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August 12, 2002

Thomas W. Lenz
Associate Regional Administrator
for Medicaid and State Operations
Centers for Medicare and Medicaid Services
Federal Office Building
601 E. 12th Street
Kansas City, MO 64106

Dear Mr. Lenz:

The Missouri Department of Social Services (DSS) submits for your review the Missouri State Children's Health Insurance Program (SCHIP) State Plan Template.

Please feel free to contact Gregory A. Vadner, Director, Division of Medical Services, at 573-751-6922 if you have any questions with regard to this matter.

Sincerely,

Dana Katherine Martin
Director

DKM:sme

Enclosures

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, (42 CFR, 457.40(b))

(Signature of Governor or designee, of State/Territory, Date Signed)

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

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

Name: Dana Katherine Martin

Position/Title: Director, Department of Social Services

Name: Gregory A. Vadner

Position/Title: Director, Division of Medical Services

Name:

Position/Title:

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

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

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

- 1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Section 2103); **OR**
- 1.1.2 Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.1.3 A combination of both of the above.

Missouri is expanding Medicaid under a Section 1115 waiver: originally submitted August 26, 1997. Title XXI moneys will be used to fund the Medicaid expansion in conjunction with this waiver.

Missouri proposes that all uninsured children with net family income up to 200 percent of the federal poverty level (300 percent gross income) be covered under a Medicaid expansion. The Medicaid expansion will occur under a Title XIX 1115 waiver. Children will include individuals age birth through age 18. No new eligible will be excluded because of pre-existing illness or condition.

Children eligible for Title XXI will receive the Medicaid package of essential medically necessary health services. Non-emergent medical transportation is the only service that will not be covered under the 1115 waiver. This benefit is so unheard of in any health insurance plan that its inclusion would serve as a significant incentive for the dropping of private coverage. Prescription drugs will be subject to the national drug rebate program requirements. Fee-for-service will be utilized in regions where MC+ is not yet available. When MC+ begins in these areas, Title XXI eligibles will be enrolled in managed care.

- 1.2 Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))
- 1.3 Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the

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Americans with Disabilities Act of **1990**, section **504** of the Rehabilitation Act of **1973**, the Age Discrimination Act of **1975**, **45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)**

1.4

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

Effective date: September 1, **1998**

Implementation date: September 1, **1998**

Effective Date: **09/01/1998**

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

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

Response: Please refer to Attachments 1, 2, and 3. Information regarding age, income, coverage by other health insurance, race, and location is currently available from Missouri's Application For Benefits. Information regarding age, income, coverage by other health insurance, race, and location will be required from Title XXI applicants. The state will require that any participant cooperate fully with the state and federal government in establishing eligibility and in providing any verification necessary as requested by the state in the initial application process or at any subsequent time. Title XXI recipients will have a distinct ME code for tracking purposes.

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

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

Response: Please refer to Attachment 4. Outreach and eligibility determination occur throughout Missouri with state offices in every county. Free materials are available and used by other entities assisting in outreach, such as other state agencies with whom DSS has interagency agreements, social welfare organizations, schools, and health care providers through outstationed eligibility workers. The Department of Social Services has interagency agreements with the Department of Health and Senior Services to develop a Well Child outreach Project, a Lead Poisoning Outreach Program, and to conduct outreach activities to identify possible Medicaid eligibles and refer them to the Division of Family Services for eligibility determination. There is no state-only child health insurance program in Missouri.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered

children who are eligible to participate in health insurance programs that involve a public-private partnership:

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

- 2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Response: Outreach and eligibility determination activities to increase the number of children with credible coverage occur throughout Missouri with state offices in every county. We propose using brochures and informational flyers to educate families about the health coverage available through Medicaid including those funded by Title XXI. We will stress that:

- Children do not have to be on TANF (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.

Information about Medicaid and the Title XXI expansion will be shared with families through the press, public speaking opportunities of executive agency staff, public service announcements, and state approved health plan and provider education.

The State will involve the MC+ Consumer Advisory Committee and coordinate with the Division of Family Services, the Department of Health and Senior Services, school districts, and other appropriate agencies or groups to include public health insurance programs in the design and implementation of the brochures, flyers, and other education material. We will continue to identify barriers to Medicaid enrollment by receiving information about those barriers from schools, hospitals, and local health departments through our regularly scheduled interagency meetings, provider association contacts, the MC+ Consumer Advisory Committee and Medical Advisory Committee Subcommittees.

The State will have a simplified mail-in application process for the expansion populations. This should overcome the burden of applying in person at a Division of Family Services office.

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Missouri will continue to outstation eligibility workers at hospitals and federally qualified health centers. The state will explore the effectiveness of expanding the sites for enrolling children in a wider variety of community settings with the MC+ Consumer Advisory Committee, advocates for children, and health care providers. We will also be cooperating with the Missouri Hospital Association in their efforts to develop an effective outreach program for not only this program, but for Medicaid children in general. Please refer to Attachment 5. We will also partner with local community groups and agencies which want to sponsor local outreach initiatives.

Income will be determined by looking at the total gross income available to the children for whom the application is being made. The current assistance group definitions used by Missouri for Medicaid budgeting will be followed. A standard income disregard equal to 100 percent of the federal poverty level will be made from the gross income figure. The net income figure will be compared to 200 percent of the federal poverty level to determine if the child(ren) is (are) eligible. To be eligible, this net figure must not exceed 200 percent of the federal poverty level for children.

It is important that the State is concerned that the Missouri SCHIP Program, MC+ For Kids, does not "crowd out" private insurance options. The following measures will help address crowd out with private insurance options:

- There will be a six month look back period for health insurance when determining eligibility. Children of parents who dropped available private health insurance coverage within the last six months will have a six month waiting period for Medicaid coverage.
- Uninsured is defined as an individual who has not had employer-subsidized health care insurance coverage for six months prior to application for payment of health care. Exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of government financed health insurance shall include, but not be limited to,:
 - ❑ Loss of employment due to factors other than voluntary termination;
 - ❑ Change to a new employer that does not provide an option for dependent coverage; or
 - ❑ Expiration of COBRA coverage period.
- Non-emergent transportation will not be covered. This benefit is so unheard of in any health insurance plan that its inclusion would serve as a significant incentive for the dropping of private coverage.

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- Crowd out will be evaluated yearly to determine if additional protections are warranted. If crowd out does become a problem the state will develop additional anti-crowd out measures as warranted by the scope and nature of the problem. Additional options may include:
 - ❑ Adding an insurance availability test to preclude participation;
 - ❑ Lengthening the look back **period**;
 - ❑ Implementing cost sharing provisions;
 - ❑ Moving to once yearly open enrollment periods for children with family income over 200 percent of gross federal poverty level; and
 - ❑ Other measures designed to efficiently deal with what the research finds.

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

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

- 3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including **any** variations. (Section 2102)(a)(4) (42CFR 457.490(a))

- 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.4900))

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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)) (42CFR 457.305(a) and 457.320(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 (so long as residency requirement is not based on length of time in state) :
- 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)) (42CFR 457.320(b))

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

4.3. Describe the methods of establishing eligibility and continuing enrollment.
(Section 2102)(b)(2)) (42CFR 457.350)

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

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

4.4. Describe the procedures that assure that:

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

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

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

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

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

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4.4.4.4. If the state provides coverage under a premium assistance program, describe:

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

The minimum employer contribution.

The cost-effectiveness determination.

4.4..5 Child health assistance is provided **to** targeted low-income children in the state who are American Indian and **Alaska** Native. (Section **2102(b)(3)(D)**) (**42 CFR 457.125(a)**)

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Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

Response: We propose using brochures and informational flyers to educate families about the health coverage available through Medicaid. We will stress that:

- Children do not have to be on TANF (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 staff, the Department of Health and Senior Services, school districts, and other appropriate agencies or groups in the design and implementation of the brochures and flyers. We will continue to coordinate eligibility outreach efforts with schools, hospitals, and local health agencies by identifying barriers to Medicaid enrollment.

We will also move to a simplified mail-in application process for the expansion populations. This should overcome the burden of applying in person at a Division of Family Services office.

