SECTION 11 - MO HEALTHNET MANAGED HEALTH CARE DELIVERY SYSTEM

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MO HealthNet provides health care services to Managed Care eligibles who meet the criteria for enrollment through Managed Care arrangements, as follows:

- Under MO HealthNet's Managed Care Program certain eligible individuals are enrolled with a MO HealthNet managed care health plan. Managed Care has been implemented in three regions of the state: Eastern (St. Louis area), Central and Western (Kansas City area) regions.

11.1 MO HEALTHNET 'S MANAGED CARE PROGRAM

Managed Care eligibles who meet specific eligibility criteria receive services through a Managed Care health plan. The Managed Care Program replaces the process of direct reimbursement to individual providers by the MO HealthNet Division (MHD). Participants enroll in a Managed Care health plan that contracts with the state to provide a specific scope of benefits. Individuals who are included in the Managed Care Program have the opportunity to choose their own Managed Care health plan and primary care provider.

11.1.A EASTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Eastern Missouri Managed Care Program (St. Louis area) began providing services to members on September 1, 1995. It includes the following counties: Franklin (036), Jefferson (050), St. Charles (092), St. Louis County (096) and St. Louis City (115). On December 1, 2000, 5 new counties were added to this region: Lincoln (057), St. Genevieve (095), St. Francois (094), Warren (109) and Washington (110). On January 1, 2008, the following three new counties were added to the Eastern region: Madison (062), Perry (079) and Pike (082).

A listing of the health plans providing services for the Eastern region Managed Care Program can be found on the MHD website at http://www.dss.mo.gov/mhd/mc/pages/healthplan.htm.

11.1.B CENTRAL MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Central Missouri Managed Care region began providing services to members on March 1, 1996. It includes the following counties: Audrain (004), Boone (010), Callaway (014), Camden (015), Chariton (021), Cole (026), Cooper (027), Gasconade (037), Howard (045), Miller (066), Moniteau (068), Monroe (069), Montgomery (070), Morgan (071), Osage (076), Pettis (080), Randolph (088) and Saline (097). On January 1, 2008, ten new counties were added to this region: Benton (008), Laclede (053), Linn (058), Macon (061), Maries (063), Marion (064), Phelps (081), Pulaski (085), Ralls (087) and Shelby (102).

A listing of the health plans providing services for the Central region Managed Care Program can be found on the MHD website at http://www.dss.mo.gov/mhd/mc/pages/healthplan.htm.

11.1.C WESTERN MISSOURI PARTICIPATING MO HEALTHNET MANAGED CARE HEALTH PLANS

The Western Missouri Managed Care Program (Kansas City area) began providing services to members on November 1, 1996. The Western Managed Care region includes the following counties: Cass (019), Clay (024), Jackson (048), Johnson (051), Lafayette (054), Platte (083) and Ray (089). St. Clair (093) and Henry (042) counties were incorporated into the Western region effective 2/1/99. On January 1, 2008 four new counties were added to this region: Bates (007), Cedar (020), Polk (084) and Vernon (108).

A listing of the health plans providing services for the Western region Managed Care Program can be found on the MHD website at http://www.dss.mo.gov/mhd/mc/pages/healthplan.htm.

11.2 MO HEALTHNET MANAGED CARE HEALTH PLAN ENROLLMENT

The state has contracted with an independent enrollment agent to assist current and future MO HealthNet Managed Care participants to make an informed decision in the choice of a MO HealthNet Managed Care health plan that meets their needs.

The Managed Care enrollment agent sends mailers/letters, etc., provides MO HealthNet Managed Care health plan option information, and has a hot line number available to participants in order to make the selection process easy and informative.

Participants who are identified as eligible for inclusion in the MO HealthNet Managed Care Program are *not* enrolled with a MO HealthNet Managed Care health plan until 15 days after they actually select or are assigned to a Managed Care health plan. When the selection or assignment is in effect, the name of the MO HealthNet Managed Care health plan appears on the interactive voice response system/point of service/Internet information. If a MO HealthNet Managed Care health plan name does *not* appear for a particular date of service, the participant is in a fee-for-service status for each date of service that a MO HealthNet Managed Care health plan is *not* listed for the participant.

