

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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides 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. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

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Missouri Application for the State Children's Health Insurance Program

**MODEL APPLICATION TEMPLATE FOR
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OF THE SOCIAL SECURITY ACT
STATE 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 State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State 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: Brian Kinkade	Position/Title: Interim Director, Department of Social Services
Name: Ian McCaslin, M.D., M.P.H	Position/Title: Director, MO HealthNet Division

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

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Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The State will use funds provided under Title XXI primarily for (check appropriate box): (42 CFR 457.70)

1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Section 2103); **OR**

1.1.2 Providing expanded benefits under the State’s Medicaid plan (Title XIX); **OR**

1.1.3 A combination of both of the above.

Response:

¹ SCHIP 1: Children under age 1	Children in families with gross incomes of more than 185% 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

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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.

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. Fee-for-service will be utilized in regions where MO HealthNet managed care is not yet available. When MO HealthNet managed care begins in these areas, Title XXI eligibles will be enrolled in MO HealthNet managed care. No new eligible will be excluded because of pre-existing illness or condition.

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SCHIP 1

Missouri proposes that uninsured children under age 1 with family income more than 185% 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 receive a benefit package of essential medically necessary health services, excluding NEMT. This benefit is so unheard of in any health insurance plan that its inclusion serve as a significant incentive for dropping of private coverage. Prescription drugs are subject to the national drug rebate program requirements. Fee-for-service is utilized in regions where MO HealthNet Managed Care is not yet available. When MO HealthNet Managed Care begins in these areas, Title XXI eligibles will be enrolled in MO HealthNet Managed Care.

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. The program does not require an asset test.

An asset test and a resource standard are the same. In Missouri, programs that have an asset test or resource standard compare the family's available assets or resources to a standard. Certain assets or resources may be excluded when determining if the family's assets or resources are below the maximum allowable to qualify for the program. Missouri does not have an asset test or resource standard for SCHIP 1. The net worth test for SCHIP 1 is \$250,000. The net worth test for SCHIP 1 children in families with income that exceeds 150% of the Federal Poverty Level (FPL) is calculated by considering the value of all assets or resources minus any debt owed. There are no assets or resources excluded when determining net worth for SCHIP 1.

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.

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- 1.2 Please 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 Please 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

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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. (42 CFR 457.130)

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

Response:

Effective date (date State incurs costs):

Initial Combination SCHIP State Plan Submission, SPA #3: September 1, 2007

SPA #4: Disapproved December 19, 2008

SPA #5: Effective May 1, 2009

SPA #6: Effective July 1, 2009

SPA #7: Withdrawn June 29, 2011

SPA #8: Effective July 1, 2011

Implementation date (date services begin):

SPA #3: September 1, 2007

SPA #4: Disapproved December 19, 2008

SPA #5: May 1, 2009

SPA #6: July 1, 2009

SPA #7: Withdrawn June 29, 2011

SPA #8: Effective July 1, 2011

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Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

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

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/Missouri_Final_Report.pdf.
Note: The Missouri Foundation for Health analyzed and compared

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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).

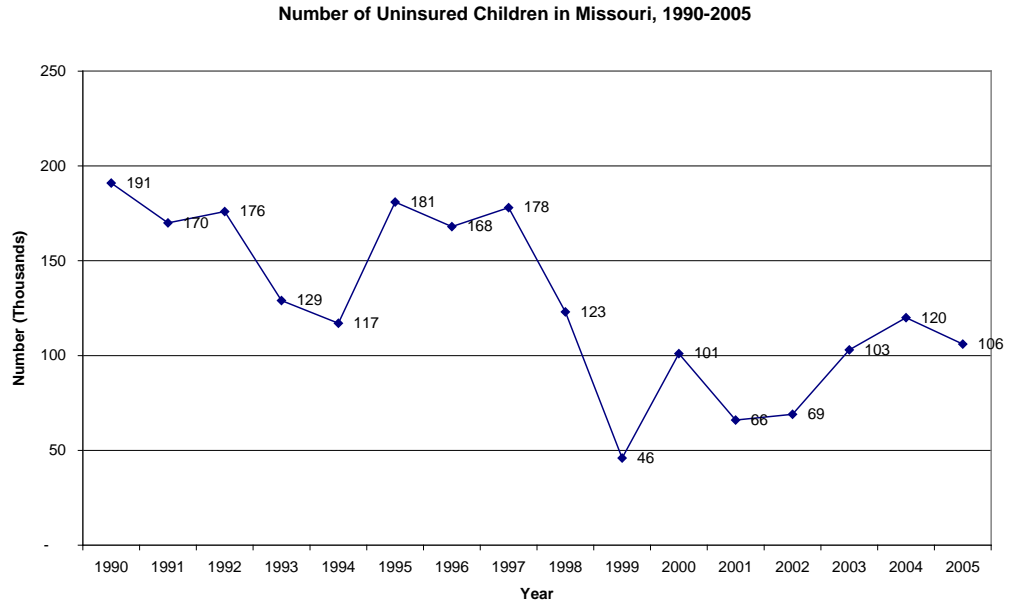
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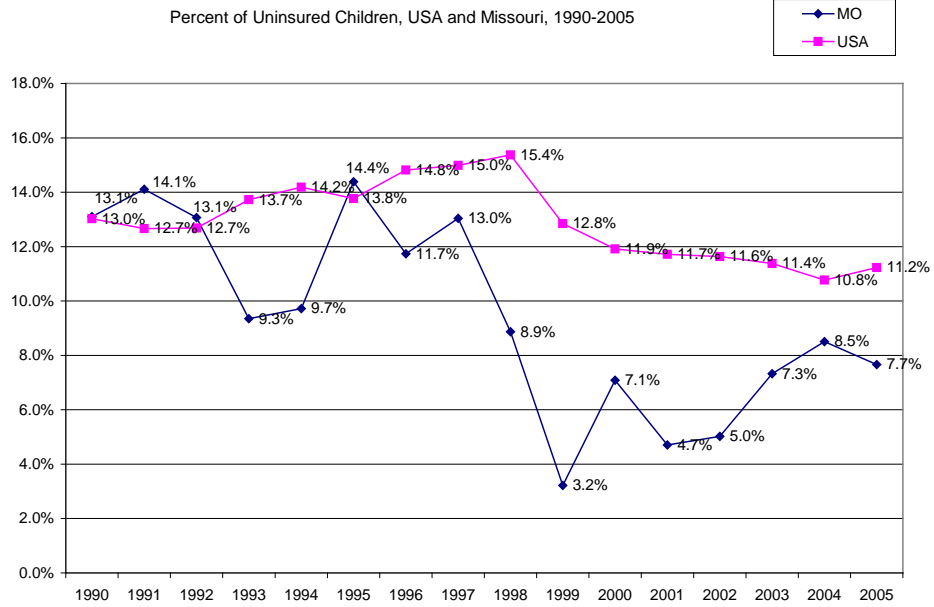
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Figure 1



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/hihist5.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/hihist5.html>.

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- 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.