We are also cooperating with the Missouri Hospital Association in their efforts to develop an effective outreach program for not only this program, but for Medicaid children in general.

We are also planning to work with local groups in designing their local outreach initiatives.

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



Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

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

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

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

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

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

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

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

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

6.1.4.1. Coverage the same as Medicaid State plan

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

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- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7. Other (Describe)

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

- 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 pre-pregnancy 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

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- devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services (Section 2110(a)(17))
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. **Any** other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

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

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

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HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

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

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

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

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

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

6.4.2. **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family

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coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

- 6.4.2.1. Purchase of family coverage is cost-effective 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)) (42CFR 457.1010(a))
- 6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))
- 6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

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Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and (appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

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

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or**, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

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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?** (42CFR 457.505)

8.1.1. **YES**

8.1.2. **NO, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other.:

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(B)) (42CFR 457.505(b))

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

8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3. No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

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

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- 8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)
- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))
- 8.7.1 Please provide an assurance that the following disenrollment protections are being applied:
- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
 - The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. (42CFR 457.570(b))
 - In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
 - The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))
- 8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))
- 8.8.1. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
 - 8.8.2. No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5)) (42CFR 457.224) (Previously 8.4.5)
 - 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
 - 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

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- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

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Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Response: Please refer to Attachment 6. The state hopes to expand health coverage, thereby decreasing the number of uninsured in Missouri. This will be accomplished with the greatest administrative efficiency through a Medicaid expansion.

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

Response: The state expects to enroll approximately 70,000 additional children in Medicaid by June 30, 1999. Please refer to Attachment 6.

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

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

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Model Application Template for the State Children's Health Insurance Program

- 9.3.7.4. satisfaction with care
- 9.3.7.5. Mental health
- 9.3.7.6. Dental care
- 9.3.7.7. other, please list:

Response: Please refer to Attachment 7, MC+ Quality Indicators.

9.3.8. Performance measures for special targeted populations.

9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

Response: This population will become part of our MC+ managed care reporting. In addition, all necessary 1115 reports and documentation will be submitted. Please refer to Attachment 8.

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)) (42CFR 457.720)

9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and

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taxes)

9.8.4. Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Response: During public hearings for Missouri's 1115 waiver amendment and in all other public discourse it was clearly stated our intent to coordinate the use of the new State Children's Health Insurance Program to expand Medicaid coverage.

These discussions have continued in numerous additional public settings, newswire stories, and in our state legislative and appropriation processes.

On an ongoing basis the MC+ Statewide Quality Assessment and Improvement (QA&I) Advisory Group will advise the Division of Medical Services regarding health policy that: improves the health status of MC+ clients; maintains or reduces the cost of health care while maintaining or improving quality of care; and describes best practices.

The role of the QA&I subcommittees will be to evaluate, refine, and recommend sentinel indicators; recommend intervention strategies; and review satisfaction and audit data as it relates to maternal and child health and behavioral health issues. The QA&I subcommittees will also communicate provider complaints and system issues to the QA&I Advisory Committee and the Division of Medical Services and respond to ad hoc requests of the QA&I Committee.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR part 457.125. (Section 2107(c)) (42CFR 457.120(c))

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

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in part 457.65(b) through (d).

Response: There has been no amendment relating to eligibility or benefits.

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9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

Planned use of funds, including --

- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Response: Please refer to Attachment 9.

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Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by **January 1** following the end of the fiscal year on the result of the assessment, and

10.2. The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

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Section 11. Program Integrity (Section 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 The state assures that services are provided in an effective and efficient manner through fee and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6.-9.8.9)*

11.2.1. 42 CFR ~~Part~~ 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. Section 1124 (relating to disclosure of ownership and related information)

11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. Section 1128A (relating to civil monetary penalties)

11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

Effective Date: 09/01/1998

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Section 12. Applicant and enrollee protections (Sections 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR part 457.1120.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR part 457.1120.

Premium Assistance: Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR part 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Effective Date: 09/01/1998

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ATTACHMENT I

ESTIMATION OF UNINSURED CHILDREN BY LEVEL OF POVERTY

OA Budget and Planning Estimate of the Number of Uninsured Children

Federal Poverty Levels	Age <1	1-5	6-12	13-17	18	Total
0-99	3,995	18,127	26,110	16,771	6,490	71,493
100-149	1,879	6,903	13,359	6,590	2,062	30,793
150-199	344	8,697	9,926	9,421	1,911	30,299
200-299	3,793	10,603	10,534	10,015	2,038	36,983
300-399	2,268	2,287	6,439	2,085	415	13,494
400+	196	3,571	3,010	4,459	136	11,372
Total	12,475	50,188	69,378	49,341	13,052	194,434

Uninsured Children that Qualify for Medicaid, but are Not Enrolled

Medicaid Poverty Ranges	185%	133%	<100%	<100%	<100%	Total
	Age <1	1-5	6-12	13-17	18	
0-99	3,995	18,127	26,110	16,771	6,490	71,493
100-149	1,879	4,649	0	0	0	6,528
150-199	246	0	0	0	0	246
200-399	0	0	0	0	0	0
400+	0	0	0	0	0	0
Total	6,120	22,776	26,110	16,771	6,490	78,267

Uninsured Children that do Not Qualify for Medicaid and are Below 300% FPL

Medicaid Poverty Ranges	185%	133%	<100%	<100%	<100%	Total
	Age <1	1-5	6-12	13-17	18	
0-99	0	0	0	0	0	0
100-149	0	2,254	13,359	6,590	2,062	24,265
150-199	98	8,697	9,926	9,421	1,911	30,053
200-299	3,793	10,603	10,534	10,015	2,038	36,983
Total	3,891	21,554	33,819	26,026	6,011	91,301

Source of OA Budget and Planning Estimate: 1996 Current Population Survey adjusted to updated 1996 population estimates for Missouri by age.

ATTACHMENT 2

1115 Waiver
 Estimated Presentation Rates for Uninsured Children

Federal Poverty Level	Birth Through Age 1	Ages 1-5	Ages 6-12	Ages 13-17	Age 18	Total
0-99%	0	0	0	0	0	0
100-149%	0	1,691	10,018	4,943	1,547	18,199
150-199%	73	6,523	7,445	7,066	1,433	22,540
200-299%	2,845	7,952	7,901	7,511	1,528	27,737
300% and above	0	0	1,167	898	207	2,272
Total	2,918	16,166	26,531	20,418	4,715	70,748

ATTACHMENT 3

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Medicaid Eligibles

Age	Eligibles	%FPL	Total by %FPL
0	27,160	185	27,160
1	23,905	133	
2	23,318	133	
3	23,791	133	
4	24,078	133	
5	24,123	133	119,215
6	22,550	100	
7	20,581	100	
8	19,069	100	
9	17,050	100	
10	16,010	100	
11	15,198	100	
12	14,691	100	
13	13,343	100	
14	13,168	100	
15	12,451	100	
16	11,713	100	
17	10,971	100	
18	9,086	100	195,881
Total	342,256		

TABLE 1: MEDICAID ELIGIBLES AS OF 06/30/97
 CLASSIFIED BY COUNTY, MECODE, SEX, AND AGE
 PROGRAM RS5TEX02 DSS RESEARCH & EVALUATION

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*_TYPE_=1 *+COUNTY=

ECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
		0	27,160	27,160	.0471
		1	23,905	51,065	.0415
		2	23,318	74,383	.0404
		3	23,791	98,174	.0413
		4	24,078	122,252	.0418
		5	24,123	146,375	.0418
		6	22,550	168,925	.0391
		7	20,581	189,506	.0357
		8	19,069	208,575	.0331
		9	17,150	225,725	.0297
		10	16,010	241,735	.0278
		11	15,198	256,933	.0264
		12	14,691	271,624	.0255
		13	13,343	284,967	.0231
		14	13,168	298,135	.0228
		15	12,451	310,586	.0216
		16	11,713	322,299	.0203
		17	10,971	333,270	.0190
		18	9,086	342,356	.0158
		19	5,659	348,015	.0098
		20	5,612	353,627	.0097
		21	5,368	358,995	.0093
		22	5,519	364,514	.0096
		23	5,069	369,583	.0088
		24	5,119	374,702	.0089
		25	4,959	379,661	.0086
		26	5,013	384,674	.0087
		27	4,521	389,195	.0078
		28	4,066	393,261	.0071
		29	4,112	397,373	.0071
		30	4,014	401,387	.0070
		31	4,107	405,494	.0071
		32	4,269	409,763	.0074
		33	4,257	414,020	.0074
		34	4,463	418,483	.0077
		35	4,276	422,759	.0074
		36	4,292	427,051	.0074
		37	4,145	431,196	.0072
		38	3,957	435,153	.0069
		39	3,688	438,841	.0064
		40	3,677	442,518	.0064
		41	3,356	445,874	.0058
		42	3,102	448,976	.0054
		43	2,998	451,974	.0052
		44	2,890	454,864	.0050
		45	2,603	457,467	.0045
		46	2,527	459,994	.0044
		47	2,444	462,438	.0042

