Rules of
Department of Social Services
Division 70—MO HealthNet Division
Chapter 1—Organization

Title 13—DEPARTMENT OF SOCIAL SERVICES
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13 CSR 70-1.010 Organization and Description

PURPOSE: This rule states the function and general organization of the Division of Medical Services to comply with the requirements of section 536.023, RSMo.

(1) General Authority and Purpose.

(A) The Missouri Division of Medical Services was created within the Department of Social Services by executive order of the governor on February 27, 1985. The Missouri General Assembly granted statutory authority to the division by adding section 208.201, RSMo effective September 28, 1987. The Division of Medical Services operates under the provisions of Chapter 208, RSMo and Title XIX of the federal Social Security Act.

(B) The Division of Medical Services is responsible for the administration of the medical assistance program in Missouri except for the determination of recipient eligibility for the program, which shall be the responsibility of the Family Support Division.

(2) Organization and Operations. The Division of Medical Services is located in Jefferson City at 615 Howerton Court. Contact can be made by writing to the division at PO Box 6500, Jefferson City, MO 65102-6500. The Division of Medical Services is divided into six (6) major organizational components—administration and five (5) sections—management services, finance, information services, program management, and pharmacy and clinical services.

(A) 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.

1. Office Services. This unit is responsible for processing invoices for all expenses incurred by the division and preparing purchase requests for all administrative supplies, equipment, and services. The unit is responsible for the internal allocation and financial monitoring of all of the division's operating expenses including all professional service consultant contracts. The unit oversees the division's reception area, processes and distributes all incoming and outgoing mail, and is responsible for the division's copy center.

(B) The Management Services section is divided into the following units:

1. Medicare Unit. This unit 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 B premiums.

2. Third Party Liability (TPL) Unit. This unit 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).

A. Cost avoidance occurs when it is known that a third-party payer is responsible for payment prior to Medicaid payment. The TPL unit verifies commercial health insurance that is received from multiple sources. The insurance data is entered into the recipient eligibility file, which is also connected to the Medicaid claims payment processing system, and serves 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 recipient has access to employer-sponsored health insurance, Medicaid will purchase the commercial health insurance if it is determined to be cost effective.

B. Post-payment recovery occurs when it is determined that a third party payer is potentially responsible for payment when a recipient receives medical services. Data matches and the Medicaid claims processing system determine potential recovery sources. TPL staff 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.

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

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

1. Managed Care Rate Setting. 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 unit 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.

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

A. Outpatient and Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Reimbursements. This group is responsible for audit of the FQHC and independent RHC cost reports, the calculation of final settlements for Outpatient Hospitals, FQHCs and RHCs, the calculation of MC+ interim payment adjustments for FQHCs and RHCs, the calculation of outlier payments for hospitals and the calculation of the prospective outpatient payment rates for outpatient hospital services. The group is also responsible for the administration of state regulations, state plan amendments, and responses to inquiries regarding reimbursement issues.

B. Nursing Home Policy and Reimbursement. This group is responsible for determining and carrying out the policy and reimbursement functions of the Medicaid program for nursing facilities. This includes auditing rate setting cost reports and determining reimbursement rates, auditing annual cost reports, analyzing nursing facility data, determining and establishing reimbursement methodologies, determining the Nursing Facility Reimbursement Allowance, and representing the division in litigation relating to nursing facility issues. The group is also responsible for the administration of state regulations, state plan amendments, and responses to inquiries regarding nursing facility reimbursement issues.

C. Hospital Policy and Reimbursement. This group is responsible for determining and carrying out the policy and reimbursement function of the Medicaid program for hospitals. This includes the day-to-day activities of hospital reimbursement such as auditing hospital cost reports, determining hospital per diem rates, determining hospital disproportionate share payments, determining Direct Medicaid add-on payments and other special payments, determining Federal Reimbursement Allowance (FRA) provider tax, providing litigation support, conducting FRA program tracking, and 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.

3. 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. During the legislative session, the unit is also responsible for reviewing all bills affecting the division, preparing fiscal notes, and attending hearings as assigned.

4. 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.

5. Premium Collections. This unit 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 unit manages the financial procedures and reporting for these programs in the state's computer system and in the Medicaid Management Information System (MMIS) to ensure the collection accurately establishes the Medicaid eligibility record and to ensure that client notices are accurate and timely.

6. Revenue Maximization. This unit is responsible for the identification and collection of revenue sources to displace general revenue. The unit is responsible for the collection of the Federal Reimbursement Allowance and the Nursing Facility Reimbursement Allowance provider taxes and reconciliation of the fund balances. The unit computes the hospital and nursing facility Upper Payment Limit used to generate additional funds through the Intergovernmental Transfer (IGT) programs. The unit is also the primary source for bill review and fiscal note analysis related to institutional reimbursement.