"OPT" OUT POPULATIONS: The Department of Social Services is allowing participants, who are currently in the MO HealthNet Managed Care Program because they receive SSI disability payments, who meet the SSI disability definition as determined by the Department of Social Services, or who receive foster care assistance or adoption subsidy benefits, the option of choosing to receive services on a fee-for-service basis or through the MO HealthNet Managed Care Program. The option is entirely up to the participant, parent or guardian.

11.3 MO HEALTHNET MANAGED CARE HEALTH PLAN INCLUDED INDIVIDUALS

Refer to Section 1.5.C, MO HealthNet Managed Care Participants, and 1.1.A, Description of Eligibility Categories, for more information on Managed Care health plan members.

Managed Care health plan members fall into 3 groups:

- Individuals with the following ME codes fall into Group 1: 05, 06, 10, 18, 19, 21, 24, 26, 40, 43, 44, 45, 60, 61 and 62.
- Individuals with the following ME codes fall into Group 4: 07, 08, 29, 30, 36, 37, 38, 50, 52, 56, 57, 63, 64, 66, 68, 69, 70 and 88.
- Individuals with the following ME codes fall into Group 5: 71, 72, 73, 74 and 75;

11.4 MO HEALTHNET MANAGED CARE HEALTH PLAN EXCLUDED INDIVIDUALS

The following categories of assistance/individuals are *not* included in the MO HealthNet Managed Care Program.

- Individuals who are eligible for both Medicare and MO HealthNet
- Individuals who are residents of a domiciliary, residential care facility or nursing home
- Individuals who are receiving MO HealthNet as a permanently and totally disabled individual
- Pregnant Women who are presumptively eligible under the Temporary Eligibility During Pregnancy (TEMP) program
- Individuals eligible for Blind Pension or Aid to the Blind
- Individuals in a state mental institution or institutional care facility
- AIDS Waiver Participants
- Missouri Children with Developmental Disabilities Waiver (ME Codes 33 and 34)
- Uninsured women losing their MO HealthNet eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women's health services for one year plus 60 days, regardless of income level.
- Women eligible for Women's Health Services, 1115 Waiver Demonstration, ME code 89. These are uninsured women who are at least 18 to 55 years of age, with a net family income at or below 185% of the Federal Poverty Level (FPL), and with assets totaling less than $250,000. These women are eligible for women's health services as long as they continue to meet eligibility requirements.

- Terminated Temporary Assistance for Needy Families (TANF) individuals who have had their medical eligibility temporarily reinstated. (ME code 81)
- Presumptive Eligibility for Children. (ME code 87)
- Voluntary Placement (ME Code 88)
- Children placed in foster homes or residential care by the Department of Mental Health (ME Codes 28, 49 and 67).
- Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary - QMB).
- Children placed in residential care by their parents if eligible for MO HealthNet on the date of placement (ME code 65).
- Women eligible under ME Codes 83 and 84 (Breast and Cervical Cancer Treatment).
- Individuals eligible under ME Code 82 (MoRx).

11.5 MO HEALTHNET MANAGED CARE MEMBER BENEFITS

The MO HealthNet Managed Care health plans are required to provide health benefits to MO HealthNet Managed Care members for each date they are enrolled in the MO HealthNet Managed Care health plan. Managed Care members select a primary care provider (PCP) to provide routine care.

MO HealthNet enrolled providers (also called MO HealthNet Managed Care approved providers) who provide services to a Managed Care member do *not* receive direct reimbursement from the state for Managed Care health plan benefits furnished while the participant is enrolled in a MO HealthNet Managed Care health plan. MO HealthNet enrolled providers who wish to provide services for MO HealthNet Managed Care members *must* contact the Managed Care health plans for participation agreements/contracts or prior authorization.