ABLE 1: MEDICAID ELIGIBLES AS OF 06/30/97
 CLASSIFIED BY COUNTY, MECODE, SEX, AND AGE
 PROGRAM RS5TEX02 DSS RESEARCH & EVALUATION

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*_TYPE_=1 **COUNTY=
 CONTINUED)

ECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUH. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
		48	2,331	464,769	.0040
		49	2,390	467,159	.0041
		50	2,403	469,562	.0042
		51	2,000	471,562	.0035
		52	2,162	473,724	.0037
		53	2,307	476,031	.0040
		54	2,332	478,363	.0040
		55	2,212	480,575	.0038
		56	2,192	482,767	.0038
		57	2,283	485,050	.0040
		58	2,161	487,211	.0037
		59	2,309	489,520	.0040
		60	2,210	491,730	.0038
		61	2,299	494,029	.0040
		62	2,228	496,257	.0039
		63	2,017	498,274	.0035
		64	2,090	500,364	.0036
		65	2,649	503,013	.0046
		66	2,658	505,671	.0046
		67	2,879	508,550	.0050
		68	2,745	511,295	.0048
		69	2,771	514,066	.0048
		70	2,847	516,913	.0049
		71	2,791	519,704	.0048
		72	2,874	522,578	.0050
		73	2,909	525,487	.0050
		74	2,797	528,284	.0048
		75	2,881	531,165	.0050
		76	2,864	534,029	.0050
		77	2,860	536,889	.0050
		78	2,755	539,644	.0048
		79	2,733	542,377	.0047
		80	2,518	544,895	.0044
		81	2,629	547,524	.0046
		82	2,669	550,193	.0046
		83	2,642	552,835	.0046
		a4	2,665	555,500	.0046
		85	2,540	558,040	.0044
		86	2,444	560,484	.0042
		87	2,329	562,181	.0040
		88	2,119	564,932	.0037
		89	1,991	566,923	.0035
		90	1,743	568,666	.0030
		91	1,599	570,265	.0028
		92	1,346	571,611	.0023
		93	1,250	572,861	.0022
		94	986	573,647	.0017
		95	814	574,661	.0014

TABLE 1: MEDICAID ELIGIBLES AS OF 06/30/97
 CLASSIFIED BY COUNTY, MECODE, SEX, AND AGE
 PROGRAM RS5TEX02 DSS RESEARCH 8 EVALUATION

(*_TYPE_=1 **COUNTY=
 CONTINUED)

MECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
		96	588	575,249	.0010
		97	483	575,732	.0008
		98	304	576,036	.0005
		99	227	576,263	.0004
		100	164	576,427	.0003
		101	102	576,529	.0002
		102	72	576,601	.0001
		103	50	576,651	.0001
		,104	19	576,670	.0000
		105	21	576,691	.0000
		106	9	576,700	.0000
		107	6	576,706	.0000
		108	4	576,710	.0000
		109	1	576,711	.0000
		111	1	576,712	.0000

4BLE 1: MEDICAID ELIGIBLES AS OF 06/30/97
CLASSIFIED BY COUNTY, MCODE, SEX, AND AGE
PROGRAM RS5TEX02 DSS RESEARCH & EVALUATION

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*_TYPE_=2 **COUNTY=

CODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
	FEHALE		340,737	340,737	.5908
	MALE		235,975	235,975	,4092

*_TYPE_=3 **COUNTY=

MECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
	FEMALE	0	13,193	13,193	.0229
	FEMALE	1	11,792	24,985	.0204
	FEMALE	2	11,355	36,340	.0197
	FEMALE	3	11,450	47,790	.0199
	FEMALE	4	11,754	59,544	.0204
	FEMALE	5	11,810	71,354	.0205
	FEMALE	6	11,130	82,484	.0193
	FEMALE	7	10,144	92,628	.0176
	FEMALE	8	9,342	101,970	.0162
	FEMALE	9	8,354	110,324	.0145
	FEMALE	10	7,847	118,171	.0136
	FEMALE	11	7,378	125,549	.0128
	FEMALE	12	7,154	132,703	.0124
	FEMALE	13	6,495	139,198	.0113
	FEMALE	14	6,478	145,676	.0112
	FEMALE	15	6,216	151,892	.0108
	FEMALE	16	6,118	158,010	.0106
	FEMALE	17	6,121	164,131	.0106
	FEMALE	18	5,860	169,991	.0102
	FEMALE	19	4,456	174,447	.0077
	FEMALE	20	4,841	179,288	.0084
	FEMALE	21	4,709	183,997	.0082
	FEMALE	22	4,811	188,808	.0083
	FEMALE	23	4,421	193,229	.0077
	FEMALE	24	4,400	197,629	.0076
	FEMALE	25	4,191	201,820	.0073
	FEMALE	26	4,153	205,973	.0072
	FEMALE	27	3,703	209,676	.0064
	FEMALE	28	3,243	212,919	.0056
	FEMALE	29	3,187	216,106	.0055
	FEMALE	30	3,057	219,163	.0053
	FEMALE	31	3,091	222,254	.0054
	FEMALE	32	3,096	225,350	.0054
	FEMALE	33	3,046	228,396	.0053
	FEMALE	34	3,099	231,495	.0054
	FEMALE	35	2,947	234,442	.0051
	FEMALE	36	2,902	237,344	.0050
	FEMALE	37	2,735	240,079	.0047
	FEMALE	38	2,497	242,576	.0043
	FEMALE	39	2,307	244,883	.0040
	FEMALE	40	2,289	247,172	.0040
	FEMALE	41	2,044	249,216	.0035
	FEMALE	42	1,882	251,098	.0033
	FEMALE	43	1,763	252,861	.0031
	FEMALE	44	1,752	254,613	.0030
	FEMALE	45	1,467	256,080	.0025
	FEMALE	46	1,539	257,619	.0027
	FEMALE	47	1,455	259,074	.0025

TABLE I: MEDICAID ELIGIBLES AS OF 06/30/97
 CLASSIFIED BY COUNTY, HECODE, SEX, AND AGE
 PROGRAM RS5TEX02 DSS RESEARCH & EVALUATION

* TYPE = 3 * COUNTY =
 (CONTINUED)

HECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
	FEMALE	48	1,443	260,517	.0025
	FEMALE	49	1,444	261,961	.0025
	FEMALE	50	1,480	263,441	.0026
	FEMALE	51	1,253	264,694	.0022
	FEMALE	52	1,308	266,002	.0023
	FEMALE	53	1,390	267,392	.0024
	FEMALE	54	1,425	268,817	.0025
	FEMALE	55	1,338	270,155	.0023
	FEMALE	56	1,357	271,512	.0024
	FEMALE	57	1,350	272,862	.0023
	FEMALE	58	1,295	274,157	.0022
	FEMALE	59	1,404	275,561	.0024
	FEMALE	60	1,377	276,938	.0024
	FEMALE	61	1,414	278,352	.0025
	FEMALE	62	1,397	279,749	.0024
	FEMALE	63	1,309	281,058	.0023
	FEMALE	64	1,354	282,412	.0023
	FEMALE	65	1,806	284,218	.0031
	FEMALE	66	1,794	286,012	.0031
	FEMALE	67	1,905	287,917	.0033
	FEMALE	68	1,862	289,779	.0032
	FEMALE	69	1,912	291,691	.0033
	FEMALE	70	1,987	293,678	.0034
	FEMALE	71	1,964	295,642	.0034
	FEMALE	72	2,063	297,705	.0036
	FEMALE	73	2,154	299,859	.0037
	FEMALE	74	2,047	301,906	.0035
	FEMALE	75	2,184	304,090	.0038
	FEMALE	76	2,153	306,243	.0037
	FEMALE	77	2,159	308,402	.0037
	FEMALE	78	2,115	310,517	.0037
	FEMALE	79	2,147	312,664	.0037
	FEMALE	80	1,958	314,622	.0034
	FEMALE	81	2,078	316,700	.0036
	FEMALE	82	2,078	318,778	.0036
	FEMALE	83	2,097	320,875	.0036
	FEMALE	84	2,145	323,020	.0037
	FEMALE	85	2,052	325,072	.0036
	FEMALE	86	1,984	327,056	.0034
	FEMALE	87	1,887	328,943	.0033
	FEMALE	88	1,743	330,686	.0030
	FEMALE	89	1,653	332,339	.0029
	FEMALE	90	1,439	333,778	.0025
	FEMALE	91	1,340	335,118	.0023
	FEMALE	92	1,150	336,268	.0020
	FEMALE	93	1,075	337,343	.0019
	FEMALE	94	851	338,194	.0015
	FEMALE	95	714	338,908	.0012

*_TYPE_=3 **COUNTY=
 CONTINUED)

ECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
FEMALE		96	521	339,429	.0009
FEMALE		97	426	339,855	.0007
FEMALE		98	271	340,126	.0005
FEMALE		99	199	340,325	.0003
FEMALE		100	145	340,470	.0003
FEMALE		101	93	340,563	.0002
FEMALE		102	68	340,631	.0001
FEMALE		103	49	340,680	.0001
FEMALE		104	18	340,698	.0000
FEMALE		105	20	340,718	.0000
FEMALE		106	9	340,727	.0000
FEMALE		107	4	340,731	.0000
FEMALE		108	4	340,735	.0000
FEMALE		109	1	340,736	.0000
FEMALE		111	1	340,737	.0000
MALE		0	13,967	13,967	.0242
MALE		1	12,113	26,080	.0210
MALE		2	11,963	38,043	.0207
MALE		3	12,341	50,384	.0214
MALE		4	12,324	62,708	.0214
MALE		5	12,313	75,021	.0214
MALE		6	11,420	86,441	.0198
MALE		7	10,437	96,878	.0181
MALE		8	9,727	106,605	.0169
MALE		9	8,796	115,401	.0153
MALE		10	8,163	123,564	.0142
MALE		11	7,820	131,384	.0136
MALE		12	7,537	138,921	.0131
MALE		13	6,848	145,769	.0119
MALE		14	6,690	152,459	.0116
MALE		15	6,235	158,694	.0108
MALE		16	5,595	164,289	.0097
MALE		17	4,850	169,139	.0084
MALE		18	3,226	172,365	.0056
MALE		19	1,203	173,568	.0021
MALE		20	771	174,339	.0013
MALE		21	659	174,998	.0011
MALE		22	708	175,706	.0012
MALE		23	648	176,354	.0011
MALE		24	719	177,073	.0012
MALE		25	768	177,841	.0013
MALE		26	860	178,701	.0015
MALE		27	818	179,519	.0014
MALE		28	823	180,342	.0014
MALE		29	925	181,267	.0016
MALE		30	957	182,224	.0017
MALE		31	1,016	183,240	.0018
MALE		32	1,173	184,413	.0020

*_TYPE_=3 **COUNTY=
 CONTINUED)

ECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
	MALE	33	1,211	1851624	.0021
	HALE	34	1,364	186,988	.0024
	MALE	35	1,329	188,317	.0023
	MALE	36	1,390	189,707	.0024
	HALE	37	1,410	191,117	.0024
	MALE	38	1,460	192,577	.0025
	MALE	39	1,381	193,958	.0024
	MALE	40	1,388	195,346	.0024
	HALE	41	1,312	196,658	.0023
	MALE	42	1,220	197,878	.0021
	MALE	43	1,235	199,113	.0021
	MALE	44	1,138	200,251	.0020
	MALE	45	1,136	201,387	.0020
	MALE	46	988	202,375	.0017
	MALE	47	989	203,364	.0017
	MALE	48	888	204,252	.0015
	MALE	49	946	205,198	.0016
	MALE	50	923	206,121	.0016
	HALE	51	747	206,868	.0013
	HALE	52	854	207,722	.0015
	MALE	53	917	208,639	.0016
	MALE	54	907	209,546	.0016
	HALE	55	874	210,420	.0015
	MALE	56	835	211,255	.0014
	MALE	57	933	212,188	.0016
	MALE	58	866	213,054	.0015
	MALE	59	905	213,959	.0016
	MALE	60	833	214,792	.0014
	MALE	61	885	215,677	.0015
	MALE	62	831	216,508	.0014
	MALE	63	708	217,216	.0012
	MALE	64	736	217,952	.0013
	MALE	65	843	218,795	.0015
	MALE	66	864	219,659	.0015
	MALE	67	974	220,633	.0017
	HALE	68	883	221,516	.0015
	MALE	69	859	222,375	.0015
	MALE	70	860	223,235	.0015
	MALE	71	827	224,062	.0014
	MALE	72	811	224,873	.0014
	MALE	73	755	225,628	.0013
	MALE	74	750	226,378	.0013
	MALE	75	697	227,075	.0012
	MALE	76	711	227,786	.0012
	HALE	77	701	228,487	.0012
	MALE	78	640	229,127	.0011
	MALE	79	586	229,713	.0010
	MALE	80	560	230,273	.0010

TABLE 1: MEDICAID ELIGIBLES AS OF 06/30/97
 CLASSIFIED BY COUNTY, HECODE, SEX, AND AGE
 PROGRAM RS5TEX02 DSS RESEARCH & EVALUATION

14:48 WEDNESDAY, JULY 16, 1997 10

*_TYPE_=3 **COUNTY=
 CONTINUED)

ECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
	MALE	81	551	230,824	.0010
	MALE	82	591	231,415	,0010
	MALE	83	545	231,960	.0009
	HALE	84	520	232,480	.0009
	MALE	85	488	232,968	.0008
	MALE	86	460	233,428	.0008
	MALE	87	442	233,870	.0008
	MALE	88	376	2341246	.0007
	MALE	89	338	234,584	.0006
	MALE	90	304	234,888	.0005
	MALE	91	259	235,147	.0004
	MALE	92	196	235,343	.0003
	HALE	93	175	235,518	,0003
	MALE	94	135	235,653	.0002
	MALE	95	100	235,753	.0002
	MALE	96	67	235,820	.0001
	MALE	97	57	235,877	.0001
	MALE	98	33	235,910	.0001
	MALE	99	28	235,938	.0000
	HALE	100	19	235,957	.0000
	MALE	101	9	235,966	.0000
	HALE	102	4	235,970	.0000
	MALE	103	1	235,971	.0000
	MALE	104	1	235,972	.0000
	HALE	105	1	235,973	.0000
	MALE	107	2	235,975	.0000

