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State/Territory Name: Missouri

State Plan Amendment (SPA) #: MO-23-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

May 14, 2024

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

Dear Todd Richardson:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) MO-23-0011, submitted on October 3, 2023, with additional information received on April 30, 2024, has been approved. The SPA has effective dates of January 1, 2023, and September 1, 2023.

This SPA updates the CHIP state plan to remove the state's premium assistance program as of January 1, 2023. The state also makes non-substantive updates to its CHIP state plan to more clearly reflect existing policies including but not limited to updates to the state's performance goal strategic objectives, covered benefits for each of Missouri's CHIP populations and to specify its previously approved 90-day lock-out period. The updates are effective September 1, 2023.

Your Project Officer is Carrie Grubert. Carrie is available to answer your questions concerning this amendment and other CHIP-related matters. Carrie's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8319
E-mail: Carrie.Grubert@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Sarah deLone/

Sarah deLone
Director

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Missouri
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b)) _____ (Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Robert Knodell Position/Title: Director, Department of Social Services

Name: Todd Richardson Position/Title: Director, MO HealthNet Division

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP

SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)

6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the

opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

Response:

[1]SCHIP 1: Children under age 1	Children in families with incomes of more than 196% but less than 300% FPL
[1]SCHIP 1: Children ages 1 through 5	Children in families with incomes of more than 151% but less than 300% FPL
[2]SCHIP 2: Children ages 1 through 5	Children in families with incomes more than 133% but less than 151% FPL

[1]SCHIP 1: Children ages 6 through 18	Children in families with incomes of more than 151% but less than 300% FPL
[2]SCHIP 2: Children ages 6 through 18	Children in families with incomes of more than 100% but less than 151% FPL

[1.] Separate SCHIP Program
[2.] Medicaid Expansion Program

As a result of the passage of Senate Bill (SB) 577 during Missouri's 94th Legislative Session in 2007, Missouri's Medical Assistance Program, formerly known as Missouri Medicaid, is now known as MO HealthNet. The title of the Division of Medical Services is now known as the MO HealthNet Division.

Presumptive Eligibility
Missouri provides presumptive eligibility for children in families with income of 150% of FPL or below until an eligibility decision is made. Missouri proposes that uninsured children age birth through age 18 with family income below 150% of the Federal Poverty Level (FPL) be covered under the MO HealthNet expansion.

Presumptive Eligibility for Show-Me Healthy Babies Program

Missouri provides presumptive eligibility until an eligibility decision is made to pregnant women with household income up to 300% of the federal poverty level (FPL) who do not otherwise qualify for another MO HealthNet Program. Self-attestation of pregnancy will be accepted when making determinations and there will be no waiting period for coverage to begin.

SCHIP 2
Children eligible for SCHIP 2 will receive the MO HealthNet package of essential medically necessary health services, including Non-Emergency Medical Transportation (NEMT). Prescription drugs will be subject to the national drug rebate program requirements. No new eligible will be excluded because of pre-existing illness or condition.

SCHIP 1
Children eligible for SCHIP 1 are uninsured children under age 1 with family income more than 196% but less than 300% of FPL and uninsured children age 1 through age 18 with family income between 151% and 300% of the federal poverty level be covered under a Separate Child Health Program. No new eligible is excluded because of pre-existing illness or condition. Children in

families with income above 150% of FPL are not eligible if they have access to affordable insurance.

Children eligible for SCHIP 1 will receive a benefit package of essential medically necessary health services, excluding Non-Emergency Medical Transportation (NEMT). Prescription drugs are subject to the national drug rebate program requirements. This benefit is so unheard of in any health insurance plan that its inclusion serves as a significant incentive for dropping of private coverage.

A joint application is used to apply for the federal/state Title XIX and Title XXI programs.

SCHIP 1 requires a premium, but does not impose co-payments, co-insurance, or deductibles.

SCHIP 1 requires children to be uninsured for six months prior to enrollment, except for children with special health care needs or when good cause for dropping insurance is found.

Show-Me Healthy Babies

Effective January 1, 2016, Missouri established the Show-Me Healthy Babies Program as a separate Children's Health Insurance Program (CHIP) for targeted low-income pregnant women and unborn children from conception to the date of birth with household incomes up to 300% of the FPL. The pregnant women shall not be otherwise eligible for coverage under the Medicaid Program, as it is administered by the State, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child.

Targeted low-income pregnant women and unborn children will receive a benefit package of essential, medically necessary health services identical to the MO HealthNet for Pregnant Women benefit package.

The unborn child's coverage period will be from date of application to birth.

For targeted low-income pregnant women and targeted low-income children, postpartum coverage will begin on the day the pregnancy ends and extend through the last day of the 12th month after the pregnancy ends.

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template.

(Section 2110(b)(5))

1.2. ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Response:

Original Plan
Effective Date: September 1, 1998
Implementation Date: September 1, 1998

SPA # 1 Compliance with final SCHIP regulations
Effective Date: September 1, 2002
Implementation Date: September 1, 2002

SPA #2: Passage of House Bill 1453
Effective Date: July 1, 2004
Implementation Date: July 1, 2004

SPA #3 Combination SCHIP - Section 1115 MC+ Demonstration
Effective Date: September 1, 2007
Implementation Date: September 1, 2007

SPA #5 Changes in Premiums - Additional Purchase Options for HIPP
Effective Date: May 1, 2009
Implementation Date: May 1, 2009

SPA #6 Exempt Temporary Income for the Decennial Census
Effective Date: July 1, 2009
Implementation Date: July 1, 2009

SPA #8 Implement the Health Services Initiative (HIS) to fund four programs
Effective Date: July 1. 2011
Implementation Date: July 1, 2011

SPA – MO-13-0021-MM1 & MO-13-0021-A – MAGI Eligibility Groups
Effective Date: December 31, 2013
Implementation Date: December 31, 2013

SPA – MO-14-0015-MM4 – Single State Agency
Effective Date: January 1, 2014
Implementation Date: January 1, 2014

SPA – MO-14-0017 – XXI Medicaid Expansion
CS3: Eligibility for Medicaid Expansion Program
Effective Date: January 1, 2014
Implementation Date: January 1, 2014

SPA – MO-14-0018-MC1 – MAGI Eligibility & Methods
CS7: Eligibility – Targeted Low Income Children
CS15: MAGI-Based Income Methodologies
Effective Date: January 1, 2014
Implementation Date: January 1, 2014

SPA – MO-14-0019 – MAGI Eligibility and Methods
CS14: Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards
Effective Date: January 1, 2014
Implementation Date: January 1, 2014

SPA – MO-14-0020 – MC5 – Non-Financial Eligibility
CS17: Non-Financial Eligibility – Residency
CS18: Non-Financial Eligibility – Citizenship
CS19: Non-Financial Eligibility – SSN
Effective Date: January 1, 2014

Implementation Date: January 1, 2014

CS20: Non-Financial Eligibility – Substitution of Coverage
CS21: Non-Payment of Premiums
Effective Date: September 1, 2014
Implementation Date: September 1, 2014

SPA – MO-14-0021 – MAGI ACA
CS24: General Eligibility – Eligibility Processing
Effective Date: October 1, 2013
Implementation Date: October 1, 2013

SPA - MO-15-0009 – Low-Income Pregnant Women and Unborn Children Coverage
Effective Date: January 1, 2016
Implementation Date: January 1, 2016

SPA – MO-15-0010 – MAGI Eligibility & Methods
CS8: Eligibility – Targeted Low Income Pregnant Women
CS9: Eligibility – Coverage from Conception to Birth
CS13: Eligibility – Deemed Newborns
Effective Date: January 1, 2016
Implementation Date: January 1, 2016

SPA – MO-15-0011 – Non-Financial Eligibility
CS29: General Eligibility – Presumptive Eligibility for Pregnant Women
Effective Date: January 1. 2016
Implementation Date: January 1, 2016

SPA – MO-17-0002 Statewide Managed Care
Effective Date: May 1, 2017
Implementation Date: May 1, 2017

SPA – MO-18-0015 Mental Health Parity
Effective Date: July 1, 2017
Implementation Date: July 1, 2017

SPA – MO-19-0014 Managed Care Final Rule
Effective Date: July 1, 2018
Implementation Date: July 1, 2018

SPA – MO-20-0015 SUPPORT Act
Effective Date: October 24, 2019

Implementation Date: October 24, 2019

SPA – MO-20-0017 Health Services Initiative
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

SPA – MO-20-0011 CHIP Disaster Relief SPA
Effective Date: March 1, 2020
Implementation Date: March 1, 2020

SPA – MO-20-0031 Non-Financial Eligibility
CS29: General Eligibility – Presumptive Eligibility for Pregnant Women
Effective Date: October 1, 2021
Implementation Date: October 1, 2021

SPA – MO-22-0034 CHIP ARP SPA
Effective Date: March 11, 2021
Implementation Date: December 21, 2022

SPA – MO-23-0021 12-month Postpartum Coverage for Pregnant Women
CS27: Postpartum covered for Pregnant Women
Effective Date: July 7, 2023
Implementation Date: July 7, 2023

SPA – MO-23-0011 – CHIP SPA Update
Effective Date: September 1, 2023
Implementation Date: September 1, 2023

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Response: In October 2021, CMS informed the MO HealthNet Division that Missouri has an Urban Indian Organization in Kansas City, Missouri. The organization is called the Kansas City Indian Center (KCIC). MHD met with KCIC on February 2, 2022 to establish the consultation process. Missouri sent a Tribal Consultation Letter to KCIC on May 1, 2023, informing them of this SPA submittal.
TN No: 23-0011; Approval Date: 5/15/2023; Effective Date: 05/01/2023

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Historical Data

Response: Information regarding age, income, coverage by other health insurance, and location is currently available from Missouri's Application for Benefits and will be required for Title XXI applicants. The State will require that any recipient cooperate fully with the state and federal government in establishing eligibility and in providing any verification necessary as requested by the State in the initial application process or at any subsequent time. Title XXI recipients will have distinct ME codes for tracking purposes. Please see Attachment 1.

Unfortunately, the extant data is quite limited. We summarize the available data below:

Missouri does not conduct its own recurring prevalence study for health insurance among resident children. However, the Missouri Department of Health and Senior Services (DHSS) commissioned a study in 2004 under a State Health Planning Grant from the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services

(DHSS). This study, the Missouri Health Care Insurance and Access (MHCIA) survey, asked questions regarding health insurance coverage of roughly 7,000 respondents. The survey found that the rate of uninsurance among Missouri children under age 19 was 3.4 percent (no standard error or confidence interval reported). The MHCIA study also reported a slightly higher rate (4.0 percent) among children in households with incomes below 300 percent of the federal poverty level. However, the sample size was too small to generate meaningful rates for additional subpopulations. The MHCIA report noted that, "Missouri's public programs cover a larger proportion of children (28.5%), while rates of group (63.9%) and individual coverage (4.2%) for children are similar to the rates of the adult population." The one-year nature of the study prohibits any trending or longitudinal analyses. For additional information, see http://www.dhss.mo.gov/DataAndStatisticalReports/MissouriFinal_Report.pdf. Note: The Missouri Foundation for Health analyzed and compared estimates from the CPS and the MHCIA surveys; its report is available at http://www.mffh.org/ShowMe8-final.pdf.

- The Census Bureau's annual Current Population Survey (CPS), specifically the Annual Social and Economic Supplement (ASEC), also provides information about health insurance status based on a survey of approximately 78,000 households nationally. For 2006, the CPS estimate for the rate of uninsured children in households with income under 200% of the federal poverty level was 33.4 percent (+/– 5.9%). Because of the relatively small sample size, the calculated rates of uninsured children by sex, race, age, etc. have such large confidence intervals that the individual point estimates are essentially without meaning and may prove highly misleading. For additional information, see http://www.census.gov/cps/.

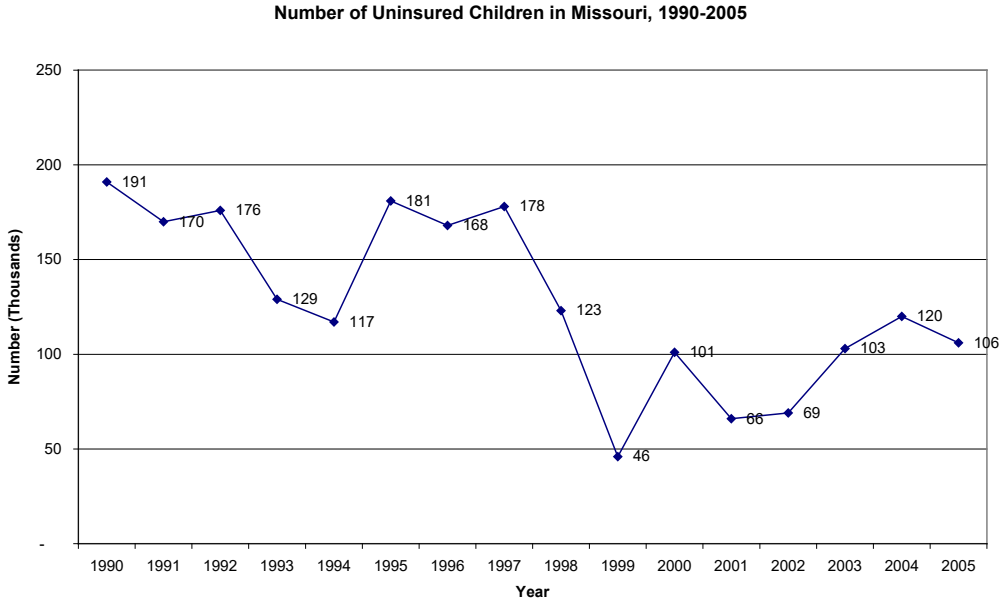
Given the paucity of data, we are unable to present the rate of uninsured children in Missouri stratified by sex, race, age, etc. (because the width of the confidence intervals would make any point estimates essentially meaningless).

With respect to the changes in the health insurance status of Missouri children since the SCHIP program went into effect in 1999, we evaluated the Census Bureau's historical CPS data:

- Looking at the most recent data, the rate of uninsured children in Missouri

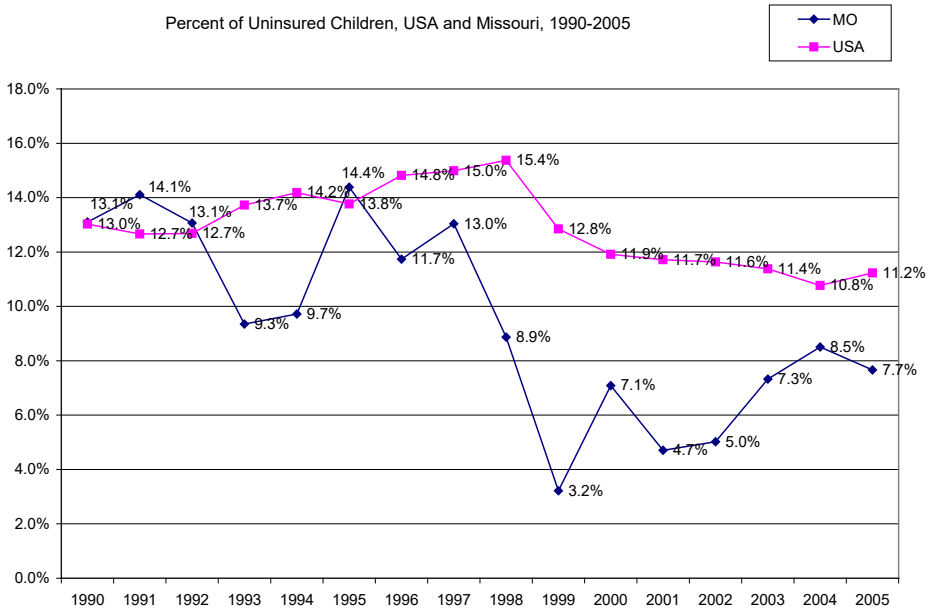
appears to have fluctuated somewhat over the past three years. The 2005 rate of 7.6 percent is down from the 2004 rate of 8.5 percent but still up from the 2003 rate of 7.3 percent. The rate continues to be about one-third less than the national average of 11.2 percent (see Figures 1 and 2).

Figure 1



Source: U.S. Census Bureau, Historical Health Insurance Tables, Table HI-5. Health Insurance Coverage by State -- Children Under 18: 1990 to 2005. Available at: http://www.census.gov/hhes/hlthins/historic/hihistt5.html.

Figure 2



Source: U.S. Census Bureau, Historical Health Insurance Tables, Table HI-5. Health Insurance Coverage by State -- Children Under 18: 1990 to 2005. Available at: http://www.census.gov/hhes/hlthins/historic/hihistt5.html.

- Taking a longer-term view, Missouri has made great strides in reducing the number of uninsured children since the mid-1990's. The average rate during the seven years prior to full implementation of the 1115 Waiver (1992-1998) is nearly twice as high as the average rate during the seven year period since implementation of the 1115 Waiver (1999-2005): the average rates for these two periods are 11.5 percent and 6.2 percent, respectively. The lower average rate since 1999 is at least partly attributable to the 1115 Waiver, which has provided insurance coverage to children who were either previously uninsured or had lost other coverage and would be uninsured in the absence of the 1115 Waiver.

For reference, additional information about the Waiver during this period is available in the "Evaluation of the Missouri Section 1115 Waiver, 2004-05," which is available http://dss.mo.gov/dms/mc/pdf/eval_1115_04-05.pdf. Specifically, see Research Question #1.

As a proxy for the rate of uninsured children in Missouri by race, we analyzed inpatient discharges in Missouri among children under age 15. This indicator is useful because Missouri hospitals routinely collect and report these data for all patients.

Additionally, because inpatient utilization is rarely elective, these data are indicative of the underlying prevalence of payers in Missouri.

Accordingly, we used data reported in the Missouri Information for Community Assessment (MICA) to generate:

- Rates of such discharges by payer by year (see Table 1);
- Rates of such discharges among self-pay patients by race by year (see Table 2); and
- Two-year rates of such discharges among self-pay patients by race by sex (see Table 3).

Please note that "Self-Pay, Etc." in Table 1 includes the following responses: self-pay, unknown, and other. Table 2 includes data for only those indicating "self-pay" as their payer.

