



OFFICE OF THE GOVERNOR

STATE OF MISSOURI  
JEFFERSON CITY  
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MEL CARNAHAN  
GOVERNOR

ROOM 216  
STATE CAPITOL  
65101

September 26, 1997

The Honorable Donna E. Shalala, Secretary  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, D.C. 20201

Dear Secretary Shalala:

Enclosed please find Missouri's Title XXI State Plan. As we have discussed, it is our intention to coordinate operation of both Title XXI and Medicaid under the 1115 waiver.

Very truly yours

Mel Carnahan

MC:dk

Enclosure

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**MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI 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,

\_\_\_\_\_  
(Signature of Governor of State/Territory, Date Signed)

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

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 (or minutes) 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: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1.  Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); OR
- 1.2.  Providing expanded benefits under the State's Medicaid plan (Title XIX); ~~OR~~ through an 1115 demonstration waiver; OR
- 1.3.  A combination of both of the above.

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**Section 2. General Background and Description of State Approach to Child Health Coverage**  
(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 section 2110(c)(2)). 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).

See attached 1115 waiver

2.2. Describe the current state effort's to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

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):

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:

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:

(Section 2102)(a)(3)

See attached 1115 waiver.

2.2.1 The state operates its Medicaid program with expanded eligibility for children as defined in the attached 1115 waiver. Outreach and eligibility occur throughout the state with state offices in every county. Free materials are available and used by other entities assisting in outreach, such as social welfare organizations, schools, and health care providers. There is no state-only child health insurance program.

2.2.2 The state cooperates fully with the privately funded Caring Foundation for Children in making referrals and receiving referrals so that there is coordination with Medicaid and maximum outreach for both programs.

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**Section 3. General Contents of State Child Health Plan (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: (Section 2102)(a)(4)

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3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

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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))**

- 4.1.1.  Geographic area served by the Plan: \_\_\_\_\_
- 4.1.2.  Age: \_\_\_\_\_
- 4.1.3.  Income: \_\_\_\_\_
- 4.1.4.  Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_
- 4.1.5.  Residency: \_\_\_\_\_
- 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: \_\_\_\_\_
- 4.1.8.  Duration of eligibility \_\_\_\_\_
- 4.1.9.  Other standards(identify and describe):  
\_\_\_\_\_

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))**

- 4.2.1.  These standards do not discriminate on the basis of diagnosis.
- 4.2.2.  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3.  These standards do not deny eligibility based on a child having a pre-existing medical condition.

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4.3. Describe the methods **of** establishing eligibility and continuing enrollment. **(Section 2102)(b)(2))**

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4.4. Describe the procedures that assure:

4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A))**

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4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. **(Section 2102)(b)(3)(B))**

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4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. **(Section 2102)(b)(3)(C))**

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4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, **25 U.S.C. 1603(c)**). **(Section 2102)(b)(3)(D))**

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4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. **(Section 2102)(b)(3)(E))**

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**Section 5. Outreach and Coordination (Section 2102(c))**

Describe the procedures used by the state to accomplish:

- 5.1 Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1))**  
~~See 2.2.1 In addition outreach will be greatly enhanced through the schools under the 1115.~~
- 5.2. Coordination of the administration of this program with other public and private health insurance programs: **(Section 2102(c)(2))**  
All current Medicaid efforts will continue under the 1115.

**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.)

- 6.1.1.  Benchmark coverage; (Section 2103(a)(1))
  - 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)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.
- 6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [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))

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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))

- 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))
- 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))

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- 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))
- 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. **Waivers - 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 waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: **(Section 2105(c)(2) and(3))**

6.3.1.  **Cost Effective Alternatives.** 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:

6.3.1.1. 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))**

6.3.1.2. 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; and **Describe the cost of such coverage on an average per child basis.** **(Section 2105(c)(2)(B)(ii))**

6.3.1.3. 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(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii))**

6.3.2.  **Purchase of Family Coverage.** Describe the plan to provide 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))**

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have 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(c)(3)(A))**

6.3.2.2. 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))**

**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))**

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**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

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. **(2102(a)(7)(B))**

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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?

8.1.1.  YES

8.1.2.  NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

8.2.1. Premiums: \_\_\_\_\_

8.2.2. Deductibles: \_\_\_\_\_

8.2.3. Coinsurance: \_\_\_\_\_

8.2.4. Other: \_\_\_\_\_

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: \_\_\_\_\_

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of 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))

8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3.  No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4.  No Federal funds will be used toward state matching requirements.  
(Section 2105(c)(4))

8.4.5.  No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6.  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))
- 8.4.7.  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))
- 8.4.8.  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))
- 8.4.9.  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))
- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B)) \_\_\_\_\_
- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:
- 8.6.1.  The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 8.6.2.  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 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:  
\_\_\_\_\_

**Section 9. Strategic Objectives and Performance Goals for the 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))  
~~The state hopes to expand health coverage to approximately 90,000 additional children under our 1115.~~
- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))  
~~The state expects to cover approximately 90,000 additional children.~~
- 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))

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1.  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2.  The reduction in the percentage of uninsured children.
- 9.3.3.  The increase in the percentage of children with a usual source of care.
- 9.3.4.  The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5.  **HEDIS** Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6.  Other child appropriate measurement set. List or describe the set used.
- 9.3.7.  If not utilizing the entire **HEDIS** Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1.  Immunizations
  - 9.3.7.2.  Well 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

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- 9.3.7.7.  Other, please list: \_\_\_\_\_
- 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))
- 9.5.  The state assures it will comply with the annual assessment and evaluation required under Section 10.1 and 10.2. (See: Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))  
This population will become part of our MC+ reporting. In addition, all necessary 1115 reports and documentation will be submitted.
- 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))
- 9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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))

- 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 1115 (relating to waiver authority)
- 9.8.5.  Section 1116 (relating to administrative and judicial review), but **only** insofar as consistent with Title XXI
- 9.8.6.  Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7.  Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8.  Section 1128A (relating to civil monetary penalties)
- 9.8.9.  Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10.  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))

See attached 1115. During public hearings for the 1115 and in all other public discourse it was clearly stated our intent was to use the children's health program to fund and support the 1115.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

See attached 1115.

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.

**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))

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

10.1.2.  Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

<u>Attributes of Population</u>	<u>Number of Children with Creditable Coverage</u>		<u>Number of Children without Creditable Coverage</u>	<b>TOTAL</b>
	<b>XIX</b>	<u>OTHERCHIP</u>		
<b>Income Level:</b>				
< 100%				
≤ 133%				
≤ 185%				
-- 200%				
> 200%				
<b>Age</b>				
0 - 1				
1 - 5				
6 - 12				
13 - 18				
<b>Race and Ethnicity</b>				
American Indian or Alaskan Native				
Asian or Pacific Islander				
Black, not of Hispanic origin				
Hispanic				
White, not of Hispanic origin				
<b>Location</b>				
MSA				
Non-MSA				

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- 10.2.  State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**
- 10.2.i.  **An** assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
- 10.2.2. **A** description and analysis of the effectiveness of elements of the state plan, including:
- 10.2.2.1.  The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
- 10.2.2.2.  The quality of health coverage provided including the types of benefits provided;
- 10.2.2.3.  The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4.  The service area of the state plan;
- 10.2.2.5.  The time limits for coverage of a child under the state plan;
- 10.2.2.6.  The state's choice of health benefits coverage and other methods used for providing child health assistance, and
- 10.2.2.7.  The sources of non-Federal funding used in the state plan.
- 10.2.3.  **An** assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

- 10.2.4.  A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5.  An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6.  A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7.  Recommendations for improving the program under this Title.
- 10.2.8.  Any other matters the state and the Secretary consider appropriate.
- 10.3.  The state assures it will comply with future reporting requirements as they are developed.
- 10.4.  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.

# ***Missouri Medicaid***

## ***1115 Waiver Amendment***

Mel Carnahan  
Governor

Submitted to the  
U.S. Department of Health & Human Services  
August 26, 1997

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# *Executive Summary*

Missouri is seeking a focused amendment to its current 1115 waiver, which was submitted on June 30, 1994 and is still pending with the Health Care Financing Administration (HCFA). This amendment will build on the efforts the state has undertaken in developing the initial 1115 waiver request, as well as in implementing the MC+ program under our 1915(b) waiver. The state is not seeking to undo all of the tremendous work of MC+, but rather build on its success in a focused and logical progression targeted at these critical groups: children, adults leaving welfare for work, uninsured custodial parents, uninsured non-custodial parents, uninsured women losing their Medicaid eligibility 60 days after the birth of their child, and uninsured working adults without children. This waiver will coordinate the use of the new State Children's Health Insurance Program funds to expand Medicaid coverage.

## **Outcomes**

- ◆ Expands coverage to children, thereby helping ensure the health of future generations.
- ◆ Support families moving from welfare into jobs.

## **Coverage**

- ◆ Uninsured children with family income up to 300 percent of the federal poverty level;
- ◆ Uninsured children, regardless of income, attending schools in Chapter I districts;
- ◆ Adults transitioning off of welfare (TANF), who would otherwise not be insured or Medicaid eligible, with family income up to 300 percent of the federal poverty level (coverage will be time limited, with a commercially-oriented benefit package and participation premiums);
- ◆ Uninsured non-custodial parents with family income up to 100 percent of the federal poverty level who are current in paying their child support;
- ◆ Uninsured non-custodial parents actively participating in Missouri's Parents' Fair Share program;
- ◆ Uninsured custodial parents with family income up to 100 percent of poverty; and
- ◆ Uninsured women losing their Medicaid eligibility 60 days after the birth of their child would be eligible for women's health services, regardless of income level, for two years.

## **Funding**

- ◆ The original waiver was never implemented because of serious questions about federal funding.
- ◆ The proposed program can be funded consistent with budget neutrality principles that have been applied to other states receiving 1115 waivers.
- ◆ As part of the waiver process, it is necessary to validate Missouri's current funding base and revenue sources in order to expand coverage to these critically important groups.

## **Development**

- ◆ We will seek HCFA approval by the end 1997, with services to begin July 1, 1998.

# Chapter 1: Overview

The Missouri Department of Social Services is amending its 1115 Medicaid waiver, which was submitted on June 30, 1994, and is still pending with the United States Health Care Financing Administration. This amendment builds on the efforts the state has undertaken in developing the original 1115 waiver proposal, as well as information gained in implementing MC+, the Medicaid managed care program, implemented under Section 1915(b) of the Social Security Act. Missouri will integrate the new State Children's Health Insurance Program (Title XXI) into its expanded Medicaid coverage.

With this amendment to its pending 1115 waiver, Missouri continues its commitment to improve medical care for its low income children and families by increasing their access to comprehensive medical services. Missouri requests expansion of MC+ and its fee-for-service Medicaid program to cover additional groups of uninsured vulnerable citizens and to demonstrate:

- ◆ Increased primary and preventive care;
- ◆ Critical support for Missouri's efforts to successfully move families from welfare to work;
- ◆ Increased access to quality health care beyond the limitations of the fee-for-service Medicaid program; and
- ◆ Quality assessment and improvement,

while continuing to control the cost of public spending; on Medicaid.

This effort will target the following critical populations:

- ◆ Uninsured children with family income up to 300 percent of the federal poverty level;
- ◆ Uninsured children, regardless of income, attending schools in Chapter I districts;
- ◆ Adults transitioning off of welfare (TANF), who would otherwise not be insured or Medicaid eligible, with family income up to 300 percent of the federal poverty level (coverage will be time limited, with a commercially-oriented benefit package and participation premiums);
- ◆ Uninsured non-custodial parents with family income up to 100 percent of the federal poverty level who are current in paying their child support;
- ◆ Uninsured non-custodial parents actively participating in Missouri's Parents' Fair Share program;
- ◆ Uninsured custodial parents with family income up to 100 percent of poverty; and
- ◆ Uninsured women losing their Medicaid eligibility 60 days after the birth of their child would be eligible for women's health services, regardless of income level, for two years.

Children will receive the current Medicaid package of medically necessary services, with the exception of non-emergency medical transportation. Adults receiving Medicaid coverage as a result of this waiver amendment will receive a package of services equivalent to that offered State of Missouri employees. Non-emergency transportation will not be included in the more commercially-oriented benefit package for the expanded adult populations. The consumer protections afforded current Medicaid eligibles will be extended to all the expanded populations. Uninsured women losing their Medicaid eligibility 60 days after the birth of their child will receive women's health services only.

We propose a 12 month lock-in to MC+ health plans to provide a solid continuum of care. The member will have the right to request transfer among health plans during the first 90 days of enrollment for any reason. The member will have the right to change at any time within the year for good cause as determined by the Department of Social Services. Possible reasons for a member to request a transfer may include, but are not limited to:

- ◆ The primary care physician or specialist with whom the recipient has an established patient/physician relationship] no longer participates in the health plan but does participate in another health plan.
- ◆ An act of cultural insensitivity that negatively impacts on the member's ability to obtain care and cannot be resolved by the health plan.

Missouri solicited public input on the 1115 waiver amendment through a combination of public hearings and newspaper notices. Provider associations and individual social service advocates were informed of the hearings by letter. Public notices were also posted in each Division of Family Services county office. Appendix 1 provides a list of other 1115 waiver amendment-related meetings.

The Department's objectives in implementing the 1115 waiver amendment are to:

- ◆ Ensure the health of future generations by integrating coverage for the uninsured into the MC+ program and Medicaid fee-for-service;
- ◆ Strengthen families by assisting the state in its efforts to move welfare recipients into jobs and remove the health care barrier to work;
- ◆ Strengthen communities by continuing integration of school-linked services, focusing on the successful Caring Communities partnerships;
- ◆ Enhance participation of children in the traditional Medicaid program through school-linked eligibility outreach;
- ◆ Increase efficiency by streamlining eligibility and increasing the number of eligibles; and
- ◆ Help move adults toward self-sufficiency by acclimating recipients to practices of standard commercial health insurance plans, such as paying premiums.

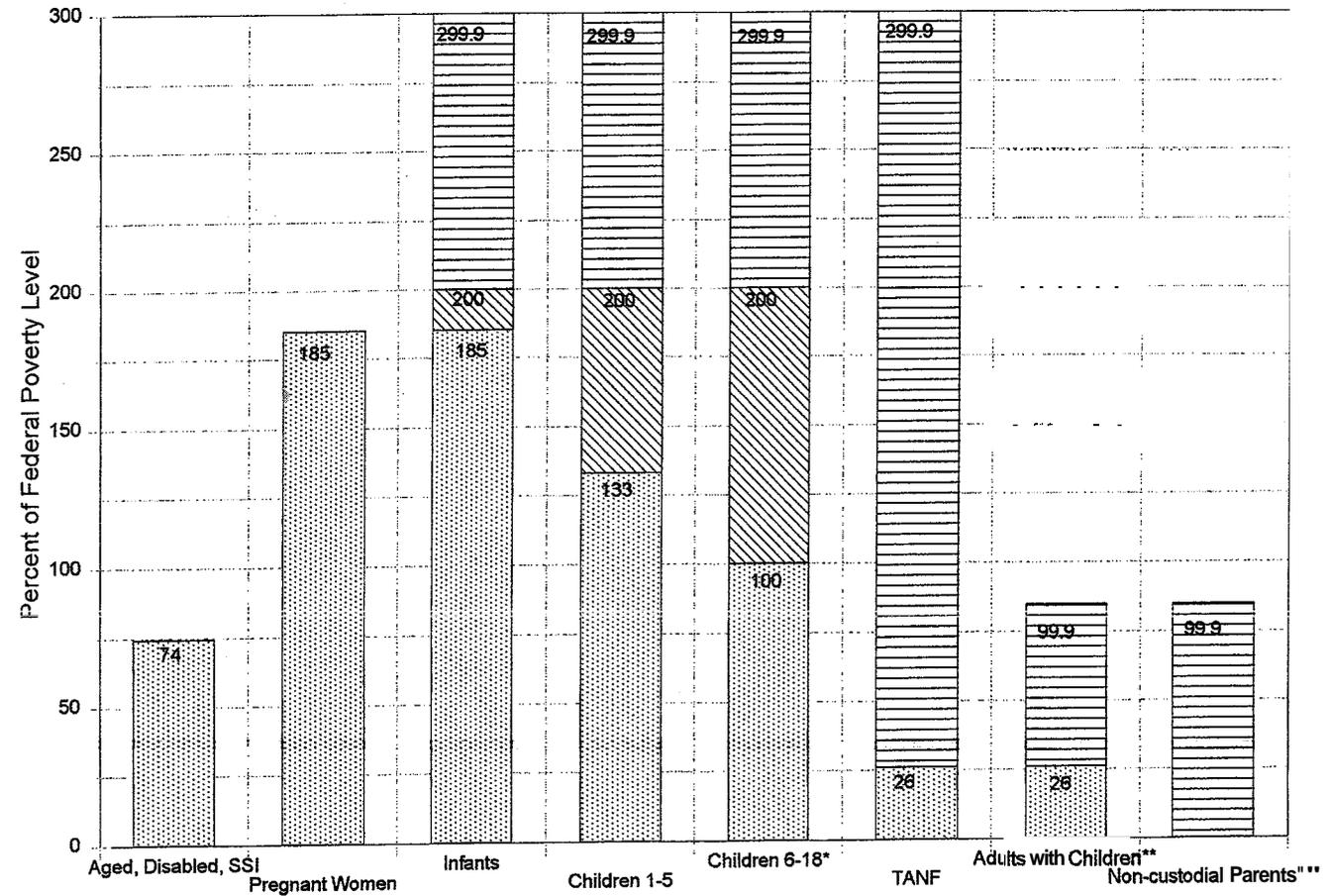
The following two pages outline the expanded eligibility groups and federal poverty levels.