The MO HealthNet Managed Care member *must* be told in advance of furnishing the service by the non Managed Care health plan provider that they are able to receive the service from the MO HealthNet Managed Care health plan at no charge. The participant *must* sign a statement that they have been informed that the service is available through the Managed Care health plan but is being provided by the non MO HealthNet Managed Care health plan provider and they are willing to pay for the service as a private pay patient.

MO HealthNet Managed Care health plan members receive the same standard benefit package regardless of the MO HealthNet Managed Care health plan they select. Managed Care health plans *must* provide services according to guidelines specified in contracts. Managed Care members are eligible for the same range of medical services as under the fee-for-service program. The Managed Care health plans may provide services directly, through subcontracts, or by referring the Managed Care member to

a specialist. Services are provided according to the medical needs of the individual and within the scope of the Managed Care health plan's administration of health care benefits.

Some services continue to be provided outside the MO HealthNet Managed Care health plan with direct provider reimbursement by the MO HealthNet Division. Refer to Section 11.7.

11.6 STANDARD BENEFITS UNDER MO HEALTHNET MANAGED CARE PROGRAM

The following is a listing of the standard benefits under the comprehensive Managed Care Program. Benefits listed are limited to members who are eligible for the service.

- Inpatient hospital services
- Outpatient hospital services
- Emergency room services
- Ambulatory surgical center, birthing center
- Physician services (including advanced practice nurse and certified nurse midwife)
- Family planning (requires freedom of choice and may be accessed out of the Managed Care Health Plan)
- Laboratory, radiology and other diagnostic services
- Maternity services (A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. Home visits are required following early discharge. Reference Section 13.20 of the Home Health Manual for more information)
- Prenatal case management
- Home health services
- Emergency (ground or air) transportation
- Nonemergency medical transportation (NEMT), except for CHIP children in ME codes 73-75.
- Services of other providers when referred by the Managed Care member's primary care provider
- Hospice services
- Durable medical equipment (including but *not* limited to orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs, walkers, diabetic supplies and equipment) and medically necessary equipment and supplies used in

connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP).

- Limited Podiatry services
- Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury. Dental services when the absence of dental treatment would adversely affect a pre-existing medical condition.
- Personal care/advanced personal care
- Adult day health care
- Optical services include one comprehensive or limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), and one pair of eyeglasses every two years (during any 24 month period of time).
- Services provided by local public health agencies (may be provided by the MO HealthNet Managed Care health plan or through the local public health agency and paid by the MO HealthNet Managed Care health plan)
    - Screening, diagnosis and treatment of sexually transmitted diseases
    - HIV screening and diagnostic services
    - Screening, diagnosis and treatment of tuberculosis
    - Childhood immunizations
    - Childhood lead poisoning prevention services, including screening, diagnosis and treatment
- Behavioral health and substance abuse services. Covered for children (except Group 4) and adults in all Managed Care regions without limits. Services shall include, but *not* be limited to:
    - Inpatient hospitalization, when provided by an acute care hospital or a private or state psychiatric hospital
    - Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, provisional licensed clinical social worker, licensed professional counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric nurse, or state certified behavioral health or substance abuse program
    - Crisis intervention/access services
    - Alternative services that are reasonable, cost effective and related to the member's treatment plan

- Referral for screening to receive case management services.