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Table 1

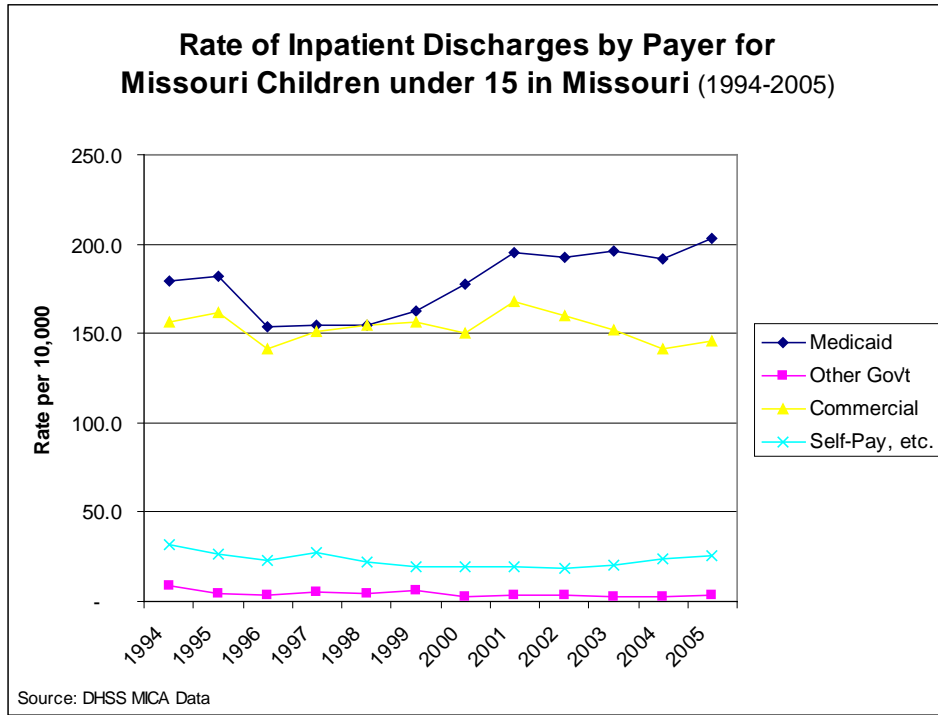
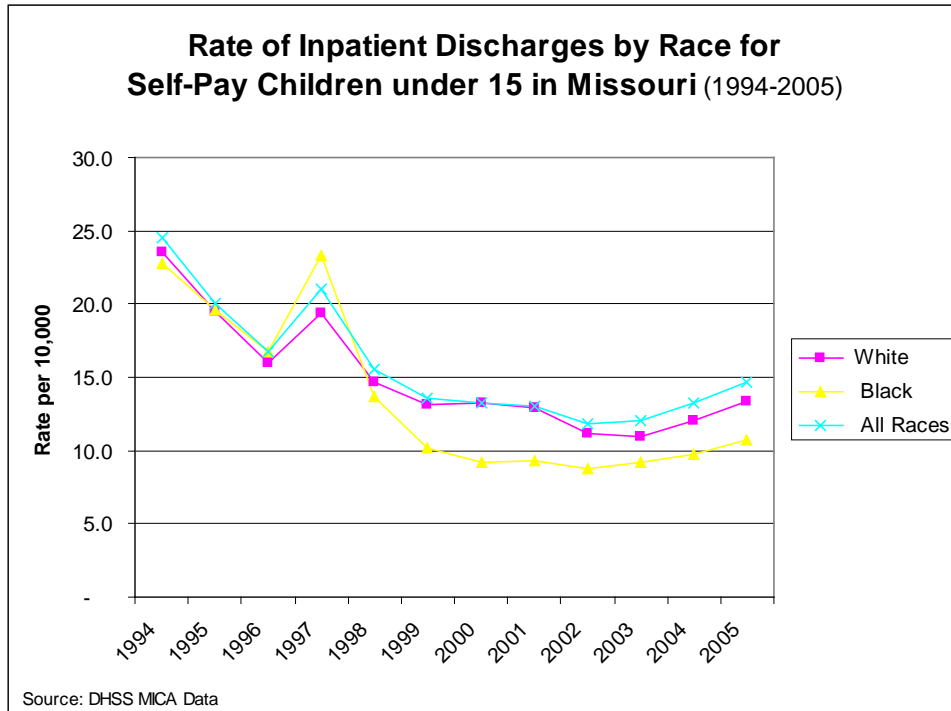


Table 2

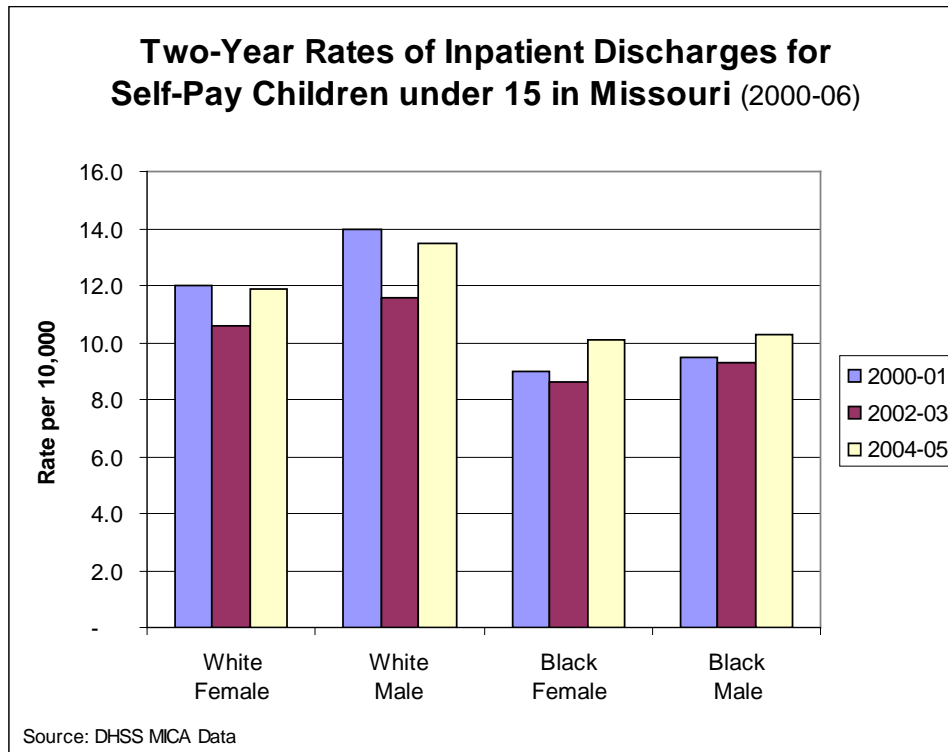


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Table 3



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 poverty 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 ESI. 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

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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/>.

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

<i>Poverty Threshold</i>	<i>Total</i>	<i>White alone</i>	<i>Black/ African Amer alone</i>	<i>Amer Indian/ Alaska Native alone</i>	<i>Asian alone</i>	<i>Native Hawaiian/ Other PI alone</i>	<i>Two or more races</i>
All Income Levels							
<i>Totals</i>	1,351,245	1,100,440	192,921	4,363	11,498	337	41,687
<i>Male</i>	674,513	547,606	94,633	2,720	7,598	337	21,620
<i>Female</i>	676,732	552,834	98,288	1,643	3,900	0	20,067
Below 100%							
<i>Totals</i>	212,552	130,472	73,620	817	1,427	0	6,215
<i>Male</i>	99,589	60,112	35,107	817	435	0	3,118
<i>Female</i>	112,963	70,361	38,512	0	992	0	3,098
100% to below 200%							
<i>Totals</i>	248,364	193,166	44,731	1,710	2,533	337	5,887
<i>Male</i>	127,146	102,184	20,701	1,454	1,062	337	1,407
<i>Female</i>	121,218	90,982	24,030	256	1,471	0	4,479
200% to below 300%							
<i>Totals</i>	270,927	216,026	40,696	301	1,576	0	12,328
<i>Male</i>	139,112	110,950	18,243	0	1,120	0	8,798
<i>Female</i>	131,815	105,076	22,453	301	455	0	3,530
300% to below 400%							
<i>Totals</i>	234,519	200,738	24,154	428	946	0	8,252
<i>Male</i>	112,685	93,515	14,991	0	542	0	3,637
<i>Female</i>	121,834	107,223	9,163	428	404	0	4,616
400% to below 500%							
<i>Totals</i>	152,132	141,519	4,707	659	3,182	0	2,065
<i>Male</i>	82,148	75,632	3,088	0	2,605	0	822
<i>Female</i>	69,984	65,888	1,618	659	577	0	1,242
500% and above							
<i>Totals</i>	232,751	218,517	5,012	449	1,833	0	6,946
<i>Male</i>	113,834	105,213	2,501	449	1,833	0	3,838
<i>Female</i>	118,918	113,305	2,511	0	0	0	3,108

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

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

<i>Poverty Threshold</i>	<i>Total</i>	<i>White alone</i>	<i>Black/ African Amer alone</i>	<i>Amer Indian/ Alaska Native alone</i>	<i>Asian alone</i>	<i>Native Hawaiian/ Other PI alone</i>	<i>Two or more races</i>
All Income Levels							
<i>Totals</i>	1,463,297	1,186,760	210,554	7,377	13,697	337	44,571
<i>Male</i>	735,256	595,516	103,502	4,024	9,039	337	22,838
<i>Female</i>	728,041	591,244	107,052	3,353	4,658	0	21,733
Below 100%							
<i>Totals</i>	243,576	156,701	77,169	817	1,863	0	7,026
<i>Male</i>	117,274	74,995	37,111	817	871	0	3,480
<i>Female</i>	126,302	81,706	40,058	0	992	0	3,546
100% to below 200%							
<i>Totals</i>	287,832	218,887	54,739	3,252	3,182	337	7,434
<i>Male</i>	148,624	116,479	25,602	2,758	1,711	337	1,737
<i>Female</i>	139,208	102,409	29,137	494	1,471	0	5,697
200% to below 300%							
<i>Totals</i>	294,041	235,610	43,700	301	1,576	0	12,854
<i>Male</i>	151,849	121,196	20,208	0	1,120	0	9,324
<i>Female</i>	142,192	114,414	23,491	301	455	0	3,530
300% to below 400%							
<i>Totals</i>	244,238	207,912	25,227	1,900	946	0	8,252
<i>Male</i>	117,942	98,772	14,991	0	542	0	3,637
<i>Female</i>	126,296	109,140	10,236	1,900	404	0	4,616
400% to below 500%							
<i>Totals</i>	158,206	146,478	4,707	659	4,297	0	2,065
<i>Male</i>	84,488	77,615	3,088	0	2,962	0	822
<i>Female</i>	73,718	68,863	1,618	659	1,335	0	1,242
500% and above							
<i>Totals</i>	235,404	221,171	5,012	449	1,833	0	6,940
<i>Male</i>	115,080	106,459	2,501	449	1,833	0	3,838
<i>Female</i>	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.

