertaining to program policy, procedure, and operations, and monitor and evaluate program effectiveness by tracking utilization patterns.

B. The unit is responsible for researching state and federal regulations, CMS directives and rulings, and reviewing Medicaid programs implemented by other states. The group analyzes data and legislation, coordinates special projects, and works with other state agencies and groups within the division to implement new Medicaid programs including the development of new manuals and procedures. The group also aids in the implementation of major changes to existing MHD programs. This unit is also responsible for policy implementation, program communication, oversight of contracts with outside vendors, certain clinical program enhancement activities, and implementation of those program enhancements. Documents such as state plan amendments and state regulations are drafted to reflect program changes.

C. This unit also researches and gathers information for program development and provides procedural support for systems changes and claims processing issues such as medical procedures and equipment prior authorization, and durable medical equipment special pricing. The unit serves as the liaison with MMIS and other units within the division to facilitate program enhancement activities.

3. Managed Care, Constituent Services, and *[Strategic Initiatives Unit.]***PACE.**

A. Managed Care. Managed Care is responsible for administration of the Managed Care Program which operates under a 1915(b) Freedom of Choice Waiver. This program provides Medicaid Managed Care services to participants in four (4) broad groups: Medical Assistance for Families, Medicaid for Children, Medicaid for Pregnant Women, and children in state custody. This group is also responsible for developing new policies and procedures for the Managed Care Program. This

unit is divided into the following groups: Managed Care Policy, Contract Development, and Compliance, and Quality Assessment.

(I) Managed Care Policy, Contract Development, and Compliance. This group is responsible for monitoring contracts. Personnel monitor the Managed Care and the Beneficiary Support System contracts to ensure providers are adhering to the terms and conditions of their agreements. The group ensures that the Managed Care Organizations (MCOs) adhere to service access guidelines, verify provider networks, and handle complaints against MCOs. The group also works with the Department of Insurance to assure MCOs are in compliance with state insurance rules and regulations. Premium Collections is also a responsibility of this group. The group is responsible for answering phones and correspondence regarding the State Children's Health Insurance Program (CHIP) **and Ticket-to-Work Health Assurance (TTWHA) program** premium cases *[and]* **as well as** spend-down pay-in cases, answering questions regarding program rules and receipt of payments.

(II) Quality Assessment. This group performs research and data analysis to address monitoring and oversight requirements established by the CMS. The group utilizes a collaborative process to develop and implement strategies to improve the health status of Medicaid participants. This process entails coordination with advisory groups, other state agencies, managed care organizations, **external quality review organizations,** providers, and the public. The group is also responsible for researching, assessing, evaluating, and reporting information regarding the quality of care provided to Managed Care members.

B. *[Constituent Services and Education. The unit is divided into the following groups: Provider and Member Educations, Provider Communication, and Participant Services.]***Education and Training. This group is responsible for training and educating providers, participants, division personnel and outside entities regarding the division's policies and procedures. The group also assists providers with the submission of Medicaid claims through provider training sessions. Additionally, this group assists with outreach to member and oversees a member forum for input.**

[(I) Provider and Member Education. This group is responsible for training and educating providers regarding the division's policies and procedures. The group also assists providers with the submission of Medicaid claims through provider workshops and individual provider training sessions. Additionally, this group assists with outreach to members and oversees a member forum for input.]

*[(II)]***(I)** Provider Communication. This group is responsible for responding to provider inquiries and concerns. Much of this communication is handled via a provider hotline. Written responses to provider inquiries are also handled by this group. The group explains difficult and complex Medicaid rules, regulations, policies, and procedures to providers.

*[(III)]***C. Constituent /***Participant]* Services. This group aids the fiscal agent's Participant Services Unit by acting as liaison with other groups within the division and handling more complex inquiries from participants. The division maintains a toll-free hotline for participants and is responsible for the Medicaid Participant Reimbursement program and handles all prior authorizations of out-of-state services. This group also handles requests for appeals from MHD participants who have had adverse actions regarding service denials or closures.

D. PACE. This group is responsible for the implementation and oversight of the PACE program. The group is responsible for coordinating PACE, developing state regulations, facilitating audits and focused reviews, and reviewing participant eligibility and enrolment.

The group maintains regular communications with PACE organizations and works with the Missouri Medicaid Audit and Compliance Unit (MMAC) on program integrity.

(E) Clinical Review, Development, and Performance: This section includes the offices of the Medical Director and Assistant Medical Director; and Registered Nurse Specialists; Durable Medical Equipment Review and Approval; Medical Program Development, Support, and Evaluation; Exceptions Management and Review; Primary Care Health Home Management; the Quality Program; the Behavioral Health Program; and the Pharmacy Program.

1. Medical Director, Assistant Medical Director, and Registered Nurse Specialists. The Medical Director oversees the unit, approves decisions, reviews medical documentation for clinical accuracy and appropriateness, participates in state fair hearings, and reviews transplant requests and prior authorization requests.

2. Medical Program Development, Support, and Evaluation. The unit provides support for both the Fee-for-Service and Managed Care programs, including the PACE program, and provides recommendations to develop evidence-based clinical guidelines to advance quality in the programs. The unit assists contractors with their medical reviews and decision-making when necessary, and reviews individual medical decisions that have been referred for state fair hearings. The unit also provides responses to legislative and other external inquiries and provides medical subject-matter support to MHD personnel.

A. Subject-matter support for the Fee-for-Service program includes, but is not limited to, determining medical necessity of requested equipment or services, making program recommendations that follow best practices and evidence-based approaches, and providing guidance regarding federal and state program requirements.

