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**State/Territory Name: Missouri**

**State Plan Amendments (SPA) #: MO-18-0015**

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Children and Adults Health Programs Group

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**MAR 21 2019**

Todd Richardson, Director  
MO HealthNet Division  
State of Missouri, Department of Social Services  
615 Howerton Court, PO Box 6500  
Jefferson City, MO 65102

Dear Mr. Richardson:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) MO-18-0015, submitted to the Centers for Medicare & Medicaid Services (CMS) on June 29, 2018 with additional information submitted on March 11, 2019, has been approved. Through this SPA, Missouri implements mental health parity requirements to ensure that treatment limitations applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits. This SPA has an effective date of July 1, 2017 with the exception of the changes highlighted below.

Section 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), requires states that provide both M/S and MH/SUD benefits to ensure that financial requirements and treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of 2705(a) of the Public Health Service Act, in the same manner in that such requirements apply to a group health plan. Missouri demonstrated compliance by providing the necessary assurances and supporting documentation that the state's application of non-quantitative treatment limitations (NQTLs) to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act.

In order to comply with CHIP parity requirements, Missouri is making the following policy changes related to NQTLs applicable to MH/SUD benefits:

- The state revised prior authorization policies in the fee-for-service (FFS) delivery system to reduce the number of services that require prior authorization. However, the state needed to make systems changes to fully implement this policy. The state is expecting to implement these system modifications by April 14, 2019.
- The state identified documentation requirements that were only applicable to behavioral health providers and intends to address the issue by no later than May 30, 2019, following state regulatory changes.

This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Page 2- Mr. Todd Richardson

Your title XXI project officer is Ms. Kristin Edwards. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Edwards' contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid & CHIP Services  
Mail Stop: S2-01-16  
7500 Security Boulevard  
Baltimore, MD 21244-1850  
Telephone: (410) 786-5480  
E-mail: kristin.edwards@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Edwards and to Mr. James Scott, Associate Regional Administrator (ARA) in our Kansas City Regional Office. Mr. Scott's address is:

Centers for Medicare & Medicaid Services  
Division of Medicaid and Children's Health  
Richard Bolling Federal Building  
601 East 12<sup>th</sup> Street, Room 355  
Kansas City, MO 64106-2808

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/signed Anne Marie Costello/

Anne Marie Costello  
Director

Enclosure

cc: Mr. James Scott, Associate Regional Administrator, Region VII, Kansas City

Missouri Application for the State Children's Health Insurance Program

1.4 Effective Dates

Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment. (42 CFR 457.65)

Effective date (date State incurs costs):

Initial Combination SCHIP State Plan Submission, SPA #3: September 1, 2007  
SPA #4: Disapproved December 19, 2008  
SPA #5: Effective May 1, 2009  
SPA #6: Effective July 1, 2009  
SPA #7: Withdrawn June 29, 2011  
SPA #8: Effective July 1, 2011  
MO-15-0009-CHIP: Effective January 1, 2016  
MO-15-0010: Effective January 1, 2016  
MO-15-0011: Effective January 1, 2016  
MO-17-002: Effective May 1, 2017  
MO-18-0015: Effective July 1, 2017

Implementation date (date services begin):

SPA #3: September 1, 2007  
SPA #4: Disapproved December 19, 2008  
SPA #5: May 1, 2009  
SPA #6: July 1, 2009  
SPA #7: Withdrawn June 29, 2011  
SPA #8: Effective July 1, 2011  
MO-15-0009-CHIP: Effective January 1, 2016  
MO-15-0010: Effective January 1, 2016  
MO-15-0011: Effective January 1, 2016  
MO-17-002: Effective May 1, 2017  
MO-18-0015: Effective July 1, 2017

Effective Date: July 1, 2017  
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Approval Date:  
Prior Approval Date: ***May 18, 2017***

**6.2- MHPAEA** Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS’s contract review process at 42 CFR 457.1201(l).

**6.2.1- MHPAEA** Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

**6.2.1.1- MHPAEA** Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

- International Classification of Disease (ICD)
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines

Response: Please see the Missouri’s MHPAEA Report for the Centers for Medicare & Medicaid Services, Section IV, Definition of MH/SUD and M/S Benefit for a description of the use of the State’s Medicaid Manual. This report is enclosed.

Other (Describe: )

**6.2.1.2- MHPAEA** Does the State provide mental health and/or substance use disorder benefits?

- Yes*
- No

**Guidance: If the State does not provide any mental health or substance use**

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**disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.**

**6.2.2- MHPAEA** Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

**6.2.2.1- MHPAEA** Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

Yes

No

**Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.**

**If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state’s provision of EPSDT.**

Response: Missouri has a combination CHIP program consisting of an expansion CHIP population and a separate CHIP population. Only the separate CHIP population is included in this response since the expansion CHIP population is subject to Medicaid regulations that do not provide for deemed compliance with parity by providing EPSDT. Missouri’s separate CHIP population does not receive a full EPSDT benefit since they do not receive NEMT benefits.

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**6.2.2.2- MHPAEA** EPSDT benefits are provided to the following:

All children covered under the State child health plan.

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

**Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.**

**6.2.2.3- MHPAEA** To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

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Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

**Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.**

### **Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations**

**Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.**

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**Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.**

**6.2.3- MHPAEA** In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

**6.2.3.1 MHPAEA** Please describe below the standard(s) used to place covered benefits into one of the four classifications.

Response: Please see Missouri’s MHPAEA Report for the Centers for Medicare & Medicaid Services, Section V, Benefit Classification for a description of the standards used to place covered benefits into one of the four classifications. This report is enclosed.

**6.2.3.1.1 MHPAEA** The State assures that:

- The State has classified all benefits covered under the State plan into one of the four classifications.
- The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

**6.2.3.1.2- MHPAEA** Does the State use sub-classifications to distinguish between office visits and other outpatient services?

- Yes
- No*

**6.2.3.1.2.1- MHPAEA** If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

- The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

**Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-**

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**classifications to distinguish between outpatient office visits from other outpatient services.**

**6.2.3.2 MHPAEA** The State assures that:

Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

**Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).**

**Annual and Aggregate Lifetime Dollar Limits**

**6.2.4- MHPAEA** A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

**6.2.4.1- MHPAEA** Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

**Guidance: A monetary coverage limit that applies to all CHIP services provided under the State child health plan is not subject to parity requirements.**

**If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.**

**6.2.4.2- MHPAEA** Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

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Yes (Type(s) of limit: \_\_\_\_\_ )

No

**Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))**

**6.2.4.3 – MHPAEA.** States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

**Guidance: Please include the state’s methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.**

**6.2.4.3.1- MHPAEA** Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

Less than 1/3

At least 1/3 and less than 2/3

At least 2/3

**6.2.4.3.2- MHPAEA** Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual

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dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

**Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on any mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on any mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.**

**If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.**

**6.2.4.3.2.1- MHPAEA** If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

- The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

**Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.**

**6.2.4.3.2.2- MHPAEA** If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

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The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

### Quantitative Treatment Limitations

**6.2.5- MHPAEA** Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify: \_\_\_\_\_ )

No

**Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.**

**6.2.5.1- MHPAEA** Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

**Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.**

**6.2.5.2- MHPAEA** Within each classification of benefits in which the State applies a

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type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

- The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

**Guidance: Please include the state’s methodology and results as an attachment to the State child health plan.**

**6.2.5.3- MHPAEA** For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

**Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))**

**6.2.5.3.1- MHPAEA** For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as

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compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

**Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))**

## Non-Quantitative Treatment Limitations

**6.2.6- MHPAEA** The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

**6.2.6.1 – MHPAEA** If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

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**Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.**

Response: Please see Missouri's MHPAEA Report for the Centers for Medicare & Medicaid Services, Section VIII, Non-Quantitative Treatment Limitations, Appendix 1, Benefit Package and Classification Grid, and Appendix 2, NQTL Determination. This report is enclosed.

**6.2.6.2 – MHPAEA** The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

**6.2.6.2.1- MHPAEA** Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

**Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.**

**6.2.6.2.2- MHPAEA** If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

#### **Availability of Plan Information**

Effective Date: July 1, 2017

***Added Information***

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Approval Date:

Prior Approval Date: May 18, 2017

**6.2.7- MHPAEA** The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

**6.2.7.1- MHPAEA** Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

- State
- Managed Care entities
- Both
- Other

**Guidance: If other is selected, please specify the entity.**

**6.2.7.2- MHPAEA** Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- State
- Managed Care entities
- Both
- Other

**Guidance: If other is selected, please specify the entity.**

**6.3.** The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42 CFR 457.480)

- 6.3.1.**  The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2.**  The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

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Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

**6.4. Additional Purchase Options-** If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

**6.4.1. ☒ Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

**6.4.1.1.** Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42 CFR 457.1005(b))

**6.4.1.2.** The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42 CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that

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receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42 CFR, 457.1005(a))

- 6.4.1.3.** The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42 CFR 457.1005(a))

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary’s satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42 CFR 457.1010)

- 6.4.2. ☒** **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42 CFR 457.1010)

- 6.4.2.1.** Purchase of family coverage is cost-effective. The State’s cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its

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demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

**6.4.2.2.** The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42 CFR 457.1010(b))

**6.4.2.3.** The State assures that the coverage for the family otherwise meets title XXI requirements. (42 CFR 457.1010(c))

**6.4.3-PA: Additional State Options for Providing Premium Assistance** (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

Yes

No

**6.4.3.1-PA** Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

**6.4.3.1.1-PA** Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

**6.4.3.1.2-PA** Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

**6.4.3.2-PA:** Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

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**6.4.3.2.1-PA** If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

**6.4.3.2.2-PA** Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

**6.4.3.2.3-PA** If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

**6.4.3.3-PA:** Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

**6.4.3.3.1-PA** Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

**6.4.3.4-PA:** Opt-Out and Outreach, Education, and Enrollment Assistance

**6.4.3.4.1-PA** Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

**6.4.3.4.2-PA** Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

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**6.4.3.5-PA Purchasing Pool-** A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

Yes

No

**6.6.3.5.1-PA** Describe the plan to establish an employer-family premium assistance purchasing pool.

**6.6.3.5.2-PA** Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

**6.6.3.5.3-PA** Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

**6.4.3.6-PA Notice of Availability of Premium Assistance-** Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

**6.4.3.6.1-PA** Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

**Section 8. Cost-Sharing and Payment**

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan, and continue on to Section 9.

**8.4.** The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

- 8.4.1.**  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)
- 8.4.2.**  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)
- 8.4.3**  No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

**8.4.1- MHPAEA**  There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

**8.4.2- MHPAEA**  If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

**8.4.3- MHPAEA**  Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary’s income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

**8.4.4- MHPAEA** Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify: \_\_\_\_\_ )

No

**Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use**

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**disorder benefits, the state must conduct a parity analysis. Please continue below.**

**Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.**

**8.4.5- MHPAEA** Does the State apply any type of financial requirements on any medical/surgical benefits?

Yes

No

**Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.**

**8.4.6- MHPAEA** Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

**Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.**

**8.4.7- MHPAEA** For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

**Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR**

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**457.496(d)(3)(i)(A)**

**8.4.8- MHPAEA** For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

**Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))**

**8.5.** Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

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## **MHPAEA REPORT FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES**

### **I. INTRODUCTION**

The Centers for Medicare & Medicaid Services (CMS) issued a final rule that applies requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid managed care organizations (MCOs), the Children's Health Insurance Program (CHIP), and Medicaid alternative benefit plans (ABPs). The purpose of the rule is to strengthen access to mental health and substance use disorder services for Medicaid participants. The rule applied parity requirements to Medicaid managed care organizations, alternative benefit plans, and the Children's Health Insurance Program (CHIP). Specific requirements included:

- Aggregate lifetime and annual dollar limits;
- Financial requirements (FR);
- Quantitative treatment limitations (QTLs);
- Non-quantitative treatment limitations (NQTLs); and
- Information requirements.

In essence, the parity rule ensures that limitations on mental health and substance use disorder (MH/SUD) services are not more restrictive than limitations on medical/surgical (M/S) services. Aggregate lifetime and annual dollar limits are limits on the total dollar amount a Medicaid program will pay for specified benefits over a beneficiary's lifetime or on an annual basis. These limits cannot be applied to (MH/SUD) benefits unless they apply to at least one third of all (M/S) benefits. In addition, limits must either be applied to both M/S and MH/SUD benefits as a whole or the limits applicable to MH/SUD benefits must be no more restrictive than those for M/S benefits. FRs and QTLs for MH/SUD benefits within a classification may not be more restrictive than the predominant FR or QTL applicable to substantially all medical/surgical benefits in that classification.

A non-quantitative treatment limitation (NQTL) may not apply to MH/SUD benefits in a classification unless, under the policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification.

Further, the Parity Rule added requirements to make certain information pertaining to mental health and substance use disorder benefits available, specifically the criteria for medical necessity determinations and reason for denial of reimbursement or payment.

Missouri (State) and its contracted Medicaid/CHIP Health Plans were required to be in compliance with the final Medicaid/CHIP parity rule on or before October 2, 2017. Missouri requested an extension of this

compliance deadline, and CMS indicated they would not proactively enforce the compliance deadline and offered technical assistance. This report demonstrates the State of Missouri's compliance with the parity requirements in 42 CFR Part 438 related to MCOs (referred to as Health Plans in Missouri). Since the Health Plans provide services to both Medicaid and CHIP beneficiaries, this report addresses both Medicaid and CHIP. Information on parity compliance for CHIP beneficiaries will also be provided as part of the CHIP state plan amendment. Missouri does not have an ABP, so those requirements do not apply.

This report reflects work by the State and its Health Plans to conduct a review of the State's Medicaid/CHIP delivery system to assess compliance with the final Medicaid/CHIP parity rule. The State staff participating in the parity assessment included representatives from the following State agencies:

- The Missouri HealthNet Division (MHD) under the Missouri Department of Social Services
- The Division of Behavioral Health (DBH) under the Department of Mental Health
- The Division of Developmental Disabilities (DoDD) under the Department of Mental Health

## II. METHODOLOGY

The approach and results of each component of the analysis are discussed in detail in later sections of this report. Missouri's approach to conducting the parity analysis followed CMS guidance as outlined in the CMS parity toolkit, *"Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs"*<sup>1</sup> and included the following steps:

1. Identifying all benefit packages to which parity applies.
2. Determining whether the State or MCO is responsible for the parity analysis (by benefit package).
3. Defining mental health (MH), substance use disorder (SUD), and medical/surgical (M/S) benefits and determining which covered benefits are MH, SUD, and/or M/S benefits.
4. Defining the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and mapping MH/SUD and M/S benefits to these classifications.
5. Determining whether any aggregate lifetime or annual dollar limits (AL/ADLs) apply to MH/SUD benefits.
6. Determining whether any financial requirements (FRs) or quantitative treatment limitations (QTLs) apply to MH/SUD benefits and testing the applicable FRs or QTLs for compliance with parity.
7. Identifying and analyzing non-quantitative treatment limitations (NQTLs) that apply to MH/SUD benefits.

## III. MEDICAID/CHIP DELIVERY SYSTEM AND BENEFIT PACKAGES

### **Medicaid/CHIP Delivery System**

Missouri operates a mandatory capitated managed care program for certain Medicaid beneficiaries and all CHIP beneficiaries. Managed care in Missouri was implemented in 1995 for certain regions of Missouri and requires certain Medicaid populations (TANF, pregnant women, and foster care) and CHIP beneficiaries to receive acute physical and limited behavioral health services through a Health Plan. Missouri's Medicaid/CHIP managed care program, operated by MHD, is authorized under the authority of a 1915(b) waiver. On May 1, 2017, Missouri extended coverage statewide for the same populations previously covered under managed care. For covered Medicaid populations and CHIP children, nearly all beneficiaries are enrolled in managed care.

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<sup>1</sup> Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>

MHD currently contracts with three Health Plans to serve Medicaid/CHIP beneficiaries: Home State Health, Missouri Care, and United Healthcare Community Health Plan. Certain services, including pharmacy and the majority of MH/SUD benefits, are provided fee-for-service (FFS). For most populations, the Health Plans provide limited MH/SUD coverage, and the remaining MH/SUD benefits are covered by DMH. For Foster Children (see Table 1), all MH/SUD benefits are covered FFS, with certain MH/SUD benefits managed by MHD and others by DMH.

**Benefit Packages**

Missouri identified eight benefit packages subject to the requirements in the final Medicaid/CHIP parity rule. See Appendix 1 for detailed information on the benefit packages, including the MH, SUD, and M/S benefits by classification. For each benefit package, Missouri covers MH and SUD benefits in each classification in which there is an M/S benefit (all four benefit classifications).

**TABLE 1 – BENEFIT PACKAGES**

| <b>Benefit Package Name</b>                              | <b>Eligibility Groups</b>  |
|--|--|
| Adults (Ages 21+)  | <ul style="list-style-type: none"> <li>• Medical Assistance (MA) for Families</li> <li>• Transitional MA</li> <li>• Refugee Assistance</li> </ul>  |
| Pregnant Women (Ages 21+)                                | <ul style="list-style-type: none"> <li>• Pregnant Women</li> </ul>   |
| CHIP – Separate (<19) <sup>1</sup>                       | <ul style="list-style-type: none"> <li>• CHIP Kids</li> </ul>  |
| Foster Children (FC) – Outside Jackson County (JC) (<21) | <ul style="list-style-type: none"> <li>• State Custody</li> </ul>  |
| FC – Outside JC (21-25)                                  | <ul style="list-style-type: none"> <li>• Foster Care</li> </ul>  |
| FC – JC (<21)  | <ul style="list-style-type: none"> <li>• Adoption Subsidy</li> </ul>   |
| FC – JC (21-25)  | <ul style="list-style-type: none"> <li>• Juvenile Courts</li> </ul>  |
| Other Children   | <ul style="list-style-type: none"> <li>• Medical Assistance (MA) for Families</li> <li>• Transitional MA</li> <li>• MO HealthNet for Newborns</li> <li>• Refugee Assistance</li> <li>• Pregnant Women (&lt;21)</li> <li>• CHIP Expansion*</li> </ul> |

<sup>1</sup>Note that effective September 1, 2007, CMS approved Missouri’s request for a combination CHIP. The CHIP combination program is comprised of a Medicaid Expansion and a Separate Child Health Insurance Program. For purposes of the parity analysis, the Separate Child Health Insurance Program (CHIP Separate) was not included under Other Children since it does not cover non-emergency medical transportation (NEMT).

**IV. DEFINITION OF MH/SUD AND M/S BENEFITS**

For purposes of the parity analysis, Missouri adopted the most recent version of the International Classification of Diseases (ICD), the ICD-10-CM, as its standard for defining MH/SUD and M/S benefits. ICD-10-CM is the current version of the ICD, which is identified in the final Medicaid/CHIP parity rule as an example of a “generally recognized independent standard of current medical practice” for defining M/S, MH, and SUD conditions.

Missouri defined MH/SUD conditions as those conditions listed in ICD-10-CM, Chapter 5 “Mental, Behavioral, and Neurodevelopmental Disorders” with the exception of:

- Conditions listed in subchapter 1, “Mental disorders due to known physiological conditions” (F01 to F09);
- Conditions listed in subchapter 8, “Intellectual disabilities” (F70 to F79); and
- Conditions listed in subchapter 9, “Pervasive and specific developmental disorders” (F80 to F89).

Missouri defined M/S conditions as those conditions listed in ICD-10-CM Chapters 1-4, subchapters 1, 8 and 9 of Chapter 5, and Chapters 6-20.

Missouri excluded subchapter 1 from the definition of MH/SUD because these mental disorders are due to known physiological conditions (e.g., vascular dementia, delirium due to known physiological conditions) and all except one require that the physiological condition be coded first, indicating that the physiological (rather than the MH) condition is the focus of services. Missouri excluded subchapters 8 and 9 from the definition of MH/SUD because these chapters identify neurodevelopmental disorders as opposed to mental or behavioral disorders.

Excluding subchapters 8 (intellectual disabilities) and 9 (developmental disorders) from the definition of MH/SUD is consistent with the State’s current structure and practice. Services for these conditions are managed by DoDD, not by MHD or DBH. In addition, not including these disorders as MH/SUD disorders is consistent with CMS’ definition of “mental disease,” in the State Medicaid Manual (SMM) Section 4390.D, which provides as follows: “...the term ‘mental disease’ includes diseases listed as mental disorders in the [ICD-9-CM], with the exception of mental retardation, senility, and organic brain syndrome.”<sup>2</sup> Also, not including F70 to F79 (intellectual disabilities) and F80 to F89 (pervasive and specific developmental disorders) is consistent with the definition of “Persons with related conditions” in 42 CFR 435.1010: “Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to (1) Cerebral palsy or epilepsy; or (2) Any other condition, other than mental illness, found to be closely related to Intellectual Disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons...” (sections (b) through (d) omitted; emphasis supplied).<sup>3</sup>

## V. BENEFIT CLASSIFICATIONS

Missouri developed the following definitions for each of the four benefit classifications identified in the Medicaid/CHIP parity rule.

**Inpatient:** All covered services or items (including medications) provided to a beneficiary in a setting for which the State pays room and board.

**Outpatient:** All covered services or items (including medications) provided to a beneficiary that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs.

**Emergency Care:** All covered services or items (including medications) delivered in an emergency department setting.

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<sup>2</sup> State Medicaid Manual – Part 4 Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R74SMM.pdf>

<sup>3</sup> 42 CFR § 435.1010 - DEFINITIONS RELATING TO INSTITUTIONAL STATUS, <https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol4/xml/CFR-2015-title42-vol4-sec435-1010.xml>

**Prescription Drugs:** Covered medications, drugs and associated supplies that require a prescription for use in an outpatient setting and other services delivered by pharmacist who works in a free-standing pharmacy.

As noted above, Missouri’s state plan covers MH and SUD benefits in each classification in which there is a M/S benefit. See Appendix 1 for a mapping of MH/SUD and M/S benefits to each classification.

#### VI. AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS (AL/ADLS)

No aggregate lifetime or annual dollar limits apply to Medicaid/CHIP MH/SUD benefits in any benefit package.

#### VII. FINANCIAL REQUIREMENTS (FRS) AND QUANTITATIVE TREATMENT LIMITATIONS (QTLS)

##### **Financial Requirements**

##### ***Inpatient, Outpatient, and Emergency Care Benefits***

For Health Plan enrollees, no financial requirements apply to Medicaid/CHIP MH/SUD benefits in any benefit package for the Inpatient, Outpatient, and Emergency Care benefit classifications.

##### ***Prescription Drug Benefits***

The Prescription Drug benefits are administered by the State and are not the financial responsibility of the Health Plans. A tiered copayment for prescription drugs applies to Medicaid/CHIP benefits. Missouri’s tiered copayment for prescription drugs is based on the Medicaid cost/payment for the drug. This tiered copayment applies to all prescription drugs and, since the benefit is administered by the State, to both Medicaid FFS beneficiaries and Health Plan enrollees. See below for the copayment schedule. The copayment amount is based on the Medicaid payment for the drug and not whether the drug is used for the treatment of a MH/SUD or M/S condition, and the same level of copayment is applied across each tier without regard to whether the drug is for the treatment of a MH/SUD or M/S condition.

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**TABLE 2 – PRESCRIPTION DRUG TIERED COPAYMENTS**

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| <b>Medicaid Payment for the Drug</b> | <b>Copayment</b> |
|--------------------------------------|------------------|
| \$10.00 or less                      | \$.50            |
| \$10.01 to \$25.00                   | \$1.00           |
| \$25.01 to \$50.00                   | \$2.00           |
| \$50.01 or more                      | \$3.00           |

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##### **Quantitative Treatment Limitations**

Missouri does not apply any quantitative treatment limitations to MH/SUD benefits that cannot be exceeded based on medical necessity. Thus, these limitations were analyzed as NQTLs (see Section VIII of this report).

#### VIII. NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTLs)

Missouri identified a list of potential NQTLs through a workgroup process using the following sources:

- Illustrative list of NQTLs in the final Medicaid/parity rule
- MHPAEA parity toolkit

- Written guidance from the Department of Labor regarding the commercial parity rule (including FAQs, MHPAEA enforcement updates, and a document identifying potential “red flag” NQTLs)
- Information from the State’s consultant
- Internal discussion

Additionally, the State developed a request for information (RFI) for each agency to complete with information needed to conduct the NQTL analysis. The RFI required information on the processes, strategies, and evidentiary standards in both writing and operations for each of the NQTLs the agency applies to MH/SUD benefits managed by the state agency. The information was further detailed by classification and benefit package. This RFI included prompts to help identify the type of information relevant to the parity analysis. Separate prompts were provided for processes, strategies, and evidentiary standards for each part of the NQTL analysis (comparability and stringency) and to collect information on how the factors apply both in writing and in operation.

In addition to collecting information on NQTLs that apply to MH/SUD benefits managed by the State (referenced as the FFS MH/SUD NQTLs), the State developed an additional request for information (RFI) to collect information from each Health Plan. The RFI required information on how the Health Plan applies the FFS NQTLs to MH/SUD and M/S benefits managed by the Health Plan as well as any additional NQTLs applied by the MCOs to MH/SUD benefits (including information on how the Health Plan applies those NQTLs to M/S benefits). The RFI included the list of NQTLs identified by the State as described above but also asked the Health Plans to identify any other NQTLs that they apply to MH/SUD benefits. The Health Plans completed a summary grid that identified which FFS MH/SUD NQTLs and other NQTLs they apply to MH/SUD benefits, by benefit package and classification, and provided information, by benefit package and classification, on the MH/SUD and M/S benefits to which the NQTL applies and the processes, strategies, and evidentiary standards for each of the NQTLs. As in the State RFI, the Health Plan RFI included prompts to help the Health Plans provide the information needed for the parity analysis. The information provided by each Health Plan was reviewed by the State, and the State conducted follow up as needed.

The State used the information from the RFIs to compare the processes, strategies, evidentiary standards and other factors for each MH/SUD NQTL as it applies to MH/SUD benefits and M/S benefits, in writing and in operation, in a classification, for each benefit package. The processes, strategies, evidentiary standards and other factors were reviewed for comparability and stringency in writing and in operation.

Tables 3-5 lists the NQTLs that apply to MH/SUD benefits and the State has determined comply with parity. The table also identifies the applicable benefit package groups and classification. In the tables below, a “✓” indicates the NQTL applies to a certain benefit package(s) and classification(s). Grayed out sections in the tables below indicate the NQTL does not apply to a certain benefit package or classification. Additional information on each NQTL and how each NQTL meets parity requirements is included in Appendix 2, described below.