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Table 3: 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.

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)

Pursuant to Section 2105(a)(1)(D)(ii), Missouri will offer “Health Services Initiatives” under the plan. The Health Services Initiatives 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. Specific Health Services Initiatives may include the following programs:

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.

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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.

Newborn home visiting programs

LPHAs offer newborn home visiting programs to high risk families. Clinical staff and other trained professionals provide a range of services to young families to ensure the healthy development of infants and toddlers.

School health programs

LPHAs provide health related services in schools and pre-schools including health education, screenings, 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.

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Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

- 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.
- 3.1 Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and 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))

Response: The Missouri DSS, MO HealthNet Division has identified eight guiding principles for the MO HealthNet, SCHIP 1, and SCHIP 2. The following principles apply to the program whether financed through Title XIX or Title XXI.

- 1) All recipients must have a medical home.
- 2) Attention to wellness of the individual (i.e., education).
- 3) Chronic care management.
- 4) Care management (resources focused towards people receiving the services they need, not necessarily because the service is available).
- 5) Appropriate setting at the right cost.
- 6) Emphasis on the individual person.
- 7) Evidenced based guidelines for improved quality care and use of resources.
- 8) Encourage responsibility and investment on the part of the recipient to ensure wellness.

The delivery systems described below apply to MO HealthNet, SCHIP 1, and SCHIP 2.

MO HealthNet Fee-For-Service Delivery System

Individuals eligible for ~~the~~ SCHIP 1 and SCHIP 2 receive their care through the MO HealthNet Fee-For-Service delivery system in regions of the State where MO HealthNet Managed Care is not operational. In areas of the State where MCOs are not operational, participants may freely choose which MO HealthNet approved providers they go to for care under the MO HealthNet Fee-For-Service delivery system.

MO HealthNet Managed Care Program

Recipients are enrolled in MCOs that are contracted with the State of Missouri. Enrollment in the MO HealthNet Managed Care Program is mandatory for individuals who reside in areas of the State where MO HealthNet Managed Care is operational. Please see Attachment 2.

Each MCO contracts with Primary Care Providers (PCP), specialists, and other providers to deliver and coordinate health care services for recipients. The MCO receives a per

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member per month (PMPM) capitation rate for providing and coordinating health care services for members.

Recipients are given an opportunity to select an MCO in his or her area of the State, as well as a PCP within that MCO. Once eligibility is established, recipients receive an enrollment packet which includes a listing of available MCOs, instructions on how to choose an MCO, and who to contact for assistance in determining if their current health care provider is participating in an MCO. Recipients may choose an MCO any time during their open enrollment period by sending in the enrollment form or contacting the Enrollment Broker to enroll over the telephone. For those individuals who do not make an MCO selection, the State uses an algorithm to assign the member to an MCO. Recipients will be covered on a Fee-For-Service basis until enrollment in the MCO is effective. The contracted Enrollment Broker handles the MCO self selection function.

All members will be enrolled in an MCO for a period of 12 consecutive months to provide a solid continuum of care. Once a member chooses an MCO or is assigned to an MCO, the member has 90 calendar days from the effective date of coverage to change MCOs for any reason.

Children in State care and custody are allowed automatic and unlimited changes in MCO choice as often as circumstances necessitate.

The MCOs must assure that members are offered freedom of choice in selecting a PCP. Each MCO shall limit its PCPs to licensed residents specializing in family and general practice, pediatrics, obstetrics and gynecology (OB/GYN), and internal medicine; registered nurses who are advance practice nurses with specialties in family practice, pediatric practice, and OB/GYN practice; and licensed physicians in the following specialties: family and general practitioners, pediatricians, OB/GYN, and internists.

- 3.2 Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the 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))

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Response: Utilization controls for targeted low-income children will vary depending on the health care delivery system from which targeted low-income children receive healthcare.

MO HealthNet Fee-For-Service Delivery System

The MO HealthNet utilization review program in the fee for service setting has a multi-prong approach very similar to those used by the MO HealthNet Managed Care delivery system. Utilization management programs in place includes pre-certification allowing payment for services and equipment that are medically necessary, appropriate, and cost-effective without compromising the quality of care to those served in the fee-for-service setting. The MO HealthNet Division has introduced an electronic health record program. The online tool called CyberAccesssm is available to request or check status of a pre-certification request. An innovative Electronic Health Record (EHR) program for MO HealthNet recipients is available to their healthcare providers. The web-based tool allows physicians to prescribe electronically, view diagnosis data, receive alerts, select appropriate preferred medications, and electronically request drug and medical prior authorizations for their fee-for-service patients.

CyberAccesssm is the first step toward a comprehensive electronic health record for MO HealthNet recipients.

In addition, the MO HealthNet Division contracts for utilization review of inpatient stays. The contractor's medical review staff must make decisions for inpatient hospital admission and continued stays in accordance with the Severity of Illness/Intensity of services screening criteria (using the most recent edition of the InterQual ISD Pediatric Acute Level of Care and Adult Level of Care) based on pertinent medical information received from the attending physician or hospital regarding the patient's condition and planned services, and in the case of continued stay reviews, whether any further care planned may be safely provided in a post hospital setting.

The Department of Health and Senior Services operates a Healthy Children and Youth (HCY) Administrative Case Management Program assists families in meeting their child's needs to function at an optimal level. Assistance is provided for:

- Access to screening services
- Follow-up on referrals to additional medical providers
- Establishment of a medical home
- Service plan development
- Follow through on the treatment plan

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Treatment is determined by the primary care provider. As a part of the Administrative Case Management role, the Special Healthcare Needs (SHCN) staff assists in securing the following services:

- Home health services
- Private duty nursing
- Personal care service
- Advanced personal care services
- HCY Case Management through Local Public Health Agencies

Eligibility:

This program is available to all MO HealthNet eligible children residing in Missouri who are in need of medically necessary services from MO HealthNet providers.

Service Coordination:

- Assisting recipients/families in identifying and accessing medically necessary services
- Establishing a medical home
- Connecting families with appropriate community resources
- Meeting with the recipient and family on an ongoing basis to plan, promote, assist and assure the implementation of services

Service (Case) Planning:

Developing an interdisciplinary plan for coordination of the required medical services.

Service Identification:

Following assessment and service planning, the SHCN service coordinator will identify the type, amount, intensity, and duration of services required to meet the case plan goals. The SHCN Service Coordinator/HCY Facilitator will identify potential service providers from which the family may choose.

Prior Authorization:

The SHCN Service Coordinator authorizes the following services:

- Private duty nursing
- Advanced personal care aide
- Personal care aide

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- Skilled nursing visits
- Administrative Case Management

Service Monitoring:

Service coordinators monitor services through regular home visits

MO HealthNet Managed Care Delivery System

The standard MO HealthNet, SCHIP 1, SCHIP 2 utilization review policies and procedures are encompassed in the currently certified and operational MO HealthNet Management Information System (MMIS) Surveillance/Utilization Review Subsystem (SURS).

Under the MO HealthNet Managed Care delivery system, the MCOs are required by contract to have Utilization Management Programs and written prior authorization, certification, utilization management, and care management policies and procedures. The policies and procedures include protocols and criteria for evaluating medical necessity, authorizing services, case management, care coordination, disease management, and detecting and addressing over and under utilization. Such protocols and criteria comply with federal and state laws and regulations.

The MCOs provide assistance to enrollees and providers to ensure the appropriate utilization of resources using prior authorization; prospective, concurrent and retrospective review; discharge planning; provider and patient profiling; and use of clinical practice guidelines.