Based on our analyses, it seems that the rate of inpatient discharges among self-pay children has increased consistently for all races and sexes since 2002. This change largely reversed the earlier declines. Additionally, it appears that the self-pay population remains sizeable and appears to be using, on average, increasing levels of inpatient utilization. However, we are unable to extrapolate from these data any changes in the demographic composition of the population of uninsured children in Missouri.

Table 1

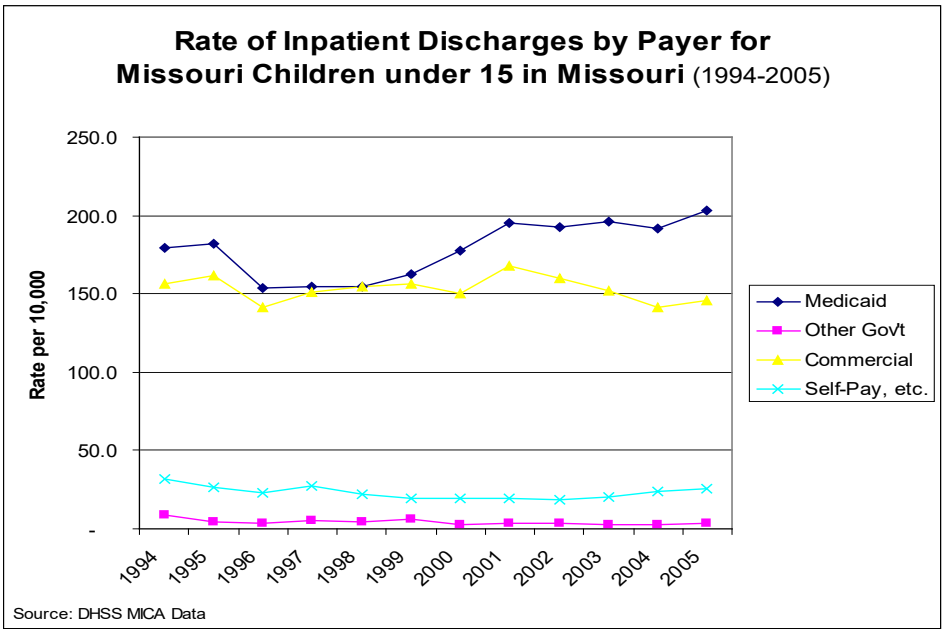


Table 2

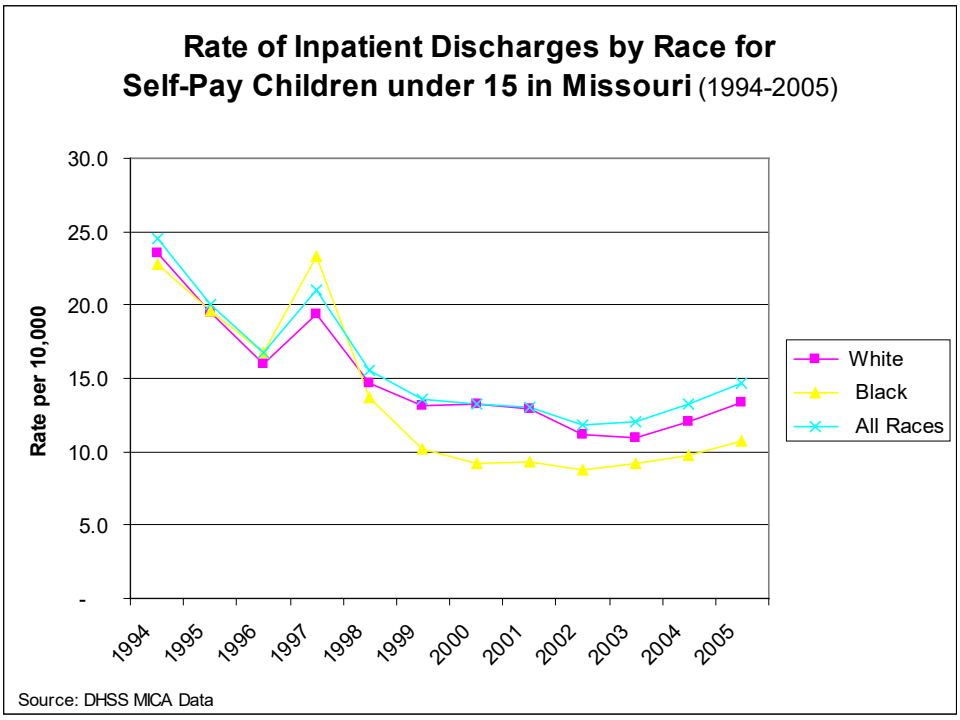
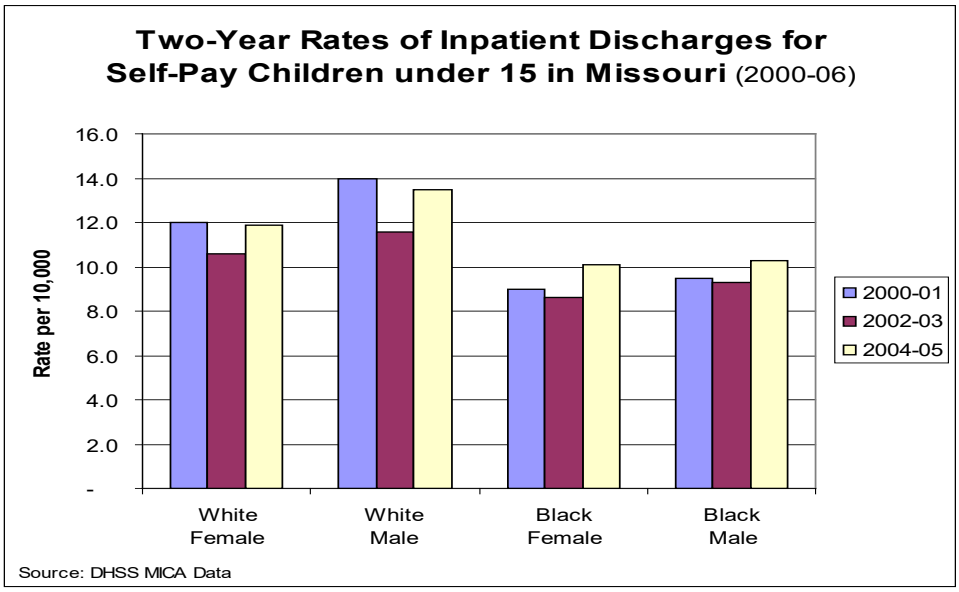


Table 3



Our analysis of Current Population Survey (CPS) data indicates approximately 1.35 million (or 92 percent) Missouri children age 18 and under had some form of creditable coverage during the year. Of those with creditable coverage, approximately 1.02 million (about three-quarters) had some form of private insurance. Employer-sponsored insurance (ESI) constitutes over 90 percent of the private coverage among Missouri children. For reference, the total population of children age 18 and under in Missouri is approximately 1.46 million. Tables 1 and 2 provide break-downs of the CPS data by poverty level, race, and sex for (i) children insured and (ii) all children in Missouri, respectively.

Looking specifically at the target population, the CPS data suggest that roughly 730,000 (or close to 90 percent) of Missouri children under 300 percent of the federal pove1ty level had some form of creditable coverage during the year. Of these, about 430,000 (roughly 60 percent) were privately-insured. As with the general population, about 90 percent of privately-insured children in the target population accessed coverage through ESL. Table 3 provides a summary of these data by poverty level.

The estimates above are three-year averages derived from data collected as part of the Annual Social and Economic Supplement (ASEC) from 2004 to 2006. Because of the relatively small sample sizes, the calculated rates of insured children by poverty level, race, and sex have quite large confidence intervals; consequently, some of the individual point estimates may prove highly misleading. For additional information, see http://www.census.gov/cps/.

Table 1: Missouri Children (age 18 and under) with Creditable Coverage

Poverty Threshold	Total	White alone	Black/ African Amer alone	Amer Indian/ Alaska Native alone	Asian alone	Native Hawaiian/ Other PI alone	Two or more races
All Income Levels							
Totals	1,351,245	1,100,440	192,921	4,363	11,498	337	41,687
Male	674,513	547,606	94,633	2,720	7,598	337	21,620
Female	676,732	552,834	98,288	1,643	3,900	0	20,067
Below 100%							
Totals	212,552	130,472	73,620	817	1,427	0	6,215
Male	99,589	60,112	35,107	817	435	0	3,118
Female	112,963	70,361	38,512	0	992	0	3,098
100% to below 200%							
Totals	248,364	193,166	44,731	1,710	2,533	337	5,887
Male	127,146	102,184	20,701	1,454	1,062	337	1,407
Female	121,218	90,982	24,030	256	1,471	0	4,479
200% to below 300%							
Totals	270,927	216,026	40,696	301	1,576	0	12,328
Male	139,112	110,950	18,243	0	1,120	0	8,798
Female	131,815	105,076	22,453	301	455	0	3,530
300% to below 400%							
Totals	234,519	200,738	24,154	428	946	0	8,252
Male	112,685	93,515	14,991	0	542	0	3,637
Female	121,834	107,223	9,163	428	404	0	4,616
400% to below 500%							
Totals	152,132	141,519	4,707	659	3,182	0	2,065
Male	82,148	75,632	3,088	0	2,605	0	822
Female	69,984	65,888	1,618	659	577	0	1,242
500% and above							
Totals	232,751	218,517	5,012	449	1,833	0	6,940
Male	113,834	105,213	2,501	449	1,833	0	3,838
Female	118,918	113,305	2,511	0	0	0	3,102

Source: U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2004 through 2006

Table 2: Missouri Children (age 18 and under) - Total

Poverty Threshold	Total	White alone	Black/ African Amer alone	Amer Indian/ Alaska Native alone	Asian alone	Native Hawaiian/ Other PI alone	Two or more races
All Income Levels							
Totals	1,463,297	1,186,760	210,554	7,377	13,697	337	44,571
Male	735,256	595,516	103,502	4,024	9,039	337	22,838
Female	728,041	591,244	107,052	3,353	4,658	0	21,733

Below 100%							
Totals	***243,576***	***156,701***	***77,169***	***817***	***1,863***	***0***	***7,026***
Male	***117,274***	***74,995***	***37,111***	***817***	***871***	***0***	***3,480***
Female	***126,302***	***81,706***	***40,058***	***0***	***992***	***0***	***3,546***
100% to below 200%							
Totals	***287,832***	***218,887***	***54,739***	***3,252***	***3,182***	***337***	***7,434***
Male	***148,624***	***116,479***	***25,602***	***2,758***	***1,711***	***337***	***1,737***
Female	***139,208***	***102,409***	***29,137***	***494***	***1,471***	***0***	***5,697***
200% to below 300%							
Totals	***294,041***	***235,610***	***43,700***	***301***	***1,576***	***0***	***12,854***
Male	***151,849***	***121,196***	***20,208***	***0***	***1,120***	***0***	***9,324***
Female	***142,192***	***114,414***	***23,491***	***301***	***455***	***0***	***3,530***
300% to below 400%							
Totals	***244,238***	***207,912***	***25,227***	***1,900***	***946***	***0***	***8,252***
Male	***117,942***	***98,772***	***14,991***	***0***	***542***	***0***	***3,637***
Female	***126,296***	***109,140***	***10,236***	***1,900***	***404***	***0***	***4,616***
400% to below 500%							
Totals	***158,206***	***146,478***	***4,707***	***659***	***4,297***	***0***	***2,065***
Male	***84,488***	***77,615***	***3,088***	***0***	***2,962***	***0***	***822***
Female	***73,718***	***68,863***	***1,618***	***659***	***1,335***	***0***	***1,242***
500% and above							
Totals	***235,404***	***221,171***	***5,012***	***449***	***1,833***	***0***	***6,940***
Male	***115,080***	***106,459***	***2,501***	***449***	***1,833***	***0***	***3,838***
Female	***120,325***	***114,712***	***2,511***	***0***	***0***	***0***	***3,102***

Source: U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2004 through 2006

Type of Coverage among Insured Missouri Children < 300% FPL

	Total	Insured	Health Insurance: Private Insurance	Health Insurance: Employment-Based Insurance
Totals	1,463,297	1,351,245	1,021,216	937,014
Below 100%	243,576	212,552	46,899	38,147
100% to below 200%	287,832	248,364	147,768	131,685
200% to below 300%	294,041	270,927	233,645	210,127
300% to below 400%	244,238	234,519	224,371	211,942
400% to below 500%	158,206	152,132	140,453	129,561
500% and above	235,404	232,751	228,080	215,552
Subtotal: < 300% FPL	825,449	731,843	428,312	379,959

Source: U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2004 through 2006.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

Response: Pursuant to Section 2105(a)(1)(D)(ii), Missouri will offer "Health Services Initiatives" under the plan. The Health Services Initiatives (HIS) will be activities for improving the health of children that are administered by Local Public Health Agencies (LPHAs) and funded by local and state funds. HSI funds will be the payor of last resort and when a service is eligible for reimbursement under Medicaid or another federal grant it will be billed to that grant. Local Public Health Agencies will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds. LPHAs will also be able to provide health education to audiences that may be broader than children under 19, but the LPHAs will ensure that HSI funds are only claimed based on the portion of children under the age of 19 in the community using a reasonable methodology.

Specific Health Services Initiatives may include the following programs:

1. Immunization programs

LPHAs provide a vital role in immunizing our children and promoting immunization among hard to reach families and communities. Immunization program costs are operational (staff related) costs only. The vaccines costs for CHIP 2 are funded through the Vaccines for Children (VFC) program; therefore the costs of the vaccines are not included in the CHIP claiming. The immunization program costs claimed under CHIP are net of revenue obtained from billing Medicaid and other insurers for administrative costs. Children enrolled in CHIP 1 are not eligible for vaccines through the VFC program.

2. Lead testing and prevention programs

LPHAs are at the forefront of monitoring and managing lead poisoning among children up to the age of six. Lead program costs include educating families about lead poisoning, testing, and case management services. The lead related program costs claimed under CHIP are net of applicable credits.

3. Newborn programs

LPHAs offer a variety of services to newborns and their parents, including newborn care education and support to high risk families, and pre-natal care management. These services can be provided in health facilities, families' homes, and/or other settings.
Clinical staff and other trained professionals provide a range of services to young families to ensure the healthy development of infants and toddlers.

4. Screening, Diagnosis and Education of Public Health Issues

LPHAs provide health related services to children under the age of 19 in a wide variety of settings, including health department facilities, schools, preschools, day care centers, churches, community centers, homes and other settings. Services include health education, screenings, diagnosis, maintenance of health records, basic nursing services and referrals as needed to other health care providers. These services are distinct and different from the services provided in schools as part of special education services authorized under IDEA.

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Response:

Section 1902(a)(73) of the Social Security Act requires any state with one or more Indian Health Programs or Urban Indian Organizations that furnish health care services, provide for a process under which the state seeks advice on a regular basis on matters prior to submission of any state plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. In October 2021, CMS informed MO HealthNet Division that Missouri has an Urban Indian Organization in Kansas City, Missouri. The organization is called the Kansas City Indian Center (KCIC). MHD met with KCIC on February 2, 2022 to establish the consultation process.

For changes that directly impact their organization or Native American enrollees, the State of Missouri will send all federally-recognized tribes, Indian Health Programs and Urban Indian Organizations (UIO) within the State of Missouri an electronic notification for all Medicaid and CHIP state plan amendments, waiver requests and demonstration project proposals prior to submission to CMS in order for tribal/UIO leaders to provide feedback. The notification will describe the purpose of the state plan amendment(s), waiver request(s) or demonstration project proposal(s), the anticipated impact on the UIO or Native American enrollees and provide information regarding the process for which to provide comments. The notification will provide a 30 day time period for review and comment.

For changes that the State determines do not directly impact the UIO or Native American enrollees, the State will still provide an email notification. The email will notify the UIO that a direct impact is not anticipated, but a review of the proposals and comments would still be welcome.

If a state plan amendment, waiver request or project proposal needs to be submitted to CMS under circumstances that would require less than 30 days' notice, the State will notify the UIO, via a phone call and a follow-up electronic notification. This notice will include a description of state plan amendment, waiver request or demonstration project proposal. It will either describe the process and time period for review and submission of comments or describe any other agreed upon process specific to the situation requiring

less than 30 days' notice.

Section 3. Methods of Delivery and Utilization Controls

☐ 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 4 (Eligibility Standards and Methodology).

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☐ Yes, the State uses a managed care delivery system for all CHIP populations.

☒ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed

care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Response: Enrollment in MO HealthNet Managed Care is mandatory statewide for SCHIP 1 and SCHIP 2 eligibles. When SCHIP 1 and SCHIP 2 are newly eligible they receive their enrollment through the Fee for Service delivery system until their enrollment with an MCO is effective. SCHIP 1 and SCHIP 2 eligibles may request to opt out of Managed Care if their initial condition changes and they meet the following criteria:

- Are eligible for Supplemental Security Income (SSI) (Title XVI of the Act),
- Meet the SSI disability definition as determined by the Department of Social Services,
- Are a child with special health care needs (Section 501(a)(1)(D) of the Act),
- Are disabled and 18 or younger (Section 1902 (e)(3) of the Act),

If any of these criteria are met, the eligible's Medicaid eligibility category will change to a non-SCHIP category.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and

delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))

- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☐ No
☒ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

Response: Pharmacy, Comprehensive Substance Abuse Treatment Services, Tobacco Cessation, Applied Behavioral Analysis, School-based Direct Services, and Transplant Services.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
  ☒ Capitation payment

Response: Missouri pays each MCO a per member per month (PMPM) to cover all services required under the comprehensive benefit package except for carved out services.

Describe population served:

Response: The PMPM is paid for all SCHIP 1 and SCHIP 2 eligible enrolled with an MCO.

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☐ Other (please explain)
  Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

☐ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☐ Other (please explain)
  Describe population served:

☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Other (please explain)

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
- ☐ Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line
☐ Development of enrollee care plans

- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State
- ☐ Provision of enrollee outreach and education activities
- ☐ Operation of a customer service call center
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
- ☐ Coordination with behavioral health systems/providers
- ☐ Other (please describe)

3.1.2.2 ☒ The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

☐ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services

to enrollees).

- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 ☒ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 ☒ The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 ☒ The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

☒ Based on public or private payment rates for comparable services for comparable populations; and
☒ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

Guidance: States that checked both boxes under 3.3.1 above do not need to make the next assurance. If the state is unable to check both boxes under 3.1.1 above, the state must check the next assurance.

☐ If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

3.3.2 ☒ The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 ☒ The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 ☒ The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

☐ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
☒ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
☐ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay a remittances but not a dental PAHP, please include this information.

If the answer to the assurance above is yes for any or all managed care entities,

please answer the next assurance:

☒ The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 ☒ The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

☒ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 ☒ The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 ☒ The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

☒ Yes
☐ No

If the State uses a default enrollment process, please make the following assurances:

☒ The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

☒ The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 ☒ The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 ☒ The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 ☒ If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section

1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

☒ The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

☒ Yes
☐ No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

☒ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

☒ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

☒ The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 ☒ The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 ☒ The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 ☒ The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 ☒ The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 ☒ The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 ☒ The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and

PCCM entity to notify its enrollees:
- That oral interpretation is available for any language and written translation is available in prevalent languages;
- That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
- How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;
- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO,

PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☒ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:

- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;

- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for emergency services; and
  - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process; and
  - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including

specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 ☐ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

Response: Pharmacy is carved out of Managed Care and paid through the Fee-for-Service Program. The state posts the following:

Drugs with Coverage Limitations and New Drug Review
https://dss.mo.gov/mhd/cs/pharmacy/pages/frequpdat.htm
Pharmacy Clinical Edits and Preferred Drug List
https://dss.mo.gov/mhd/cs/pharmacy/pages/clinedit.htm
PDL Searchable Database
https://mopdl.gainwelltechnologies.com/

3.5.15 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).

3.5.16 ☒ The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 ☒ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.

3.5.18 ☒ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

Guidance: The State should also complete Section 3.10 (Program Integrity).

3.6.1 ☒ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☒ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☒ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete the remaining assurances in Section 3.6 (3.6.4 through 3.6.20.

3.6.4 ☒ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.5 ☒ The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

3.6.6 ☒ The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

3.6.7 ☒ The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 ☒ The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;

- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☒ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☒ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☒ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the

enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

3.6.14 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 ☒ The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 ☒ The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;

- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity's services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

3.6.17 ☒ The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 ☒ The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 ☒ The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 ☒ The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

3.7.1 ☒ The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.7 (3.7.2 through 3.7.9).

3.7.2 The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

- ☒ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
- ☒ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
- ☒ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
- ☒ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- ☒ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the subcontractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- ☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- ☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written

agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and

☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 ☒ The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 ☒ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 ☒ The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State

has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 ☒ The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 ☒ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☒ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete Section 3.9. States with PCCMs and/or PCCM entities should be adhering to the State's review process for benefits.

3.9.1 ☒ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☒ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☒ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

☐ Yes
☒ No

Guidance: Only states that answered yes to assurance 3.9.4 need to complete the next assurance (3.9.5).

3.9.5 ☐ The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 ☒ The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 ☒ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 ☒ The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 ☒ The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 ☒ The State assures that the notice of an adverse benefit determination explains:

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical

necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

3.9.11 ☒ The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 ☒ The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

☒ Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

☒ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

☒ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

☒ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

☒ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of

the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

☒ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☒ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 ☒ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 ☒ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 ☒ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☒ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires

and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☒ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☒ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☐ The State assures that if it offers an external medical review:

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

Response: Missouri does not offer an external medical review.

3.9.24 ☒ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

3.9.25 ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26 ☒ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 ☒ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

Guidance: The State should complete Section 11 (Program Integrity) in addition to Section 3.10.

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the first seven assurances (3.10.1 through 3.10.7).

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management

arrangements or procedures designed to safeguard against fraud and abuse, including:

☒ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;

☒ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and

☒ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☒ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☒ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☒ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the

termination of the provider agreement with the MCO, PIHP or PAHP;

- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 ☒ The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

3.10.6 ☒ The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 ☒ The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

3.10.8 ☒ The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))

3.10.9 ☒ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 ☒ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 ☒ The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

- ☒ Encounter data in the form and manner described in 42 CFR 438.818.
- ☒ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
- ☒ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- ☒ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- ☒ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
- ☒ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

☒ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

☒ It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

☒ It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 ☒ The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 ☒ The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3).

Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

3.11.1 ☒ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 ☒ The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 ☒ The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

Guidance: Only states with PCCMs, or PCCM entities need to answer the next assurance (3.11.4).

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

☐ Yes
☐ No

Guidance: Only states with MCOs and states that answered yes to assurance 3.11.4 need to complete the next three assurances (3.11.5 through 3.11.7).

3.11.5 ☒ The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 ☒ The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 ☒ The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

Guidance: The State should complete Sections 7 (Quality and Appropriateness of Care) and 9 (Strategic Objectives and Performance Goals and Plan Administration) in addition to Section 3.12.

Guidance: States with MCO(s), PIHP(s), PAHP(s), or certain PCCM entity/ies (PCCM entities whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes - see 42 CFR 457.1240(f)) - should complete the applicable sub-sections for each entity type in this section, regarding 42 CFR 457.1240 and 1250.

3.12.1 Quality Strategy

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities need to complete section 3.12.1.

3.12.1.1 ☒ The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;

- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 ☒ The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 ☒ The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

3.12.1.4 ☒ The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 ☒ The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).

3.12.1.6 ☒ The State assures that it will submit to CMS:

- A copy of the initial quality strategy for CMS comment and feedback

prior to adopting it in final; and

- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☒ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:

- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 ☒ The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next two assurances (3.12.2.1.1 and 3.12.2.1.2).

3.12.2.1.1 ☒ The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization

of services; and

- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

Guidance: A State may request an exemption from including the performance measures or performance improvement programs established by CMS under 42 CFR 438.330(a)(2), by submitting a written request to CMS explaining the basis for such request.

3.12.2.1.2 ☒ The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and

- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.2.2.

3.12.2.2.1 ☒ The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 ☒ The State assures that it annually requires each MCO, PIHP, and PAHP to:
1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 ☒ The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:
- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.3.

3.12.3.1 ☒ The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received

accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).

3.12.3.2 ☒ The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.4.

☒ The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for comment, has identified performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5 and 3.12.5.1.

☒ The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 ☒ The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 ☒ The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next three assurances (3.12.5.2.1 through 3.12.5.2.3). Under 42 CFR 457.1250(a), the State, or its agent or EQRO, must conduct the EQR-related activity under 42 CFR 438.358(b)(1)(iv) regarding validation of the MCO, PIHP, or PAHP's network adequacy during the preceding 12 months; however, the State may permit its contracted MCO, PIHP, and PAHPs to use information from a private accreditation review in lieu of any or all the EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

3.12.5.2.1 ☒ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 ☐ The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

Response: Missouri has not elected to use non-duplication for the three Mandatory EQR-related activities.

3.12.5.2.3 ☐ The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

Response: Missouri has not elected to use non-duplication for the three Mandatory EQR-related activities.

Guidance: Only states with PCCM entities need to complete the next assurance (3.12.5.2.4).

3.12.5.2.4 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5.3.

3.12.5.3.1 ☒ The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 ☒ The State assures that only a qualified EQRO will produce the

EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 ☒ The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

3.12.5.3.4 ☒ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;

- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☒ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☒ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☒ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☒ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 ☒ The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 ☒ The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

Superseding Pages of MAGI CHIP State Plan Material

State: Missouri

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
MO-14-0017 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
MO-14-0018-MC1 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS15	Eligibility – Targeted Low Income Children MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate within a separate subsection under section 4.3
MO-14-0019 Effective/Implementation	MAGI Eligibility & Methods	CS14	Children Ineligible for Medicaid as a Result of the Elimination of	Incorporate within a separate subsection under section 4.1

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Date: January 1, 2014			Income Disregards	
MO-14-0020 – MC5 Effective/Implementation Date: January 1, 2014 Effective/Implementation Date: September 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – SSN Non-Financial Eligibility – Substitution of Coverage Non-Payment of Premiums	Section 4.1.5 Section 4.1.0; 4.1-LR; 4.1.1-LR Section 4.1.9.1 Section 4.4.4 Section 8.7
MO-15-0010 Effective/ Implementation Date: January 1, 2016	MAGI Eligibility & Methods	CS8 CS9 CS13	Eligibility- Targeted Low Income Pregnant Women Eligibility- Coverage from Conception to Birth Eligibility – Deemed Newborns	 Incorporate within a separate subsection under section 4.3
MO-15-0011 Effective/ Implementation Date: January 1, 2016	Non-Financial Eligibility	CS29	General Eligibility - Presumptive Eligibility for Pregnant Women	Incorporate within a separate subsection under section 4.3
MO-22-0032 Effective/ Implementation Date: October 1, 2021	Non-Financial Eligibility	CS29	General Eligibility - Presumptive Eligibility for Pregnant Women	Supersedes previous CS29
MO-23-0021 **Effective/**	Extended Postpartum	CS27	General Eligibility – Continuous Eligibility	

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Implementation Date: July 7, 2023				

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

Response: Please see the CS3 template for a description of income standards for Medicaid Expansion Children.

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

Response: Please see the CS18 for citizenship verification requirements.

4.1.1 ☐ Geographic area served by the Plan if less than Statewide:

4.1.2 ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

Response: Please see the CS7, CS8, and CS9 for the income standard.

4.1.2.1-PC ☒ Age: Confirmed pregnancy through birth (SHO #02-004, issued November 12, 2002)

Response: Please see the CS9.

4.1.3 ☒ Income of each separate eligibility group (if applicable):

Response: Please see the CS7, CS8, and CS9 for income.

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through 300% of the FPL (SHO #02-004, issued November 12, 2002)

Response: Please see the CS9.

4.1.4 ☐ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state):

Response: Please see the CS17.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Response: Not applicable.

4.1.7 ☒ Access to or coverage under other health coverage:

Response: Eligible children must be uninsured and not have access to affordable insurance.

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:

Response: Please see the CS27.

4.1.9 ☒ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Response: A Social Security Number and documentation of citizenship and alien status for children who are covered by SCHIP 1 and SCHIP 2. A net worth test of $250,000 is also required. Children with special healthcare needs must still be uninsured to qualify and cannot have access to affordable health insurance. Access to affordable insurance available through employment, a group membership, or from a private company causes ineligibility. In addition, children in families with gross income above 150% of the FPL cannot have access to affordable employer sponsored or private health insurance. These children must pay a premium to be eligible (a cost sharing provision).

The following is a description of the affordability test for both groups:
Three percent of 150% of the FPL for a family of three, for families with a gross income of more than 150% and up to 185% FPL.
Four percent of 185% of the FPL for a family of three, for families with a gross income of more than 185% and up to 225% FPL.
Five percent of 225% of the FPL for a family of three, for families with a gross income of more than 225% but less than 300% FPL.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

Response: Missouri requires a SSN for all participants who are requesting benefits except for participants in the unborn group, newborns, presumptive eligibility, and those who meet an exemption such as a religious exemption.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☐ Continuous eligibility

Response: Please see the CS27.

4.1-PW ☒ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Response: Please see the CS8.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☐ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☐ Elected for children under age

4.1.1-LR ☐ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2-DS ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Response: The methods of establishing eligibility and continuing enrollment for SCHIP 1 and SCHIP 2 is the same as for all MO HealthNet recipients. There are several ways to obtain an application. The application is available online and can be downloaded from the DSS website at https://dssmanuals.mo.gov/wp-content/uploads/2020/09/IM-1SSL-Fillable-Secured-6-24-21.pdf. Individuals can call a toll free number in Missouri to request that an application be mailed to them, or they may call their local FSD Office to request that an application be mailed. Applications are available at hospitals, local public health agencies, mental health facilities, and schools. Individuals may also apply by visiting their local FSD Office. Applications are available in English, Spanish, Bosnian, or Vietnamese, and translation services are available. The application is a two-page document that asks for:

- Mailing address;
- All children, parents/guardians and stepparents who live in the home;
- The Social Security Numbers (SSN) and citizenship or immigration status of those persons applying for coverage. SSNs are required only for MO HealthNet applicants. SSNs are not required for any individual who is not applying for assistance. The parent's SSN can be used to assist in verifying the family's income. However, the parent's SSN is not required. The instructions explaining whose SSNs are required are attached to the application. For simplification, FSD limits the application to one page. There is not room on one page for the instructions and the application. 42 CFR 457.340(b) does not prohibit asking for the parent's SSNs; it only prohibits a state requiring the SSN from a non-applicant.

- Information about employment, child care costs, other income, net worth, health insurance coverage, and absent parent information

Applications are processed and eligibility determinations are made within 30 days of receipt. FSD requires documentation (verification) of citizenship or immigration status and income. Applicants are notified in writing when a decision is made.

Applications are considered complete when they are signed by the claimant. If information is needed to make a determination of eligibility, the claimant is provided a written request for the information and given at least 10 days to provide it. The claimant is informed about reporting requirements and that it is against the law to obtain benefits to which they are not entitled. FSD staff provides information about income guidelines and the eligibility criteria as well as time limits for processing an application. FSD requires documentation of citizenship or immigration status for eligible children and verification of the family's income.

FSD does not have a durational requirement for residency. The eligible family members must state they are Missouri residents.

It is important to note that the State is concerned that SCHIP 1 does not "crowd out" private insurance options. The following measures will help address crowd out of private insurance options:

- Please see the CS20, which was approved on September 1, 2014.

Continuing Enrollment: Please see the CS27.

Families are required to report changes in circumstances (i.e., family size, income) within 10 days of when the change occurred. A reinvestigation is a re-determination of continued eligibility. The family completes an IM-1U, "Missouri MC+ Review" or a FA402, "Family Medical Assistance" reinvestigation form as part of the reinvestigation process. This form asks for names of all household members, address, income, and insurance information. It also asks about citizenship and immigration status and networth. The family is required to respond to the questions asked on the form and submit current income verification. Upon receipt of the form, FSD will determine if additional information is needed to complete the review based on claimant's responses. If so, FSD makes a written request for the information and allows at least 10 days for a response. When a change is reported to the FSD, the Eligibility Specialist makes a determination of continued eligibility and notifies the family in writing when a decision is made. SCHIP 1 and SCHIP 2 cases are closed following a notice to the family if the family fails to complete an annual reinvestigation. A complete review of eligibility is conducted annually.

In Missouri, reinvestigation means the same as re-determination. The family is not required to re-apply. However, an annual reinvestigation is required. A significant difference between an application for MO HealthNet and a reinvestigation for MO HealthNet is the amount of

documentation required. Applicants are required to submit verification of citizenship and SSN documentation for individuals who are applying. Citizenship and SSNs are not re-verified for those same individuals during a reinvestigation. A copy of the form used for MO HealthNet reinvestigations is attached.

Premium Collection and Reinstatement Process: For children ages birth through age 18 with family income between 150% and 300% FPL, the premiums are detailed in the premium chart. Please see Attachment 3.

Annual Reinvestigations: The notification and hearing process followed for SCHIP 1 and SCHIP 2 is the same as for all MO HealthNet recipients. Reinvestigations are conducted annually. The reinvestigation process begins by mailing the family a two-page reinvestigation form to complete and return. The form asks the family to list:

- Mailing address;
- All children, parents/guardians and stepparents who live in the home and their Social Security Numbers, citizenship or immigration status;
- Information about employment, child care costs, other income, net worth, health insurance coverage, and absent parent information.

Eligibility continues while the reinvestigation process is being completed. If a point of ineligibility is discovered, the family is notified and given an opportunity to request a hearing. The notification and hearing process followed for SCHIP 1 and SCHIP 2 is the same as for all MO HealthNet recipients.

At the State's discretion, the following provisions related to timeliness standards and deadlines may be modified or waived in response to a disaster or emergency:

- Waiving deadlines for timely processing applications, renewals, and other related documents during the emergency period for any and all CHIP applicants or recipients; and,
- Delaying acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by a State or Federally declared disaster area such that processing the change in a timely manner is not feasible. The state will continue to act on the required changes in circumstance described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d).

At the State's discretion, the following provisions related to establishing eligibility for CHIP may be modified or waived in response to a disaster or emergency:

- Granting an extension of the reasonable opportunity period for non-citizens declaring to be in satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the ninety-day reasonable opportunity period due to the State or Federally declared disaster or public

health emergency.

At the State's discretion, the following provisions related to deterring private insurance crowd-out may be modified or waived in response to a disaster or emergency:

- Waiving otherwise required proof that a CHIP applicant or recipient does not have access to other affordable insurance, including waiving the requirement to obtain quotes from other insurers;
- Presuming applicants for and recipients of CHIP have demonstrated good cause for dropping private or other employer-sponsored health insurance coverage during the disaster period; and
- Waiving lookback periods for establishing availability of private or other employer-sponsored health insurance for CHIP applicants and recipients.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

☒ Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. ☒ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☐ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not

apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

Response: FSD uses the same application for MO HealthNet, SCHIP 1, and SCHIP 2. The same Eligibility Specialist makes the eligibility determination for MO HealthNet, SCHIP 1, and SCHIP 2. Children are determined ineligible for regular MO HealthNet before being approved for SCHIP 1 or SCHIP 2. The application form asks about health insurance the family has and whether or not they have access to insurance.

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

Response: FSD uses the same application for SCHIP 1 and SCHIP 2. The same Eligibility Specialist makes the eligibility determination for MO HealthNet, SCHIP 1, and SCHIP 2. Children are determined ineligible for regular MO HealthNet before being approved for SCHIP 1 or SCHIP 2.

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Response: FSD uses the same application for SCHIP 1 and SCHIP 2. The same Eligibility Specialist makes the eligibility determination for MO HealthNet, SCHIP 1, and SCHIP 2. Children are determined ineligible for regular MO HealthNet before being approved for SCHIP 1 or SCHIP 2.

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for

coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

Response: In October 2021, CMS informed MO HealthNet Division that Missouri has an Urban Indian Organization in Kansas City, Missouri. The organization is called the Kansas City Indian Center (KCIC).