**TABLE 3 – NQTLS – HOME STATE HEALTH**

| NQTL Name   | Adults |    |    |    | Pregnant Women |    |    |    | CHIP— Separate |    |    |    | FC – JC (<21) |    |    |    | FC – JC (21-25) |    |    |    | FC - Outside JC (<21) |    |    |    | FC - Outside JC (21-25) |    |    |    | Other Children |    |    |    |
|---|--------|----|----|----|----------------|----|----|----|----------------|----|----|----|---------------|----|----|----|-----------------|----|----|----|-----------------------|----|----|----|-------------------------|----|----|----|----------------|----|----|----|
|   | IP     | OP | EC | PD | IP             | OP | EC | PD | IP             | OP | EC | PD | IP            | OP | EC | PD | IP              | OP | EC | PD | IP                    | OP | EC | PD | IP                      | OP | EC | PD | IP             | OP | EC | PD |
| Prior Authorization* / Concurrent Review* / Retrospective Review  | ✓      | ✓  |    | ✓  | ✓              | ✓  |    | ✓  | ✓              | ✓  |    | ✓  | ✓             | ✓  |    | ✓  | ✓               | ✓  |    | ✓  | ✓                     | ✓  |    | ✓  | ✓                       | ✓  |    | ✓  | ✓              | ✓  |    | ✓  |
| Step Therapy/Fail First Requirements*   |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |
| Documentation Requirements*   | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Development/ Modification/ Addition of Medical Necessity/ Medical Appropriateness/ Level of Care Guidelines* and Experimental/ Investigational Determinations | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Network Admission Requirements – Provider Enrollment and Credentialing*   | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Provider Type Exclusions*   | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Provider Reimbursement* / Usual, Customary and Reasonable (UCR) Determinations (out-of-network provider reimbursement)*                                       | ✓      | ✓  |    | ✓  | ✓              | ✓  |    | ✓  | ✓              | ✓  |    | ✓  | ✓             | ✓  |    | ✓  | ✓               | ✓  |    | ✓  | ✓                     | ✓  |    | ✓  | ✓                       | ✓  |    | ✓  | ✓              | ✓  |    | ✓  |
| Geographic Restrictions* / Travel Time/Distance Requirements* / Standards for Out-of-Network Coverage*  | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Drugs not Covered Pursuant to Section 1927(d)(2)  |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |
| Early Refills   |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |
| Tiered Copayments   |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |

\*Applies to FFS MH/SUD

IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs

**TABLE 4 – NQTLS – MISSOURI CARE**

| NQTL Name   | Adults |    |    |    | Pregnant Women |    |    |    | CHIP— Separate |    |    |    | FC – JC (<21) |    |    |    | FC – JC (21-25) |    |    |    | FC - Outside JC (<21) |    |    |    | FC - Outside JC (21-25) |    |    |    | Other Children |    |    |    |
|---|--------|----|----|----|----------------|----|----|----|----------------|----|----|----|---------------|----|----|----|-----------------|----|----|----|-----------------------|----|----|----|-------------------------|----|----|----|----------------|----|----|----|
|   | IP     | OP | EC | PD | IP             | OP | EC | PD | IP             | OP | EC | PD | IP            | OP | EC | PD | IP              | OP | EC | PD | IP                    | OP | EC | PD | IP                      | OP | EC | PD | IP             | OP | EC | PD |
| Prior Authorization* / Concurrent Review* / Retrospective Review  | ✓      | ✓  |    | ✓  | ✓              | ✓  |    | ✓  | ✓              | ✓  |    | ✓  | ✓             | ✓  |    | ✓  | ✓               | ✓  |    | ✓  | ✓                     | ✓  |    | ✓  | ✓                       | ✓  |    | ✓  | ✓              | ✓  |    | ✓  |
| Documentation Requirements*   | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Development/ Modification/ Addition of Medical Necessity/ Medical Appropriateness/ Level of Care Guidelines* and Experimental/ Investigational Determinations | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Network Admission Requirements – Provider Enrollment and Credentialing*   | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Provider Type Exclusions*   | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Provider Reimbursement* / Usual, Customary and Reasonable (UCR) Determinations (out-of-network provider reimbursement)*                                       | ✓      | ✓  | ✓  | ✓  | ✓              | ✓  | ✓  | ✓  | ✓              | ✓  | ✓  | ✓  | ✓             | ✓  | ✓  | ✓  | ✓               | ✓  | ✓  | ✓  | ✓                     | ✓  | ✓  | ✓  | ✓                       | ✓  | ✓  | ✓  | ✓              | ✓  | ✓  | ✓  |
| Geographic Restrictions* / Travel Time/Distance Requirements* / Standards for Out-of-Network Coverage*  | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Drugs not Covered Pursuant to Section 1927(d)(2)  |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |
| Early Refills   |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |
| Tiered Copayments   |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |

\*Applies to FFS MH/SUD  
 IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs

**TABLE 4 – NQTLS – UNITEDHEALTHCARE**

| NQTL Name   | Adults |    |    |    | Pregnant Women |    |    |    | CHIP— Separate |    |    |    | FC – JC (<21) |    |    |    | FC – JC (21-25) |    |    |    | FC - Outside JC (<21) |    |    |    | FC - Outside JC (21-25) |    |    |    | Other Children |    |    |    |
|---|--------|----|----|----|----------------|----|----|----|----------------|----|----|----|---------------|----|----|----|-----------------|----|----|----|-----------------------|----|----|----|-------------------------|----|----|----|----------------|----|----|----|
|   | IP     | OP | EC | PD | IP             | OP | EC | PD | IP             | OP | EC | PD | IP            | OP | EC | PD | IP              | OP | EC | PD | IP                    | OP | EC | PD | IP                      | OP | EC | PD | IP             | OP | EC | PD |
| Prior Authorization* / Concurrent Review* / Retrospective Review  | ✓      | ✓  |    | ✓  | ✓              | ✓  |    | ✓  | ✓              | ✓  |    | ✓  | ✓             | ✓  |    | ✓  | ✓               | ✓  |    | ✓  | ✓                     | ✓  |    | ✓  | ✓                       | ✓  |    | ✓  | ✓              | ✓  |    | ✓  |
| Outlier Review  | ✓      | ✓  | ✓  |    | ✓              | ✓  | ✓  |    | ✓              | ✓  | ✓  |    | ✓             | ✓  | ✓  |    | ✓               | ✓  | ✓  |    | ✓                     | ✓  | ✓  |    | ✓                       | ✓  | ✓  |    | ✓              | ✓  | ✓  |    |
| Documentation Requirements*   | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Development/ Modification/ Addition of Medical Necessity/ Medical Appropriateness/ Level of Care Guidelines* and Experimental/ Investigational Determinations | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Network Admission Requirements – Provider Enrollment and Credentialing*   | ✓      | ✓  | ✓  |    | ✓              | ✓  | ✓  |    | ✓              | ✓  | ✓  |    | ✓             | ✓  | ✓  |    | ✓               | ✓  | ✓  |    | ✓                     | ✓  | ✓  |    | ✓                       | ✓  | ✓  |    | ✓              | ✓  | ✓  |    |
| Provider Type Exclusions*   | ✓      | ✓  |    |    | ✓              | ✓  |    |    | ✓              | ✓  |    |    | ✓             | ✓  |    |    | ✓               | ✓  |    |    | ✓                     | ✓  |    |    | ✓                       | ✓  |    |    | ✓              | ✓  |    |    |
| Provider Reimbursement* / Usual, Customary and Reasonable (UCR) Determinations (out-of-network provider reimbursement)*                                       | ✓      | ✓  | ✓  | ✓  | ✓              | ✓  | ✓  | ✓  | ✓              | ✓  | ✓  | ✓  | ✓             | ✓  | ✓  | ✓  | ✓               | ✓  | ✓  | ✓  | ✓                     | ✓  | ✓  | ✓  | ✓                       | ✓  | ✓  | ✓  | ✓              | ✓  | ✓  | ✓  |
| Geographic Restrictions* / Travel Time/Distance Requirements* / Standards for Out-of-Network Coverage*  | ✓      | ✓  | ✓  |    | ✓              | ✓  | ✓  |    | ✓              | ✓  | ✓  |    | ✓             | ✓  | ✓  |    | ✓               | ✓  | ✓  |    | ✓                     | ✓  | ✓  |    | ✓                       | ✓  | ✓  |    | ✓              | ✓  | ✓  |    |
| Drugs not Covered Pursuant to Section 1927(d)(2)  |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |
| Early Refills   |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |
| Tiered Copayments   |        |    |    | ✓  |                |    |    | ✓  |                |    |    | ✓  |               |    |    | ✓  |                 |    |    | ✓  |                       |    |    | ✓  |                         |    |    | ✓  |                |    |    | ✓  |

\*Applies to FFS MH/SUD

IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs

# APPENDIX 1 — BENEFIT PACKAGE AND CLASSIFICATION GRID

| Benefit  | MH/SUD or M/S Benefit | Benefit Classification <sup>1</sup> | Adults | Pregnant Women | CHIP— Separate | FC – JC (<21) | FC – JC (21-25) | FC - Outside JC (<21) | FC - Outside JC (21-25) | Other Children |
|--|-----------------------|-------------------------------------|--------|----------------|----------------|---------------|-----------------|-----------------------|-------------------------|----------------|
| <b>Health Plan Benefit Package</b>                                     |                       |                                     |        |                |                |               |                 |                       |                         |                |
| Ambulance (emergency only)   | Both                  | EC                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Ambulatory Surgical Care   | M/S                   | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Birthing Center  | M/S                   | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Certified Nurse Practitioners  | Both                  | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Comprehensive Day Rehabilitation                                       | M/S                   | OP                                  |        | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Dental Services  | M/S                   | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Dentures   | M/S                   | OP                                  |        | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Diabetes Self-Management Training                                      | M/S                   | OP                                  |        | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Durable Medical Equipment  | M/S                   | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Emergency Medical, BH and SA Services, and Post-Stabilization Services | Both                  | EC                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Family Planning Services   | M/S                   | IP/OP                               | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Healthy Children and Youth program (i.e., EPSDT)                       | Both                  | OP                                  |        |                | ✓              | ✓             |                 | ✓                     |                         | ✓              |
| Hearing Aids (Audiology)   | M/S                   | OP                                  |        | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Home Health Services   | M/S                   | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Hospice Services   | M/S                   | IP/OP                               | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Inpatient Hospital Services  | Both                  | IP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Laboratory and X-ray services  | Both                  | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Non-Emergency Medical Transportation                                   | Both                  | OP                                  | ✓      | ✓              |                | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Nurse midwife  | M/S                   | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Optical  | M/S                   | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Orthodontics   | M/S                   | OP                                  |        |                | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Outpatient Hospital Services   | Both                  | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Personal Care  | Both                  | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Physician/Advanced Practice Nurse Services/FQHC/RHC                    | Both                  | IP/OP                               | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Podiatry Services  | M/S                   | OP                                  | ✓      | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |

| Benefit   | MH/SUD or M/S Benefit | Benefit Classification <sup>1</sup> | Adults        | Pregnant Women | CHIP— Separate | FC – JC (<21) | FC – JC (21-25) | FC - Outside JC (<21) | FC - Outside JC (21-25) | Other Children |
|---|-----------------------|-------------------------------------|---------------|----------------|----------------|---------------|-----------------|-----------------------|-------------------------|----------------|
| Private Duty Nursing  | M/S                   | OP                                  |               |                | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Psychologists   | MH/SUD                | OP                                  | ✓             | ✓              | ✓              | FFS           | FFS             | FFS                   | FFS                     | ✓              |
| Rehabilitation Services   | Both                  | OP                                  |               |                | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Social Workers/Counselors   | Both                  | OP                                  | ✓             | ✓              | ✓              | FFS           | FFS             | FFS                   | FFS                     | ✓              |
| Targeted Case Management — HCY & Lead, Prenatal                           | Both                  | OP                                  | Prenatal Only | Prenatal Only  | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Transplant Related Services (Pre-Transplant and Post-Transplant Services) | M/S                   | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| <b>FFS-Only Services</b>  |                       |                                     |               |                |                |               |                 |                       |                         |                |
| Applied Behavioral Analysis   | M/S                   | OP                                  |               |                | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Environmental Lead Assessment   | M/S                   | OP                                  |               |                | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| ICF/MR  | M/S                   | IP                                  |               |                |                | ✓             | ✓               | ✓                     | ✓                       |                |
| Nursing Facility  | M/S                   | IP                                  |               |                |                |               |                 |                       |                         |                |
| Pharmacy  | Both                  | PD/OP <sup>2</sup>                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Targeted Case Management (TCM) — Foster Care                              | Both                  | OP                                  |               |                |                | ✓             | ✓               |                       |                         |                |
| TCM — SMI/SED and MRDD  | Both                  | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Transplants   | M/S                   | IP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| <b>Community Psych Rehab Services</b>                                     |                       |                                     |               |                |                |               |                 |                       |                         |                |
| - Assertive Community Treatment   | MH/SUD                | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| - Co-Occurring Services   | MH/SUD                | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| - Community Support   | MH/SUD                | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| - Consultation Services   | MH/SUD                | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| - Crisis Intervention and Resolution                                      | MH/SUD                | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| - Day Treatment - Youth   | MH/SUD                | OP                                  |               |                | ✓              | ✓             |                 | ✓                     |                         | ✓              |
| - Evidence Base Practices   | MH/SUD                | OP                                  |               |                | ✓              | ✓             |                 | ✓                     |                         | ✓              |
| - Evaluation and Treatment Plans  | MH/SUD                | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| - Family Assistance   | MH/SUD                | OP                                  |               |                | ✓              | ✓             |                 | ✓                     |                         | ✓              |
| - Family Support  | MH/SUD                | OP                                  |               |                | ✓              | ✓             |                 | ✓                     |                         | ✓              |
| - Individual and Group Professional PSR (Ages 5+)                         | MH/SUD                | OP                                  | ✓             | ✓              | ✓              | ✓             | ✓               | ✓                     | ✓                       | ✓              |

| Benefit  | MH/SUD<br>or M/S<br>Benefit | Benefit<br>Classific<br>ation <sup>1</sup> | Adults | Pregnant<br>Women | CHIP—<br>Separate | FC – JC<br>(<21) | FC – JC<br>(21-25) | FC -<br>Outside<br>JC (<21) | FC -<br>Outside<br>JC (21-<br>25) | Other<br>Children |
|--|-----------------------------|--|--------|-------------------|-------------------|------------------|--------------------|-----------------------------|-----------------------------------|-------------------|
| - Inpatient Diversion (Child & Adult)  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Intensive Community Psychiatric Rehab                                      | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Medication Services  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Medication Administration  | MH/SUD                      | PD/OP                                      | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Metabolic Syndrome Screening   | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Peer Support Services  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Professional Parent Home   | MH/SUD                      | OP   |        |                   | ✓                 | ✓                |                    | ✓                           |                                   | ✓                 |
| - Psychosocial Rehabilitation  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - PSR Illness Management and Recovery  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - School Based Services  | MH/SUD                      | OP   |        |                   | ✓                 | ✓                |                    | ✓                           |                                   | ✓                 |
| - Treatment Family Home  | MH/SUD                      | OP   |        |                   | ✓                 | ✓                |                    | ✓                           |                                   | ✓                 |
| <b>Comprehensive Substance Treatment and Rehabilitation (CSTAR) Services</b> |                             |  |        |                   |                   |                  |                    |                             |                                   |                   |
| - Assessment and Diagnostic Testing  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Adolescent Treatment Support (Ages 12-17)                                  | MH/SUD                      | OP   |        |                   | ✓                 | ✓                |                    | ✓                           |                                   | ✓                 |
| - Collateral Dependent Counseling (Individual and Group)                     | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Communicable Disease Counseling  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Community Support  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Comprehensive Assessment   | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Day Treatment  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Extended Day Treatment   | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Family Therapy (Office and Home)   | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Group Counseling   | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Group Therapeutic Substance Use Education                                  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Individual Counseling  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Medically Monitored Inpatient Detoxification                               | MH/SUD                      | IP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Medication Services  | MH/SUD                      | OP   | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |
| - Opioid Treatment Program   | MH/SUD                      | PD/OP                                      | ✓      | ✓                 | ✓                 | ✓                | ✓                  | ✓                           | ✓                                 | ✓                 |

| Benefit  | MH/SUD or M/S Benefit | Benefit Classification <sup>1</sup> | Adults | Pregnant Women | CHIP— Separate | FC – JC (<21) | FC – JC (21-25) | FC - Outside JC (<21) | FC - Outside JC (21-25) | Other Children |
|--|-----------------------|-------------------------------------|--------|----------------|----------------|---------------|-----------------|-----------------------|-------------------------|----------------|
| <b>1915(c) Home and Community Based Services Waivers</b> |                       |                                     |        |                |                |               |                 |                       |                         |                |
| Adult Day Care Waiver (Ages 18–63)                       | M/S                   | OP                                  | ✓      | ✓              |                | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| DD Comprehensive Waiver                                  | M/S                   | OP                                  | ✓      | ✓              |                | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Division of DD Community Support Waiver                  | M/S                   | OP                                  | ✓      | ✓              |                | ✓             | ✓               | ✓                     | ✓                       | ✓              |
| Partnership for Hope                                     | M/S                   | OP                                  | ✓      | ✓              |                | ✓             | ✓               | ✓                     | ✓                       | ✓              |

<sup>1</sup> IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drugs

<sup>2</sup> Pharmacy benefits grouped in the Outpatient benefit classification include physician administered drugs.

## APPENDIX 2 — NQTL DETERMINATION

The compliance analysis and determination for each NQTL, by benefit package and classification, is provided in this Appendix. The compliance analysis includes the MH/SUD and M/S benefits to which the NQTL applies; which entity (the Health Plan, MHD, DBH, or DoDD) manages the benefits; the parity analysis (comparability and stringency of the processes, strategies, evidentiary standards, and other factors used in applying the NQTL); and the compliance determination.

Since both the State and the Health Plans administer MH/SUD benefits for all benefit packages except those for Foster Children, the analysis and compliance determination for the NQTLs that the State applies to FFS MH/SUD benefits (identified in Tables 3-5 of the narrative with an asterisk) for all benefit packages (except those for Foster Children) include information about both the State and Health Plan managed benefits.

NQTL: Prior Authorization (PA) / Concurrent Review (CR) / Retrospective Review (RR)

Health Plan/State: Home State Health/Fee-for-Service

Benefit Package(s): Adults (21+), Pregnant Women (21+), Children: COA 1 (0-20), PW (0-20), CHIP Exp. (0-18), and CHIP Separate (0-18), COA 4 if admission is for combination of physical and behavioral health

Classification: Inpatient (IP)

**MH/SUD Benefits/Providers**

**M/S Benefits/Providers**

Home State Health: IP MH, IP SUD

Home State: inpatient admissions M/S

FFS: N/A

FFS: Transplant

**Compliance Analysis**

Both MH/SUD and M/S require PA for scheduled IP services. Emergency admissions and continued stays for both MH/SUD and M/S are subject to CR. RR applies when services have already been provided. Inpatient admissions are subject to authorizations since they are high cost and best practice is to treat in the least restrictive setting that meets the individual's clinical needs. For both MH/SUD and M/S services, PA/CR facilitates better care coordination for the member and indicates to the HEALTH PLAN the need to assess for care management services.

MH/SUD and M/S PA and CR requests may be submitted by phone, fax, or web. MH/SUD RR requests are submitted by fax or mail; M/S RR requests may be submitted by fax, phone, or web. MH/SUD uses LOCUS/CALOCUS, as required by the state, as well as clinical policy guidelines. M/S uses Interqual guidelines and Centene clinical policies. For M/S, nonclinical and clinical staff review PA requests., and clinical staff review CR, and RR requests. For MH/SUD, reviewers of PA, CR, and RR requests are licensed clinicians, as required by the state. For MH/SUD and for M/S denial rates are reviewed at least quarterly. Both MH/SUD and M/S require annual inter-rater reliability training/testing for utilization management staff and both require a 90% score. The timeframe for reviewing standard M/S PA requests is 36 hours to include one working day. Urgent M/S PA requests are completed within 24 hours. For MH/SUD PA reviews for scheduled admissions are completed within an hour of notification. For both MH/SUD and M/S, CR requests are completed within 24 hours. Nearly all MH/SUD inpatient admissions are emergent. For both MH/SUD and M/S requests for PA and CR, if the first reviewer is unable to approve, the second reviewer is a psychiatrist/physician, respectively. The provider and member have appeal rights in the event of an adverse determination. If the denial is upheld, members have the right to a state fair hearing, and providers can appeal to the administrative hearings commission.

PA / CR / RR requirements are reviewed and updated annually or as assigned by the state. For both MH/SUD and M/S, some facility contracts do not allow for RR. MH/SUD contracts allow for RR unless specifically excluded, but for M/S, contracts do not allow for RR unless specifically included, thus RR is less restrictive for MH/SUD as compared to M/S.

Transplant services are provided to health plan members through FFS. The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's Patient Selection Protocol and Patient Selection Criteria for the type of transplant to be performed. The patient must have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division. Physician reviews request and if not approved by first reviewer, it is sent to second physician reviewer.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Prior Authorization (PA) / Concurrent Review (CR) / Retrospective Review (RR)

Health Plan/State: Home State Health, FFS

Benefit Package(s): Category of Aid (COA) 4 (Ages 0-20), including ME 38 (ages 21-25), and foster children in and out of Jackson County

Classification: Inpatient

| <b>MH/SUD Benefits/Providers</b>      | <b>M/S Benefits/Providers</b>         |
|---------------------------------------|---------------------------------------|
| Home State: N/A<br>FFS: MH IP, SUD IP | Home State: M/S IP<br>FFS: Transplant |

**Compliance Analysis**

Both MH/SUD (provided to health plan members through FFS) and M/S require PA for scheduled IP services. Emergency admissions and continued stays for both MH/SUD and M/S are subject to CR. RR applies when services have already been provided. Inpatient admissions are subject to authorizations since they are high cost and best practice is to treat in the least restrictive setting that meets the individual's clinical needs. For M/S services, PA facilitates better care coordination for the member and indicates to the health plan the need to assess for care management services.

MH/SUD (provided to health plan members through FFS) PA and CR requests are by phone, fax, or online. MH/SUD RR requests are submitted by fax or mail. Conduent utilizes the Milliman Care Guidelines® screening criteria to establish a benchmark length of stay for all inpatient hospitalizations. Strategy: authorization is required for services that are high cost and/or have potential for overutilization. MH/SUD uses Milliman Care Guidelines (MCG). For MH/SUD, reviewers of PA, CR, and RR requests are LPNs and RNs. MH/SUD requires inter-rater reliability training of utilization management staff. For MH/SUD certifications meeting criteria, CONDUENT (FFS) expects to certify the admission at the time of the initial request when made via CyberAccess or telephone. MH/SUD Certifications meeting criteria when submitted by written or fax request will be made by the end of the next working day. For MH/SUD requests for PA and CR, if the first reviewer is unable to approve, the second reviewer is a psychiatrist. Members have the right to appeal to Conduent for fee-for-service benefits and the right to a state fair hearing if the denial is upheld by Conduent.. Providers can appeal to the health plan for health plan covered services and to Conduent for fee-for-service covered benefits and to the administrative hearings commission in the event of disagreement with the initial appeal response.

M/S PA and CR requests are by phone, fax, or online. M/S RR requests may be submitted by fax, phone, or web. M/S uses Interqual guidelines and Centene clinical policies. For M/S, nonclinical and clinical staff review PA, CR, and RR requests. M/S requires annual inter-rater reliability training/testing for utilization management staff. The timeframe for reviewing standard M/S PA requests is 36 hours to include one working day. Urgent M/S PA requests are completed within 24 hours. For M/S requests for PA and CR, if the first reviewer is unable to approve, the second reviewer is a physician. Members and providers have the same appeal rights for MH/SUD and M/S. Members have the right to the health plan appeal process for health plan covered services and

state fair hearing for health plan covered services (after exhausting the health plan appeal process). Members have the right to appeal to Conduent for fee-for-service benefits and the right to a state fair hearing if the denial is upheld by Conduent.. Providers can appeal to the health plan for health plan covered services and to Conduent for fee-for-service covered benefits and to the administrative hearings commission in the event of disagreement with the initial appeal response.

PA / CR / RR requirements are reviewed and updated annually or as assigned by the state. For MH/SUD, RR is available through Conduent. For M/S, some facility contracts do not allow RR.

Transplant services are provided to HEALTH PLAN members through FFS. The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's Patient Selection Protocol and Patient Selection Criteria for the type of transplant to be performed. The patient must have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division. Physician reviews request and if not approved by first reviewer, it is sent to second physician reviewer.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

| <p>NQTL: Prior Authorization (PA), Concurrent Review (CR), Retrospective Review</p> <p>Health Plan/State: Home State Health / FFS</p> <p>Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate</p> <p>Classification: Outpatient</p>  |   |
|--|---|
| MH/SUD Benefits/Providers  | M/S Benefits/Providers  |
| <p>Home State: MH/SUD IOP, PHP, ECT, MH/SUD provider specific contract</p> <p>FFS: CSTAR</p>   | <p>Home State: Home health services, pain management, non-emergent services with non-par providers, genetic testing, non-emergent CT scans, non-emergent MRI, dental procedures</p> <p>FFS: HCBS waiver services, ABA, abortion</p> |
| Compliance Analysis  |   |
| <p>PA is required on selected MH/SUD outpatient services (e.g., IOP, PHP, ECT, specific contracts), but CR does not apply in the outpatient classification. Requests submitted by mail, fax, or web for MH/SUD services, but M/S service requests may be submitted by phone, fax, or web. Retrospective reviews are available for MH/SUD and M/S services if provider contract allows. MH/SUD contracts allow RR unless specifically excluded, whereas M/S contract do not allow RR unless specifically included. Clinical staff authorize PAs for MH/SUD services, but nonclinical and clinical staff authorize M/S PAs. Clarify role of nonclinical staff for M/S reviews. Evidence: use LOCUS/CALOCUS required by the state for MH/SUD services. For M/S services, InterQual criteria are used. Strategy: authorization required for services that are high cost and/or have the potential for overutilization. Timeliness of decision: 24 hours urgent, 36 hours routine for both MH/SUD and M/S services. IRR score required is 90% for both MH/SUD and M/S. If denied: provider and can appeal by phone, fax, or mail within 30 days; peer to peer review is offered; only physicians make adverse decisions for both MH/SUD and M/S services.</p> <p>CSTAR – Authorization required when exceed dollar package limits for SUD services and exceed 60 days of adolescent treatment support program. PA is requested through DMH CIMOR system. Licensed or credentialed staff review PA requests. Clinical rationale for additional dollars for continuation of intensive services is required. Evidence: history of individuals exceeding package dollar limits. Practice guidelines include ASAM components.</p> <p>Strategy: authorization required for services that are high cost and/or have the potential for overutilization.</p> <p>Timeliness of decision: 36 hours to include one working day.</p> |   |

If denied: participant and provider have appeal rights within 30 days.

FFS M/S: All ABA services require PA. Requests are submitted by fax or by mail. Clinical documentation of medical necessity is required. Requests are reviewed by licensed behavior analyst. Strategy: authorization required for services that are high cost and/or have the potential for overutilization. Evidence: Missouri best practice guidelines and BACB best practice guidelines. Abortion services are limited by medical necessity in accordance with the Hyde Amendment. Requests are by fax or mail and are reviewed by RN and physician. HCBS waiver service require PA.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

| <p>NQTL: Prior Authorization (PA), Concurrent Review (CR), Retrospective Review (RR)<br/> Health Plan/State: Home State Health / FFS / DMH<br/> Benefit Package(s): COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court<br/> Classification: Outpatient</p>  |   |
|--|---|
| MH/SUD Benefits/Providers  | M/S Benefits/Providers  |
| <p>Home State: N/A – provided through FFS for this population<br/> FFS: outpatient therapy, psychological testing if under age 3, CSTAR</p>  | <p>Home State: Home health services, pain management, non-emergent services with non-par providers, genetic testing, non-emergent CT scans, non-emergent MRI, dental procedures<br/> FFS: HCBS waiver services, ABA, abortion</p> |
| Compliance Analysis  |   |
| <p>FFS MH/SUD (provided through FFS for this population) – PA required beyond 4 hours in a rolling year for family, group, or individual therapy and for psychological testing if under age 3. CR does not apply. RR applies only in the event of retroactive eligibility. PA is requested by phone, fax, mail, or online. Clinical staff authorize PAs. PA form requires diagnosis, demographics, service requested, and attestation regarding training in EBP if applicable, that services are developmentally appropriate if under 5, that patient/guardian has agreed to treatment plan, whether court ordered, communication with other providers, treatment plan provided to CD case manager if applicable, if result of an EPSDT screen. Evidence: history of overutilization and cost overruns. Strategy: authorization required for services that are high cost and/or have the potential for overutilization.<br/> Timeliness of decision: Decisions typically made same day; online decisions are immediate.<br/> If denied: participant has appeal rights within 90 days; provider has appeal rights within 30 days</p> <p>CSTAR – Authorization required when dollar package limits for SUD services are exceeded and when adolescent treatment support exceeds 60 days. PA is requested through DMH CIMOR system and reviewed by licensed or credentialed staff. CR requests can be submitted by phone, fax, email, or mail. Clinical rationale for additional dollars for continuation of intensive services is required. The DBH also offers a specialized CSTAR Program solely to participants between the ages of 12 and 17 years inclusive (exceptions to age criteria may be authorized through the Clinical Utilization Review process) and their families.</p> |   |

Exceptions to these age requirements may be authorized through clinical utilization review documenting behavior and experience appropriate for the services available. Evidence: practice guidelines include ASAM components. Strategy: authorization required for services that are high cost and/or have the potential for overutilization. Review completed within 36 hours to include one working day. To the extent feasible, a review request from a provider shall be made prior to delivery of services. If denied: appeal must be in writing, identify the reason for the appeal, and be received or postmarked within thirty (30) days of receiving notice that service authorization has been discontinued.

HSH M/S: Request submitted by phone, fax, or web. Nonclinical and clinical staff utilized for PA reviews. Evidence: InterQual criteria are used. Strategy: authorization required for services that are high cost and/or have the potential for overutilization.. Timeliness of decision: 24 hours urgent, 36 hours routine. If denied: provider can appeal by phone, fax, or mail within 30 days; peer to peer review is offered; only physicians make adverse decisions.

FFS M/S: All ABA services require PA. Requests are submitted by fax or by mail. Clinical documentation of medical necessity is required. Requests are reviewed by licensed behavior analyst. Strategy authorization required for services that are high cost and/or have the potential for overutilization. Evidence: Missouri best practice guidelines and BACB best practice guidelines. Abortion services are limited by medical necessity in accordance with the Hyde Amendment. Requests are by fax or mail and are reviewed by RN and physician. HCBS waiver service require PA.

**State Compliance Determination**

| Complies                 | Follow up                           | Doesn't Comply           | Action:   |
|--------------------------|-------------------------------------|--------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | State is reforming FFS policies to allow more services prior to authorization requirements. |

NQTL: Prior Authorization / Concurrent Review / Retrospective Review  
 Health Plan/State: Missouri Care / FFS  
 Benefit Package(s): Adults (21+), Pregnant Women (21+), Children: COA 1 (0-20), PW (0-20), CHIP Exp. (0-18), and CHIP Separate (0-18), COA 4 if admission is for combination of physical and behavioral health  
 Classification: Inpatient

| MH/SUD Benefits/Providers  | M/S Benefits/Providers                   |
|--|--|
| Missouri Care: MH IP, SUD IP; Residential Treatment;<br>FFS: N/A | Missouri Care: All IP<br>FFS: Transplant |

**Compliance Analysis**

Missouri Care does not require mental health/substance use disorder (MH/SUD) or medical/surgical (M/S) providers to obtain prior authorization (PA) for emergent inpatient admissions; notification of inpatient admission is required within 24 hours for both MH/SUD and M/S providers for CR. Residential treatment requires PA ahead of time (this is scheduled, not emergent). Scheduled inpatient M/S admissions require PA. RR applies when a member was admitted emergently and discharged from hospital prior to CR taking place. RR requests must be submitted within 90 days of discharge date for both MH/SUD and M/S. RR determinations are made within 30 calendar days. CR is completed every 1 to 2 days for continued stay for both MH/SUD and M/S services. Nationally recognized guidelines developed by third parties (LOCUS/CALOCUS, Interqual) are used for PA and CR to establish medical necessity for both MH/SUD and M/S services except that M/S utilizes WellCare Clinical Coverage Guidelines when WellCare medical directors have developed guidelines for the service requested. UM process and timeframes are the same for MH/SUD and M/S providers; if requested service does not meet medical necessity criteria, the clinical reviewer forwards to medical director for review; peer to peer conversation is offered in the event of adverse decisions. For MH/SUD and M/S, peer to peer conversation is offered in the event of adverse decision if requested within 3 days. For M/S considerations, reviewers are RNs or physicians, for MH/SUD considerations, reviewers are licensed clinicians or psychiatrists.

Evidence/rationale for applying PA, CR, and RR for both MH/SUD and M/S services is due to services that are high cost and/or have the potential for overutilization.