## 1115 Waiver Eligibility Groups

<u>Current Medicaid</u>	<u>Title XXI (SCHIP)*</u>	<u>1115 Waiver</u>
Aged, disabled, Supplemental Security Income (SSI)		No expansion; current eligibility rule will continue to apply
AFDC rules in effect July 16, 1996		No expansion; current eligibility rule will continue to apply
Children in state custody		No expansion; current eligibility rule will continue to apply
Pregnant women 0 - 185 percent federal poverty level		No expansion; current eligibility rule will continue to apply, except that uninsured women losing their Medicaid eligibility 60 days after the birth of their child would be eligible for women's health services, regardless of income level, for two years
Infants (0 - 1) 0 - 185 percent	186 - 200 percent	Up to 300 percent of the federal poverty level
Children (1 - 5) 0 - 133 percent	134 - 200 percent	Up to 300 percent of the federal poverty level
Children (6 - 18) 0 - 100 percent	100 - 200 percent	Up to 300 percent of the federal poverty level
		Uninsured children attending schools in districts designated "Chapter I"
		Working parent(s) transitioning off welfare with family income up to 300 percent of the federal poverty level
		Parents' Fair Share participant
		Uninsured non-custodial parent paying child support with family income up to 100 percent of the federal poverty level
		'Uninsured custodial parents up to 100 percent of the federal poverty level

\* State Children's Health Insurance Program

## 1115 Waiver Eligibility Groups



\* Uninsured children attending schools in Chapter I districts eligible regardless of income  
 \*\* Custodial parents up to 80% of poverty; adults transitioning off welfare up to 250% of poverty  
 \*\*\* Non-custodial parents paying child support or in Parents' Fair Share

1997 Poverty Level Guidelines, Annual Income					
Family Size	100%	133%	185%	200%	300%
1	\$7,890.00	\$10,494.00	\$14,597.00	\$15,780.00	\$23,670.00
2	<del>\$10,610.00</del> \$10,610.00	\$14,111.00	\$19,629.00	\$21,220.00	\$31,830.00
3	\$13,330.00	\$17,729.00	\$24,661.00	\$26,660.00	\$39,990.00

Minimum wage: September 1997 = \$5.15
40 hour a week @ 52 weeks = \$10,712

### Missouri's 1115 Waiver Amendment Timeline

March 1997	Meet with federal officials concerning the 1115 waiver
March 11, 1997	Concept paper completed, timeline completed
March 14, 1997	Arrange for actuarial services
March 31, 1997	First draft of 1115 waiver amendment outline completed
March 31, 1997	Outline for actuarial needs and work plan completed
May 14, 1997	First draft of 1115 waiver amendment finished
May 21 - June 23, 1997	Public education concerning the 1115 waiver amendment
July 1, 1997	1915(b) waiver renewal and independent evaluation submitted to HCFA
July 31, 1997	1115 waiver amendment completed with public input
August, 1997	1115 waiver amendment submitted
End of 1997	1115 waiver approval
July 1, 1998	Implementation
July 1, 1999	implementation of pilot project

## *Chapter 2: Demonstration Design*

### **Offering Health Coverage to More Missourians**

This 1115 waiver program, once implemented, will integrate Missouri's existing fee-for-service program, its 1915(b) statewide managed care waiver program, known as MC+, and the new State Children's Health Insurance Program. Coordinating the use of the new State Children's Health Insurance Program will take advantage of the substantial purchasing power of our existing Medicaid program. We propose to expand Medicaid coverage to the following populations: uninsured children up to 300 percent of the federal poverty level, uninsured adults leaving welfare for work, very low income uninsured non-custodial parents paying child support, very low income uninsured custodial parents, and uninsured women losing their Medicaid eligibility 60 days after the birth of their child would be eligible for women's health services, regardless of income level, for two years.

Missouri also requests a demonstration project to expand coverage to higher income individuals and/or to provide health care coverage for uninsured working adults without children for a limited geographic area beginning in the second year of the waiver. This project will use community resources including premiums from the uninsured, premiums from employers, or state and federal dollars already spent for medical care for the uninsured. The pilot project would only be undertaken if cost neutrality is demonstrated.

To ensure that all children have a good start in life, it is vital that Missouri create the opportunity for mothers, fathers, and children to have comprehensive, preventive health care. Studies of health insurance in the United States show that compared with the insured, the uninsured are less likely to use preventive health services. The uninsured have more avoidable hospitalization, higher inpatient mortality, higher overall mortality, and more diagnoses indicating later stages of life-threatening diseases. Lack of insurance typically translates into delayed access to care, under-use of primary care providers, over-reliance on expensive emergency care, and less inpatient hospital care.

A recently completed Missouri Department of Health report analyzing 1995 data found dramatically different treatment patterns for Missourians based on insurance coverage. The uninsured were one-third more likely to use emergency rooms than insured Missourians, but the uninsured were 54 percent less likely to receive inpatient care. Previous similar reports found that the uninsured received care that costs 40 percent less, raising questions about the quality of medical attention they received. Even with respect to immunizations – which usually are offered at little or no cost in public health clinics – two-year olds in uninsured Missouri families obtained them at only a 55 percent rate compared to 77 percent for privately insured families. More than 10 percent of all hospitalizations for uninsured children could have been avoided with routine primary care.

To ensure Missourians have the opportunity to achieve economic security and prosperity, it is a priority that the number of Missourians with health care coverage increases. The 1115 waiver proposal provides such an opportunity. The state Medicaid program currently pays for care of the uninsured through the disproportionate share program. Through this waiver amendment, Missouri hopes to move approximately 70,000 children and 60,000 adults from "uninsured" into the "insured" category. The state will receive a better return on its health care dollar if money is spent on primary and preventive care rather than on emergency and delayed care.

### **Incorporation of the 1915(b) Waiver**

Missouri requests that the populations currently served by the 1915(b) statewide managed care waiver (MC+ program) be incorporated into this 1115 waiver amendment.

Under MC+, health plans contract with the state and are paid a monthly capitation payment for providing services for each enrollee. Health plans are chosen based on competitive bids submitted by licensed Health Maintenance Organizations (HMOs) for standard benefit packages. A competitive, negotiated bidding process is conducted under state purchasing law. An independent evaluation team reviews proposals. Bids are evaluated on cost, expertise of personnel, experience and reliability, and proposed method of performance, which includes access. Bids are made on a regional basis to take into account varying health care costs and utilization for each region. On-site readiness reviews are routinely conducted. In accordance with Executive Order 94-03, state agencies shall have a goal of awarding at least five percent of the total value of all contracts to businesses that qualify as Minority Business Enterprises as defined in Section 33.750, RSMo (1994). Division of Medical Services contracts have the same goal. Missouri has awarded multiple contracts in each MC+ region to ensure access.

### **Current MC+ Enrollment**

Participation in MC+ is mandatory for certain Medicaid eligibility groups within the regions in operation. There are four eligibility groups for whom participation is mandatory, as shown in the 1915(b) waiver renewal submitted June 30, 1997:

- ◆ Children eligible for Medicaid based on ifamily income;
- ◆ Families meeting Aid to Families with Dependent Children (AFDC) requirements that were in effect on July '16, 1996;
- ◆ Pregnant women;
- ◆ Children in state custody (physical health only); and
- ◆ Refugees.

Medicaid recipients in these mandatory groups who are eligible for Supplemental Security Income (SSI) or who meet the medical requirements to receive SSI disability

payments have the option of choosing to receive services on a fee-for-service basis rather than enrollment in MC+.

The following Medicaid recipients are not currently required to enroll in MC+ and will continue to be exempt from managed care:

- ◆ Individuals enrolled in both Medicare and Medicaid;
- ◆ Permanently and totally disabled recipients;
- ◆ individuals residing in a nursing home or intermediate care facility for individuals with mental retardation;
- ◆ General relief recipients;
- ◆ Pregnant women eligible under the temporary eligibility during pregnancy program;
- ◆ Blind pension or aid to the blind recipients;
- ◆ Recipients residing in a state mental institution or institutional care facility;
- ◆ Individuals eligible under the waiver for people with mental retardation or developmental disabilities or AIDS waiver; and
- ◆ Recipients with comprehensive private commercial insurance (effective September 1, 1997, for recipients in the MC+ eastern region only).

### **Changing Health Plans**

We propose a 12 month lock-in to health plans to provide a solid continuum of care. Once a member chooses a health plan or is assigned to a health plan, he or she will have 90 days from the date the member receives notice of enrollment in which to change health plans for any reason. After the 90 day period, the member will be allowed to change health plans for any reason every 12 months thereafter. A notice will be provided at least 60 days before each annual enrollment opportunity. Members will have the right to change health plans for good cause as determined by the Department of Social Services at any time within the year. These provisions are consistent with the process for change of enrollment outlined in the Medicaid Managed Care provision of the Balanced Budget Reconciliation Act.

### **MC+ By Region**

The MC+ program has been operating in the eastern region since September 1, 1995, the central region since March 1, 1996, and western and northwestern regions since January 1, 1997. Total eligibles in those four regions are projected at 291,600 in FY98.

Region	Enrollment	Implementation	Contract Period	Contract Expiration
Eastern Missouri	June 20, 1995	September 1, 1995	August 1, 1995 - July 31, 1996; one-year renewal period	July 31, 1997 (to be extended to August 31, 1997)
Eastern Missouri Rebid	July 1, 1997	September 1, 1997	September 1, 1997 - August 31, 1998; two-year renewal period	August 31, 2000
Central Missouri	January 1, 1996	March 1, 1996	January 1, 1996 - December 31, 1996; one-year renewal period	December 31, 1997 (to be extended to February 28, 1998)
Western Missouri	October 1, 1996	January 1, 1997	November 1, 1996 - October 31, 1997; one-year renewal period	October 31, 1998
Northwestern Missouri	October 1, 1996	January 1, 1997	November 1, 1996 - October 31, 1997; one-year renewal period	October 31, 1998

The regions are comprised of the following counties:

Eastern

St. Louis  
Franklin  
Jefferson  
St. Charles  
St. Louis City

Central

Audrain  
Boone  
Callaway  
Camden  
Chariton  
Cole  
Cooper  
Gasconade  
Howard  
Miller  
Moniteau  
Monroe  
Montgomery  
Morgan  
Osage  
Pettis  
Randolph  
Saline

Western

Cass  
Clay  
Jackson  
Johnson  
Lafayette  
Platte  
Ray

Northwestern

Andrew  
Atchison  
Buchanan  
Caldwell  
Carroll  
Clinton  
Daviess  
DeKalb  
Gentry  
Grundy  
Harrison  
Holt  
Livingston  
Mercer  
Nodaway  
Worth

A map which depicts the current MC+ regions is included as Appendix 2.

Region	Number of Counties	MC+ Enrollees (FY98 average)	All Other Medicaid Recipients not in MC+	Percentage in MC+
Eastern MC+	5	154,000	57,300	73%
Central MC+	18	33,500	11,500	74%
Western MC+	7	84,600	29,200	74 <sup>1/a</sup>
Northwestern MC+	16	19,500	7,400	72%
Rest of state	69	0	212,700	0%
Total	115	291,600	318,100	48%

The MC+ program will be expanded to the southwest region of Missouri beginning August 1, 1998. A timeline for implementation of MC+ in Southwest Missouri and a map showing the counties that are tentatively scheduled to be included in MC+ is provided in Appendix 3.

### Administration

The MC+ program is administered by the Division of Medical Services office located in Jefferson City, Missouri. The division has a managed care section in the Service Delivery Unit which has primary responsibility for operation of the MC+ program. In addition, a regional administrator is assigned to each MC+ region. Regional administrators are the primary contact between the division and the various health plans contracted to provide MC+ services.

A detailed explanation of how Other division staff are assigned to manage and service the programs in managed care is provided in Appendix 4.

### Benefits and Services

Services not covered under the MC+ program are obtained in the same manner as under the regular Medicaid program.

## MC+

MC+ services provided by the health plans must include:

- ◆ Inpatient hospital services
- ◆ Outpatient hospital services
- ◆ Emergency room services
- ◆ Ambulatory surgical center, birthing center
- ◆ Physician, advanced practice nurse, and certified nurse midwife services
- ◆ Maternity benefits for inpatient hospital and certified nurse midwife -- The health plan shall provide coverage for a minimum of 48 hours of inpatient hospital services following a vaginal delivery and a minimum of 96 hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo.
  - A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. The health plan is to provide coverage for post-discharge care to the mother and her newborn. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization, and be documented in the patient's medical record. The first post-discharge visit shall occur within 24 to 48 hours. Post-discharge care shall consist of a minimum of two visits, at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests, and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. **A**

health plan must seek approval from the state prior to utilizing another nationally recognized medical organization's guidelines.

- ◆ Family planning services
- ◆ Pharmacy benefits, excluding protease inhibitors
- ◆ Dental services
  - e Dental services for adults are covered in the MC+ eastern region effective September 1, 1997.
  - Adult coverage will be expanded to other regions at the time of the next contract.
- ◆ Laboratory, radiology, and other diagnostic services
- ◆ Preventive care
- ◆ Prenatal case management
- ◆ Hearing aids and related services
  - e Hearing aids and related services for adults are covered in the MC+ eastern region effective September 1, 1997.
  - e Adult coverage will be expanded to other regions at the time of the next contract.
- ◆ Optical services
  - e Optical services for adults are covered in the MC+ eastern region effective September 1, 1997.
  - e Adult coverage will be expanded to other regions at the time of the next contract.
- ◆ Home health services
- ◆ Adult day health care services
  - e Day health care services for adult!; are covered in the MC+ eastern region effective September 1, 1997.
  - Adult coverage will be expanded to other regions at the time of the next contract.
- 4 Personal care services
  - e Personal care services for adults are covered in the MC+ eastern region effective September 1, 1997.
  - Adult coverage will be expanded to other regions at the time of the next contract.
- ◆ Comprehensive day rehabilitation (for certain persons with disabling impairments as the result of a traumatic head injury)
- ◆ Emergent and non-emergent transportation
- ◆ Behavioral health
  - e Equivalent to 30 inpatient days and 20 outpatient visits a year
  - e Medicaid will pay fee-for-service for mental health services needed that exceed the 30/20 limitation if these services are Medicaid approved and provided by a Medicaid enrolled provider.
- 4 Services of other providers when referred by the health plan's primary care provider
- ◆ Hospice services
- ◆ Durable medical equipment (including, but not limited to: orthotic and prosthetic devices, oxygen, wheelchairs, and walkers)

- ◆ Podiatry
- ◆ Services provided by local health agencies (may be provided by the health plan or through an arrangement between the local health agency and the health plan)
  - Screening, diagnosis, and treatment of sexually transmitted diseases
  - HIV screening and diagnostic services
  - Screening, diagnosis, and treatment of tuberculosis
  - Childhood immunizations
  - e Childhood lead poisoning prevention services including screening, diagnosis, and treatment
- ◆ Emergency medical services – Emergency medical services are defined as those health care items and services furnished or required to evaluate and treat a sudden and unforeseen situation or occurrence or a sudden onset of a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:
  - Death
  - Placing the patient's health in serious jeopardy
  - Permanent impairment of bodily functions
  - Serious dysfunction of any bodily organ or part
  - Serious harm to a member or others due to an alcohol or drug abuse emergency
  - e Injury to self or bodily harm to others
  - With respect to a pregnant woman who is having contractions:
    - (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn.
- ◆ Early, periodic screening, diagnosis, and treatment services (EPSDT), also known as the Healthy Children and Youth (HCY) program, provides services for individuals under age 21
  - HCY screens including interval history, unclothed physical, anticipatory guidance, lab/immunizations, lead screen (verbal risk assessment and blood levels mandatory 6-72 months), developmental screen, and vision,, hearing, and dental screens
  - e Dental services including orthodontics for individuals under age 21
  - e Hearing aids and related services
  - Eye exams and glasses
  - Private duty nursing
  - Psychology/counseling services
  - e Physical, occupational, and speech therapy
  - Augmentative communication devices, oxygen, I.V. therapy, orthotic and prosthetic devices, and all medically necessary durable medical equipment services and medical supplies
  - Home health

- e Personal care
- e Unlimited medically necessary inpatient and outpatient services
- e Case management
- e Behavioral health services (all medically necessary services)

### **Current Services Provided Outside MC+**

The following services are available to MC+ enrollees outside the MC+ health plan and will be reimbursed to Medicaid-enrolled providers on a fee-for-service basis only by the state:

- ◆ Adults (age 21 and over) included in the MC+ health plan will have a supplemental benefit package to ensure they receive all services currently offered under the Medicaid program. The supplemental services will be coordinated by the MC+ health plan. The following services are included in the adult's supplemental package:
  - Mental health services beyond the 30 inpatient/20 outpatient will be covered when furnished by a mental health provider currently eligible to provide services as a mental health provider for Missouri Medicaid adults.
  - e Dental services\*
  - e Hearing aids and related services"
  - e Personal care services\*
  - e Adult day health care services\*
  - e Optical services?
- ◆ Physical, occupational and speech therapy services specified in individual Education Plans (IEP) or therapy services specified in individual Family Service Plan (IFSP)
- ◆ Environmental lead assessments for children with elevated blood lead levels
- ◆ Lab tests performed by the Department of Health as required by law (e.g., metabolic testing for newborns, blood lead testing)
- ◆ Bone marrow and organ transplant services (corneal tissue transplants are covered as an outpatient benefit). Services include the hospital stay from the date of transplant through the date of discharge, procurement, and physician services related to the transplant and procurement procedures. Pre-transplant and services following discharge are the responsibility of the MC+ health plan.
- ◆ Behavioral health services for MC+ health plan enrolled children (under 21) in the care and custody of the Division of Family Services

\*Effective September 1, 1997, these services are included in the MC+ comprehensive benefit package for the eastern region only. The same services will be included in the comprehensive benefit package as new regional contracts are awarded. MC+ enrollees are notified of this change in their enrollment packet.