Missouri exempts children who are members of federally-recognized tribes from cost- sharing requirements as stipulated in Section 2103(e)(1)(A). Children who identify themselves as American Indian or Native Alaskan on the SCHIP application will be notified that, upon receipt of documentation of tribal membership, they will no longer be required to submit monthly premiums. Any premiums paid will be reimbursed within 45 days of receipt of documentation of tribal membership. The materials sent to all new enrollees will include information on the cost-sharing exemption for members of federally-recognized American Indian or Native Alaskan tribes to ensure that those not indicating race on the application will be notified of this exemption.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold

applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Response: Outreach and eligibility determination for MO HealthNet occurs throughout Missouri with State offices in every county. Free materials are available and used by other entities assisting in outreach, such as other State agencies with which Department of Social Services (DSS) has interagency agreements, social welfare organizations, schools, and health care providers through outstationed Eligibility Specialists. Through the interagency agreement between the DSS and the Department of Health and Senior Services (DHSS), a Well Child Outreach Project and a Lead Poisoning Outreach Program have been developed and implemented and outreach activities are conducted to identify possible MO HealthNet eligibles and refer them to the Family Support Division (FSD) for eligibility determination. There is an application on the DSS website at https://mydss.mo.gov/healthcare/apply that can be printed, completed, and mailed in, or completed online. Applications are also available at hospitals, local public health agencies, mental health

facilities, and schools. Individuals can call a toll- free number in Missouri to request that an application be mailed to them or they can call their local FSD office to request an application be mailed.

Missouri will continue to outstation Eligibility Specialists at hospitals and federally qualified health centers. The State will explore the effectiveness of expanding the sites for enrolling children in a wider variety of community settings with the Managed Care Consumer Advisory Committee, advocates for children, and health care providers.

Show-Me Healthy Babies Program:
The Department of Social Services (DSS) shall provide information about the Show-Me Healthy Babies Program to maternity homes as defined in section 135.600, pregnancy resource centers as defined in section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. DSS shall consider allowing such agencies and programs to assist in the enrollment of unborn children in the program, and in making determinations about presumptive eligibility and verification of the pregnancy.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

Response: The State cooperates fully with the privately funded Caring Foundation for Children in making referrals and receiving referrals so that there is coordination with MO HealthNet and maximum outreach for both programs. The MO HealthNet Statewide Coalition, which was formally funded by Missouri's Covering Kids and Families grant from The Robert Wood Johnson Foundation, continues to provide outreach. Due to the large number of organizations that assist in outreach, Missouri continues to rely on them to be our voice in the community. The Missouri Primary Care Association is the lead agency for the grant.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the

enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

Response: Outreach assistance through schools/agencies/organizations working with eligible families is the primary outreach tool utilized by the MO HealthNet Statewide Coalition. These partners educate families and distribute materials developed and produced through the Covering Kids and Families grant. Prior to the grant funding ending, the Coalition used the grant to produce and distribute printed materials. In 2006, more than 180,000 fliers and 9,000 posters were distributed. While the funding ended, the Coalition continues to provide outreach and holds quarterly meetings to share information and strategize. Coalition members help educate families and distribute outreach materials.

Outreach and eligibility determination activities to increase the number of children with creditable coverage occur throughout Missouri with State offices in every county. The State uses brochures and informational flyers to educate families about the health coverage available through the MO HealthNet Division.

Missouri stresses that:

- Children do not have to be on TANF (cash assistance) to be MO HealthNet eligible;
- Children may receive MO HealthNet benefits even if both parents live in the home; and
- One or both parents can work full-time and the children may still be MO HealthNet eligible.

Information about MO HealthNet is shared with families through the press, public speaking opportunities of executive agency staff, public service announcements, and Managed Care Organizations (MCOs).

The State involves the Managed Care Consumer Advisory Committee and

coordinates with the FSD, the DHSS, school districts, and other appropriate agencies or groups to include public health insurance programs in the design and implementation of the brochures, flyers, and other education material. Missouri continues to identify barriers to MO HealthNet enrollment by receiving information about those barriers from schools, hospitals, and local public health agencies through regularly scheduled interagency meetings, provider association contacts, and the Managed Care Consumer Advisory Committee.

Missouri continues to outstation Eligibility Specialists at some hospitals and federally qualified health centers. Missouri continues agreements that allow federally qualified health centers and local public health agencies to accept applications on behalf of the FSD. The State will explore the effectiveness of expanding the sites for enrolling children in a wider variety of community settings with the Managed Care Consumer Advisory Committee, advocates for children, and health care providers.

The State will also be cooperating with the Missouri Hospital Association in their efforts to develop an effective outreach program for MO HealthNet children. We will also partner with local community groups and agencies which want to sponsor local outreach initiatives.

Income will be determined by looking at the total gross income available to the children for whom the application is being made. The current assistance group definitions used by Missouri for MO HealthNet budgeting will be followed. A standard income disregard equal to 100% of the FPL will be made from the gross income figure. The net income figure will be compared to 200% of FPL to determine if the child(ren) is (are) eligible. To be eligible, this net figure must not exceed 200% of FPL for children. There are no other disregards for SCHIP 1 children.

An assistance group is comprised of the child for whom benefits are being requested and his or her biological or adoptive parents if living together in the same household.

Please see the CS20 template which addresses substitution of coverage.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

Response: Missouri will use brochures and informational flyers to educate families about the health coverage available through MO HealthNet, SCHIP 1, and SCHIP 2. We will stress that:

- Children do not have to be on TANF (cash assistance) to be MO HealthNet eligible;
- Children may receive MO HealthNet benefits even if both parents live in the home; and
- One or both parents can work full-time and the children may still be MO HealthNet eligible.

Outreach Plan: The outreach plan has five major components:

- Statewide public information campaign
- Expanded training
- Improved case-specific problem resolution
- Systems changes; and
- Support for regional and local initiatives, including the outstationing of eligibility workers.

The outreach program for SCHIP 1 and SCHIP 2 will continue to complement and build upon current MO HealthNet outreach initiatives. Through the outreach plan Missouri will ensure that all uninsured families in Missouri are aware of the health care coverage that is available to them. As a result, Missouri expects to enroll eligible families into MO HealthNet, SCHIP 1 and SCHIP 2.

Outreach assistance through schools/agencies/organizations working with eligible families is the primary outreach tool utilized by the MO HealthNet Statewide Coalition. These partners educate families and distribute materials developed and produced through the Covering Kids and Families grant. Prior to the grant funding ending, the Coalition used the grant to produce and distribute printed materials. In 2006, more than 180,000 fliers and 9,000 posters were distributed.

While the funding ended, the Coalition continues to provide and hold quarterly meetings to share information and strategize. Coalition members help educate families and distribute outreach materials.

Missouri has not targeted outreach to any specific populations. However, the MO HealthNet Statewide Coalition translated their 2006 materials into Spanish.

Missouri will involve the Managed Care Consumer Advisory Committee, the FSD staff, the DHSS, school districts, and other appropriate agencies or groups in the design and implementation of the brochures and flyers. Missouri will continue to coordinate eligibility outreach efforts with schools, hospitals, and local public health agencies by identifying barriers to MO HealthNet enrollment.

FSD allows individuals to make application in hospitals, federally qualified health centers, and some local public health agencies. FSD Eligibility Specialists are located in some of these locations. In other locales applicants receive assistance from facility staff that has been trained on the application process by FSD.

The FSD policy manual delineates the application process and program requirements. FSD staff receives training on the rules and eligibility requirements and application procedures. The manual is updated by Income Maintenance Memoranda on an as-needed basis.

The Phone Center is centralized in one FSD county office. Phone center staff can be reached Monday through Friday, 8:00 am to 5:00 pm by calling 1-888-275-5908. A voice mail system is in place for incoming calls received after regular business hours.

The Phone Center is staffed by experienced Eligibility Specialists whose duties include:

- Answering phone inquiries;
- Accepting and processing applications;
- Making referrals;
- Mailing applications;
- Processing Breast and Cervical Cancer Treatment applications mailed to the center by Show Me Healthy Women providers; and
- Processing presumptive eligibility applications mailed to the center by designated providers.

Section 6. Coverage Requirements for Children's Health Insurance

☐ 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 proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the

American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☒ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. ☒ Coverage of all benefits that are provided to children under the the same as Medicaid State plan, including Early Periodic Screening Diagnosis and Treatment (EPSDT)

Show-Me Healthy Babies Program

Targeted low income pregnant women will receive a benefit package of essential medically necessary health services identical to the MO Health Net for Pregnant Women benefit package. This benefit program includes NEMT.

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in □457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☒ Other (Describe)

Response: Except for NEMT, Missouri will provide the identical package of covered services to SCHIP 1 and SCHIP 2 recipients as is currently provided to MO HealthNet recipients under Title XIX. NEMT is not covered for children in families with income more than 150% FPL at the end of the eligibility period. Coverage may revert to SCHIP 1 or SCHIP 2 after the first year, depending on the child's eligibility.

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP

plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

Response: The covered services checked below apply to targeted low-income children in SCHIP 1 and SCHIP 2. Show Me Healthy Babies (SMHB) enrollees in the targeted low-income pregnant women group and from conception to the end of pregnancy group receive EPSDT services consistent with Medicaid requirements.

Information included in this section is from the MO HealthNet Managed Care Policy Statements (https://mydss.mo.gov/media/pdf/mhd-mo-healthnet-managed-care-policy-statements).

6.2.1. ☒ Inpatient services (Section 2110(a)(1))
Response:

Inpatient Hospital

An acute inpatient service, which requires the submission of an inpatient claim, is one in which the hospital expects to provide service to the member in the hospital for a 24 hour period or longer. The stay is considered inpatient upon the issuance of written physician orders to that effect. The service is still considered inpatient if the intent is to stay 24 hours or longer even though the member dies, is discharged, or is transferred to another institution and does not actually stay in the hospital 24 hours. Services in an observation room, regardless of the length of time, without a formal admission are not considered inpatient services.

Mandatory Length of Stay

House bills number 1069, 794, 807, 936, 1128, 1153, and 102 were enacted by the 88th General Assembly to mandate that insurance coverage is provided for inpatient maternity benefits. Coverage shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and newly born child.

A shorter length of hospital stay for services related to maternity and newborn care may be approved only if:

1. The shorter stay meets with the approval of the attending physician after

consulting with the mother.
    - The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization
2. The insurance entity provides coverage for post-discharge care to the mother and her newborn.

Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. Services provided by the registered professional nurse or physician shall include, but not be limited to:

- Physical assessment of the newborn and mother
- Parent education
- Assistance and training in breast or bottle feeding
- Education and services for complete childhood immunizations
- The performance of any necessary and appropriate clinical tests
- Submission of a metabolic specimen satisfactory to the state laboratory

Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality observed by the nurse, in the condition of the mother or the child, shall be reported to the attending physician as medically appropriate.

"Attending physician" shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.

Program Limitations

Inpatient care that is not medically necessary and services not provided at an acute care level are not covered. Most inpatient admissions must be pre-certified by the MO HealthNet Managed Care health plan using criteria that is based on sound medical evidence. Specialty pediatric hospitals, as defined in 13 CSR 70-15.010 (2) (P), use criteria specified by the Fee-For-Service Program.

Emergency admissions are exempt from the pre-certification process. A post-admission certification must be requested following the emergency admission.

Retrospective reviews are done for admissions if no admission pre-certification was done because the time requirements were not met or the member's eligibility is not established on the date of admission.

Hospitals should contact Conduent at (800) 766-0686 for certification for inpatient days that are not included in the comprehensive benefit package for the MO HealthNet Managed Care health plan and are included as a fee-for-service benefit

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

Response:

An outpatient hospital that is licensed by its state's licensing authority and certified under Medicare Conditions of Participation may participate in the MO HealthNet Outpatient Hospital Program. For the purposes of the MO HealthNet Fee-For-Service Program an off-site entity is considered to be an outpatient hospital if it is designated by Medicare as part of the hospital and given a Medicare number assigned to the hospital.

Off-site satellite clinics or remote clinics not designated by Medicare as part of the hospital may not participate in the MO HealthNet Outpatient Hospital Program. Such entities may be enrolled as MO HealthNet clinic providers.

Outpatient hospital services are those services provided to a member not admitted by the hospital as an inpatient, but is registered on the hospital records as an outpatient and receives services from the hospital.

The following types of treatment and services are covered when provided in the outpatient hospital clinic or emergency room and under the direct supervision of a physician, nurse practitioner or podiatrist:

- Preventive
- Diagnostic
- Therapeutic
- Palliative
- Therapies including
    - Chemotherapy
    - Radiation therapy
    - Physical therapy
        - Effective 09/01/05 physical therapy will only be covered by

MHD in the outpatient setting for children under the age of 21, blind, pregnant women, and nursing home residents.
    - Routine dialysis treatment
- Medical and surgical supplies
- Administration cost of medications given on site
- Injections and immunization (but not administration of such)
- Observation up to 24 hours
- Observation from 24 up to 72 hours only when administering and monitoring

6.2.3. ☒ Physician services (Section 2110(a)(3))
Response:

Physician Services

The following is a summary of benefits. This is an overview only and should not be considered a comprehensive statement.

- Services rendered in a private practice setting
- The appropriate level of evaluation and management (E/M) procedure code, i.e., office/outpatient, inpatient hospital, consultations, emergency department, critical care, home visits, nursing facility services, newborn care, etc.
- Healthy Children and Youth (HCY) screens
- Office medical supplies over and above those usually included in the office visit
- Office surgical procedures
- Hemodialysis and peritoneal dialysis services
- Continuous ambulatory peritoneal dialysis (CAPD) in the home
- Eye examinations or special ophthalmological services
- Vestibular functions tests
- Physical medicine services to assist in the diagnosis, recovery and rehabilitation of members performed in the office, clinic, home, or outpatient department hospital
- Surgical procedures in the CPT range 10004-69990
- Foot care which involves the removal of corns, calluses or growths, trimming of toenails (grinding, debridement, or reduction), and other hygienic or preventive maintenance when the member has a diagnosis of diabetes mellitus or other peripheral vascular disease and the member is eligible for these services
- Assistant-at-surgery if the procedure customarily requires the services of

an assistant surgeon and the surgery itself is a covered service
- Multiple surgical procedures performed on the same member, on the same date of service, by the same provider, for the same or separate body systems through separate incisions are to be reported with documentation
- Post-operative care for 30 days is included in the surgical procedure
- Injections/immunizations
- Radiology procedures
- Laboratory procedures
- Prenatal care
- Delivery services
- Neonatal intensive care
- Newborn resuscitation • Newborn care in the hospital
- Newborn care other than hospital
- Gastroplasty and gastric bypass for morbid obesity are to be reported when performed as treatment of hypothalamic lesion, Cushings syndrome, hypothyroidism, cardiac and respiratory diseases, diabetes mellitus or hypertension and require prior authorization (PA)
- Allergy sensitivity tests
- Immunotherapy (desensitization, hyposensitization)
- Therapeutic allergens;

6.2.4. ☒ Surgical services (Section 2110(a)(4))
Response:

The Ambulatory Surgical Center program provides a place for operative procedures that can be safely performed in an outpatient setting. The procedures must be able to be completed within the maximum time of 90 minutes (42 CFR 416.65). This is the maximum length of time that a member may be placed under anesthesia in an ASC. The ASC program closely approximates the coverage of Medicare in identifying the procedures that may be performed in an ASC.

Providers must be Medicare certified as an ASC and licensed by the Department of Health and Senior Services. Providers are required to have an agreement with a local hospital for purposes of providing emergency medical coverage on an as needed basis.

Note: Physician's professional services are reimbursed directly to the physician or other provider performing the service

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

Response:

Refer to the response for 6.2.4 Surgical Services.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
Response:

Carved out and provided by the fee-for-service program.

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))
Response:

Not covered and would be paid for out of pocket.

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
Response:

Under the Clinical Laboratory Improvement Amendments Act of 1988 (CLIA), all independent laboratories, hospital, physician offices, nursing homes, or other laboratory testing sites, as defined at 42 CFR 493.2, must have either a CLIA Certificate of Waiver, or Certificate of Registration, along with a CLIA identification number to legally perform clinical laboratory testing anywhere in the United States. Laboratories licensed by an approved state program are exempt from this policy.

Laboratories that perform lab procedures for the MO HealthNet Managed Care health plans must be registered to perform the procedures.

Limitations

Only one (1) trip fee, for mobile x-ray unit, is allowed per trip regardless of the number of members seen, whether in a nursing facility, custodial care facility, or the MO HealthNet member's home or other place of residence.

Laboratory tests for blood lead levels are mandated by CMS and MO HealthNet Services, for all children between 6 months and 72 months. A blood lead level test must be performed at 12 and 24 months.

The MO HealthNet Managed Care health plans are responsible for the following laboratory procedures processed by the Department of Health and Senior Services, State Health Laboratory:

- 83655 Lead
- 82760 Galactose
- 82775 Galactose-1-phosphate uridyl transferase, quantitative
- 84437 Thyroxine, total requiring elution
- 84443 Thyroid stimulating hormone (TSH)
- 83020 Hemoglobin, electophoresis

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

Response:

Required to provide family planning services and must provide freedom of choice for family planning and reproductive health services which may be accessed out of network.

Examples of reproductive health services are:

- Family planning counseling/education on various methods of birth control
- Contraception management
- Insertion of Norplant
- IUD
- Depo Provera injections
- Pap test
- Pelvic exams
- Sexually transmitted disease (STD) testing

Sterilization procedures are not covered for members under the age of 21. The member must sign the (Sterilization) Consent Form at least 30 days, but not more than 180 days, prior to the date of the sterilization procedure.