Transplant services are provided to health plan members through FFS. The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's

Patient Selection Protocol and Patient Selection Criteria for the type of transplant to be performed. The patient must have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division. Physician reviews request and if not approved by first reviewer, it is sent to second physician reviewer.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Prior Authorization (PA) / Concurrent Review (CR) / Retrospective Review (RR)

Health Plan/State: Missouri Care, FFS

Benefit Package(s): Category of Aid (COA) 4 (Ages 0-20), including ME 38 (ages 21-25), and foster children in and out of Jackson County

Classification: Inpatient

| MH/SUD Benefits/Providers   | M/S Benefits/Providers                   |
|---|--|
| Missouri Care: N/A<br>FFS: MH IP, SUD IP  | Missouri Care: All IP<br>FFS: Transplant |
| <b>Compliance Analysis</b>  |  |
| <p>Missouri Care does not require medical/surgical (M/S) providers to obtain prior authorization (PA) for emergent inpatient admissions; notification of inpatient admission is required within 24 hours for M/S providers. Interqual guidelines are used to establish medical necessity for M/S services except that M/S utilizes WellCare Clinical Coverage Guidelines when WellCare medical directors have developed guidelines for the service requested. Authorization requests are submitted via phone, fax, or secure email. Timeframe for decision is within 24 hours. Inter-rater reliability training is completed annually. Denial rates are reviewed at least monthly. Peer to peer conversation is offered if adverse decision is made. Second reviewer is a psychiatrist, and members and providers have appeal rights to health plan. After appeal to health plan, member may have state fair hearing. After appeal to health plan, provider may appeal to administrative hearings commission.</p> <p>For MH/SUD (provided to health plan members through FFS), PA is not required for emergent admissions; certification review takes place after admission. MH/SUD PA and CR requests are by phone, fax, or online. MH/SUD RR requests are submitted by fax or mail. Conduent utilizes the Milliman Care Guidelines® screening criteria to establish a benchmark length of stay for all inpatient hospitalizations. Strategy: authorization is required for services that are high cost and/or have potential for overutilization. MH/SUD uses Milliman Care Guidelines (MCG). For MH/SUD, reviewers of PA, CR, and RR requests are LPNs and RNs. MH/SUD requires inter-rater reliability training of utilization management staff. For MH/SUD certifications meeting criteria, CONDUENT (FFS) expects to certify the admission at the time of the initial request when made via CyberAccess or telephone. MH/SUD Certifications meeting criteria when submitted by written or fax request will be made by the end of the next working day. For MH/SUD requests for PA and CR, if the first reviewer is unable to approve, the second reviewer is a psychiatrist. Members have the right to appeal to Conduent for fee-for-service benefits and the right to a state fair hearing if the denial is upheld by Conduent.. Providers can appeal to the health plan for health plan covered services and to Conduent for fee-for-service covered benefits and to the administrative hearings commission in the event of disagreement with the initial appeal response.</p> |  |

Participants have the right to a state fair hearing for M/S.

Residential treatment may be accessed through Children’s Division referral process which uses the Childhood Severity of Psychiatric Illness (CSPI) completed by trained nonclinical CD staff.

Evidence/rationale for applying PA, CR, RR for M/S and MH/SUD is to ensure member is getting right level of care for their current condition and that they’re meeting medical necessity criteria.

Transplant services are provided to health plan members through FFS . The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility’s Patient Selection Protocol and Patient Selection Criteria for the type of transplant to be performed. The patient must have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn’t Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

| <p>NQTL: Prior Authorization (PA), Concurrent Review (CR), Retrospective Review<br/> Health Plan/State: Missouri Care / FFS<br/> Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate<br/> Classification: Outpatient</p>  |   |
|--|---|
| MH/SUD Benefits/Providers  | M/S Benefits/Providers  |
| <p>Missouri Care: MH/SUD IOP, PHP, OP that exceeds the applicable monthly or annual limit, short term residential (not covered by the Medicaid state plan), intensive in-home (not covered by the Medicaid state plan) FFS: CSTAR</p>  | <p>Missouri Care: ASC, comprehensive day rehab-TBI, certain diabetic care, certain diagnostic services, DME over \$500, home health, hospice, infusion services, ICF, personal care, certain podiatry services, private duty nursing, prosthetic and orthotic devices over \$500<br/> FFS: ABA services</p> |
| Compliance Analysis  |   |
| <p>Missouri Care – PA required on selected MH/SUD services. CR is not utilized for MH/SUD in the outpatient classification. RR is not utilized for MH/SUD or M/S services in the outpatient classification. M/S PA requests are submitted via fax, web, or phone. MH/SUD PA requests are by fax, phone, or secure email. Clinical staff authorize PAs for both MH/SUD and M/S services. Evidence: MH/SUD services use LOCUS/CALOCUS required by the state,. Strategy: authorization required for services that are high cost and/or have the potential for overutilization . M/S services use InterQual criteria or WellCare Clinical Coverage Guidelines when they have been developed for the service requested.</p> <p>Timeliness of decision: 24 hours urgent, 36 hours routine for both MH/SUD and M/S services. For both MH/SUD and M/S services, if denied: peer to peer is offered; adverse determinations by physician only; member has appeal rights.</p> <p>CSTAR – Authorization required when exceed dollar package limits for SUD services and exceed 60 days of adolescent treatment support program. PA is requested through DMH CIMOR system. Licensed or credentialed staff review PA requests. Clinical rationale for additional dollars for continuation of intensive services is required. Evidence: history of individuals exceeding package dollar limits. Practice guidelines include ASAM components.</p> |   |

Strategy: authorization required for services that are high cost and/or have the potential for overutilization.  
 Timeliness of decision: 36 hours to include one working day.  
 If denied: participant and provider have appeal rights within 30 days.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

| <p>NQTL: Prior Authorization (PA), Concurrent Review (CR), Retrospective Review (RR)<br/> Health Plan/State: Missouri Care / Missouri FFS / DMH<br/> Benefit Package(s): COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court<br/> Classification: Outpatient</p>  |  |
|---|--|
| MH/SUD Benefits/Providers   | M/S Benefits/Providers   |
| <p>Missouri Care: N/A – provided through FFS for this population<br/> FFS: outpatient therapy, psychological testing if under age 3, CSTAR</p>  | <p>Missouri Care: ASC, comprehensive day rehab-TBI, certain diabetic care, certain diagnostic services, DME over \$500, home health, hospice, infusion services, ICF, personal care, certain podiatry services, private duty nursing, prosthetic and orthotic devices over \$500<br/> FFS: HCBS waiver services, ABA, abortion</p> |
| Compliance Analysis   |  |
| <p>FFS MH/SUD (provided through FFS for this population) – PA required beyond 4 hours in a rolling year for family, group, or individual therapy and for psychological testing if under age 3. CR does not apply. RR applies only in the event of retroactive eligibility. PA is requested by phone, fax, mail, or online. Clinical staff authorize PAs. PA form requires diagnosis, demographics, service requested, and attestation regarding training in EBP if applicable, that services are developmentally appropriate if under 5, that patient/guardian has agreed to treatment plan, whether court ordered, communication with other providers, treatment plan provided to CD case manager if applicable, if result of an EPSDT screen. Evidence: history of overutilization and cost overruns. Strategy: authorization required for services that are high cost and/or have the potential for overutilization .<br/> Timeliness of decision: Decisions typically made same day; online decisions are immediate.<br/> If denied: participant has appeal rights within 90 days; provider has appeal rights within 30 days</p> <p>CSTAR – Authorization required when dollar package limits for SUD services are exceeded and when adolescent treatment support exceeds 60 days. PA is requested through DMH CIMOR system and reviewed by licensed or credentialed staff. CR requests can be submitted by phone, fax, email, or mail. Clinical rationale for additional dollars for continuation of intensive services is required. The DBH also offers a specialized CSTAR Program solely to participants between the ages of 12 and 17 years inclusive (exceptions to age criteria may be authorized through the Clinical Utilization Review process) and their families.</p> |  |

Exceptions to these age requirements may be authorized through clinical utilization review documenting behavior and experience appropriate for the services available. Evidence: practice guidelines include ASAM components. Strategy: authorization required for services that are high cost and/or have the potential for overutilization. Review completed within 36 hours to include one working day. To the extent feasible, a review request from a provider shall be made prior to delivery of services. If denied: appeal must be in writing, identify the reason for the appeal, and be received or postmarked within thirty (30) days of receiving notice that service authorization has been discontinued.

Missouri Care M/S – RNs review requests for PA. CR and RR are not utilized. Strategy: authorization required for services that are high cost and/or have the potential for overutilization. Evidence: use InterQual and WellCare coverage guidelines when they have been developed for the service requested. Timeliness of decision: 24 hours urgent, 36 hours routine. If denied: peer to peer is offered; adverse determinations by physician only; member has appeal rights.

FFS M/S: All ABA services require PA. Requests are submitted by fax or by mail. Clinical documentation of medical necessity is required. Requests are reviewed by licensed behavior analyst. Strategy is to ensure medical necessity of these time-intensive services. Evidence: Missouri best practice guidelines and BACB best practice guidelines. Abortion services are limited by medical necessity in accordance with the Hyde Amendment. Requests are by fax or mail and are reviewed by RN and physician. HCBS waiver services require PA.

**State Compliance Determination**

| Complies                 | Follow up                           | Doesn't Comply           | Action: State is reforming FFS policies to allow more services prior to authorization requirements. |
|--------------------------|-------------------------------------|--------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |   |

NQTL: Prior Authorization (PA) / Concurrent Review (CR) / Retrospective Review (RR)  
 Health Plan/State: UnitedHealthcare, FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate  
 Classification: Inpatient

| MH/SUD Benefits/Providers | M/S Benefits/Providers |
|---------------------------|------------------------|
|---------------------------|------------------------|

|                                |                                |
|--------------------------------|--------------------------------|
| UHC: MH IP, MH SUD<br>FFS: N/A | UHC: M/S IP<br>FFS: Transplant |
|--------------------------------|--------------------------------|

**Compliance Analysis**

UnitedHealthcare - PA not required for MH/SUD or M/S inpatient admissions that are direct/emergent. M/S scheduled inpatient admissions require prior authorization. The process and timeframes described for both MH/SUD and M/S PA and CR are the same. MH/SUD and M/S requests are by phone, and, when available, clinical information can be provided via access to EMR; clinical information is required. Authorization is provided within 24 hours of receipt of the request for both MH/SUD and M/S. Peer to peer occurs within 3 business days of facility being notified of denial of inpatient level of care for MH/SUD and M/S. Only physicians make adverse determinations, and physician has 2 days to make a final determination. This is the same for MH/SUD and M/S. An LPC, LCSW, or licensed psychologist reviews MH/SUD inpatient admissions, while RNs review M/S inpatient admissions. Purpose of PA / CR / RR for both MH/SUD and M/S is to ensure medical necessity is met, detect and manage over- and under-utilization, assist with discharge planning and care management, identify quality improvement opportunities. RR occurs when the initial request for clinical review occurs after member is discharged (e.g., weekend or holiday admissions).

Per 13 CSR 70-3.180 Medical Pre-Certification Providers are required to seek pre-certification for certain specified services listed in the provider manuals, provider bulletins, or clinical edits criteria before delivery of the services. For both MH/SUD and M/S UHC analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The prior authorization list is to help drive more cost-effective quality health care for our members through reduction of services that fall outside of evidence-based guidelines ensuring that member receives clinically appropriate services at the right time in the right setting. The prior authorization list is reviewed on an annual basis to determine where the management of the benefits can be removed and added to the prior authorization list.

UHC uses LOCUS-CALOCUS for MH/SUD per State contract; however, inpatient preservice review is based on Treatment Milestone Assessment that is an algorithm that uses a combination of age, diagnosis, and history of prior admission to determine an authorization for initial length of stay. If the member does not have a prior admission history, then an administrative authorization based on proprietary

evidence-based clinical guidelines will determine the authorization for the initial length of stay. MCG used for M/S admissions. For both MH/SUD and M/S if, through appeal, the provider establishes proof of authorization or mitigating circumstances, the claim is then reviewed for medical necessity and paid in full.

The health plan uses LOCUS-CALOCUS guidelines and Optum Policy and Coverage Decision documents for MH/SUD PA, CR, and RR requests for IP services and uses MCG Care guidelines and medical policy for M/S PA, CR, and RR requests.

Transplant services are provided to health plan members through FFS. The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's Patient Selection Protocol and Patient Selection Criteria for the type of transplant to be performed. The patient must have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division. Physician reviews request and if not approved by first reviewer, it is sent to second physician reviewer.

| State Compliance Determination      |                          |                          |         |
|-------------------------------------|--------------------------|--------------------------|---------|
| Complies                            | Follow up                | Doesn't Comply           | Action: |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Prior Authorization (PA) / Concurrent Review (CR) / Retrospective Review (RR)

Health Plan/State: UnitedHealthcare, FFS

Benefit Package(s): Category of Aid (COA) 4 (Ages 0-20), including ME 38 (ages 21-25), and foster children in and out of Jackson County

Classification: Inpatient

| <b>MH/SUD Benefits/Providers</b> | <b>M/S Benefits/Providers</b>  |
|----------------------------------|--------------------------------|
| UHC: N/A<br>FFS: MH IP, MH SUD   | UHC: M/S IP<br>FFS: Transplant |

**Compliance Analysis**

For M/S, UHC does not require PA for inpatient admissions that are direct/emergent, per state contract. M/S scheduled inpatient admissions require prior authorization. When a member presents in an emergency room or for admission assessment, a pre-service authorization may be obtained within 24 hours of the receipt of the request. A request may be made via phone with clinical information. An RN will make a determination within 24 hours of the receipt of the request. A peer to peer with the medical director occurs within 3 business days of the facility being notified of a denial of an inpatient level of care. Only an MD can make an adverse determination. The MD has two days to make a final determination. M/S requests are by phone, and, when available, clinical information can be provided via access to EMR; clinical information is required for PA. Authorization is provided within 24 hours of receipt of the request for M/S. Peer to peer occurs within 3 business days of facility being notified of denial of inpatient level of care for M/S. RNs review M/S inpatient admissions.

For MH/SUD (provided to health plan members through FFS), PA is not required for emergent admissions; certification review takes place after admission. MH/SUD PA and CR requests are by phone, fax, or online. MH/SUD RR requests are submitted by fax or mail. Conduent utilizes the Milliman Care Guidelines® screening criteria to establish a benchmark length of stay for all inpatient hospitalizations. Strategy: authorization is required for services that are high cost and/or have potential for overutilization. MH/SUD uses Milliman Care Guidelines (MCG). For MH/SUD, reviewers of PA, CR, and RR requests are LPNs and RNs. MH/SUD requires inter-rater reliability training of utilization management staff. For MH/SUD certifications meeting criteria, CONDUENT (FFS) expects to certify the admission at the time of the initial request when made via CyberAccess or telephone. MH/SUD Certifications meeting criteria when submitted by written or fax request will be made by the end of the next working day. For MH/SUD requests for PA and CR, if the first reviewer is unable to approve, the second reviewer is a psychiatrist. Members have the right to appeal to Conduent for fee-for-service benefits and the right to a state fair hearing if the denial is upheld by Conduent.. Providers can appeal to the health plan for health plan covered services and to Conduent for fee-for-service covered benefits and to the administrative hearings commission in the event of disagreement with the initial appeal response.

Per 13 CSR 70-3.180 Medical Pre-Certification Providers are required to seek pre-certification for certain specified services listed in the provider manuals, provider bulletins, or clinical edits criteria before delivery of the services. For M/S UHC analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The prior authorization list is to help drive more cost-effective quality health care for our members through reduction of services that fall outside of evidence-based guidelines ensuring that member receives clinically appropriate services at the right time in the right setting. The prior authorization list is reviewed on an annual basis to determine where the management of the benefits can be removed and added to the prior authorization list.

Transplant is carved out. The transplant prior authorization process requires the transplant facility or transplant surgeon to submit documentation that verifies the transplant candidate has been evaluated according to the facility's Patient Selection Protocol and Patient Selection Criteria for the type of transplant to be performed. The patient must have been accepted as a transplant candidate by the facility before prior authorization requests can be considered for approval by the MO HealthNet Division.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Prior Authorization (PA), Concurrent Review (CR), Retrospective Review (RR)  
 Health Plan/State: UnitedHealthcare / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate  
 Classification: Outpatient

| MH/SUD Benefits/Providers   | M/S Benefits/Providers  |
|---|---|
| United Healthcare: ECT, Psychiatric review of records, psychological testing if 5 hours or more<br>FFS: CSTAR | United Healthcare: Durable Medical Equipment and prosthetics, Home health, Private duty nursing, Cosmetic surgeries, Potential non-covered Medicaid services, Outpatient Chemotherapy, Outpatient Radiology, Surgical procedures<br>FFS: ABA services |

**Compliance Analysis**

UHC: Request by phone or EMR for MH/SUD and M/S. For MH/SUD and M/S services, requests must include clinical information, and are reviewed by licensed clinicians. Evidence: authorization required for services that are high cost and/or have the potential for overutilization . PA list is reviewed annually to determine needed changes and the purpose is to help drive more cost-effective quality health care for members through reduction of services that fall outside of evidence-based guidelines. LOCUS/CALOCUS used for MH/SUD (but not relevant for above services); MCG criteria are used for M/S services. Licensed healthcare professionals complete the initial review of PA requests for both MH/SUD and M/S. Timeliness of decision: 24 hours urgent, 36 hours routine for both MH/SUD and M/S requests. For both MH/SUD and M/S services, if denied: peer to peer is offered, adverse determinations are by physician only, and members have appeal rights.

CSTAR – Authorization required when exceed dollar package limits for SUD services and exceed 60 days of adolescent treatment support program. PA is requested through DMH CIMOR system. Licensed or credentialed staff review PA requests. Clinical rationale for additional dollars for continuation of intensive services is required. Evidence: history of individuals exceeding package dollar limits. Practice guidelines include ASAM components.

Strategy: authorization required for services that are high cost and/or have the potential for overutilization.

Timeliness of decision: 36 hours to include one working day.

If denied: participant and provider have appeal rights within 30 days.

FFS M/S: All ABA services require PA. Requests are submitted by fax or by mail. Clinical documentation of medical necessity is required. Requests are reviewed by licensed behavior analyst. Strategy: authorization required for services that are high cost and/or have the potential for overutilization. Evidence: Missouri best practice guidelines and BACB best practice guidelines. Abortion services are limited by medical necessity in accordance with the Hyde Amendment. Requests are by fax or mail and are reviewed by RN and physician. HCBS waiver services require PA.

| State Compliance Determination      |                          |                          |         |
|-------------------------------------|--------------------------|--------------------------|---------|
| Complies                            | Follow up                | Doesn't Comply           | Action: |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

| <p>NQTL: Prior Authorization (PA), Concurrent Review (CR), Retrospective Review (RR)<br/> Health Plan/State: UnitedHealthcare / Missouri FFS / DMH<br/> Benefit Package(s): COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court<br/> Classification: Outpatient</p>   |  |
|---|--|
| MH/SUD Benefits/Providers   | M/S Benefits/Providers   |
| <p>UnitedHealthcare : N/A – provided through FFS for this population<br/> FFS: outpatient psychotherapy, psychological testing if under age 3, CSTAR</p>  | <p>UnitedHealthcare: Durable Medical Equipment and prosthetics, Home health, Private duty nursing, Cosmetic surgeries, Potential non-covered Medicaid services, Outpatient Chemotherapy, Outpatient Radiology, Surgical procedures<br/> FFS: HCBS waiver services, ABA, abortion</p> |
| Compliance Analysis   |  |
| <p>FFS MH/SUD (provided through FFS for this population) – PA required beyond 4 hours in a rolling year for family, group, or individual therapy and for psychological testing if under age 3. CR does not apply. RR applies only in the event of retroactive eligibility. PA is requested by phone, fax, mail, or online. Clinical staff authorize PAs. PA form requires diagnosis, demographics, service requested, and attestation regarding training in EBP if applicable, that services are developmentally appropriate if under 5, that patient/guardian has agreed to treatment plan, whether court ordered, communication with other providers, treatment plan provided to CD case manager if applicable, if result of an EPSDT screen. Evidence: history of overutilization and cost overruns. Strategy: authorization required for services that are high cost and/or have the potential for overutilization .</p> <p>Timeliness of decision: Decisions typically made same day; online decisions are immediate.<br/> If denied: participant has appeal rights within 90 days; provider has appeal rights within 30 days</p> <p>CSTAR – Authorization required when dollar package limits for SUD services are exceeded and when adolescent treatment support exceeds 60 days. PA is requested through DMH CIMOR system and reviewed by licensed or credentialed staff. CR requests can be submitted by phone, fax, email, or mail. Clinical rationale for additional dollars for continuation of intensive services is required. The DBH also offers a specialized CSTAR Program solely to participants between the ages of 12 and 17 years inclusive (exceptions to age criteria may be authorized through the Clinical Utilization Review process) and their families.</p> |  |

Exceptions to these age requirements may be authorized through clinical utilization review documenting behavior and experience appropriate for the services available. Evidence: practice guidelines include ASAM components. Strategy: authorization required for services that are high cost and/or have the potential for overutilization. Review completed within 36 hours to include one working day. To the extent feasible, a review request from a provider shall be made prior to delivery of services. If denied: appeal must be in writing, identify the reason for the appeal, and be received or postmarked within thirty (30) days of receiving notice that service authorization has been discontinued.

UHC M/S: Requests are submitted online, by phone, or fax. Requests include specified clinical information. Licensed healthcare professionals complete the initial review of PA requests. Timeliness of decision: 24 hours urgent, 36 hours routine. If denied: peer to peer is offered; adverse determinations by physician only; member has appeal rights. Evidence: to ensure clinical appropriateness and reduce overutilization. Strategy: authorization required for services that are high cost and/or have the potential for overutilization.

FFS M/S: All ABA services require PA. Requests are submitted by fax or by mail. Clinical documentation of medical necessity is required. Requests are reviewed by licensed behavior analyst. Strategy is to prevent overutilization and ensure medical necessity of these time-intensive services. Evidence: Missouri best practice guidelines and BACB best practice guidelines. Abortion services are limited by medical necessity in accordance with the Hyde Amendment. Requests are by fax or mail and are reviewed retrospectively by RN and physician. HCBS waiver services require PA.

**State Compliance Determination**

| Complies                 | Follow up                           | Doesn't Comply           | Action: State is reforming FFS policies to allow more services prior to authorization requirements. |
|--------------------------|-------------------------------------|--------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |   |

NQTL: Outlier Review  
 Health Plan/State: UnitedHealthcare  
 Benefit Package(s): Adults (21+), Pregnant Women (21+), Children: COA 1 (0-20), PW (0-20), CHIP Exp. (0-18), and CHIP Separate (0-18),  
 Classification: Emergency

| MH/SUD Benefits/Providers  | M/S Benefits/Providers     |
|----------------------------|----------------------------|
| UHC: Emergency<br>FFS: N/A | UHC: Emergency<br>FFS: N/A |

**Compliance Analysis**

**MH/SUD and M/S:** Outlier review is used to identify facilities with utilization or costs that may be outside the expected normal for their services. Internal Quality of Care, use of diagnostic services and admission rates, are standardly used to identify outlier facilities. Claims coding data is standardly used to address ED physician care. Fraud, Waste, Abuse, and Error (FWAE) Outlier reviews are conducted for FWA activities. Outlier review may also be used to identify facilities or providers who may need education on standard medical practices or assistance in improving their internal systems of care. United uses many national health care initiatives to address outlier identification such as the Accountable Care Act, the Centers for Medicare and Medicaid Services (CMS) programs and the National Priority Partnership (NPP) goals

- CMS Hospital Compare web site for reporting
- CMS Quality Strategy
- NPP goals of decreasing: Hospital mortality rates; and
- Potentially preventable ER visits

In addition, national standard code sets for non-emergency emergency room utilization are used to identify possible excess ED usage and physician coding errors

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Outlier Review  
 Health Plan/State: UnitedHealthcare  
 Benefit Package(s): Adults (21+), Pregnant Women (21+), Children: COA 1 (0-20), PW (0-20), CHIP Exp. (0-18), and CHIP Separate (0-18),  
 Classification: Outpatient

| MH/SUD Benefits/Providers                | M/S Benefits/Providers                   |
|--|--|
| UHC: All outpatient services<br>FFS: N/A | UHC: All outpatient services<br>FFS: N/A |

**Compliance Analysis**

**MH/SUD and M/S:** Internal Quality of Care and HEDIS quality measures are standardly used to assess for over- and under-utilization by providers. The Quality team, independently licensed RN's, reviews HEDIS measures monthly.

Provider education and outreach is performed for providers who are assessed as experiencing over- or under-utilization by the quality team. Fraud, Waste, Abuse, and Error (FWAE) Outlier reviews are conducted for FWA activities. Outlier review may also be used to identify facilities or providers who may need education on standard medical practices or assistance in improving their internal systems of care. United uses many national health care initiatives to address outlier identification such as the Accountable Care Act, the Centers for Medicare and Medicaid Services (CMS) programs and the National Priority Partnership (NPP) goals

- CMS Hospital Compare web site for reporting
- CMS Hospital Readmissions Reduction Program
- CMS Hospital-acquired conditions payment adjustment
- CMS Quality Strategy
- NPP goals of decreasing: Hospital mortality rates; and
- Potentially preventable ER visits and short-stay admissions and
- Preventable hospital readmissions.

NQTL: Outlier Review  
 Health Plan/State: UnitedHealthcare  
 Benefit Package(s): Adults (21+), Pregnant Women (21+), Children: COA 1 (0-20), PW (0-20), CHIP Exp. (0-18), and CHIP Separate (0-18),  
 Classification: Inpatient

| MH/SUD Benefits/Providers | M/S Benefits/Providers |
|---------------------------|------------------------|
|---------------------------|------------------------|

Inpatient Admissions.

Inpatient Admissions.

**Compliance Analysis**

**MH/SUD and M/S:** Internal Quality of Care and HEDIS quality measures are standardly used to assess for over- and under-utilization by providers.

The Quality team, independently licensed RN's, reviews HEDIS measures monthly. Provider education and outreach is performed for providers who are assessed as experiencing over- or under-utilization by the quality team. Fraud, Waste, Abuse, and Error (FWAE) Outlier reviews are conducted for FWA activities. Outlier review may also be used to identify facilities or providers who may need education on standard medical practices or assistance in improving their internal systems of care. United uses many national health care initiatives to address outlier identification such as the Accountable Care Act, the Centers for Medicare and Medicaid Services (CMS) programs and the National Priority Partnership (NPP) goals

- CMS Hospital Compare web site for reporting
- CMS Hospital Readmissions Reduction Program
- CMS Hospital-acquired conditions payment adjustment
- CMS Quality Strategy
- NPP goals of decreasing: Hospital mortality rates; and

- Potentially preventable ER visits and short-stay admissions and
- Preventable hospital readmissions.

In addition, United Healthcare has developed a proprietary methodology that uses LOCUS-CALOCUS Guidelines adjusted with its extensive data warehouse to develop normative values for hospital length of stay.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Outlier Review  
 Health Plan/State: UnitedHealthcare  
 Benefit Package(s): Category of Aid (COA) 4 (Ages 0-20), including ME 38 (ages 21-25), and foster children in and out of Jackson County  
 Classification: Outpatient

| MH/SUD Benefits/Providers | M/S Benefits/Providers                   |
|---------------------------|--|
| UHC: N/A<br>FFS: N/A      | UHC: All outpatient services<br>FFS: N/A |

**Compliance Analysis**

This NQTL is not used in FFS MH/SUD services.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Documentation Requirements  
 Health Plan/State: Home State / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers           | M/S Benefits/Providers   |
|-------------------------------------|--|
| Home State<br>FFS for COA 4 / CSTAR | Home State<br>FFS: Transplant; ABA, HCBS Waiver, Abortion, IEP therapy services, private duty nursing and personal care IEP services, First steps services, audiology IEP services |

**Compliance Analysis**

FFS behavioral health services regulation on documentation is more stringent than the MHD general regulation that applies to all providers. Specific elements are required for treatment plans, assessments, and progress notes. Reimbursement is recouped if audit finds documentation requirements are not met. Home State follows the same documentation requirements as the state.

CSTAR –

**Processes:** When an individual presents for services and is determined eligible, the provider must complete the DLA-20© and enter the assessments results/scores in to CIMOR in order to bill.

**Submission and Staffing:** Provider completes the DLA-20© and enters the assessment scores into CIMOR. Staff conducting the DLA-20© must be trained by a trained trainer that received training from the developer. Approved bachelor's level staff or a qualified addiction professional (QAP) may administer the DLA-20©.

**Strategy:** The assessment helps to guide treatment, know where and what the individual needs assistance with. It is also to collect data for individuals served in the program as a measure of progress in treatment and CSTAR service efficacy. Tying the billing to the assessment helps ensure quality and needed services are being delivered to the individual. Outcomes measurement and monitoring helps individuals with substance use disorder manage their treatment which can reduce the need for specialized, high cost services.

**Timeline:** DLA-20© documentation expected prior to billing per DBH policy, but no edit in system to prevent billing.

**Evidence:** Published research supports use of this instrument.

**State Compliance Determination**

| Complies                 | Follow up                           | Doesn't Comply           | Action:                               |
|--------------------------|-------------------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Amendment filed for 13 CSR 70-98.015. |

NQTL: Documentation Requirements  
 Health Plan/State: Missouri Care / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers   | M/S Benefits/Providers  |
|---|---|
| Missouri Care<br>FFS for COA 4 / CSTAR / Targeted Case Management | Missouri Care<br>FFS: Transplant; ABA, HCBS Waiver, Abortion, IEP therapy services, private duty nursing and personal care IEP services, First steps services, audiology IEP services |

**Compliance Analysis**

FFS behavioral health services regulation on documentation is more stringent than the MHD general regulation that applies to all providers. Specific elements are required for treatment plans, assessments, and progress notes. Reimbursement is recouped if audit finds documentation requirements are not met. Missouri Care follows the same documentation requirements as the state.

CSTAR –

**Processes:** When an individual presents for services and is determined eligible, the provider must complete the DLA-20© and enter the assessments results/scores in to CIMOR in order to bill.