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Section 4. Eligibility Standards and Methodology. (Section 2102(b))

- 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 5.
- 4.1 The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42 CFR 457.305(a) and 457.320(a))
- 4.1.1 Geographic area served by the Plan: **Response:** SCHIP 1 and SCHIP 2 are available statewide.
- 4.1.2 Age: **Response:** MO HealthNet's SCHIP 1 is available to children age birth through age 18. MO HealthNet's SCHIP 2 is available to children age one through age 18.
- 4.1.3 Income: **Response:** The State's upper gross income limit is 300% of FPL. The standard income disregard equal to 100% of the FPL is made from the gross income figure of 300% of FPL. The net income figure will be compared to 200% FPL to determine if the child(ren) is (are) eligible. To be eligible, this net figure must not exceed 200% FPL for children. All wages paid by the U. S. Census Bureau for temporary employment related to Decennial Census activities are excluded in years in which there is a federal census.
- 4.1.4 Resources (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:** Eligible children must be a Missouri resident
- 4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility):
- 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: **Response:** Children are deemed eligible until FSD determines otherwise. FSD makes eligibility determinations on all applications within 30 days. Re-determinations, which are known in Missouri as reinvestigations, are conducted annually whether a change is reported or not. Once determined eligible, children are deemed to remain eligible until

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FSD determines they are no longer eligible due to no longer meeting eligibility criteria caused by a change in household circumstances or other change. However, the family does not need to re-apply and this is what is meant by "deemed eligible until FSD determines otherwise". Families are required to report changes, and FSD makes a determination of continued eligibility considering the change. Lastly, SCHIP 1 and SCHIP 2 cases are closed following a notice to the family if the family fails to complete an annual reinvestigation.

- 4.1.9 Other standards (identify and describe): **Response:** Other standards (identify and describe): 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.

- 4.2 The State assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42 CFR 457.320(b))

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

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

4.3 Describe the methods of establishing eligibility and continuing enrollment.
(Section 2102)(b)(2)) (42 CFR 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 <http://www.dss.mo.gov/mhk/appl.htm>. 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

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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:

- There will be a six month look back period for health insurance when determining eligibility. Children whose parents' available private health insurance coverage was dropped within the last six months will have a six month waiting period under SCHIP 1. Uninsured is defined as a child (children) under age 19 who does not have creditable health insurance coverage as described at 42 CFR 457.10 and 45 CFR 146.113 that minimally provides coverage for physician's services and hospitalization. The six month look back applies. To be eligible for SCHIP 1, the child must be uninsured.
- Uninsured children are children under age 19 who do not have creditable health insurance coverage as described at 42 CFR 457.10 and 45 CFR 146.113. A child covered by health insurance at the time eligibility is determined is ineligible unless the insurance is already paid for by Missouri's Health Insurance Premium Payment Program (HIPP). If the health insurance is dropped without good cause or the child does not have a special healthcare needs exception, the child is ineligible for six months from the month coverage ended.
- The six month look back period refers to the six months prior to application. If an uninsured child lost or dropped insurance coverage in the six months prior to application, FSD explores if the reason the child is uninsured meets a good cause reason or if the child meets a special healthcare exception.
- Good cause is defined as loss of insurance coverage resulting from no action taken by the insured. Good cause reasons are:
 - A parent's or guardian's loss of employment due to factors other than voluntary termination;
 - A parent's or guardian's employment with a new employer that does not provide an option for dependent coverage;
 - Expiration of a parent's or guardian's dependent Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage period;

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- Lapse of a child's (children's) health insurance when maintained by an individual other than custodial parent or guardian;
- Lapse of a child's (children's) health insurance when the lifetime maximum benefits under their private health insurance have been exhausted;
- Lapse of a child's (children's) health insurance when the health insurance plan does not cover an eligible child's preexisting condition; or
- Discontinuance of Health Insurance Premium Payment (HIPPP).
- For children in families with gross income above 225% of the FPL there is a 30 day waiting period from the date of application for coverage. The 30 day waiting period does not apply to children and families with gross income below 225% FPL. These children under 225% of the FPL shall not be subject to the 30-day waiting period as long as the children meet all other qualifications for eligibility.
 - Any child identified as having special health care needs, defined as a condition which left untreated would result in the death or serious physical injury of a child, that does not have access to affordable employer-subsidized health care insurance will be exempt from the requirement to be without health care coverage for six months in order to be eligible for services, and the 30-day waiting period as long as the child meets all other qualifications for eligibility. Special healthcare needs are established based on a written statement from the child's treating physician.
- 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. The affordability guidelines are:
 - 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.
- 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:
 - 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.

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Continuing Enrollment: Once determined eligible, the children remain eligible until FSD determines they are no longer eligible. Their coverage does not automatically end at 12 months. FSD performs annual reinvestigations to determine continued eligibility.

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 net worth. 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.

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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.

- 4.3.1 Describe the State's policies governing enrollment caps and waiting lists (if any) (Section 2106(b)(7)) (42 CFR 457.305(b))

Check here if this section does not apply to your state.

- 4.4 Describe the procedures that assure that:

- 4.4.1 Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a **group** health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR 457.350(a)(1)) 457.80(c)(3))

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.

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- 4.4.2 The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42 CFR 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 The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR 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. Check the appropriate box. (Section 2102)(b)(3)(C)) (42 CFR 457.805) (42 CFR 457.810(a)-(c))

- 4.4.4.1 Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

Response: There is a six month look back period for health insurance when determining eligibility. Children whose available health insurance coverage was dropped within the last six months without good cause will have a six month waiting period for SCHIP 1 coverage. The six month look back period does not apply to children in families with income below 150% FPL.

- 4.4.4.2 Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

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Response: Crowd-out will be monitored by comparing the increase in MO HealthNet enrollment concurrent with the decrease in private insurance enrollment. The State of Missouri has implemented several safeguards against crowd-out, including a six-month waiting period and cost-sharing requirements. The application process for Missouri also has a number of other crowd-out deterrents built in. Although Missouri has taken several steps to simplify the application process by reducing the size of its application and accepting applications in the mail, it has also built more steps into the verification process than many states use to ensure that only applications from eligible individuals are accepted. For example, Missouri requires applicants with income between 150% and 300% of FPL to obtain two quotes from private insurers as proof that affordable insurance alternatives do not exist. In addition, children with incomes between 226% and 300% of FPL have a six-month penalty applied if they fail to pay required SCHIP 1 premiums and are not eligible for coverage until the six months expire. This penalty provision does not apply to those children between 150% and 225% of FPL who may fail to pay a required premium. There is a six-month waiting period for children who drop insurance without good cause, except for children with special health care needs. Children in families with income above 150% of FPL are not eligible if they have access to affordable insurance. In addition, families with income above 225% FPL have a 30 day waiting period before eligibility begins.

In addition to monitoring the increase in MO HealthNet enrollment and the decrease in private insurance enrollment, the State will use data and information from several sources to further analyze whether the availability of SCHIP is the causative agent in the reduction of private insurance enrollment. Because the vast majority of private insurance, particularly for children, is employer-sponsored insurance the State will focus its analysis in this area. These additional data provide additional information about the number of business providing private health insurance to employees, the cost of such insurance to employees, the take-up rate of private employer-sponsored health insurance, and the labor market. The data are both national level and Missouri specific. Analysis of these data will allow the

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State to better assess whether the availability of SCHIP or whether market factors effecting the availability and cost of private insurance are the causative agent(s) in any reduction in private insurance enrollment and any increase in SCHIP enrollment. The following data sources will be utilized:

- The Medical Expenditure Panel Survey (MEPS) Insurance Component. Data are available by state; as of July 11, 2007 Missouri specific data are available for the years 1996 – 2004.
- Data from the annual "Employer Health Benefits Survey" conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET). The data are national only; as of July 11, 2007, the most recent survey results available were from 2006.
- State and Area Employment, Hours and Earnings data from the U.S. Department of Labor, Bureau of Labor Statistics (BLS). BLS data, are collected each month; as of July 11, 2007, the most recent data are from May 2007.

In addition to using data, the State will augment its analysis through the use of recently published research and studies in the area of substitution and crowd-out.

- 4.4.4.3 Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

Response: Refer to response in section 4.4.4.2.

- 4.4.4.4 If the State provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

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The cost-effectiveness determination.

- 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: CMS officials have held that Missouri has no federally-recognized American Indian/Native American tribes within the state, and, therefore, Missouri has no specific obligations pursuant to 42 CFR § 457. The fact that Missouri has no federally-recognized American Indian/Native American tribes was affirmed by the CMS Region VII office as recently as May 2007.