(D) The Information Services section is divided into the following units:

1. Payment Systems. This unit is responsible for coordinating and implementing the more advanced modifications to the Medicaid Management Information System (MMIS). The implementation of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) is an example of an advanced modification to the MMIS. The unit ensures that a structured approach is used so as not to disrupt any of the automated Medicaid claims processing and the information retrieval system currently in place.

2. Medicaid Management Information System. This unit is responsible for oversight and monitoring of the fiscal agent (Infocrossing Healthcare Services, Inc.) contract and acts as liaison between the division and Infocrossing. The unit is responsible for maintaining the claims processing system by reviewing claims payment issues, establishing corrective action plans and designating specific tasks to Infocrossing. This unit is also responsible for processing ad hoc requests from other units within the division.

3. Provider Enrollment. This unit is responsible for enrolling and disenrolling providers. The unit maintains all updates and changes to the provider enrollment files and processes direct deposit applications. The unit responds to provider inquiries and notifies providers when their application is processed and when a provider number is issued. The unit is also responsible for entering rate changes for providers and developing a system whereby much of the provider enrollment process can be completed electronically.

4. Program Integrity Unit. This unit is primarily responsible for monitoring statewide utilization and program compliance of Medicaid fee-for-service providers and recipients. The unit conducts post-payment audits/reviews and researches complaints. Following an audit/review, the unit may, among other actions: issue educational letters; recover improperly paid funds; refer cases of suspected fraudulent activities to the Attorney General's Medicaid Fraud Control Unit or other appropriate licensing bodies; request a corrective action plan; and/or recommend internal policy changes to improve and/or clarify program policy. Other responsibilities of the unit include, but are not limited to, the Recipient Lock-In Program and monitoring the Medstat Fraud and Abuse Detection System.

(E) The Program Management section is divided into the following units:

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

A. Managed Care Contract Compliance. This group is responsible for monitoring contracts. Staff monitor the Managed Care 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.

B. Quality Assessment. This group performs research and data analysis to address monitoring and oversight requirements established by the Centers for Medicare and Medicaid Services. The group utilizes a collaborative process to develop and implement strategies to improve the health status of Medicaid recipients. This process entails coordination with advisory groups, other state agencies, managed care organizations, providers, and the public. The group is also responsible for researching, assessing, evaluating, and reporting information regarding the quality of care provided to MC+ Managed Care members and Fee-For-Service recipients.

2. Program Relations. The unit is divided into the following groups:

A. Provider Education. This group is responsible for training and educating providers on 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.

B. 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 interprets and explains difficult and complex Medicaid rules, regulations, policies, and procedures to providers.

C. Recipient Services. This group aids the fiscal agent's Recipient Services Unit by acting as liaison with other groups within the division and handling more complex inquiries from recipients. The division maintains a toll-free hotline for recipients and is responsible for the Medicaid Recipient Reimbursement program and handles all prior authorizations of out-of-state services.

D. Premium Collections. This group is responsible for answering phones and correspondence regarding the State Children's Health Insurance Program premium cases and Spenddown pay-in cases. Staff explain program rules and answer questions regarding receipt of payments.

3. Fee-For-Service Program. This 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 and services which are not typically reimbursed by Medicaid. Staff in this unit also interact with advisory committees to obtain guidance in 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.

A. Program Development. This group is responsible for researching state and federal regulations, Centers for Medicare and Medicaid Services 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. Staff in this group also aid in the implementation of major changes to existing Medicaid programs.

(F) The Pharmacy and Clinical Services section is divided into the following units:

1. Pharmacy Exceptions. This unit 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 operate an Internet-based system to process requests for drug products which have been denied through the usual claims processing system. This unit is also responsible for responding to requests for certain prior authorized services, such as insulin pumps and supplies, as well as those through the Exception Process for essential medical items or services which are not typically reimbursed through the Medicaid program.

2. Pharmacy Enhancement (Fiscal). This unit is responsible for performing fiscal analyses on proposed cost-containment initiatives, maintaining existing reporting systems, overseeing payments for contracted services, and tracking fiscal data for the program. It assists in the preparation of fiscal notes, budget preparation, and bill reviews on pharmacy related issues. In addition, the unit is responsible for administering the pharmacy tax program and nursing facility returns. This unit is also responsible for the collection of rebates from pharmaceutical manufacturers contracted with Centers for Medicare and Medicaid Services to participate in the federal Drug Rebate Program, and for collection of supplemental rebates from manufacturers participating in the state's Supplemental Rebate Program. Manufacturers are invoiced quarterly by the unit 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. The federal and state rebate programs operate in much the same way.