The MO HealthNet Managed Care health plans must ensure:

- All lab and x-ray services provided as part of a family planning encounter are payable as family planning services
- All exams, laboratory, and x-ray services for family planning purposes are covered for children and adults
- HIV blood screening testing performed as part of a package of screening testing and counseling provided to women and men in conjunction with a family planning encounter is payable as family planning services
- A pregnancy test is family planning related:
    - When provided at the time at which family planning services are initiated for an member

    - At points after the initiation of family planning services where the member may not have used the particular family planning method properly
    - If the member is having an unusual response to the family planning method
- Services are provided/prescribed by physician/advanced practice nurse for medically approved diagnosis, treatment, counseling, drug, supply, or device to members of childbearing age
- For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering a member permanently incapable of reproducing and must always be reported as family planning services, in accordance with mandated federal regulations 42 CFR 441.250 - 441.259
- The (Sterilization) Consent Form, PSFL-200, meets all the criteria required by the Centers for Medicare and Medicaid Services in 42 CFR 441.250 through 441.259
- A properly completed (Sterilization) Consent Form, PSFL-200, is obtained from the performing provider

Federal regulations 42 CFR 441.250 - 441.259 require the following:

- Informed consent has been given
- The member must be mentally competent
- The member must be at least 21 years of age on the date of signing the consent form
- The member must sign the (Sterilization) Consent Form at least 30 days, but not more than 180 days, prior to the date of the sterilization procedure. The day after the signing is considered the 1st day when counting the 30 days. The only exceptions to this time requirement are premature delivery or emergency abdominal surgery:
    - For premature delivery, the consent form must be completed and signed by the member at least 72 hours prior to sterilization and at least 30 days prior to the expected date of delivery
    - For emergency abdominal surgery, the consent form must be completed and signed by the member at least 72 hours prior to the sterilization procedure.
- The following procedures require a (Sterilization) Consent Form, PSFL-200:
    - Vasectomy, unilateral or bilateral (separate procedure), including post-op semen examination(s)
    - Laparoscopy, surgical-with fulguration of oviducts (with or without transection)

- Laparoscopy, surgical-with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
- Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
- Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure) o Ligation or transection of fallopian tube(s) when done at the time of cesareansection or intra-abdominal surgery (not a separate procedure)
- Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach

Limitations

These services are not covered:

- Condoms and family planning devices or supplies available as non-prescribed, over- the counter products
- Reversal of a sterilization procedure
- Abortions for the purpose of family planning. Abortions are not family planning services, and should not be reported as such
- Hysterectomies for the purpose of family planning
- Procreative management, i.e. tubal reversal, artificial insemination, etc.

6.2.10. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
Response:

DME is equipment that is necessary and reasonable for the treatment of the member's illness or injury or to improve the functioning of a malformed or permanently inoperative body part. These items must be for use in the MO HealthNet Managed Care member's home when ordered by the MO HealthNet Managed Care member's PCP or nurse practitioner.

Limitations

Benefits under the DME program are limited to the following:

- All medically necessary non-sterile ostomy supplies for ostomates are covered

- Augmentative communication devices
- Equipment such as wheelchairs, walkers (including batteries and accessories), hospital beds, canes, crutches, and decubitus care equipment
- Ventilators
- CPAP and BiPap devices
- Continuous glucose monitors (CGMs) and Tubeless Insulin Pumps – standalone CGMs(e.g. Dexcom, FreeStyle Libre) and tubeless insulin pumps (e.g. OminiPod), shall be covered through the FFS Pharmacy Program
    - Other Diabetic equipment and supplies shall continue to be covered by the Managed Care health plan
- Orthotic and prosthetic devices
- Six prosthetic sheaths or socks are allowed per limb, per member, per 12-month period
- Orthopedic shoes are covered only if they are an integral part of a brace. "Integral"means that the shoes are necessary for completeness of the brace
- Orthopedic shoes for a member with a diagnosis of diabetes are covered. The shoes do not have to be an integral part of a brace
- Home parenteral nutrition.

6.2.11. ☒ Disposable medical supplies (Section 2110(a)(13))
Response:

Children under the age of 21

DME benefits for children include items such as diapers, medical supplies, enteral nutrition, PKU nutrition, and positioning equipment. Benefits under the DME program for children under the age of 21 may only be limited by medical necessity. Medically necessary items or services identified as a result of a physician or health care provider visit or exam must be covered for members under the age of 21.

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.12. ☒ Home and community-based health care services (Section 2110(a)(14))
Response:

Personal care services are provided as a cost effective alternative to nursing home

placement. Federal law does not require that a physician prescribe personal care services. Fee-for-service personal care is available to any member who is assessed by the Department of Health and Senior Services, Division of Senior and Disability Services at a nursing home level of care.

Members are considered eligible for personal care services when an initial in-home assessment completed on a Home and Community Based Referral/Assessment form scores 21 points or greater.

MO HealthNet Managed Care health plans must provide all medically necessary personal care services. MO HealthNet Managed Care health plans must continue to provide personal care services to members who are receiving personal care services when they become enrolled in aMO HealthNet Managed Care health plan.

Maximum monthly payment for personal care services is limited to 100% of the average monthly fee-for-service cost for care in a nursing facility.

Developmental Disabilities (DD) Home and Community Based Waivers

The Division of DD, within the Department of Mental Health, administers four MO HealthNet Home and Community Based Waivers. Individuals eligible for MO HealthNet and who have intellectual/developmental disabilities may apply to participate in:

- DD Comprehensive Waiver
- Missouri Children's Developmental Disabilities Waiver (MOCDD)
- DD Community Support Waiver
- Partnership for Hope Waiver

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.13. ☒ Nursing care services (Section 2110(a)(15))
Response:

Skilled nursing care services are covered when the services are reasonable and necessary to the treatment of an illness or injury; the services are performed by licensed nurse; the services are required on an intermittent basis; and the services are ordered by and included in the plan of care established by a physician.

Psychiatric nursing services are covered when the following criteria are met:

- The member has one of the following primary ICD-9CM psychiatric diagnoses certified in writing by a psychiatrist
  - Schizophrenic disorders (295.2x, 295.3x, 295.4x, 295.6x, 295.7x, or 295.9x)
  - Paranoia (297.1)
  - Bipolar disorders (296.4x to 296.5x, or 296.6x)
  - Unspecified psychosis (298.9)
  - Major depression recurrent (296.3x)
  - Dementia and other conditions complicated with delusional disorder, mood disorder or anxiety disorder (290.12, 290.13, 290.20, 290.21, 290.42, 290.41, 290.43, 300.21 or 300.22).
- The member requires active treatment under the care of a physician on either an outpatient or inpatient basis as a result of a psychiatric disorder
- The services are prescribed by a physician and provided in accordance with a plan of care which clearly documents the need for services and is reviewed by the physician at least every sixty days
- The services are delivered by a nurse with specialized psychiatric training
- The objectives of the prescribed active treatment are measurable by physical criteria (i.e., increased appetite, increased energy level, appropriate affect) and the treatment and results are well documented.

6.2.14. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)
Response:

Abortion services are not a MO HealthNet Managed Care health plan benefit. The Fee-For-Service Program will reimburse Abortion services (including RU486) only in medical emergencies or when necessary to save the life of the mother.

6.2.15. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
Response:

Members under the age of 21

MO HealthNet Managed Care health plans are required to provide dental services for child members under the age of 21.

Dental services include, but are not limited to, diagnostic, preventive, and restorative procedures, post orthodontic services, and medically necessary oral and maxillofacial surgeries. Expanded services, such as comprehensive

orthodontics, are covered.

Screening

It is recommended that preventive dental services and oral treatment for children begin at age 6-12 months and be repeated every six (6) months or as medically indicated. Although an oral screening may be part of a physical examination, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), states that it does not substitute for examination through direct referral to a dentist

Limitations

MO HealthNet limitations for certain dental services include, but are not limited to, specific time intervals, age, or primary or permanent teeth

6.2.16. ☒ Vision screenings and services (Section 2110(a)(24))

6.2.17. ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.18. ☒ Case management services (Section 2110(a)(20))
Response:

Targeted Case Management (TCM)

TCM services include the following:

- Arrangement, coordination, and participation in the assessment to ensure that all areas of the family and individual's lives are assessed to determine unique strengths and needs.
- Coordination of the service plan implementation, including linking individuals and families to services, arranging the supports necessary to access resources, and facilitating communication between service providers.
- Monitoring the service delivery plan with the individual and family participation to determine the adequacy and sufficiency of services and supports, goal attainment, need for additional assistance, and continued appropriateness of services and goals.
- Documentation of all aspects of intensive targeted case management services including case openings, participation in assessments, plans, referrals, progress notes,contacts, rights and grievance procedures, discharge planning, and case closure.

TCM services are carved out of the MO HealthNet Managed Care program. MOHealthNet Fee-For Service will reimburse TCM services provided by DMH Division of Behavioral Health administrative agents.

The MO HealthNet Managed Care health plans and their behavioral health subcontractors will refer members seeking TCM services to the appropriate administrative agent/community mental health center (CMHC) in the area. The CMHC will conduct an assessment to determine if the individual meets criteria as having a serious emotional disorder or serious behavioral health disorder and is eligible for TCM.

The MO HealthNet Managed Care health plan remains responsible for all services included in the comprehensive benefit package.

The MO HealthNet Managed Care health plan and CMHC are jointly responsible for coordinating services which may include participation in Family Support Teams to outline the individual's and family's needs, strengths and services/supports across all involved parties.

The TCM provider and MO HealthNet Managed Care health plan are responsible for documentation of services provided and denial of any services.

Developmental Disabilities (DD) Home and Community Based Waivers

Every individual who is determined eligible for Division of DD services is eligible for case management services. Case management for individuals who are MO HealthNet eligible, including participants in DD Home and Community Based Waivers, is provided as targeted case management. Targeted case management services are provided by qualified developmental disabilities professionals (QDDPs) employed by the Division's regional offices and County Senate Bill 40 Boards and other not for profit entities that contract with the Division of DD to provide case management services.

6.2.19. ☒ Care coordination services (Section 2110(a)(21))
Response:

Refer to 6.2.18 Case Management Services as Case Management and Care Coordination are used interchangeably in Missouri.

6.2.20. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
Response:

MO HealthNet Managed Care health plans are required to provide medically necessary Healthy Children and Youth Program services (HCY), physical therapy (PT), occupational therapy (OT), and speech therapy (ST) and supplies used for casting and splinting to child members under age 21. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Physical, occupational, and speech therapy services identified in a child's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) will not be the responsibility of the MO HealthNet Managed Care health plan. These services will be paid fee-for-service by the MO HealthNet Division. Therapy services are paid fee-for-service when they are included in an IEP as defined by the Individuals with Disabilities Education Act-Part B (34 CFR 300) or an IFSP as defined by the Individuals with Disabilities Education Act-Part C (34 CFR 303).

Medically necessary PT, OT, and ST services not identified in a child's IEP or IFSP are the responsibility of the MO HealthNet Managed Care health plan. This includes developmental as well as maintenance therapy. The health plan shall be financially liable and shall not delay the provision of any medically necessary services pending completion of the IEP or IFSP.

MO HealthNet Managed Care health plans shall have a written process for the coordination and collaboration of medically necessary therapy services including services provided in an educational setting. The child's primary care provider should be involved in the development of the IEP or IFSP even though the MO HealthNet Managed Care health plan is not responsible for payment of IEP/IFSP related PT, OT, and ST services.

The MO HealthNet Managed Care health plan must have written parental consent for a school to release IEP records. Medically necessary equipment and supplies used in connection with the PT, OT, and ST services are the responsibility of the MO HealthNet Managed Care health plan.

6.2.21. ☒ Hospice care (Section 2110(a)(23))
Response:

MO HealthNet Managed Care health plans are required to provide hospice services when a terminally ill MO HealthNet Managed Care member elects hospice. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

The hospice benefit is designed to meet the needs of members with life-limiting illnesses and to help their families cope with related problems and feelings. Hospice care is an approach to treatment that recognizes that the impending death of a member warrants a change in focus from curative care to palliative care. Hospice utilizes an interdisciplinary team to provide comprehensive services that are primarily directed toward keeping the member at home with minimal disruption in normal activities and keeping the member and family as physically and emotionally comfortable as possible. To be eligible to elect hospice care in the Fee-For-Service Program, a physician must certify members as terminally ill with a life expectancy of six months or less if the disease runs its normal course.

Hospice care cannot be prescribed or ordered by a physician. The member must elect hospicecare and agree to seek only palliative care for the duration of the hospice election.

Program Limitations

Hospice benefits include, but are not limited to, home care, physician care, inpatient care, nursing home room and board, and all services for the palliation and management of the terminal illness. If a member elects hospice and then enters a nursing home, the MO HealthNet Managed Care health plan is responsible for the nursing home costs.

The following is a list of covered services included in the hospice benefit:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and who is working under the direction of a physician
- Physician services performed by a doctor of medicine or osteopathy to meet the general medical needs of the member to the extent that these needs are not met by the attending physician
- Counseling services, including dietary counseling, provided to both the member and the family members or other persons caring for the member at home. Counseling services must be available and may be provided both for the purpose of training the member’s family or other caregiver and for helping the member and the caregivers to adjust to the member’s approaching death
- Dietary counseling, when required, must be provided by a qualified individual

- Spiritual counseling, including notice to the member as to the availability of clergy
- Counseling provided by members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice
- Bereavement services under the supervision of a qualified professional. There must be an organized program for the provision of these services
- Short term inpatient care required for procedures necessary for acute or chronic symptom management or for pain control
- Short term inpatient respite care (maximum of 5 days per calendar month) furnished as a means of providing respite for the member's family or other persons caring for the member at home
- Medical appliances and supplies. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the member's terminal illness
- Room and board in a MO HealthNet-certified nursing facility
- Home health aide services furnished by certified aides and homemaker services. Aides may provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the member. Aide services must be provided under the general supervision of a registered nurse
- Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills
- All drugs (prescription and over the counter) and biologicals used primarily for pain or symptom control of the terminal illness are covered under the MO HealthNet Fee- For Service Program.

Concurrent Care for Children in Hospice

Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made. The hospice provider continues to be responsible for all services related to the palliation and support services for the terminally ill.

Guidance: See guidance for section 6.1.4.1 for a guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check this box.

6.2.22. ☐ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

6.2.22.1 ☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.23. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.24. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

Response: Box unchecked as a Medicaid SPA, which utilized section 4.22 of the State Plan was approved. This SPAremoved the premium requirement tied to HIPP.

6.2.25. ☒ Medical transportation (Section 2110(a)(26))

Response:

MO HealthNet Managed Care health plans are required to provide emergency medical transportation by ground or air when medically necessary and appropriate. Non-emergency medical transportation (NEMT) must be provided to MO HealthNet Managed Care members who do not have the ability to provide their own transportation to and from health care services including health care services that are carved out of the MO HealthNet Managed Care contracts. Ancillary services related to the NEMT must also be provided.

NEMT services are covered for all Managed Care ME Codes except 08, 52, 57, 64, 73-75, and 97.

NEMT Transportation Requirements

MO HealthNet Managed Care health plans must arrange NEMT services for MO HealthNet Managed Care members accessing MO HealthNet covered services. In addition, MO HealthNetManaged Care health plans must arrange NEMT services for one parent/guardian or an attendant, if requested or

appropriate, to accompany children under the age of 21. Participants under the age of 17 will require the presence of a parent/guardian or another adult while being transported. Transportation will not be provided for a child under the age of 17 who is unaccompanied unless they are an emancipated minor.

MO HealthNet Managed Care health plans are not required to provide transportation to MO HealthNet Managed Care members with access to free transportation at no cost to them, however, such MO HealthNet Managed Care members may be eligible for ancillary services.

MO HealthNet Managed Care health plans must ensure that NEMT services are available 24 hours per day, 7 days per week, when medically necessary. Also, MO HealthNet Managed Care health plans are not required to provide NEMT services to pharmacy services or to Durable Medical Equipment providers that provide free delivery or mail order services.

Some services already include NEMT. The MO HealthNet Managed Care health plan is not responsible to provide NEMT to these services. Examples are:

- Comprehensive Substance Treatment Abuse and Rehabilitation (CSTAR) services
- Hospice services
- Developmental Disability (DD) waiver services;
- Adult day care services
- Services provided in the home

NEMT Ancillary Service Requirements

The MO HealthNet Managed Care health plan shall authorize and arrange the least expensive and most appropriate ancillary services if the medical appointment requires an overnight stay, and volunteer, community, or other ancillary services are not available at no charge to the MO HealthNet Managed Care member.

For participants under the age of 21, ancillary services may include an attendant or one parent/guardian to accompany the child.

The MO HealthNet Managed Care health plan shall authorize and arrange ancillary services for the parent/guardian when the child is inpatient in a hospital setting and meets the following criteria:

- The hospital does not provide ancillary services without cost to the

participant's parent/guardian
- The hospital is more than 120 miles from the participant's residence
- Hospitalization is related to a MO HealthNet covered transplant service

If the MO HealthNet Managed Care member meets the criteria specified above, the MO HealthNet Managed Care health plan shall also authorize and arrange ancillary services to eligible MO HealthNet Managed Care members who have access to free transportation at no charge to the MO HealthNet Managed Care member or receive transportation from a Public Entity and such ancillary services were not included as part of the transportation service.

NEMT is not covered for children in families with income above 150% FPL. Emergency ambulance services are covered for a recipient whose life or health is in danger. NEMT is covered for children in families with income of and less than 150% FPL.

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.26. ☐ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.27. ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Response: Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

COVID-19 Vaccine:
- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:
- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of

diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:
- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
    - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
    - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
    - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:
- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule

☒ American Academy of Pediatrics/ Bright Futures
☐ Other Nationally recognized periodicity schedule (please specify:)
☒ Other (please describe: Missouri clarified guidance to providers ensuring the AAP/Bright Futures recommended preventive services and screenings are being provided. Revisions of State regulations are in process. Missouri's clarification of the expectation that providers use the AAP/Bright Futures guidelines is not delayed by the time frame needed for the revision of the state regulation. Missouri took the following steps to communicate this clarification:

- A provider bulletin was published on the state's website and distributed to providers and the state's contracted health plans through a provider email blast.
- The state's on-line Provider Manuals were updated with the clarification.
- State staff sent a written communication to each contracted health plan discussing the clarification. The communication requires each health plan to document that their related materials provided to their contracted providers and their websites are either already compliant or have been updated.
- The state's Provider Education Unit l provided training that will be posted to the state's website.
- The clarification was discussed at the Quality Assurance and Improvement Committee meeting which includes state staff, contracted health plans, and other stakeholders.
- Missouri's state regulation already requires providers to use the screening frequency required by the American Academy of Pediatrics. The state clarified the regulation effective August 30, 2021 that the AAP/Bright Futures guidelines must be followed.