B. Subject-matter support for the Managed Care program includes, but is not limited to, determining medical necessity of requested equipment or services, making program recommendations that follow best practices and evidence-based approaches, providing guidance regarding federal and state program requirements, reviewing clinical information related to quality outcomes, reviewing the health plans' care management programs, reviewing claims and benefit denials as needed, and coordinating with other state agencies regarding shared population health mandates.

3. Exceptions Management and Review. An administrative exception may be made on a case-by-case basis to limitations and restrictions. The unit provides oversight of these reviews which may be of a routine or an emergency nature.

4. Primary Care Health Home Management. The unit is responsible for oversight of all aspects of this program including internal systems, program expansion, collaboration with the managed care unit and the contracted health plans, data collection, and analysis.

5. Durable Medical Equipment (DME) Review and Approval. This group evaluates all requests and has a call center for DME, optical, and alternative therapies for pain management and approves or denies these requests. It also responds to inquiries from providers, medical consultants, and public officials related to MHD policies and procedures. It also evaluates possible program abuse, suspected fraud, dual services, and helps to improve program efficiency.

6. Quality Program. This group is responsible for a variety of data analyses relating to various grants and initiatives throughout MHD, including those related to Health Home, women and infant health, and asthma. Annual and quarterly quality data from the Managed Care Organizations are processed by this group, which also produces a series of reports and graphs from that data, and it also prepares and disseminates reports for distribution to the MCOs regarding immunizations, members with special needs, lead screenings, etc. Annual CMS Core Set measures are calculated

and reported by this group. It also responds to numerous ad hoc data requests throughout the year from administrators, managers, the legislature, and assorted outside interests.

7. Behavioral Health Program. This group is responsible for overseeing the purchase and delivery of behavioral health services on behalf of MHD fee-for-service and managed care participants. It is responsible for research, analysis, development, implementation, and monitoring of behavioral health services covered by MHD, including the precertification process for approval of individual, family, and group psychotherapy for fee-for-service participants. This unit researches evidence-based and best practices to inform policy revision. Personnel in this unit participate in annual clinical reviews of managed care health plans and monitor compliance with mental health and substance use disorder parity standards. They also interact with community advisors for input on complex behavioral health care issues, coordinate and assist in the development of provider training, and provide clinical and policy consultation to other Department of Social Services (DSS) divisions and to other state agencies. This unit is responsible for provider bulletins and manuals as well as state plan amendments and state regulations related to behavioral health services changes. This unit is responsible for providing clinical input regarding behavioral health conditions and services as related to various MHD and managed care initiatives. It is responsible for researching state and federal regulations, CMS directives and rulings, and other state Medicaid programs and services.

8. Pharmacy Program. The Pharmacy Program includes Pharmacy Operations, Pharmacy Reviews and Hearings, and the Pharmacy Clinical group.

A. Pharmacy Operations. The pharmacy operations group maintains the listing of payable drug products and management of the drug pricing methodology for the pharmacy department to ensure proper drug claim payment. The group houses the pharmacy administration helpdesk which communicates with providers on issues processing drug claims, including drug pricing. Pharmacy Operations also processes pharmacy provider bulletins, hot tips, regulations, provider manuals, and State Plan Amendments. In addition, the unit reviews requests for compounded prescriptions, medically necessary over-the-counter drugs, non-reference diabetic supplies, and medication requests for participants enrolled in Hospice to determine whether the medication is related to the terminal illness.

B. Pharmacy Reviews and Hearings. The unit provides clinical review for pharmacy prior authorizations when necessary and utilizes physician consultants when additional clinical review or peer-to-peer consultation is needed or requested.

C. Pharmacy Clinical Group. This group operates a toll-free hotline for providers to request overrides on drug products with restricted access due to clinical or fiscal edits and prior authorization. The hotline staff in this unit process requests for drug products which have been denied through the usual claims processing system.

(I) The group is responsible for the implementation and maintenance of clinical pharmacy cost saving initiatives. This unit is responsible for the review, implementation, and maintenance of the Preferred Drug List (PDL) and all clinical and fiscal edits. It also oversees the prior authorization of all new drug products and monitoring of the drug pipeline. All clinical drug information and pharmacoeconomic evidence-based reviews are organized for presentation to the Drug Use Review Board (DUR). Online point-of-sale clinical edits are established to assure cost effective and appropriate drug usage.

(II) Internal clinical management for fee-for-service patients is performed, including identification and monitoring of drug regimens outside normal parameters, and working with patients' healthcare providers to reach desired outcomes.

D. Missouri Rx Plan. This group is responsible for the ongoing operations of the Missouri Rx Plan, which pays fifty percent (50%) of the member's out-of-pocket cost for prescription drugs covered by the Medicare Prescription Drug Program and by the member's Medicare Part D Plan formulary for dual eligible participants.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. This rule was previously filed as 13 CSR 40-81.005. Emergency rule filed Sept. 15, 1987, effective Sept. 28, 1987, expired Jan. 25, 1988. Original rule filed Oct. 1, 1987, effective Jan. 29, 1988. Amended: Filed July 2, 1992, effective Feb. 26, 1993. Amended: Filed April 14, 2006, effective Oct. 30, 2006. Amended: Filed Aug. 23, 2021, effective March 30, 2022.* ***Amended: Filed Month Day, Year***

**Original authority: 208.201, RSMo 1987, amended 2007, and 660.017, RSMo 1993, amended 1995.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, P.O. Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*