**Submission and Staffing:** Provider completes the DLA-20© and enters the assessment scores into CIMOR. Staff conducting the DLA-20© must be trained by a trained trainer that received training from the developer. Approved bachelor's level staff or a qualified addiction professional (QAP) may administer the DLA-20©.

**Strategy:** The assessment helps to guide treatment, know where and what the individual needs assistance with. It is also to collect data for individuals served in the program as a measure of progress in treatment and CSTAR service efficacy. Tying the billing to the assessment helps ensure quality and needed services are being delivered to the individual. Outcomes measurement and monitoring helps individuals with substance use disorder manage their

treatment which can reduce the need for specialized, high cost services.

**Timeline:** DLA-20© documentation expected prior to billing per DBH policy, but no edit in system to prevent billing.

**Evidence:** Published research supports use of this instrument.

**State Compliance Determination**

| Complies                 | Follow up                           | Doesn't Comply           | Action:                               |
|--------------------------|-------------------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Amendment filed for 13 CSR 70-98.015. |

NQTL: Documentation Requirements  
 Health Plan/State: UnitedHealthcare / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers  | M/S Benefits/Providers   |
|--|--|
| UnitedHealthcare<br>FFS for COA 4 / CSTAR / Targeted Case Management | UnitedHealthcare<br>FFS: Transplant; ABA, HCBS Waiver, Abortion, IEP therapy services, private duty nursing and personal care IEP services, First steps services, audiology IEP services |

**Compliance Analysis**

FFS behavioral health services regulation on documentation is more stringent than the MHD general regulation that applies to all providers. Specific elements are required for treatment plans, assessments, and progress notes. Reimbursement is recouped if audit finds documentation requirements are not met. UnitedHealthcare follows the same documentation requirements as the state.

CSTAR –

**Processes:** When an individual presents for services and is determined eligible, the provider must complete the DLA-20© and enter the assessments results/scores in to CIMOR in order to bill.

**Submission and Staffing:** Provider completes the DLA-20© and enters the assessment scores into CIMOR. Staff conducting the DLA-20© must be trained by a trained trainer that received training from the developer. Approved bachelor's level staff or a qualified addiction professional (QAP) may administer the DLA-20©.

**Strategy:** The assessment helps to guide treatment, know where and what the individual needs assistance with. It is also to collect data for individuals

served in the program as a measure of progress in treatment and CSTAR service efficacy. Tying the billing to the assessment helps ensure quality and needed services are being delivered to the individual. Outcomes measurement and monitoring helps individuals with substance use disorder manage their treatment which can reduce the need for specialized, high cost services.

**Timeline:** DLA-20© documentation expected prior to billing per DBH policy, but no edit in system to prevent billing.

**Evidence:** Published research supports use of this instrument.

**State Compliance Determination**

| Complies                 | Follow up                           | Doesn't Comply           | Action:                               |
|--------------------------|-------------------------------------|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Amendment filed for 13 CSR 70-98.015. |

NQTL: Development, Modification, Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines  
 Health Plan/State: Home State Health / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers  | M/S Benefits/Providers  |
|--|---|
| <p>Home State Health – Inpatient: Mental Health Hospital Inpatient, Residential Treatment<br/>           FFS ACT, CMHC Healthcare Home, Youth TCM, Adult TCM</p> | <p>Home State Health - Inpatient: Hospice, Hospital Services, Maternity Services, Nursing Home Care, Transplant Services, Skilled Nursing Facility, Surgical Services, Physician Services<br/>           FFS: Transplant; ABA, HCBS Waiver, Abortion, IEP therapy services, private duty nursing and personal care IEP services, First steps services, audiology IEP services</p> |

**Compliance Analysis**

HSH – MH/SUD: Centene clinical policies developed through corporate clinical policy team. These policies emphasize clinical guidelines rather than service limitations. Begin with data analysis and research which is presented as a business case to their payment policy approval committee. Upon approval by committee, policy is developed and sent to clinical policy committee for edits. Policy is then sent to Centene plan president, CMOS, chief compliance officers, vice presidents of medical management, and vice presidents of networking for feedback. Policy is finalized after feedback from that group. Presented to individual plan committee for approval. Goes out 60 days prior to implementation. If MO HealthNet policy changes, it is sent to medical director for approval.

HSH – M/S and MH/SUD review annually. McKesson Interqual guidelines and MHD policy manuals and Centene clinical policies are utilized for M/S. LOCUS/CALOCUS are utilized for MH/SUD. Process for establishing clinical policies is same for MH/SUD and M/S.

DMH –  
 ACT - Admission Criteria were developed based on research related to the evidence-based practice and consultation with national experts. Once criteria was developed by DBH, stakeholders were provided the opportunity to comment and provide feedback on

the proposed eligibility criteria. Discussions resulted in the current eligibility requirements. This eligibility applies to individuals over the age 16.

TCM - This service was based on federal guidelines, with consultation of stakeholders. Individuals must have an emergent or urgent situation and meet the criteria per current DSM.

CMHC Healthcare Home - Admission Criteria were developed based on research related and consultation with national experts. Criteria was developed by DBH along with stakeholders, including the Coalition of Behavioral Health Centers and providers. Discussions around the development of health care home was the initiated as a result of the Affordable Care Act. State Plan was submitted and approved by CMS for the Health Care Home service.

FFS: M/S services – medical necessity / level of care criteria based on peer-reviewed evidence base and national/state best practice guidelines. MH/SUD services - (provided to COA 4 managed care members through FFS) updated and reviewed annually with Milliman Care Guidelines (MCG) update.

| State Compliance Determination      |                          |                          |         |
|-------------------------------------|--------------------------|--------------------------|---------|
| Complies                            | Follow up                | Doesn't Comply           | Action: |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Development, Modification, Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines  
 Health Plan/State: Missouri Care / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers   | M/S Benefits/Providers   |
|---|--|
| Missouri Care – Inpatient: Mental Health Hospital Inpatient, Residential Treatment<br>FFS ACT, CMHC Healthcare Home, Youth TCM, Adult TCM | Missouri Care - Inpatient: Hospice, Hospital Services, Maternity Services, Nursing Home Care, Transplant Services, Skilled Nursing Facility, Surgical Services, Physician Services<br>FFS: Transplant; ABA, HCBS Waiver, Abortion, IEP therapy services, private duty nursing and personal care IEP services, First steps services, audiology IEP services |

**Compliance Analysis**

WellCare’s Clinical Coverage Guidelines (CCG) for both M/S and MH/SUD are evidence based documents detailing the medical necessity of given procedure or technologies for the purposes of making coverage decisions under WellCare administered health benefit plans. Development of a new CCG is prompted if criteria currently being used does not include criteria for the requested service and/or the contractual requirements. Wellcare’s current CCGs are reviewed and updated annually. WellCare’s CCGs are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of health care practitioner/providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies. InterQual criteria are used for M/S services, and LOCUS/CALOCUS for MH/SUD services.

DMH –  
 ACT - Admission Criteria were developed based on research related to the evidence-based practice and consultation with national experts. Once criteria was developed by DBH, stakeholders were provided the opportunity to comment and provide feedback on the proposed eligibility criteria. Discussions resulted in the current eligibility requirements. This eligibility applies to individuals over the age 16.  
 TCM - This service was based on federal guidelines, with consultation of stakeholders. Individuals must have an emergent or

urgent situation and meet the criteria per current DSM.

CMHC Healthcare Home - Admission Criteria were developed based on research related and consultation with national experts. Criteria was developed by DBH along with stakeholders, including the Coalition of Behavioral Health Centers and providers. Discussions around the development of health care home was the initiated as a result of the Affordable Care Act. State Plan was submitted and approved by CMS for the Health Care Home service.

FFS M/S services – medical necessity / level of care criteria based on peer-reviewed evidence base and national/state best practice guidelines. MH/SUD services - (provided to COA 4 managed care members through FFS) updated and reviewed annually with Milliman Care Guidelines (MCG) update.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

| <p>NQTL: Development, Modification, Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines</p> <p>Health Plan/State: UnitedHealthcare / FFS</p> <p>Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court</p> <p>Classification: Inpatient and Outpatient</p>   |   |
|--|---|
| MH/SUD Benefits/Providers  | M/S Benefits/Providers  |
| <p>UnitedHealthcare – Inpatient: Mental Health Hospital Inpatient, Residential Treatment, outpatient MH/SUD services</p> <p>FFS ACT, CMHC Healthcare Home, Youth TCM, Adult TCM</p>  | <p>UnitedHealthcare – Inpatient and Outpatient M/S services</p> <p>FFS: Transplant; ABA, HCBS Waiver, Abortion, IEP therapy services, private duty nursing and personal care IEP services, First steps services, audiology IEP services</p> |
| Compliance Analysis  |   |
| <p>For both MH/SUD and M/S services, the health plan/subcontractor develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.</p> <p>The health plan may consult with professional clinical consultants, peer review committees, or other appropriate sources for recommendations regarding whether particular services, supplies or accommodations provided or to be provided to a Member are/were medically necessary. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion. Guidelines are reviewed and updated annually for both M/S and MH/SUD services.</p> <p>For both MH/SUD and M/S services, unproven services are services, including medications, which are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-</p> |   |

reviewed medical literature.

DMH –

ACT - Admission Criteria were developed based on research related to the evidence-based practice and consultation with national experts. Once criteria was developed by DBH, stakeholders were provided the opportunity to comment and provide feedback on the proposed eligibility criteria. Discussions resulted in the current eligibility requirements. This eligibility applies to individuals over the age 16.

TCM - This service was based on federal guidelines, with consultation of stakeholders. Individuals must have an emergent or urgent situation and meet the criteria per current DSM.

CMHC Healthcare Home - Admission Criteria were developed based on research related and consultation with national experts. Criteria was developed by DBH along with stakeholders, including the Coalition of Behavioral Health Centers and providers. Discussions around the development of health care home was the initiated as a result of the Affordable Care Act. State Plan was submitted and approved by CMS for the Health Care Home service.

FFS M/S services – medical necessity / level of care criteria based on peer-reviewed evidence base and national/state best practice guidelines. MH/SUD services - (provided to COA 4 managed care members through FFS) updated and reviewed annually with Milliman Care Guidelines (MCG) update.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

| <p>NQTL: Network Admission Requirements: Provider Enrollment and Credentialing</p> <p>Health Plan/State: Home State Health / FFS</p> <p>Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court</p> <p>Classification: Inpatient and Outpatient</p>   |  |
|---|--|
| MH/SUD Benefits/Providers   | M/S Benefits/Providers   |
| <p>Home State Health – Inpatient and Outpatient: Applicable to all provider and practitioner types under consideration for network participation.</p> <p>FFS (outpatient): CPR, CSTAR, Adult TCM, &amp; Youth TCM, clinic option providers (for COA 4);</p> <p>Inpatient (COA 4 if behavioral health admission only)</p>  | <p>Home State Health – Inpatient and Outpatient: Applicable to all provider and practitioner types under consideration for network participation.</p> <p>FFS: Inpatient and Outpatient: Applicable to all provider and practitioner types during enrollment.</p> |
| Compliance Analysis   |  |
| <p><b>Home State:</b></p> <p>Average length of time for MO initial credentialing is 12 days from Clean File determination to Credentials Committee Date (Q2 2017 data). Recredentialing applications are processed in accordance with NCQA requirements with all recredentialing occurring within 36 months. At the end of 36 months, if a provider has not recredentialled, they are terminated from our Network. However, if, in their 37th month, they provide their recredentialing documentation and are approved by Credentials Committee, per NCQA standards, we are able to reinstate the provider. For a practitioner or organizational provider (“provider”, collectively) to be considered for network admission, the provider must complete our application process online and submit all credentialing information, valid business documents, and licensing information. The provider is then sent a network participation agreement requesting signature. The provider's application for network participation is accepted and network participation agreement executed upon successful completion of our credentialing process in accordance with NCQA Standards and Guidelines, regulatory requirements, and managed care contractual obligations. Our provider network is continually enhanced and maintained in order to meet or exceed network adequacy requirements. • All providers within MO are credentialed the same. As we do not distinguish between provider types/specialties during credentialing. Home State Health Plan will accept and utilize the CAQH Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180 (as amended), as the credentialing application for all practitioner credentialing in compliance with section 2.18.8c of the contract. Home State Health Plan requires verification of Bureau of Narcotics and Dangerous Drugs</p> |  |

issued by the Missouri Department of Health & Human Services, if applicable. A current copy of the certificate is considered a valid source and meeting the requirement. Alternately, this may be verified online at: <https://webapp01.dhss.mo.gov/mohworx/RegistrantSearch.aspx>

• As per Missouri 376.1578: The Company shall assess a health care practitioner's credentialing information and make a decision as to whether to approve or deny the practitioner's credentialing application within sixty (60) business days of the date of receipt of the completed application. A completed application is a practitioner's application to a health carrier that seeks the health carrier's authorization for the practitioner to provide patient care services as a member of the health carrier's network and does not omit any information which is clearly required by the application form and the accompanying instructions. The sixty-day (60) deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:

- a. A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;
- b. Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;
- c. Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or
- d. A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.

NP's, PA's, and provisionally licensed professionals are required to have a supervising physician form completed by an in-network physician.

FFS – For MH/SUD and M/S, individual providers must submit copy of professional license and Medicare letter (if Medicare enrolled). For MH/SUD and M/S hospitals must be currently licensed by the Department of Health & Senior Services and Medicare certified as a hospital. Must submit a copy of the hospital license and Medicare certification letter.

DMH –

**Processes: (CPR, CSTAR & TCM)** Provider agencies must be certified under both CPR and Core Rules state regulations in order to deliver and be reimbursed for CPR services by the Missouri Medicaid program, MO HealthNet. The DBH Division assures the agency has the ability and the qualified staff to deliver core services. The certification unit may make a site visit to determine if the agency meets certification standards, and/or require proof of other relevant accreditation status. If the provider is nationally accredited for behavioral health care from CARF International, The Joint Commission, or Council On Accreditation (COA) the department shall grant certification upon receipt of completed application and proof of national accreditation.

**Submission and Staffing: (CPR, CSTAR, & TCM)** The steps for obtaining certification start with the provider agency completing a DBH certification application form and submitting that form to the DBH certification unit for review and approval. The form is submitted via mail, fax or electronically. The persons reviewing the DBH certification application form must meet the requirement as a Program Specialist and receive appropriate training which includes but is not limited to job shadowing, review of manuals, knowledge of standards, etc.

**Strategy: (CPR, CSTAR & TCM)** To verify the provider agency applying for certification meet requirements in the Code of State Regulation that allows them to provide quality, effective services. Eligibility, safety, and quality care concerns are the primary factors in requiring that provider agencies seeking to provide services that meet certain minimal standards.

**Timeline: (CPR, CSTAR, & TCM)** DBH certification unit has 30 days in which to determine whether the agency is eligible to be considered for certification.

Additional time is required for site visit and determination if provider meets certification standards for agencies not nationally accredited. Failure to fully and accurately provide required information may increase certification time or result in non-certification. Provider certification is reviewed every three years.

**Evidence: (CPR, CSTAR, & TCM)** State statute requires certification. The DBH Division, based on extensive experience in delivering quality behavioral health services, has determined that providers of CPR services should meet certain standards for staffing, administration, and service delivery that promote quality care for persons with serious mental illnesses. Practice guidelines support the rationale for this NQTL. TCM is supported by federal guidance.

**Appeal: (CPR, CSTAR, & TCM)** Providers can appeal the decision if denied certification. If provider is denied certification or if their certification is revoked they may appeal to the Department Director. Then the provider's appeal is reviewed and a decision is made on the appeal. Provider has 30 days from the date of the notification of denial or revocation of certification to appeal to the Director. Provider must provide written notification/justification of appeal.

**Processes: (CPR)** This is a certification standard which: - When a provider agency hires a staff person to perform services or functions that require the individual staff meet staff requirements for applicable services. The agency assure persons used as QMHPs, Peer Supports in the CPR program meet one of the categories of staff specified in state regulations. This may include primary source verification of educational degree, license, or certification. -Requires CPR provider agencies have a process for granting and periodically reviewing clinical privileges to staff and establishes minimum elements for that process. When new staff are hired the agency must go through a process to grant clinical privileges for staff delivering services; and clinical privileges must be reviewed and renewed at a minimum every two (2) years. This is a process carried out by provider agencies, and they may develop their own forms to guide and support this. Agencies may require additional approval to perform certain services in addition to certification.

**Access Crisis Intervention Programs (CPR):** This NQTL applies to both adults and children and youth. State regulation requires that providers meet minimum staffing requirements for their ACI system for both the 24 hour crisis hotline and the mobile crisis response. Staff are required to have certain qualifications and experience, and trained appropriately. When a person is hired to work in the ACI system, that triggers the provider agency must go through a process that insures the person meets certain qualifications and is trained appropriately. There is also a requirement for continuing education and training with minimum hours that must be completed annually and within a two (2) year period. The provider agency may develop forms to guide and document this process at their discretion.

**Intensive CPR – Residential (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR. It limits provider agencies operating the Intensive CPR Residential service to only those who operate CPR programs, and are approved for the service by DMH. It also requires that the clients receiving this service are enrolled in the rehabilitation level of care. The trigger is when a provider agency wants to become a provider of these services, and when they want to start enrolling clients. When a provider agency wants to start providing this service they must notify DMH, DBH Division, and receive approval to deliver the service. Then when they enroll clients to be served, the provider must assure they are enrolled in the correct level of care. The team of staff that provide these services must be trained to provide the services and must be supervised by the QMHP.

**Peer Support (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. It sets forth the staff qualifications and service definition for Certified Missouri Peer Specialists who deliver peer support services. When a provider agency wants to employ a person to provide peer support services, they must assure the person has at least a high school diploma or equivalent and has received the required training and passed the test in order to be a Certified Missouri Peer Specialist.

**Psychosocial Rehabilitation (CPR):** When an agency develops a psychosocial rehabilitation (PSR) program they must have that program either accredited by CARF, or licensed as a day program by DMH under licensure regulations. This NQTL further directs that if certification standards are more restrictive than licensure standards, then certification standards should prevail. Further, it limits the person assigned as the director of the adult PSR program must be a qualified mental health professional. For the youth PSR program the director of the program must be a qualified mental health professional with at least two (2) years of relevant work experience.

This is in the Missouri Medicaid Provider Manual for CPR and sets limitations on how many persons can be served in an adult PSR program in relation to staffing. Staff to client ratios may not exceed 1:16; program needs or client mix may require even lower staff to client ratios; and at least one (1) staff person must be present at all times at the program site. When provider agencies are planning staffing coverage for a PSR program, they need to assure they have adequate staffing to meet these requirements.

These are requirements in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. One (1) full time equivalent mental health professional shall be available during the provision of services. The staffing ratios shall be based on the client's age. For those clients between the ages of three (3) and 11, the staffing ratio shall be one (1) staff to four (4) clients. For those clients between the ages of 12 and 17, the staffing ratio shall be one (1) staff to six (6) clients. Other staff of the PSR team shall be composed of the following providers as needed by the children: 1. a registered nurse; 2. an occupational therapist; 3. a recreational therapist; 4. a rehabilitation therapist; 5. a community support specialist; or, 6. family assistance worker.

**Individual and Group Counseling PSR (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. It sets forth the staff qualifications and training requirements for persons providing Individual and Group Professional PSR. It is required that whenever a provider agency hires a staff person to provide Individual and Group Professional PSR, they must assure the person hired meets one of the staffing qualifications and has received the required training in mental health services. Qualified staff must be a professional counselor licensed or provisionally licensed under Missouri law and with specialized training in mental health services; or, a clinical social worker licensed or master social worker licensed under Missouri law and with specialized training in mental health services; or, a psychologist licensed or provisionally licensed or temporary licensed under Missouri law with specialized training in mental health services. Staff providing individual and group professional psychosocial rehabilitation services must have additional initial training such as, cognitive behavioral therapy, creating a recovery based mental treatment plan, illness management and recovery, motivational interviewing, and introduction to DBT.

**PSR – IMR (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. This limits providers of the PSR-IMR service to only those who have been approved by the DBH Division. Providers must submit in writing to the division a plan to implement this service along with planned curriculum, in order to get approval. The trigger is when a provider agency decides to implement this service for the first time, or to add new curriculum to a PSR-IMR program already operating.

**Co-Occurring Services (CPR):** This is a requirement in the CPR state regulation, regarding qualified staff who work in Integrated Dual Disorders Treatment (IDDT) programs. This sets forth minimum requirements for a person to be considered a QMHP or Qualified Addiction Professional (QAP) and meet co-occurring counselor competency requirements established by DBH. When an agency hires a person for a QAP position in an IDDT program, they must assure they meet one of the two qualification types above.

This is a requirement in the CPR state regulation regarding fidelity reviews and quality improvement plans in Integrated Dual Disorders Treatment (IDDT) programs. Agencies delivering these services are required to follow the SAMHSA evidence based guidelines for IDDT, are required to receive fidelity reviews from the DBH Division, and are required to have a quality improvement plan as specified above. The trigger is an agency starting to implement an IDDT program, and annually thereafter when fidelity reviews come due. DBH staff utilize a standardized tool and form in fidelity reviews. It is required that agencies receive a fidelity review initially and annually thereafter. In addition the provider agency must develop and maintain a quality improvement plan that

meets certain requirements in the regulation. DBH Division staff who conduct fidelity reviews must be trained and knowledgeable in IDDT.

**Co-Occurring Services - Individual Counseling, Group Counseling, Group Education, and Co-Occurring Assessment Supplement (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. This establishes who an eligible staff person is to provide Co-Occurring Individual Counseling, Co-Occurring Group Counseling, Co-Occurring Group Education and Co-Occurring Assessment Supplement in an IDDT program. When a provider agency hires a person to deliver Co-Occurring Individual Counseling, Co-Occurring Group Counseling, and Co-Occurring Assessment Supplement in an IDDT program, they must assure the person is either a QMHP or a Qualified Addiction Professional (QAP), and meet co-occurring counselor competency requirements established by DMH. When a provider agency hires a person to deliver Co-Occurring Group Education in an IDDT program, they must assure the person has documented education and experience related to the topic presented and either be or be supervised by a QMHP or a QAP who meets co-occurring counselor competency requirements established by DMH.

**Assertive Community Treatment (CPR):** This is in state regulation and establishes minimum staffing requirements for Assertive Community Treatment (ACT) teams. When a provider agency hires staff for their ACT teams they must assure those staff meet requirements as follows:

- The team shall have adequate nursing capacity by meeting one (1) of the following:
  - A registered professional nurse with six (6) months of psychiatric nursing experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation
  - During the first year of program operation, a registered professional nurse shall work with no more than fifty (50) individuals as a seventy-five percent (75%) Full-Time Equivalent (FTE) for up to twelve (12) months;
- A team leader who is a qualified mental health professional as defined in 9 CSR 30-4.030(2)(HH) that is full time with one (1) year of supervisory experience and a minimum of two (2) years of experience working with adults with serious mental illness in community settings;
- The team shall have adequate substance abuse treatment capacity by meeting one (1) of the following: 1. A substance abuse specialist who is a qualified substance abuse professional (QSAP) as defined in 9 CSR 10-7.140(2)(RR)1. or 2. with one (1) year of training or supervised experience in substance abuse treatment shall be assigned to no more than fifty (50) individuals; or 2. If the QSAP is not assigned to a team full time or is assigned to a team with less than fifty (50) individuals, the QSAP shall attend at least two (2) team meetings per week; or 3. A QSAP who has less than one (1) year experience in Integrated Dual Disorders Treatment (IDDT) shall be actively acquiring twenty-four (24) hours of training in IDDT-specific content and receive supervision from experienced IDDT staff;
- The team shall have adequate vocational specialization capacity by meeting one (1) of the following:
  - A vocational specialist who qualifies as a community support worker as defined in 9 CSR 30-4.034(2)(H)1. with one (1) year of experience and training in vocational rehabilitation and supported employment shall be available to no more than fifty (50) individuals; or
  - If the vocational specialist is not assigned to a team full time or is assigned to a team with less than fifty (50) individuals, the vocational specialist shall attend at least two (2) team meetings per week; or
  - A vocational specialist with six (6) months of vocational experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation;
- The team shall include a peer specialist which shall be self-identified as a present or former primary consumer of mental health services; be assigned full time to a team and shall participate in the clinical responsibilities and functions of the team in providing direct services; and serve as a model, a support, and a resource for the team members and individuals being served by the first year of program operation. Peer specialists, at a minimum, shall meet the qualifications of a community support assistant as defined in 9 CSR 30-4.030(2)(P) and 9 CSR 30-4.034(2)(H)2.;
- The team shall include a program assistant. A team of one hundred (100) individuals requires one (1) Full Time Equivalent (FTE) prorated based on

team size. The program assistant shall have education and experience in human services or office management. The program assistant shall organize, coordinate, and monitor all non-clinical operations of the team including but not limited to the following:

- Managing medical records;
- Operating and coordinating the management information system; and
- Triaging telephone calls and coordinating communication between the team and individuals receiving ACT services;
- Other team members may be assigned to work exclusively with the team and must qualify as a community support worker or a qualified mental health professional as defined in 9 CSR 30-4.034 (2)(H)1. or 9 CSR 30-4.030(2)(HH); and
- In addition to training required in 9 CSR 30-4.034, team members shall receive ongoing training relevant to ACT services.

**Contract (CPR & TCM):** This NQTL applies to both adults and children and youth. These requirements are in the Administrative Agent Master Contract agreement. Administrative Agents are required to operate CPR programs for adults and children and youth, and TCM programs for adults and children and youth.

- Further, this NQTL requires that they employ one or more full time Community Mental Health Liaisons (CMHLs), and sets forth minimum qualifications and training requirements for a CMHL. These liaison positions shall be filled by experienced, qualified mental health professionals who are: (a) Trained in assessment and crisis intervention; (b) Knowledgeable about the local system of care including, but not limited to, the operation of the community providers, the Access Crisis Intervention (ACI) system, inpatient psychiatric resources, civil commitment procedures, and guardianship laws; and c. Knowledgeable about behavioral health disorders and co-occurring disorders.
- Contractors are required to incorporate trauma informed approaches into service delivery. As the agency develops policies, procedures, and processes to assess and serve clients, they should be considering trauma informed approaches. It is required that administrative agents incorporate trauma informed approaches into service delivery that actively consider the likelihood of a consumers trauma experience.

**(CSTAR)** Initial certification request and/or renewal process for existing certification by a provider. In order for an agency to be a CSTAR provider they must submit an application to DBH requesting CSTAR certification; they must comply with applicable standards as stated in the rule in addition to program specific rules as stated in standards. Agency must then be approved by DMH as a CSTAR provider. This process needs to be done initially and then every three years, the provider will have to complete the DBH certification application. The organization must comply with the standards applicable to each program for which certification is being sought.

Staff vacancy, new service and/or service expansion triggers hiring of qualified professionals. Provider must be knowledgeable of staff qualifications for each service. The agencies must hire/train staff and supervise staff and ensure continuous eligibility for service provision. Qualified staff must be available before services can be delivered. The person responsible for ensuring qualified staff for a given service must be knowledgeable of the service requirements.

Provider must obtain primary source verification to determine potential staff's status to determine:

- If the person is eligible to provide the service now or if the person is a student and not currently eligible through prior experience and/or education.
- If the person meets the requirements of an:
  - Qualified Substance Abuse Professional
    - A physician or qualified mental health professional meeting the educational/experiential/supervision requirements for licensure as

established by the Missouri Division of Professional Registration who has at least one year of full-time experience in the treatment or rehabilitation of persons with substance use disorders; or

- A person meeting the educational/experiential/supervision requirements for certification or registration as a substance abuse professional by the Missouri Substance Abuse Professional Credentialing Board.

- Associate Counselor

- The associate counselor is a trainee that must meet requirements set forth by the Missouri Credentialing Board or the appropriate board of professional registration within the Department of Economic Development.

- Licensed Mental Health Professional

- Provisional licensure as a mental health professional will satisfy the licensure requirement for designation as a QAP, including the qualifications required to deliver trauma-related and co-occurring disorders-related services. However, all other requirements related to provider qualifications must be met and demonstrated.

- Community Support Specialist

- Must meet one of the following qualifications:

- A mental health professional as defined in 9 CSR 10 – 7.140 (2) (QQ);
- An individual with a bachelor’s degree in a human services field, which includes social work, psychology, nursing, education, criminal justice, recreational therapy, human development and family studies, counseling, child development, gerontology, sociology, human services, behavioral science and rehabilitation counseling;
- An individual with any four year degree and two years of qualifying experience;
- An individual with any four year combination of higher education and qualifying experience, or
  - An individual with four years of qualifying experience.
- Qualifying experience must include delivery of service to individuals with mental illness, substance use disorder or developmental disabilities. Experience must include some combination of the following:
  - Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus;
  - Teaching and modeling for individuals how to cope and manage psychiatric, developmental or substance use issues while encouraging the use of natural resources;
  - Supporting efforts to find and maintain employment for individuals and/or to function appropriately in families, school and communities;
  - Assisting individuals to achieve the goals and objectives on their person centered individualized treatment plans.

- It is also required that the Community Support Specialist complete the necessary orientation and training requirements specified by DMH.

- Co-Occurring Counselor

- Co-occurring disorder individual counseling is provided by either a person licensed by the Missouri Division of Professional Registration as a mental health professional who is practicing within their current competence; or, a person certified by the Missouri Credentialing Board as a professional working in co-occurring disorders who is practicing within their current competence.