- The Eastern Shawnee Tribe of Oklahoma tribe is not associated with Missouri in the Federal Register's "Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs" (Vol. 72, No. 55 / Thursday, March 22, 2007).
- The Eastern Shawnee Tribe of Oklahoma (<http://www.easternshawnee.org/index.html> and <http://www.eighttribes.org/eastern-shawnee/>) listed above is actually centered on the Oklahoma/Missouri border.
- Article II of the Constitution of the Eastern Shawnee Tribe (<http://thorpe.ou.edu/constitution/eastshawcons.html>) states that "...Eastern Shawnee lands, which are located in the north east section of the State of Oklahoma, and such other territory as may hereafter be added thereto."

This evidence is fully consistent with the CMS' position that Missouri has no federally-recognized American Indian/Native American tribes within the state.

Recognizing that a member of a tribe may re-locate to the State, Missouri will exempt 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

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those not indicating race on the application will be notified of this exemption.

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Section 5. Outreach (Section 2102(c))

5.1 (formally 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42 CFR 457.80(b))

5.1.1 (formally 2.2.1) The steps the State is currently taking to identify and enroll all uncovered 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. The State will have a simplified mail-in application process. This should overcome the burden of applying in person at an FSD office. There is an application on the DSS website at <http://www.dss.mo.gov/mhk/appl.htm> 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.

5.1.2 (formally 2.2.2) The steps the State is currently taking to identify and enroll all uncovered 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

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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.

- 5.2 (formally 2.3) Describe the procedures the State uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and 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. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42 CFR 457.80(c))

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

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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.

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:

- There will be a six month look back period for health insurance when determining eligibility. Children whose parents' available private health insurance coverage was dropped within the last six months will have a six month waiting period under SCHIP 1. Uninsured is defined as a child (children) under age 19 who does not have creditable health insurance coverage as described at 42 CFR 457.10 and 45 CFR 146.113 that minimally provides coverage for physician's services and hospitalization. The six month look back applies. To be eligible for SCHIP 1, the child must be uninsured.
- Uninsured children are children under age 19 who do not have creditable health insurance coverage as described at 42 CFR 457.10 and 45 CFR 146.113. A child covered by health insurance at the time eligibility is determined is ineligible unless the insurance is already paid for by Missouri's Health Insurance Premium Payment Program (HIPP). If the health insurance is dropped without good cause or the child does not have a special healthcare needs exception, the child is ineligible for six

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- months from the month coverage ended.
- The six month look back period refers to the six months prior to application. If an uninsured child lost or dropped insurance coverage in the six months prior to application, FSD explores if the reason the child is uninsured meets a good cause reason or if the child meets a special healthcare exception.
- Good cause is defined as loss of insurance coverage resulting from no action taken by the insured. Good cause reasons are:
 - A parent's or guardian's loss of employment due to factors other than voluntary termination;
 - A parent's or guardian's employment with a new employer that does not provide an option for dependent coverage;
 - Expiration of a parent's or guardian's dependent Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage period;
 - Lapse of a child's (children's) health insurance when maintained by an individual other than custodial parent or guardian;
 - Lapse of a child's (children's) health insurance when the lifetime maximum benefits under their private health insurance have been exhausted;
 - Lapse of a child's (children's) health insurance when the health insurance plan does not cover an eligible child's preexisting condition; or
 - Discontinuance of Health Insurance Premium Payment.
- For children in families with gross income above 225% of the FPL there is a 30 day waiting period from the date of application for coverage. The 30 day waiting period does not apply to children and families with gross income below 225% FPL. These children under 225% of the FPL shall not be subject to the 30-day waiting period as long as the children meet all other qualifications for eligibility.
 - Any child identified as having special health care needs, defined as a condition which left untreated would result in the death or serious physical injury of a child, that does not have access to affordable employer-subsidized health care insurance will be exempt from the requirement to be without health care coverage for six months in order to be eligible for services, and the 30-day waiting period as long as the child meets all other qualifications for eligibility. Special healthcare needs are established based on a written statement from the child's treating physician.
 - 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. The affordability guidelines are
 - 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.

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- 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:
 - 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.

Non-Emergency Medical Transportation

- Children in families with gross income below 150% will be covered. Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could not have been omitted without adversely affecting the recipient's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
- Children in families with gross income between 150% through 300% will not be covered. This benefit is so unheard of in any health insurance plan that its inclusion would serve as a significant incentive for the dropping of private coverage.

Crowd out will be evaluated yearly to determine if additional protections are warranted. If crowd out does become a problem the State will develop additional anti-crowd out measures as warranted by the scope and nature of the problem. Additional options may include:

- Adding an insurance availability test to preclude participation
- Lengthening the look back period;
- Implementing cost sharing provisions;
- Moving to once yearly open enrollment periods for children with family income over 200% of gross FPL;
- Other measures designed to efficiently deal with what the research finds.

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5.2-ELThe 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.

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)) (42 CFR 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.

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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 have been trained on the application process by FSD.

The FSD policy manual delineates the application process and program requirements. FSD staff receive 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.

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Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

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 7.

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

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

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

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

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.)

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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3 Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

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

6.1.4.1 Coverage the same as Medicaid State plan

6.1.4.2 Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

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- 6.1.4.3 Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population
- 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
- 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 (Please provide a sample of how the comparison will be done)
- 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.

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)) (42 CFR 457.490)

Response: The services checked below are generally covered for MO HealthNet categorically needy eligibles and would be covered for SCHIP 1 and SCHIP 2, depending on the need of the recipient. All these services are subject to the same limitations and prior approvals as they are in the approved MO HealthNet State Plan. Please see Attachments 9 and 9a.

The following specific services are found in the MO HealthNet State Plan Amendment:

- Over the Counter Medicine – Section 3.1-A, page 15aa.
- Outpatient Mental Health Services – Section 3.1-A, page 1. Although outpatient mental health services are not delineated, they are a covered service under Missouri's State Plan Amendment.
- Dental Services - Section 3.1-A, pages 10f and 18d.
- Outpatient Substance Abuse Treatment and Outpatient Substance Abuse Treatment Services - Section 3.1-A, page 17aaa.

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- Care Coordination - Section 3.1-A, pages 1a-1 and 1a-2, 1b-1 to 1b-3, 1c to 7c, 1f to 5f, and 1g to 10g. The State of Missouri uses the terms Case Management and Care Coordination interchangeably.
- Rehabilitative Services - Section 3.1-A, page 17.

The MO HealthNet Program rules include, but are not limited to, benefit limits, extension of benefit limit procedures, prior authorization requirements, and age limits for services.

- 6.2.1 Inpatient services (Section 2110(a)(1))
- 6.2.2 Outpatient services (Section 2110(a)(2))
- 6.2.3 Physician services (Section 2110(a)(3))
- 6.2.4 Surgical services (Section 2110(a)(4))
- 6.2.5 Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

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- 6.2.6 Prescription drugs (Section 2110(a)(6))
- 6.2.7 Over-the-counter medications (Section 2110(a)(7))
- 6.2.8 Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9 Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10 Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11 Outpatient mental health services, other than services described in 6.2.19., but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12 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))
- 6.2.13 Disposable medical supplies (Section 2110(a)(13))
- 6.2.14 Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15 Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16 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 (Section 2110(a)(16))
- 6.2.17 Dental services (Section 2110(a)(17))
- 6.2.18 Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19 Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20 Case management services (Section 2110(a)(20))
- 6.2.21 Care coordination services (Section 2110(a)(21))
- 6.2.22 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23 Hospice care (Section 2110(a)(23))
- 6.2.24 Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25 Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26 Medical transportation (Section 2110(a)(26))

Response: 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.

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- 6.2.27 Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28 Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))
- 6.3 The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42 CFR 457.480)
- 6.3.1 The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2 The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*
- 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% 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 (42 CFR 457.1005(a))

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

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

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

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

6.4.2.1 Purchase of family coverage is cost-effective relative to the amounts that the State would have

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paid to obtain comparable coverage only of the targeted
low-income children involved; and (Describe the associated costs
for purchasing the family coverage relative to the coverage for the
low income children.) (Section 2105(e)(3)(A)) (42 CFR 457.1010(a))

Response: The Health Insurance Premium Payment (HIPP) Program is a MO HealthNet Program that pays for the cost of health insurance premiums, coinsurance, deductibles, and copayments for certain MO HealthNet participants. The program purchases health insurance for MO HealthNet eligible persons when it is determined cost effective. Similarly, the HIPP Program purchases health insurance for MO HealthNet For Kids eligible children when it is determined the health insurance does not meet the affordability test, but is found to be cost effective. Cost effective means that it costs less to buy the health insurance to cover medical care than to pay for the same services with MO HealthNet funds. When determining the cost effectiveness of a health insurance plan, the following data is considered: the cost of the insurance premium, coinsurance and deductible; the scope of services covered, the average anticipated MO HealthNet utilization by age, sex, geographic location and coverage group, and annual administrative expenditures. The analysis is based on the data of the MO HealthNet participants enrolled in the insurance plan. The average MO HealthNet expenditures are based upon a peer grouping consisting of age, sex, coverage group and county from the previous year. If the cost of the insurance premiums and cost sharing for the insurance plan is likely to be less than the average MO HealthNet expenditures, the policy is considered to be cost effective. See Attachment 12 for a specific example.