3. Pharmacy Enhancement (Clinical). This unit 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). It also oversees the prior authorization of all new drug products and conducts drug pricing research. All clinical drug information and pharmacoeconomic evidence-based reviews are organized for presentation to the Drug Prior Authorization Committee and the Drug Use Review Board (DUR). Online point of sale clinical edits are established to assure cost effective and appropriate drug usage, and override requests for medically necessary over-the-counter drugs or non-reference diabetic supplies are reviewed. This unit provides manual pricing for certain exceptions claims, assists providers with exceptions claim inquiries, and updates spreadsheets for reference by the Exceptions Unit help desk. Provider education is provided for the Medicaid pharmacy program as well as for Medicare D and Missouri Rx claims inquiries. Emergency overrides are reviewed for patients unable to access benefits through Medicare D. This unit updates the listing of drug products on the Maximum Acquisition Cost (MAC)/Federal Upper Limit (FUL) lists. In addition, pharmacy prior authorizations are reviewed for recipients enrolled in Hospice to determine whether the medication is related to the terminal illness. Internal clinical management and coordination of care 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.

4. Program Operations and Policy. This unit is responsible for policy implementation, program communications, oversight of contracts with outside vendors for pharmacy and certain clinical program enhancement activities, and implementation of those program enhancements. Program and policy documents such as state plan amendments and state regulations are drafted to reflect program changes. Provider bulletins and announcements are posted on the Internet and program manuals are updated. This unit researches and gathers information for program development, and provides procedural support for systems changes and claims processing issues such as behavioral health prior authorization, medical procedures and equipment prior authorization, and durable medical equipment special pricing and rebates. This unit serves as the liaison with MMIS and other units within the division to facilitate program enhancement activities. Special retrospective audits are conducted to detect incorrect billings, make appropriate claims adjustments, and provide billing education. In addition, the unit provides administrative support for the Drug Use Review (DUR) Board and Regional DUR Committee, as well as assistance with enrolling providers in the Disease Management Program.

5. Missouri Rx Plan. This unit is responsible for the ongoing operations of the Missouri Rx Plan, which provides certain pharmaceutical benefits to certain elderly and disabled residents of the state, facilitates coordination of benefits between the Missouri Rx Plan and the federal Medicare D drug benefit program established by the Medicare Modernization Act of 2003, and enrolls such individuals into the plan. This unit also facilitates the Missouri Rx Plan Advisory Commission, with members including the lieutenant governor and members of the legislature, which is tasked with providing advice on guidelines, policies, and procedures necessary to establish the Missouri Rx Plan, educating Missouri residents on quality prescription drug programs and cost-containment strategies in medication therapy; and assisting Missouri residents in enrolling or accessing prescription drug assistance programs for which they are eligible. As a component of these duties, this unit oversees the production, maintenance, and regular updates of an Internet listing of prescription drug cost information for easy access by all members of the public.

6. Psychology Program. This unit is responsible for the implementation and maintenance of the Psychology/Counseling Program. This unit oversees the prior authorization of psychological services as required for enrolled populations. Clinical guidelines are reviewed by the Medicaid Non-Pharmaceutical Mental Health Services Prior Authorization Advisory Committee for clinical recommendations and input. The unit is also responsible for policy implementation, program communications, and consultation with provider education activities regarding psychological services. Consultation with the

Program Operations and Policy Unit insures policy documents such as bulletins, state plan amendments and state regulations are drafted to reflect program changes. Quality Improvement reviews of provider practice patterns and patient utilization are conducted to insure best practice approaches are implemented. Clinical oversight and consultation based upon evidence based approaches is offered to other state agencies and units, as well as professional boards and organizations.

AUTHORITY: section 208.201, RSMo 2000. 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.*

**Original authority: 208.201, RSMo 1987.*

13 CSR 70-1.020 Standards for Privacy of Individually Identifiable Health Information

PURPOSE: The state of Missouri, Department of Social Services, MO HealthNet Division, is committed to protecting the confidentiality of protected health information of applicants and participants of the Medical Assistance MO HealthNet Program. This rule describes how health care information about MO HealthNet applicants and participants may be used and disclosed and how MO HealthNet participants can get access to their personal health information.

(1) General Authority. There are many state and federal laws and regulations that safeguard applicants' and participants' protected health information. Section 1902(a)(7) of the federal Social Security Act requires that a state plan for medical assistance must provide safeguards which restrict the use or disclosure of information concerning applicants and participants to purposes directly connected with the administration of the plan. The Health Insurance Portability and Accountability Act (HIPAA) represents the first comprehensive federal protection of patient privacy (45 *Code of Federal Regulations*, parts 160–164). Passed by the United States Congress in 1996, HIPAA sets national standards to protect personal health information, reduces health care fraud, and makes health coverage more portable. The entire health care industry must implement HIPAA, including state governments.