- Trauma Counselor

- Trauma individual counseling is provided by a licensed mental health professional who is a qualified addiction professional (QAP). Qualified staff must have specialized trauma training and/or equivalent work experience and shall utilize an evidence-based treatment model for the delivery of this service.; or

- Has the ability/training/etc. to provide:

- Any CSTAR Service
  - Intake Assessment – Qualified Addiction Professional (reviews and interprets assessment data and meets with consumer to develop treatment recommendations), and licensed diagnostician (renders a five-axis diagnosis). Other components included in service description:
    - Outcome Measurement – Community Support Worker or Qualified Addiction Professional; and
    - Assessment and Diagnostic Update – Qualified Addiction Professional (reviews and interprets assessment data and meets with consumer to develop treatment recommendations), and licensed diagnostician (renders a five-axis diagnosis)
  - Community Support – Community Support Worker
  - Individual Counseling – Qualified Addiction Professional or Associate Counselor. Evidence based interventions requires Licensed Mental Health Professional that is a Qualified Addiction Professional with relevant training/experience or specific credentials.
  - Group Counseling – Qualified Addiction Professional or Associate Counselor
  - Group Therapeutic Substance Abuse Education – Individual with appropriate background, experience and knowledge and demonstrated competencies and skills
  - Day Treatment – Activities and interventions delivered under supervision of Qualified Addiction Professional
  - Family Therapy – Licensed or certified marriage and family therapist, or qualified professional as defined in 9 CSR 30-3.110(6)(D)
  - Codependency Counseling – Family Therapist or Qualified Addiction Professional with appropriate training
  - Detoxification Services – A team that includes a licensed physician or Advanced Practice Nurse, registered and licensed nursing staff and other specialty trained staff
  - Medication Services – Licensed Physician or Advanced Practice Nurse
  - Extended Day Treatment – Licensed, Registered Nurse
- Group Therapeutic Substance Use Disorder Education
  - Group therapeutic substance use disorder education services shall be provided by an individual who:
    - Is suited by education, background or experience to teach the information being presented;
    - Demonstrates competency and skill in educational techniques;
    - Has knowledge of the topic(s) being taught; and,
    - Is present with participants throughout the group therapeutic substance use disorder education session.
  - In addition, staff who provide information about human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) shall have completed a department approved or comparable training program.
- Trauma Group Education
  - Trauma group education must be provided by staff with specialized training in trauma and addiction.
- Family Therapy
  - Unless otherwise approved and documented by DMH, family therapy shall be performed by a person who:
    - Is licensed in Missouri as a marital and family therapist; or
    - Is certified by the American Association of Marriage and Family Therapists; or
    - Has a graduate (doctoral or masters) degree in psychology, social work or counseling and has at least one year of supervised experience in family counseling and has specialized training in family counseling; or has a graduate (doctoral or masters) degree in psychology, social work or counseling and receives close supervision from an individual who meets the above requirements; or,
    - A degreed, qualified addiction professional who receives close supervision from an individual that meets the above

requirements.

- Collateral Dependent Counseling
  - Assessments, individual counseling and group counseling services provided to children under age 12 shall be provided by:
    - A social worker, counselor, psychologist or physician licensed in Missouri who has at least one year of full-time experience in the assessment and treatment of children; or,
    - A graduate of an accredited college or university with a master's degree in social work, psychology, counseling, psychiatric nursing or closely related field, which has at least two years of full-time equivalent experience in the treatment and assessment of children. Group collateral dependent services for therapeutic substance use disorder education for children under age 12 shall be provided by a graduate of an accredited college or university with a bachelor's degree in counseling, psychology, social work or closely related field.
- Individual and Group Counseling
  - A majority of the program's staff who provide individual and group counseling shall be qualified substance abuse professionals.
- Extended Day Treatment
  - This service consists of medical and other consultative services provided by a registered nurse for the purposes of monitoring and managing a participant's health, and medication management.
  - A registered nurse (RN) with relevant education, experience, and competency is available on site or by phone for 24-hour supervision.
- Opioid Treatment Program
  - When a person works in an Opioid Treatment setting the provider must provide or arrange and document ongoing training that consists of at least 14 hours of training for all staff working in an Opioid Treatment setting every 2 years. The provider must include in their HR processes a method to ensure trainings are occurring, staff are attending and training is documented with at least 14 hours of training every 2 years.
- Adolescent Treatment Support
  - Service delivery staff shall:
    - Have training and demonstrate expertise regarding the treatment of both substance use disorders and other disorders related to adolescents; and,
    - Receive clinical supervision by an appropriately licensed, certified, or otherwise credentialed person with experience in the treatment of adolescents.
    - Participants shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.
- Communicable Disease Counseling
  - Prior to being tested for HIV, counseling must be provided by individuals who are knowledgeable about communicable diseases including HIV, TB and STDs through training and/or previous employment experience.
  - Staff's knowledge shall include awareness of risks, disease management/treatment and resources for care, and confidentiality requirements when working with special populations. Post-test counseling may be provided for those testing positive for either HIV or TB. Staff providing these services shall also be competent to therapeutically assist consumers to understand and appropriately respond to test results. Post-test counseling for HIV or TB must also be knowledgeable about services and care coordination available through the DHSS.

- Supervision

- Credentials for Supervisor of Counselors. Unless otherwise required by these rules, supervision of counselors must be provided by a qualified substance abuse professional who has
  - A degree from an accredited college in an approved field of study; or
  - Four (4) or more year's employment experience in the treatment and rehabilitation of persons with substance abuse problems.
- Credentials for Supervisor of Community Support Workers. A community support worker shall be supervised by an individual with
  - A master's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least one (1) year of full-time equivalent experience in providing community support services; or
  - A bachelor's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least two (2) years of full-time equivalent experience in providing community support services; and
  - Demonstrated competencies in the areas of supervision and substance abuse treatment and rehabilitation by virtue of experience and/or training.

Other Applicable Program Requirements. A CSTAR program shall meet the following additional requirements, when the department determines that they are applicable:

- Services offered on a residential basis shall comply with requirements for residential treatment; and
- Requirements as a specialized program for adolescents or as a specialized program for women and children shall be met, where applicable.

All detoxification services shall be provided in a humane manner and shall ensure the safety and well-being of persons served.

- There shall be monitoring and assessment of the person's physical and emotional status during the detoxification process.
  - Vital signs shall be taken on a regular basis, with the frequency determined by client need based on a standardized assessment instrument.
  - Blood alcohol concentration may be monitored upon admission and thereafter as indicated. Further testing of urine or blood may be conducted by qualified personnel.
- Staff coverage in residential settings shall ensure the continuous supervision and safety of clients.
  - Two (2) staff members shall be on-site at all times, and additional staff may be required, as warranted by the size of the program and the responsibilities and duties of staff members.
  - Staff providing direct supervision and monitoring of clients shall demonstrate competency in recognizing symptoms of intoxication, impairment and withdrawal; monitoring vital signs; and understanding basic principles and resources for substance abuse treatment.
  - Clients shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.

When the Department notifies providers of newly required training, the provider would ensure staff received the required training and document training within the timeframe set by the Department. The providers must provide or arrange for their staff to receive specified training.

If a religious entity contracts with DMH, the religious organization must meet the same requirements as non-religious organizations per block grant as well as comply with federal requirement pertaining to charitable choice provisions and regulations.

**(TCM)** A provider of TCM services is an entity that is designated by the DMH. Designation is contingent upon the provision of the core services listed below. These services may be provided directly or by subcontract. The required service functions include the following:

- Assessment and periodic reassessment
- Case Coordination

- Case Monitoring
- Case Documentation
- Supported Community Living (SCL) Functions

TCM services are provided by community mental health facilities approved to provide this service by the Department of Mental Health.

Administrative Agent of DMH hire and employs Targeted Case Managers and QMHP for the purpose of administration of TCM. Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

- Targeted Case Managers
  - For youth, must at a minimum be a graduate from an accredited four (4) year college or university with a specialization in sociology, psychology, social work, or closely related fields and at least one (1) year of full-time equivalent experience in working with children and families.
  - For adults, must have graduated from an accredited four (4) year college or university with a specialization in sociology, psychology, social work, or closely related fields or a graduate from an accredited four (4) year college or university with related work experience. Relevant human service delivery experience can be substituted on a year for year basis for the four year degree.
- A qualified mental health professional (QMHP) for the purpose of administration of the MO HealthNet TCM, is defined as:
  - A physician licensed under Missouri law to practice medicine or osteopathy and with training in mental health services or one year of experience, under supervision, in treating problems related to mental illness and serious emotional disturbances.
  - A psychiatrist licensed under Missouri law as a physician and who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association, or other training program identified as equivalent by DMH.
  - A psychologist licensed under Missouri law to practice psychology with specialized training in mental health services.
  - A professional counselor licensed under Missouri law to practice counseling with specialized training in mental health services.
  - A clinical social worker licensed under Chapter 337 RSMo.
  - A psychiatric nurse licensed under Chapter 335 RSMo., as a registered professional nurse with at least two years of experience in a psychiatric or substance use disorder treatment setting or a master's degree in psychiatric nursing.
  - An individual possessing a master's or doctorate degree in counseling and guidance, vocational counseling, pastoral counseling, rehabilitation counseling and guidance, psychology, family therapy, or related field, who has successfully completed a practicum or has one year of experience under the supervision of a qualified mental health professional.
  - An occupational therapist certified by the American Occupational Therapy Certification Board, registered in Missouri, who has a bachelor's degree and has completed a practicum in a psychiatric setting or has one year experience in a psychiatric setting or has a master's degree and has completed either a practicum in a psychiatric setting or has one year of experience in a psychiatric setting.
  - An advanced practice nurse under Chapter 335.016 RSMo who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the board of nursing.
  - A psychiatric pharmacist who is a registered pharmacist in good standing with the Missouri Board of Pharmacy who is a board certified pharmacist (BCPP) through the Board of Pharmaceutical Specialties or a registered pharmacist currently in a psycho-pharmacy residency where the service has been supervised by a board certified psychiatric pharmacist.

**(HCH)** Provider initially must complete an application form. Enrollment forms must be completed in order for an individual to be part of a HCH. The HCH

provider must complete specified forms and submit to DBH, including monthly implementation report and monthly status report, monthly hospitalization follow-up report in addition they have to complete an attestation and send to MO HealthNet to support the services were provided and they have to submit data to a contracted population health platform.

Agencies must meet staffing requirements for HCH Directors, Nurse Care Managers, care coordinators and Primary Care Physician Consultants per the staffing memo. HCH organizations must also meet national accreditation standards for HCHs. They must maintain CPR certification and contract with DBH and fulfill all requirements such as participation in scheduled trainings, meetings/phone conferences/webinars and submission of data as required.

(HCH) In order to be a CMHC HCH, the provider must be certified as a CPR provider and hold a contract with DBH/DMH. They have to apply to DBH to be a HCH and be approved based on staffing patterns and expected practices. The DBH then recognizes the organization as an adult and or youth HCH.

Initial and renewal of recognition as CMHC HCH every 3 years.

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#### **Submission and Staffing:**

**(CPR)** This requires that all personnel provided by contracted agencies have criminal background checks in accordance with state law. When a contracted provider agency hires a new staff person, it is required that staff at contracted agencies have background checks completed. Depending on the service there is also a requirement for continuing education, training with minimum hours that must be completed annually and within a two (2) year period and passing any applicable test. The provider agency may develop forms to guide and document this process at their discretion. Some services require a staff to client ratio. The provider must also complete a clinical privileges process for staff to assure they meet qualification and training requirements to provide those services. Clinical privileging process must be done initially and every 2 years for all staff providing CPR service.

**(CSTAR)** Provider verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Depending on the service there is also a requirement for continuing education, training with minimum hours that must be completed within a two (2) year period. Some services require a staff to client ratio.

**(TCM)** Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

**(HCH)** Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

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#### **Strategy:**

**(CPR)** The purpose is to assure: staff with service and management responsibility meet certain minimal standards; agencies have the staffing in place to provide quality services; and that persons providing behavioral health services have the qualifications and skills to provide services.

Clinical efficacy and safety concerns are the primary factors.

**(CSTAR)** The purpose of this NQTL is to ensure staff are appropriately trained and qualified to provide services, stay abreast of and demonstrate competency regarding changes and evolving practices in the field. The state sets staff qualifications and competency requirements in order to ensure quality service provision for the delivery of culturally sensitive and evidenced based practices. Factors in determining the NQTL include safety, clinical efficacy, quality of care, and quality services. We want to ensure that the services being delivered are not doing more harm than good.

**(TCM)** The purpose of this NQTL is to ensure services are responsive to the individual's full range of needs and to assure services are provided by a qualified professional operating within their scope of practice. Clinical efficacy, elasticity of demand, licensing and accreditation were considered when determining the NQTL.

**(HCH)** The purpose of the HCH is to provide better care coordination and chronic disease monitoring of individuals with serious mental illness or severe emotional disturbance ultimately reducing costs and decreasing mortality. The purpose of the organization's required certification, accreditation and data reporting is to ensure quality outcome measures are met. Eligibility and coverage confirmation; safety concerns; cost of treatment; variability in cost and quality; clinical efficacy.

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**Evidence:**

**(CPR)** General best practices, SAMSHA, practice guideline, national standards, stakeholder involvement

**(CSTAR)** General best practices, SAMSHA, practice guideline, national standards, stakeholder involvement

**(TCM)** CMS guidance and SSA as follows:

- CMS-2237-IFC(3) states "case management services are comprehensive and must include all of the following: assessment of an eligible individual (42 CFR 440.169(d)(1)); development of a specific care plan (42 CFR 440.169(d)(2)); referral to services (42 CFR 440.169(d)(3)); and monitoring activities (42 CFR 440.169(d)(4))." To allow for consistent monitoring, oversight and timely updates/revisions the criteria for the provider is reviewed every three years if provider is not accredited. If provider is accredited criteria is reviewed every 3 or 4 years depending on accreditation body standards. MO HealthNet TCM provider manual is reviewed and updated yearly.
- Section 1905(a)(13) of the Social Security Act and 42 CFR §440.130(d) provide that States may cover rehabilitative services: "including any medical or remedial services (provided in a facility, a home, or other setting)recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. CMS 2237 IFC requires states to specify provider qualifications. CMS guidance CMS-2237-IFC (7) states "When a target group consists solely of individuals with developmental disabilities or chronic mental illness, States may limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services". To allow for consistent monitoring of required staff qualifications, certification for the provider is reviewed every three years if provider is not accredited.

If provider is accredited criteria is reviewed every 3 or 4 years depending on accrediting body standards. MO HealthNet TCM provider manual is reviewed and updated yearly.

**(HCH)** Published research-CATIE study that references that individuals with serious mental illness die 25 years younger than the general population due to preventable chronic diseases. DBH also utilizes population health data to determine target areas of treatment. DMH utilizes the data submitted to DBH from HCH providers to help providers focus their treatment. Criteria was developed by DBH along with stakeholders, including the Coalition of Behavioral Health Centers and providers.

**Appeal:**

**(All)** DMH Exceptions Committee hears requests for waiver to a rule regarding staff qualifications for services.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

NQTL: Network Admission Requirements: Provider Enrollment and Credentialing  
 Health Plan/State: Missouri Care / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers  | M/S Benefits/Providers   |
|--|--|
| <p>Missouri Care – Inpatient and Outpatient: Applicable to all provider and practitioner types under consideration for network participation.</p> <p>FFS (outpatient): CPR, CSTAR, Adult TCM, &amp; Youth TCM, clinic option providers (for COA 4);<br/>           Inpatient (COA 4 if behavioral health admission only)</p> | <p>Missouri Care – Inpatient and Outpatient: Applicable to all provider and practitioner types under consideration for network participation.</p> <p>FFS: Inpatient and Outpatient: Applicable to all provider and practitioner types during enrollment.</p> |

**Compliance Analysis**

**Missouri Care:**

WellCare provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. WellCare performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation. Policy(ies): C7CR-009, C7CR-001, C7CR-004, C7CR-009-PR-001.

The State of Missouri requires that Missouri Care contract and credential multiple CMHC, FQHC, RHC, LPHA and other like Agencies. The requirements for credentialing are:

- An Application
- Proof of Accreditation / State or Health Plan Site visit
- Proof of Federal or State Designation as a qualifying Agency

- General Liability

Missouri Care's goal length of time for the credentialing and re-credentialing process for MH/SUD and for M/S providers is less than 60 days. Our current turnaround time is <35 days.

**FFS** – For MH/SUD and M/S, individual providers must submit copy of professional license and Medicare letter (if Medicare enrolled). For MH/SUD and M/S hospitals must be currently licensed by the Department of Health & Senior Services and Medicare certified as a hospital. Must submit a copy of the hospital license and Medicare certification letter.

**DMH** –

**Processes: (CPR, CSTAR & TCM)** Provider agencies must be certified under both CPR and Core Rules state regulations in order to deliver and be reimbursed for CPR services by the Missouri Medicaid program, MO HealthNet. The DBH Division assures the agency has the ability and the qualified staff to deliver core services. The certification unit may make a site visit to determine if the agency meets certification standards, and/or require proof of other relevant accreditation status. If the provider is nationally accredited for behavioral health care from CARF International, The Joint Commission, or Council On Accreditation (COA) the department shall grant certification upon receipt of completed application and proof of national accreditation.

**Submission and Staffing: (CPR, CSTAR, & TCM)** The steps for obtaining certification start with the provider agency completing a DBH certification application form and submitting that form to the DBH certification unit for review and approval. The form is submitted via mail, fax or electronically. The persons reviewing the DBH certification application form must meet the requirement as a Program Specialist and receive appropriate training which includes but is not limited to job shadowing, review of manuals, knowledge of standards, etc.

**Strategy: (CPR, CSTAR & TCM)** To verify the provider agency applying for certification meet requirements in the Code of State Regulation that allows them to provide quality, effective services. Eligibility, safety, and quality care concerns are the primary factors in requiring that provider agencies seeking to provide services that meet certain minimal standards.

**Timeline: (CPR, CSTAR, & TCM)** DBH certification unit has 30 days in which to determine whether the agency is eligible to be considered for certification. Additional time is required for site visit and determination if provider meets certification standards for agencies not nationally accredited. Failure to fully and accurately provide required information may increase certification time or result in non-certification. Provider certification is reviewed every three years.

**Evidence: (CPR, CSTAR, & TCM)** State statute requires certification. The DBH Division, based on extensive experience in delivering quality behavioral health services, has determined that providers of CPR services should meet certain standards for staffing, administration, and service delivery that promote quality care for persons with serious mental illnesses. Practice guidelines support the rationale for this NQTL. TCM is supported by federal guidance.

**Appeal: (CPR, CSTAR, & TCM)** Providers can appeal the decision if denied certification. If provider is denied certification or if their certification is revoked they may appeal to the Department Director. Then the provider's appeal is reviewed and a decision is made on the appeal. Provider has 30 days from the date of the notification of denial or revocation of certification to appeal to the Director. Provider must provide written notification/justification of appeal.

**Processes: (CPR)** This is a certification standard which: - When a provider agency hires a staff person to perform services or functions that require the individual staff meet staff requirements for applicable services. The agency assure persons used as QMHPs, Peer Supports in the CPR program meet one of the categories of staff specified in state regulations. This may include primary source verification of educational degree, license, or certification. -Requires CPR provider agencies have a process for granting and periodically reviewing clinical privileges to staff and establishes minimum elements for that process. When new staff are hired the agency must go through a process to grant clinical privileges for staff delivering services; and clinical privileges must be reviewed and renewed at a minimum every two (2) years. This is a process carried out by provider agencies, and they may develop their own forms to guide and support this. Agencies may require additional approval to perform certain services in addition to certification.

**Access Crisis Intervention Programs (CPR):** This NQTL applies to both adults and children and youth. State regulation requires that providers meet minimum staffing requirements for their ACI system for both the 24 hour crisis hotline and the mobile crisis response. Staff are required to have certain qualifications and experience, and trained appropriately. When a person is hired to work in the ACI system, that triggers the provider agency must go through a process that insures the person meets certain qualifications and is trained appropriately. There is also a requirement for continuing education and training with minimum hours that must be completed annually and within a two (2) year period. The provider agency may develop forms to guide and document this process at their discretion.

**Intensive CPR – Residential (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR. It limits provider agencies operating the Intensive CPR Residential service to only those who operate CPR programs, and are approved for the service by DMH. It also requires that the clients receiving this service are enrolled in the rehabilitation level of care. The trigger is when a provider agency wants to become a provider of these services, and when they want to start enrolling clients. When a provider agency wants to start providing this service they must notify DMH, DBH Division, and receive approval to deliver the service. Then when they enroll clients to be served, the provider must assure they are enrolled in the correct level of care. The team of staff that provide these services must be trained to provide the services and must be supervised by the QMHP.

**Peer Support (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. It sets forth the staff qualifications and service definition for Certified Missouri Peer Specialists who deliver peer support services. When a provider agency wants to employ a person to provide peer support services, they must assure the person has at least a high school diploma or equivalent and has received the required training and passed the test in order to be a Certified Missouri Peer Specialist.

**Psychosocial Rehabilitation (CPR):** When an agency develops a psychosocial rehabilitation (PSR) program they must have that program either accredited by CARF, or licensed as a day program by DMH under licensure regulations. This NQTL further directs that if certification standards are more restrictive than licensure standards, then certification standards should prevail. Further, it limits the person assigned as the director of the adult PSR program must be a qualified mental health professional. For the youth PSR program the director of the program must be a qualified mental health professional with at least two (2) years of relevant work experience. This is in the Missouri Medicaid Provider Manual for CPR and sets limitations on how many persons can be served in an adult PSR program in relation to staffing. Staff to client ratios may not exceed 1:16; program needs or client mix may require even lower staff to client ratios; and at least one (1) staff person must be present at all times at the program site. When provider agencies are planning staffing coverage for a PSR program, they need to assure they have adequate staffing to meet these requirements.

These are requirements in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. One (1) full time equivalent mental health professional shall be available during the provision of services. The staffing ratios shall be based on the client's age. For those clients between the ages of three (3) and 11, the staffing ratio shall be one (1) staff to four (4) clients. For those clients between the ages of 12 and 17, the staffing ratio shall be one (1) staff to six (6) clients. Other staff of the PSR team shall be composed of the following providers as needed by the children: 1. a registered nurse; 2. an occupational therapist; 3. a recreational therapist; 4. a rehabilitation therapist; 5. a community support specialist; or, 6. family assistance worker.

**Individual and Group Counseling PSR (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. It sets forth the staff qualifications and training requirements for persons providing Individual and Group Professional PSR. It is required that whenever a provider agency hires a staff person to provide Individual and Group Professional PSR, they must assure the person hired meets one of the staffing qualifications and has received the required training in mental health services. Qualified staff must be a professional counselor licensed or provisionally licensed under Missouri law and with specialized training in mental health services; or, a clinical social worker licensed or master social worker licensed under Missouri law and with specialized training in mental health services; or, a psychologist licensed or provisionally licensed or temporary licensed under Missouri law with specialized training in mental health services. Staff providing individual and group professional psychosocial rehabilitation services must have additional initial training such as, cognitive behavioral therapy, creating a recovery based mental treatment plan, illness management and recovery, motivational interviewing, and introduction to DBT.

**PSR – IMR (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. This limits providers of the PSR-IMR service to only those who have been approved by the DBH Division. Providers must submit in writing to the division a plan to implement this service along with planned curriculum, in order to get approval. The trigger is when a provider agency decides to implement this service for the first time, or to add new curriculum to a PSR-IMR program already operating.

**Co-Occurring Services (CPR):** This is a requirement in the CPR state regulation, regarding qualified staff who work in Integrated Dual Disorders Treatment (IDDT) programs. This sets forth minimum requirements for a person to be considered a QMHP or Qualified Addiction Professional (QAP) and meet co-occurring counselor competency requirements established by DBH. When an agency hires a person for a QAP position in an IDDT program, they must assure they meet one of the two qualification types above.

This is a requirement in the CPR state regulation regarding fidelity reviews and quality improvement plans in Integrated Dual Disorders Treatment (IDDT) programs. Agencies delivering these services are required to follow the SAMHSA evidence based guidelines for IDDT, are required to receive fidelity reviews from the DBH Division, and are required to have a quality improvement plan as specified above. The trigger is an agency starting to implement an IDDT program, and annually thereafter when fidelity reviews come due. DBH staff utilize a standardized tool and form in fidelity reviews. It is required that agencies receive a fidelity review initially and annually thereafter. In addition the provider agency must develop and maintain a quality improvement plan that meets certain requirements in the regulation. DBH Division staff who conduct fidelity reviews must be trained and knowledgeable in IDDT.

**Co-Occurring Services - Individual Counseling, Group Counseling, Group Education, and Co-Occurring Assessment Supplement (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. This establishes who an eligible staff person is to provide Co-Occurring Individual Counseling, Co-Occurring Group Counseling, Co-Occurring Group Education and Co-Occurring Assessment Supplement in an IDDT program. When a provider agency hires a person to deliver Co-Occurring Individual Counseling, Co-Occurring Group Counseling, and Co-Occurring Assessment Supplement in an IDDT program, they must assure the person is either a QMHP or a Qualified Addiction Professional (QAP), and meet co-occurring counselor competency requirements established by DMH. When a provider agency hires a person to deliver Co-Occurring Group Education in an IDDT program, they must assure the person has documented education and experience related to the topic presented and either be or be supervised by a

QMHP or a QAP who meets co-occurring counselor competency requirements established by DMH.

**Assertive Community Treatment (CPR):** This is in state regulation and establishes minimum staffing requirements for Assertive Community Treatment (ACT) teams. When a provider agency hires staff for their ACT teams they must assure those staff meet requirements as follows:

- The team shall have adequate nursing capacity by meeting one (1) of the following:
  - A registered professional nurse with six (6) months of psychiatric nursing experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation
  - During the first year of program operation, a registered professional nurse shall work with no more than fifty (50) individuals as a seventy-five percent (75%) Full-Time Equivalent (FTE) for up to twelve (12) months;
- A team leader who is a qualified mental health professional as defined in 9 CSR 30-4.030(2)(HH) that is full time with one (1) year of supervisory experience and a minimum of two (2) years of experience working with adults with serious mental illness in community settings;
- The team shall have adequate substance abuse treatment capacity by meeting one (1) of the following: 1. A substance abuse specialist who is a qualified substance abuse professional (QSAP) as defined in 9 CSR 10-7.140(2)(RR)1. or 2. with one (1) year of training or supervised experience in substance abuse treatment shall be assigned to no more than fifty (50) individuals; or 2. If the QSAP is not assigned to a team full time or is assigned to a team with less than fifty (50) individuals, the QSAP shall attend at least two (2) team meetings per week; or 3. A QSAP who has less than one (1) year experience in Integrated Dual Disorders Treatment (IDDT) shall be actively acquiring twenty-four (24) hours of training in IDDT-specific content and receive supervision from experienced IDDT staff;
- The team shall have adequate vocational specialization capacity by meeting one (1) of the following:
  - A vocational specialist who qualifies as a community support worker as defined in 9 CSR 30-4.034(2)(H)1. with one (1) year of experience and training in vocational rehabilitation and supported employment shall be available to no more than fifty (50) individuals; or
  - If the vocational specialist is not assigned to a team full time or is assigned to a team with less than fifty (50) individuals, the vocational specialist shall attend at least two (2) team meetings per week; or
  - A vocational specialist with six (6) months of vocational experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation;
- The team shall include a peer specialist which shall be self-identified as a present or former primary consumer of mental health services; be assigned full time to a team and shall participate in the clinical responsibilities and functions of the team in providing direct services; and serve as a model, a support, and a resource for the team members and individuals being served by the first year of program operation. Peer specialists, at a minimum, shall meet the qualifications of a community support assistant as defined in 9 CSR 30-4.030(2)(P) and 9 CSR 30-4.034(2)(H)2.;
- The team shall include a program assistant. A team of one hundred (100) individuals requires one (1) Full Time Equivalent (FTE) prorated based on team size. The program assistant shall have education and experience in human services or office management. The program assistant shall organize, coordinate, and monitor all non-clinical operations of the team including but not limited to the following:
  - Managing medical records;
  - Operating and coordinating the management information system; and
  - Triaging telephone calls and coordinating communication between the team and individuals receiving ACT services;
- Other team members may be assigned to work exclusively with the team and must qualify as a community support worker or a qualified mental health professional as defined in 9 CSR 30-4.034 (2)(H)1. or 9 CSR 30-4.030(2)(HH); and
- In addition to training required in 9 CSR 30-4.034, team members shall receive ongoing training relevant to ACT services.

**Contract (CPR & TCM):** This NQTL applies to both adults and children and youth. These requirements are in the Administrative Agent Master Contract

agreement. Administrative Agents are required to operate CPR programs for adults and children and youth, and TCM programs for adults and children and youth.

- Further, this NQTL requires that they employ one or more full time Community Mental Health Liaisons (CMHLs), and sets forth minimum qualifications and training requirements for a CMHL. These liaison positions shall be filled by experienced, qualified mental health professionals who are: (a) Trained in assessment and crisis intervention; (b) Knowledgeable about the local system of care including, but not limited to, the operation of the community providers, the Access Crisis Intervention (ACI) system, inpatient psychiatric resources, civil commitment procedures, and guardianship laws; and c. Knowledgeable about behavioral health disorders and co-occurring disorders.
- Contractors are required to incorporate trauma informed approaches into service delivery. As the agency develops policies, procedures, and processes to assess and serve clients, they should be considering trauma informed approaches. It is required that administrative agents incorporate trauma informed approaches into service delivery that actively consider the likelihood of a consumers trauma experience.

**(CSTAR)** Initial certification request and/or renewal process for existing certification by a provider. In order for an agency to be a CSTAR provider they must submit an application to DBH requesting CSTAR certification; they must comply with applicable standards as stated in the rule in addition to program specific rules as stated in standards. Agency must then be approved by DMH as a CSTAR provider. This process needs to be done initially and then every three years, the provider will have to complete the DBH certification application. The organization must comply with the standards applicable to each program for which certification is being sought.

Staff vacancy, new service and/or service expansion triggers hiring of qualified professionals. Provider must be knowledgeable of staff qualifications for each service. The agencies must hire/train staff and supervise staff and ensure continuous eligibility for service provision. Qualified staff must be available before services can be delivered. The person responsible for ensuring qualified staff for a given service must be knowledgeable of the service requirements.