The HIPP Program cannot find health insurance policies for MO HealthNet recipients, rather it purchases policies already available to recipients through employers, former employers, labor

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unions, credit unions, church affiliations, other organizations, or individual policies. The HIPP Program is the same program the State currently uses. There have been no changes implemented in the HIPP Program.

The State will provide employer-sponsored insurance (ESI)/HIPP coverage for the SCHIP 2 children and those in the SCHIP 1 program when it is determined to be cost effective. When a HIPP application is received the information is verified by contacting the employer for group policies or the insurance company if it is an individual policy. It is necessary to verify the amount of the premium, how often it will be paid, and whether the premium is payroll deducted or paid directly to employer or insurance company.

The benefit package is reviewed for deductibles, copays, and coinsurance amounts that the policyholder would be responsible for. The effective date of the policy and the claims address are verified by contacting the insurance company. The application is then processed in the HIPP system to determine cost effectiveness of the policy and the policy holder is notified of the determination by letter.

The HIPP application is processed in the HIPP system to determine cost effectiveness of the policy by entering the peer grouping information into the system. The peer grouping information includes age, gender, Medical Eligibility Code (ME Code), county code, and the coverage code for the policy. The system determines the average cost of healthcare that was expended in the previous year for each Medicaid recipient in that group. The system then compares that information with the Group Health Plan costs which includes the annual premium amount, annual policy deductibles, and annual coinsurance amounts. As part of the HIPP application process, the HIPP system compares the services provided under the Group Health Plan, including exclusions for pre-

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existing conditions and exclusions to enrollment and lifetime maximum benefits imposed, with the services to which the individual is entitled under the MO HealthNet Program. Coverage of services not provided under the Group Health Plan, but to which the individual is entitled under the MO HealthNet Program, are provided under MO HealthNet as wrap-around services.

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

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

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Section 7. Quality and Appropriateness of Care

- 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.
- 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. (2102(a)(7)(A)) (42 CFR 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
- 7.1.3 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

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Missouri Application for the State Children's Health Insurance Program 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.

7.2 Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42 CFR 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)) (42 CFR 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

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Missouri Application for the State Children's Health Insurance Program 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.

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- 7.2.2 Access to covered services, including emergency services as defined in 42 CFR part 457.10. (Section 2102(a)(7)) 42 CFR 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)) (42 CFR 457.495(c))

Response: The delivery systems described below apply to MO HealthNet, SCHIP 1, and SCHIP 2.

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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)) (42 CFR 457.495(d))

Response

MO HealthNet Fee-For-Service Delivery System

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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 hotline 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

- 7.2.5 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

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Section 8. Cost Sharing and Payment (Section 2103(e)

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? (42 CFR 457.505)

8.1.1 YES.

8.1.2 NO, skip to question 8.8.

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 and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(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.

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- 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 Responsibility									
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

8.2.2 Deductibles: **Response:** None

8.2.3 Coinsurance or copayments: **Response:** None

8.2.4 Other: **Response:** None

- 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)(B))) (42 CFR 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

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Missouri Application for the State Children's Health Insurance Program 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.

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

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

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- 8.5 Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5% 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)) (42 CFR 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)) (42 CFR 457.535)

Response: CMS officials have held that Missouri has no federally-recognized American Indian/Native American tribes within the state, and, therefore, Missouri has no specific obligations pursuant to 42 CFR § 457. The fact that Missouri has no federally-recognized American Indian/Native American tribes was affirmed by the CMS Region VII office as recently as May 2007.

- The Eastern Shawnee Tribe of Oklahoma tribe is not associated with Missouri in the Federal Register's "Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs" (Vol. 72, No. 55 / Thursday, March 22, 2007).
- The Eastern Shawnee Tribe of Oklahoma (<http://www.easternshawnee.org/index.html> and <http://www.eighthtribes.org/eastern-shawnee/>) listed above is actually centered on the Oklahoma/Missouri border.
- Article II of the Constitution of the Eastern Shawnee Tribe (<http://thorpe.ou.edu/constitution/eastshawcons.html>) states that "...Eastern Shawnee lands, which are located in the north east section of the State of Oklahoma, and such other territory as may hereafter be added thereto."

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This evidence is fully consistent with the CMS' position that Missouri has no federally-recognized American Indian/Native American tribes within the state.

Recognizing that a member of a tribe may re-locate to the State, Missouri will exempt 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 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505(c))

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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 226% and 300% of FPL have a six-month penalty applied if they fail to pay required premiums and are not eligible for coverage until the six months expire. This penalty provision does not apply to those children between 150% and 225% of FPL who may fail to pay a required premium. However, for children between 150% and 225% of FPL, coverage ends if no payment is received. Coverage for these children resumes after the next payment is received.

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.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- 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. (42 CFR 457.570(a))
- 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. (42 CFR 457.570(b))
- 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. (42 CFR 457.570(b))
- The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42 CFR 457.570(c))

Response: The Late Payment Notice notification allows

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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.

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)) (42 CFR 457.220)
- 8.8.2 No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. Section 2105(c)(5) (42 CFR 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)) (42 CFR 457.626(a)(1))

Response: 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:

- There will be a six month look back period for health insurance when determining eligibility. Children whose parents' available private health insurance coverage was dropped within the last six months will have a six month waiting period under SCHIP 1. Uninsured is defined as a child (children) under age 19 who does not have creditable health insurance coverage as described at 42 CFR 457.10 and 45 CFR 146.113 that minimally provides coverage for physician's services and hospitalization. The six month look back applies. To be eligible for SCHIP 1, the child must be uninsured.

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- Uninsured children are children under age 19 who do not have creditable health insurance coverage as described at 42 CFR 457.10 and 45 CFR 146.113. A child covered by health insurance at the time eligibility is determined is ineligible unless the insurance is already paid for by Missouri's Health Insurance Premium Payment Program (HIPP). If the health insurance is dropped without good cause or the child does not have a special healthcare needs exception, the child is ineligible for six months from the month coverage ended.
- The six month look back period refers to the six months prior to application. If an uninsured child lost or dropped insurance coverage in the six months prior to application, FSD explores if the reason the child is uninsured meets a good cause reason or if the child meets a special healthcare exception.
- Good cause is defined as loss of insurance coverage resulting from no action taken by the insured. Good cause reasons are:
 - A parent's or guardian's loss of employment due to factors other than voluntary termination;
 - A parent's or guardian's employment with a new employer that does not provide an option for dependent coverage;
 - Expiration of a parent's or guardian's dependent Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage period;
 - Lapse of a child's (children's) health insurance when maintained by an individual other than custodial parent or guardian;
 - Lapse of a child's (children's) health insurance when the lifetime maximum benefits under their private health insurance have been exhausted;
 - Lapse of a child's (children's) health insurance when the health insurance plan does not cover an eligible child's preexisting condition; or
 - Discontinuance of Health Insurance Premium Payment (HIPP).
- For children in families with gross income above 225% of the FPL there is a 30 day waiting period from the date of application for coverage. The 30 day waiting period does not apply to children and families with gross income below 225% FPL. These children under 225% of the FPL shall not be subject to the 30-day waiting period as long as the children meet all other qualifications for eligibility.
- Any child identified as having special health care needs, defined as a condition which left untreated would result in the death or serious physical injury of a child, that does not have access to affordable employer-subsidized health care insurance will be exempt from the requirement to be without health care coverage for six months in order to be eligible for services, and the 30-day waiting period as long as the child meets all other qualifications for eligibility. Special healthcare needs are established based on a written statement from the child's treating physician.
- Children with special healthcare needs who do not have access to affordable employer-subsidized health insurance are exempt from the six month penalty

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for loss of insurance coverage without good cause and the 30 day waiting period for children in families with income of more than 225% FPL.

- 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. The affordability guidelines are:
 - 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.
- 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:
 - 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.