*_TYPE_=4 **COUNTY=

ECODE DESCRIPTION	SEX	AGE	ELIGIBLES	ACCUM. ELIGIBLES	RATIO OF LINE ITEM TO TOTAL
NIATCHED	.	.	143	143	.0002
1-OLD AGE ASST (OAA)	.	.	948	948	.0016
2-BLIND PENSION (BP)	.	.	2,549	2,549	.0044
3-AID TO BLIND (AB)	.	.	945	945	.0016
4-AID TO DISABLED (APTD)	.	.	2,263	2,263	.0039
5-AFDC CARETAKER (ADULT)	.	.	56,769	56,769	.0984
6-AFDC DEPENDENT (CHILD)	.	.	133,936	133,936	.2322
7-FOSTER CARE (FC)	.	.	4,988	4,988	.0086
8-CHILD WELFARE SERVICES (CWS)	.	.	311	311	.0005
9-GENERAL RELIEF (GR)	.	.	3,338	3,338	.0058
0-VIETNAMESE REFUGEE	.	.	51	51	.0001
1-MEDICAL ASST-OAA (MA-OAA)	.	.	60,246	60,246	.1045
2-MEDICAL ASST-AB (MA-AB)	.	.	17	17	.0000
3-MEDICAL ASST-PTD (MA-PTD)	.	.	80,723	80,723	.1400
4-NURSING CARE-OAA (NC-OAA)	.	.	6,035	6,035	.0105
5-NURSING CARE-AB (NC-AB)	.	.	2	2	.0000
6-NURSING-CARE-PTD (NC-PTD)	.	.	4,682	4,682	.0081
8-UNBORN CHILD (MECODE 18)	.	.	2,580	2,580	.0045
9-CUBAN REFUGEE	.	.	19	19	.0000
1-HAITIAN REFUGEE	.	.	4	4	.0000
3-MEDICAL ASST-AFDC	.	.	128	128	.0002
4-RUSSIAN JEW	.	.	754	754	.0013
6-ETHIOPIAN REFUGEE	.	.	199	199	.0003
8-DMH-FC	.	.	12	12	.0000
9-DYS-FC	.	.	87	87	.0002
6-ADOPTION SUB/FFP	.	.	485	485	.0008
7-TITLE XIX/FFP (HDN-FFP)	.	.	3,538	3,538	.0061
0-MEDICAID FOR CHILDREN	.	.	142,897	142,897	.2478
1-ICF-MR POVERTY	.	.	401	401	.0007
3-PREGNANT-WOMEN-60-DAYS	.	.	453	453	.0008
4-PREGNANT-WOMEN-60-DAYS-POV	.	.	2,070	2,070	.0036
15-MEDICAID FOR PREGNANT WOMEN	.	.	9,243	9,243	.0160
5-QUALIFIED MEDICARE BENEFICIARY	.	.	9,340	9,340	.0162
6-ADOP. SUB/IV-E	.	.	3,078	3,078	.0053
7-ADOP. SUB HDN	.	.	1,714	1,714	.0030
0-GENERAL RELIEF NEWBORNS	.	.	7,462	7,462	.0129
11-MEDICAID PREGNANT WOMEN (FFP/HIF)	.	.	1,511	1,511	.0026
2-MEDICAID FOR CHILDREN (FFP/HIF)	.	.	31,291	31,291	.0543
3-CHILD WELFARE SERVICES (FFP/HIF)	.	.	1,254	1,254	.0022
4-GROUP HOMES (HIF)	.	.	246	246	.0004

ATTACHMENT 4

October 31, 1997

OUTREACH EFFORTS FOR MEDICAID PROGRAMS
Fee-For-Service Program

TYPE	IF USED PLEASE CHECK	ONGOING ACTIVITY	BRIEF DESCRIPTION
1. Newsletters- What topic, sent to what types of groups	✓	As needed	Medicaid Newsletter for Dept. Of Elementary & Secondary Education distributed to public schools
	✓		Recipient notice informing clients of the new toll free number to call for nonemergency medical transportation assistance (888-163-951-3).
	✓	Yes	Bulletins are issued as needed to targeted provider groups (phys., APN, etc.) to inform of policy changes, clarification of existing policies and procedures.
2. 800 numbers	✓	Yes	Numbers for: Provider Relations 800-392-0938 Recipient Services 800-392-2161 Exceptions Unit 800-392-8030 Non-Emergency Medical Transportation 888-863-9513
	✓	Yes	Receive requests for drug prior authorization and emergency exception requests for non-covered items/services from physicians.
3. E-mail newsletter/communications	---		Not applicable
4. Speakers' bureau or designated spokespersons	✓	Yes	Name groups spoken to in the last 12 months East West GateWay Area Agencies on Aging Department of Health Head Injury Case Workers Mid America Regional Council Mo Public Transit Association annual meeting Department of Health Council
	✓	As Needed	Collaborative Trainings with MC+ case managers and First Steps service coordinators re: Early Intervention Services. Trainings were in each MC+ area. Presented the above collaborative efforts at NECTAS (National Early Childhood Technical Assistance System) Managed Care Meeting.

TYPE	IF USED PLEASE CHECK	ONGOING ACTIVITY	BRIEF DESCRIPTION
5. Brochures	✓	As Requested	Healthy Children and Youth (HCY) Pamphlet -Distributed to recipients at the time of application (115 local Division of Family Services offices) -Provided to over 33 service organizations including March of Dimes, Kids Under 21, Black Health Care Coalition, Kansas City Maternal Child Health Coalition, Catholic Services for Children and Youth, Birthright, YouthNet, among others. -Printed in Spanish (1997)
	✓	When requested	Medicaid and You, pamphlets on Medicaid spenddown, Qualified Medicaid Beneficiary, Family Services in Missouri, etc.
	✓	Yes	Non-Emergency Medical Transportation program pamphlets distributed with Medicaid approval letters sent by Division of Family Services and Area Agency on Aging.
6. News releases	✓	As Needed	As needed to announce information about program
7. Response to inquires on programs-how are these handled	J	As Needed	Media inquires coordinated through the Department of Social Service's Office of Communications
	J	Yes	Recipient Services Unit handles calls from recipients, Program Management responds to complex inquiries, and Provider Communications-inquiries from Providers.
	✓	Yes	A written response is sent to the inquirer usually under the Director of Social Services or Director of Medical Services signature. Occasionally, a verbal response is made-this occurs with telephone inquiries-sometimes followed by a written response as well.
8. Representative members of community organizations	✓	Monthly	List organizations: MO Planning Council for Developmental Disabilities
			Various Provider Associations
		Quarterly	State Interagency Coordinating Council (for early intervention services)

TYPE	IF USED PLEASE CHECK	ONGOING ACTIVITY	BFUEF DESCRIPTION
. Posters	J	1997 First year Scheduled as a yearly contest	"Well Child Checkup" statewide poster contest. Teachers of Family and Consumer Sciences classes throughout the state were invited to make the poster contest project part of the curriculum taught on child health and development. 180 teachers agreed to participate and were provided educational materials on a variety of subjects some which were well child clinics, Tel-Link material, prenatal care, substance abuse, immunizations, child safety, and HCY exams. The 2 winning students were invited to Jefferson City to meet the Governor and each received an award.
0. Educational materials	✓	Yes	Provider manuals
	J	Yes	-Message on the Audio Response Unit and POS terminal. -Physician's Seminars and training scheduled on periodic basis or upon request.
1. Videos	---	---	N/A
2. Health promotion campaigns	---	---	See #9
.3. Media appearances with breaking news	✓	Yes	-DOH staff made appearances on broadcast and media programs in KC, St. Louis, Columbia, Joplin, Springfield, St. Joseph, and Kirksville promoting EPSDT. * Not Breaking News
14. Health fairs and community related trade shows	✓	As Scheduled	Present at Comprehensive School Health Conference (statewide conf.)
	✓	As Scheduled	-Department of Health exhibited Healthy Children and Youth and well child care information at events such as: St. Louis and Kansas City Black and Latino Expos, Child Abuse/Neglect Conference, Maternity Fair, A Baby Affair, Conference on Young Years.
15. Internet Web pages	J	Yes	Home page on the Internet under development.
16. Public Service Announcements- Radio/TV	✓	Yes	Radio/TV announcements (Dept. Of Health) See #13
17. Complaint resolution team	✓	Yes	All recipients have right to file complaint/grievance/hearing

TYPE	IF USED PLEASE CHECK	ONGOING ACTIVITY	BEUEF DESCRIPTION
Others-please list: Training	✓	As Needed	Provide information and training regarding AIDS Waiver services to service coordination staff.

MC+ Outreach

Health Plan contracts require that the health plan must have an established process for reminders, follow-ups, and outreach to members. This process shall include notifying children of upcoming periodic screenings according to a periodicity schedule established by the state agency. The current schedule is contained in Attachment 8. At the time of notification, the plans must offer transportation and scheduling assistance and provide this assistance if necessary. The health plan shall submit to the state a quarterly report that identifies its performance regarding:

- (a) Written notification of upcoming or missed key points of contact within a set time period, taking into consideration language and literacy capabilities of members.
- (b) Telephone protocols to remind members of upcoming visits and follow-up on missed appointments within a set time period.
- (c) Protocols for conducting outreach with non-compliant members, including home visits, as appropriate.