Provider must obtain primary source verification to determine potential staff's status to determine:

- If the person is eligible to provide the service now or if the person is a student and not currently eligible through prior experience and/or education.
- If the person meets the requirements of an:
  - Qualified Substance Abuse Professional
    - A physician or qualified mental health professional meeting the educational/experiential/supervision requirements for licensure as established by the Missouri Division of Professional Registration who has at least one year of full-time experience in the treatment or rehabilitation of persons with substance use disorders; or
    - A person meeting the educational/experiential/supervision requirements for certification or registration as a substance abuse professional by the Missouri Substance Abuse Professional Credentialing Board.
  - Associate Counselor
    - The associate counselor is a trainee that must meet requirements set forth by the Missouri Credentialing Board or the appropriate board of professional registration within the Department of Economic Development.
  - Licensed Mental Health Professional
    - Provisional licensure as a mental health professional will satisfy the licensure requirement for designation as a QAP, including the qualifications required to deliver trauma-related and co-occurring disorders-related services. However, all other requirements

related to provider qualifications must be met and demonstrated.

- Community Support Specialist
  - Must meet one of the following qualifications:
    - A mental health professional as defined in 9 CSR 10 – 7.140 (2) (QQ);
    - An individual with a bachelor’s degree in a human services field, which includes social work, psychology, nursing, education, criminal justice, recreational therapy, human development and family studies, counseling, child development, gerontology, sociology, human services, behavioral science and rehabilitation counseling;
    - An individual with any four year degree and two years of qualifying experience;
    - An individual with any four year combination of higher education and qualifying experience, or
      - An individual with four years of qualifying experience.
  - Qualifying experience must include delivery of service to individuals with mental illness, substance use disorder or developmental disabilities. Experience must include some combination of the following:
    - Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus;
    - Teaching and modeling for individuals how to cope and manage psychiatric, developmental or substance use issues while encouraging the use of natural resources;
    - Supporting efforts to find and maintain employment for individuals and/or to function appropriately in families, school and communities;
    - Assisting individuals to achieve the goals and objectives on their person centered individualized treatment plans.
  - It is also required that the Community Support Specialist complete the necessary orientation and training requirements specified by DMH.
- Co-Occurring Counselor
  - Co-occurring disorder individual counseling is provided by either a person licensed by the Missouri Division of Professional Registration as a mental health professional who is practicing within their current competence; or, a person certified by the Missouri Credentialing Board as a professional working in co-occurring disorders who is practicing within their current competence.
- Trauma Counselor
  - Trauma individual counseling is provided by a licensed mental health professional who is a qualified addiction professional (QAP). Qualified staff must have specialized trauma training and/or equivalent work experience and shall utilize an evidence-based treatment model for the delivery of this service.; or
- Has the ability/training/etc. to provide:
  - Any CSTAR Service
    - Intake Assessment – Qualified Addiction Professional (reviews and interprets assessment data and meets with consumer to develop treatment recommendations), and licensed diagnostician (renders a five-axis diagnosis). Other components included in service description:
      - Outcome Measurement – Community Support Worker or Qualified Addiction Professional; and
      - Assessment and Diagnostic Update – Qualified Addiction Professional (reviews and interprets assessment data and meets with consumer to develop treatment recommendations), and licensed diagnostician (renders a five-axis diagnosis)
    - Community Support – Community Support Worker
    - Individual Counseling – Qualified Addiction Professional or Associate Counselor. Evidence based interventions requires Licensed Mental Health Professional that is a Qualified Addiction Professional with relevant training/experience or specific credentials.

- Group Counseling – Qualified Addiction Professional or Associate Counselor
- Group Therapeutic Substance Abuse Education – Individual with appropriate background, experience and knowledge and demonstrated competencies and skills
- Day Treatment – Activities and interventions delivered under supervision of Qualified Addiction Professional
- Family Therapy – Licensed or certified marriage and family therapist, or qualified professional as defined in 9 CSR 30-3.110(6)(D)
- Codependency Counseling – Family Therapist or Qualified Addiction Professional with appropriate training
- Detoxification Services – A team that includes a licensed physician or Advanced Practice Nurse, registered and licensed nursing staff and other specialty trained staff
- Medication Services – Licensed Physician or Advanced Practice Nurse
- Extended Day Treatment – Licensed, Registered Nurse
- Group Therapeutic Substance Use Disorder Education
  - Group therapeutic substance use disorder education services shall be provided by an individual who:
    - Is suited by education, background or experience to teach the information being presented;
    - Demonstrates competency and skill in educational techniques;
    - Has knowledge of the topic(s) being taught; and,
    - Is present with participants throughout the group therapeutic substance use disorder education session.
  - In addition, staff who provide information about human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) shall have completed a department approved or comparable training program.
- Trauma Group Education
  - Trauma group education must be provided by staff with specialized training in trauma and addiction.
- Family Therapy
  - Unless otherwise approved and documented by DMH, family therapy shall be performed by a person who:
    - Is licensed in Missouri as a marital and family therapist; or
    - Is certified by the American Association of Marriage and Family Therapists; or
    - Has a graduate (doctoral or masters) degree in psychology, social work or counseling and has at least one year of supervised experience in family counseling and has specialized training in family counseling; or has a graduate (doctoral or masters) degree in psychology, social work or counseling and receives close supervision from an individual who meets the above requirements; or,
    - A degreed, qualified addiction professional who receives close supervision from an individual that meets the above requirements.
- Collateral Dependent Counseling
  - Assessments, individual counseling and group counseling services provided to children under age 12 shall be provided by:
    - A social worker, counselor, psychologist or physician licensed in Missouri who has at least one year of full-time experience in the assessment and treatment of children; or,
    - A graduate of an accredited college or university with a master’s degree in social work, psychology, counseling, psychiatric nursing or closely related field, which has at least two years of full-time equivalent experience in the treatment and assessment of children. Group collateral dependent services for therapeutic substance use disorder education for children under age 12 shall be provided by a graduate of an accredited college or university with a bachelor’s degree in counseling, psychology, social work or closely related field.

- Individual and Group Counseling
  - A majority of the program's staff who provide individual and group counseling shall be qualified substance abuse professionals.
- Extended Day Treatment
  - This service consists of medical and other consultative services provided by a registered nurse for the purposes of monitoring and managing a participant's health, and medication management.
  - A registered nurse (RN) with relevant education, experience, and competency is available on site or by phone for 24-hour supervision.
- Opioid Treatment Program
  - When a person works in an Opioid Treatment setting the provider must provide or arrange and document ongoing training that consists of at least 14 hours of training for all staff working in an Opioid Treatment setting every 2 years. The provider must include in their HR processes a method to ensure trainings are occurring, staff are attending and training is documented with at least 14 hours of training every 2 years.
- Adolescent Treatment Support
  - Service delivery staff shall:
    - Have training and demonstrate expertise regarding the treatment of both substance use disorders and other disorders related to adolescents; and,
    - Receive clinical supervision by an appropriately licensed, certified, or otherwise credentialed person with experience in the treatment of adolescents.
    - Participants shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.
- Communicable Disease Counseling
  - Prior to being tested for HIV, counseling must be provided by individuals who are knowledgeable about communicable diseases including HIV, TB and STDs through training and/or previous employment experience.
  - Staff's knowledge shall include awareness of risks, disease management/treatment and resources for care, and confidentiality requirements when working with special populations. Post-test counseling may be provided for those testing positive for either HIV or TB. Staff providing these services shall also be competent to therapeutically assist consumers to understand and appropriately respond to test results. Post-test counseling for HIV or TB must also be knowledgeable about services and care coordination available through the DHSS.
- Supervision
  - Credentials for Supervisor of Counselors. Unless otherwise required by these rules, supervision of counselors must be provided by a qualified substance abuse professional who has
    - A degree from an accredited college in an approved field of study; or
    - Four (4) or more year's employment experience in the treatment and rehabilitation of persons with substance abuse problems.
  - Credentials for Supervisor of Community Support Workers. A community support worker shall be supervised by an individual with
    - A master's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least one (1) year of full-time equivalent experience in providing community support services; or
    - A bachelor's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least two (2) years of full-time equivalent experience in providing community support services; and
    - Demonstrated competencies in the areas of supervision and substance abuse treatment and rehabilitation by virtue of experience

and/or training.

Other Applicable Program Requirements. A CSTAR program shall meet the following additional requirements, when the department determines that they are applicable:

- Services offered on a residential basis shall comply with requirements for residential treatment; and
- Requirements as a specialized program for adolescents or as a specialized program for women and children shall be met, where applicable.

All detoxification services shall be provided in a humane manner and shall ensure the safety and well-being of persons served.

- There shall be monitoring and assessment of the person's physical and emotional status during the detoxification process.
  - Vital signs shall be taken on a regular basis, with the frequency determined by client need based on a standardized assessment instrument.
  - Blood alcohol concentration may be monitored upon admission and thereafter as indicated. Further testing of urine or blood may be conducted by qualified personnel.
- Staff coverage in residential settings shall ensure the continuous supervision and safety of clients.
  - Two (2) staff members shall be on-site at all times, and additional staff may be required, as warranted by the size of the program and the responsibilities and duties of staff members.
  - Staff providing direct supervision and monitoring of clients shall demonstrate competency in recognizing symptoms of intoxication, impairment and withdrawal; monitoring vital signs; and understanding basic principles and resources for substance abuse treatment.
  - Clients shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.

When the Department notifies providers of newly required training, the provider would ensure staff received the required training and document training within the timeframe set by the Department. The providers must provide or arrange for their staff to receive specified training.

If a religious entity contracts with DMH, the religious organization must meet the same requirements as non-religious organizations per block grant as well as comply with federal requirement pertaining to charitable choice provisions and regulations.

**(TCM)** A provider of TCM services is an entity that is designated by the DMH. Designation is contingent upon the provision of the core services listed below.

These services may be provided directly or by subcontract. The required service functions include the following:

- Assessment and periodic reassessment
- Case Coordination
- Case Monitoring
- Case Documentation
- Supported Community Living (SCL) Functions

TCM services are provided by community mental health facilities approved to provide this service by the Department of Mental Health.

Administrative Agent of DMH hire and employs Targeted Case Managers and QMHP for the purpose of administration of TCM. Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

- Targeted Case Managers
  - For youth, must at a minimum be a graduate from an accredited four (4) year college or university with a specialization in sociology,

psychology, social work, or closely related fields and at least one (1) year of full-time equivalent experience in working with children and families.

- For adults, must have graduated from an accredited four (4) year college or university with a specialization in sociology, psychology, social work, or closely related fields or a graduate from an accredited four (4) year college or university with related work experience. Relevant human service delivery experience can be substituted on a year for year basis for the four year degree.
- A qualified mental health professional (QMHP) for the purpose of administration of the MO HealthNet TCM, is defined as:
  - A physician licensed under Missouri law to practice medicine or osteopathy and with training in mental health services or one year of experience, under supervision, in treating problems related to mental illness and serious emotional disturbances.
  - A psychiatrist licensed under Missouri law as a physician and who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association, or other training program identified as equivalent by DMH.
  - A psychologist licensed under Missouri law to practice psychology with specialized training in mental health services.
  - A professional counselor licensed under Missouri law to practice counseling with specialized training in mental health services.
  - A clinical social worker licensed under Chapter 337 RSMo.
  - A psychiatric nurse licensed under Chapter 335 RSMo., as a registered professional nurse with at least two years of experience in a psychiatric or substance use disorder treatment setting or a master's degree in psychiatric nursing.
  - An individual possessing a master's or doctorate degree in counseling and guidance, vocational counseling, pastoral counseling, rehabilitation counseling and guidance, psychology, family therapy, or related field, who has successfully completed a practicum or has one year of experience under the supervision of a qualified mental health professional.
  - An occupational therapist certified by the American Occupational Therapy Certification Board, registered in Missouri, who has a bachelor's degree and has completed a practicum in a psychiatric setting or has one year experience in a psychiatric setting or has a master's degree and has completed either a practicum in a psychiatric setting or has one year of experience in a psychiatric setting.
  - An advanced practice nurse under Chapter 335.016 RSMo who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the board of nursing.
  - A psychiatric pharmacist who is a registered pharmacist in good standing with the Missouri Board of Pharmacy who is a board certified pharmacist (BCPP) through the Board of Pharmaceutical Specialties or a registered pharmacist currently in a psycho-pharmacy residency where the service has been supervised by a board certified psychiatric pharmacist.

**(HCH)** Provider initially must complete an application form. Enrollment forms must be completed in order for an individual to be part of a HCH. The HCH provider must complete specified forms and submit to DBH, including monthly implementation report and monthly status report, monthly hospitalization follow-up report in addition they have to complete an attestation and send to MO HealthNet to support the services were provided and they have to submit data to a contracted population health platform.

Agencies must meet staffing requirements for HCH Directors, Nurse Care Managers, care coordinators and Primary Care Physician Consultants per the staffing memo. HCH organizations must also meet national accreditation standards for HCHs. They must maintain CPR certification and contract with DBH and fulfill all requirements such as participation in scheduled trainings, meetings/phone conferences/webinars and submission of data as required.

**(HCH)** In order to be a CMHC HCH, the provider must be certified as a CPR provider and hold a contract with DBH/DMH. They have to apply to DBH to be a HCH and be approved based on staffing patterns and expected practices. The DBH then recognizes the organization as an adult and or youth HCH.

Initial and renewal of recognition as CMHC HCH every 3 years.

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**Submission and Staffing:**

**(CPR)** This requires that all personnel provided by contracted agencies have criminal background checks in accordance with state law. When a contracted provider agency hires a new staff person, it is required that staff at contracted agencies have background checks completed. Depending on the service there is also a requirement for continuing education, training with minimum hours that must be completed annually and within a two (2) year period and passing any applicable test. The provider agency may develop forms to guide and document this process at their discretion. Some services require a staff to client ratio. The provider must also complete a clinical privileges process for staff to assure they meet qualification and training requirements to provide those services. Clinical privileging process must be done initially and every 2 years for all staff providing CPR service.

**(CSTAR)** Provider verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Depending on the service there is also a requirement for continuing education, training with minimum hours that must be completed within a two (2) year period. Some services require a staff to client ratio.

**(TCM)** Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

**(HCH)** Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

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**Strategy:**

**(CPR)** The purpose is to assure: staff with service and management responsibility meet certain minimal standards; agencies have the staffing in place to provide quality services; and that persons providing behavioral health services have the qualifications and skills to provide services. Clinical efficacy and safety concerns are the primary factors.

**(CSTAR)** The purpose of this NQTL is to ensure staff are appropriately trained and qualified to provide services, stay abreast of and demonstrate competency regarding changes and evolving practices in the field. The state sets staff qualifications and competency requirements in order to ensure quality service provision for the delivery of culturally sensitive and evidenced based practices. Factors in determining the NQTL include safety, clinical efficacy, quality of care, and quality services. We want to ensure that the services being delivered are not doing more harm than good.

**(TCM)** The purpose of this NQTL is to ensure services are responsive to the individual's full range of needs and to assure services are provided by a qualified professional operating within their scope of practice. Clinical efficacy, elasticity of demand, licensing and accreditation were considered when determining the NQTL.

**(HCH)** The purpose of the HCH is to provide better care coordination and chronic disease monitoring of individuals with serious mental illness or severe emotional disturbance ultimately reducing costs and decreasing mortality. The purpose of the organization's required certification, accreditation and data reporting is to ensure quality outcome measures are met. Eligibility and coverage confirmation; safety concerns; cost of treatment; variability in cost and quality; clinical efficacy.

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**Evidence:**

**(CPR)** General best practices, SAMSHA, practice guideline, national standards, stakeholder involvement

**(CSTAR)** General best practices, SAMSHA, practice guideline, national standards, stakeholder involvement

**(TCM)** CMS guidance and SSA as follows:

- CMS-2237-IFC(3) states "case management services are comprehensive and must include all of the following: assessment of an eligible individual (42 CFR 440.169(d)(1)); development of a specific care plan (42 CFR 440.169(d)(2)); referral to services (42 CFR 440.169(d)(3)); and monitoring activities (42 CFR 440.169(d)(4))." To allow for consistent monitoring, oversight and timely updates/revisions the criteria for the provider is reviewed every three years if provider is not accredited. If provider is accredited criteria is reviewed every 3 or 4 years depending on accreditation body standards. MO HealthNet TCM provider manual is reviewed and updated yearly.
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- Section 1905(a)(13) of the Social Security Act and 42 CFR §440.130(d) provide that States may cover rehabilitative services: "including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. CMS 2237 IFC requires states to specify provider qualifications. CMS guidance CMS-2237-IFC (7) states "When a target group consists solely of individuals with developmental disabilities or chronic mental illness, States may limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services". To allow for consistent monitoring of required staff qualifications, certification for the provider is reviewed every three years if provider is not accredited. If provider is accredited criteria is reviewed every 3 or 4 years depending on accrediting body standards. MO HealthNet TCM provider manual is reviewed and updated yearly.

**(HCH)** Published research-CATIE study that references that individuals with serious mental illness die 25 years younger than the general population due to preventable chronic diseases. DBH also utilizes population health data to determine target areas of treatment. DMH utilizes the data submitted to DBH from HCH providers to help providers focus their treatment. Criteria was developed by DBH along with stakeholders, including the Coalition of Behavioral

Health Centers and providers.

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**Appeal:**

**(All)** DMH Exceptions Committee hears requests for waiver to a rule regarding staff qualifications for services.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           | Action: |
|-------------------------------------|--------------------------|--------------------------|---------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |         |

|   |                                     |                                |   |
|---|-------------------------------------|--------------------------------|---|
| <p>NQTL: Exclusions for Specific Types of Providers<br/> Health Plan/State: Missouri Care / FFS<br/> Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court<br/> Classification: Inpatient and Outpatient</p>  |                                     |                                |   |
| <b>MH/SUD Benefits/Providers</b>  |                                     | <b>M/S Benefits/Providers</b>  |   |
| Missouri Care: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services  |                                     | Missouri Care: N/A<br>FFS: N/A |   |
| <b>Compliance Analysis</b>  |                                     |                                |   |
| <p>Missouri Care: Follows FFS policy regarding exclusion of licensed marital and family therapists from enrolling / network admission.</p> <p>FFS: Licensed marital and family therapists are not enrolled as providers. Licensed clinical social workers may provide services to children in any setting, but services to adults are limited to FQHC, RHC, CMHC settings. Licensed professional counselors may provide services to children in any setting, but services to adults are limited to CCBHC.</p> |                                     |                                |   |
| <b>State Compliance Determination</b>   |                                     |                                |   |
| <b>Complies</b>   | <b>Follow up</b>                    | <b>Doesn't Comply</b>          | <b>Action: MHD is amending state plan to add these providers.</b> |
| <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input type="checkbox"/>       |   |

NQTL: Network Admission Requirements: Provider Enrollment and Credentialing

Health Plan/State: UnitedHealthcare / FFS

Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court

Classification: Inpatient and Outpatient

| <b>MH/SUD Benefits/Providers</b>   | <b>M/S Benefits/Providers</b>   |
|--|---|
| <p>UnitedHealthcare – Inpatient and Outpatient: Applicable to all provider and practitioner types under consideration for network participation.</p> <p>FFS (outpatient): CPR, CSTAR, Adult TCM, &amp; Youth TCM, clinic option providers (for COA 4);<br/>Inpatient (COA 4 if behavioral health admission only)</p> | <p>UnitedHealthcare – Inpatient and Outpatient: Applicable to all provider and practitioner types under consideration for network participation.</p> <p>FFS: Inpatient and Outpatient: Applicable to all provider and practitioner types during enrollment.</p> |

**Compliance Analysis**

**UnitedHealthcare:**  
For both MH/SUD and M/S, providers must meet all credentialing criteria to be eligible for network participation.  
Participation criteria for practitioners include:

1. Education
  - Psychiatrists must have graduated from medical school and successful completion of either a residency program or other clinical training and experience for their specialty and scope of practice.
  - M.D.s and D.O.s: graduation from an allopathic or osteopathic medical school and successful completion of either a residency program or other clinical training and experience for their specialty and scope of practice.
  - Chiropractors: graduation from chiropractic college
  - Dentists: graduation from dental school

• Non-physician providers must be: A doctoral and/or master's level psychologist, social worker behavioral health care specialist or a Master's level psychiatric clinical nurse, must be licensed to practice independently by the state in which they practice.

## 2. Licensing

Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices.

## 3. Admitting privileges

For MH/SUD, hospital privileges are not required. However if applicant has hospital staff privileges, those privileges must be in good standing at a network hospital. Privileges at any hospital must not have been suspended during the past 12 months due to inappropriate, inadequate or tardy completion of medical records or for quality of care issues. For M/S, must have full hospital privileges, without material restrictions, conditions or other disciplinary action at a minimum of one Participating (Network) hospitals or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing Entity determines that Applicant's practice requires such privileges.

4. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant practices (unless such Certificate is not required for the Applicant's practice).

## 5. Medicare/Medicaid Program Participation Eligibility

Must not be ineligible, excluded or debarred from participation in Medicare, Medicaid or other related state and federal programs, or terminated for cause from same, and must be without any sanctions levied by the Office of the Inspector General or General Services Administration or other disciplinary action by any federal or state entities identified by CMS.

## 6. Work History

Must provide a 5 year employment history. Gaps longer than 6 months must be explained by the applicant and found acceptable by the credentialing committee.

## 7. Liability Insurance or state approved alternative

## 8. Site visits are completed when required by Credentialing Authorities

The average length of time for the credentialing and re-credentialing process for both MH/SUD and M/S providers is within 60 business days from completed application received, per state requirements.

## 9. Network participation

For both MH/SUD and M/S, applicant must not have been denied initial participation, or terminated within the preceding 24 months prior to application, or at any time during the term of the Provider Participation Agreement. (for reasons other than network need).

Participation Criteria for facilities include:

- Must be licensed or certified by designated state agency as required by state law
- Must have appropriate levels of malpractice insurance coverage
- Must not be ineligible, excluded, or debarred from federal programs with no sanctions from OIG or GSA or any state licensing or oversight agency
- Must have appropriate accreditation from a national or state accreditation body accepted by credentialing entity. If facility is not accredited, a site visit is required.

Practitioners and facilities are credentialed in timelines required by NCQA/CMS/ and state laws. Most stringent timeline requirement is applied.

Practitioners and facilities are recredentialed every three (3) years using the above criteria

**State Specific Requirements:**

Credentialing entity is required to make a decision whether to approve or deny a practitioner's credentialing application within 60 business days of receipt of completed credentialing application.

For MH/SUD and for M/S facilities, credentialing and recredentialed occur within 60 business days from completed application received date.

The purpose is to ensure properly qualified providers are delivering services to our members. Providers must meet certain levels of clinical competency and practice performance in order to maintain the quality and integrity of our network.

UHC adheres to national accreditation and provider certification standards as required by NCQA, CMS and respective state laws.

If there is no network provider who can provide the service and is within a reasonable travel distance from the member. Single case agreement will be allowed on 100% of Medicaid.

**FFS** – For MH/SUD and M/S, individual providers must submit copy of professional license and Medicare letter (if Medicare enrolled). For MH/SUD and M/S hospitals must be currently licensed by the Department of Health & Senior Services and Medicare certified as a

hospital. Must submit a copy of the hospital license and Medicare certification letter.

DMH –

**Processes: (CPR, CSTAR & TCM)** Provider agencies must be certified under both CPR and Core Rules state regulations in order to deliver and be reimbursed for CPR services by the Missouri Medicaid program, MO HealthNet. The DBH Division assures the agency has the ability and the qualified staff to deliver core services. The certification unit may make a site visit to determine if the agency meets certification standards, and/or require proof of other relevant accreditation status. If the provider is nationally accredited for behavioral health care from CARF International, The Joint Commission, or Council On Accreditation (COA) the department shall grant certification upon receipt of completed application and proof of national accreditation.

**Submission and Staffing: (CPR, CSTAR, & TCM)** The steps for obtaining certification start with the provider agency completing a DBH certification application form and submitting that form to the DBH certification unit for review and approval. The form is submitted via mail, fax or electronically. The persons reviewing the DBH certification application form must meet the requirement as a Program Specialist and receive appropriate training which includes but is not limited to job shadowing, review of manuals, knowledge of standards, etc.

**Strategy: (CPR, CSTAR & TCM)** To verify the provider agency applying for certification meet requirements in the Code of State Regulation that allows them to provide quality, effective services. Eligibility, safety, and quality care concerns are the primary factors in requiring that provider agencies seeking to provide services that meet certain minimal standards.

**Timeline: (CPR, CSTAR, & TCM)** DBH certification unit has 30 days in which to determine whether the agency is eligible to be considered for certification. Additional time is required for site visit and determination if provider meets certification standards for agencies not nationally accredited. Failure to fully and accurately provide required information may increase certification time or result in non-certification. Provider certification is reviewed every three years.

**Evidence: (CPR, CSTAR, & TCM)** State statute requires certification. The DBH Division, based on extensive experience in delivering quality behavioral health services, has determined that providers of CPR services should meet certain standards for staffing, administration, and service delivery that promote quality care for persons with serious mental illnesses. Practice guidelines support the rationale for this NQTL. TCM is supported by federal guidance.

**Appeal: (CPR, CSTAR, & TCM)** Providers can appeal the decision if denied certification. If provider is denied certification or if their certification is revoked they may appeal to the Department Director. Then the provider's appeal is reviewed and a decision is made on the appeal. Provider has 30 days from the date of the notification of denial or revocation of certification to appeal to the Director. Provider must provide written notification/justification of appeal.

**Processes: (CPR)** This is a certification standard which: - When a provider agency hires a staff person to perform services or functions that require the individual staff meet staff requirements for applicable services. The agency assure persons used as QMHPs, Peer Supports in the CPR program meet one of the categories of staff specified in state regulations. This may include primary source verification of educational degree, license, or certification. -Requires CPR provider agencies have a process for granting and periodically reviewing clinical privileges to staff and establishes minimum elements for that process. When new staff are hired the agency must go through a process to grant clinical privileges for staff delivering services; and clinical privileges must be reviewed and renewed at a minimum every two (2) years. This is a process carried out by provider agencies, and they may develop their own forms to

guide and support this. Agencies may require additional approval to perform certain services in addition to certification.

**Access Crisis Intervention Programs (CPR):** This NQTL applies to both adults and children and youth. State regulation requires that providers meet minimum staffing requirements for their ACI system for both the 24 hour crisis hotline and the mobile crisis response. Staff are required to have certain qualifications and experience, and trained appropriately. When a person is hired to work in the ACI system, that triggers the provider agency must go through a process that insures the person meets certain qualifications and is trained appropriately. There is also a requirement for continuing education and training with minimum hours that must be completed annually and within a two (2) year period. The provider agency may develop forms to guide and document this process at their discretion.

**Intensive CPR – Residential (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR. It limits provider agencies operating the Intensive CPR Residential service to only those who operate CPR programs, and are approved for the service by DMH. It also requires that the clients receiving this service are enrolled in the rehabilitation level of care. The trigger is when a provider agency wants to become a provider of these services, and when they want to start enrolling clients. When a provider agency wants to start providing this service they must notify DMH, DBH Division, and receive approval to deliver the service. Then when they enroll clients to be served, the provider must assure they are enrolled in the correct level of care. The team of staff that provide these services must be trained to provide the services and must be supervised by the QMHP.

**Peer Support (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. It sets forth the staff qualifications and service definition for Certified Missouri Peer Specialists who deliver peer support services. When a provider agency wants to employ a person to provide peer support services, they must assure the person has at least a high school diploma or equivalent and has received the required training and passed the test in order to be a Certified Missouri Peer Specialist.

**Psychosocial Rehabilitation (CPR):** When an agency develops a psychosocial rehabilitation (PSR) program they must have that program either accredited by CARF, or licensed as a day program by DMH under licensure regulations. This NQTL further directs that if certification standards are more restrictive than licensure standards, then certification standards should prevail. Further, it limits the person assigned as the director of the adult PSR program must be a qualified mental health professional. For the youth PSR program the director of the program must be a qualified mental health professional with at least two (2) years of relevant work experience.

This is in the Missouri Medicaid Provider Manual for CPR and sets limitations on how many persons can be served in an adult PSR program in relation to staffing. Staff to client ratios may not exceed 1:16; program needs or client mix may require even lower staff to client ratios; and at least one (1) staff person must be present at all times at the program site. When provider agencies are planning staffing coverage for a PSR program, they need to assure they have adequate staffing to meet these requirements.

These are requirements in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. One (1) full time equivalent mental health professional shall be available during the provision of services. The staffing ratios shall be based on the client's age. For those clients between the ages of three (3) and 11, the staffing ratio shall be one (1) staff to four (4) clients. For those clients between the ages of 12 and 17, the staffing ratio shall be one (1) staff to six (6) clients. Other staff of the PSR team shall be composed of the following providers as needed by the children: 1. a registered nurse; 2. an occupational therapist; 3. a recreational therapist; 4. a rehabilitation therapist; 5. a community support specialist; or, 6. family assistance worker.

**Individual and Group Counseling PSR (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. It sets forth the staff qualifications and training requirements for persons providing Individual and Group Professional PSR. It is required that whenever a provider agency hires a staff person to provide Individual and Group Professional PSR, they must assure the person hired meets one of the

staffing qualifications and has received the required training in mental health services. Qualified staff must be a professional counselor licensed or provisionally licensed under Missouri law and with specialized training in mental health services; or, a clinical social worker licensed or master social worker licensed under Missouri law and with specialized training in mental health services; or, a psychologist licensed or provisionally licensed or temporary licensed under Missouri law with specialized training in mental health services. Staff providing individual and group professional psychosocial rehabilitation services must have additional initial training such as, cognitive behavioral therapy, creating a recovery based mental treatment plan, illness management and recovery, motivational interviewing, and introduction to DBT.

**PSR – IMR (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. This limits providers of the PSR-IMR service to only those who have been approved by the DBH Division. Providers must submit in writing to the division a plan to implement this service along with planned curriculum, in order to get approval. The trigger is when a provider agency decides to implement this service for the first time, or to add new curriculum to a PSR-IMR program already operating.