- 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)) (42 CFR 457.622(b)(5))

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- 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)) (42 CFR 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)) (42 CFR 457.475)

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Section 9. Strategic Objectives and Performance Goals and Plan Administration

(Section 2107)

- 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)) (42 CFR 457.710(b))

Response: The State's objectives are:

1. Reduce the number of children in Missouri without health insurance coverage.
2. Increase access to care.
3. Increase the number of children in Missouri who have access to a regular source of healthcare coverage.
4. Improve the health of Missouri's medically uninsured children through the use of preventive care.

- 9.2 Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42 CFR 457.710(c))

Response:

Objective 1: Reduce the number of children in Missouri without health insurance coverage.

Performance goal: Increase enrollment in SCHIP 1 and SCHIP 2 of uninsured children.

Baseline: The State will use the current enrollment data for SCHIP 1 and SCHIP 2 population as reported to CMS on the CMS-64EC, CMS-64.21E and entered into the Statistical Enrollment Data System as the baseline measurement. These reports show end of quarter actual and unduplicated ever enrolled figures. Please see Attachment 7.

Target Improvement Level: Enroll more uninsured children.

Objective 2: Increase access to care.

Performance goal: Increase enrollment of physicians.

Baseline: As of May 21, 2007, there were 15,605 physicians enrolled in MO HealthNet.

Target Improvement Level: Enroll more physicians in MO HealthNet.

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.

Baseline: As of May 5, 2007, 88% of recipients self-selected a PCP.

Target Improvement Level: Increase the number of recipients who self-select a PCP.

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Objective 4: Improve the health of Missouri's medically uninsured children through the use of preventive care.

Performance goal: Assess how many children receive recommended well visits and screens.

Baseline: As of Missouri State Fiscal Year 2006, the total number of eligibles receiving at least one initial or periodic screen was 275,101.

Target Improvement Level: Increase the number of recommended well visits and screens received by children.

Specific measurements of the target improvement levels for the four objectives are:

1. Continue to reduce the number of uninsured children in Missouri with an overall goal of reducing the total to less than 100,000. For reference, the number of uninsured children in Missouri (calculated on the basis of CPS data) fell to a low of 46,000 in 1999, but it subsequently increased to a high of 120,000 in 2004. We will monitor our progress towards this objective by reviewing the table published annually by the U.S. Census Bureau entitled "Historical Health Insurance Tables (Table HI-5): Health Insurance Coverage by State – Children under 18."
2. Reverse the recent declines in enrollment in the existing 1115 Waiver program and increase total SCHIP 1 and SCHIP 2 enrollment. The State aims to achieve and maintain an overall combined enrollment target of 76,000 children in SCHIP 1 and SCHIP 2 by the end of Federal Fiscal Year 2008 (see attachment 10). For reference, existing 1115 Waiver enrollment has fallen from almost 74,400 in October 2005 to roughly 63,500 in April 2007. The State will monitor progress toward this objective by reviewing the Monthly Management Report published by the Missouri Department of Social Services, Family Support Division.
3. Reverse the recent declines in the number of children subject to premium payment in the program and maintain enrollment therein at or more than 20,000 children. With the imposition of the new premium structure over the last year, enrollment in the existing 1115 Waiver has decreased from over 30,000 in October 2005 to about 20,000 in April 2007. With additional outreach and education, the State will acclimate more families to the program and restore their enrollment, and attract new families to the program as an alternative to remaining uninsured. The State will monitor progress toward this objective by reviewing the Monthly Management Report published by the Missouri Department of Social Services, Family Support Division.

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- 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)) (42 CFR 457.710(d))

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 as measured by the number 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 child care
 - 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, please list:

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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)) (42 CFR 457.720)
- 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)) (42 CFR 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 of audit. (Section 2107(b)(3)) (42 CFR 457.720)
- 9.7 The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42 CFR 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)) (42 CFR 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)
- 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 insuring ongoing public involvement. (Section 2107(c)) (42 CFR 457.120(a) and (b))

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Response: To ensure public involvement in the design and implementation of SCHIP 1 and SCHIP 2, 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 and SCHIP 2, 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

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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 part 457.125. (Section 2107(c)) (42 CFR 457.120(c))

Response: There are no federally recognized Indian Tribes and Organizations in the State.

CMS officials have held that Missouri has no federally-recognized American Indian/Native American tribes within the state, and, therefore, Missouri has no specific obligations pursuant to 42 CFR § 457. The fact that Missouri has no federally-recognized American Indian/Native American tribes was affirmed by the CMS Region VII office as recently as May 2007.

- The Eastern Shawnee Tribe of Oklahoma tribe is not associated with Missouri in the Federal Register's "Indian Entities Recognized and

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Eligible To Receive Services From the United States Bureau of Indian Affairs" (Vol. 72, No. 55 / Thursday, March 22, 2007).

- The Eastern Shawnee Tribe of Oklahoma (<http://www.easternshawnee.org/index.html> and <http://www.eighttribes.org/eastern-shawnee/>) listed above is actually centered on the Oklahoma/Missouri border.
- Article II of the Constitution of the Eastern Shawnee Tribe (<http://thorpe.ou.edu/constitution/eastshawcons.html>) states that "...Eastern Shawnee lands, which are located in the north east section of the State of Oklahoma, and such other territory as may hereafter be added thereto."

This evidence is fully consistent with the CMS' position that Missouri has no federally-recognized American Indian/Native American tribes within the state.

Recognizing that a member of a tribe may re-locate to the State, Missouri will exempt 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.

- 9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in part 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.

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9.10 Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42 CFR 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 sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Response:

Benefit Costs Insurance Payments

Total projected costs for the SCHIP 1 and SCHIP 2 populations. Federal Fiscal Year (FFY) 2009 expenditures include actual expenditures of the one quarter available and projected expenditures of the three quarters not yet available. Based on the last year of historical expenditures, the State expects a 2% annual trend.

Member months are calculated from the CMS 64.21E Line 1, per CMS instructions. FFY 2009 member months include actual member months of the one quarter available and projected member months of the three quarters not yet available. Based on the last year of historical expenditures, the State expects member months to grow approximately .50% annually.

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PMPM is calculated by the average monthly Total Costs divided by Member Months.

Beneficiary Cost Sharing Payments

The premium amount expected to be collected during FFY 2009 and FFY 2010. Based on the last year of historical cost sharing payments, the State expects a 2% annual trend. Children ages birth through 18 with family income between 150% and 300% FPL are required to pay a monthly premium.

Net Benefit Cost

Insurance Payments less Beneficiary Cost Sharing Payments.

Administration Costs

FFY 2009 expenditures include actual expenditures of the one quarter available and projected expenditures of the three quarters not yet available. Based on the last year of historical expenditures, the State is projecting an increase in administrative costs. The State expects administrative costs to grow approximately 2.0% annually.

Health Services Initiatives

Since we are requesting an effective date of July 1, 2011, the FFY 2012 expenditures include actual expenditures of the two (2) quarters available, projected expenditures of the two quarters not yet available, and the projected expenditures of the Health Services Initiative.

The source of expenditures for the Health Services Initiative is Local Public Health Agencies (LPHAs) who use Certifications of Public Expenditures (CPE) to demonstrate that the funds are local and state in origin.

Based on the last year of historical expenditures and the inclusion of the "Health Services Initiatives" the State is projecting an increase in administrative costs. The increase falls within the 10% Administrative Cost Ceiling.

Please see Attachment 8.

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Bold/Italics Added Information

~~Strikethrough~~ Deleted Information

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Section 10. Annual Reports and Evaluations (Section 2108)

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)) (42 CFR 457.750)

- 10.1.1 The progress made in reducing the number of uncovered 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. (42 CFR 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.

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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)) (42 CFR 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)) (42 CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 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)
- 11.3 Fraud and Abuse

Response: The delivery systems described below apply to MO HealthNet, SCHIP 1 and SCHIP 2.

MO HealthNet Fee-For-Service Delivery System

Fraud and Abuse Detection System (FADS) -- Thomson Medstat's Advantage Suite[®] for Fraud Detection is a comprehensive, multi-functional solution for identification and investigation of fraud, waste, and abuse. It provides financial, utilization, eligibility, and quality of care reporting capabilities; in addition, it provides rules-based capabilities for detecting and investigating potential fraud, abuse and waste. The system detects known patterns of aberrant behavior and can automatically "alert" the user when such a pattern is detected. It provides drill-down paths and ad hoc inquiry capabilities to support data investigation at the

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provider, recipient, and detailed claim level. The Advantage Suite database provides users with access to integrated MO HealthNet Division paid and denied healthcare claims, managed care encounter records, provider enrollment information, eligibility data, financial records, and other detail-level data.