- Inpatient services – Patients with a dual diagnosis admission (physical and behavioral) will have their physical health hospital days covered by the MC+ health plan. Medically necessary inpatient days for the behavioral health services beyond what is necessary for the physical health diagnosis must be certified by the Division of Medical Services medical review agent.
- Outpatient visits are not the responsibility of the MC+ health plan for this group of enrollees when provided by:
  - ▶ Comprehensive Substance Treatment Abuse and Rehabilitation (C-STAR) provider
  - ▶ Psychiatrist
  - ▶ Licensed psychologist, licensed clinical social worker, licensed counselor
  - ▶ Psychiatric advance practice nurse or home health psychiatric nurse
- ◆ C-STAR program
- ◆ Community psychiatric rehabilitation program
- ◆ Sexual Assault Examination (SAFE) and Child Abuse Resource Education (CARE) exams and all related diagnostic studies which ascertain the likelihood of sexual or physical abuse performed by SAFE-trained providers
- ◆ Protease inhibitors
- ◆ Abortion services, subject to Medicaid program benefits and limitations

### Improvements Over Fee-for-Service

Managed care offers Medicaid recipients a number of advantages over traditional fee-for-service Medicaid. For example, each MC+ enrollee chooses a health plan and a primary care provider from within the network of the health plan. MC+ enrollees are guaranteed access to primary care and other services, as needed. Health plans must ensure that:

- ◆ Routine exams are scheduled within thirty days;
- ◆ Urgent care is scheduled within *two* days; and
- ◆ Emergency services must be available at all times.

These same safeguards will be part of the managed care contracts to provide coverage for the expanded populations.

Under the traditional fee-for-service Medicaid program, recipients may have difficulty accessing primary care, dental care, or needed specialty services, and often resort to using the emergency room for non-emergent illnesses such as ear infections or influenza. MC+ health plans must ensure that children receive all EPSDT exams (complete physicals on a regular schedule), are fully immunized, and receive all medically necessary services. MC+ health plans are required to provide case management to ensure that services, especially children's and pregnant women's, are properly coordinated. The

state may track service utilization and costs under the traditional Medicaid program, but is not able to effectively control costs or monitor quality of care. MC+ provides the means to control costs, but more importantly, to ensure access, manage and coordinate benefits, and monitor quality of care and outcomes. The established MC+ program will serve as a foundation for this demonstration.

## **Expanded Populations**

### **Coverage for Uninsured Children**

Nationally, more than half of all uninsured children's families earn moderate incomes -- between \$17,280 and \$28,800 a year according to the U.S. Census Bureau. Most of Missouri's uninsured children come from homes in which parents are trying to do their best to put food on the table and provide a decent, safe place to live.

#### **Federal Poverty Level**

Missouri proposes that all uninsured children up to 300 percent of the federal poverty level be covered with the full range of Medicaid services, excluding non-emergency medical transportation. Children will include individuals age birth through age 18. No new eligible will be excluded because of pre-existing illness or condition.

There will be protections against dropping or foregoing private coverage, including a six month waiting period and insurance availability screen through the Division of Medical Services Health Insurance Premium Payment (HIPP) program.

- ◆ Children of parents who dropped available private insurance coverage within the last six months, without good cause as determined by the Department of Social Services, will have a six month waiting period for Medicaid coverage.
- ◆ Where economically cost effective, the state will use the HIPP program to obtain available coverage through available commercial insurance, and any non-covered services that are included in the Medicaid package will be obtained through MC+ or fee-for-service where MC+ is not available.

### **Chapter I School District Programs**

**All** uninsured children enrolled in a school district with 50 percent or higher concentration of students from poor families will be Medicaid eligible with a streamlined eligibility process. There will be no income test for children in these school districts. A list of the Chapter I eligible school districts is included herein as Appendix 5.

Chapter I of the Elementary and Secondary Education Act authorizes public schools with a 50 percent or higher concentration of students from poor families to use federal

funds to operate an "upgraded school wide program." During the 1996-1997 school year, 91 Missouri public school districts were participating in the Chapter I school-wide program. To ensure the on-going learning readiness and to optimize the development and wellness of the 140,000 low income children in Chapter I districts in Missouri, the efforts of public schools and health care providers must be better coordinated and integrated. With this waiver Missouri communities would be permitted to use a district-wide approach to determine Medicaid eligibility. Income computations for eligibility would not be necessary.

The conceptual design of the Chapter I district-wide program reflects an assumption that beyond a certain break point (at least 50 percent of the children enrolled in the school district are from low income families), funds can be maximized by allowing dollars to be used for all students in the school. This is in contrast to the current Medicaid methodology which makes no provision for this area-based eligibility approach. This waiver would allow for demonstration of a Medicaid administrative mechanism to facilitate comprehensive, school-linked service strategies by extending program benefits to all children in school districts whose enrollment is largely low income.

A Chapter I school district's involvement in the eligibility process would be completely voluntary and would be to send the Medicaid application packet home with the child. The Medicaid application could not be submitted without the parent's signature. School districts may also choose to engage in more active outreach efforts and education about MC+.

There will be coordination efforts offered to all schools, especially Caring Communities schools. The Caring Communities approach is Missouri's strategy for schools, neighborhoods, and public agencies to link services and supports to achieve better results for children and families. Public schools and surrounding neighborhoods with a high potential for successful implementation of school-linked services were selected in several community partnership areas. This coordination effort focuses on identifying currently eligible Medicaid children, as well as those who will become eligible under this waiver, and assisting them in gaining eligibility. Information on the eligibility status of a school district's students will be shared with any cooperating district so school officials may do one-on-one targeted outreach and education about MC+. This effort will efficiently reach eligible children, resulting in better health outcomes, stronger families, and improved school performance.

### **Services for Children in Expanded Eligibility Groups**

Children will receive the Medicaid package of medically necessary health services. Non-emergency medical transportation will not be a covered service. Fee-for-service will be utilized in regions where MC+ is not yet available. When MC+ begins in these areas, this population will be enrolled in managed care.

## **Coverage for Uninsured Parents**

With this 1115 waiver, Missouri will extend Medicaid coverage to certain groups of uninsured adults. Protections against dropping or foregoing private coverage will include an insurance availability screen. Where economically cost effective the state may use the HIPP program to obtain coverage. In determining eligibility, resources will be disregarded.

## **Working Parents with Children**

Adults transitioning off of welfare (TANF) will be eligible to participate in Missouri's expanded Medicaid program if they would otherwise not be insured or Medicaid eligible. To be eligible a person must have met the eligibility requirements and exhausted their twelve months of transitional Medicaid coverage. They would move directly from the twelfth month of transitional to the working parents Medicaid coverage. This coverage will be available through state and federal funding for two years. To remain eligible a person must remain employed and have a Medicaid eligible child in the home. The family income must remain under 300 percent of the federal poverty level to maintain coverage. Resources will be disregarded. Eligibility will be reviewed on an annual basis.

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## **Private Participation**

After the initial two year program, beneficiaries in an area with MC+ will have the option to continue their health coverage by paying the premium cost directly to the health plan for the length of the 1115 waiver. This will be at the same rate that the state pays per member for coverage during the year, beginning the 13th month after the end of transitional Medicaid. Adjustments to these private participation rates will occur as the state's rates change. The state and federal government will not financially participate in cost sharing in this arrangement, but the state will require such coverage be available in its MC+ contracts. The health plans will be required to allow employers to pay part or all of this cost on behalf of eligible employees.

MC+ health plans will be required to accept payments on a monthly basis. Payments received over 15 calendar days late will terminate coverage. The health plan must send an overdue notice no later than five calendar days after the due date reminding the participant of the importance of timely payment and the date-certain deadline to receive payment or lose coverage. Notices sent after the five calendar days must give the participant a specific date, no less than ten calendar days after the date the notice is sent.

## Non-custodial Parents

Parents' Fair Share Participants -- Certain non-custodial parents actively participating in the Missouri Parents' Fair Share program will be eligible for Medicaid under this waiver amendment. Continued participation and cooperation in Parents' Fair Share is mandatory for continued Medicaid eligibility.

The Parents' Fair Share program is a cooperative program operated by the Missouri Division of Child Support Enforcement and the Missouri Division of Family Services. Parents' Fair Share is a program to assist non-custodial parents find employment, meet their child support obligation, become self sufficient, and improve their relationship with their children.

To be eligible for Parents' Fair Share the non-custodial parent must meet the following requirements:

- ◆ Must reside in the State of Missouri;
- ◆ Must have one child receiving TANF benefits, food stamps, or Title XIX benefits in the State of Missouri (the child cannot reside with the non-custodial parent);
- ◆ Must be the legal or presumed parent of the child (paternity can not be in question); and
- ◆ Must be unemployed or underemployed (working fewer than 40 hours a week at minimum wage or less).

The Parents' Fair Share program is available in all counties in the State of Missouri. Participation is voluntary, but a non-custodial parent may be ordered into the program by the courts as a condition of probation for failure to pay child support.

Parents' Fair Share Enrollments by Fiscal Year	
Fiscal Year	Enrollments
1992	252
1993	272
1994	353
1995	598
1996	813
1997	807

There will be no premiums for Parents' Fair Share participants.

Low Income Uninsured Non-custodial Parents – Uninsured non-custodial parents with income up to 100 percent of the federal poverty level who are actively paying child support at or above their legally obligated amount will be eligible for Medicaid under this waiver amendment. The non-custodial parent must remain current in their child support obligation to maintain Medicaid eligibility. The state will monitor that child support is paid before establishing eligibility for that month. A person must apply in order to receive Medicaid services. Income levels will be reviewed on an annual basis. There will be no retroactive eligibility. Coverage will be available for a maximum of two consecutive years.

### **Low Income Uninsured Custodial Parents**

Low Income Uninsured Custodial Parents – Uninsured custodial parents with income up to 100 percent of the federal poverty level will be eligible for Medicaid for a maximum of two consecutive years. A person must apply in order to receive Medicaid services. Eligibility will be verified on an annual basis, and there will be no retroactive eligibility.

Uninsured Women Losing Medicaid Eligibility -- Uninsured women losing their Medicaid eligibility 60 days after the birth of their child will be eligible for women's health services, regardless of income level, for a maximum of two consecutive years after their Medicaid eligibility expires. A woman must apply in order to receive these services. These women are eligible for the two-year period for the following services only:

- ◆ Contraception management;
- ◆ Insertion of Norplant;
- ◆ IUD;
- ◆ Deprovera injections;
- ◆ Pap test;
- ◆ Pelvic exams;
- ◆ Sexually transmitted disease testing and treatment;
- ◆ Family planning counseling/education on various methods of birth control;
- or
- 4 Drugs, supplies, or devices related to the women's health services described above when they are prescribed by a physician or advanced practice nurse.

There will be no premiums for this coverage.

### **Services for Adults in Expanded Eligibility Groups**

Coverage for adults in the expanded eligibility categories will be bid by health plans according to MC+ regions but with a more commercially-oriented benefit package than that provided to children. Services will be provided fee-for-service where MC+ is not yet available.

Services will include a package of benefits equivalent to that offered State of Missouri employees as outlined below.

- ◆ Allergy injections
- ◆ Ambulance service – Ground services covered at 100 percent if medically necessary or with prior approval; air services covered at 100 percent in emergency cases or with prior approval. Non-emergency medical transportation is not covered.
- ◆ Contraceptives
- ◆ Dental care – Treatment to reduce trauma as a result of accidental injury or oral surgery when medically necessary
- ◆ Durable medical equipment
- ◆ Emergency care
- ◆ Eye and vision care – Treatment of disease or to reduce trauma as a result of an accident
- ◆ Hearing aids and testing -- Hearing aids covered once every two years
- ◆ Home health care -- Covered when authorized by primary care provider
- ◆ Hospice care -- Coverage provided at same level as applicable benefit
- ◆ Hospital benefits for mental and nervous disorder -- Hospitalization for mental health and alcohol and drug abuse limited to combined **30 days/year**; partial hospitalization may be provided on a two for one exchange (i.e., any combination of 60 partial days and/or 30 inpatient days)
- ◆ Hospital benefits for alcohol and drug abuse -- Same as for mental and nervous disorder above
- ◆ Hospital room and board -- Provided in full; must be arranged by primary care provider
- ◆ Injections
- ◆ Maternity coverage – Prenatal visits, delivery costs, and routine post-natal visits are covered
- ◆ Organ transplants -- The following organ transplants covered at 100 percent: bone marrow, cornea, kidney, liver, heart, and lung when: (1) neither experimental or investigational, and (2) medically necessary as determined by primary care provider.
- ◆ Outpatient diagnostic lab and x-ray -- Provided in full
- ◆ Outpatient mental and nervous disorder -- Maximum 20 visits per year. Group therapy may be provided on a two for one exchange (i.e., any combination of 40 group sessions and/or 20 individual sessions) .
- ◆ Oxygen (outpatient)
- ◆ Physical therapy and rehabilitation services
- ◆ Physician services
- ◆ Prescription drugs – Maximum **30 day** supply
- ◆ Preventative services – Annual physical exams, immunizations, pap smears; mammograms, well-woman exams
- ◆ Skilled nursing facility -- Benefits are limited to 120 days per calendar year, provided in full (subject to medical necessity)
- ◆ Surgery

There will be a yearly individual benefit maximum of \$50,000. If expenditures for an individual reach \$50,000 for all services within a 12 month period, Medicaid eligibility ends for that 12 month period. The one year period will coincide with the date the individual becomes Medicaid eligible.

Uninsured women eligible under the women's health category will not be eligible for this full range of health services.

### **Premiums**

- ◆ Premium participation to increase participant responsibility and move coverage closer to that found in the commercial market. (Parents' Fair Share participants and those under the women's health program will be exempt from paying premiums.)
  - e Premium payments during the first year of the coverage:
    - \$5 at the time of each provider visit and \$5 per prescription
  - e Premium payments during the second year of the coverage:
    - \$10 at the time of each provider visit and \$5 per prescription

### **Eligibility Determination for New Populations;**

The state may delay implementation of the waiver or cap enrollment in any area in which there is insufficient resources to provide services under the waiver.

For the new eligibility groups added under the 1115 waiver amendment and all children we propose that eligibility intake and redetermination be initiated through a direct mail process. The approval/disapproval process could be conducted by a centralized unit using a calculation for new eligibles under the 1115 waiver based upon gross income and standard deductions. We propose calculating the standard deductions by determining the average percentage now disregarded and adjusted in the **AFDC** program as of July 16, 1996. This formula could then be programmed into a computer system to be automatically applied based upon income and family size. Missouri will not consider income of any relative as available to an individual except for a spouse of an individual or a parent for a child who is under the age of 19. We propose self-declaration for citizenship and family composition. Our toll-free telephone system for Medicaid recipients to call with questions will be expanded. Interviews could be conducted by telephone. Local Division of Family Services offices will have program information available and be able to provide assistance in completing applications on an as-needed basis, but they would not be the preferred application site.

### **Enrollment Procedure for New Populations**

Enrollment into a MC+ health plan is currently performed through an enrollment broker under contract with the State of Missouri. Methods utilized to achieve this

enrollment include telephone, mailings, and on-site. The state may use the same enrollment broker concept for this program or it may choose to use the centralized application operation for the enrollment activities,

## Consumer Protections

MC+ program consumer protections include:

- ◆ Consumer satisfaction surveys;
- ◆ Complaint and fair hearing/grievance procedure (Appendix 6);
- ◆ Right to change health plans as allowed by federal law or for good cause as determined by the Department of Social Services;
- ◆ Right to change doctors, minimum of twice a year;
- ◆ Access and appointment standards;
- Prohibition against discrimination or separating MC+ enrollees from other patients;
- ◆ Marketing restrictions;
- ◆ Health plans must accept assigned members; prohibited from disenrolling;
- ◆ Member handbooks with multilingual access;
- ◆ Self-referral for mental health and family planning services; and
- ◆ Consumer advisory committee.