**Co-Occurring Services (CPR):** This is a requirement in the CPR state regulation, regarding qualified staff who work in Integrated Dual Disorders Treatment (IDDT) programs. This sets forth minimum requirements for a person to be considered a QMHP or Qualified Addiction Professional (QAP) and meet co-occurring counselor competency requirements established by DBH. When an agency hires a person for a QAP position in an IDDT program, they must assure they meet one of the two qualification types above. This is a requirement in the CPR state regulation regarding fidelity reviews and quality improvement plans in Integrated Dual Disorders Treatment (IDDT) programs. Agencies delivering these services are required to follow the SAMHSA evidence based guidelines for IDDT, are required to receive fidelity reviews from the DBH Division, and are required to have a quality improvement plan as specified above. The trigger is an agency starting to implement an IDDT program, and annually thereafter when fidelity reviews come due. DBH staff utilize a standardized tool and form in fidelity reviews. It is required that agencies receive a fidelity review initially and annually thereafter. In addition the provider agency must develop and maintain a quality improvement plan that meets certain requirements in the regulation. DBH Division staff who conduct fidelity reviews must be trained and knowledgeable in IDDT.

**Co-Occurring Services - Individual Counseling, Group Counseling, Group Education, and Co-Occurring Assessment Supplement (CPR):** This is a requirement in the Missouri Medicaid Provider Manual for CPR, and also in CPR state regulations. This establishes who an eligible staff person is to provide Co-Occurring Individual Counseling, Co-Occurring Group Counseling, Co-Occurring Group Education and Co-Occurring Assessment Supplement in an IDDT program. When a provider agency hires a person to deliver Co-Occurring Individual Counseling, Co-Occurring Group Counseling, and Co-Occurring Assessment Supplement in an IDDT program, they must assure the person is either a QMHP or a Qualified Addiction Professional (QAP), and meet co-occurring counselor competency requirements established by DMH. When a provider agency hires a person to deliver Co-Occurring Group Education in an IDDT program, they must assure the person has documented education and experience related to the topic presented and either be or be supervised by a QMHP or a QAP who meets co-occurring counselor competency requirements established by DMH.

**Assertive Community Treatment (CPR):** This is in state regulation and establishes minimum staffing requirements for Assertive Community Treatment (ACT) teams. When a provider agency hires staff for their ACT teams they must assure those staff meet requirements as follows:

- The team shall have adequate nursing capacity by meeting one (1) of the following:
  - A registered professional nurse with six (6) months of psychiatric nursing experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation
  - During the first year of program operation, a registered professional nurse shall work with no more than fifty (50) individuals as a seventy-five

percent (75%) Full-Time Equivalent (FTE) for up to twelve (12) months;

- A team leader who is a qualified mental health professional as defined in 9 CSR 30-4.030(2)(HH) that is full time with one (1) year of supervisory experience and a minimum of two (2) years of experience working with adults with serious mental illness in community settings;
- The team shall have adequate substance abuse treatment capacity by meeting one (1) of the following: 1. A substance abuse specialist who is a qualified substance abuse professional (QSAP) as defined in 9 CSR 10-7.140(2)(RR)1. or 2. with one (1) year of training or supervised experience in substance abuse treatment shall be assigned to no more than fifty (50) individuals; or 2. If the QSAP is not assigned to a team full time or is assigned to a team with less than fifty (50) individuals, the QSAP shall attend at least two (2) team meetings per week; or 3. A QSAP who has less than one (1) year experience in Integrated Dual Disorders Treatment (IDDT) shall be actively acquiring twenty-four (24) hours of training in IDDT-specific content and receive supervision from experienced IDDT staff;
- The team shall have adequate vocational specialization capacity by meeting one (1) of the following:
  - A vocational specialist who qualifies as a community support worker as defined in 9 CSR 30-4.034(2)(H)1. with one (1) year of experience and training in vocational rehabilitation and supported employment shall be available to no more than fifty (50) individuals; or
  - If the vocational specialist is not assigned to a team full time or is assigned to a team with less than fifty (50) individuals, the vocational specialist shall attend at least two (2) team meetings per week; or
  - A vocational specialist with six (6) months of vocational experience shall work with no more than fifty (50) individuals on a full-time basis during the first year of program operation;
- The team shall include a peer specialist which shall be self-identified as a present or former primary consumer of mental health services; be assigned full time to a team and shall participate in the clinical responsibilities and functions of the team in providing direct services; and serve as a model, a support, and a resource for the team members and individuals being served by the first year of program operation. Peer specialists, at a minimum, shall meet the qualifications of a community support assistant as defined in 9 CSR 30-4.030(2)(P) and 9 CSR 30-4.034(2)(H)2.;
- The team shall include a program assistant. A team of one hundred (100) individuals requires one (1) Full Time Equivalent (FTE) prorated based on team size. The program assistant shall have education and experience in human services or office management. The program assistant shall organize, coordinate, and monitor all non-clinical operations of the team including but not limited to the following:
  - Managing medical records;
  - Operating and coordinating the management information system; and
  - Triaging telephone calls and coordinating communication between the team and individuals receiving ACT services;
- Other team members may be assigned to work exclusively with the team and must qualify as a community support worker or a qualified mental health professional as defined in 9 CSR 30-4.034 (2)(H)1. or 9 CSR 30-4.030(2)(HH); and
- In addition to training required in 9 CSR 30-4.034, team members shall receive ongoing training relevant to ACT services.

**Contract (CPR & TCM):** This NQTL applies to both adults and children and youth. These requirements are in the Administrative Agent Master Contract agreement. Administrative Agents are required to operate CPR programs for adults and children and youth, and TCM programs for adults and children and youth.

- Further, this NQTL requires that they employ one or more full time Community Mental Health Liaisons (CMHLs), and sets forth minimum qualifications and training requirements for a CMHL. These liaison positions shall be filled by experienced, qualified mental health professionals who are: (a) Trained in assessment and crisis intervention; (b) Knowledgeable about the local system of care including, but not limited to, the operation of the community providers, the Access Crisis Intervention (ACI) system, inpatient psychiatric resources, civil commitment procedures, and guardianship laws; and c. Knowledgeable about behavioral health disorders and co-occurring disorders.
- Contractors are required to incorporate trauma informed approaches into service delivery. As the agency develops policies, procedures, and

processes to assess and serve clients, they should be considering trauma informed approaches. It is required that administrative agents incorporate trauma informed approaches into service delivery that actively consider the likelihood of a consumers trauma experience.

**(CSTAR)** Initial certification request and/or renewal process for existing certification by a provider. In order for an agency to be a CSTAR provider they must submit an application to DBH requesting CSTAR certification; they must comply with applicable standards as stated in the rule in addition to program specific rules as stated in standards. Agency must then be approved by DMH as a CSTAR provider. This process needs to be done initially and then every three years, the provider will have to complete the DBH certification application. The organization must comply with the standards applicable to each program for which certification is being sought.

Staff vacancy, new service and/or service expansion triggers hiring of qualified professionals. Provider must be knowledgeable of staff qualifications for each service. The agencies must hire/train staff and supervise staff and ensure continuous eligibility for service provision. Qualified staff must be available before services can be delivered. The person responsible for ensuring qualified staff for a given service must be knowledgeable of the service requirements.

Provider must obtain primary source verification to determine potential staff's status to determine:

- If the person is eligible to provide the service now or if the person is a student and not currently eligible through prior experience and/or education.
- If the person meets the requirements of an:
  - Qualified Substance Abuse Professional
    - A physician or qualified mental health professional meeting the educational/experiential/supervision requirements for licensure as established by the Missouri Division of Professional Registration who has at least one year of full-time experience in the treatment or rehabilitation of persons with substance use disorders; or
    - A person meeting the educational/experiential/supervision requirements for certification or registration as a substance abuse professional by the Missouri Substance Abuse Professional Credentialing Board.
  - Associate Counselor
    - The associate counselor is a trainee that must meet requirements set forth by the Missouri Credentialing Board or the appropriate board of professional registration within the Department of Economic Development.
  - Licensed Mental Health Professional
    - Provisional licensure as a mental health professional will satisfy the licensure requirement for designation as a QAP, including the qualifications required to deliver trauma-related and co-occurring disorders-related services. However, all other requirements related to provider qualifications must be met and demonstrated.
  - Community Support Specialist
    - Must meet one of the following qualifications:
      - A mental health professional as defined in 9 CSR 10 – 7.140 (2) (QQ);
      - An individual with a bachelor's degree in a human services field, which includes social work, psychology, nursing, education, criminal justice, recreational therapy, human development and family studies, counseling, child development, gerontology, sociology, human services, behavioral science and rehabilitation counseling;
      - An individual with any four year degree and two years of qualifying experience;
      - An individual with any four year combination of higher education and qualifying experience, or

- An individual with four years of qualifying experience.
  - Qualifying experience must include delivery of service to individuals with mental illness, substance use disorder or developmental disabilities. Experience must include some combination of the following:
    - Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus;
    - Teaching and modeling for individuals how to cope and manage psychiatric, developmental or substance use issues while encouraging the use of natural resources;
    - Supporting efforts to find and maintain employment for individuals and/or to function appropriately in families, school and communities;
    - Assisting individuals to achieve the goals and objectives on their person centered individualized treatment plans.
  - It is also required that the Community Support Specialist complete the necessary orientation and training requirements specified by DMH.
- Co-Occurring Counselor
  - Co-occurring disorder individual counseling is provided by either a person licensed by the Missouri Division of Professional Registration as a mental health professional who is practicing within their current competence; or, a person certified by the Missouri Credentialing Board as a professional working in co-occurring disorders who is practicing within their current competence.
- Trauma Counselor
  - Trauma individual counseling is provided by a licensed mental health professional who is a qualified addiction professional (QAP). Qualified staff must have specialized trauma training and/or equivalent work experience and shall utilize an evidence-based treatment model for the delivery of this service.; or
- Has the ability/training/etc. to provide:
  - Any CSTAR Service
    - Intake Assessment – Qualified Addiction Professional (reviews and interprets assessment data and meets with consumer to develop treatment recommendations), and licensed diagnostician (renders a five-axis diagnosis). Other components included in service description:
      - Outcome Measurement – Community Support Worker or Qualified Addiction Professional; and
      - Assessment and Diagnostic Update – Qualified Addiction Professional (reviews and interprets assessment data and meets with consumer to develop treatment recommendations), and licensed diagnostician (renders a five-axis diagnosis)
    - Community Support – Community Support Worker
    - Individual Counseling – Qualified Addiction Professional or Associate Counselor. Evidence based interventions requires Licensed Mental Health Professional that is a Qualified Addiction Professional with relevant training/experience or specific credentials.
    - Group Counseling – Qualified Addiction Professional or Associate Counselor
    - Group Therapeutic Substance Abuse Education – Individual with appropriate background, experience and knowledge and demonstrated competencies and skills
    - Day Treatment – Activities and interventions delivered under supervision of Qualified Addiction Professional
    - Family Therapy – Licensed or certified marriage and family therapist, or qualified professional as defined in 9 CSR 30-3.110(6)(D)
    - Codependency Counseling – Family Therapist or Qualified Addiction Professional with appropriate training
    - Detoxification Services – A team that includes a licensed physician or Advanced Practice Nurse, registered and licensed nursing staff and other specialty trained staff
    - Medication Services – Licensed Physician or Advanced Practice Nurse

- Extended Day Treatment – Licensed, Registered Nurse
- Group Therapeutic Substance Use Disorder Education
  - Group therapeutic substance use disorder education services shall be provided by an individual who:
    - Is suited by education, background or experience to teach the information being presented;
    - Demonstrates competency and skill in educational techniques;
    - Has knowledge of the topic(s) being taught; and,
    - Is present with participants throughout the group therapeutic substance use disorder education session.
  - In addition, staff who provide information about human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) shall have completed a department approved or comparable training program.
- Trauma Group Education
  - Trauma group education must be provided by staff with specialized training in trauma and addiction.
- Family Therapy
  - Unless otherwise approved and documented by DMH, family therapy shall be performed by a person who:
    - Is licensed in Missouri as a marital and family therapist; or
    - Is certified by the American Association of Marriage and Family Therapists; or
    - Has a graduate (doctoral or masters) degree in psychology, social work or counseling and has at least one year of supervised experience in family counseling and has specialized training in family counseling; or has a graduate (doctoral or masters) degree in psychology, social work or counseling and receives close supervision from an individual who meets the above requirements; or,
    - A degreed, qualified addiction professional who receives close supervision from an individual that meets the above requirements.
- Collateral Dependent Counseling
  - Assessments, individual counseling and group counseling services provided to children under age 12 shall be provided by:
    - A social worker, counselor, psychologist or physician licensed in Missouri who has at least one year of full-time experience in the assessment and treatment of children; or,
    - A graduate of an accredited college or university with a master's degree in social work, psychology, counseling, psychiatric nursing or closely related field, which has at least two years of full-time equivalent experience in the treatment and assessment of children. Group collateral dependent services for therapeutic substance use disorder education for children under age 12 shall be provided by a graduate of an accredited college or university with a bachelor's degree in counseling, psychology, social work or closely related field.
- Individual and Group Counseling
  - A majority of the program's staff who provide individual and group counseling shall be qualified substance abuse professionals.
- Extended Day Treatment
  - This service consists of medical and other consultative services provided by a registered nurse for the purposes of monitoring and managing a participant's health, and medication management.
  - A registered nurse (RN) with relevant education, experience, and competency is available on site or by phone for 24-hour supervision.
- Opioid Treatment Program
  - When a person works in an Opioid Treatment setting the provider must provide or arrange and document ongoing training that

consists of at least 14 hours of training for all staff working in an Opioid Treatment setting every 2 years. The provider must include in their HR processes a method to ensure trainings are occurring, staff are attending and training is documented with at least 14 hours of training every 2 years.

- Adolescent Treatment Support
  - Service delivery staff shall:
    - Have training and demonstrate expertise regarding the treatment of both substance use disorders and other disorders related to adolescents; and,
    - Receive clinical supervision by an appropriately licensed, certified, or otherwise credentialed person with experience in the treatment of adolescents.
    - Participants shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.
- Communicable Disease Counseling
  - Prior to being tested for HIV, counseling must be provided by individuals who are knowledgeable about communicable diseases including HIV, TB and STDs through training and/or previous employment experience.
  - Staff's knowledge shall include awareness of risks, disease management/treatment and resources for care, and confidentiality requirements when working with special populations. Post-test counseling may be provided for those testing positive for either HIV or TB. Staff providing these services shall also be competent to therapeutically assist consumers to understand and appropriately respond to test results. Post-test counseling for HIV or TB must also be knowledgeable about services and care coordination available through the DHSS.
- Supervision
  - Credentials for Supervisor of Counselors. Unless otherwise required by these rules, supervision of counselors must be provided by a qualified substance abuse professional who has
    - A degree from an accredited college in an approved field of study; or
    - Four (4) or more year's employment experience in the treatment and rehabilitation of persons with substance abuse problems.
  - Credentials for Supervisor of Community Support Workers. A community support worker shall be supervised by an individual with
    - A master's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least one (1) year of full-time equivalent experience in providing community support services; or
    - A bachelor's degree from an accredited college or university in social work, counseling, psychology or a closely related field and at least two (2) years of full-time equivalent experience in providing community support services; and
    - Demonstrated competencies in the areas of supervision and substance abuse treatment and rehabilitation by virtue of experience and/or training.

Other Applicable Program Requirements. A CSTAR program shall meet the following additional requirements, when the department determines that they are applicable:

- Services offered on a residential basis shall comply with requirements for residential treatment; and
- Requirements as a specialized program for adolescents or as a specialized program for women and children shall be met, where applicable.

All detoxification services shall be provided in a humane manner and shall ensure the safety and well-being of persons served.

- There shall be monitoring and assessment of the person's physical and emotional status during the detoxification process.
  - Vital signs shall be taken on a regular basis, with the frequency determined by client need based on a standardized assessment instrument.
  - Blood alcohol concentration may be monitored upon admission and thereafter as indicated. Further testing of urine or blood may be conducted by qualified personnel.
- Staff coverage in residential settings shall ensure the continuous supervision and safety of clients.
  - Two (2) staff members shall be on-site at all times, and additional staff may be required, as warranted by the size of the program and the responsibilities and duties of staff members.
  - Staff providing direct supervision and monitoring of clients shall demonstrate competency in recognizing symptoms of intoxication, impairment and withdrawal; monitoring vital signs; and understanding basic principles and resources for substance abuse treatment.
  - Clients shall be supervised at all times by a staff member with current certification in first aid and cardiopulmonary resuscitation.

When the Department notifies providers of newly required training, the provider would ensure staff received the required training and document training within the timeframe set by the Department. The providers must provide or arrange for their staff to receive specified training.

If a religious entity contracts with DMH, the religious organization must meet the same requirements as non-religious organizations per block grant as well as comply with federal requirement pertaining to charitable choice provisions and regulations.

**(TCM)** A provider of TCM services is an entity that is designated by the DMH. Designation is contingent upon the provision of the core services listed below. These services may be provided directly or by subcontract. The required service functions include the following:

- Assessment and periodic reassessment
- Case Coordination
- Case Monitoring
- Case Documentation
- Supported Community Living (SCL) Functions

TCM services are provided by community mental health facilities approved to provide this service by the Department of Mental Health.

Administrative Agent of DMH hire and employs Targeted Case Managers and QMHP for the purpose of administration of TCM. Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

- Targeted Case Managers
  - For youth, must at a minimum be a graduate from an accredited four (4) year college or university with a specialization in sociology, psychology, social work, or closely related fields and at least one (1) year of full-time equivalent experience in working with children and families.
  - For adults, must have graduated from an accredited four (4) year college or university with a specialization in sociology, psychology, social work, or closely related fields or a graduate from an accredited four (4) year college or university with related work experience. Relevant human service delivery experience can be substituted on a year for year basis for the four year degree.
- A qualified mental health professional (QMHP) for the purpose of administration of the MO HealthNet TCM, is defined as:
  - A physician licensed under Missouri law to practice medicine or osteopathy and with training in mental health services or one year of experience, under supervision, in treating problems related to mental illness and serious emotional disturbances.
  - A psychiatrist licensed under Missouri law as a physician and who has successfully completed a training program in psychiatry approved by

the American Medical Association, the American Osteopathic Association, or other training program identified as equivalent by DMH.

- A psychologist licensed under Missouri law to practice psychology with specialized training in mental health services.
- A professional counselor licensed under Missouri law to practice counseling with specialized training in mental health services.
- A clinical social worker licensed under Chapter 337 RSMo.
- A psychiatric nurse licensed under Chapter 335 RSMo., as a registered professional nurse with at least two years of experience in a psychiatric or substance use disorder treatment setting or a master's degree in psychiatric nursing.
- An individual possessing a master's or doctorate degree in counseling and guidance, vocational counseling, pastoral counseling, rehabilitation counseling and guidance, psychology, family therapy, or related field, who has successfully completed a practicum or has one year of experience under the supervision of a qualified mental health professional.
- An occupational therapist certified by the American Occupational Therapy Certification Board, registered in Missouri, who has a bachelor's degree and has completed a practicum in a psychiatric setting or has one year experience in a psychiatric setting or has a master's degree and has completed either a practicum in a psychiatric setting or has one year of experience in a psychiatric setting.
- An advanced practice nurse under Chapter 335.016 RSMo who has had education beyond the basic nursing education and is certified by a nationally recognized professional organization as having a nursing specialty, or who meets criteria for advanced practice nurses established by the board of nursing.
- A psychiatric pharmacist who is a registered pharmacist in good standing with the Missouri Board of Pharmacy who is a board certified pharmacist (BCPP) through the Board of Pharmaceutical Specialties or a registered pharmacist currently in a psycho-pharmacy residency where the service has been supervised by a board certified psychiatric pharmacist.

**(HCH)** Provider initially must complete an application form. Enrollment forms must be completed in order for an individual to be part of a HCH. The HCH provider must complete specified forms and submit to DBH, including monthly implementation report and monthly status report, monthly hospitalization follow-up report in addition they have to complete an attestation and send to MO HealthNet to support the services were provided and they have to submit data to a contracted population health platform.

Agencies must meet staffing requirements for HCH Directors, Nurse Care Managers, care coordinators and Primary Care Physician Consultants per the staffing memo. HCH organizations must also meet national accreditation standards for HCHs. They must maintain CPR certification and contract with DBH and fulfill all requirements such as participation in scheduled trainings, meetings/phone conferences/webinars and submission of data as required.

(HCH) In order to be a CMHC HCH, the provider must be certified as a CPR provider and hold a contract with DBH/DMH. They have to apply to DBH to be a HCH and be approved based on staffing patterns and expected practices. The DBH then recognizes the organization as an adult and or youth HCH.

Initial and renewal of recognition as CMHC HCH every 3 years.

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**Submission and Staffing:**

**(CPR)** This requires that all personnel provided by contracted agencies have criminal background checks in accordance with state law. When a contracted provider agency hires a new staff person, it is required that staff at contracted agencies have background checks completed. Depending on the service

there is also a requirement for continuing education, training with minimum hours that must be completed annually and within a two (2) year period and passing any applicable test. The provider agency may develop forms to guide and document this process at their discretion. Some services require a staff to client ratio. The provider must also complete a clinical privileges process for staff to assure they meet qualification and training requirements to provide those services. Clinical privileging process must be done initially and every 2 years for all staff providing CPR service.

**(CSTAR)** Provider verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Depending on the service there is also a requirement for continuing education, training with minimum hours that must be completed within a two (2) year period. Some services require a staff to client ratio.

**(TCM)** Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

**(HCH)** Administrative agent verifies proof of education, licensure and previous work experience, as well as maintain personnel records (i.e. maintain copies of proof of education, licensure and past work experience in personnel file/records). Individual must meet requirement prior to rendering services.

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**Strategy:**

**(CPR)** The purpose is to assure: staff with service and management responsibility meet certain minimal standards; agencies have the staffing in place to provide quality services; and that persons providing behavioral health services have the qualifications and skills to provide services. Clinical efficacy and safety concerns are the primary factors.

**(CSTAR)** The purpose of this NQTL is to ensure staff are appropriately trained and qualified to provide services, stay abreast of and demonstrate competency regarding changes and evolving practices in the field. The state sets staff qualifications and competency requirements in order to ensure quality service provision for the delivery of culturally sensitive and evidenced based practices. Factors in determining the NQTL include safety, clinical efficacy, quality of care, and quality services. We want to ensure that the services being delivered are not doing more harm than good.

**(TCM)** The purpose of this NQTL is to ensure services are responsive to the individual's full range of needs and to assure services are provided by a qualified professional operating within their scope of practice. Clinical efficacy, elasticity of demand, licensing and accreditation were considered when determining the NQTL.

**(HCH)** The purpose of the HCH is to provide better care coordination and chronic disease monitoring of individuals with serious mental illness or severe emotional disturbance ultimately reducing costs and decreasing mortality. The purpose of the organization's required certification, accreditation and data reporting is to ensure quality outcome measures are met. Eligibility and coverage confirmation; safety concerns; cost of treatment; variability in cost and

quality; clinical efficacy.

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**Evidence:**

**(CPR)** General best practices, SAMSHA, practice guideline, national standards, stakeholder involvement

**(CSTAR)** General best practices, SAMSHA, practice guideline, national standards, stakeholder involvement

**(TCM)** CMS guidance and SSA as follows:

- CMS-2237-IFC(3) states "case management services are comprehensive and must include all of the following: assessment of an eligible individual (42 CFR 440.169(d)(1)); development of a specific care plan (42 CFR 440.169(d)(2)); referral to services (42 CFR 440.169(d)(3)); and monitoring activities (42 CFR 440.169(d)(4))." To allow for consistent monitoring, oversight and timely updates/revisions the criteria for the provider is reviewed every three years if provider is not accredited. If provider is accredited criteria is reviewed every 3 or 4 years depending on accreditation body standards. MO HealthNet TCM provider manual is reviewed and updated yearly.
- Section 1905(a)(13) of the Social Security Act and 42 CFR §440.130(d) provide that States may cover rehabilitative services: "including any medical or remedial services (provided in a facility, a home, or other setting)recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. CMS 2237 IFC requires states to specify provider qualifications. CMS guidance CMS-2237-IFC (7) states "When a target group consists solely of individuals with developmental disabilities or chronic mental illness, States may limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services". To allow for consistent monitoring of required staff qualifications, certification for the provider is reviewed every three years if provider is not accredited. If provider is accredited criteria is reviewed every 3 or 4 years depending on accrediting body standards. MO HealthNet TCM provider manual is reviewed and updated yearly.

**(HCH)** Published research-CATIE study that references that individuals with serious mental illness die 25 years younger than the general population due to preventable chronic diseases. DBH also utilizes population health data to determine target areas of treatment. DMH utilizes the data submitted to DBH from HCH providers to help providers focus their treatment. Criteria was developed by DBH along with stakeholders, including the Coalition of Behavioral Health Centers and providers.

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**Appeal:**

**(All)** DMH Exceptions Committee hears requests for waiver to a rule regarding staff qualifications for services.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           |  |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |

NQTL: Exclusions for Specific Types of Providers  
 Health Plan/State: UnitedHealthCare / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers  | M/S Benefits/Providers             |
|--|------------------------------------|
| UnitedHealthCare : Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services | UnitedHealthCare : N/A<br>FFS: N/A |

**Compliance Analysis**

UnitedHealthCare : Follows FFS policy regarding exclusion of licensed marital and family therapists from enrolling / network admission.

FFS: Licensed marital and family therapists are not enrolled as providers. Licensed clinical social workers may provide services to children in any setting, but services to adults are limited to FQHC, RHC, CMHC settings. Licensed professional counselors may provide services to children in any setting, but services to adults are limited to CCBHC.

**State Compliance Determination**

|          |           |                |  |
|----------|-----------|----------------|--|
| Complies | Follow up | Doesn't Comply | Action: MHD is amending state plan to add these providers. |
|----------|-----------|----------------|--|

|                          |                                     |                          |  |
|--------------------------|-------------------------------------|--------------------------|--|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |  |
|--------------------------|-------------------------------------|--------------------------|--|

|   |                                     |                                 |  |
|---|-------------------------------------|---------------------------------|--|
| <p>NQTL: Exclusions for Specific Types of Providers<br/> Health Plan/State: Missouri Care / FFS<br/> Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court<br/> Classification: Inpatient and Outpatient</p>  |                                     |                                 |  |
| <b>MH/SUD Benefits/Providers</b>  |                                     | <b>M/S Benefits/Providers</b>   |  |
| Missouri Care : Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services   |                                     | Missouri Care : N/A<br>FFS: N/A |  |
| <b>Compliance Analysis</b>  |                                     |                                 |  |
| <p>Missouri Care: Follows FFS policy regarding exclusion of licensed marital and family therapists from enrolling / network admission.</p> <p>FFS: Licensed marital and family therapists are not enrolled as providers. Licensed clinical social workers may provide services to children in any setting, but services to adults are limited to FQHC, RHC, CMHC settings. Licensed professional counselors may provide services to children in any setting, but services to adults are limited to CCBHC.</p> |                                     |                                 |  |
| <b>State Compliance Determination</b>   |                                     |                                 |  |
| <b>Complies</b>   | <b>Follow up</b>                    | <b>Doesn't Comply</b>           | <b>Action: MHD is amending state plan to add these providers</b> |
| <input type="checkbox"/>  | <input checked="" type="checkbox"/> | <input type="checkbox"/>        |  |

NQTL: Provider Reimbursement / Usual, Customary, and Reasonable Determination  
 Health Plan/State: Home State Health / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers  | M/S Benefits/Providers   |
|--|--|
| Home State Health: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services | Home State Health: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services |

**Compliance Analysis**

**Home State:**  
 For both MH/SUD and M/S, provider agreements are based on state Medicaid or federal (Medicare) published fee schedules. The vast majority are paid 100% of the published rates and are updated based on published changes from the state. The state or federal billing codes are reviewed on a routine basis to ensure that all services are being adjudicated properly. Review state Medicaid/Medicare rates for approved services, offer these rates at 100% of schedule. We do not use U&C rates for Medicaid/Medicare providers, we pay non-par providers 100% of the state rate or the non-par state fee schedule. If provider does not accept 100% of state rates; then we follow the below.

**Research:**

1. Review location do we already have existing providers in this location, services – do they have services not found in another area?
2. Are they specific to a certain demographic, ie: age, programming, etc.
3. Network need – is this provider filling a network gap?
4. How much membership would the provider access?

If, yes to 1-3 proceed to next steps  
 Claims/UM Review

1. Review claim utilization for existing codes
2. Speak to clinical team regarding any quality issues and discuss network need if applicable
3. Research to quality for any reported concerns

#### Proposal

1. Create table of scenarios with adjusted rates in X% increments of published guardrails
2. Review guardrails from adjacent states
3. If all items are favorable, if higher than 3% of guardrails, send to VP of Network for prior approval before sending to provider

Triggers to adjust provider fee schedules are based on requests from providers, or review of claims data and the same steps as above

The state Medicaid or Medicare rates are the baseline for reimbursements. Other factors may be considering such as network need, specialized services and provider types. Increases are based on state Medicaid or Medicare rates.

With the exception of emergency room services, all non-participating providers and services require prior authorization. If the provider does not obtain authorization, the claims will be denied. Non-par providers will be paid the state Medicaid or Medicare unless they request a single case agreement. If one is requested an agreement will be signed for that specific case.

Network adequacy is evaluated each quarter by formal reporting utilizing an analytics tool that generates coverage maps. Deficiencies would be shown and addressed. Based on any inadequacy by specialty or by county, the behavioral health vendor along with HSH would explore which area providers are not participating and the history of any negotiations. Emails received from providers as well as health plan responses are stored.

#### **FFS:**

The MO HealthNet Division is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The Division establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers;
- Allows for no adverse impact on private-pay patients;
- Assures a reasonable rate to protect the interests of the taxpayers; and
- Provides incentives that encourage efficiency on the part of medical providers.