ATTACHMENT 5

care coverage to uninsured kids, and there are millions of kids who are eligible who have just not **signed up** for the program.” A number of reasons might explain the failure of children being enrolled in Medicaid:

- many parents don't realize their children are eligible for Medicaid;
- some families are daunted by a complex set of rules and application forms; and
- some families don't want to be a part of a welfare-type program.

Missouri Medicaid and Outreach. Staffmembers of MHA, the Division of Medical Services and the Division of Family Services met recently to outline joint initiatives related to Medicaid outreach. We are exploring two options for action:

- publishing the Medicaid application on the Internet; and
- developing a screening protocol to be used to help hospital employees screen patient information of adult patients in the hospital to determine whether they have children at home who are uninsured and eligible for Medicaid.

Missouri Congressional Delegation to Remain at Current Size. According to the Census Bureau's new state population estimates, Texas will gain two congressional seats and seven other states will gain one seat. Eight states will lose a congressional seat. So far, Missouri is unaffected by the shifting of population from the Northeast to the South and Southwest.

Next Week Next week, we again will be reporting on a full range of federal and state policy developments and legislative activity. You will find **Legislative Lookout** included in next week's mailing as the Missouri General Assembly convenes on **January 7**. We look forward to working with you in the new year to help you improve the health status of your communities. (Fine)

CDC PUBLISHES REVISED IMMUNIZATION RECOMMENDATIONS

The Centers for Disease Control and Prevention (CDC) published in the December 26, 1997, Morbidity and Mortality Weekly Report recommendations for IMMUNIZATION OF HEALTH CARE WORKERS. This report summarizes recommendations of the Advisory Committee on Immunization Practices on using certain immunizing agents on health care workers in the United States. It was prepared in consultation with the Hospital Infection Control Practices Advisory Committee (HICPAC) and is consistent with current HICPAC guidelines for infection control in health care personnel.

CDC believes these recommendations can assist hospital administrators, infection control practitioners, employee health physicians, and health care workers in optimizing infection prevention and control programs. Background information for each vaccine-preventable disease and specific recommendations for use of each vaccine are presented.

- **Is Caring Communities creating a new bureaucracy at the state or community level?**
 - * No. Locally, **Caring Communities** brings together the many stakeholders and existing entities in a community to develop more effective and efficient **integrated solutions** to complex problems.
 - * At the state level, **seven** state agencies are working together and with communities to reduce fragmentation, duplication and get better results. The seven state agencies jointly engage in strategic planning, budgeting, training and evaluation.
- **How many Community Partnerships and Caring Communities sites are there?**

There are 14 community partnerships whose sphere of influence has the potential to impact 56% of the state's population. There are 87 Caring Communities school/neighborhood sites. The state agencies are working with seven additional counties to develop Community Partnerships.
- **Does Caring Communities burden schools when they should be focusing on educating children?**

No. Quite the opposite. Surveys show that school personnel view Caring Communities as an effective way to reduce the burden placed on schools giving them greater ability to focus on teaching. The surveys also reveal increased parental involvement, greater respect for teachers, increased community resources for the school and positive changes in their neighborhood.
- **How are Community Partnership areas selected?**

The state agencies jointly perform an assessment of need and capacity indicators by county. Counties that are identified with the greatest need and capacity are invited to develop a community partnership and to enter into an agreement with the state agencies to improve six core results.
- **How are Caring Communities sites selected?**

The state agencies have minimum criteria for sites. Community partnerships may add additional criteria. Community partnerships conduct an assessment of need and capacity and recommend potential school/neighborhood sites to the state agencies. Communities and state agencies agree together on sites for designation.
- **What is the process for determining funding allocations and distributing Caring Communities funding?**

State agencies allocate funds through a funding formula. The formula now in effect is: *Total student population of largest district in the county X .20 X 400.*
- **What dollars support Caring Communities?**

Caring Communities is supported by a \$22.4 million state appropriation. The original source for the \$22.4 million dollar state appropriation was federal earnings from child welfare. Community plans to achieve the six core results are also supported by local investments with at least one in five dollars spent in FY97 being from local sources. Funds flow from the state agencies to the fiscal agent of the Community Partnership. Statewide, 80% of the Caring Communities dollars support services, and 20% fund technical assistance and administrative oversight.
- **How many children are being served?**

Nearly 40,000 children. However, Caring Communities serves the entire family rather than the child only. Many activities serve entire neighborhoods.

- **How are results being measured?**
 - * An independent evaluation protocol is in place.
 - * The **state agencies and communities** have agreed to **18 benchmarks**. Data is **being tracked** on multiple levels: statewide, at the community level (by zip code), within the **targeted schools** and **among core participants**.
 - * A baseline process study **has** been condumnd by the Center for the Study of **social** Policy.
 - * Communities are **engaging in** additional independent evaluations.
- **what has been accomplished? What results have been documented?**

Conditions are changing for the better for children and youth in Caring Communities (and are getting better faster than in the rest of the state) as reflected by the following:

Of the seven benchmarks for **which** data have been collected for more than one year:

Between FY96 and 97:

- ◆ **Substantiated child abuse and neglect** decreased **5% statewide**, bur **7% in Caring Communities neighborhoods**.
- **New commitments for delinquency** increased statewide but decreased **20% in Caring Communities neighborhoods**
- + **Recommitments for delinquency** decreased **4% statewide** bur decreased **43% in Caring Communities neighborhoods**.

Between FY95 and 96:

- ◆ **Hospital treatment** due to injuries decreased **3% statewide** but decreased **6% in Caring Communities neighborhoods**.
- ◆ **Preventable hospitalizations** decreased **16% statewide** but decreased **24% in Caring Communities neighborhoods**.

See the Key Strategies by Core Result document regarding activities which contributed to these improvements.

Benchmark data show that Caring Communities are currently in the neighborhoods with the highest needs, in the schools with the highest needs, working with the children with the highest needs. This suggests that Caring Communities have been targeted where they are most needed

Other Significant Accomplishments:

- ◆ **Increased employment**- from 95-97 Kansas City's welfare to work initiative moved **1342 individuals from welfare to work** that **have not returned to welfare**.
- ◆ **Increased parental and community involvement** as documented through evaluative surveys.
- **Based on independent case studies**, the quantity of **available services and supports to families in Caring Communities has been greatly improved**.
- ◆ Based on independent cases **studies**, community engagement in decision making **has been greatly** enhanced. Thousands of **volunteers** are engaged in neighborhood **and** community decision making and development.
- ◆ Schools are serving as centers of community.
- ◆ Blending of **state and local and public and private resources**; at least one of five dollars spent in FY97 came from local sources.
- ◆ **Academic achievement scores have improved in several sites**.



ISSUE: HEALTH CARE FOR CHILDREN AND FAMILIES

Goal *Optimize the access to and the quality of health care services.*

Outcome #3 <i>(What do we want to achieve?)</i>	<ul style="list-style-type: none">◆ Maximize cost avoidance in delivering health care services.
Outcome Measure <i>(How will we measure success?)</i>	<ul style="list-style-type: none">◆ \$92 million in cost avoidance statewide by the year 2000◆ Number of MC+ recipients
Objective <i>(What will we do?)</i>	<ul style="list-style-type: none">◆ Move traditional fee-for-service payments into a managed care environment.
Strategies <i>(How will we achieve our objectives?)</i>	<ul style="list-style-type: none">◆ Rollout MC+ in the remaining areas of the state.◆ Children's Behavioral Wealth Initiative -- An inter-departmental team (DESE, DSS, DOH, DMH, and consumers) has received a grant from the Robert Wood Johnson Foundation to study and pilot an interagency comprehensive system of care for children with severe disabilities and persistent mental health needs. The initiative will be piloted in St. Louis and Central Missouri in the spring of 1998.◆ Develop transitional models for areas of the state where access to health care is an issue such as Primary Care Case Management.◆ Reduce the state's reliance on disproportionate share funding by expanding medical coverage for the uninsured.