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

Response: All participants in the expansion group and separate CHIP group receive these benefits. The below services are available to all children unless otherwise noted. Benefits are not subject to limitations unless otherwise noted.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

Response: Missouri is developing an online provider resource page for EPSDT that links to the AAP/Bright Futures Periodicity Schedule as well as to validated behavioral health screening tools for use in primary care settings. The managed care plans will also be responsible for facilitating the use of these tools in primary care settings.

- A provider bulletin was published on the state's website and distributed to providers and the state's contracted health plans through a provider email blast.
- The state's on-line Provider Manuals were updated with the clarification.
- State staff sent a written communication to each contracted health plan discussing the clarification. The communication requires each health plan to document that their related materials provided to their contracted providers and their websites are either already compliant or have been updated.
- The state's Provider Education Unit l provided training that will be posted to the state's website.
- The clarification was discussed at the Quality Assurance and Improvement Committee meeting which includes state staff, contracted health plans, and other stakeholders.
- Missouri's state regulation already requires providers to use the screening frequency required by the American Academy of Pediatrics. That state clarified the regulation effective August 30, 2021 clarifying that the

AAP/Bright Futures guidelines must be followed.

Additionally, a webpage on the state's website focuses on provider resources for EPSDT that link to the AAP/Bright Futures
Periodicity Schedule as well as to validated behavioral health screening tools for use in primary care settings. The state's Provider Education unit has developed a training webinar that is posted on the state's website for access by all providers.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: Individual, group, and family counseling/psychotherapy are available for mental health and substance use disorders for children and adult participants, and these services are limited only by medical necessity. These services may be provided by community mental health centers, certified community behavioral health organizations, or by licensed, enrolled behavioral health practitioners.

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

Response: All FDA approved medications for tobacco cessation are covered. Individual tobacco cessation counseling services are covered without prior authorization requirements and are provided by or under the supervision of a physician or any other health care professional who is legally authorized to furnish such services under state law and who is authorized to provide Medicaid coverable services other than tobacco cessation services. Counseling visits are limited to one per day but there are no weekly, monthly, or annual limits and no limits on quit attempts within a specific period of time.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

Response:
All FDA approved medications used for medication assisted treatment are covered and may be prescribed by enrolled providers within their scope of state licensure and SAMHSA waiver if required. Methadone for OUD is provided by Opioid Treatment Programs (OTP) in accordance with federal rules. Individual, family, and group counseling services are also covered for opioid use disorders but are not required as a condition of being prescribed medication for opioid use disorder. Each type of counseling is limited to one per day and five per month, but these limits are soft limits that may be exceeded if medically necessary. The limits also are not specific to OUD and AUD conditions.

6.3.2.3.2- BH ☒ Alcohol Use Disorder

Response:
All medications used for medication assisted treatment are covered and may be prescribed by enrolled providers within their scope of state licensure and SAMHSA waiver if required. Individual, family, and group counseling services are also covered for opioid use disorders but are not required as a condition of being prescribed medication for alcohol use disorder.

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response:

Mental Health and SUD (adults and youth)**:** Peer and family support services are coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. Peer and family support services are person-centered and promote participant ownership of the plan of care.
Components of both peer and caregiver support include:

- Person-centered planning to promote the development of self-advocacy.
- Empowering the individual to take a proactive role in the development, updating and implementation of their person-centered plan.
- Crisis support.
- Assisting the participant and families in the use of positive self-management techniques, problem-solving skills, coping mechanisms, symptom management, and communication strategies identified in the person-centered plan so that the individual remains in the least restrictive settings; achieves recovery and

resiliency goals; self-advocates for quality physical and behavioral health services and medical services in the community.

- Assisting individuals/families in identifying strengths and personal/family resources to aid recovery/promoting resilience, and to recognize their capacity for recovery/resilience. Serving as an advocate, mentor, or facilitator for resolution of issues and skills necessary to enhance and improve the health of a child/youth with substance use or co-occurring disorders.
- Providing information and support to parents/caregivers of children with emotional disorders so they have a better understanding of the individual's needs, the importance of their voice in the development and implementation of the individualized treatment plan, the roles of the various providers, and the importance of the "team" approach; and assisting in the exploration of options to be considered as part of treatment.

6.3.2.5- BH ☒ Caregiver Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: Support services may be provided to the participant's family and significant others when such services are for the direct benefit of the participant, in accordance with the participant's needs and treatment goals identified in the participant's individualized treatment plan, and for assisting in the participant's recovery.
Components of both peer and caregiver support are listed above under peer support.

6.3.2.6- BH ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Response: Respite Care is not covered under CHIP. Children in need of respite care will be evaluated to determine whether the child is eligible for the state's Medicaid Comprehensive Community Support and MOCDD 1915(c) waivers.

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: Intensive short-term, home-based, crisis intervention services. These services are offered so that families can, through intervention, learn to nurture their children, improve their functioning, and gain support within their community to help the family remain safely together.

Intensive In-Home Services may be appropriate for families that have a child or children at risk of removal from the home due to abuse, neglect, family violence, mental illness, emotional disturbance, juvenile delinquency, or other circumstances.

Intensive In-Home Services combine skill-based intervention with maximum flexibility so that services are available to families according to their needs. The services available focus helping families in crisis improve their household so that they can safely remain together. Services are available statewide and include:

- Individual and family counseling
- Parenting education
- Child development training
- Household maintenance education
- Nutritional training
- Job readiness training
- Referrals to other community services

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: Medically necessary on-site services to maintain an individual in a community setting who has a history of failure in multiple community settings and/or the presence of ongoing risk of harm to self or others which would otherwise require inpatient treatment. This service is provided on a daily basis by a multi- disciplinary team. This service does not include the provision of room and board. When a child/adolescent is receiving this service, it is vital that the parents/guardians be actively involved in the program if the child/adolescent is to receive the full benefit of the program. Therefore, services may be provided to the participant's family and significant others when such services are for the direct benefit of the participant, in accordance with the participant's needs and treatment goals identified in the participant's individualized treatment plan, and for assisting in the participant's recovery.

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: A comprehensive service designed to reduce the disability resulting from mental illness, emotional disorders, and/or substance use disorders; restore functional skills of daily living; and build natural supports and solution-oriented interventions intended to achieve the recovery identified in the goals and/or objectives as set forth in the individualized treatment plan. This service may be provided to the participant's family and significant others when such services are for the direct benefit of the participant, in accordance with the participant's needs and treatment goals identified in the participant's individualized treatment plan, and for assisting in the participant's recovery. Most contact occurs in community locations where the person lives, works, attends school, and/or socializes.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response:

Mental health: Day Treatment for Youth is an intensive array of services provided in a structured, supervised environment designed to reduce symptoms of a psychiatric disorder and maximize functioning to a level that they can attend school, and interact in their community and family setting adaptively. Services are individualized based on the child's needs and include a multidisciplinary approach of care under the direction of a psychiatrist. The provision of educational services shall be in compliance with Individuals with Disabilities Education Act 2004 and Section 167.126, RSMo.

Key service functions include, but are not limited to the following:

a. providing integrated treatment combining education, counseling and family interventions;
b. promoting active involvement of parents or guardians in the program;
c. providing consultation and coordination to establish and maintain continuity of care with the child/family's private service providers;
d. coordinating and information sharing, consistent with Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act, and discharge planning with the school;
e. requesting screening and assessment reports for special education from the school;
f. planning with the school how the individualized education needs of each child will be addressed; and
g. additional core services as prescribed by the department.

Substance use disorder: Day treatment combines group rehabilitative support with medically necessary activities that are both structured and therapeutic and focus on providing opportunities for participants to apply and practice healthy skills, decision-making and appropriate expression of thoughts and feelings. This service is designed to assist the individual with compensating for, or eliminating functional deficits, and interpersonal and/or environmental barriers associated with substance use disorders. The intent is to restore, to the fullest extent possible, the individual to an active and productive member of his or her family, community, and/or culture. This service is provided in a group setting.

Key service functions of day treatment may include, but are not limited to, the following:

- When a beneficiary's skills are negatively impacted by a substance use disorder, providing group rehabilitative support, based on individualized needs and treatment plans, designed to promote an understanding of the relevance of the nature, course and treatment of substance use disorders, to assist participants in understanding their individual recovery needs and how they can restore functionality.
- Assistance in the development and implementation of lifestyle changes needed to cope with the side effects of addiction or psychotropic medications, and/or to promote recovery from the disabilities, negative symptoms and/or functional deficits associated with substance use disorder.
- Assistance with the restoration of skills and use of resources to address symptoms that interfere with activities of daily living and community integration.

The day treatment service limitation is:

- Group Rehabilitative Support may not be billed as a separate service while a participant is in day treatment.

Mental Health – Psychosocial Rehabilitation for Adults**:** Equivalent to day treatment and is designed to assist the individual with compensating for, or eliminating functional deficits, and interpersonal and/or environmental barriers associated with mental illness and/or substance use disorders. The intent of psychosocial rehabilitation is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture. This service is provided in a group setting.

Key components include:

- When a beneficiary's skills are negatively impacted by mental illness, an emotional disorder, and/or SUD, helping individuals restore skills and resources to address symptoms that interfere with activities of daily living and community integration.
- Assisting in the development and implementation of lifestyle changes needed to cope with the side effects of psychotropic medications, and/or to promote recovery from the disabilities, negative symptoms and/or functional deficits associated with mental illness, emotional disorders, and/or SUDs.

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: Coverage of partial hospitalization with XXI funds is only available as an

ILOS. If approved, the health plan may provide the ILOS to an individual at the health plan's option if it is a cost-effective alternative to another covered service.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response:

Mental health (under 21): Acute inpatient psychiatric hospitalization (not residential) is covered and is limited only by medical necessity, as determined by CALOCUS criteria in managed care and by MCG criteria in fee-for-service.

Federal regulations at Title 42 CFR 441 Subpart D and 456 Subparts D and G are very specific about the requirements for psychiatric services for participants under age twenty-one (21) in psychiatric facilities. Before admission to a psychiatric hospital, the physician member of the team responsible for the certification of need for services must make a medical evaluation of a participant's need for care in the hospital. The team responsible for certification of need for services must make a psychiatric and social evaluation. The medical evaluation must include:

1. diagnoses;
2. summary of present medical findings;
3. medical history;
4. mental and physical functional capacity;
5. prognoses; and
6. a recommendation by a physician concerning:
    a. admission to the mental hospital; or
    b. continued care in the mental hospital for individuals who apply for MO HealthNet while in the mental hospital.

Admission Status: The status of the child or youth at time of admission determines whether an independent team or the facility's interdisciplinary team is responsible for the certification of need for inpatient care.
It is important for psychiatric hospitals serving children and youths under age twenty-one (21) to determine whether or not an admission is an emergency. The type of admission determines if the certification for need for inpatient services and the medical/psychiatric/social evaluation must be made by an independent team or the hospital's interdisciplinary team. Following is a

definition of psychiatric emergency.

A psychiatric emergency is a condition requiring immediate psychiatric intervention as evidenced by:

1. impairment of mental capacity whereby the person is unable to act in his/her own best interest; or
2. behavior that is by intent an action dangerous to others; or
3. behavior and action that is dangerous to self.

Independent Review Team: If the admission is not an emergency and the individual is an eligible MO HealthNet participant at the time of admission, an independent team must make the certification of need on admission. The timeframe for completion of emergent vs. planned admission certification requests is the same.

It is the hospital's responsibility to establish an independent team. The team must include at a minimum a physician knowledgeable in mental illnesses and one other mental health professional. Team members must not be affiliated with the admitting hospital. Referrals made by the child's or youth's attending physician, if not affiliated with the hospital, can serve as the independent team for that admission. A physician and other mental health professionals employed part time by the hospital can be members of the independent team if they maintain a private practice or work at another hospital not under the same ownership at least fifty percent (50%) of the time.

Interdisciplinary Review Team: If the admission is an emergency or if the individual applies or is approved for MO HealthNet while in the facility, the facility's interdisciplinary team is responsible for the certification of need for inpatient care. The interdisciplinary team is responsible for the plan of care. For emergency admissions, certification of need must be made within fourteen (14) days of admission. Certification of need for individuals who become MO HealthNet eligible while in the hospital must be made before submitting a claim for payment and must cover any period for which MO HealthNet claims are made.

The required composition of the treatment facility's interdisciplinary team is given in state regulation at CSR 70-15.070. The team must have either:

1. A psychiatrist; or
2. A doctoral psychologist and a physician; or
3. A physician with training and experience treating mentally ill patients, and a psychologist with a master's degree.

In addition the team must include at least one other individual or professional who is either a psychiatric social worker, a registered nurse, an occupational therapist, or a master's level psychologist. The registered nurse and occupational therapist must have specialized training or experience in treating mentally ill individuals.

Certification of Need for Services: For inpatient psychiatric services provided in a psychiatric facility, an appropriate team must certify that:

- Ambulatory care resources in the community do not meet the needs of the youth;
- Proper treatment of the individual's condition requires inpatient services under the direction of a physician; and
- The services can reasonably be expected to improve the patient's condition or prevent further regression, so that services are no longer needed.

A Certification of Need for Psychiatric Services (IM-71) form is used to document and certify the need for inpatient psychiatric service. The form must be signed and dated by two of the team members, including the physician member. Blank IM-71 forms are kept in the Family Support Division office. A copy of a completed IM- 71 form should be sent to the Family Support Division office in the participant's county of residence.

Plan of Care: An individual plan of care must be developed and implemented within fourteen (14) days of admission and reviewed every thirty (30) days by the facility's interdisciplinary team.
The plan of care must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the participant's situation and reflects the need for inpatient psychiatric care;
2. Be developed by a team of professionals in consultation with the participant, the parents, legal guardians, or others to whose care the participant will be released after discharge;
3. State treatment objectives;
4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
5. Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the participant's family, school, and community upon discharge.

Active Treatment: Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care. Reference 42 CFR 441.154.

Mental health (adult): Inpatient services provided in an institution for mental disease (IMD) are not reimbursed for any MO HealthNet participant between the ages of twenty-one (21) and sixty-five (65), consistent with the federal IMD exclusion rules. Pregnancy status does not impact the IMD exclusion. However, adults may receive inpatient psychiatric treatment in psychiatric hospital that do not meet the definition of an IMD. For example, in a psychiatric unit of a general hospital or in a free-standing psychiatric hospital with fewer than 17 beds. Inpatient psychiatric hospitalization is limited only by medical necessity as determined by LOCUS criteria in managed care and MCG criteria in fee-for-service.

Substance Use Disorder (youth and adults): Alcohol and drug rehabilitation is not covered as an inpatient service. Inpatient detoxification services for the acute phase of substance use disorder is covered through the MO HealthNet hospital program . The initial length of stay is a maximum of three days and may be extended beyond three days if medically necessary.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☐ Residential Treatment
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Response: This service is not provided under the CHIP state plan. Children and pregnant women in need of mental health or substance abuse services provided through Comprehensive Substance Treatment and Rehabilitation Services (CSTAR) for SUD are referred to the Department of Mental Health Services to be assessed for behavioral health services, including residential treatment. If children or pregnant women meet clinical criteria for residential treatment services, they receive these services as long as medically necessary through the Department of Mental Health Services using state general revenue. There are no funding restrictions or limitations.

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

Response:

Inpatient hospital detoxification services: Inpatient detoxification services for the acute phase of substance use disorder is covered through the MO HealthNet hospital program. The initial length of stay is a maximum of three days and may be extended beyond three days if medically necessary.

Medically Monitored Detoxification: Detoxification is the process of withdrawing a participant from a specific psychoactive substance (alcohol, illegal drugs, and/or prescription medications) in a safe and effective manner to restore the participant to the functionality of someone not under the influence of drugs or alcohol. This service consists of the provision of care to participants whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24-hour supervised medical care and monitoring; however, the full resources of a hospital setting are *not* necessary. This service is provided in a residential setting, of 16 beds or less, certified by the DMH; however, this service does not include the provision of room and board.

The unit of service for medically monitored detoxification (MMD) is one day. The day the individual is admitted to MMD counts as day one. Thereafter, every day the individual is present past midnight will count as an additional day.

Medically Monitored Detoxification Service Limitations: Length of stay in an MMD program is limited to five days. Additional days may be authorized through Clinical Utilization Review.

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: Emergency behavioral health (including SUD and mental 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 means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, 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.

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: Community Support (for SUD and/or mental illness) includes supporting and assisting participants in crises to access needed treatment services to resolve a crisis. Peer and family support services also include crisis support.

Certified Community Behavioral Health Organization (CCBHO) services include crisis intervention. Psychotherapy for crisis is also covered in other clinics and individual and group practices without limitation.

Crisis Intervention is designed to interrupt and/or ameliorate a behavioral health crisis experience. The goal of crisis intervention is symptom reduction, stabilization, and restoration to a previous level of functioning.

Components include:

- 24-hour crisis hotlines
- 24 hour mobile crisis response
- Clinic-based crisis interventions and resolution
- Preliminary assessment of risk, mental status, and medical stability
- Stabilization of immediate crisis
- Determination of the need for further evaluation and/or behavioral health services
- Linkage to needed additional treatment services

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: For both mental health and SUD conditions, including services for adults and children/youth, development of a continuing recovery plan is a key part of discharge planning, transitioning to lower levels of care, and maintaining community tenure.

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: For managed care members, managed care health plans are responsible for care coordination of services included in the comprehensive managed care benefit package and for those services provided through the fee-for-service delivery system.

Community Support is provided by community mental health centers, which are certified by the Department of Mental Health. This is a comprehensive service, for adults and children/youth, to reduce the disability resulting from mental illness, emotional disorders, and/or substance use disorders; restore functional skills of daily living; and build natural supports and solution-oriented interventions intended to achieve the recovery identified in the goals and/or objectives as set forth in the individualized treatment plan.

6.3.7.1- BH ☐ Intensive wraparound
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Response: Wraparound funds are GR funded services and supports that can assist in stabilizing the youth's home environment such as necessary food for family, safety equipment/items (e.g. locks for exterior doors, utility payments).