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The

percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds. Total expenditures for MO HealthNet must be within the appropriation limits established by the General Assembly. If the expenditures do not stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the efficiency. Reimbursement for Behavioral Health services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the State Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service. Under a fee system each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. In determining what this fee should be, the MO HealthNet Division uses the following guidelines:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee;
- Medicare's allowable reasonable and customary charge payment or cost-related payment, if applicable;
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services. The MO HealthNet Division then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           |  |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |

| <p>NQTL: Provider Reimbursement / Usual, Customary, and Reasonable Determination<br/> Health Plan/State: Missouri Care Health / FFS<br/> Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court<br/> Classification: Inpatient and Outpatient</p>  |  |
|---|--|
| MH/SUD Benefits/Providers   | M/S Benefits/Providers   |
| <p>Missouri Care Health: Covered Inpatient and Outpatient Services<br/> FFS: Covered Inpatient and Outpatient Services</p>  | <p>Missouri Care Health: Covered Inpatient and Outpatient Services<br/> FFS: Covered Inpatient and Outpatient Services</p> |
| Compliance Analysis   |  |
| <p><b>Missouri Care:</b><br/> For both MH/SUD and M/S, WellCare utilizes the fee schedules prescribed by the State for reimbursing providers. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule. None of the following factors affect how reimbursement rates are determined:</p> <ul style="list-style-type: none"> <li>• Service Type</li> <li>• Geographic Market</li> <li>• Service demand</li> <li>• Provider Supply</li> <li>• Practice Size</li> <li>• Medicare reimbursement rates</li> <li>• Licensure</li> </ul> <p>*WellCare utilizes the fee schedule prescribed by the State for reimbursing providers as noted above. All providers are reimbursed at 100%</p> |  |

of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.

Missouri Care utilizes the States Medicaid Fee Schedule for establishing rates statewide. Inpatient and outpatient reimbursement rates are based on the state's annually published rates which are calculated utilizing the providers annual cost report. In the event there is a need to deviate from this standard; a market feasible rate is negotiated through collaborative negotiations to elicit the greatest value. Exceptions are approved by the VP of Field Network Management and the Plan President. Missouri Care reimburses out of network providers at 100% of the current Missouri Medicaid rate and payment methodology.

**FFS:**

The MO HealthNet Division is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The Division establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers;
- Allows for no adverse impact on private-pay patients;
- Assures a reasonable rate to protect the interests of the taxpayers; and
- Provides incentives that encourage efficiency on the part of medical providers.

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds. Total expenditures for MO HealthNet must be within the appropriation limits established by the General Assembly. If the expenditures do not stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the efficiency. Reimbursement for Behavioral Health services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the State Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service. Under a fee system each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. In determining what this fee should be, the MO HealthNet Division uses the following guidelines:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee;

- Medicare’s allowable reasonable and customary charge payment or cost-related payment, if applicable;
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services. The MO HealthNet Division then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn’t Comply           |  |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |

NQTL: Provider Reimbursement / Usual, Customary, and Reasonable Determination  
 Health Plan/State: UnitedHealthcare Health / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers  | M/S Benefits/Providers   |
|--|--|
| UnitedHealthcare Health: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services | UnitedHealthcare Health: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services |

**Compliance Analysis**

**UnitedHealthcare:**

Reimbursement is based on the providers' contracts. In general UnitedHealthcare uses the current MHD fee schedules and payment methodology as the basis for inpatient, outpatient, and emergency care contracting. Incentives may be used in addition in order to improve the robustness of the provider network in areas of need.

Reimbursement is also based on application of NCCN edits, CMS edits, and internal proprietary policies applied to reduce duplication and abuse of standard CPT and HCPCS codes.

Steps:

1. Review most current fee schedule/rates from MO Medicaid website
2. Local C&S Finance approve rates if above 100% of MO Medicaid

3. All pricing is based upon MO Medicaid fee schedules

4. Any request for increases to a providers Medicaid fee schedule is directed to Network Management. If the request is made during an open negotiation, NM works with C&S Finance to assess the viability of the requested rates. NM will then negotiate the rates as appropriate with the provider.

5. Rates are reassessed after the initial term of the agreement ends with the provider

United uses the current MHD fee schedules and payment methodologies in order to reduce provider abrasion and improve contracting consistency. The final methodology applied to each provider will depend on the details of any negotiated contract. Contracts and fee schedules may be adjusted to establish appropriate provider networks and to address issues such service type, geographic market, demand for services, supply, practice size, provider qualifications, etc.

United uses the Medicaid fee schedule as the basis for provider contracts in order to most closely mimic the current state methodology for establishing medical cost expectations.

**FFS:**

The MO HealthNet Division is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The Division establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers;
- Allows for no adverse impact on private-pay patients;
- Assures a reasonable rate to protect the interests of the taxpayers; and
- Provides incentives that encourage efficiency on the part of medical providers.

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds. Total expenditures for MO HealthNet must be within the appropriation limits established by the General Assembly. If the expenditures do not stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the efficiency. Reimbursement for Behavioral Health services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the State Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for

covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service. Under a fee system each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established. In determining what this fee should be, the MO HealthNet Division uses the following guidelines:

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- Medicare's allowable reasonable and customary charge payment or cost-related payment, if applicable;
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services. The MO HealthNet Division then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

| State Compliance Determination      |                          |                          |  |
|-------------------------------------|--------------------------|--------------------------|--|
| Complies                            | Follow up                | Doesn't Comply           |  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |

NQTL: Geographic Restrictions / Travel Time and Distance Requirements / Standards for Out of Network Coverage  
 Health Plan/State: Home State Health / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers  | M/S Benefits/Providers   |
|--|--|
| Home State Health: Covered Inpatient and Outpatient Services<br>FFS: CPR and Covered Inpatient and Outpatient Services for COA 4 | Home State Health: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services |

**Compliance Analysis**

**Home State:**  
 HSH has a comprehensive network of contracted IP and OP providers and makes every effort to manage care within the contracted network. However, HSH will authorize services to non-participating providers as needed to ensure timely access to quality care if there are no appropriate contracted providers, if a member requires services when outside the service area or to ensure transition and continuity of care. Authorization for non-participating providers is managed by HSH's Medical Management team including concurrent review, utilization management and medical directors. Once the authorization is approved, Medical Management notifies the Network Management Department and a Single Case Agreement is executed to document the agreed upon services and reimbursement. This document is signed by both the provider(s) and HSH and a copy returned to the provider and placed in HSH file.

If an in-network provider who is qualified and able to provide the service is not available the following occurs:

The UM designee will send the request for Medical Director Review with the following documentation.

- i. Reason for requesting an out-of-network provider

- ii. Name and specialty of the out-of-network provider
- iii. Results of the in-network search
- v. Medical necessity review, if required
- vi. Any additional information

Upon evaluation of the Medical Director outcome.

- i. UM designee will follow approval and/or denial process per plan policies (UM.05 – Timeliness of UM Decisions and Notifications and UM.07 – Adverse Determination (Denial) Notices)

If an out-of-network provider is approved:

- i. Authorization is entered into the Clinical Documentation System and notice is provided as defined in UM.05.
  - o The provider will be notified of how to access information related to plan billing and payment (ex. plan website, provider manuals, state fee schedule, etc.).
  - o If the provider states they are not willing to accept the applicable fee schedule, the provider will be notified that a Single Case Agreement (SCA) is required and if rates can't be agreed upon, the authorization may be denied and another provider may be found to serve the member.

Special considerations

- a. Out-of-network Inpatient Admissions and/or Urgent Requests.
  - i. Out-of-network inpatient admissions may occur as a result of an emergency urgent situation. The Plan will evaluate the unique circumstances surrounding the health care needs of the member.
  - ii. Authorization is not required for emergent/urgent care.
    - Once the member becomes stable, Care Management (CM) will assist in transitioning the member to an in-network facility/provider.
    - If the member is unable to be transitioned in-network, the Plan continues to monitor the member's condition and authorizes services as appropriate.
- b. Out-of-network requests are considered when a participating provider is only affiliated with an out-of-network facility and may require Advisor Review (follow Health Plan policy).
- c. Out-of-network providers are considered for second opinion requests based on member contract, and may require Advisor Review (follow Health Plan policy).
- d. Inpatient or outpatient "out of area services" will be considered for treatment of unexpected illness or injury. Advisor Review may be

required for approval (per Health Plan policy).

- i. A CM will assist in transition to an in-network provider as appropriate.

With the exception of emergency room services, all non-participating providers and services require prior authorization. If the provider does not obtain authorization, the claims will be denied. Non-par providers will be paid the state Medicaid or Medicare unless they request a single case agreement. If one is requested an agreement will be signed for that specific case.

MH/SUD standards for out-of-network coverage are applied in accordance with MO HealthNet Managed Care contractual requirements in order to ensure that enrollees have access to medically necessary services and to ensure a smooth transfer of care from nonparticipating to participating providers, as needed. MH/SUD provider network adequacy is regularly assessed against MO HealthNet Managed Care contractual standards in order to identify potential care access gaps and determine where an enrollee's best interest can be served by out-of-network coverage.

Network adequacy is reviewed on an ongoing basis to assess members' access to care across the state. Our database and website are updated on a daily basis to ensure current information regarding in-network and out-of-network providers is available to all HSH employees and our members. This policy applies to all non-participating providers with the exception of emergency services. The Single Case Agreement policy is reviewed at least annually and may be revised to accommodate needed changes at any time.

**FFS (applies for COA 4 members):**

All non-emergency, MO HealthNet-covered services that are to be performed or furnished out of state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved. Out of state is defined as *not* within the physical boundaries of the state of Missouri or within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the state of Missouri. A PA Request *form* is *not* required for out-of-state non-emergency services. To obtain prior authorization for out-of-state, non-emergency services, *a written request must* be submitted (and may be faxed). The written request *must* include:

1. A brief past medical history;
2. Services attempted in Missouri;
3. Where the services are being requested and who will provide them; and
4. Why services can't be performed in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/MO HealthNet crossover claims;
2. All foster care children living outside the state of Missouri. However, non-emergency services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a foster care child;
3. Emergency ambulance services; and
4. Independent laboratory services.

CPR – Although 9 CSR 30-4.039 specifies 1 ½ hours of travel time is reasonable to ensure access, services may be provided in member’s home or community via telehealth. DBH reviews and responds to inquiries related to travel time.

**State Compliance Determination**

| Complies                            | Follow up                | Doesn't Comply           |  |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |

NQTL: Geographic Restrictions / Travel Time and Distance Requirements / Standards for Out of Network Coverage  
 Health Plan/State: Missouri Care Health / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers   | M/S Benefits/Providers  |
|---|---|
| Missouri Care Health: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services | Missouri Care Health: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services |

**Compliance Analysis**

**Missouri Care:**

The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is). C7CR-009

For both MH/SUD and M/S, Missouri Care does contract with bordering states.

Although Missouri Care does not typically contract with out of state (non-bordering) providers, Missouri Care will enter into a Single Case Agreement upon specific clinical need for MH/SUD or M/S service out of state.

The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services. The State’s benefit plan design dictates how members can access out of network benefits.

If Missouri Care’s network is unable to provide necessary services covered under the contract to a particular member, it is the policy of Missouri Care to adequately and timely cover these services out of network for the member, for as long as Missouri Care is unable to provide them. Missouri Care will ensure that no member residing in the service area must travel an unreasonable distance to obtain covered services. The out of network providers will coordinate with Missouri Care with respect to payment and ensure that the cost to the member is no greater

than it would be if the services were furnished within the network. Once the Missouri Care clinical team identifies a need for an out of network provider, Missouri Care’s network team will outreach and negotiate a Single Case Agreement.

**FFS (applies for COA 4 members):**

All non-emergency, MO HealthNet-covered services that are to be performed or furnished out of state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved. Out of state is defined as *not* within the physical boundaries of the state of Missouri or within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the state of Missouri. A PA Request *form* is *not* required for out-of-state non-emergency services. To obtain prior authorization for out-of-state, non-emergency services, a *written request must* be submitted (and may be faxed). The written request *must* include:

1. A brief past medical history;
2. Services attempted in Missouri;
3. Where the services are being requested and who will provide them; and
4. Why services can’t be performed in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/MO HealthNet crossover claims;
2. All foster care children living outside the state of Missouri. However, non-emergency services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a foster care child;
3. Emergency ambulance services; and
4. Independent laboratory services.

CPR – Although 9 CSR 30-4.039 specifies 1 ½ hours of travel time is reasonable to ensure access, services may be provided in member’s home or community via telehealth. DBH reviews and responds to inquiries related to travel time.

| State Compliance Determination |           |                |  |
|--------------------------------|-----------|----------------|--|
| Complies                       | Follow up | Doesn’t Comply |  |
|                                |           |                |  |

NQTL: Geographic Restrictions / Travel Time and Distance Requirements / Standards for Out of Network Coverage  
 Health Plan/State: UnitedHealthcare / FFS  
 Benefit Package(s): Adults (Ages 21+), Pregnant Women (Ages 21+), Children: COA 1, PW (0-20), CHIP Exp., CHIP Separate, COA 4: foster children (ages 0-25), adoption subsidy, DYS, juvenile court  
 Classification: Inpatient and Outpatient

| MH/SUD Benefits/Providers   | M/S Benefits/Providers  |
|---|---|
| UnitedHealthcare: Covered Inpatient and Outpatient Services<br>FFS: CPR and Covered Inpatient and Outpatient Services for COA 4 | UnitedHealthcare: Covered Inpatient and Outpatient Services<br>FFS: Covered Inpatient and Outpatient Services |

**Compliance Analysis**

**UnitedHealthcare:**  
 For both MH/SUD and M/S services, individuals accessing benefits are expected to seek treatment from network professionals and facilities within the state or contiguous states. When a service is clearly not available from a network provider, arrangements may be made for an out of network provider who otherwise meets United standards of care, including having or being willing to obtain an Missouri Medicaid provider ID.

Services not meeting the criteria of emergent/Acute are not covered out of network. Emergent and unplanned admissions are reimbursed based on the fee schedule when appropriate or through a single case agreement. UHC does contract with providers in bordering states. Process: M/S will contract under a single case agreement (SCA) when services are rendered to a MO member in another state. The out-of-state provider must call the HP for authorization to treat. The intake nurses will inquire of the provider if they are willing to provide the services at 100% of the Missouri Medicaid rate. If the provider accepts, then a note is entered by the intake nurse into the system so the claim can be paid. A SCA is not necessary under these circumstances. If the out-of-state provider will not accept 100% of Missouri Medicaid, then a SCA form is sent to Network Management. Once the SCA form is received, the appropriate contractor is assigned to the SCA. This person will, in turn, negotiate a rate with the provider. Once this is complete, the SCA is entered into the system so the claim will be properly

adjudicated.

All benefits are subject to this NQTL. The plan allows for access to emergent care outside of the state including unplanned IP admissions and emergent Outpatient care.

UnitedHealthcare contracts with all providers as designated in the state Provider Agreement. In addition in areas along our border states we attempt to contract with facilities that are able to service Missouri Medicaid members.

Services not meeting the criteria of emergent/Acute are not covered out of network. Emergent and unplanned admissions are reimbursed based on established UCR process (fee schedule INN, accommodation OON). UHC follows geographic standards specified by the state for both MH/SUD and M/S services.

**FFS (applies for COA 4 members):**

All non-emergency, MO HealthNet-covered services that are to be performed or furnished out of state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, *must* be prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved. Out of state is defined as *not* within the physical boundaries of the state of Missouri or within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the state of Missouri. A PA Request *form* is *not* required for out-of-state non-emergency services. To obtain prior authorization for out-of-state, non-emergency services, *a written request must* be submitted (and may be faxed). The written request *must* include:

1. A brief past medical history;
2. Services attempted in Missouri;
3. Where the services are being requested and who will provide them; and
4. Why services can't be performed in Missouri.

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/MO HealthNet crossover claims;
2. All foster care children living outside the state of Missouri. However, non-emergency services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a foster care child;
3. Emergency ambulance services; and
4. Independent laboratory services.

CPR – Although 9 CSR 30-4.039 specifies 1 ½ hours of travel time is reasonable to ensure access, services may be provided in member’s home or community via telehealth. DBH reviews and responds to inquiries related to travel time.

**State Compliance Determination**

| <b>Complies</b>                     | <b>Follow up</b>         | <b>Doesn't Comply</b>    |  |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |

NQTL: Drugs Not Covered Pursuant to Section 1927(d)(2)

Health Plan/State: State

Benefit Package(s): All

Classification: Prescription Drugs

| MH/SUD Benefits/Providers         | M/S Benefits/Providers         |
|-----------------------------------|--------------------------------|
| Certain MH/SUD prescription drugs | Certain M/S prescription drugs |

**Compliance Analysis**

MO HealthNet covers certain drugs specified in section 1927(d)(2) of the Social Security Act and excludes others.

The excluded categories and MO HealthNet's exceptions noted in parentheses are listed below:

- A. Agents when used for weight loss.
- B. Agents when used to promote fertility. (MO HealthNet covers Aromatase inhibitors for cancer and cancer drugs are not edited)
- C. Agents when used for cosmetic purposes or hair growth.
- D. Agents when used for the symptomatic relief of cough and colds. (MO HealthNet has a covered Cough & Cold list)  
[http://dss.mo.gov/mhd/cs/pharmacy/pdf/cough\\_cold.pdf](http://dss.mo.gov/mhd/cs/pharmacy/pdf/cough_cold.pdf)
- E. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- F. Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter (OTC) monograph process for purposes of promoting, and when used to promote, tobacco cessation. (MO HealthNet has a covered list of OTC products) [http://dss.mo.gov/mhd/cs/pharmacy/pdf/otc\\_coveredproducts.pdf](http://dss.mo.gov/mhd/cs/pharmacy/pdf/otc_coveredproducts.pdf)
- G. Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
- H. Barbiturates. (MO HealthNet covered in accordance with 1927(d)(7))
- I. Benzodiazepines. (MO HealthNet covered in accordance with 1927(d)(7))
- J. Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile

dysfunction, for which the agents have been approved by the Food and Drug Administration.

Certain drugs may have both medically-necessary indications and lifestyle indications. In these cases, in order to verify medical necessity, prior authorization is required (see Prior Authorization NQTL analysis below).

Section 1927(d)(2) of the Social Security Act allows the exclusion of certain drugs that may not always be medically necessary, generally considered “lifestyle drugs” (used to improve quality of life rather than for alleviating pain or managing or curing an illness). These include agents for weight loss, to promote fertility, for cosmetic purposes and to treat sexual or erectile dysfunction. MO HealthNet’s decision to exclude these drugs is not based on whether the drugs are used for a MH/SUD condition or a M/S condition; the processes, strategies, and evidentiary standards appear to be the same for both MH/SUD and M/S medications.

**State Compliance Determination**

Complies



NQTL: Requiring Use of Preferred Drugs Before Approving Non-Preferred Agents (Step Therapy)

Health Plan/State: State

Benefit Package(s): All

Classification: Prescription Drugs

| MH/SUD Benefits/Providers         | M/S Benefits/Providers         |
|-----------------------------------|--------------------------------|
| Certain MH/SUD prescription drugs | Certain M/S prescription drugs |

**Compliance Analysis**

MO HealthNet's preferred drug list (PDL) requires members to try and fail preferred agents prior to receiving non-preferred agents, a common practice known as Step Therapy (ST).

If a member is prescribed a non-preferred agent prior to trying the preferred agent(s), a claim for a non-preferred agent will be denied. Once preferred agents are filled, the tried and failed medications are documented in a member's claims history. The past claims records will serve to fulfill ST in the payer system and allow the non-preferred agent to be filled without further intervention. If the preferred agent is not prescribed to the member because the physician believes it is not the appropriate therapy for a given member, the physician may use the prior authorization process to seek an exception to the ST requirement.

Members are required to try and fail preferred agents prior to receiving non-preferred agents to encourage the use of cost-effective drug therapies (preferred agents) prior to being able to fill the more expensive drug therapies (non-preferred agents). Preferred agents are more cost-effective than non-preferred agents. Preferred agents typically account for nearly 80% of a program's total prescription fills, but only 20%-30% of the cost. A recent Blue Cross/Blue Shield study using pharmacy data from years 2010 through 2016 reinforced this general split between preferred drugs (primarily generics) and non-preferred; the study can be accessed here: [https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/BCBS.HealthOfAmericaReport.RisingCostsPatentedDrugs\\_1.pdf](https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/BCBS.HealthOfAmericaReport.RisingCostsPatentedDrugs_1.pdf)

ST requirements are primarily based on a medication's cost and generic/brand status. Thus, the strategies, processes and evidentiary standards appear to be comparable and of the same stringency, regardless of whether the medications are for treatment of MH/SUD or M/S conditions or both.

|                                       |          |                                     |
|---------------------------------------|----------|-------------------------------------|
| <b>State Compliance Determination</b> | Complies | <input checked="" type="checkbox"/> |
|---------------------------------------|----------|-------------------------------------|

NQTL: Prior Authorization  
 Health Plan/State: State  
 Benefit Package(s):All  
 Classification: Prescription Drugs

| MH/SUD Benefits/Providers         | M/S Benefits/Providers         |
|-----------------------------------|--------------------------------|
| Certain MH/SUD prescription drugs | Certain M/S prescription drugs |

**Compliance Analysis**

MO HealthNet’s PDL covers some medications only with advance approval from MO HealthNet, a common practice known as prior authorization. To obtain prior authorization for a drug, the prescriber may either call the request in to the prior authorization phone line or fax a completed request form to MO HealthNet.

Requests for prior authorization will be evaluated and MO HealthNet will provide a response by telephone or other telecommunication device within 24 hours. If required, a 72-hour supply of a covered outpatient drug can be dispensed in an emergency situation, except with respect to the drugs on the list of drugs permissible for exclusion.

MO HealthNet has two groups involved in developing prior authorization requirements, the MO HealthNet Drug Prior Authorization Committee and the Drug Use Review (DUR) Board. The MO HealthNet Drug Prior Authorization Committee consists of three practicing pharmacists, three physicians and one registered nurse. The DUR Board consists of clinicians appointed by the governor and confirmed by the senate. A quorum of two-thirds (2/3) of the total members, including no fewer than two (2) physicians or two (2) pharmacists, is required for the DUR Board to act in its official capacity.

The MO HealthNet Drug Prior Authorization Committee reviews medications, prescribing guidelines and accepted clinical practice to recommend medications for prior authorization. The DUR Board reviews and approves or rejects the recommendations.

Circumstances leading the Drug Prior Authorization Committee and DUR board to recommend the requirement of prior authorization include, but are not limited to, the following:

Medical necessity is not clearly evident.

Potential for diversion, misuse and abuse.

High cost of care relative to similar therapies.

Opportunity for unlabeled use defined as the use of a drug product in doses, patient populations, indications or routes of administration that are not reflected in the FDA approved product labeling.

Medications may be limited to the maximum FDA approved dose.

Medications may be limited to the minimum FDA approved age limitations.

Drug classes where there is an identified potential for not keeping within the MO HealthNet policy guidelines.

New drugs that come to market that are in one of the therapeutic categories covered by the PDL.

Certain drugs, for example those in Social Security Act section 1927(d)(2), may have both medically-necessary indications and lifestyle indications. In these cases, in order to verify medical necessity, prior authorization is required.

Pain medications, such as opioids, have a high street value and are prone to addiction and misuse. One recent case involving 12 U.S. attorneys' offices resulted in \$150 million in DEA civil penalties against McKesson Corp., a distributor of pharmaceuticals, to address its failure to report suspicious opioid orders. Prior authorization for drugs with this potential helps to manage and monitor the quantity being dispensed.

As addressed above in ST, cost-effective treatments are preferred over more expensive equivalent treatments. To gain exception to trying and failing the cost-effective option, prior authorization may be used.

Opportunity exists for unlabeled use defined as the use of a drug product in doses, patient populations, indications or routes of administration that are not reflected in the FDA approved product labeling.

PAs are used for the purpose of containing costs and to ensure the proper utilization of drug therapies. The Drug Prior Authorization Committee recommends PAs based on FDA prescribing guidelines and accepted clinical practice. All recommendations must be reviewed and approved by the DUR Board prior to implementation. The strategies, processes and evidentiary standards appear to be comparable and of the same stringency, regardless of whether the medications are for treatment of MH/SUD or M/S conditions or both.

|                                |          |                                     |
|--------------------------------|----------|-------------------------------------|
| State Compliance Determination | Complies | <input checked="" type="checkbox"/> |
|--------------------------------|----------|-------------------------------------|

|   |                               |                                     |
|---|-------------------------------|-------------------------------------|
| NQTL: Early Refills<br>Health Plan/State: State<br>Benefit Package(s): All<br>Classification: Prescription Drugs  |                               |                                     |
| <b>MH/SUD Benefits/Providers</b>  | <b>M/S Benefits/Providers</b> |                                     |
| All MH/SUD prescription drugs   | All M/S prescription drugs    |                                     |
| <b>Compliance Analysis</b>  |                               |                                     |
| <p>Prescription refills for MO HealthNet members are not allowed until 75% of the previous fill has been used (85% for opioids). If the prescriber has changed the directions for a member's medication requiring an early refill, the pharmacy may call Pharmacy Services with the new dosing details to gain an approval.</p> <p>Early refill edits help to prevent stockpiling and abuse. Exceptions to the early refill restriction can be approved through the prior authorization process when necessary, for example if medication has been lost or stolen, or if a member is planning for extended travel.</p> <p>MO HealthNet's early refill edits are applied uniformly across all drug categories, with the exception of opioids, which have a higher threshold due to their abuse and addiction potential. The strategies, processes and evidentiary standards appear to be comparable and of the same stringency, regardless of whether the medications are for treatment of MH/SUD or M/S conditions or both.</p> |                               |                                     |
| <b>State Compliance Determination</b>   | Complies                      | <input checked="" type="checkbox"/> |

NQTL: Shared Pharmacy Dispensing Fees (Copays)

Health Plan/State: State

Benefit Package(s):All

Classification: Prescription Drugs

**MH/SUD Benefits/Providers**

**M/S Benefits/Providers**

All MH/SUD prescription drugs

All M/S prescription drugs

**Compliance Analysis**

Shared dispensing fees are assessed by MO HealthNet when the claim is submitted by the pharmacy. The pharmacist is responsible for assessing the shared dispensing fees at point of sale when dispensing the medication to the member.

Shared dispensing fees are assessed to share health care costs between payers and members, and to avoid members seeking unneeded services. In order to share the cost proportionately, the State set shared dispensing fees by tier to charge lower shared dispensing fees for less expensive drugs and higher shared dispensing fees for more expensive drugs.

MO HealthNet's shared dispensing fees are tiered as follows:

Drug ingredient cost between \$0–\$10.00 = \$0.50 shared dispensing fee

Drug ingredient cost between \$10.01–\$25.00 = \$1.00 shared dispensing fee

Drug ingredient cost higher than \$25.00 = \$2.00 shared dispensing fee

- 
- All members are assessed the shared dispensing fees, with the exception of the following which are excluded:  
Services to participants under age 19;

Services to institutionalized participants who are residing in a skilled nursing facility, intermediate care facility, adult boarding home, psychiatric hospital or FFS participants in a residential care facility;

Services to foster care children under 26 years of age;

|  |          |                                     |
|--|----------|-------------------------------------|
| <p>Services to all Medicare/MO HealthNet participants with crossover claims as primary coverage;</p> <p>Those drugs specifically identified as relating to family planning services;</p> <p>Emergency services in an outpatient clinic or emergency room;</p> <p>Services provided to pregnant women which are directly related to the pregnancy or a complication of the pregnancy;</p> <p>Services provided to persons receiving MO HealthNet under the categories of Aid to the Blind; and</p> <p>Services which are prescribed and identified as relating to an Early Periodic Screening, Diagnosis and Treatment Program screening or referral service.</p> <p>○</p> <p>○ Shared dispensing fees are assessed to share health care costs between payers and members, and to avoid members seeking unneeded services. The copays are based on the overall cost of the medication, and thus, are applied with the same comparability and stringency regardless of whether the drug is for MH/SUD or M/S conditions.</p> |          |                                     |
| <b>State Compliance Determination</b>  | Complies | <input checked="" type="checkbox"/> |

NQTL: Reimbursement for prescription drugs

Health Plan/State: State

Benefit Package(s):All

Classification: Prescription Drugs

**MH/SUD Benefits/Providers**

All MH/SUD prescription drugs

**M/S Benefits/Providers**

All M/S prescription drugs

**Compliance Analysis**

MO HealthNet’s reimbursement logic is designed to fairly compensate providers for providing prescription drugs.

The State reimburses pharmacy providers as follows:

Federal Upper Limit (FUL), if no FUL then State SMAC, if no State Maximum Allowable Cost (SMAC) then Wholesale Acquisition Cost (WAC) minus 3.1%.\*

FUL is a national benchmark maintained by CMS. In aggregate, CMS requires FFS Medicaid pharmacy programs to reimburse at or below the FUL rate for all drugs with FUL rates available.

WAC is a regularly updated pharmacy industry pricing benchmark. WAC is based on manufacturer-reported prices. Government program payers generally pay at WAC or less for brand drugs, with further discounts on generic drugs achieved through the use of SMAC lists.

These pricing benchmarks help the State responsibly use Medicaid funds while also providing adequate reimbursement to pharmacies to ensure beneficiary access. If a pharmacy is unable to dispense a medication at the SMAC rate and still cover its costs, the pharmacy can appeal to the State for a pricing review and provide evidence of their actual purchase price.

Missouri’s Medicaid reimbursement logic is designed to fairly compensate providers for providing prescription drugs. The MO HealthNet logic is based on industry-standard payment metrics that generally are considered to adequately compensate pharmacy providers for medications.

○ The reimbursement logic is based on pricing metrics that are determined by market pricing forces, not by the condition that the medication treats, and thus the

processes, strategies, and evidentiary standards are applied with the same comparability and stringency regardless of whether the drug is for MH/SUD or M/S conditions.

○

*\*Reimbursement logic in place, but not yet granted final CMS approval*

**State Compliance Determination**

Complies