ATTACHMENT 6

STRATEGIC PLAN Missouri Department of Social Services Fiscal Year 1999

ISSUE: HEALTH CARE FOR CHILDREN AND FAMILIES

Goal Optimize the access to and the quality of health care services.

<p>Outcome #2 <i>(What do we want to achieve?)</i></p>	<ul style="list-style-type: none"> ◆ Show Me Result -- Increase the percent of Missourians with health insurance.
<p>Outcome Measure <i>(How will we measure success?)</i></p>	<ul style="list-style-type: none"> ◆ An additional 70,000 children receiving health care services by the year 2000.
<p>Objective <i>(What will we do?)</i></p>	<ul style="list-style-type: none"> ◆ Provide expanded medical coverage for children and parents transitioning from welfare to work.
<p>Strategies <i>(How will we achieve our objectives?)</i></p>	<ul style="list-style-type: none"> ◆ Medicaid Expansion -- Targeted Medicaid Waiver Initiative for working parents (1115 Waiver) ◆ Children's Health Initiative

ATTACHMENT 7

PLAN REPORTED MC - QUALITY INDICATORS

<i>EASTERN/CENTRAL REGIONS: SECOND YEAR</i>	
GENERAL REQUIREMENTS: (QUARTERLY REPORTS)	
1.	Complaints and grievances with resolutions.
2.	Number and reasons for transfers among PCPs
HEDIS REQUIREMENTS: (ANNUAL REPORTS)	
3.	(H) Childhood Immunization Status (2 year old)
4.	(H) Adolescent Immunization Status
5.	(H) Well child Visits in the First 15 Months of Life
6.	(H) Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
7.	(H) Adolescent Well-Care Visits
8.	(H) Cervical Cancer Screening
9.	(H) Follow-up after hospitalization for mental illness.
10.	(H) Check-ups After Delivery
11.	(H) Annual dental visit
12.	(H) Ambulatory Care
13.	(H) Mental Health Utilization - Percentage of Members Receiving IP/Day/Night Care and Ambulatory Service
OTHER DATA: (ANNUAL REPORTS)	
14.	Monitoring of 24 hour coverage.
15.	Member Satisfaction Survey (State Provided)
16.	Chemical Dependency Utilization - Percentage of Members Receiving IP/Day/Night Care and Ambulatory Service
17.	Sentinel Events (Occurrences)

PLA' \TA COLLECTION REQUIREMENTS: HEDIS ators will be collected in accordance with HEL ,0 guidelines for the numerators and denominators. The plan must indicate which method, hybrid or administrative, **was** utilized to collect the data.. The reporting schedule is as follows:

1. All indicators will be collected for the 1997 calendar year. The data collection period **is** January 1, 1997 through December 31, 1997.
2. The reports are due June 30, 1998.
3. Indicator 16 will be collected in accordance with the HEDIS indicators with one exception, the requirement for continuous enrollment has been omitted.

QUALITY INDICATORS	
DMS INTERNAL DATA SOURCES:	
1.	Complaints and grievances.
2.	Number and reasons for transfers between plans and disenrollments.
DOH DATA SOURCES:	
3.	(H) Adolescent Immunization Status
4.	(H) Well child Visits in the First 15 Months of Life
5.	Number of enrollees seeking initial prenatal care visit during: <ul style="list-style-type: none"> a. Preconception b. First trimester c. Second trimester d. Third trimester
6.	Birth weight - total number of births by weight category for each live birth. <ul style="list-style-type: none"> ◆ <500 Gms. _____ ◆ 500-1499 Gms. _____ ◆ 1500-1999 Gms. _____ ◆ 2000-2499 Gms. _____ ◆ ≥2500 Gms. _____ ◆ Stillborn fetuses _____
7.	All delivered single or multiple live or still born fetus(es) of greater than or equal to 22 weeks gestation.
8.	Pregnancy outcome <ul style="list-style-type: none"> a. Fetal loss >29 weeks b. Number of live births by: type of birth (cs, vbac, vaginal)
9.	Total number of members provided prenatal care.

QUALITY INDICATORS

- | | |
|-----|---|
| 10. | Sexually Transmitted Diseases -
a. Chlamydia - ICD 099.53
b. Gonorrhea - ICD 091.0
c. Syphilis - ICD 98.0 and 97.9 |
| 11. | Percent of pregnant women on WIC |
| 12. | Number of Acute inpatient behavioral health and average length of stay |
| 13. | Inadequate Prenatal Care |
| 14. | Smoking During Pregnancy |
| 15. | Spacing <18 months since last birth |
| 16. | Births to mothers <18 years of age |
| 17. | Family Planning Opportunities |

ATTACHMENT 8

MISSOURI DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL SERVICES

☆ QUALITY 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:

MISSOURI CARING COMMUNITIES

Facts and Frequently Asked Questions

■ What is the Family Investment Trust?

The Family Investment Trust (FIT) is a state level public-private partnership created in 1993 by executive order. The executive order charged FIT with developing measures with state agencies to improve conditions for children and families and with assisting local communities in establishing collaborative processes. The FIT Board is comprised of the directors of the Departments of Corrections, Economic Development, Elementary and Secondary Education, Health, Labor and Industrial Relations, Mental Health, and Social Services, and private sector members appointed by the Governor. The Family Investment Trust provides a vehicle for the state agencies to work together and with the private sector. Community Partnerships and Caring Communities are key elements of the strategic plan to improve systems to achieve better results.

• What is Caring Communities?

Caring Communities is a school-linked/school-based process whereby integrated systems are designed, developed and monitored through a partnership among families, schools and local citizens to improve six core results.

• What is a Community Partnership?

A Community Partnership is a broadly representative county or multi-county governance structure that accepts sustained responsibility for the planning, development and financing of integrated systems to improve six core results for children and families. The Community Partnership works collaboratively with seven state agencies and functions as the parent board for the Caring Communities sites.

• What are the six core results of Caring Communities?

- * Parents working
- * Children safe in their families and families safe in their communities
- * Young children ready to enter school
- * Children and families that are healthy
- * Children and youth succeeding in school
- * Youth ready to enter the work force and become productive citizens

• What does the recent addition of the Departments of Corrections and Economic Development bring to the partnership?

The Department of Corrections provides another important level of support to the core results of parents working and children and families safe through its commitment to improving public safety, developing effective community interventions, establishing cooperative efforts through partnerships and preparing offenders to be productive citizens.

The Department of Economic Development is charged with making Missouri a world class place to live and work by creating and sustaining economic security and opportunity, fostering self-sufficient communities and ensuring the high-quality of essential services. The Department will work with Caring Communities to create an economically prosperous environment, which in turn will create more self-sufficient communities consisting of strong families and successful children.

ATTACHMENT 9

**Funding Sources for Missouri's CHIP
Program through the 1115 Waiver
Five Year Projection**

Title XXI Children Medical Costs	General Revenue	Provider Tax	Federal Funds	Total Funds
Year One	\$9,187,854	\$15,151,690	\$63,118,394	\$87,457,938
Year Two	\$9,787,058	\$16,139,460	\$67,233,806	\$93,160,324
Year Three	\$10,527,331	\$17,359,779	\$72,318,102	\$100,205,212
Year Four	\$11,310,098	\$18,650,147	\$77,694,248	\$107,654,493
Year Five	\$12,157,368	\$20,046,847	\$83,513,410	\$115,717,625

02/12/98

Missouri Medicaid 1115 Waiver Amendment

Year 1 with the Waiver-Title XXI Children

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$29,500,398	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$540,585	N/A
Total Member Months		N/A	270,808	N/A
Per Capita (=TE/TMM)		N/A	\$110.93	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$6,818,458	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$120,338	N/A
Total Member Months		N/A	60,273	N/A
Per Capita (=TE/TMM)		N/A	\$115.12	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$16,647,957	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$289,655	N/A
Total Member Months		N/A	145,077	N/A
Per Capita (=TE/TMM)		N/A	\$116.75	N/A