If a person is MC+ eligible and does not choose a health plan, the person will be auto assigned to a health plan. These current consumer protections will be part of the contracts for services for the populations eligible as a result of this waiver.

## Outreach

We propose using brochures of the Southern Institute on Children and Families, or something similar, developed by focus groups of employers and recipients, to educate families about the health coverage available through Medicaid. We will stress that:

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

We will involve the MC+ Consumer Advisory Committee, the Division of Family Services income maintenance staff, and other appropriate agencies or groups in the design and implementation of the mail-in eligibility process. We will also continue to coordinate eligibility outreach efforts with schools, hospitals, and local health departments by identifying barriers to Medicaid enrollment.

## *Chapter 3: Waiver Administration*

### **Access and Quality Measures**

The purpose of a continuous quality and improvement process is to assure access to quality service in the MC+ program and the program for the expanded eligibles under the 1115 waiver program. The quality assessment measures contained in Missouri's Quality Assessment and Improvement Plan, Appendix 7, will employ a variety of methods and tools to measure outcomes of service that is provided. The goal is to monitor health care services provided to MC+ enrollees and waiver eligibles by the health plans and compliance with federal, state, and contract requirements. The health plans must meet program standards for quality improvements, systems, member services, provider services, record keeping, organizational structure, adequacy of personnel, access standards, and data reporting as outlined in the MC+ contracts. Quality control measures will be taken from the Health Plan Employer and Data Information Set (HEDIS) and other internally developed measurements. HEDIS is a strong public/private effort that includes a standardized set of measures to assess and encourage the continual improvement in the quality of health care. Specifically, Medicaid HEDIS includes additional quality and access measures which respond more directly to the needs of women and children, who make up the majority of MC+ enrollees. Medicaid HEDIS is intended to be used collaboratively by the agency and managed care plans to:

- ◆ Provide the agency with information on the performance of the contracted health plans;
- ◆ Assist health plans in quality improvement efforts;
- ◆ Support emerging efforts to inform Medicaid clients about managed care plan performance; and
- ◆ Promote standardization of managed care plan reporting across the public and private sectors.

### **Contract Compliance Measures**

Along with quality control/assessment, monitoring health plan compliance to contractual requirements is a primary method to measure whether the goals of managed care are being met. Contractual compliance monitoring begins with the issuance of the Request for Proposal (RFP) for the specific benefit package in question. The RFP contains standards for HMO licensure and solvency, network composition and access requirements, consumer protections, member services, primary care provider responsibilities, and other important requirements. Prior to contract awards, health plan proposals are reviewed and scored on the basis of cost, experience and reliability, expertise of personnel, and proposed method of performance by an interdepartmental team as part of the Office of Administration contract award process.

After contract award and prior to start-up, health plan provider networks are analyzed to assure adequate development of the provider network to meet the health care needs of Medicaid recipients. A readiness review is also conducted to assess the health plan's operational readiness to begin serving MC+ enrollees. The readiness review looks at each health plan's operations in member services, provider services, and quality assessment in an effort to assure health plans have adequate resources, such as numbers of doctors, contracts with hospitals and specialty providers, and client services staff, to meet the needs of their enrollees. Health plans are required to submit a provider demographic file so that MC+ enrollees will have access to important information about providers before they choose a health plan. With this information, recipients can choose between the different health plans' provider networks to assist them when making their very important choice of health plan. The file can tell recipients which primary care providers are available, along with the office locations and office hours. They can learn about the hospitals in each health plan as well as other specialty providers.

The division will continue to monitor contract compliance for the duration of the contract. This is measured through a variety of methods:

- ◆ Geographic accessibility (Geo Access) analysis tells the agency the percentage of Medicaid recipients who have access to particular providers within a specific mile radius.
- ◆ Annually the division reviews specific aspects of health plan operations. This may include health plan member services, provider services, quality assessment operations, and claims payment systems.
- ◆ Member satisfaction with the health plans is another method for measuring success of the MC+ program.
- ◆ Specific quality assessment measures include:
  - All quality assessment and improvement (QAI) reports are received within the 45 day due date;
  - All initial six month and annual QAI reports received from all health plans as required;
  - Auto assign rate, transfer numbers by region and health plan;
  - Numbers for new enrollment by region and reasons for leaving MC+;
  - Provider relations unit provides data on the number of calls concerned with MC+, provider/recipient comments/concerns, complaints, and positive comments; and
  - Consumer and provider feedback.

An internal Medical Review Committee has been formed to provide review of issues, protocols, and complaints which require a clinical opinion. Forms used by the committee are included as Appendix 8. The Record Request Form is used by the Division of Medical Services Surveillance, Utilization, and Review Unit to request records from health plans and providers to be reviewed by the committee. The Request for Review

Form includes the information which is necessary for the committee to begin the review process. Upon completion of the form the medical review process is initiated. Records of all requests are maintained and quarterly reports prepared which outline the request, committee decision, and health plan response.

## Evaluation

As required by Missouri's 1915(b) waiver, the Health Services Management Group of the University of Missouri-Columbia performed an independent external review of the quality of services furnished by each health plan in the eastern and central MC+ regions of Missouri, the accessibility to care within the plans, and the balance between cost to provide services and quality of care under MC+. Medical record review for the evaluation was conducted through a subcontract with the Missouri Patient Care Review Foundation. The results of the review were provided in the 1915(b) waiver renewal application.

To assure access to quality services funded by the new State Children's Health Insurance Program and this 1115 waiver, the Department of Social Services will employ a variety of methods to measure outcomes. This includes an annual external review administered by an independent professional review organization (PRO) or PRO-like entity. A successful managed care program must identify and intervene with high risk enrollees to keep their health costs down and to provide quality care responsive to the enrollees' health problems. As the preceding statement indicates, the costs of providing care must be balanced with the quality of care delivered to ensure that the enrollees' health problems are appropriately addressed. A critical component in ensuring that the services being delivered to Missouri MC+ recipients are appropriate and of high quality is the independent external review of the process and the outcomes achieved. The purpose of the external review function is:

- ◆ To provide the state and federal governments an independent assessment of the balance between cost to provide services and quality of care and accessibility to health care delivered to Missouri MC+ recipients; and
- ◆ To identify problems in health care and contribute to improving the care of all Missouri MC+ risk-reimbursed HMOs.

Assessing the quality of care delivered to Missouri MC+ recipients includes a variety of analyses:

- ◆ What services are provided to the current Medicaid population and expanded population that have a major impact on the health status of the population being evaluated? That is, are the services being provided those services which should be provided?
- ◆ Are the services being provided by the health plans accessible? Are the health plans delivering the services at a quality level consistent with pre-

determined standards of practice? This includes a comparison of accepted treatment guidelines/protocols with actual treatment processes. It also compares actual access times for appointments, referrals, on-site waiting time, and knowledge of accessibility by MC+ participants with acceptable standards.

- ◆ Are the reports and data being collected by the Missouri MC+ program and the program for the expanded eligibles appropriate and sufficient to answer the above questions on a continuing basis?

## *Chapter 4: Caseload and Cost Estimates*

The Missouri 1115 waiver amendment will extend health care to approximately 130,000 medically uninsured statewide in the first year of the waiver. This chapter provides background information about the methods and data sources used to develop the proposed 1115 waiver budget.

### **Caseload**

#### **Federal Poverty Level**

The Office of Administration, Division of Budget and Planning, estimates that based on the 1996 Current Population Survey, there are 194,434 uninsured children in Missouri through age 18. Of that amount, 169,568 are estimated to be below 300 percent of the federal poverty level. Also included in the Division of Budget and Planning's number are Medicaid-eligible children that have not enrolled in the Medicaid program. We estimate that 78,267 of the uninsured population below 300 percent of the federal poverty level are already Medicaid eligible. This leaves 91,301 that would be eligible under the waiver. We assumed a 75 percent presentation rate, leaving 68,476 new eligibles.

#### **Chapter I School District Programs**

The 1115 waiver seeks to make all children in Chapter I school districts Medicaid eligible. All children under 300 percent of the federal poverty level will already be reflected in this group. In estimating the number of children in a Chapter I district, we calculate an additional 26,339 children will be eligible. Based on the Office of Administration, Division of Budget and Planning's uninsured calculations, we estimate 11.5 percent (above 300 percent) of this group will not have insurance. The eligible population is 3,029, with a 75 percent presentation rate of 2,272.

#### **Working Parents with Children**

According to the Missouri Division of Family Services (DFS), the caseload for the transitional Medicaid population has been constant over the last 38 months. This population has averaged 11,723 people. Of this group, 69.85 percent are adults (8,189 people). DFS estimates 30 percent of this population remains eligible for the full 12 months of transitional Medicaid. We assume that you must remain eligible for 12 months of transitional Medicaid to be eligible for 1115 waiver services. We estimate that 205 adults will be added each month through the end of the second year, with a maximum caseload of about 4,913 adults at the point the caseload levels off. We assume that some of the TANF population that does not complete 12 months of transitional may be

incentivized by this program and remain in transitional. We are unable to estimate this number; however, in order to address this, we did not recognize the standard 75 percent presentation rate reduction.

### **Parents' Fair Share Participants**

We estimate the average number of participants in this program to be 263. While the number of eligible people for the program continues to grow, the number of active participants has been constant. People in this program are in training and do not have incomes above 100 percent of the federal poverty level. We are assuming a 75 percent presentation rate, and expect 197 new Medicaid eligibles.

### **Low Income Uninsured Non-custodial Parents**

Division of Child Support Enforcement (DCSE) works with 156,500 absent parents who are actively paying child support. DCSE does not track the income level of these parents. We assumed these parents represent a cross section of Missouri. This means that the levels of income for this population mirrors that of Missouri as a whole. Based on 1996 Current Population Survey data, we determined that 17.54 percent of the Missouri adult population are uninsured. Of the 156,500 parents currently paying child support, 27,440 would be uninsured. DOH has determined in its December 1995 report entitled *Uninsured Missouri* that of the uninsured, 34 percent have incomes below 100 percent of the federal poverty level. This reduces the 27,440 to 9,330. We assumed a 75 percent presentation rate, leaving an estimate of new Medicaid eligibles at 6,998.

### **Low Income Uninsured Custodial Parents**

This population will be based on working adults not on AFDC (cash payments) or Medicaid, with at least one Medicaid child in the home. Through the Department of Social Services Research and Evaluation we have determined there are 86,646 single parent households and 5,215 two parent households that have children that qualify for Medicaid (Medicaid for Children). The households have been analyzed to determine how many are below 100 percent of the federal poverty level based on the number of people in the home. This yielded 60,394 single parent households and 2,609 two parent households. In total, there are 65,612 potential eligibles (60,394 + (2,609 x 2 people)). Assuming a 75 percent presentation rate, we would expect 49,209 to apply for Medicaid.

### **Uninsured Women Losing Medicaid Eligibility**

This group will be provided women's health services for two consecutive years after 60 days postpartum (when current Medicaid eligibility expires). We determined the number of eligibles to be 2,740. We projected that of these women, 1,064 will be re-enrolled in Medicaid over the next year. This left 1,677 on average each month that would be potentially eligible for women's health services through the wavier. At the end of two years the total population would be 40,248. We determined that the population

re-enrolling in Medicaid would have a few months of eligibility under the waiver for the time between 60 days postpartum and becoming Medicaid eligible. We have determined an average of 2.1 months of eligibility under the waiver. This would add a full time equivalent of 186 people per month. The total population at the end of two years would be 44,712 (40,248 + 4,464). Assuming a 75 percent presentation rate, we expect 33,534 people to apply for Medicaid.

Eligible Populations			
Eligibility Group	Adults	Children	Total
Children up to 300 percent of the federal poverty level		91,301	91,301
Chapter I school district programs		3,029	3,029
Working parents with children	4,913		4,913
Missouri Parents' Fair Share Program	263		263
Low income uninsured non-custodial parents	9,330		9,330
Low income uninsured custodial parents	65,612		65,612
Uninsured women losing Medicaid eligibility	44,712		44,712
Total	124,830	94,330	219,160

Expected New Medicaid Applicants*			
Eligibility Group	Adults	Children	Total
Children up to 300 percent of the federal poverty level		68,476	68,476
Chapter I school district programs		2,272	2,272
Working parents with children	4,913		4,913
Missouri Parents' Fair Share Program	197		197
Low income uninsured non-custodial parents	6,998		6,998
Low income uninsured custodial parents	49,209		49,209
Uninsured women losing Medicaid eligibility	33,534		33,534
Total	94,851	70,748	165,599

\* Assumes a 75 percent presentation rate.

### Cost Estimates of 1115 Waiver Population

Population	Enrollees	Annual Cost			
		Adult Rate \$121.90 PMPM	Women's Health Services \$16.65 PMPM	Child Rate \$103.66 PMPM	Kick Payment \$3,303.16 birth
Children up to 300 percent of the federal poverty level	68,476 Children			\$85.2 million	
Chapter I school district programs	2,272 Children			\$2.8 million	
Working parents with children <sup>1</sup>	4,913 Adults	\$7.2 million			
Parents' Fair Share Participants	197 Adults	\$.3 million			
Low income uninsured non-custodial parents	6,998 Adults	\$10.2 million			
Low income uninsured custodial parents	49,209 Adults	\$72.0 million			
Uninsured women losing Medicaid eligibility	33,534 Adults		\$6.7 million		
Maternity benefits	1,000 Adults				\$3.3 million
<b>Total by Category</b>		<b>\$89.7 million</b>	<b>\$6.7 million</b>	<b>\$88.0 million</b>	<b>\$3.3 million</b>
Total	\$187.7 million				
Less Projected Premiums	(7.2) million				
<b>Grand Total</b>	<b>\$180.5 million</b>				

<sup>1</sup> Amount reflects higher second year costs.

## Major Assumptions in Establishing Rates

Below are the major assumptions used in establishing the per member per month rates for the cost estimates.

### Adult Rates

- ◆ Adult rates 21 + from the eastern rebid were used.
- ◆ Rates were increased by 10 percent to allow for adverse selection.
- ◆  $\$110.82 \times 110 \text{ percent} = \$121.90$ .

### Women's Health Services

- ◆ The 1996 2082 reports were used to determine the projected cost of women's health services.
- ◆ Rates were increased by 10 percent to adjust for unduplicated recipient count on the form 2082 to obtain a full time equivalent number.
- ◆  $\$15.14 \times 110 \text{ percent} = \$16.65$ .

### Children

- ◆ The per member per month child rates, 20 and below, from the eastern rebid were used.
- ◆ Rates were increased by 10 percent to allow for adverse selection.
- ◆ Assumes a \$1.50 per member per month reduction in the rate based on not providing non-emergency medical transportation.
- ◆  $\$95.74 - \$1.50 = \$94.24 \times 110 \text{ percent} = \$103.66$ .

### Maternity Rates

- ◆ We assumed 17.12 percent of the female population would need maternity benefits.
- ◆ A one-time payment (kick payment) of \$3,303.16 was assumed.

### Funding

As part of the waiver process it is necessary to validate Missouri's current funding base and revenue sources in order to expand coverage to these critically important groups. This funding base must capture all current costs and be available to meet the needs of this program.

## *Chapter 5: Waivers Requested*

In order for the State of Missouri to implement the waiver, it requests the following waivers of statutory and regulatory requirements.

### **Service Related**

#### **Comparability**

Section 1902(a)(10)(B) of the Social Security Act (the "Act") and 42 C.F.R. § 440.230-250 require that the amount, duration, and scope of services be equally available to all recipients within an eligibility category, and also be equally available to categorically eligible recipients. Missouri's demonstration project will provide a comprehensive health care package to all categorically eligible Medicaid recipients and those uninsured children with family income up to 300 percent of the federal poverty level. A more commercially-oriented benefit package will be provided for the expanded adult population. Missouri will continue to use a fee-for-service approach for individuals not enrolled in MC+. That group includes dual eligibles, individuals in long-term care facilities (intermediate care facilities for the mentally retarded and nursing facilities), individuals with disabilities, and Medicaid recipients residing in areas of the state where MC+ is not yet available. Benefits will be administered differently for project participation in the managed care groups, as opposed to recipients in the fee-for-service program. In order to account for any differences in amount, duration, or scope of services for recipients who will be enrolled in managed care as opposed to the fee-for-service plan and to accommodate the more commercially-oriented package for adults eligible as a result of the waiver, Missouri requests that these provisions be waived.