(2) Definitions.

(A) Health Insurance Portability and Accountability Act of 1996 (HIPAA). This law established "portability" requirements, allowing employees to "take their coverage with them" when they changed jobs. The "Administrative Simplification" section of the law deals with privacy, security of health care information, and standardized formats for electronic health care transactions (such as submission of health care claims).

(B) Protected Health Information. A term established under the HIPAA privacy rules, it refers to individually identifiable health information, in whatever medium it is transmitted or maintained (e.g., paper, electronic, or even oral), including demographic information, that is created or received by a health care provider, health plan, employer, or health care clearinghouse and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

(C) Treatment, Payment and Health Care Operations (TPO) includes all of the following:

1. Treatment means the provision, coordination, or management of health care and related services, consultation between providers relating to an individual, or referral of an individual to another provider for health care.

2. Payment means activities undertaken by a health plan to obtain premiums or determine/fulfill responsibility for coverage or provision of benefits, or by a provider or health plan to obtain or provide reimbursement for health care, including determinations of eligibility or coverage, billing, collections activities, medical necessity determinations and utilization review.

3. Health care operations includes functions such as quality assessment and improvement activities, case management and care coordination, reviewing competence or qualifications of health care professionals, conducting training programs, licensing and credentialing activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, business planning and development, and general business and administrative activities (including activities relating to the sale, transfer or merger of the covered entity).

(3) Disclosures of Health Information Required or Allowed by Law. The Department of Social Services, the single state MO HealthNet agency, may use an applicant's or participant's individually identifiable health information for treatment, payment, or health care operations. For example, individually identifiable health information may be used to determine disability for a public assistance program; when reviewing a request from the treating physician for a MO HealthNet service that requires a prior approval; and when processing claims and other requests for medical care payments. The Department of Social Services, MO HealthNet Division may also report information for research purposes and matters concerning organ donations. The research must be for helping the MO HealthNet program. The Department of Social Services, MO HealthNet Division shall report:

(A) Contagious and reportable diseases, including, but not limited to, those defined by 19 CSR 20-20.020, birth defects, cancer, or other information for public health purposes;

(B) Firearm injuries and other trauma events;

(C) Reactions to problems with medicines;

(D) To the police when required by law;

(E) When the court orders the Department of Social Services to;

(F) To the government to review how Department of Social Services programs are working;

(G) To a provider or other insurance company who needs to know if a participant is enrolled in one of the Department of Social Services programs;

(H) To Workers' Compensation for work related injuries;

(I) Birth, death, and immunization information;

(J) To the federal government when they are looking into something important to protect our country, the President, and other government workers;

(K) Information about victims of abuse, neglect, or domestic violence to a government authority to the extent the disclosure is required by law; and

(L) Medical eligibility when that information is used for a governmental function, such as local public health agency using eligibility information to determine eligibility for local health programs.

(4) Other Uses and Disclosures Require the Applicant's or Participant's Written Authorization. For other situations, the Department of Social Services will ask for the applicant's or participant's or their representative's written authorization before using or disclosing information. The applicant or participant or their representative may cancel this authorization at any time in writing. The Department of Social Services cannot take back any

uses or disclosures already made with the applicant's or participant's or their representative's authorization.

(5) Applicant or Participant Rights to Restrict or Request Protected Health Information. An applicant or participant or their representative has the right to:

(A) Receive private information from the Department of Social Services by other means or at another place;

(B) Have their doctor see their health information, unless it is psychotherapy notes taken by a mental health provider that are kept separate from the rest of the individual's medical record;

(C) Request a change of their medical information if they think some of the information is wrong; and

(D) Request a list of medical information the Department of Social Services shared that was not for treatment, payment, or health care operations or as required by federal law. Beginning in April 2003 an applicant or participant or their representative can get a list of where their health information has been sent, unless it was sent for treatment, payment, checking to make sure they received quality care, or to make sure the laws are being followed, on forms prepared by the Department of Social Services.

1. If the individual requests a copy of the protected health information or agrees to a summary or explanation of such information, the covered entity may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:

A. Copying, including the cost of supplies for and labor of copying, the protected health information requested by the individual;

B. Postage, when the individual has requested the copy, or summary or explanation, be mailed;

C. Preparing an explanation or summary of the protected health information; and

D. Requests for information in other formats such as diskettes, audio/video tapes, slides, will be invoiced at the rate the agency actually paid for the format used.

AUTHORITY: section 208.201, RSMo Supp. 2007. Original rule filed Feb. 3, 2003, effective Sept. 30, 2003. Amended: Filed Oct. 12, 2007, effective April 30, 2008.*

**Original authority: 208.201, RSMo 1987, amended 2007.*