Northwest Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$3,491,653	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$65,778	N/A
Total Member Months		N/A	32,946	N/A
Per Capita (=TE/TMM)		N/A	\$107.98	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$15,142,228	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$263,458	N/A
Total Member Months		N/A	131,956	N/A
Per Capita (=TE/TMM)		N/A	\$116.75	N/A

Remainder of the State

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$15,857,244	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$280,858	N/A
Total Member Months		N/A	140,671	N/A
Per Capita (=TE/TMM)		N/A	\$114.72	N/A

Statewide Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$87,457,938	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	1,560,772	N/A
Total Member Months		N/A	781,729	N/A
Per Capita (=TE/TMM)		N/A	\$113.87	N/A

Year 1 with the Waiver-Working Parents with Children

East Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$2,329,403	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$38,144	N/A
Total Member Months		N/A	19,105	N/A
Per Capita (=TE/TMM)		N/A	\$123.92	N/A

Central Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$543,333	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$8,490	N/A
Total Member Months		N/A	4,252	N/A
Per Capita (=TE/TMM)		N/A	\$129.78	N/A

West Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$1,592,423	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$20,435	N/A
Total Member Months		N/A	10,235	N/A
Per Capita (=TE/TMM)		N/A	\$157.58	N/A

Northwest Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$288,674	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$4,640	N/A
Total Member Months		N/A	2,324	N/A
Per Capita (=TE/TMM)		N/A	\$126.20	N/A

Southwest Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$1,448,396	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$18,586	N/A
Total Member Months		N/A	9,309	N/A
Per Capita (=TE/TMM)		N/A	\$157.58	N/A

Remainder of the State

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$1,405,946	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$19,814	N/A
Total Member Months		N/A	9,924	N/A
Per Capita (=TE/TMM)		N/A	\$143.67	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$7,608,175	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	110,109	N/A
Total Member Months		N/A	55,149	N/A
Per Capita (=TE/TMM)		N/A	\$139.95	N/A

Missouri Medicaid 1115 Waiver Amendment

Year 1 with the Waiver-Missouri Parents' Fair Share Program

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$93,404	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$1,529	N/A
Total Member Months		N/A	766	N/A
Per Capita (=TE/TMM)		N/A	\$123.92	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$21,786	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$340	N/A
Total Member Months		N/A	170	N/A
Per Capita (=TE/TMM)		N/A	\$129.78	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$63,853	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$819	N/A
Total Member Months		N/A	410	N/A
Per Capita (=TE/TMM)		N/A	\$157.58	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$11,575	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$186	N/A
Total Member Months		N/A	93	N/A
Per Capita (=TE/TMM)		N/A	\$126.20	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$58,077	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$745	N/A
Total Member Months		N/A	373	N/A
Per Capita (=TE/TMM)		N/A	\$157.58	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$56,375	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$794	N/A
Total Member Months		N/A	398	N/A
Per Capita (=TE/TMM)		N/A	\$143.67	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$305,070	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	4,415	N/A
Total Member Months		N/A	2,211	N/A
Per Capita (=TE/TMM)		N/A	\$139.95	N/A

Year 1 with the Waiver-Low Income Uninsured Non-Custodial Parents

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$3,317,964	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$54,332	N/A
Total Member Months		N/A	27,213	N/A
Per Capita (=TE/TMM)		N/A	\$123.92	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$773,915	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$12,092	N/A
Total Member Months		N/A	6,057	N/A
Per Capita (=TE/TMM)		N/A	\$129.78	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$2,268,222	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$29,107	N/A
Total Member Months		N/A	14,578	N/A
Per Capita (=TE/TMM)		N/A	\$157.58	N/A

Northwest Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$411,183	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$6,610	N/A
Total Member Months		N/A	3,311	N/A
Per Capita (=TE/TMM)		N/A	\$126.20	N/A

Southwest Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$2,063,072	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$26,474	N/A
Total Member Months		N/A	13,260	N/A
Per Capita (=TE/TMM)		N/A	\$157.58	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$2,002,608	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$28,223	N/A
Total Member Months		N/A	14,136	N/A
Per Capita (=TE/TMM)		N/A	\$143.67	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$10,836,965	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$56,838	N/A
Total Member Months		N/A	78,554	N/A
Per Capita (=TE/TMM)		N/A	\$139.95	N/A

Missouri medicaid 1115 Waiver Amendment

Year 1 with the Waiver-Low Income Uninsured Custodial Parents

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$23,331,482	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$382,055	N/A
Total Member Months		N/A	191,356	N/A
Per Capita (=TE/TMM)		N/A	\$123.92	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$5,442,064	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	585,032	N/A
Total Member Months		N/A	42,589	N/A
Per Capita (=TE/TMM)		N/A	\$129.78	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$15,949,836	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	4	N/A
Total Member Months			3	N/A
Per Capita (=TE/TMM)			\$157.58	N/A

Northwest Reaion

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$2,891,386	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	646,479	N/A
Total Member Months		N/A	23,280	N/A
Per Capita (=TE/TMM)		N/A	\$126.20	N/A

Southwest Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$14,507,249	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$186,162	N/A
Total Member Months		N/A	93,241	N/A
Per Capita (=TE/TMM)		N/A	\$157.58	N/A

Remainder of the State

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$14,082,069	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$198,458	N/A
Total Member Months		N/A	99,400	N/A
Per Capita (=TE/TMM)		N/A	\$143.67	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$76,204,086	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	1,102,881	N/A
Total Member Months		N/A	552,380	N/A
Per Capita (=TE/TMM)		N/A	\$139.95	N/A

Year 1 with the Waiver-Uninsured Women Losing Medicaid Eligibility

East Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$2,371,875	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$80,356	N/A
Total Member Months		N/A	130,402	N/A
Per Capita (=TE/TMM)		N/A	\$20.19	N/A

Central Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$527,897	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$57,946	N/A
Total Member Months		N/A	29,023	N/A
Per Capita (=TE/TMM)		N/A	\$20.19	N/A

West Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Expenditures	DSH	N/A	N/A	N/A
	Admin	N/A	\$139,477	N/A
Total Member Months		N/A	69,859	N/A
Per Capita (=TE/TMM)		N/A	\$20.19	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$288,554	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$31,674	N/A
Total Member Months		N/A	15,864	N/A
Per Capita (=TE/TMM)		N/A	\$20.19	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A		
	DSH	N/A		
	Admin	N/A		
Total Member Months		N/A	\$126,862	N/A
Per Capita (=TE/TMM)		N/A	63,540	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$1,232,065	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$135,241	N/A
Total Member Months		N/A	67,737	N/A
Per Capita (=TE/TMM)		N/A	\$20.19	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Expenditures	DSH	N/A	N/A	N/A
	Admin	N/A	751,555	N/A
Total Member Months		N/A	376,425	N/A
Per Capita (=TE/TMM)		N/A	\$20.19	N/A

Missouri Medicaid 1115 Waiver Amendment

Year 1 with the Waiver-Maternity Benefits

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$1,270,909	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$706	N/A
Total Member Months		N/A	354	N/A
Per Capita (=TE/TMM)		N/A	\$3,597.08	N/A

		Service Only	Capitated	System
Total Expenditures	Medical	N/A	\$319,656	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$157	N/A
Total Member Months		N/A	79	N/A
Per Capita (=TE/TMM)		N/A	\$4,064.74	N/A

West Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$583,122	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$378	N/A
Total Member Months		N/A	189	N/A
Per Capita (=TE/TMM)		N/A	\$3,081.05	N/A

Northwest Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$109,655	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$86	N/A
Total Member Months		N/A	43	N/A
Per Capita (=TE/TMM)		N/A	\$2,551.68	N/A

Southwest Region

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$530,381	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$344	N/A
Total Member Months		N/A	172	N/A
Per Capita (=TE/TMM)		N/A	\$3,081.05	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$611,229	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	\$367	N/A
Total Member Months		N/A	184	N/A
Per Capita (=TE/TMM)		N/A	\$3,330.56	N/A

		Fee-For-Service Only	Fully Capitated	PCCM System
Total Expenditures	Medical	N/A	\$3,424,952	N/A
	DSH	N/A	N/A	N/A
	Admin	N/A	2,037	N/A
Total Member Months		N/A	1,020	N/A
Per Capita (=TE/TMM)		N/A	\$3,358.24	N/A