#### **Uniformity**

Section 1902(a)(1) of the Act and 42 C.F.R. § 431.50 require that the state Medicaid plan be in effect for all services and all eligible recipients in all political subdivisions of the state. The type of managed care plans available under the demonstration may vary by geographic area of the state. Moreover, there will no longer be uniformity in benefits because the fee-for-service population may receive benefits in a different manner than those enrolled in MC+. Also, adults made eligible as a result of the waiver will receive a more commercially-oriented package than those who are categorically eligible. Therefore, Missouri requests a waiver of this section.

#### **Eligibility Standards**

Section 1902(a)(10)(A) of the Act requires states to provide medical assistance to certain categories of Medicaid recipients in addition to those either receiving or deemed to be receiving medical assistance on the basis of certain welfare categories under the

Social Security Act. That section also allows states to (extend coverage to optional categories of individuals. The State of Missouri requests a waiver of Section 1902(a)(10)(A) and the implementing regulations at 42 C.F.R. Part 435 in order to extend coverage under the waiver to certain categories of uninsured individuals in the state regardless of whether they satisfy the optional or mandatory categories for Medicaid eligibility.

### **Eligibility Procedures**

Section 1902(a)(17) of the Act and 42 C.F.R. Part 435 establish procedures for taking into account income or resources of individual; who are not receiving assistance under Aid to Families with Dependent Children (AFDC) rules in effect on July 16, 1996 or Supplemental Security Income. The state requests a waiver of this section to the extent it is necessary to waive resource limitations for this waiver eligible population. The state requests a waiver of this section to the extent it is necessary in order to deny Medicaid coverage for the uninsured population for six months if a parent or spouse has dropped insurance. No request is made to waive resource limitations for individuals who are eligible due to a determination of categorical eligibility.

### **Freedom of Choice**

Section 1902(a)(23) of the Act and 42 C.F.R. § 431.51 require a state plan to pay for medical assistance from any institution, agency, community pharmacy, or person qualified to perform the delivery of services. The demonstration will allow participants to choose among available health plans. To the extent this is seen as a limitation on freedom of choice, a waiver is appropriate and necessary.

### **Cost Sharing**

Sections 1902(a)(14) and 1916 describe the circumstances when a state may impose cost sharing, such as copayments, deductible;, and coinsurance, and limit the charges to "nominal" amounts. Specific limits are listed at 42 C.F.R. §§ 447.50-447.59. The state requests a waiver of these sections to allow premiums to be charged to adult beneficiaries made eligible as a result of this 1115 waiver. The schedule of premiums is set forth in Chapter 2.

### **Utilization and Quality of Care Review**

Missouri requests a waiver from Sections 1903(g), 1903(i), 1902(a)(26), (30), (31) of the Act, and related regulations, to account for any minor technical differences that may exist between the waiver's stringent utilization and quality of care review procedures and the federal requirements. The state specifically requests a waiver of medical necessity reviews for those Medicaid recipients enrolled in MC+. In a managed care program such as MC+, the health plans assume the responsibility for confining

services to what is medically necessary, and the capitation payment approach gives them substantial incentive to confine care to what is medically necessary. State review would be redundant, intrusive, and unnecessary. There are other safeguards in the program to ensure that the health plans provide care that is medically necessary; the requested waiver would not impact those safeguards. No waiver of quality of care requirements is sought.

### **Third Party Liability**

Section 1902(a)(25) of the Act and 42 C.F.R. Part 433 require that the state identify liability of and seek reimbursement from third parties before paying claims. The state requests a waiver from the specific requirements established under these sections since under the demonstration project the state will reduce all capitation rates by an actuarially appropriate amount to reflect the average amount of funds that can be recovered from third parties.

### **Disproportionate Share Hospital Payments**

Section 1902(a)(13) of the Act and implementing regulations provide for payment to hospitals that takes into account the situation of hospitals that serve a disproportionate number of low income patients. Under the waiver, the state will no longer pay hospitals directly for the population covered by the waiver capitation. Rather, hospitals will be paid by the health plans. Missouri seeks a waiver of this section to enable the state to satisfy the obligation to disproportionate share hospitals through the capitation amount paid to the health plans in accordance with the terms of the waiver program.

### **Citizenship Declaration**

Section 1137(d) of the Act, incorporated into the Medicaid program by Section 1902(a)(46), requires that all applicants submit written declarations of their citizenship or alien status, and that the state obtain documentation of the applicant's alien status and verify that documentation with the Immigration and Naturalization Service. Missouri seeks to rely upon written declarations of citizenship status and to employ verification only when necessary. Since Section 1137(d) appears to make documentation and verification mandatory for every alien, the state has requested a waiver to avoid strict compliance with these requirements. Missouri does intend to require verification in every case where there is reason to question the applicant's declaration of United States and Missouri citizenship or legal alien status. Thus, relieving the state from the necessity of documentation and verification in every alien case should not pose any significant risk of unauthorized persons becoming part of the program.

## **Hospice Care**

Sections 1902(a)(10), 1902(a)(13)(D), 1905(a)(18), and 1905(o) of the Act, and implementing regulations, allow states to cover hospice care under Medicaid. Section 1905(o) appears to call for a choice by Medicaid eligibles of either receiving hospice care or other care related to the condition giving rise to the diagnosis of a terminal illness. Under a capitated system, there is no reason to require a managed care organization to force this choice. There may well be circumstances in which some services pertaining to the terminal illness will be appropriate, even for an individual in hospice care. Since all of the services will be covered by a single capitation, there is no cost impact in granting the waiver.

## **Restrictions on Information Disclosure**

Section 1902(a)(7) and 42 CFR § 431.301 require that disclosure of information concerning applicants and recipients be restricted to purposes directly connected with the administration of the Medicaid plan. To the extent needed to allow schools, health plans, and primary care providers access to the data base of all children enrolled in Medicaid for the purposes of case management of prevention activities such as health screenings and immunizations, as well as focused outreach efforts by cooperating schools, a waiver of Section 1902(a)(7) is requested.

## **Retroactive Eligibility**

Section 1902(a)(34) and 42 C.F.R. § 435.914 require states retroactively to provide medical assistance for up to three months prior to the date that an application for such assistance is made. The State of Missouri requests a waiver of these requirements because it will not offer retroactive eligibility to new populations made eligible as a result of the waiver.

## **Payment Related**

The state requests that HCFA grant any other waiver that HCFA deems to be required in order to implement the demonstration as described in this document. Missouri requests that, pursuant to Section 1115(a)(2), HCFA participate in the following costs that would not otherwise be eligible for reimbursement under Medicaid.

## **Income Limitations**

Section 1903(f) of the Act, and 42 C.F.R. § 435.100 et. seq., prohibit payments under Medicaid to states that implement eligibility standards in excess of the maximums allowed by regulations. Missouri requests a waiver to expand eligibility for health care coverage to children and adults transitioning off of welfare with family incomes up

to 300 percent of the federal poverty level and certain other adults up to 100 percent of the federal poverty level. The expanded eligibility will not result in cost increases because of the offsetting savings from other aspects of the demonstration.

### **Capitation Contract Requirements**

The state requests a waiver of § 1903(m)(2)(A)(iii) (42 C.F.R. § 434.71) in order to permit coverage of individuals not meeting Medicaid eligibility requirements and to permit the state to establish capitation rates in the manner specified in this application. A waiver is also requested of 42 C.F.R. §§ 434.6, 14, 23, 25, 40, 53, 59, 65, 70, 71, and 72 to the extent that these provisions contain detailed requirements that may be construed as inconsistent with the intent of the demonstration. The state is not requesting a waiver of the requirement that it guarantee Medicaid eligibles will continue to receive services if their enrollment from an HMO is terminated for any reason other than loss of eligibility.

### **Erroneous Payments**

Section 1903(u) of the Act and 42 C.F.R. § 431 Subpart P permit HCFA to withhold federal financial participation (FFP) for a state's erroneous excess payments for medical assistance. Specifically, HCFA may reduce FFP where erroneous payments exceed three percent of total medical assistance expenditures. Missouri requests a waiver of this requirement to the extent that benefits provided under the waiver to the uninsured who would not otherwise be eligible for Medicaid could be deemed to constitute erroneous payments.

### **Upper Payment Limits for Capitation Contract Requirements**

Section 1903(i) of the Act and 42 C.F.R. § 447.361 establish certain standards for state payment rates. Sections 1903(i)(3)-(14) limit the amount that a state may pay to providers for certain services. Because services will be provided by a managed care plan, which will arrange payment of individual providers, the state seeks a waiver of these provisions.

42 C.F.R. § 447.361 prohibits payment on a capitation basis to be made to a contractor where capitation payments exceed the costs of Medicaid "on a fee-for-service basis, to an actuarially equivalent non-enrolled population group." The state requests a waiver because there will be no "actuarially equivalent non-enrolled" group in light of the fact that the waiver will extend to non-Medicaid populations. There will be an overall cost limit on the waiver program; this is a technical waiver that will not impact on that limit.

## **Institutions for Mental Diseases**

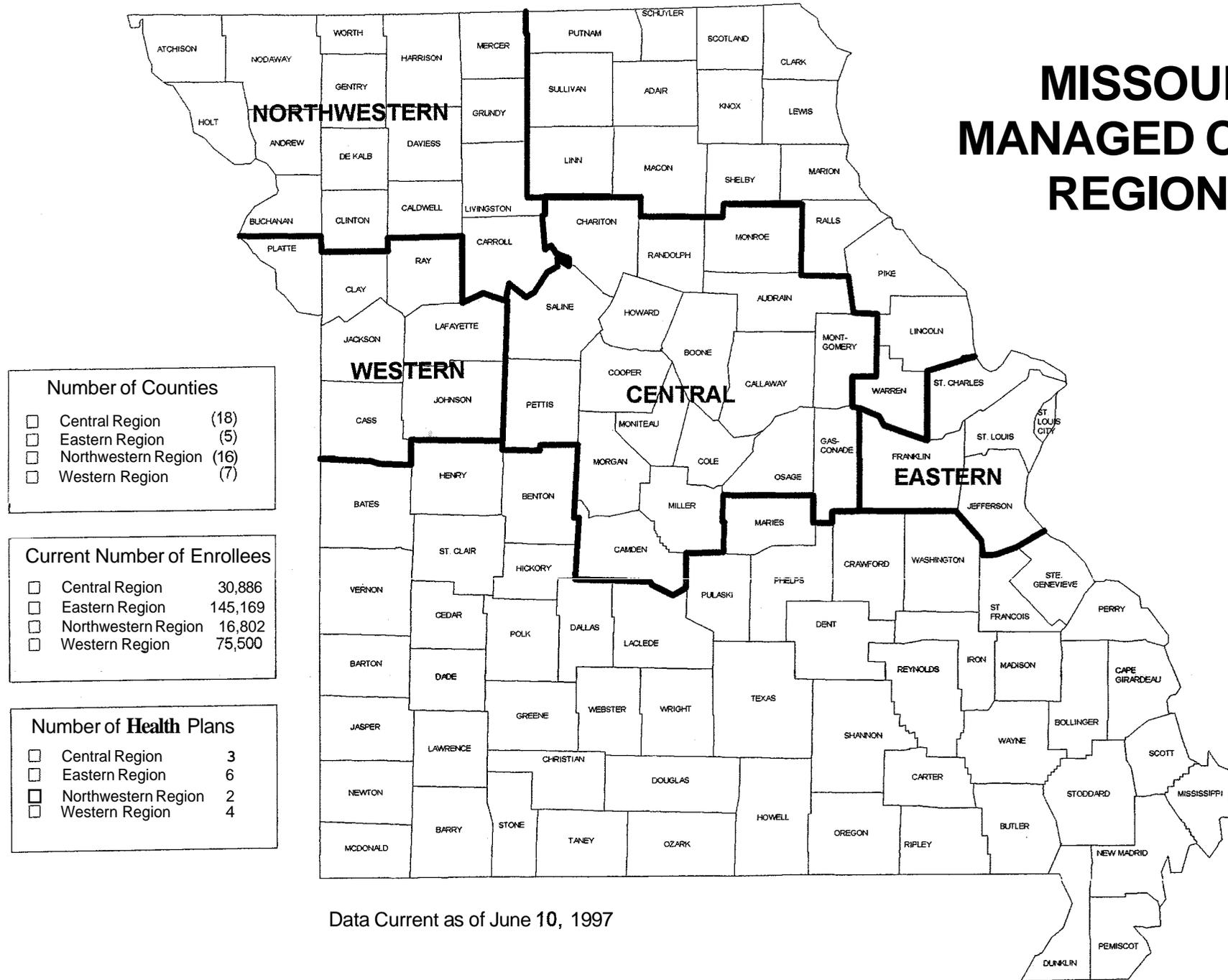
Sections 1902(a)(10), 1905(a)(1), 1905(a)(14), 1905(a)(16), 1905(h), and 1905(i) of the Act, and implementing regulations, limit coverage for inpatient psychiatric care to individuals ages 21 and under, or 65 and over. Missouri seeks a waiver of these requirements in order to enable it to provide a full range of appropriate services to non-elderly adults requiring inpatient psychiatric care and alcohol and other drug treatment. Missouri requests a waiver of these sections to the extent necessary to provide inpatient psychiatric and substance abuse treatment for the waiver members between 22 and 64.

# *Appendixes*

**1115 Waiver Amendment-Related Meetings**

March 6, 1997	Staff working group
April 14, 1997	Conference call between staff and consultants
May 1, 1997	Conference call between staff and consultants
May 6, 1997	Staff working group
May 14, 1997	Staff working group
May 20, 1997	Conference call between staff and consultants
June 9, 1997	Staff working group
June 16, 1997	Public hearing, Kansas City, Missouri
June 18, 1997	Public hearing, Columbia, Missouri
June 24, 1997	Public hearing, St. Louis, Missouri
July 28, 1997	Meeting between Division of Medical Services and representatives of the WATCH Coalition

# MISSOURI MANAGED CARE REGIONS

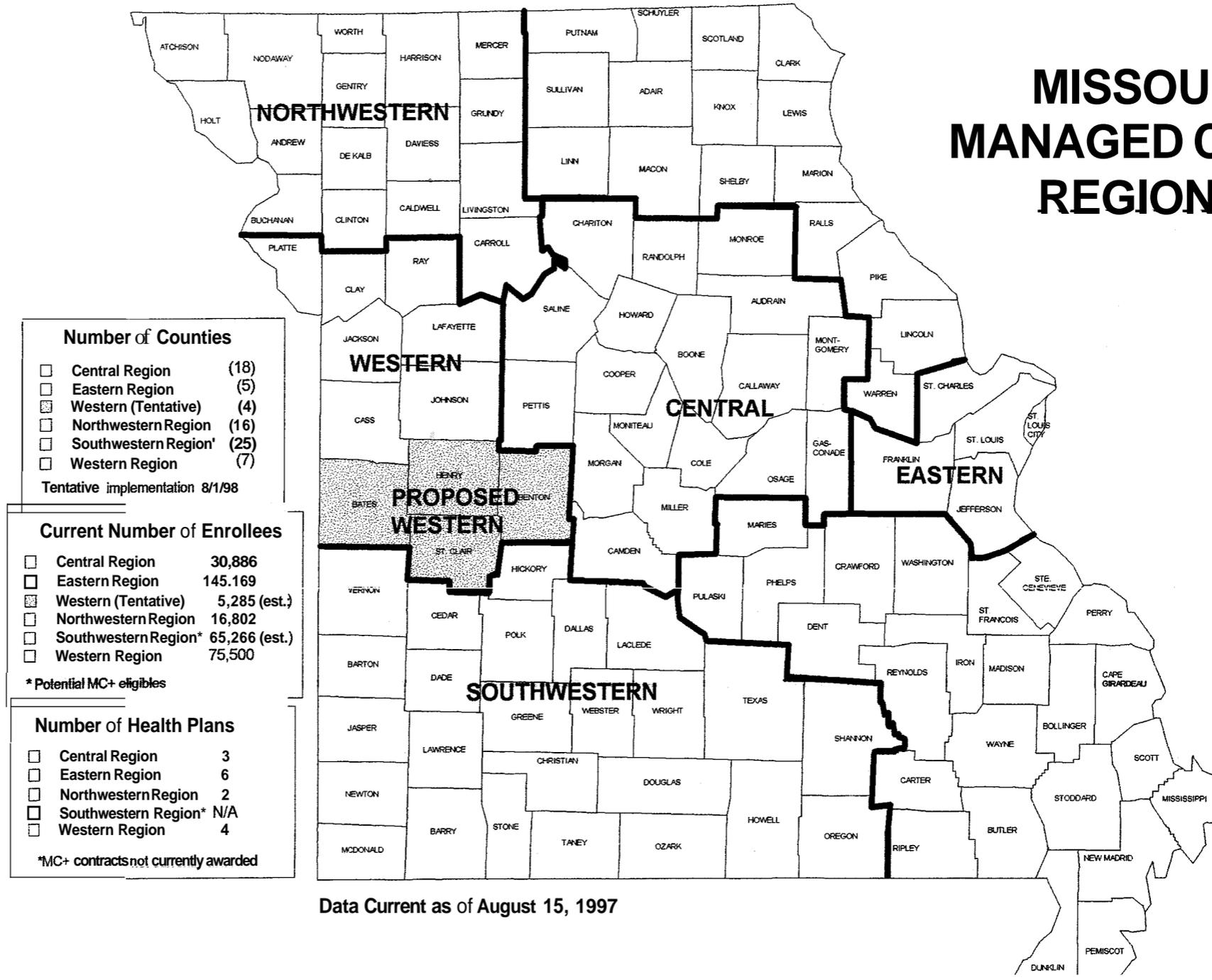


Data Current as of June 10, 1997

Missouri Managed Care Timeline  
Southwestern Region

September 5, 1997	Request for Proposal released
September 17, 1997	Pre-proposal conference
October 17, 1997	Bids due, 2:00 pm
December 5, 1997	Contracts awarded
February 9-13, 1998	Readiness reviews for health plans
May 1, 1998	Open enrollment begins
July 15, 1998	Open enrollment ends
August 1, 1998	Services begin