- Behavioral health and substance abuse services that are court ordered, 96 hour detentions, and for involuntary commitments.
- Behavioral health and substance abuse services to transition the Managed Care member who received behavioral health and substance abuse services from an out-of-network provider prior to enrollment with the MO HealthNet Managed Care health plan. The MO HealthNet Managed Care health plan shall authorize out-of-network providers to continue ongoing behavioral health and substance abuse treatment, services, and items for new Managed Care members until such time as the new Managed Care member has been transferred appropriately to the care of an in-network provider.
- Early, periodic, screening, diagnosis and treatment (EPSDT) services also known as healthy children and youth (HCY) services for individuals under the age of 21. Services include but are *not* limited to:
  - HCY screens including interval history, unclothed physical, anticipatory guidance, lab/immunizations, lead screening (verbal risk assessment and blood lead levels, [mandatory 6-72 months]), developmental screen and vision, hearing, and dental screens
  - Orthodontics
  - Private duty nursing
  - Psychology/counseling services (Group 4 children in care and custody receive psychology/counseling services outside the Managed Care Health Plan). Refer to ME Codes listed for Group 4, Section 1.5.C
  - Physical, occupational and speech therapy (IEP and IFSP services may be accessed out of the. MO HealthNet Managed Care health plan)
  - Expanded services in the Home Health, Optical, Personal Care, Hearing Aid and Durable Medical Equipment Programs
- Transplant related services. The MO HealthNet Managed Care health plan is financially responsible for any inpatient, outpatient, physician, and related support services including pre-surgery assessment/evaluation prior to the date of the actual transplant surgery. The Managed Care health plan is responsible for the pre-transplant and post-transplant follow-up care.

11.6.A BENEFITS FOR CHILDREN AND WOMEN IN A MO HEALTHNET CATEGORY OF ASSISTANCE FOR PREGNANT WOMEN

A child is anyone less than twenty-one (21) years of age. For some members the age limit may be less than nineteen (19) years of age. Some services need prior approval before getting them. Women must be in a MO HealthNet category of assistance for pregnant women to get these extra benefits.

- Comprehensive day rehabilitation, services to help you recover from a serious head injury;
- Dental services – All preventive, diagnostic, and treatment services as outlined in the MO HealthNet State Plan;
- Diabetes self management training for persons with gestational, Type I or Type II diabetes;
- Hearing aids and related services;
- Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses per year, and, for children under age twenty-one (21), HCY/EPSDT optical screen and services;
- Podiatry, medical services for your feet;
- Services that are included in the comprehensive benefit package, medically necessary, and identified in the IFSP or IEP (except for physical, occupational, and speech therapy services).
- Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all other therapies.

11.7 SERVICES PROVIDED OUTSIDE THE MO HEALTHNET MANAGED CARE PROGRAM

The following services are available to MO HealthNet Managed Care members outside the MO HealthNet Managed Care Program and are reimbursed to MO HealthNet approved providers on a fee-for-service basis by the MO HealthNet Division:

- Abortion services (subject to MO HealthNet Program benefits and limitations)
- Physical, occupational and speech therapy services for children included in:
  - the Individual Education Plan (IEP); or
  - the Individual Family Service Plan (IFSP)
- Environmental lead assessments for children with elevated blood lead levels
- Community Psychiatric Rehabilitation program services
- Comprehensive substance treatment and rehabilitation (CSTAR) services
- Lab tests performed by the Department of Health and Senior Services as required by law (e.g., metabolic testing for newborns)

- SAFE and CARE exams and related diagnostic studies furnished by a SAFE-CARE trained MO HealthNet approved provider
- MRDD waiver services for MRDD waiver participants included in all Managed Care regions.
- Bone marrow/stem cell and solid organ transplant services (corneal tissue transplants are covered as an outpatient benefit under the MO HealthNet Managed Care health plan). Services include the hospital stay from the date of transplant through the date of discharge, procurement, and physician services related to the transplant and procurement procedures. Pre-transplant and post-transplant follow-up care after the inpatient transplant discharge are the responsibility of the MO HealthNet Managed Care health plan.
- Behavioral health services for MO HealthNet Managed Care children (group 4) in state care and custody
    - Inpatient services—patients with a dual diagnosis admission (physical and behavioral) have their hospital days covered by the MO HealthNet Managed Care Health Plan.
    - Outpatient behavioral health visits are *not* the responsibility of the MO HealthNet Managed Care health plan for Group 4 members when provided by a:
        - comprehensive substance treatment and rehabilitation (CSTAR) provider
        - licensed psychiatrist
        - licensed psychologist, provisionally licensed psychologist, licensed clinical social worker, licensed master social worker, licensed professional counselor or provisionally licensed professional counselor
        - Psychiatric Clinical Nurse Specialist, Psychiatric Mental Health Nurse Practitioner state certified behavioral health or substance abuse program
        - Missouri certified substance abuse counselor
        - a qualified behavioral health professional in the following settings:
            - federally qualified health center (FQHC)
            - rural health clinic (RHC)
- Pharmacy services
- Home birth services
- Targeted Case Management for Behavioral Health Services

11.8 QUALITY OF CARE

The state has developed quality improvement measures for the MO HealthNet Managed Care health plan and will monitor their performance.