If the review findings question the provider's license or certification, an appropriate referral is made to the Missouri Division of Professional Registration. If the review findings question the practitioner's Bureau of Narcotic and Dangerous Drugs (BNDD) prescribing privileges, the appropriate referral is made to BNDD. If a question of potential fraud exists, the case is referred to the Office of Attorney General/MO HealthNet Fraud Control Unit (OAG/MFCU).

Missouri Statute allows for the MO HealthNet provider's appeal of the result of the MO HealthNet Division's post payment reviews. If the provider is adversely affected by the MO HealthNet Division's decision, he/she may appeal the decision to the Administrative Hearing Commission.

Missouri Medicaid Audit and Compliance (MMAC) Unit is the agency within the Missouri DSS that is responsible for referring all cases of suspected provider fraud to the OAG/MFCU. The Missouri DSS has a Memorandum of Understanding (MOU) with OAG/MFCU. One of the requirements of the MOU is to conduct monthly meetings to exchange information and discuss potential cases. Evaluation criteria are based on the specific requirements stated in each program's MO HealthNet Manual and updated by MO HealthNet Bulletins. All programs are evaluated for adequate documentation.

The MMAC Unit conducts post payment reviews of MO HealthNet providers to determine the propriety of claims reimbursed by MO HealthNet and monitors the utilization of MO HealthNet services in the State. Following a preliminary review, if the reviewer is suspicious of fraud the case must be referred to the OAG/MFCU.

Suspicion of fraud can be determined by unexplained or unreasonable billing patterns. In a preliminary review by Program Integrity staff the reviewer is comparing the claim data to the provider's treatment records. Suspicion of fraud can be repeated findings of lack of documentation (false claims), up coding (billing higher level codes than what is documented), and/or inadequate documentation.

MO HealthNet providers are selected to be reviewed from either referral, exception reports, and/or other system generated reports. Referrals concerning possible misutilization may be received from providers, recipients, consultants,

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employees of the MO HealthNet Division, as well as staff from other agencies. Exception reports are produced on providers that have exceptional patterns of utilization, or that deviate from established norms. Medstat/Advantage Suite leads are on providers and recipients who have a suspected pattern of waste or abuse.

A review of MO HealthNet claims reimbursed is performed on each of the selected providers or project in order to determine program compliance. This review is completed by either desk review or field review. The appropriateness and quality of service are also considered for the claims being reviewed. If a question regarding the quality of service, medical necessity or medical interpretation exists, the case is referred to the Division's State Consultant(s) for review.

The final outcome of a provider review may include one or more of the following administrative actions: determination of overpayment, withholding of payments, transfer to closed-end agreement, provider education, prepayment review, referral to another state agency, or suspension or termination of the provider's MO HealthNet participation agreement.

If an overpayment is identified, a certified mailing is sent to the provider outlining all errors noted in the review and informing the provider of the total amount overpaid. The provider is also notified of any repayment options available to them.

The MMAC Unit monitors MO HealthNet recipient utilization of services. The MMAC Unit uses several resources including, but not limited to, the Fraud and Abuse Detection System and referrals, to detect MO HealthNet recipient aberrant utilization patterns. Recipients with a pattern of suspected abuse are reviewed by Program Integrity staff to determine if there is legitimate cause for the excessive utilization or if there is suspicion of possible abuse of the MO HealthNet Program. Based on the outcome of the analysis, the recipient is educated regarding the appropriate use of MO HealthNet services or, if warranted, the recipient is placed on Lock-In status if the utilization pattern is not supported by a medical need. The recipient can be locked-in to a pharmacy or to a physician or to both based on the aberrant behavior. Suspicion of recipient fraud, such as MO HealthNet identification card sharing and false income reporting, is referred to the MO HealthNet Investigation Unit within the DSS for further investigation and referral to law enforcement.

MO HealthNet Managed Care Delivery System

In accordance with Missouri Statute, MO HealthNet Managed Care contract requirements, and policy statements regarding fraud and abuse, the MCOs must perform fraud and abuse prevention, coordination, detection, investigation, and enforcement

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regarding fraud and abuse activities by, but not limited to, MCOs, providers, subcontractors, MO HealthNet beneficiaries, MO HealthNet managed care enrollee or employees. The MCOs must report to and cooperate with the DSS, MO HealthNet Division and other key players as appropriate. On a quarterly basis, the MCOs report fraud and abuse activities, to the Quality Services Unit of the MO HealthNet Division, as indicated in the QI Strategy.

Each MCO must implement internal controls, policies and procedure for prevention, coordination, detection, investigation, enforcement and reporting of fraud and abuse in accordance with the MO HealthNet Managed Care contract and the MCO's Fraud and Abuse Plan. The policies and procedures shall articulate the MCO's commitment to comply with all applicable federal and state standards. The MCO's Fraud and Abuse Plan must designate a compliance officer and compliance committee that is responsible for the Fraud and Abuse Program and activities. The MCO must submit a written Fraud and Abuse Plan to the state agency for approval prior to implementation. Any changes to the approved fraud and abuse plan must have state agency approval prior to implementation.

11.3.1 In accordance with the Recipient Lock-In Program, the MCOs must implement a method to limit or restrict the use of the recipient's MO HealthNet identification care to designated providers of medical services. The MCO must submit its lock-in policies and procedures to the state agency for approval prior to implementation. When a member or provider is suspected of fraud or abuse, the MCO notifies the state agency of the suspected activity as well as includes the information in their quarterly reporting.

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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.

Eligibility and Enrollment Matters

- 12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR part 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, and SCHIP 2. 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:

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- 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.

Health Services Matters

- 12.1 Please describe the review process for health services matters that complies with 42 CFR part 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, and SCHIP 2. 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 MCO's 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

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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.

Premium Assistance Programs

- 12.2 If providing coverage through a group health plan that does not meet the requirements of 42 CFR part 457.1120, please 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.

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Attachment 8

CHIP Budget

STATE: Missouri	FFY Budget	FFY Budget
Federal Fiscal Year	2011 Costs	2012 Costs
State's enhanced FMAP rate	74.30%	74.42%
Benefit Costs		
Insurance payments		
Managed care	\$ 76,455,793	\$ 81,165,815
FFY 2011: (\$142.17 PMPM @ 44,814 eligibles)		
FFY 2012: (\$149.95 PMPM @ 46,410 eligibles)		
Fee for Service	\$ 81,100,876	\$ 84,478,706
FFY 2011: (\$189.90 PMPM @ 35,589 eligibles)		
FFY 2012: (\$203.87 PMPM @ 36,859 eligibles)		
Total Benefit Costs	\$ 157,556,669	\$ 165,644,521
(Offsetting beneficiary cost sharing payments)	\$ (4,905,170)	\$ (4,905,170)
Net Benefit Costs	\$ 152,651,499	\$ 160,739,351
Cost of Proposed SPA Changes – Benefit		
Administration Costs		
Personnel		
General administration		
Contractors/Brokers	\$ 2,917,877	\$ 3,186,801
Claims Processing		
Outreach/marketing costs		
Health Services Initiatives	\$ 1,150,000	\$ 4,600,000
Other		
Total Administration Costs	\$ 4,067,877	\$ 7,786,801
10% Administrative Cap	\$ 16,961,278	\$ 17,859,928
Cost of Proposed SPA Changes	\$ 1,150,000	\$ 4,600,000
Federal Share	\$ 116,442,496	\$ 125,417,162
State Share	\$ 40,276,880	\$ 43,108,990
Total Costs of Approved CHIP Plan	\$ 156,719,376	\$ 168,526,152

NOTE: The Federal Fiscal Year (FFY) runs from October 1st through September 30th. FFY actuals through Quarter ending March 31, 2012. Remaining Quarters are projected.

The Source of State Share Funds:

Missouri Application for the State Children's Health Insurance Program

Source of State Funds are 16% of General Revenue under the Current House Bill. The remaining is a combination of general revenue equivalents.

The general revenue equivalents source of State funds are Medicaid Managed Care Organization Allowance Fund, Federal Reimbursement Allowance Fund, Health Initiatives Fund, Pharmacy Rebates Fund, Premium Fund, and Federal Funds. These non-federal funding sources are appropriated by the Missouri General Assembly.

Missouri's hospital tax is titled the Federal Reimbursement Allowance Fund which is a general revenue equivalent. The reference to the Federal Fund is the federal dollars earned from claims which is appropriated by the General Assembly. The non-federal funding sources are the sources previously listed as Medicaid Managed Care Organization Allowance Fund, Federal Reimbursement Allowance Fund, Health Initiatives Fund, Pharmacy Rebates Fund, and Premium Fund.

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