# MISSOURI MANAGED CARE REGIONS



**Number of Counties**

☐ Central Region	(18)
☐ Eastern Region	(5)
▨ Western (Tentative)	(4)
☐ Northwestern Region	(16)
☐ Southwestern Region*	(25)
☐ Western Region	(7)

Tentative implementation 8/1/98

**Current Number of Enrollees**

☐ Central Region	30,886
☐ Eastern Region	145,169
▨ Western (Tentative)	5,285 (est.)
☐ Northwestern Region	16,802
☐ Southwestern Region*	65,266 (est.)
☐ Western Region	75,500

\* Potential MC+ eligibles

**Number of Health Plans**

☐ Central Region	3
☐ Eastern Region	6
☐ Northwestern Region	2
☐ Southwestern Region*	N/A
☐ Western Region	4

\*MC+ contracts not currently awarded

Data Current as of August 15, 1997

**Missouri Vision Statement**

*Missouri will be a statewide community, in which state government encourages and supports the pursuit of dreams, security, justice, and opportunity, while working to protect individual rights and freedoms.*

*Missouri state government shall work with its proud citizens to offer the best quality of life, including:*

- ◆ *Health, safety, and needed support;*
- ◆ *World-class schools that lead to good jobs;*
- ◆ *Good homes in vibrant towns and neighborhoods;*
- ◆ *A vigorous economy;*
- ◆ *A productive and respected natural environment; and*
- ◆ *The opportunity to succeed.*

*Missouri state government will be more accountable to Missouri citizens, putting people before bureaucracy. We will rely on integrity, effectiveness, and common sense to exceed the public's expectations of responsiveness and excellence, and provide value and dividends for every dollar invested. The measure of success will be results for our customers.*

*Missouri state government, in partnership with private citizens, will move forward with confidence and hope, staking out a successful and secure future.*

**Missouri Department of Social Services  
Mission Statement**

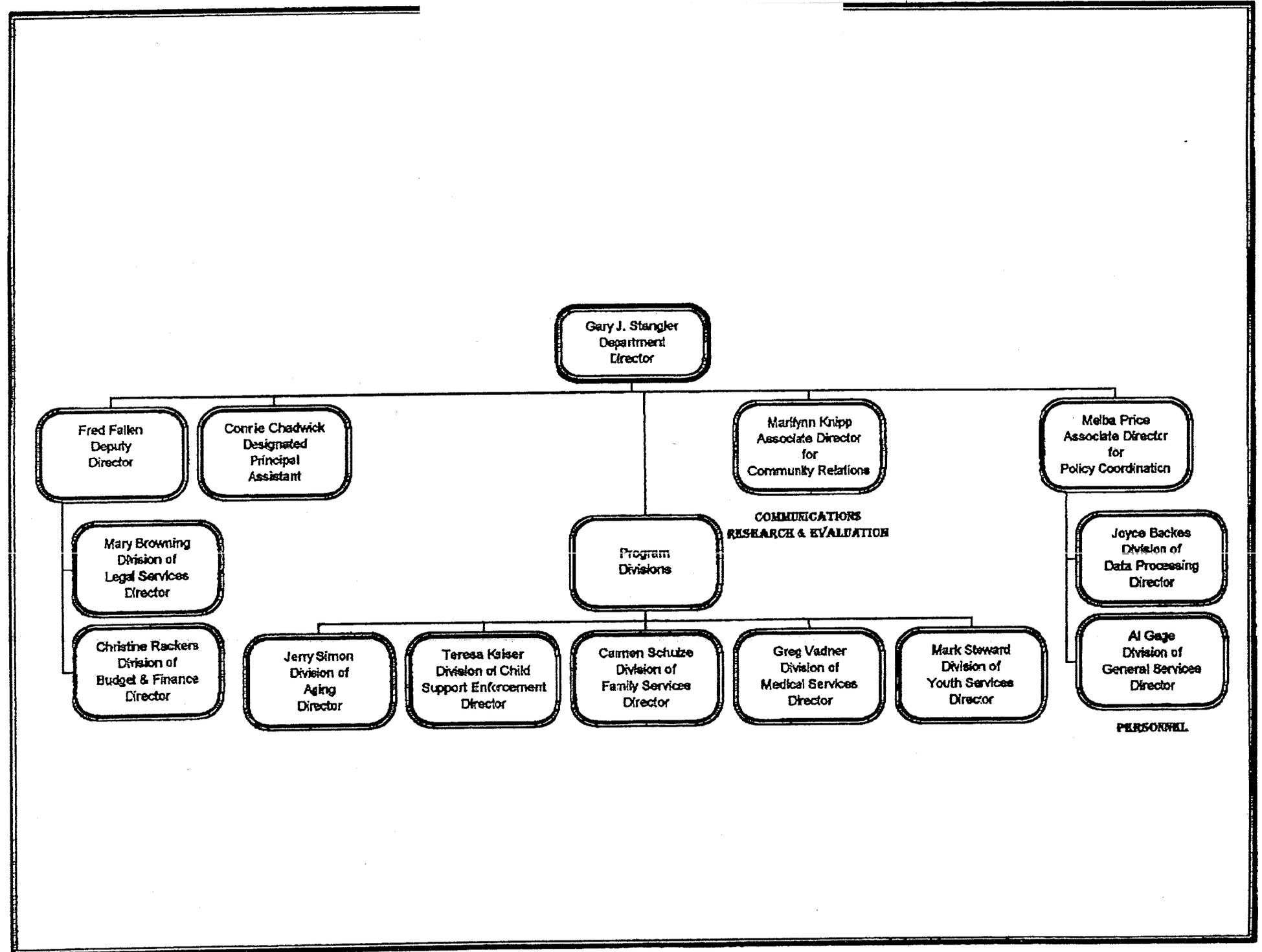
*To maintain or improve the quality of life for the people in the State of Missouri by providing the best possible services to the public with respect, responsiveness and accountability, which will enable individuals and families to better fulfill their potential.*

**Missouri Division of Medical Services  
Vision Statement**

*Missouri's low income and vulnerable citizens will have access to excellent health care in order to maximize their quality of life and independence. We are committed to purchasing services that are cost effective and appropriate. We value and respect our partners in health care delivery.*

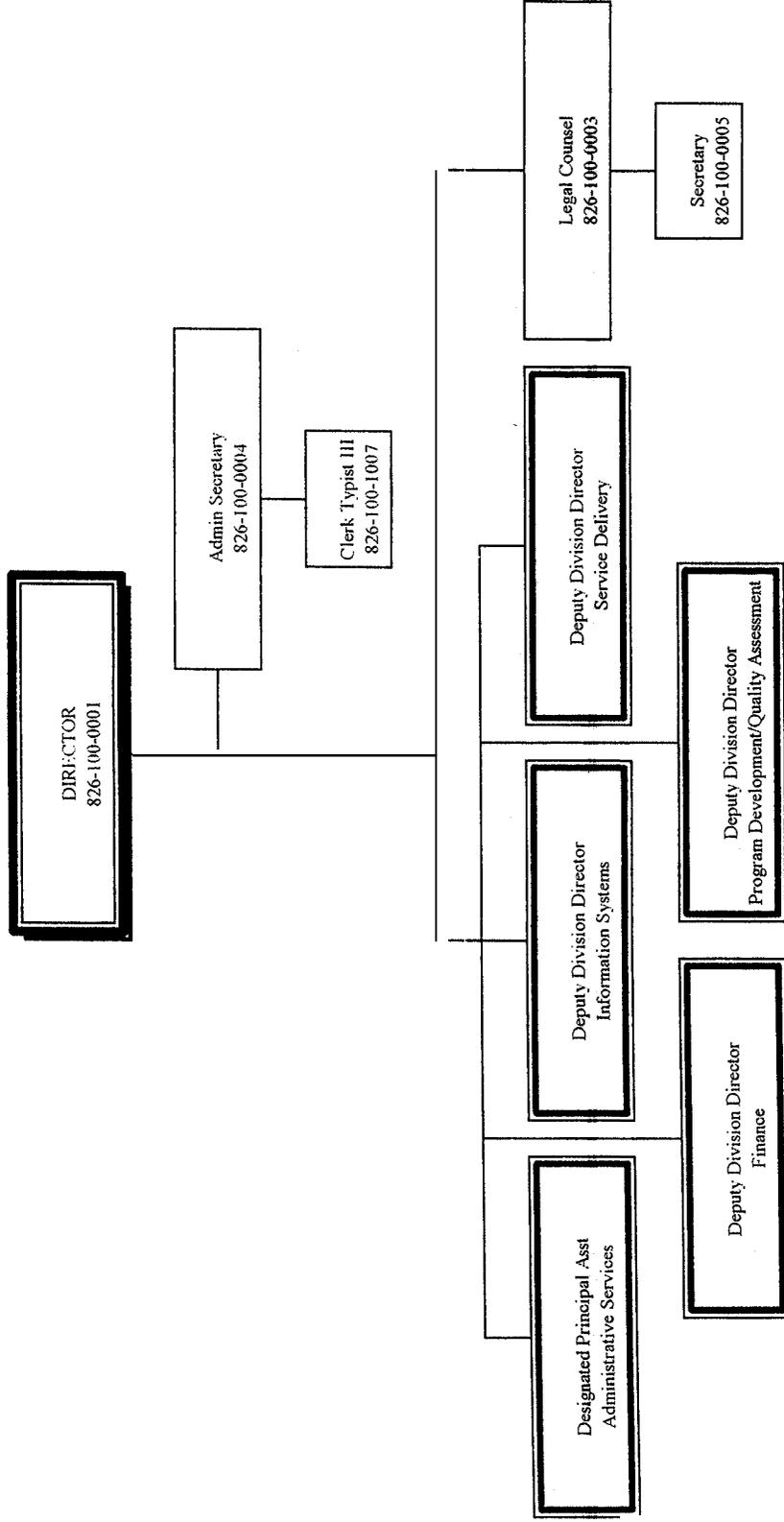
**Missouri Division of Medical Services  
Mission Statement**

*The purpose of the Division of Medical Services is to purchase and monitor health care services for low income and vulnerable citizens of the State of Missouri. The agency assures quality health care through development of service delivery systems, standards setting and enforcement, and education of providers and recipients. We are fiscally accountable for maximum and appropriate utilization of resources.*



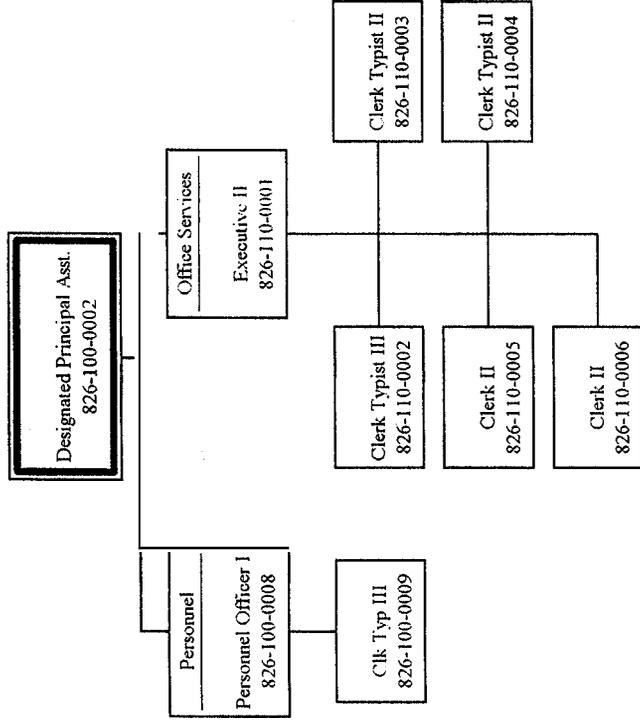
# MO DIVISION OF MEDICAL SERVICES ADMINISTRATION