11.9 IDENTIFICATION OF MO HEALTHNET MANAGED CARE PARTICIPANTS

Participants who are included in the MO HealthNet Managed Care Program are identified on the Internet or interactive voice response (IVR) system when verifying eligibility. The response received identifies the name and telephone number of the participant's selected MO HealthNet Managed Care health plan. For MO HealthNet Managed Care members, the response also includes the identity of the MO HealthNet Managed Care member's primary care provider (PCP). Providers who need to contact the PCP, may contact the Managed Care health plan to confirm the PCP on the State's system has not recently changed. Participants who are eligible for the MO HealthNet Managed Care Program and enrolled with a MO HealthNet Managed Care health plan *must* have their basic benefit services provided by or prior authorized by the MO HealthNet Managed Care health plan. Refer to Section 1 for additional information on identification of participants in MO HealthNet Managed Care Programs.

MO HealthNet Managed Care health plans may also issue their own individual Managed Care Health Plan ID cards. The individual *must* be eligible for managed health care and enrolled with the MO HealthNet Managed Care health plan on the date of service for the MO HealthNet Managed Care health plan to be responsible for services. Providers *must* verify the eligibility status and Managed Care health plan enrollment status on all MO HealthNet Managed Care participants before providing service.

11.9.A NON-BILLING MO HEALTHNET PROVIDER

MO HealthNet Managed Care health plan providers who have a valid agreement with one or more Managed Care health plans but who are *not* enrolled as a participating MO HealthNet provider may access the Internet or interactive voice response (IVR) only if they enroll with MO HealthNet as a "Non-Billing MO HealthNet Provider." Providers are issued an atypical provider identifier that permits access to the Internet or IVR; however, it is *not* valid for billing MO HealthNet on a fee-for-service basis. Information regarding enrollment as a "Non-Billing MO HealthNet Provider" can be obtained by contacting the Provider Enrollment Unit at mmac.providerenrollment@dss.mo.gov.

11.10 EMERGENCY SERVICES

Emergency medical/behavioral health services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and are needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition for MO HealthNet Managed Care health plan members means medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others; or
6. With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery or; (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

Post stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

11.11 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system and finance model for the frail elderly that replicates the original model pioneered at the San Francisco On Lok site in the early 1980s. The fully capitated service delivery system includes: primary care, restorative therapy, transportation, home health care, inpatient acute care, and nursing facility long-term care when home and community-based services are no longer appropriate. Services are provided at the PACE center, the home, in the hospital, or in a nursing facility, depending upon the needs of the individual. The goal is to maximize each participant's potential and continued residence in the home and community by providing preventive primary care and other support. Enrollment in the PACE program is always voluntary. Participants have the option to disenroll and return to the fee-for-service system at any time. A fully capitated PACE provider receives a monthly capitation from Medicare and/or MO HealthNet. All medical services that the individual requires while enrolled in the program are the financial responsibility of the fully capitated PACE provider. A successful PACE site serves 150 to 300 enrollees in a limited geographical area. The Balanced Budget Act of 1997 established PACE as a permanent provider under Medicare and allowed states the option to pay for PACE services under MO HealthNet.