6.3.7.2- BH ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: For both mental health and SUD conditions, including services for adults and children/youth, development of a discharge and aftercare/continuing recovery plan includes, if applicable, securing a successful transition to continued services.

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Response: Managed Care Health Plans are responsible for providing care management to selected members (screening for care management is required for members who are pregnant or who have specific diagnoses, including but not limited to, autism spectrum disorder, serious mental illness, moderate to severe substance use disorder; or who meet specific criteria including admission to a psychiatric hospital or residential substance use treatment program). The health plan's care management service shall focus on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving

patterns of issues that have negative quality, health, and cost impact; and creating opportunities and systems to enhance outcomes. The health plan may use a Section 2703 designated health home provider or the local community care coordination program (LCCCP) provider to perform care management functions if the health home and LCCCP provider are members of the health plan network. In this event, the health plan shall have processes in place to monitor service delivery. Physical health and behavioral health care management shall be integrated to the greatest extent possible. The health plan shall have a team of mixed specialists working together to provide the best level of integrated care management to all MO HealthNet members using an approach that includes both consistent interpersonal integration as well as integrated care management systems.

Targeted Case Management Youth: This service includes arrangement, coordination, and participation in the assessment to ensure that all areas of the child and family's life are assessed to determine unique strengths and needs. Coordination includes linking and arranging the supports necessary to access resources and facilitates communication between service providers.

Targeted Case Management Adult: This service is intended to assist participants in gaining access to needed psychiatric treatment and rehabilitation, as well as other medical, social, and educational services and supports.

6.3.9- BH ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☐ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☐ Substance Use Disorders

☐ InterQual
☐ Mental Health ☐ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☒ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☒ Mental Health ☒ Substance Use Disorders

☐ CASII (Child and Adolescent Service Intensity Instrument)

☐ Mental Health ☐ Substance Use Disorders

☐ CANS (Child and Adolescent Needs and Strengths)
☐ Mental Health ☐ Substance Use Disorders

☒ State-specific criteria (e.g. state law or policies) (please describe)
☒ Mental Health ☒ Substance Use Disorders

Response: For mental health, in addition to CALOCUS/LOCUS for inpatient psychiatric admissions, Missouri uses the DLA20 for adults and for children ages 6 and above, the DECA-C, Ages and Stages Social Emotional Screening tool; and the PECFAS in community settings for ages 2-5. For SUD services, state developed criteria distinguish three levels of outpatient care, apart from detoxification services or withdrawal management. These levels are called Community-based Primary Treatment, Intensive Outpatient Treatment, and Supported Recovery. People are assessed on a variety of components in order to determine the best level of care. These components include, but are not limited to, the following: symptom severity, need for structure and close monitoring, need for stabilization of emotional and behavioral functioning, willingness to actively engage in therapeutic activities, and availability of natural and community supports.

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

Response: Missouri has contractual requirements for managed care organizations to utilize LOCUS/CALOCUS for inpatient psychiatric admissions. The MCOs contract with Community Psych Rehab providers who are required by Department of Mental Health policy to use the DLA-20 for adults and children ages 6 and above, and the DECA-C, Ages and Stages Emotional

Screening Tool, or PECFAS for children ages 2 to 5.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

☐ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule
☒ Other (description attached)

Response: The MO HealthNet Division follows the Bright Futures Periodicity schedule as a standard for pediatric preventive services. Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics (AAP) and supported by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA).

6.2.2-DC ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by

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HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

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

6.2.2- MHPAEA Section 2103(c)(6)(B) of 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 §457.496(b) related to deemed compliance.

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.

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, §457.496(b)(3) limits deemed compliance to those children only and you must complete Section 6.2.3- MHPAEA to complete 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 (§457.496(b)(2)). 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)).

☐ 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 §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.

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 (§§457.496(d)(2)(ii); 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-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. However if a state does provide any mental health or substance use disorders, 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.

Annual and Aggregate Lifetime 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 (§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: If there are no aggregate lifetime or annual dollar limit 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.

☐ 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 (§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 (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 (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, as applicable, 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 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 (§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 least1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (§§457.496(c)(4)(i)(B); 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 §§457.496(c)(4)(i)(B) and 457.496(c)(4)(ii). Please include the state's methodology 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 (§457.496(c)(2)(i); (§457.496(c)(2)(ii)):

☐ 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 financial requirements 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 type of QTL on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class 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 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. (§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. (§457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology 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? (§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. (§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 §§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 compared to all medical/surgical benefits in the classification, as described in §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. (§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 predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§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 predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§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 (§§457.496(d)(4); 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.

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, provider reimbursement rates and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in §457.496(d)(4)(ii).

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 services provided by out of network providers?

☒ Yes

☐ No

6.2.6.2.2- MHPAEA If yes, 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

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.

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

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

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

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)) (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)) (42CFR 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)) (42CFR 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 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. (42CFR, 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)) (42CFR 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)) (42CFR 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)) (42CFR 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 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)) (42CFR 457.1010(b))

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

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))

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 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality**- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality

improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ 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 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

7.1.2. ☒ Performance measurement

7.1.2 (a) ☒ CHIPRA Quality Core Set

Response: MO HealthNet Managed Care health plans submit reports on Adult and Child Core Sets that reflect results stratified by several categories: gender, age group (as defined in each measure's specifications), race, ethnicity, and region (urban/rural).

The specific core sets are determined through coordination with the health plans and their HEIDS vendor (Inovalon).

7.1.2 (b) ☐ Other

7.1.3. ☐ Information strategies

7.1.4. ☒ Quality improvement strategies

Response: SCHIP 1 and SCHIP 2 is not a MO HealthNet entitlement but it will be implemented as a MO HealthNet look-alike program. SCHIP 1 and SCHIP 2 will use MO HealthNet's comprehensive benefit package, with the exception of not providing NEMT for children in families with income above 150% FPL, MO HealthNet Managed Care, and the Fee-For- Service delivery system, all quality and appropriateness of care measures, and grievance procedures.
In keeping with federal and state regulations, the MCOs must meet program standards for monitoring and evaluating systems as outlined in the MO HealthNet Managed Care contract. Each MCO must implement a Quality Improvement (QI) strategy that addresses the standards as noted but is not limited to the requirements within the MO HealthNet Managed Care QI Strategy or the MO HealthNet Managed Care contract. The MCOs provide the State with regular reports of utilization and quality assessment including special needs; lead poisoning prevention; member grievances and appeals; provider complaints; grievances and appeals; and fraud and abuse detection. An annual evaluation contains information related to utilization and clinical performance, accessibility standards, quality indicators, performance improvement projects, care management, and subcontractor oversight. Performance measures are reported in accordance with Health Plan Employer Data and Information Set (HEDIS) specifications. The required HEDIS measures are outlined in the QI Strategy. Please see Attachment 4.

The DHSS grants access to Missouri Health Strategic Architectures and Information Cooperative (MOHSAIC), DHSS' integrated public health information system, to public health staff, health care providers, and others who have a legal right to the information to better provide care and services. DHSS is responsible for assuring the confidentiality of data and information. Access to data is granted in accordance with state and federal laws. Access is limited to data needed to fulfill the requestor's responsibilities and/or to provide services. The MOHSAIC system is utilized by the MO HealthNet Fee-For-Service and MO HealthNet Managed Care Programs. The DHSS also monitors services provided to members with special health care needs.

External monitoring includes an annual, external quality review of the MCOs by an external quality review organization. The review is comprised of a compliance review analysis, encounter data validation, medical record review, and validation of MCO performance improvement projects and measures.

An external, annual evaluation will be conducted on SCHIP 1 and SCHIP 2. The evaluation is for the collection and analysis of information about SCHIP 1 and SCHIP 2 to study the impact of state agency policy decisions about the SCHIP 1 and SCHIP 2 on the enrollees in the program and on program participation by the uninsured.

Show-Me Healthy Babies Program
At least annually, an external evaluation will be conducted on the Show- Me Healthy Babies Program, analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities, and persons by enrolling unborn children in the Show-Me Healthy Babies Program.

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

Response: The delivery systems described below apply to MO HealthNet, SCHIP 1, and SCHIP 2.

MO HealthNet Fee-For-Service Delivery System
The MO HealthNet Division continues to identify barriers and develop strategies that guarantee maximum screening of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible children under both MO HealthNet Fee-For-Service and MO HealthNet Managed Care. The MO HealthNet Division continues to collaborate with other state and local agencies to identify problem areas that affect the screening and health care of children.

Activities to increase awareness of the importance of preventative health screenings include, but are not limited to, the following:

- The MO HealthNet Division continues to provide brochures regarding available EPSDT services. Missouri FSD county offices, and any other entity requesting supplies, distribute the EPSDT brochures. Please see Attachment 5.
- Reminder letters are sent to each child on or shortly after they become age appropriate for a health screen according to the periodicity schedule. Please see Attachment 6.
- The MO HealthNet Division allows providers to use electronic record keeping of the ESPDT screening components instead of the paper screening forms.
- The MO HealthNet Division held meetings with health care providers and other state agencies to review and revise the EPSDT screening forms.

The MO HealthNet Division continues outreach efforts in conjunction with DHSS through a cooperative agreement. Collaboration between the two agencies consists of:

- Local public health agencies continue to view and download county-specific EPSDT reports each month for outreach and follow-up. The EPSDT reports are available electronically.
- Participation in initiatives of DHSS that support well child issues—Folic Acid Advisory Group and the Crosswalk Team.
- Initiate collaborative meetings in conjunction with the SCHIP 1 and SCHIP 2. This statewide effort brings together local public health agencies and schools to enhance outreach efforts to families of children eligible for SCHIP 1 and SCHIP 2.
- Well child care (including Health Children and Youth (HCY) exams) information about SCHIP 1 and SCHIP 2 is available on the DHSS website, *Baby Your Baby* pages: http://www.dhss.mo.gov/babyyourbaby/.

MO HealthNet Managed Care Delivery System

The contract with the MCOs include service accessibility standards for 24-hour coverage, travel distance standards, appointment standards, and care management. The monitoring of the standards is further outlined in the QI Strategy. The HEDIS measures in the QI Strategy include childhood immunizations, well child visits, adolescent well child visits, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The State continues to include language in the MO HealthNet Managed Care

contracts tying EPSDT performance to capitation payments.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Response: The comprehensive benefit package for SCHIP 1 and SCHIP 2 includes emergency medical/mental health services.

The contract with the MCOs include service accessibility standards for 24-hour coverage, prior authorization, travel distance standards, appointment standards, and care management. The monitoring of the standards is further outlined in the QI Strategy.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

Response: The delivery systems described below apply to MO HealthNet, SCHIP 1, and SCHIP 2.

MO HealthNet Managed Care Delivery System

The contract with the MCOs include service accessibility standards for 24-hour coverage, prior authorization, travel distance standards, appointment standards, and care management. The monitoring of the standards is further outlined in the QI Strategy.

In addition, the MCO shall have established written policies and procedures concerning:

- How a member may obtain a referral to an out-of-network provider when the MCO does not have a health care provider with appropriate training or experience in the network to meet the particular health care needs of the member;
- How a member, with a condition which requires on-going care from a specialist, may request a standing referral to such a specialist; and
- How a member, with a life-threatening condition or disease, either of which requires a specialized medical care over a prolonged period of time, may request and obtain access to a specialty care center.

The MCO must provide adequate access to physician specialists for PCP

referrals and employ or contract with physician specialists in sufficient numbers to ensure specialty services can be made available in a timely manner. The MCO shall have protocols for coordinating care between PCPs and specialists which include the expected response time for consults between PCPs and specialists.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Response:

MO HealthNet Fee-For-Service Delivery System

Under the MO HealthNet Program, certain covered services and equipment require approval from the DSS, MO HealthNet Division, prior to provision of the service as a condition of reimbursement. Prior authorization is used to promote the most effective and appropriate use of available services and to determine in conjunction with the ordering provider, the medical necessity of the service.

Providers are required to seek prior authorization for certain specified services before delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.
Certain services require prior authorization only when provided in a specific place or when they exceed certain limits.

The Pharmacy and Clinical Services Unit of the MO HealthNet Division operates a toll-free hotline for providers to request overrides on drug products with restricted access due to clinical or fiscal edits and prior authorization. The hot- line staff operate an internet web portal-based system to process requests for drug products, which have been denied through the point-of-service claims processing system.
The Unit is also responsible for responding to requests through the Exception Process for essential medical items or services, including insulin pumps and supplies, which are not typically reimbursed through the MO HealthNet Program.

The MCOs have written policies and procedures for prior authorization of non-emergency services and the time frames in which authorizations will be processed (approved or denied) and providers and members are notified. The policies and

procedures include the requirement to not exceed 14 calendar days following the receipt of the request of service to provide approval or denial.

MO HealthNet Managed Care Delivery System

The MCOs have written policies and procedures for prior authorization of non-emergency services and the time frames in which authorizations will be processed (approved or denied) and providers and members are notified. The policies and procedures include the requirement to not exceed 14 calendar days following the receipt of the request of service to provide approval or denial.

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.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☒ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☒ Premiums:

Response: The premium amounts are calculated according to Missouri State law (the State Fiscal Year Budget and MO Revised Statute Section 208.640). Families of children in SCHIP 1 shall pay the following premium based on family size and income to be eligible to receive services:

- Enrollees with incomes above 150 percent of the FPL and up to 185 percent of the FPL shall pay four percent of the difference in income between 150 and 185 percent of the FPL.
- Enrollees with incomes above 185 percent of the FPL and up to

225 percent of the FPL shall pay:
  - four percent of the difference in income between 150 and 185 percent of the FPL;
  - plus eight percent of the amount of difference in income between 185 percent of the FPL and 225 percent of the FPL.

- Enrollees with incomes above 225 percent of the FPL and up to 300 percent of the FPL shall pay:
  - four percent of the difference in income between 150 and 185 percent of the FPL;
  - plus eight percent of the amount of difference in income between 185 percent of the FPL and 225 percent of the FPL;
  - plus 14 percent of the amount of difference in income between 225 and 300 percent of the FPL.
- In no case shall the family be charged more than 5% of the family's gross income. The premium invoicing system is designed to not invoice a monthly premium in excess of 5% of the family's gross annual income divided by twelve (12).

The following table presents an example of the premium calculation.

SCHIP 1 Premium Responsibilty											
Amount of Family Income	0 - 150 FPL		150 - 185 FPL		185 - 225 FPL		225- 300 FPL				**5% Income Test**
Premium Amount:	0	+	(Income at 185 - Income at 150) * .04	+	(Income at 225 - Income at 185) * .08	+	(Income at 300 - Income at 225) * .14	=	Premium Responsibility		**Not to exceed 5% of Family Income**
Example Using July 1, 2009 FPL											
Income:	0 - $1,354.00	+	($2,823 - $2,289) = $539 * .04 = $21	+	($3,434 - $2,823) = $611 * .08 = $49	+	($4,578 -$3,434) = $1,144 * .14 = $160				
Family of 3: 150 - 185	0	+	$21	+	$0	+	0	=	$21		$2,289 * .05 = $114
Family of 3: 185 - 225	0	+	$21	+	$49	+	0	=	$70		$2,823 * .05 = $141
Family of 3: 225 - 300	0	+	$21	+	$49	+	$160	=	$230		$3,434 * .05 = $172 Cut back premium to $172

At the State's discretion, provisions related to premium collection and other cost-sharing provisions may be modified or waived in response to a disaster or emergency as outlined in section 1.4, including the following:

- Freezing any scheduled increases to CHIP premiums; and,
- Waiving premiums.

8.2.2. ☐ Deductibles:

8.2.3. ☐ Coinsurance or copayments:

8.2.4. ☐ Other:
Response: The Show-Me Healthy Babies Program does not have any cost-sharing requirements.

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

Response: The Eligibility Specialist at FSD mails an approval notice to recipients when they are approved for SCHIP 1. The approval notice advises the recipients if they must pay a premium to be eligible for coverage and the premium chart is attached to the approval notice.

Following initial approval for coverage, an invoice is mailed to recipients each month billing them for the next month's premium. The monthly invoice also directs recipients to contact their FSD Eligibility Specialist to report any changes in income, family size, or address. The recipient is asked to report such changes within 10 days of receipt of the invoice. The premium chart and information about premiums may also be found on the DSS website and in outreach/educational materials.

The premium is based on family size and income to ensure that no family pays more than 5% of their income for coverage. The invoice that is due in July for August health care coverage reflects the new premium amount. The premium chart is updated and mailed to recipients annually each June.

The Missouri General Assembly considered and approved a statutory change to allow for the submission of a combination SCHIP State Plan in Senate Bill 577 passed by the 94th Missouri General Assembly on May 18, 2007, and signed by the Governor on July 2, 2007.

To ensure public input in Missouri's Separate Children's Health Insurance Program, the MO HealthNet Division conducts quarterly meetings with the following groups.

- Managed Care Consumer Advisory Committee
- All Plan Meeting
- Quality Assessment and Improvement Advisory

These meetings are scheduled one year in advance and are open to group members, MO HealthNet Division personnel, and invited guests. These meetings are also open to members of the public. Meeting notices are posted at the State Capitol, the Broadway State Office Building, Department of Social Services offices, the Howerton Building, the Jefferson Building, and on the MO HealthNet Division website at http://www.dss.mo.gov/mhd/.

A presentation on the change from a Medicaid expansion to a combination SCHIP program was given at the June 20, 2007 Managed Care Consumer Advisory Committee meeting. A similar presentation will be given at the Quality Assessment and Improvement Advisory group meeting on July 25, 2007, and the All Plan Meeting on July 26, 2007.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

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)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-

appropriate immunizations. (Section 2103(e)(2)) (42CFR 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)) (42CFR 457.515(f))

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in §457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits (§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 (§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 §457.560 (§457.496(d)(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: 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 disorder benefits, the state must conduct a parity analysis. Please continue below.

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 proportion 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) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits (§457.496(d)(3)(i)(E)).

Guidance: Please include the state's methodology 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? (§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. (§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 §457.496(d)(3)(i)(B)(1)) 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. (§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

predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§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 predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§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))

Response: Premium adjustments are calculated annually with an effective date of July 1. The premium is based on family size and income to ensure that no family pays more than 5% of their income for coverage. The formula used to calculate the monthly premium amount each year includes a factor to ensure the annual aggregate cost-sharing for a family does not exceed 5% of the family's income for the length of the child's eligibility period.