December 23, 1996

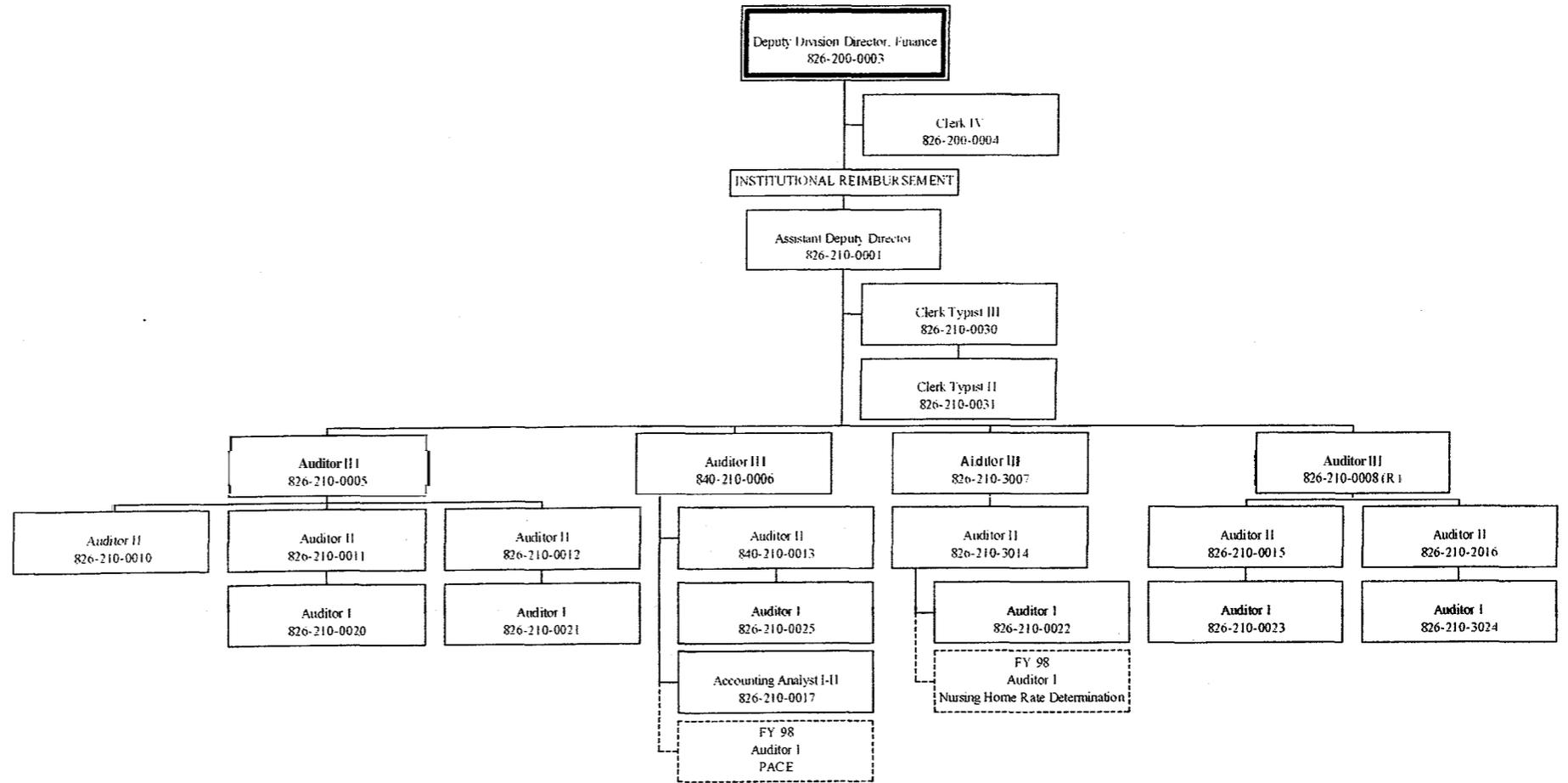


# ADMINISTRATIVE SERVICES

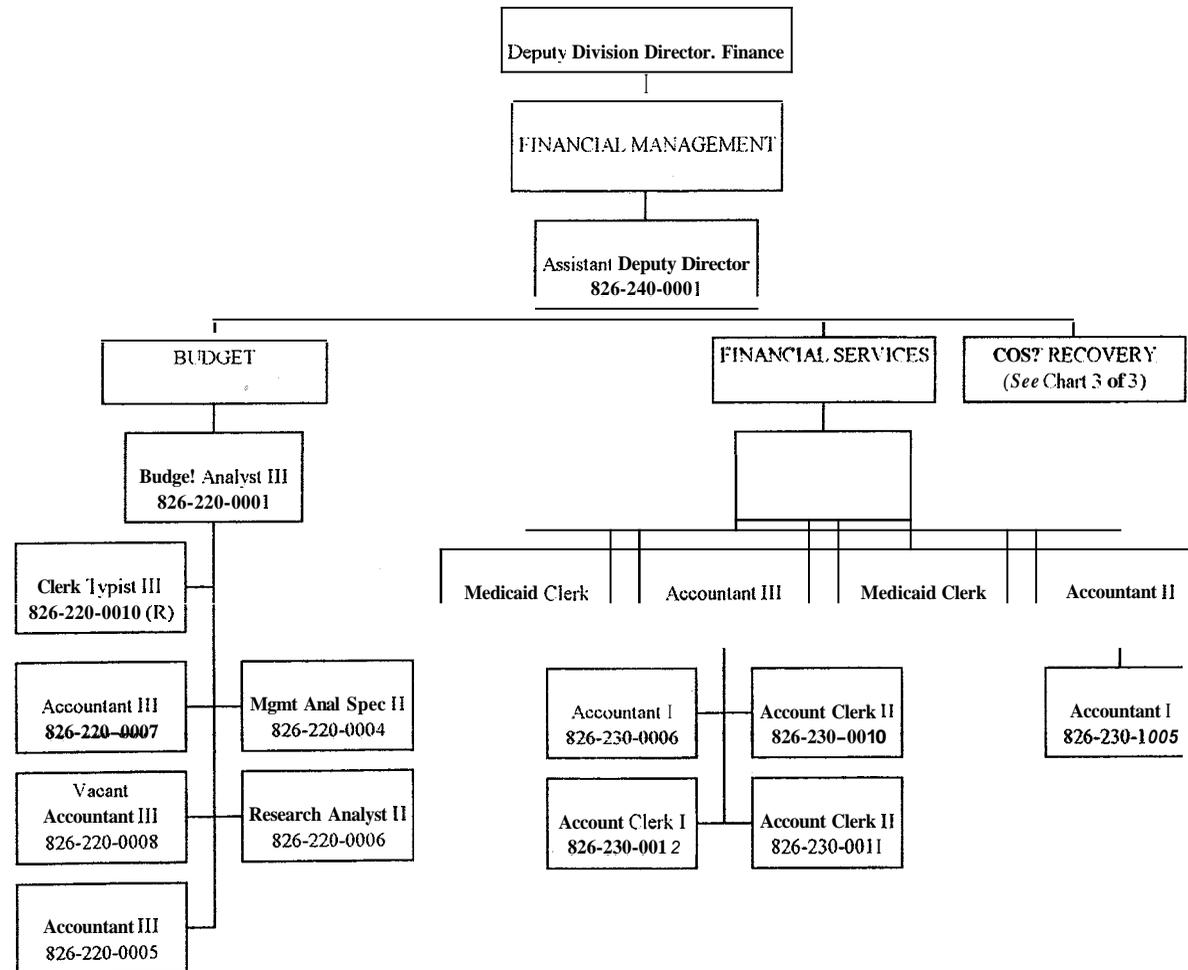
April 24, 1997



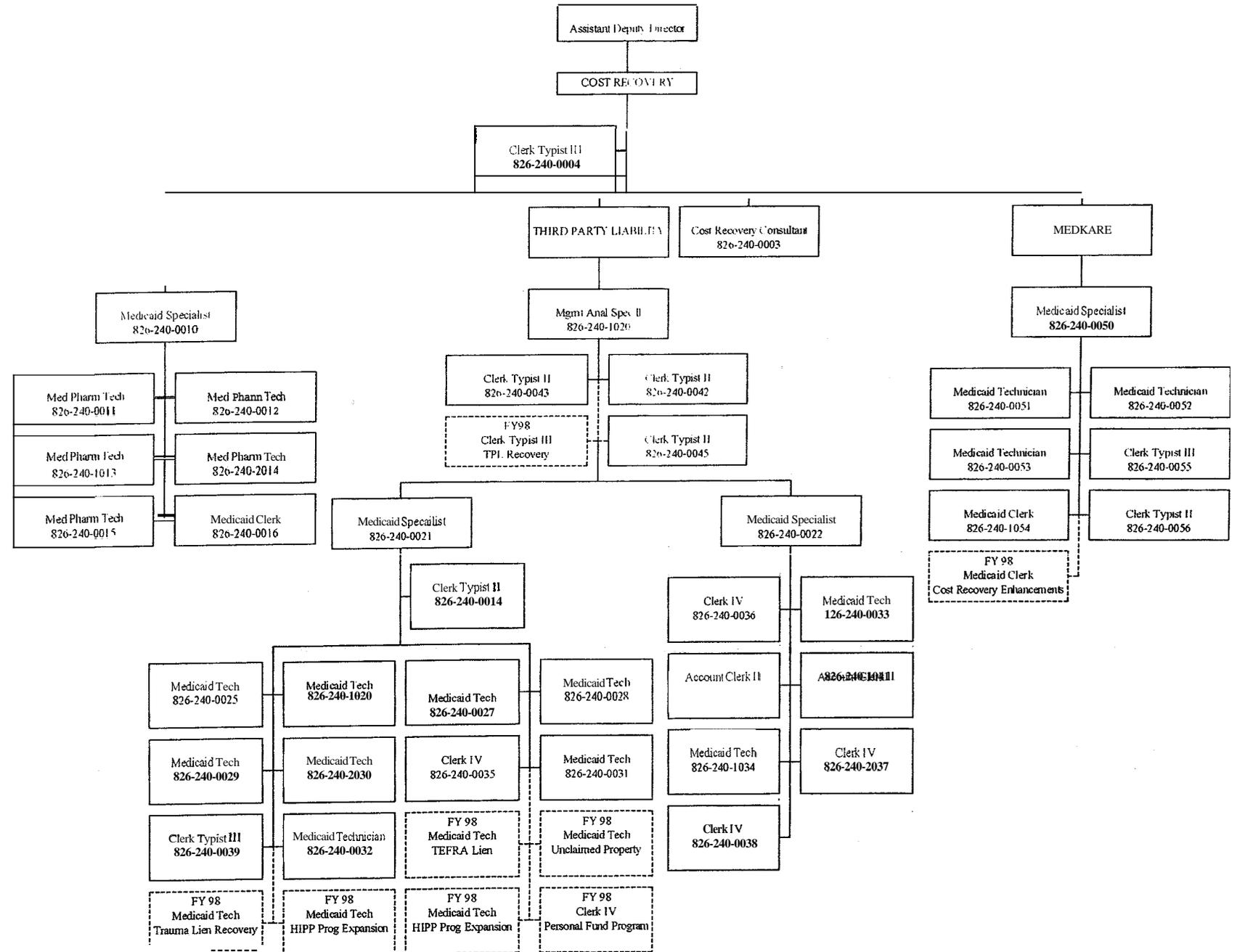
# FINANCE



# FINANCE

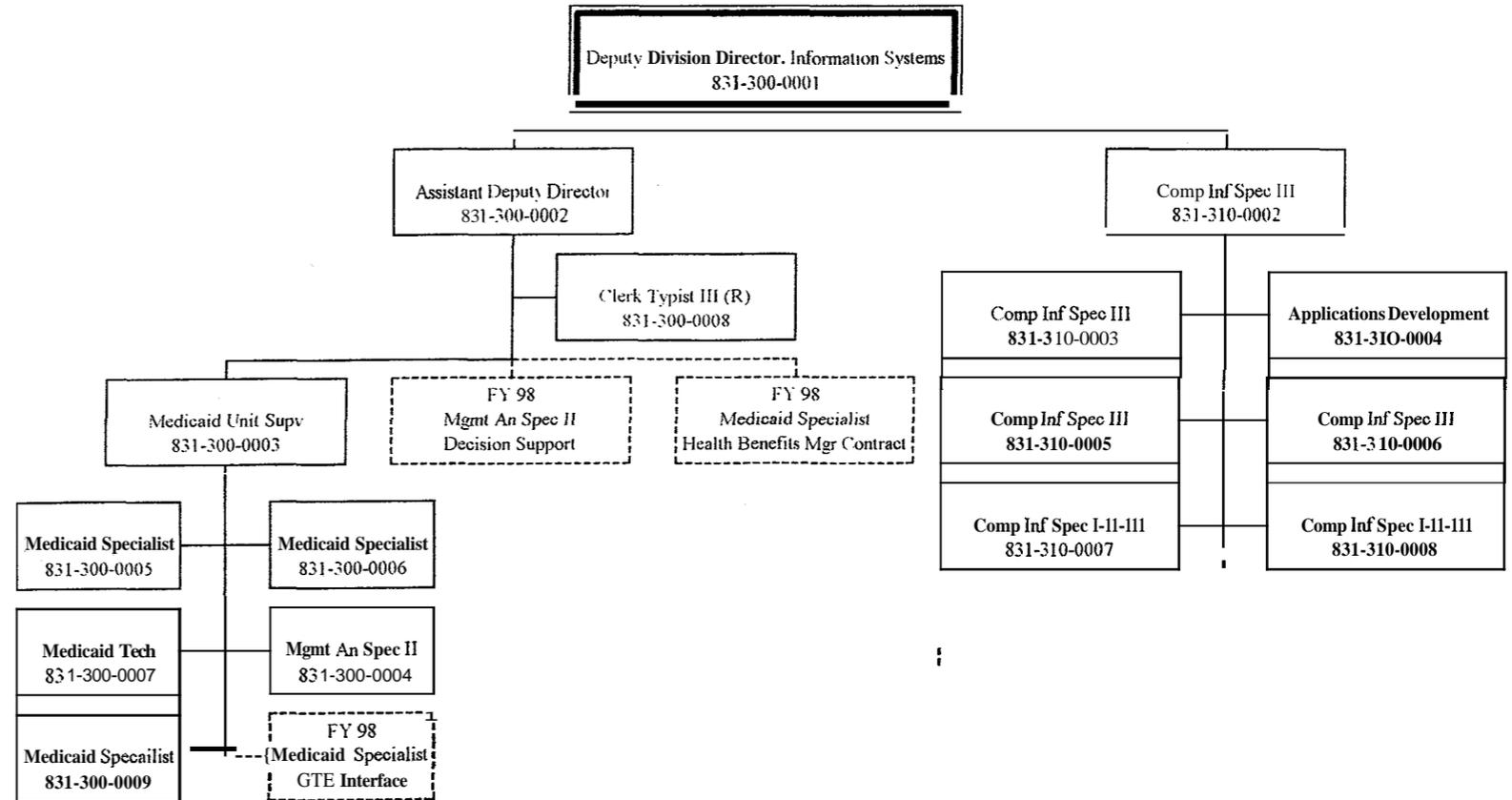


# FINANCE



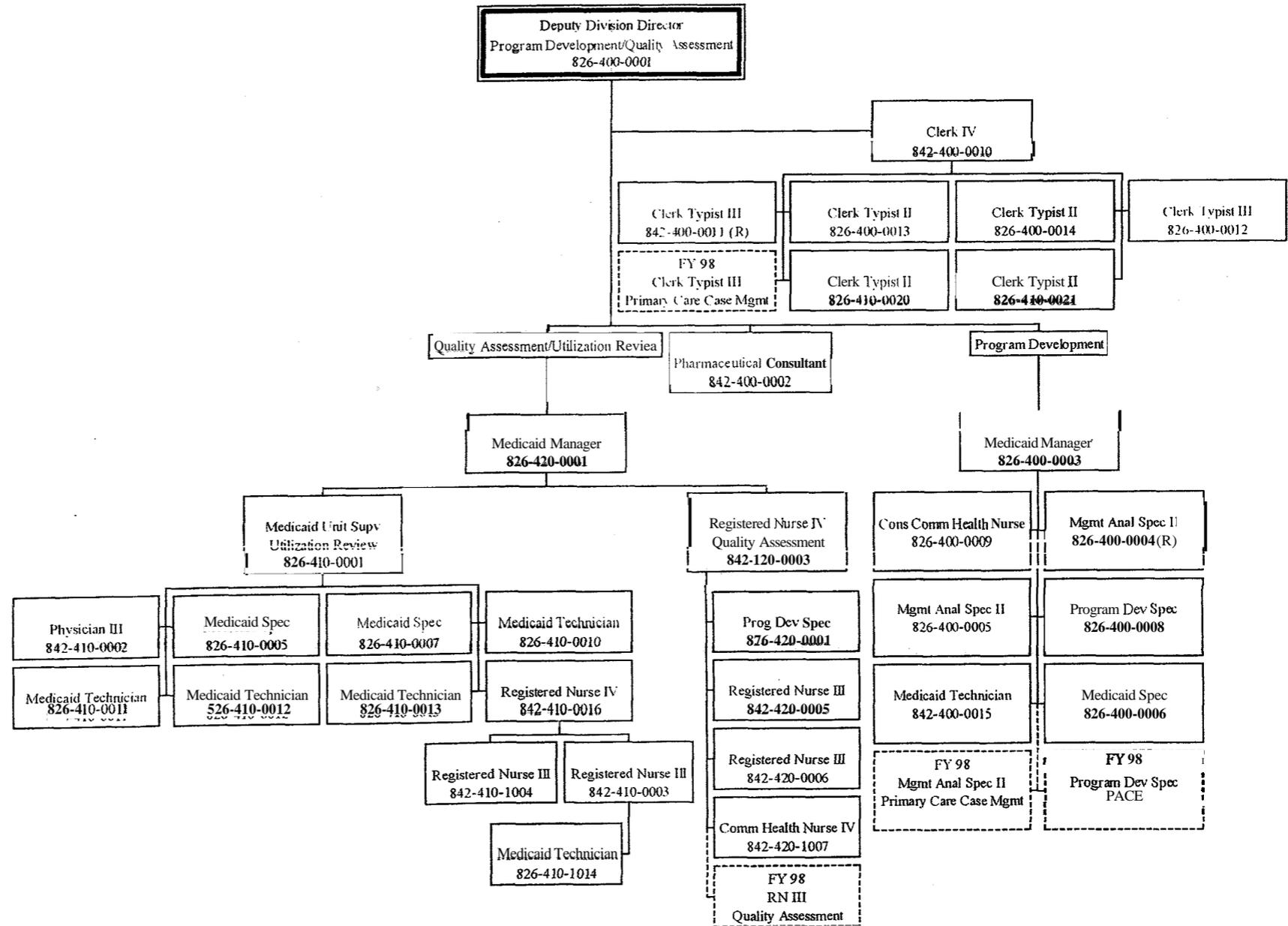
# INFORMATION SYSTEMS

January 9, 1997 \*

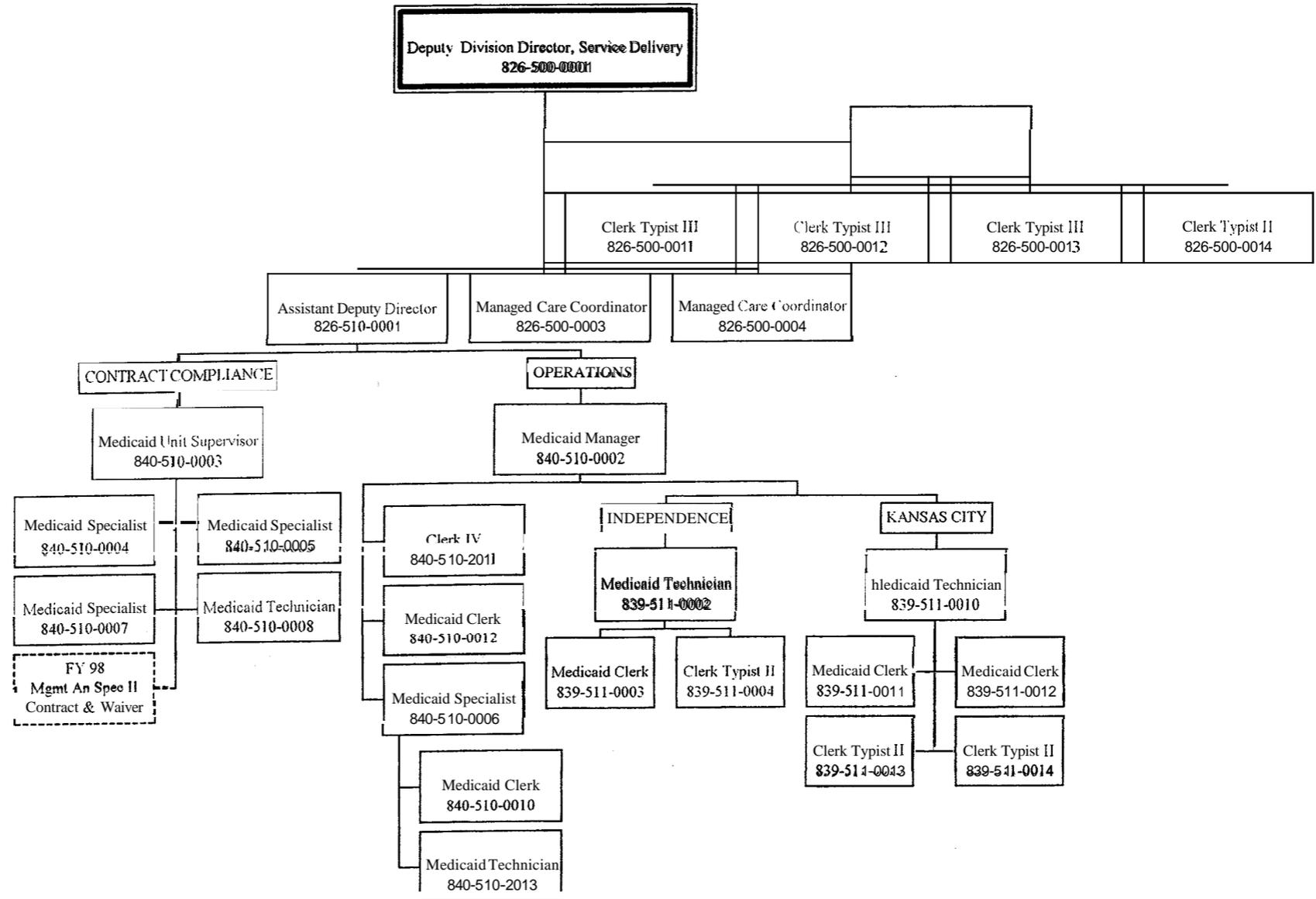


# PROGRAM DEVELOPMENT/QUALITY ASSESSMENT (PDQA)

March 17 1997



# SERVICE DELIVERY



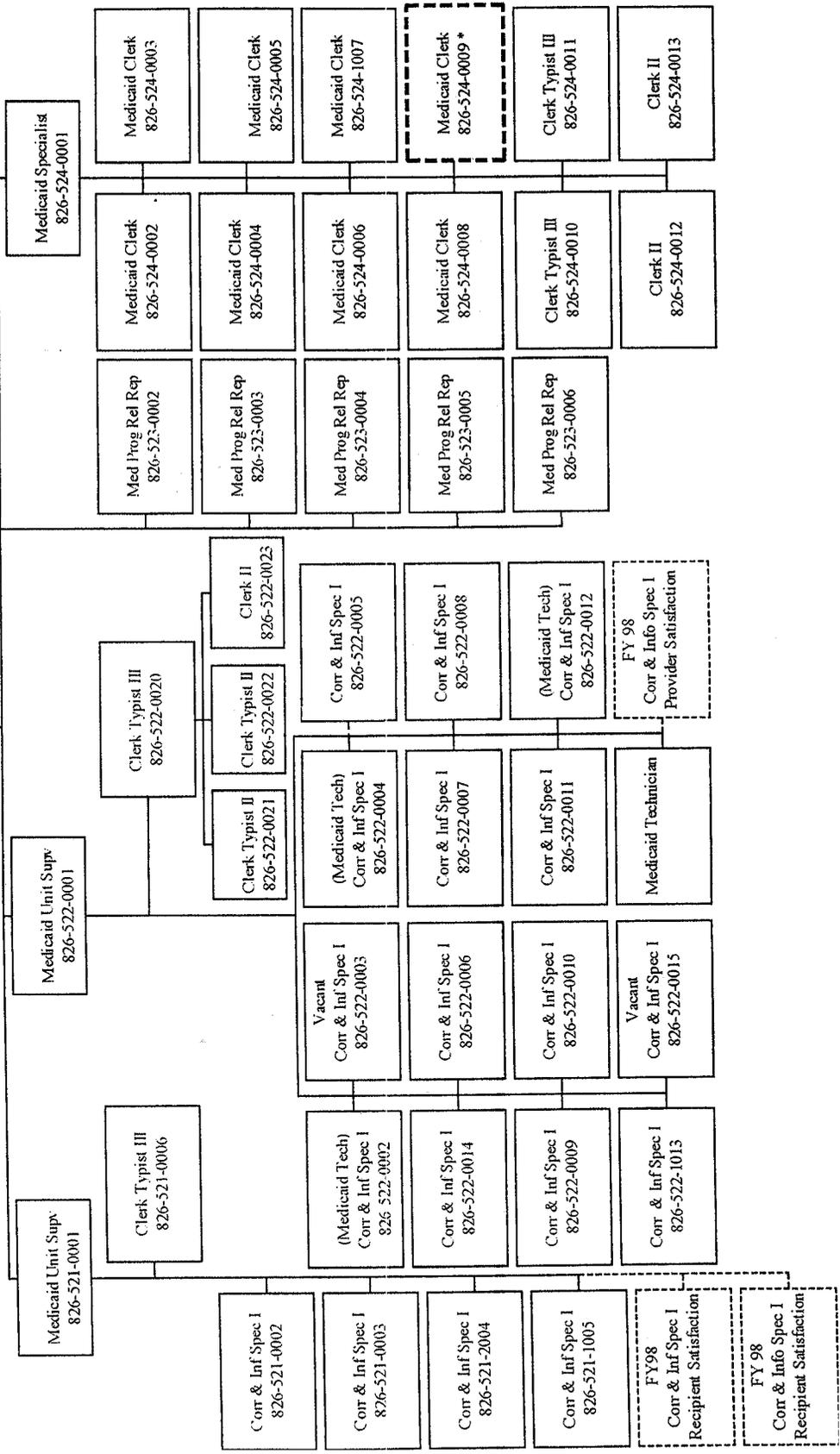
# SERVICE DELIVERY

Deputy Division Director, Service Delivery

## PROGRAM RELATIONS

Program Relations Supv  
826-520-0001

Clerk Typist III  
826-520-0003





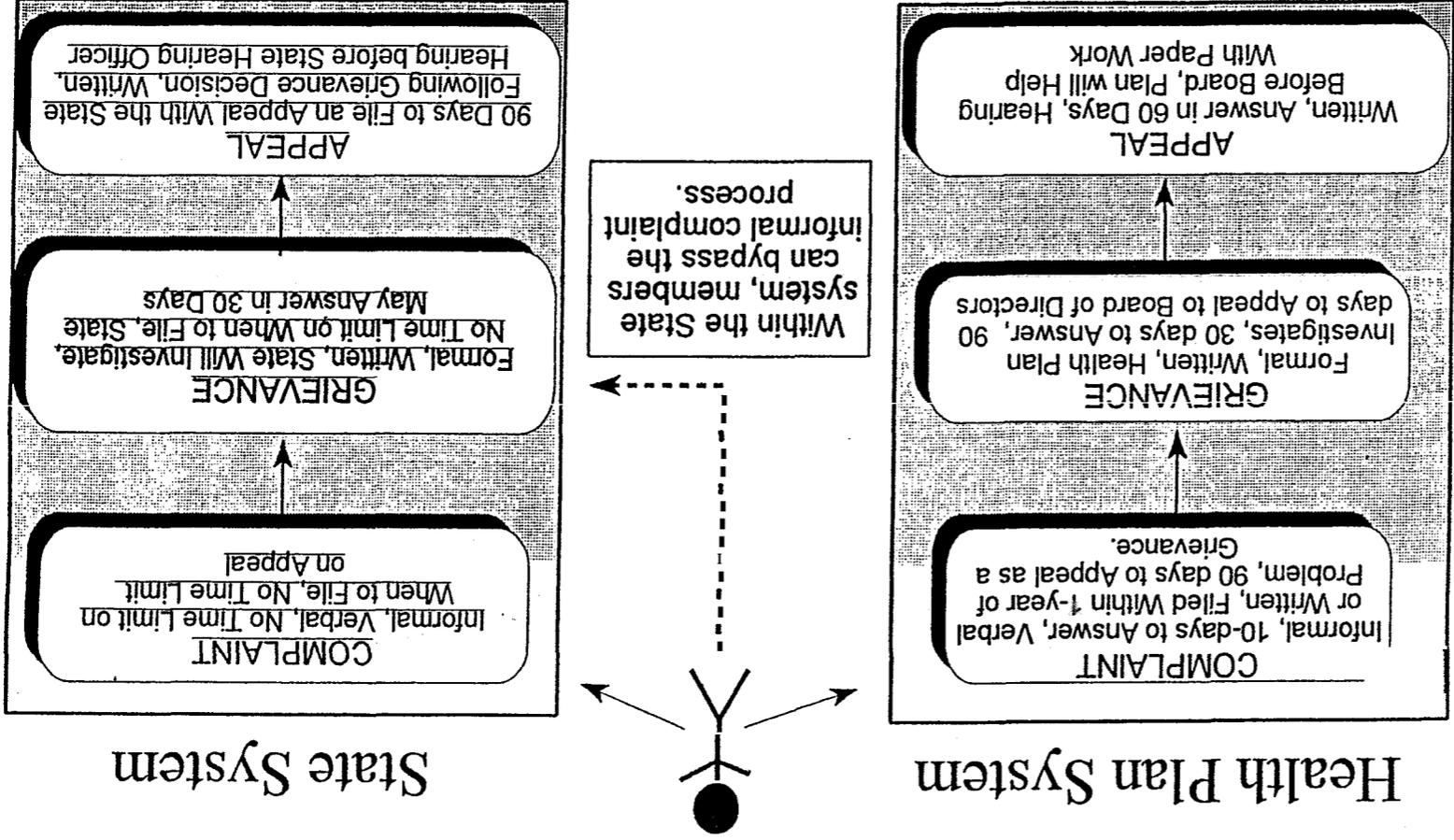
## Districts with Chapter I Schools

<u>District Name</u>	<u>Enrollment</u>	<u>District Name</u>	<u>Enrollment</u>
Wellston	660	Hermitage R-IV	410
Hayti R-II	895	Gideon 37	437
St. Louis City	41,623	Calhoun R-VIII	192
North Daviess R-III	120	Clearwater R-I	1,218
Kansas City 33	36,465	Summersville R-II	64
Oregon-Howell R-III	276	Climax Springs R-IV	272
Lesterville R-IV	305	Risco R-II	229
Spickard R-II	53	Ridgeway R-V	160
North Mercer Co. R-III	218	Greenfield R-IV	542
Caruthersville 18	1,431	Roscoe C-1	113
Jennings	2,629	Kennett 39	2,052
North Harrison R-III	240	East Prairie R-II	1,191
Morgan Co. R-I	398	Eminence R-I	358
Lutie R-VI	226	West Nodaway Co. R-I	394
North Pemiscot Co. R-I	483	West Plains R-VII	2,134
Charleston R-I	1,549	Cainsville R-I	115
Southland C-9	400	Fair Play R-II	384
Winona R-III	515	Neelyville R-IV	655
Clarkton C-4	380	Pattonsburg R-II	184
Craig R-III	168	Montrose R-XIV	119
New Madrid Co. R-I	2,116	Arcadiis Valley R-II	1,251
Laquey R-V	611	Campbell R-II	695
Scott Co. Central Schools	419	Sheldon R-VIII	196
Norwood R-I	413	Willow Springs R-IV	1,271
Dora R-III	295	Twin Rivers R-X	1,135
Normandy	5,959	Lakeland R-III	470
Delta C-7	302	Maplewood-Richmond Heights	1,269
Couch R-I	258	Richwoods R-VII	273
Greenville R-II	929	Bosworth R-V	146
Naylor R-II	434	Verona R-VII	325
Weaubleau R-III	385	Thayer R-II	570
Van Buren R-I	580	Gainesville R-V	732
Humansville R-IV	434	East Carter Co. R-II	815
Senath-Hornersville C-8	812	Wheatland R-II	332
Marquand-Zion R-VI	226	Braymer C-4	347
South Pemiscot Co. R-V	765	Newtown-Harris R-III	97
Mountain View-Birch Tree R-III	1,334	Norborne R-VIII	233
Hume R-VIII	171	Hale R-I	172
Hancock Place	1,579	Bunker R-III	318
Malden R-I	1,211	Riverview Gardens	5,646
Ripley Co. R-IV	198	Cooter R-IV	188
Bakersfield R-IV	337	Niangua R-V	374
Skyline R-II	217		<u>140,861</u>
Macks Creek R-V	389		
Alton R-IV	750		
Breckenridge R-I	123		
South Iron Co. R-I	414		
Ripley Co. R-III	172		
Doniphan R-I	1,725		

# MCA+ COMPLAINT & GRIEVANCE SYSTEM

8/16

Members can file with the State and health plan at the same time.  
 But the State may wait for the plan to look into the problem first.



# MISSOURI DEPARTMENT OF SOCIAL SERVICES

## DIVISION OF MEDICAL SERVICES

### ☆ DUALITY ASSESSMENT AND IMPROVEMENT PLAN ☆

#### *☆ Purpose ☆*

To assure access to quality service in the Managed Care Plus (MC+) Program, the Division of Medical Services, Quality Assessment Unit will employ a variety of methods and tools to measure outcomes of service that are provided through the health plans and promote the process of ongoing quality improvement. Quality of care will be measured and evaluated in a regular, ongoing manner utilizing the following approach.

#### *☆ Goal ☆*

The goal is to monitor health care services provided to MC+ members by the health plans in compliance with Federal, State, and contract requirements; and to develop a process through which the Division of Medical Services can collegially work with the health plans to establish objectives and timetables for improvement of service delivery where indicated.