11.11.A PACE PROVIDER AND SERVICE AREA

Missouri and CMS have entered into a three-way program agreement with Alexian Brothers Community Services (ABCS) of St Louis. Services are provided to eligible individuals who reside in areas with the following zip codes:

63005	63011	63017	63021	63025	63026	63031	63033
63034	63038	63040	63042	63043	63044	63049	63069

63074	63088	63101	63102	63103	63104	63105	63106
63107	63108	63109	63110	63111	63112	63113	63114
63115	63116	63117	63118	63119	63120	63121	63122
63123	63124	63125	63126	63127	63128	63129	63130
63131	63132	63133	63134	63135	63136	63137	63138
63139	63140	63141	63143	63144	63145	63146	63147

11.11.B ELIGIBILITY FOR PACE

The PACE program is one more option along the continuum of long-term care services available under the Department of Health and Senior Services' (DHSS) "Missouri Care Options" (MCO) program, which offers a variety of home and community-based services to prevent or delay entry into a nursing facility. PACE targets individuals who require services above and beyond the standard package of in-home services available through MCO. The DHSS is the entry point for assessment for PACE program eligibility and referral to the PACE provider. Referrals for the program may be made to the DHSS office in St. Louis by calling (314) 340-7300.

The target population for this program includes individuals age 55 and older, identified by DHSS through a health status assessment with a score of at least 21 points on the nursing home level of care assessment; and who reside in the service area.

11.11.C INDIVIDUALS NOT ELIGIBLE FOR PACE

Individuals *not* eligible for PACE enrollment include:

- persons who are under age 55;
- persons residing in a State Mental Institution or Intermediate Care Facility for the Mentally Retarded (ICF/MR);
- persons enrolled in the Managed Care program;
- persons currently enrolled with a MO HealthNet hospice provider;

11.11.D LOCK-IN IDENTIFICATION OF PACE INDIVIDUALS

When a DHSS-assessed individual meets the program criteria and chooses to enroll in the PACE program, the PACE provider has the individual sign an enrollment agreement and the DHSS locks the individual into the PACE provider for covered PACE services. Lock-in information is available to providers through the Internet and Interactive Voice Response (IVR) at (573) 635-8908. A PACE Lock-In Provider is recognized by an "89" provider number. Enrollment in a PACE program is always voluntary and participants have the option to disenroll and return to the fee-for-service system at any time.

11.11.E PACE COVERED SERVICES

Once the individual is locked into the PACE provider, the PACE provider is responsible for providing the following covered PACE services;

- physician, clinic, advanced practice nurse, and specialist (ophthalmology, podiatry, audiology, internist, surgeon, neurology, etc.);
- nursing facility services;
- physical, occupational, and speech therapies (group or individual);
- non-emergency medical transportation (including door-to-door services and the ability to provide for a companion to travel with the client when medically necessary);
- emergency transportation;
- adult day health care services;
- optometry and ophthalmology services including eye exams, eyeglasses, prosthetic eyes, and other eye appliances;
- audiology services including hearing aids and hearing aid services;
- dental services including dentures;
- mental health and substance abuse services including community psychiatric rehabilitation services;
- oxygen, prosthetic and orthotic supplies, durable medical equipment and medical appliances;
- health promotion and disease prevention services/primary medical care;
- in-home supportive care such as homemaker/chore, personal care and in-home nutrition;
- pharmaceutical services, prescribed drugs, and over the counter medications;
- medical and surgical specialty and consultation services;
- home health services;
- inpatient and outpatient hospital services;
- services for chronic renal dialysis chronic maintenance dialysis treatment, and dialysis supplies;
- emergency room care and treatment room services;
- laboratory, radiology, and radioisotope services, lab tests performed by DHSS and required by law;
- interdisciplinary assessment and treatment planning;

- nutritional counseling;
- recreational therapy;
- meals;
- case management, care coordination;
- rehabilitation services;
- hospice services;
- ambulatory surgical center services;
- other services determined necessary by the interdisciplinary team to improve and maintain the participants overall health status.

No fee-for-service claims are reimbursed by MO HealthNet for participants enrolled in PACE.

Services authorized by MHD prior to the effective enrollment date with the PACE provider, are the responsibility of MHD. All other prior authorized services *must* be arranged for or provided by the PACE provider and are *not* reimbursed through fee-for-service.

END OF SECTION

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