At the time of application, the recipient is advised to contact their FSD Eligibility Specialist to report any changes in income, family size, or address. The monthly invoice also directs recipients to contact their Eligibility Specialist to report any changes in income, family size, or address. The recipient is asked to report any changes within 10 days of receipt of the invoice.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

Response:

Missouri exempts children who are members of federally-recognized tribes from cost-sharing requirements as stipulated in Section 2103(e)(1)(A). Children who identify themselves as American Indian or Native Alaskan on the SCHIP application will be notified that, upon receipt of documentation of tribal membership, they will no longer be

required to submit monthly premiums. Any premiums paid will be reimbursed within 45 days of receipt of documentation of tribal membership. The materials sent to all new enrollees will include information on the cost-sharing exemption for members of federally-recognized American Indian or Native Alaskan tribes to ensure that those not indicating race on the application will be notified of this exemption.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Response: Premium payments are for 30 days of coverage and are paid one month in advance. A failure to pay notice is sent to recipients who have not made a payment, giving them a 30 day grace period to pay. Children with incomes between 225% and 300% of FPL have a ninety (90) day penalty applied if they fail to pay required premiums and are not eligible for coverage until the ninety (90) days expire. This penalty provision does not apply to those children between 150% and 225% of FPL who may fail to pay a required premium.. Children cannot be disenrolled during a continuing eligibility (CE) period.

The Notice of Case Action provides for Hearing Rights due to failure to pay a required premium. If they request a hearing within ten days of the date of the notice, they will continue to receive benefits.

Once the recipient receives an adverse action notice they can call, write, or email to request a hearing. Once the hearing request is received, the recipient is mailed a Hearing Packet which must be completed and returned. When the Hearing Packet is returned, the Hearing Unit with the Division of Legal Services (DLS) is notified. DLS sets the time and date for the hearing. The recipient can present evidence or have someone testify on their behalf. The DLS Hearing Officer asks all the questions, and the recipient and the DLS Hearing Officer are given the opportunity to respond and present evidence. After the hearing is complete the DLS Hearing Officer makes a decision based on the evidence presented. Once the decision is complete all parties are notified and whatever action is taken.

At the State's discretion, provisions related to deadlines and timeliness may be modified or waived in response to a disaster or emergency as outlined in section 1.4, including the following:

- Allow waiver of penalty for failure to pay premiums for undue hardship. If the premium obligation is not met during the emergency period, Missouri will not

discontinue coverage; and,

- The premium lock-out policy is temporarily suspended and coverage is available regardless of whether the family has paid their outstanding premium for existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

Response: The Late Payment Notice notification allows SCHIP 1 participant Hearing Rights. If they request a hearing within ten days of the date of the notice, they will continue to receive benefits.

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. ☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4 ☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

Response: Once the recipient receives an adverse action notice they can call, write, or email to request a hearing. Once the hearing request is received the recipient is mailed a Hearing Packet which must be completed and returned. When the Hearing Packet is returned, the Hearing Unit with the Division of Legal Services (DLS) is notified. DLS sets the time and date

for the hearing. The recipient can present evidence or have someone testify on their behalf. The DLS Hearing Officer asks all the questions, and the recipient and the DLS Hearing Officer are given the opportunity to respond and present evidence. After the hearing is complete the DLS Hearing Officer makes a decision based on the evidence presented. Once the decision is complete all parties are notified and whatever action is taken.

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

Response*:* Refer to the CS20 form.

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section

2107(a)(2)) (42CFR 457.710(b))

Response:

The State's strategic objectives are:

Objective #1: Reduce the number of uninsured children.
Objective #2: Increase access to care.
Objective #3: Increase the number of children in Missouri who have access to a regular source of healthcare coverage.
Objective #4: Improve the health of Missouri's medically uninsured children through the use of preventive care, including annual dental visits.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Response:

Objective #1: Reduce the number of uninsured children.
Performance Goals:

1. Reduce the number of insured children by 0.02% annually by decreasing the rate of uninsured children to 11.75%.
2. Increase CHIP enrollment by 0.02% annually by enrolling at least 110,000 participants.
3. Increase Medicaid enrollment by 2% annually by enrolling at least 665,000 participants.

Objective #2: Increase access to care.
Performance Goal:

- Increase the enrollment of MO HealthNet primary care providers by 2% annually by enrolling at least 3,000 providers.

Objective #3: Increase the number of children in Missouri who have access to a regular source of healthcare coverage.
Performance Goal:

- Decrease the percent of children matched to a PCP through auto-assignment by increasing the amount by 5% annually to a rate of at least 10%.

Objective #4: Improve the health of Missouri's medically uninsured children through the use of preventive care, including annual dental visits.
Performance Goals:

1. Increase the number of children who receive EPSDT screening by 2% annually by increasing the rate to 44%.
2. Increase the number of children who receive annual dental visits by 3% annually by increasing the rate to 44%.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Response: The CHIP program has the following strategic goals: reduce the number of children and unborn children in Missouri without health insurance coverage; ensure appropriate access to care; promote wellness and prevention; ensure cost effective utilization of services; promote member satisfaction with experience of care. The Missouri Department of Social Services, MO HealthNet Division (DSS/ MHD) conducts

a separate annual evaluation of Missouri's program for health care for uninsured children, the Children's Health Insurance Program (CHIP). This annual report is submitted to the General Assembly as required by Section 208.650, RSMo. The report analyzes the successes of the program and its importance to Missouri's children. The State also utilizes this report to recognize opportunities for improvement in the program and collaborate with our health plans to improve outcomes of care. Missouri also analyzes network adequacy based on the standards established in Missouri's Code of State Regulations (20 CSR 400-7.095). This allows the State to ensure gaps in access to care do not impact our participants. DSS/MHD collaborates with the Missouri Department of Health and Senior Services (DHSS) to monitor preventable hospitalizations for the CHIP population. Providing access to quality care at a young age continues to show a downward trend in hospitalizations and emergency room visits. Since 2009, preventable hospitalizations for all diagnoses in the CHIP population have declined from 10.9 per 1,000 Missouri children to 6.5 per 1,000 Missouri children in 2020. During this same timeframe, emergency room visits have also declined. In 2009, there were 590 Missouri children admitted to the emergency room. In 2020 there were only 274. The DSS/MHD collaborated with our contracted managed care health plans to develop a new performance withhold model based on HEDIS rates. Historically, this program was based on home-grown measures that we found difficult to collect data on and recognize improvement and impact. Beginning in January 2021, this program was based on 15 HEDIS measures, three of which target the CHIP population. These are Well-Child Visits in the First 30 Months of Life (0-15 months) 6+ Visits, Well-Child Visits in the first 30 months of life (15-30 months) two or more visits, and Annual Dental Visits. HEDIS rates from CY21 will be used as a baseline for evaluation of performance in CY22/SFY 2023.By utilizing HEDIS measures, Missouri will be able to better identify opportunities for improvement and highlight successes. CAHPS survey results are also analyzed utilized to monitor the satisfaction with the experience of care received among CHIP participants. Missouri is above the national average with respect to satisfaction related to actual providers and satisfaction with the child's health plan annually to ensure CHIP participants have the appropriate access to care. Missouri is above the national average on specialty care measures and is within one percent of the national average for the preventative care access measure. CAHPS is also utilized to monitor the satisfaction with the experience of care received among CHIP participants. Missouri is above the national average with respect to satisfaction related to actual providers and satisfaction with the child's health plan.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the

health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- **9.3.7.1.** ☒ Immunizations
- **9.3.7.2.** ☒ Well childcare
- **9.3.7.3.** ☒ Adolescent well visits
- **9.3.7.4.** ☒ Satisfaction with care
- **9.3.7.5.** ☒ Mental health
- **9.3.7.6.** ☒ Dental care
- **9.3.7.7.** ☒ Other, list:

Response: Please see Attachment 4, MO HealthNet Managed Care Quality Improvement Strategy, Exhibits 1 and 3.

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. ☒ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

Response: This population will become part of our SCHIP 1 and SCHIP 2 reporting. All necessary SCHIP 1 and SCHIP 2 reports and documentation will be submitted. Please refer to Attachment 4.

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. ☒ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Response: To ensure public involvement in the design and implementation of SCHIP 1, SCHIP 2, and the Show-Me Healthy Babies Program, the MO HealthNet Division considers suggestions made to the Missouri General Assembly. The Missouri General Assembly holds a series of public hearings in conjunction with the approval of the annual budget for Missouri and as they consider changes in state law.

In addition, to ensure public involvement in SCHIP 1, SCHIP 2, and the Show-Me Healthy Babies Program, the Quality Assessment and Improvement Advisory (QA&I) Group, a partnership of representatives for the major stakeholders in the Missouri MO HealthNet Managed Care Program, collaborates for the purpose of:

- Ensuring that high-quality care is provided to MO HealthNet Managed Care members enrolled in MO HealthNet Managed Care and helping MO HealthNet be accountable to the public and MO HealthNet Managed Care members;

- Adopting appropriate broad measurable population-based quality indicators, including measures of access, utilization, structure, process, outcomes, member satisfaction, and risk behaviors;
- Interpreting quality data prioritizing areas for improvement, and recommending improvement activities;
- Monitoring the care provided to this group of MO HealthNet Managed Care members for serious variances from high quality processes and outcomes;
- Fostering, supporting, and enhancing the quality improvement programs of individual MCOs and provider groups;
- Providing a forum where quality concerns of the MO HealthNet Division, other state agencies, MCOs, providers, and MO HealthNet Managed Care members can be communicated, thus forming a public-private partnership dedicated to improving the health of MO HealthNet Managed Care members.

The QA&I meetings are open to members of the public. Meeting discussions are open to group members, MO HealthNet personnel, and invited guests. The meeting agenda includes an open forum in which input from the public is solicited for discussion, comment, and review. QA&I meetings are scheduled one year in advance and held quarterly. Meeting notices are posted at the State Capitol, the Broadway Building, the DSS offices at the Howerton Building, and the Jefferson Building, and on the MO HealthNet website at http://www.dss.mo.gov/mhd/.

On an ongoing basis the QA&I Advisory Group will advise the MO HealthNet Division regarding health policy that: improves the health status of MO HealthNet clients, maintains or reduces the cost of health care while maintaining or improving quality of care, and describes best practices.

The role of the QA&I subcommittees will be to evaluate, refine, and recommend sentinel indicators, recommend intervention strategies, and review satisfaction and audit data as it relates to maternal and child health and behavioral health issues. The QA&I subcommittees will also communicate provider complaints and system issues to the QA&I Advisory Committee and the MO HealthNet Division and respond to ad hoc requests of the QA&I Committee.

The MO HealthNet Managed Care Consumer Advisory Committee (CAC) was formed to advise the Director of the MO HealthNet Division on issues relating to enrollee participation in the MO HealthNet Managed Care Program. The committee meets quarterly in Jefferson City and consists of a minimum of 15

enrollees and advocates. The CAC meetings provide updates from other state agencies that would impact their benefits. The MCOs also attend the meetings. CAC members are given the opportunity to suggest agenda items for each meeting. A notice of open meeting is posted prior to the meetings. The notice of open meeting includes the agenda items for the meetings.

The MO HealthNet Division also conducts Quarterly All Plan Meetings for the MCOs. These meetings are an opportunity for the MO HealthNet Division and the MCOs to discuss issues related to the MO HealthNet Managed Care Program. The meetings also provide updates from other state agencies that affect the MO HealthNet Managed Care Program. A notice of open meeting is posted prior to the meetings. The notice of open meeting includes the agenda items for the meetings. The MCOs are given an opportunity to suggest agenda items for each meeting.

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Response:

Section 1902(a)(73) of the Social Security Act requires any state with one or more Indian Health Programs or Urban Indian Organizations that furnish health care services, provide for a process under which the state seeks advice on a regular basis on matters prior to submission of any state plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. In October 2021, CMS informed MO HealthNet Division that Missouri has an Urban Indian Organization in Kansas City, Missouri. The organization is called the Kansas City Indian Center (KCIC). MHD met with KCIC on February 2, 2022 to establish the consultation process.

For changes that directly impact their organization or Native American enrollees, the State of Missouri will send all federally-recognized tribes, Indian Health Programs and Urban Indian Organizations (UIO) within the State of Missouri an electronic notification for all Medicaid and CHIP state plan amendments, waiver requests and demonstration project proposals prior to submission to CMS in order for tribal/UIO leaders to provide feedback. The notification will describe the purpose of the state plan amendment(s), waiver request(s) or demonstration project proposal(s), the anticipated impact on the UIO or Native American enrollees and provide information regarding the process for which to provide comments. The notification will provide a 30 day time period for review and comment.

For changes that the State determines do not directly impact the UIO or Native American enrollees, the State will still provide an email notification. The email will notify the UIO that a direct impact is not anticipated, but a review of the proposals and comments would still be welcome.

If a state plan amendment, waiver request or project proposal needs to be submitted to CMS under circumstances that would require less than 30 days' notice, the State will notify the UIO, via a phone call and a follow-up electronic notification. This notice will include a description of state plan amendment, waiver request or demonstration project proposal. It will either describe the process and time period for review and submission of comments or describe any other agreed upon process specific to the situation requiring less than 30 days' notice.

The State will use the consultation process to provide notice of proposed pregnant women expansions when they occur.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Response: The Missouri General Assembly holds a series of public hearings in conjunction with the approval of the annual budget for Missouri and as they consider changes in State law. Once the hearings are complete and the budget has been approved, the premium amounts are calculated. A notice is mailed to affected individuals 30 days prior to implementation of changes. A monthly invoice is mailed to participants thirty days in advance, billing them for the next month's premium. The premium chart and information regarding premiums is posted on the Department of Social Services' website and in outreach and educational materials. Public Notice is also provided through amendments to 13 CSR 70- 4.080, State Children's Health Insurance Program, published in the Missouri Register with a 30 day public comment period.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

Response: Missouri does not use Express Lane eligibility.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
    - Projected amount to be spent on health services;

    - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
    - Assumptions on which the budget is based, including cost per child and expected enrollment.
    - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
    - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

CHIP Budget

STATE:	**FFY Budget**
Federal Fiscal Year	
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate	
Fee for Service	
Total Benefit Costs	
(Offsetting beneficiary cost sharing payments)	

STATE:	FFY Budget
Net Benefit Costs	
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	
General administration	
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	
Other	
Total Administration Costs	
10% Administrative Cap	
Cost of Proposed SPA Changes	
Federal Share	
State Share	
Total Costs of Approved CHIP Plan	

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds:

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. **Annual Reports.** The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uninsured low-income children and

report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC ☒ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

☐ 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 to Section 12.

11.1. ☒ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

- **11.2.1.** ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- **11.2.2.** ☒ Section 1124 (relating to disclosure of ownership and related information)
- **11.2.3.** ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- **11.2.4.** ☒ Section 1128A (relating to civil monetary penalties)
- **11.2.5.** ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- **11.2.6.** ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded

eligibility under the State's Medicaid plan.

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Response:

Missouri maintains an independent State fair hearing process as required by federal law and regulation, as amended for MO HealthNet, SCHIP 1, SCHIP 2**,** and the Show-Me Healthy Babies Program. The State fair hearing process shall provide recipients an opportunity for a State fair hearing before an impartial hearing officer. The parties to the State fair hearing include recipients, his or her representative, or the representative of a deceased recipient's estate. The State agency shall comply with decisions reached as a result of the State fair hearing process. MO HealthNet, SCHIP 1, and SCHIP 2 recipients have the right to request information regarding:

- The right to request a State fair hearing.
- The procedures for exercising the rights to appeal or request a State fair hearing.
- Representing themselves or use legal counsel, a relative, a friend, or other spokesperson.
- The specific regulations that support or the change in federal or state law that requires the action.
- The individual's right to request a State fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.
- A State fair hearing within 90 calendar days from the notice of action.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

Response: Missouri maintains an independent State fair hearing process as required by federal law and regulation, as amended for MO HealthNet, SCHIP 1, SCHIP 2**,** and the Show-Me Healthy Babies Program. The State fair hearing process shall provide recipients an opportunity for a State fair hearing before an impartial hearing officer. The parties to the State fair hearing include recipients, his or her representative, or the representative of a deceased recipient's estate, and the MCOs if applicable. The State agency and/or MCO shall comply with decisions reached as a result of the State fair hearing process. MO HealthNet, SCHIP 1, and SCHIP 2 recipients have the right to request information

regarding:

- The right to request a State fair hearing.
- The procedures for exercising the rights to appeal or request a State fair hearing.
- Representing themselves or use legal counsel, a relative, a friend, or other spokesperson.
- The specific regulations that support or the change in federal or state law that requires the action.
- The individual's right to request a State fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.
- A State fair hearing within 90 calendar days from the MCOs notice of action.

The State must reach its decisions within the specified timeframes:

- Standard resolution:
    - Within 90 calendar days of the date the member filed the appeal with the MCO if the member filed initially with the MCO (excluding the days the enrollee took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
- Expedited resolution (if the appeal was heard first through the MCO appeal process): within three working days from the state agency's receipt of a hearing request for a denial of a service that:
    - Meets the criteria for an expedited appeal process but was not resolved using the MCOs expedited appeal timeframes, or
    - Was resolved wholly or partially adversely to the member using the MCOs expedited appeal timeframes.

Expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the MCO appeal process): within three working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of

eligibility.

Response: Premium Assistance through HIPP was removed as part of MO SPA 22-0012. This SPA utilized Section 4.22 of the State Plan.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
    a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
    b. performed under the general supervision or at the direction of a physician, or
    c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. IN GENERAL- Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
    a. who has been determined eligible by the State for child health assistance under the State plan;
    b. (i) who is a low-income child, or
    (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
    c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
    a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
    b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. MEDICAID APPLICABLE INCOME LEVEL- The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

assistance under Section 1902(l)(2) for the age of such child.

5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term ‘targeted low-income pregnant woman’ means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term ‘child’ means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. POVERTY LINE DEFINED- The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term ‘uninsured child’ means a child that does not have creditable health coverage.