#### *☆ Overview ☆*

The plans must meet program standards for quality improvement, systems, member services, provider services, record keeping, organizational structure, adequacy of personnel, access standards, and data reporting as outlined in the managed care contract. In addition, quality standards must meet or exceed the requirements of 42 CFR 434.34.

The Quality Assessment process includes an internal review administered by the health plan, an internal review by the state, and an annual external review administered by an independent PRO or PRO-like entity. Components of the quality assessment process include the following:

1. Plan Report of Quality Assessment and Improvement
  - A. The plans will provide the State with regular reports of internal utilization and quality assessment reviews. Frequency and types of reports include:
    1. Quarterly Reports: Quarterly reports are due 45 working days following the last day of the quarter. Required reports are as follows:



















**DMSION OF MEDICAL SERVICES  
INTERNAL MEDICAL REVIEW COMMITTEE  
RECORD REQUEST FORM**

Date: \_\_\_\_\_

**TO:**

Name: \_\_\_\_\_

Company: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**REQUEST:**

Federal Regulation 42 CFR 431.107 provides for the required provider agreement and specifies that providers, "on requests, furnish to the Medicaid agency," records to disclose the extent of services furnished to Medicaid recipients and any information regarding payments claimed by the provider. This is included in the Provider Agreement where "failure to submit" or "retain adequate documentation" may result in recovery of payments or sanctions to participation. State regulation 13 CSR 70-3.030 defines "records" and "adequate documentation," and states records must be retained and made available on request to the Medicaid agency or its authorized agents. The managed care contract also requires health plans and its providers to maintain records and furnish them to the state upon request.

A release of information does not need to be secured from the recipient to forward the requested information due to the above federal and state regulation.

The following information is requested for clinical review by the Division of Medical Services Internal Medical Review Committee.

Member/Recipient Name: \_\_\_\_\_

DCN: \_\_\_\_\_ DOB: \_\_\_\_\_

Date(s) of Service Provided or Denied: \_\_\_\_\_

Documents requested \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Division of Medical Services Staff Signature: \_\_\_\_\_

Please fax or overnight the above information requested within 4 working days to:

Division of Medical Services  
615 Howerton Court  
Jefferson City, MO 65109

Fax: 573/526-4650  
Phone: 573/751-3399

Large empty rectangular box for additional information or notes.

DIVISION OF MEDICAL SERVICES  
INTERNAL MEDICAL REVIEW COMMITTEE  
REQUEST FOR REVIEW FORM

INFORMATION REQUIRED FOR COMMITTEE TO REVIEW CASE

Date: \_\_\_\_\_ Requestor: \_\_\_\_\_

Approval/Management's Signature: \_\_\_\_\_

**MC+ HEALTH PLAN/FEE-FOR-SERVICE PROVIDER INFORMATION**

Contact Name \_\_\_\_\_

Health Plan/Provider \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**PATIENT INFORMATION**

Member/Recipient Name: \_\_\_\_\_

DCN: \_\_\_\_\_ DOB: \_\_\_\_\_

Has recipient/provider contacted:

Health Plan's Member Services Yes \_\_\_\_\_ No \_\_\_\_\_

Health Plan's Provider Services Yes \_\_\_\_\_ No \_\_\_\_\_

Filed a complaint \_\_\_\_\_ grievance \_\_\_\_\_ appeal \_\_\_\_\_ with the health plan  
(please check what has been **filed** with the health plan) Yes \_\_\_\_\_ No \_\_\_\_\_

If **any** documentation has been requested, please specify what has been requested, who it has been requested from, the expected arrival date and to whom it is being sent.

\_\_\_\_\_  
\_\_\_\_\_

**DESCRIPTION OF REQUEST**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Respond to (please include address if someone other than DMS personnel):

\_\_\_\_\_  
\_\_\_\_\_

Please forward this form and any other information to:

SURS Unit

Large empty rectangular box for additional information or signature.